The Leadership Trinity: Examining the Interplay Between Healthcare Organisational Context, Collective Leadership and Leadership Effectiveness in the Health Sector - A Multiple Case Study of District Hospitals in the Western Cape Province, South Africa.

Dr Dickson Rodney Otieno Okello

Thesis Presented for the Degree of

DOCTOR OF PHILOSOPHY IN PUBLIC HEALTH

in the Department of Public Health and Family Medicine

Faculty of Health Sciences

UNIVERSITY OF CAPE TOWN

2021

Supervisors:

Professor Lucy Gilson: Health Policy and Systems Division, University of Cape Town, South Africa.

Professor Gerry McGivern: Organisation and Human Resource Management (OHRM) Group at Warwick Business School, University of Warwick, United Kingdom.

University of Cape Town

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

University of Cape Town

FESTINA LENTE

Dedication

To my son **Jabali Sean Droo Okello** for enduring my absence as I completed the doctoral journey

Abstract

To address the current leadership challenges within the South African health system, it is important to understand what influences the nature and practice of leadership within healthcare organisations. This thesis presents research about the interlinkages between context, leadership practices and staff satisfaction and morale – as indicators of leadership effectiveness - in district hospitals. The study represents one of the few detailed empirical inquiries into these issues in South Africa and adds to the still limited body of relevant empirical evidence in low- and middle-income countries.

The research specifically drew on organisational and leadership theory to shape its strategies of data collection and analysis. It was conducted in two case study, district-level, hospitals. Multiple sources of data were collected, including document reviews, non-participant observations, and in-depth qualitative interviews. Data from staff satisfaction surveys carried out separately from this study were also considered. The in-depth interviews involved the three broad cadres of clinical, nursing, and administrative staff working within the hospitals, including those with and without formal managerial roles. Thematic analysis was applied in analysing experience in each case study hospital and also in cross-case analysis. This analysis involved iterative inductive, deductive, and abductive processes.

The thesis generates insights about the leadership practices experienced in the case study hospitals that may both engender (positive practices) or undermine (negative practices) staff satisfaction and morale. Positive leadership practices also nurtured the collective leadership that itself enhanced teamworking and influenced the hospital context to spread collective leadership more widely. These leadership practices were, in turn, influenced by contextual elements internal and external to the hospital, some of which themselves had possible consequences for staff satisfaction and morale. Critical features of hospital external context included hospitals' histories and backgrounds, as well as the wider bureaucratic context of rigidity in which they are situated. Key features of hospital internal context influencing collective leadership were, meanwhile, internal power structures and processes, professional identity, and cross-professional relationships.

This analysis of the interactions between hospital context, collective leadership and staff satisfaction and morale illuminates the complex dynamics of hospitals. This *Leadership Trinity* offers insights of relevance to health system reform in South Africa,

and more specifically, to implementation of current National Health Insurance proposals.

Acknowledgements

I owe much appreciation to my supervisors, Professors Lucy Gilson, and Gerry McGivern, without whose guidance, inspiration, encouragement, and endless support this research and thesis would never have been planned, carried out, analysed, and written. Prof Gilson's tremendous intellectual and material contributions throughout the research, was pivotal from the conceptualisation to the final product. In the same light, Professor McGivern's guidance in analysis and interpretive approaches, in addition to providing space and resources at Warwick Business School, contributed to new ways of looking at the data. I wish to make special thanks to the professors and researchers whose intellectual discussions, while I spent time at Warwick Business School, contributed immensely to the reflective interpretations of the data. I hereby express my appreciation to them.

I also want to express my appreciation and gratitude to the Chief Executive Officers, managers and respondents who participated in the study, for granting me permission and access to their hospitals. Without their corporation, this research would not have been conducted timeously and accordingly to meet the expected ethical standards.

Comments and suggestions provided by staff and colleagues at University of Cape Town's Health Policy and Systems Division and Health Economics Unit, and the Collaboration for Health Systems Analysis and Innovation (CHESAI) were particularly important during the proposal phase and initial analysis of the research. I thank them for their insightful suggestions, comments, and queries. Particularly, CHESAI offered material support through direct scholarship and facilitation to attend conferences, workshops, and PhD and academic retreats. Specific and special mentions and thanks to Emeritus Professor Di McIntyre, through The South African Research Chairs Initiative (SARChI), for her material support for the first three years of the research.

It would be very remiss of me to forget the financial support from Africa Population Health Research Centre (APHRC) through the African Doctoral Dissertation Research Funding (ADDRF), in addition to facilitating my participation in the Methodology and Analysis Workshops in Nairobi, Kenya.

Finally, special thanks to my brother Nicholas and his wife Eunice, and my sister Christine for their moral support. My friends Daniel Munene, Dr Erick Bunyasi, Uchenna Igwe, Dr Chinwe Obuaku, Caleb Omondi, and Lilian Muthoni Ndonga, your morale-boosting endeavours during the journey are acknowledged. Also, thanks to The Ng'ang'a Family (Chris, Shiru, Rehema and Maisha) for their support in the final

year of writing the thesis – not forgetting the furry trio of Asante, Tima and Zuri who kept me company during the writing. Nomathibana Ziyanda Okello (née Matshoba), your unfaltering encouragement was pivotal in the completion of this doctoral journey – I am highly grateful to you for nudging me on.

Plagiarism Declaration

Name: Dickson Rodney Otieno Okello

Student Number: OKLDIC001

Course: PPH 7055W Public Health thesis

Declaration

I know that plagiarism is wrong. Plagiarism is to use another's work and pretend that it is one's own.

I have used the American Psychological Association 6th Edition convention for citation and referencing. Each contribution to, and quotation in, this thesis from the work(s) of other people has been attributed and has been cited and referenced.

This thesis is my own work.

I have not allowed and will not allow anyone to copy my work with the intention of passing it off as his or her own work.

Signed by candidate

Signature ________________________________

Date ____**01/03/2021**________________________

Table of Contents

Dedication i

Abstract ii

Acknowledgements iv

Plagiarism Declaration vi

Table of Contents vii

List of Figures xii

List of Tables xii

List of Text Boxes xiv

List of Acronyms and Abbreviations xiv

Glossary of Terms xvi

Chapter 1: Introduction to the Leadership Trinity Study 1

1.0 Introduction 1

1.1 The Rationale for a study on hospital context and leadership 2

1.1.1 Hospitals and leadership in the LMIC health systems 2

1.1.2 Healthcare leadership in South African health system and hospitals 4

1.2 The knowledge contribution of this research 6

1.3 Research questions and objectives, and thesis outline 7

1.3.1 Research Question 7

1.3.2 Research aim and specific objectives 7

1.3.3 Thesis outline 8

1.4 Chapter Summary 9

Chapter 2: Literature Review 11

2.0 Introduction 11

2.1 Approaches to the search and identification of relevant literature 11

2.2 Leadership in LMIC health systems, hospitals, and other organisations 14

2.3 Methodological Gaps in the Empirical Leadership Literature 20

2.4 Chapter Summary 20

Chapter 3: Definition of Terms and Conceptualizing the Leadership Trinity Framework 22

3.0 Introduction 22

3.1 Theoretical Foundation for this Study on the Interrelationships between Context and Leadership 22

3.2 Understanding Leadership as a Situated and Collective Practice 23

3.3 Healthcare Organisational Effectiveness and Staff Satisfaction and Morale 25

3.4 Understanding Health Care Organisational Context 26

3.4.1 External Organisational Context 28

3.4.2 Internal Organisational Context 29

3.5 Chapter Summary 31

Chapter 4: Research Methodology and Study Design 33

4.0 Introduction 33

4.1 Ontological and Epistemological Standpoints 33

4.2 Research Method and Study Design 34

4.2.1 Case Study Design 35

4.2.2 Description of Cases and Study Settings 35

4.3 Approaches to Data Collection and Data Sources 36

4.3.1 Document Reviews 38

4.3.2 Hospitals' Routine Data – Staff Satisfaction Survey 40

4.3.3 Non-Participant Observation 41

4.3.4 In-depth Interviews 42

4.3.5 Journaling/Researcher Diary 45

4.3.6 Data Management, Safety and Monitoring 46

4.4 Data Analysis 46

4.4.1 Unit of analysis 48

4.4.2 Data Transcription, Coding and Within-Case Analysis 49

4.4.3 Cross-Case Analysis 52

4.5 Study Rigour and Trustworthiness 53

4.6 Research Ethics and Approvals 56

4.6.1 Access and Approvals 56

4.6.2 Anonymity 56

4.6.3 Informed Consent Process, Privacy and Confidentiality 57

4.7 Study and methodological limitations 58

4.8 Chapter summary 58

Chapter 5: South Africa and the Western Cape – Key Contextual Factors Influencing the Public Healthcare System 60

5.0 Introduction 60

5.1 Key South African Governance, Health and Health Care Features 60

5.2 National and Provincial Policymaking and Critical Health Policy Directions 63

5.3 The Western Cape province and its Health System 66

5.4 Strategies for Leadership and Management Development 72

5.5 Human Resource Management Processes 74

5.6 Chapter Summary 76

Chapter 6: Findings from District Hospital A 78

6.0 Introduction 78

6.1 Hospital overview and history 78

6.1.1 Hospital setting and overview 78

6.1.2 The history of downgrading and budgetary pressures 79

6.2 Transitions and experience in hospital leadership 81

6.2.1 Hospital structures, processes, and leadership transitions 81

Human resource processes, guidelines, and policy frameworks 84

6.2.2 Leadership practices and experience in DHA 85

6.2.3 The morale of staff in DHA 93

Factors that influence staff satisfaction and morale 93

Variation between cadres 99

6.3 Organisational context and its influence over leadership experience in DHA 101

6.3.1 DHA's Internal hospital context 102

6.3.2 DHA's External hospital context 109

6.4 Chapter summary 115

Chapter 7: Findings from District Hospital B 116

7.0 Introduction 116

7.1 Hospital overview and history 116

7.1.1 Basic overview 116

7.1.2 Commissioning experience 117

7.1.3 Hospital budget – "More to do with less" 119

7.2 The experience of leadership in DHB 121

7.2.1 Core structures, processes, and relationships 121

Organisational relationships 125

7.2.2 The practice of leadership in the hospital 126

7.2.3 Staff morale in DHB 132

Influences over staff morale 132

Variation between cadres 138

7.3 Organisational context and its influence over leadership experience in DHB 141

7.3.1 DHB's Internal hospital context 142

7.3.2 DHB's External hospital context 151

7.4 Chapter Summary 154

Chapter 8: Cross-Case Analysis of the District Hospitals 156

8.0 Introduction 156

8.1 Leadership practices and experiences of collective leadership across hospitals 158

8.2 Hospital histories 165

8.3 Influences of bureaucratic rigidity and managerial hierarchies on leadership practices 170

8.3.1 External Bureaucratic context 170

8.3.2 Structures and processes of power as internal hospital context 176

8.3.3 Nursing hierarchies 182

8.4 Professional identities 185

8.5 Cross-professional relationships in the hospitals 190

8.6 Chapter Summary 198

Chapter 9: Discussion; Policy and Research Implications, Study Limitations and Directions for Future Research 200

9.0 Introduction 200

9.1 Hospital context and leadership practices 200

9.1.1 Overall experience 200

9.1.2 Context and cross-professional relationships 203

9.2 Hospital leadership practices and organisational performance 205

9.2.1 Collective leadership 205

9.2.2 Staff satisfaction and morale 208

9.3 The (largely) constraining influence of bureaucratic context on hospital leadership 209

9.4 Policy-relevant implications 211

9.4.1 Strengthening collective leadership within hospitals 212

9.4.2 Leadership development 214

9.5 Study Limitations 216

9.6 Directions for future research 218

9.7 Chapter summary 219

Chapter 10: Concluding Statements 222

10.1 The relevance of the thesis for health system development in LMICs 222

10.2 Epilogue - Researcher reflexive statement 223
References *225*
Annexures *257*
Annexure 1: Staff Satisfaction Survey 2016 Findings for DHA 257
Annexure 2: Staff Satisfaction Survey 2016 Findings for DHB 277
Annexure 3: Observation Topic Guide 299
Annexure 4: Interview Topic Guide 300
Annexure 5: UCT Human Research Ethics Committee Approval Letter 305
Annexure 6: Approval Letter from District Hospital A 306
Annexure 7: Approval Letter from District Hospital B 307
Annexure 8: Approval Letter from Western Cape Department of Health 308
Annexure 9: Informed Consent, Privacy and Confidentiality 309

List of Figures

Figure 1.1: Overall research process and thesis outline [Page 9]

Figure 3.1: A Framework for Health Care Organisational Context, Leadership Practices, and Leadership Effectiveness: Staff Satisfaction and Morale [Page 32]

Figure 4.1: Approaches to data collection [Page 37]

Figure 4.2: Iterative data analysis process for each hospital case [Page 49]

Figure 5.1: Cape Metro Health District boundary [Page 70]

Figure 6.1: DHA's real Budget and Expenditure against Metro District averages for 2014/15 to 2018/19 Financial Years, 2015/16 prices [Page 80]

Figure 6.2: Main DHA staff reporting lines [Page 82]

Figure 6.3: Positive leadership practices that promote staff satisfaction and morale in DHA [Page 86]

Figure 6.4: Negative leadership practices that undermine staff satisfaction and morale in DHA [Page 90]

Figure 6.5: Interlinkage between leadership practices and staff satisfaction and morale in DHA [Page 92]

Figure 6.6: Interaction between context, leadership practices and staff satisfaction and morale in DHA [Page 102]

Figure 6.7: Interaction between external context, internal context, and leadership practices in DHA [Page 110]

Figure 7.1: DHB's real Budget and Expenditure against Metro District averages for 2014/15 to 2018/19 Financial Years, 2015/16 prices [Page 120]

Figure 7.2: Main DHB staff reporting lines [Page 121]

Figure 7.3: Positive leadership practices that promote staff satisfaction and morale in DHB [Page 127]

Figure 7.4: Negative leadership practices that undermine staff satisfaction and morale in DHB [Page 130]

Figure 7.5: Interaction between context and leadership practices in DHB [Page 142]

Figure 7.6: Interaction between external context, internal context, and leadership practices in DHB [Page 152]

Figure 8.1: Representation of the interplay in cross-case analysis [Page 157]

Figure 8.2*:* Hospital power structure and hierarchy [Page 177]

List of Tables

Table 2.1: Inclusion and exclusion criteria [Page 13]

Table 4.1: List of documents reviewed [Page 39]

Table 4.2: Breakdown of respondents in DHA [Page 43]

Table 4.3: Breakdown of respondents in DHB [Page 43]

Table 4.4: Steps for rigour and trustworthiness at each hospital [Page 53]

Table 5.1: Mid-year population estimates for South Africa, 2015 to 2018 [Page 62]

Table 5.2: Population Distribution by District [Page 66]

Table 5.3: Social Determinants of Health in the Cape Town Metropole Region [Page 67]

Table 5.4: Western Cape Department of Health Facilities [Page 68]

Table 5.5: Provincial Health Budget against the Total Provincial Budget [Page 69]

Table 6.1: Factors associated with high or positive staff satisfaction and morale in DHA [Page 93]

Table 6.2: Factors associated with low or negative staff satisfaction and morale in DHA [Page 94]

Table 6.3: Examples of intrinsic factors for staff satisfaction and morale in DHA [Page 95]

Table 6.4: Leadership practices and collegial relationships in DHA [Page 96]

Table 6.5: DHA Physical design [Page 97]

Table 6.6: Performance management and skills development issues in DHA [Page 98]

Table 6.7: Workload and resourcing in DHA [Page 99]

Table 6.8: Staff satisfaction, morale, and commitment in DHA [Page 101]

Table 6.9: Organisational relationships and teamwork in DHA [Page 103]

Table 6.10: Organisational perceptions in DHA [Page 104]

Table 7.1: Factors associated with high or positive staff satisfaction morale in DHB [Page 132]

Table 7.2: Factors associated with low or negative staff satisfaction and morale in DHB [Page 133]

Table 7.3: Examples of intrinsic factors for satisfaction and morale in DHB [Page 133]

Table 7.4: Leadership practices and collegial relationships in DHB [Page 135]

Table 7.5: DHB Physical design [Page 136]

Table 7.6: Performance management and skills development issues in DHB [Page 137]

Table 7.7: Workload and resourcing in DHB [Page 138]

Table 7.8: Staff satisfaction, morale, and commitment in DHB [Page 140]

Table 7.9: Organisational relationships and teamwork in DHB [Page 143]

Table 7.10: Organisational perceptions in DHB [Page 143]

Table 8.1: Comparison of Leadership Practices in Case-Study Hospitals [Page 158]

Table 8.2: Understanding Leadership Practices [Page 159]

Table 8.3: Exemplary quotes on leadership practices [Page 160]

Table 8.4: Comparison of history and background of DHA and DHB [Page 166]

Table 8.5: Summary table of key findings relevant to bureaucracy and managerial hierarchies at both hospitals [Page 170]

Table 8.6: Definitions of Sources of Power [Page 178]

Table 8.7: Comparison of intangible software in DHA and DHB [Page 185]

Table 8.8: Comparison of the factors influencing cross-professional relationships between DHA and DHB [Page 190]

List of Text Boxes

Box 2.1: Example of search terms and phrases [Page 12]

Box 2.2: Journals accessed for literature search [Page 12]

Box 6.1: Services and Staff at District Hospital A [Page 79]

Box 6.2: Example of positive leadership practices that enhance staff satisfaction and morale in DHA [Page 88]

Box 6.3: Exemplary quotes on negative leadership practices that undermine staff satisfaction and morale in DHA [Page 91]

Box 7.1: Services and Staff at District Hospital B [Page 117]

Box 7.2: Example of leadership practices that enhance staff satisfaction and morale in DHB [Page 129]

Box 7.3: Exemplary quotes on negative leadership practices that undermine staff satisfaction and morale in DHB [Page 134]

Box 8.1: The Public Finance Management Act of 1999 [Page 171]

Box 8.2: Decisions on hospital budget and HRM [Page 173]

Box 8.3: Definition and understanding of power [Page 176]

Box 8.4: Nursing identity, hierarchies, and power [Page 183]

List of Acronyms and Abbreviations

APL – Approved Posts List

CAQDAS – Computer-Aided Qualitative Data Analysis Software

CCMA - Commission for Conciliation, Mediation and Arbitration

CDC – Community Day Care

CEO – Chief Executive Officer

CHC – Community Health Centre

COSATU - Congress of South African Trade Unions

C^{2}AIR^2 – Caring Competence, Accountability, Innovation, Responsiveness and Respect

CL – Collective Leadership

CLP – Collective Leadership Practices

CoCT – City of Cape Town

DD – Deputy Director

DH – District Hospital

DHA – District Hospital A

DHB – District Hospital B

DHMT – District Health Management Team

DHS – District Health Services

DoH – Department of Health

EC – Emergency care

ECC – Establishment Control Committee

ECG – Electrocardiogram

EMT – Executive Management Team

EOC – External Organisational Context

ExtendMT – Extended Management Team

GDP – Gross Domestic Product

GNI – Gross National index

HC – Health Care

HCO – Health Care Organisation

HIC – High Income Countries

HR – Human Resources

HRH – Human Resources for Health

IOC – Internal Organisational Context

LE – Leadership Effectiveness

LCF – Leadership competency Framework

LT – Leadership Trinity

LTF – Leadership Trinity Framework

LMICs – Low-and-Middle Income Countries

MDHS – Metro District Health Services

MTSF – Medium Term Strategic Framework

NDoH – National Department of Health

NHA – National Health Act

NHI – National Health Insurance

OSD – Occupation-specific Dispensation

PDoH – Provincial Department of Health

PHC – Primary Health Care

SAMA – South Africa Medical Association

SDA – Skills Development Act

SDLA – Skills Development Levies Act

SETA – Sector Education and Training Authorities

SPMS – Staff Performance Management System

WC – Western Cape

WCP – Western Cape Province

WCPDoH – Western Cape Department of Health

ZAR - South African Rand

Glossary of Terms

Term	Definition
Abductive Analysis	Analytic approach that generates theory from qualitative interviews and observations to give meaning to the best explanations
Case Study	Empirical research used to generate in-depth, multi-faceted understanding of a complex phenomenon in its real-life context.
Collective Leadership	A form of widespread leadership embedded in multiple individuals and involving interpersonal relationships
Constructivism	Philosophical view knowledge, reality, experiences, and artefacts are created or constructed through social interactions among people and groups
Deductive Analysis	Analytic approach that draws generalised conclusions or statements based on specific scenarios that are generally assumed to be true and are used to test existing theory
Distributed Leadership	A group activity that shifts focus from characteristics of an individual leader to more systemic perspective that works through interactions of multiple actors across the organisation
External Context	The immediate constructed physical and social environment or surrounding within which hospitals operate
Hardware	Comprises of the infrastructure, structure, organisation, technology, and resourcing of the hospitals or health system
Healthcare Organisational Context	The environment within which hospitals as social systems operate, and whose specific goals are to promote patient care and health through curative and preventative services, teaching, and research.
High Income Countries	Countries or economies with a GNI per capita, calculated using the World Bank Atlas method of, $12,536 or more
Inductive Analysis	Analytic approach that directly draws conclusions from data or makes broad generalizations from specific observations before inferring an explanation or a theory
Intangible Software	Internal characteristics of an organisation that do not exist in physical form and are characterised by culture such as teamwork, camaraderie, the processes of information sharing and the sub-cultures within teams.

Internal Context	The actual setting or environment where organisational activities take place to achieve organisational goals
Laissez-faire Leadership	Leadership style where staff are given all the decision-making and problem-solving authority while managers become facilitators who do not make effort to motivate or satisfy staff needs and is associated with poor relationships amongst staff
Leadership	An individual's or group of individuals ability to socially influence, motivate, and enable a group of people or followers to achieve organizational goals
Leadership Effectiveness	The successful outcome or attainment of organisational goals that is influenced by the social interactions and relationships between actors within the organisation
Leadership Trinity	The interplay between organisational context, leadership practices and leadership effectiveness in an organisation to achieve organisational goals
Low Income Countries	Countries or economies with a GNI per capita, calculated using the World Bank Atlas method, of $4,045 or less
Management	The process of planning, organizing, directing, and controlling a group of actors in combination with other resources to accomplish organizational goals
Middle Income Countries	Countries or economies with a GNI per capita, calculated using the World Bank Atlas method, between $4,046 and $12,535
Purposive Sampling	A technique used in qualitative research to identify and select cases and participants who are rich in information, are knowledgeable and experienced with the phenomena under study
Qualitative Research	An iterative form of inquiry that involves the interpretive analysis of information collected about beliefs, feelings, values, and motivations that underlie people’s behaviours in their natural settings to understand phenomena under study to gather deeper insights into a problem or generate new ideas.
Shared Leadership	Interactive influence process where two or more individuals in a team engage in leadership to achieve team or organizational goals. It involves collaborative effort, but one individual still remains in charge of the team or organisation with emphasis on equal sharing of information and participation
Tangible Software	Internal aspect of an organisation characterised by decision-making channels, the spread of power and authority, human resource management processes and rules and regulations;
Transactional Leadership	Leadership style that involves manipulation and social exchange when leaders use rewards or negative feedback to obtain the required performance from their followers.
Transformational Leadership	Leadership style whereby leaders stimulate and inspire individuals to grow and develop their own leadership - empowering followers and aligning the goals and objectives of individuals, leaders, groups, teams and the organisation

Chapter 1: Introduction to the Leadership Trinity Study

1.0 Introduction

This thesis examines the interplay and the influence of healthcare organisational (HCO) context over leadership practices and leadership effectiveness through staff satisfaction and morale in public hospitals. This case study research was undertaken in two district-level, hospitals in the Western Cape province of South Africa.

Three critical starting points for the current study were drawn from the wider research on leadership undertaken across sectors and over many years in high income countries. First, although defined in various ways in organisational theory (Pierce & Newstrom, 2011; Yukl, 2006; Yukl & Lepsinger, 2005; Kotter, 1990; Bass, 1985), leadership has increasingly come to be seen as a process of social influence (Day & Antonakis, 2011; Edmonstone, 2011; Bolden, 2004; Day, 2001) that is distinct from 'management', understood as addressing resource management, systems of control, problem solving and the production of standards and consistency (Kotterman, 2006; Yukl & Lepsinger, 2005; Kotter, 1990). Moreover, public sector literature also describes administrative and bureaucratic leadership, further noting the role of power and hierarchy in the practice of leadership (Van Wart, 2003; Trottier, Van Wart, & Wang, 2008).

Second, in conceptual and empirical research on leadership in high income countries (HICs), leadership is also being considered as a collective practice, rather than a function of individual leaders' characteristics or traits (Endrissat and von Arx, 2013; Denis, Langley and Sergi, 2012; Bolden, 2011; Raelin, 2011; Gronn, 2009; Pearce, Conger and Locke, 2008; Carroll, Levy and Richmond, 2008). Collective leadership refers to the form of leadership embedded in multiple individuals and involving interpersonal relationships (Denis et al., 2012; Hiller, Day, & Vance, 2006). Collective leadership roles are spread amongst diverse groups of individuals with different sets of skills, and who formally and informally share information to harness their collective behaviours (Yammarino, Salas, Serban, Shirreffs, & Shuffler, 2012; Friedrich, Vessey, Schuelke, Ruark, & Mumford, 2009).

Third, the conceptual thinking on collective leadership recognises that the social context of an organisation has a critical influence over leadership practices as such leadership is socially situated in everyday experiences and incorporates the actions and emotions of both staff and managers (Oc, 2018; Friedrich, Griffith, & Mumford,

2016; Brazier, 2005; Antonakis, Avolio, & Sivasubramaniam, 2003; Osborn, Hunt, & Jauch, 2002; Denis, Lamothe, & Langley, 2001). However, a review of empirical research noted that only limited work has examined the association between leadership and organisational context (Porter & McLaughlin, 2006). Indeed, much of the available conceptual and empirical literature has examined organisational phenomena separately from each other and so has failed to consider how different organisational facets or dimensions are relevant to leadership (Roman, 2017; Lewis, 2015; Dinh et al., 2014; Day, Fleenor, Atwater, Sturm, & McKee, 2014; Ovretveit et al., 2011; Zigan, Macfarlane, & Desombre, 2009; Vroom & Jago, 2007; Scott, Mannion, Marshall, & Davies, 2003).

Beyond these starting points, in this introduction chapter, I, first, outline the health policy and system rationale for this study in South Africa, a middle-income African country. Second, I summarise the knowledge contributions of the study. Third I outline the overall research question, research aim and specific objectives that underpin this thesis on the interplay between HCO context, collective leadership practices and leadership effectiveness – or more specifically, staff satisfaction and morale. I also present an outline of the overall thesis. Finally, I give a summary of the chapter.

1.1 The Rationale for a study on hospital context and leadership

1.1.1 Hospitals and leadership in the LMIC health systems

A well-functioning health system comprises various integrated components, also referred to as building blocks (World Health Organization, 2007). Hospitals are themselves a microcosm of the wider health system, spanning all building blocks, and are critical for the delivery of good quality health care (Kruk et al., 2018; Harrison & Coppola, 2007). In low- and middle-income countries (LMICs), hospitals generally capture the majority, more than half, of total public healthcare expenditure and resources (World Health Organization, 2007) and so also have a strong impact on overall system efficiency (Heerdegen, Aikins, Amon, Agyemang, & Wyss, 2020; Preker and Harding, 2003; Newbrander, Barnum and Kutzin, 1992).

The importance of public hospitals within every health system, and the organisation and leadership of district hospitals specifically, continue to shape key global policy debates. These hospitals play a key role in the health system by providing a link between basic and advanced healthcare services (Heerdegen et al., 2020; Preker &

Harding, 2003). District hospitals act as the first point of referral level in rural and urban districts (World Health Organization, 1992) and also offer referrals down the system towards primary and community care (Balabanova et al., 2013). They are, therefore, in a position to foster collaborative practices for better system functioning that improve the quality of care (Kruk et al., 2018). Indeed, global evidence indicates that good access to district hospitals supports the overall equity of health systems (Gilson, Doherty, Loewenson, & Francis, 2007). In Thailand, for example, strategic investment and good governance at district level is associated with the delivery of high quality public health care and the successful implementation of Universal Healthcare (Tangcharoensathien, Witthayapipopsakul, Panichkriangkrai, Patcharanarumol, & Mills, 2018; Balabanova et al., 2013).

Public hospitals are also foreseen to play an important role in Universal Health Coverage (UHC) reforms across countries by enabling quality medical care and engendering hospital leadership in the health system (Lewis, 2015; Murray & Frenk, 2000). However, experience suggests that public hospitals in LMICs regularly under-perform – as reflected in poor patient satisfaction, high mortality rates, poor management, and poor revenue cycles (Fetene et al., 2019; Kruk et al., 2018; Russell, Bennet, & Mills, 1999; Newbrander et al., 1992).

In the 1990s, these experiences led to calls for enhanced hospital autonomy to support improved hospital functioning and quality of care, also strengthening the wider health system (Mills, Rasheed and Tollman, 2006; Collins *et al.*, 1999; McPake, 1996; Mills, 1990). Hospital autonomy refers to the allocation of greater managerial authority to hospital managers, lessening some of the wider public sector bureaucratic constraints imposed on their governance (Collins *et al.*, 1999; McPake, 1996). Such autonomy would enable hospitals to set their own operational policies and would give hospital leadership more authority over decisions on budget use and administrative decision-making, while still operating within the confines and accountability mechanisms of the broader public system (Newbrander et al., 1992).

The available research suggests that leadership matter for performance, especially in autonomous hospitals (Fetene *et al.*, 2019; Lewis, 2015; Russell, Bennett and Mills, 1999). Globally, there is also recognition of the importance of leadership and organisational culture change in improving quality of care. For example, evidence suggests that organisational culture, leadership and performance may be interlinked in healthcare settings (Mannion, Davies and Marshall, 2005; Scott *et al.*, 2003; Davies, Nutley and Mannion, 2000), have impact on positive patient outcomes

(Braithwaite, Herkes, Ludlow, Testa, & Lamprell, 2017), and with further links between performance and satisfaction (Judge, Thoreson, Bono, & Patton, 2001).

Despite their important role in health systems, there is, however, scant research on hospitals and how they operate, outside HICs (Lewis, 2015). In LMICs, there is, in particular, very little research on hospital leadership, reflecting the dearth of empirical research on leadership in any health setting in these countries (Gilson & Agyepong, 2018).

1.1.2 Healthcare leadership in South African health system and hospitals

The South African health system comprises a mix of public and private healthcare services, with the majority of the population utilising the under-resourced public services (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). The overall system is inefficient and inequitable and remains challenged by the legacies of apartheid (Delobelle, 2013; Mayosi et al., 2012; Coovadia et al., 2009; Gilson & McIntyre, 2007). Hospitals play an important role in service delivery in the strongly hospi-centric public system, but their continuing challenges include poor staff satisfaction and morale (Labonté et al., 2015; Blaauw et al., 2013).

To address its weaknesses, the South African health system has been under constant reform since 1994. The development of the District Health Systems (DHS) and the strengthening of primary health care (PHC), with district hospitals as the first referral point, has been an important cornerstone of these reforms (Pillay & Barron, 2011; Pillay, McCoy, & Asia, 2001; Owen, 1995).

The need to strengthen health system leadership and governance has also been identified as important. Specifically, the fourth and fifth priorities in the National Department of Health (NDoH) medium term strategic 10-point plan 2010/11 – 2012/13, identified improvement of management in the South African health care system as essential for efficient health care delivery (RSA National DoH, 2010). This plan emphasised that where skills' gaps were identified, suitable and relevant training would be provided to eligible health care managers. In addition, the establishment of a management and leadership academy for health managers was envisaged.

The 2011 National Policy on Regulating Management of Hospitals, meanwhile, specifically aimed at ensuring that the management of hospitals is underpinned by principles of effectiveness, efficiency and transparency as enshrined in the National Health Act (RSA National DoH, 2011b). Recent proposals for National Health

Insurance (NHI) again emphasise the critical role of health care leadership and include, specifically, improvements of structures, culture, and performance in district hospitals (RSA National DoH, 2019).

Meanwhile, in the Western Cape Province (WCP), where this research was conducted, the Department of Health (DoH) has specifically espoused the need to spread or distribute leadership practices within the health system. The Healthcare 2030 strategy document outlines four issues that need to be addressed to strengthen leadership capabilities of hospital managers and clinicians within the province (Western Cape Government DoH, 2014). These are the complexity of the health system; the distributive nature of power among professional groups; the multidisciplinary nature of care; and the peculiarity of the norms and hierarchies of the different health professions.

Several wider reviews and commentary pieces make suggestions about key factors to consider in strengthening hospital and health system leadership. Commonly these reviews point to the important influence of organisational context over leadership. Matsoso & Strachan (2011), for example, argue that organisational or work environment and performance management systems are essential for leadership and the overall performance of the South African health system in delivering quality patient-centred services. Gilson & Daire (2011), meanwhile, argue that organisational structure and culture are critical challenges for leadership, and are important features to consider in building a health system that is resilient and responsive to the South African population health needs (Elloker, Olckers, Gilson, & Lehmann, 2013).

Finally, based on a review and an exploratory research report on South African and international literature, Jane Doherty (Doherty, 2014; Doherty, 2013) has specifically considered clinical governance and the roles of clinicians in transforming public facilities for provision of better quality of care. The wide-ranging problems she identifies in public hospitals include, among others, inadequate authority for active management of health facilities (level of decentralisation), problematic organisational structure, unrealistic budgets, slow and unresponsive personnel management, underdevelopment of management skills and inconsistent management structures. The author specifically recommends integration of clinical leadership in district hospitals judging that the organisational culture of such hospitals is conducive for teamwork (as compared to larger hospitals, which possess more complex hierarchies).

However, reflecting wider LMIC experience, there is very little empirical research on any aspect of health system leadership in South Africa. The little available includes research to develop competency frameworks (Pillay, 2008; Schaay, Sanders and Kruger, 2011; Pillay, 2010) or studies that have examined specific leadership traits and behaviours (Maboko, 2012; Botma, Botha and Nel, 2012; Mash et al., 2008; Dovey, 2002). Only at most a handful of studies offer insights about the influence of organisational context over leadership and different indicators of organisational performance. For example, a study assessed the link between leadership and organisational values, culture and performance in Cape Town's Primary Healthcare services but failed to succinctly outline the leadership practices and other features of context (Mash, Govender, Isaacs, De Sa, & Schlemmer, 2013).

1.2 The knowledge contribution of this research

Overall, as outlined in more detail in Chapter Two, there is a dearth of empirical research on leadership, and specifically on hospital leadership, in LMICs (Gilson & Agyepong, 2018). In the South African health system, specifically, little evidence exists about hospital leadership experience, and the contextual factors influencing it. Yet the National Department of Health argues that effective leadership is vital for the future of healthcare in the country (RSA National DoH, 2011c).

The currently limited understanding about LMIC hospital functioning and more specifically, the impact of, and influences over, hospital leadership is the key knowledge gap this research seeks to address. Very specifically, no empirical inquiry has as yet examined the influence of organisational context over collective leadership and organisational and leadership effectiveness in South African hospital settings.

This research is important because of the widely recognised role and potential contribution of hospitals, and particularly public district hospitals, to overall health system performance in LMICs. To support future system reform, including UHC reforms such as the South African NHI proposals, it is critical to understand hospital and district hospital leadership experiences as a basis for drawing lessons about how to strengthen their leadership and performance. Such work can, moreover, draw from the wider conceptual work about leadership already undertaken in HIC settings, as more fully considered in Chapter Three. It can also contribute empirical findings of relevance to the wider leadership literature, given the noted gap in empirical enquiry into the association between leadership and organisational context (Porter & McLaughlin, 2006).

1.3 Research questions and objectives, and thesis outline

1.3.1 Research Question

How does organisational context influence leadership practices and affect staff satisfaction and morale, as an indicator of leadership effectiveness, in district hospitals in the Western Cape Province, South Africa?

1.3.2 Research aim and specific objectives

The aim of this research was to examine the interplay between organisational context, leadership practices, and staff satisfaction and morale, using two case studies of district hospitals in the Western Cape Province. Together with this aim, the study sought to achieve the following objectives:

a. To understand how district hospital managers and staff experience leadership practices and the influence of organisational context over them.

b. To determine through analysis the key features of the internal and external organisational context in district hospitals that are relevant to leadership practices and staff satisfaction and morale, as indicators of leadership effectiveness.

c. To determine through analysis the pathways through which organisational context influences leadership practices and staff satisfaction and morale in district hospitals.

d. To consider how collective leadership can be strengthened in district hospitals.

Theoretical and empirical research in HICs suggest that leadership is a day-to-day practice that has recurring patterns in relationships, decision-making and power dynamics within a socially constructed context (Endrissat and von Arx, 2013; Raelin, 2011; Denis, Langley and Rouleau, 2010; Carroll, Levy and Richmond, 2008). In this research, then, leadership practices are understood to be processes which involve interpersonal relationships and social influence within the uncertain workplace or organisational context, and which encourage the distribution of leadership processes amongst co-workers (Day et al., 2014; Bilhuber Galli & Muller-Stewens 2012; Edmonstone 2011; Raelin, 2011; Denis, Langley and Rouleau, 2010; ; Bolden 2004; Day 2001). Chapter Three also presents a more detailed explanation and understanding of the conceptual underpinnings of this study.

1.3.3 Thesis outline

Figure 1.1 provides a flow diagram of this research study and thesis, showing the critical steps taken to collect and examine empirical evidence about the association between HCO context, leadership practices and staff satisfaction and morale. In Chapter Two I present the leadership literature review focused primarily on LMIC healthcare and organisational leadership. Then, in Chapter Three, I outline the conceptual framework and key conceptual definitions generated from relevant theory.

Afterward, in Chapter Four, I discuss the methodological approaches to study design, data collection, data analysis (including routine survey data), data management and the measures to ensure study rigour and trustworthiness. In this methodology chapter, I describe the detailed qualitative research data collection and analysis undertaken, and discuss the surveys done at the hospital that are used as corroborative quantitative data. The methodology chapter is then followed by Chapter Five, which presents a description of South African and Western Cape Provincial settings, to set the scene for the detailed presentation of the empirical findings.

Next, in the two successive Chapters Six and Seven, I report results from the two study cases where I outline results on how the phenomena under study play out in each hospital. Chapter Eight presents the cross-case analysis, drawing out deeper insights about the phenomena through comparison of experiences across the two case study hospitals. Chapter Nine discusses how the study's overall findings contribute to the broader LMIC literature on district hospitals and their leadership, as well as the policy and research implications, and, finally, the study limitations. Finally, in Chapter Ten, I present concluding statements about study relevance and my own personal research journey.

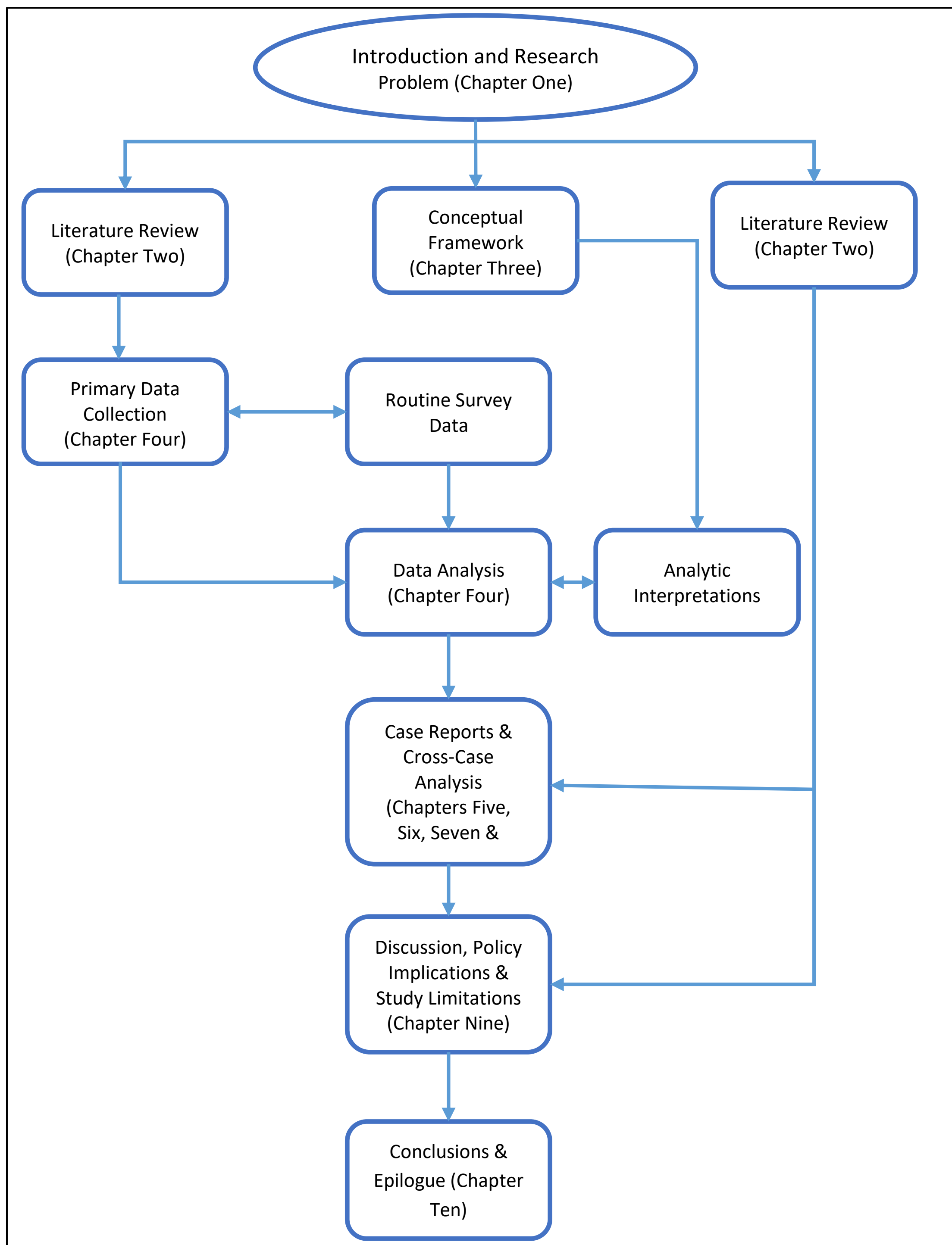


***Figure 1.1**: Overall Research Process and Thesis Outline*

1.4 Chapter Summary

This thesis reports empirical research in two district hospitals in the Western Cape Province, South Africa. This chapter has presented the rationale for and overview of the thesis as a whole. Despite the critical role of hospitals within health systems such

as that of South Africa, and the acknowledged importance of leadership to quality of care and service delivery in hospitals, there is limited empirical research addressing district hospital leadership in South Africa and other LMICs. This is the research gap that this thesis addresses.

The thesis purposefully takes a holistic or comprehensive approach, examining the relationship or association between leadership and other organisational phenomena. As noted in the wider conceptual literature on leadership, situational and contextual factors play important roles in the emergence and practice of leadership (Vroom and Jago, 2007; Dinh *et al.*, 2014). Yet research in LMICs has given little attention to contextual and organisational influences over leadership practices and staff satisfaction and morale.

Subsequent chapters present fuller reviews of the literature and theory underpinning the thesis, as well as its methods, context, findings, implications, and conclusions.

Chapter 2: Literature Review

2.0 Introduction

Chapter Two, the literature review, examines the existing LMIC literature on healthcare leadership and leadership in general, identifying the gaps in the existing evidence base. In this chapter, and in the overall thesis, I follow the definition of authors who define leadership as a relational practice that is socially situated in everyday experiences, and which incorporates the emotions of both staff and managers in formal and informal leadership roles (Endrissat and von Arx, 2013; Raelin, 2011; Denis, Langley and Rouleau, 2010; Carroll, Levy and Richmond, 2008).

At the onset, I outline the systematic manner with which I sourced study-relevant literature on leadership. After that, I discuss the literature on healthcare leadership in LMICs and South Africa that are relevant to this study. Then, I highlight the empirical and methodological gaps that this research thesis aims to fill, in order to contribute to research on healthcare organisational context and leadership. Lastly, I provide a summary of this review chapter.

2.1 Approaches to the search and identification of relevant literature

A detailed search for the literature for this study considered published work in different electronic databases. Given the research question, the primary focus of the search was empirical literature that specifically addressed leadership and linked contextual issues in hospitals. Articles on empirical research on hospitals or HCO and leadership were selected using pre-determined inclusion and exclusion criteria and according to the characteristics specific to each database, search filters, and Boolean phrases (Bown & Sutton, 2010).

The literature reviewed for this study are drawn from different disciplines because the phenomena of focus have been independently researched in various fields such as healthcare, organisational behaviour, leadership, management, public administration, organisational psychology, and organisational sociology. I derived keywords and phrases for the search and combined them using Boolean operators “AND” and “OR” (see **Box 2.1**).

Box 2.1: Example of search terms and phrases

KEY (("organi*ations" OR "healthcare organi*ation*" OR "health care organi*ation*" OR "healthcare industry" OR "health care industry" OR "hospital*" OR "clinic" OR "culture" OR "structure" OR "context") AND ("leadership" OR "healthcare leadership" OR "health care leadership" OR "hospital leadership" OR "nurs* leadership" OR "physician leadership" OR "leadership practices" OR "clinical leadership" OR "hospital adminis*" OR "hospital management") AND ("leadership effectiveness" OR "effective leadership" OR "effectiveness" OR "motivation" OR "morale" OR "satisfaction" OR "attitude of health personnel") (LIMIT-TO (ACCESS TYPE(OpenAccess) AND (LIMIT-TO (PUBYEAR, 2019) OR LIMIT-TO (PUBYEAR, 1999))

The databases where I searched, accessed, and retrieved relevant literature include SCOPUS, Web of Science, Medline via PubMed, EBSCO Host (including CINHAL - Cumulative Index of Nursing and Allied Health, PsycINFO and Africa-Wide), and Google Scholar. In addition, I extended the search to specific journals (see **Box 2.2**).

Box 2.2: Journals accessed for literature search

Administrative Science Quarterly	Journal of Public Administration
Africa Journal of Management	Leadership in Healthcare Services
African Journal of Economic and Management Studies	Leadership Quarterly
British Journal of Healthcare Management	Management Dynamics
Health Policy and Planning	Public Administration
Healthcare Leadership Review	Public Administration Review
International Journal of Healthcare Management	Public Performance and Management Review
International Journal of Public Administration	Public Policy and Administration
International Journal of Public Administration Research and Theory	Social Science Citation Index
International Review of Administrative Sciences	South African Journal of Business Management
Journal of Health Management	South African Journal of Economic and Management Sciences
Journal of Healthcare Leadership	South African Journal of Education
Journal of Healthcare Management	South African Journal of Human Resource Management
Journal of Organisational Behaviour	

I selected electronic databases and journals because I deemed them suitable in providing relevant articles based on the variation of the inclusion and exclusion criteria in **Table 2.1**. Mendeley (Copyright © 2019 Mendeley Ltd) was the preferred tool for managing references upon completion and retrieval of the search results.

Table 2.1: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Empirical studies on leadership using qualitative, quantitative, or mixed methods approaches	Literature whose findings and discussions are not relevant to the three phenomena under study
Studies on healthcare and other public organisations	Studies with insufficient information
Studies done in LMICs, later extended to HICs	Studies that do not specify geographical setting
Full text available in the University of Cape Town library subscription	Articles whose full text are not openly accessible
Studies published in English between 1999 to 2019	Studies in languages other than English and published before 1999

Despite the vast global literature on leadership in healthcare, the search only yielded a handful of studies that assessed both the context of hospital leadership and leadership practices in South Africa and other LMICs. To broaden the search, research from other LMIC health settings was included as well as some non-health literature from LMICs that considers organisational context as an influence on organisational leadership.

To make the review manageable, due to the breadth and depth of overall literature on leadership, I made a critical decision to bound the literature search. I primarily considered literature from South Africa and LMICs between 1999 and 2020, and as an attempt to capture a wider range of existing work from LMICs, with additional theoretical literature from HICs. I do not, however, provide a systematic comprehensive review of all literature published over the 20-year period because this was not feasible for this study. Instead, I present a traditional narrative review providing a comprehensive summary of literature on leadership in South Africa and LMICs, to identify gaps, refine, focus, and shape research objectives.

In addition, this allowed the identification of theoretical and conceptual frameworks useful for this study (Ryan, Coughlan, & Cronin, 2007). Although this approach may be seen as limiting the extent of literature reviewed, the presented review offers important perspectives that dominate the debates and thinking on healthcare and organisational leadership. The inclusion and exclusion criteria guided the critical

appraisal whereby selected articles were carefully and systematically examined for their relevance to the phenomena under study, quality of research methodology, and key messages from research.

2.2 Leadership in LMIC health systems, hospitals, and other organisations

In the limited existing literature on African organisational leadership, there are relatively few studies on leadership practices and their outcome in HCOs, as noted in a review on leadership in healthcare in sub-Saharan Africa (Curry, Taylor, Chen, & Bradley, 2012). A Ghanaian comparative case study of public and private hospitals (Aseweh Abor, Abekah-Nkrumah, & Abor, 2008) showed that governance structures positively influenced leadership practices in public hospitals where the CEOs had medical background and the roles of the CEO and the hospital board chairperson were differentiated. However, this study did not also consider the types of leadership practiced and their potential influence on, for example, satisfaction and motivation of the staff.

While noting the nature of hospitals as complex adaptive systems, a recent study in Kenya found, however, that inadequate financing, limited hospital autonomy and decision-making ability, ineffective leadership influenced the capacity for priority setting (Barasa, Molyneux, English, & Cleary, 2017). Other studies in the LMIC have also started to recognise the important role of leadership capacity and organisational capacity in influencing the motivation of staff in the context of performance-based financing. The multiple case study in district hospitals and primary health facilities in Burkina Faso by Fillol et al., (2019) showed how perceptions of organisational factors influenced staff motivation towards performance-based financing, with specific reference to the impact of hierarchical leadership styles, as reflected in feedback on performance, and levels of resource availability.

Increasingly, a broad range of LMIC studies have examined transformational and transactional leadership styles[1] in hospitals, for example in public hospitals in Morocco (Belrhiti, Van Damme, Belalia, & Marchal, 2020) and Ghana (Aberese-Ako, Agyepong, & van Dijk, 2018), health regions in Uganda (Musinguzi, Conrad, Namale,

---

[1]It is important to note that leadership research focusing on individual leadership behaviour such as charismatic leadership and transformational and transactional leadership is more common in high income countries, although gaining prominence in LMICs (B. M. Bass, 1990; B. Bass & Avolio, 1993; Shamir, House, & Arthur, 1993; Shamir & Howell, 1999; B. M. Bass, Avolio, Jung, & Berson, 2003).

Rutebemberwa, Dahal, Nahirya-Ntege, & Kekitiinwa, 2018), among obstetric care staff in Malawi (Chipeta, Bradley, Chimwaza-Manda, & McAuliffe, 2016), in different organisations in Brazil (Araujo & Figueiredo, 2019; Abelha, Carneiro, & Cavazotte, 2018), and among nurses in Malaysia (Adi, Noor, Rahman, & Yushuang, 2013).

Transformational leadership is a process by which leaders stimulate and inspire individuals to grow and develop their own leadership - empowering followers and aligning the goals and objectives of individuals, leaders, groups, teams and organisation (Diaz-Saenz, 2011; Bass & Riggio, 2006; Avolio & Gardner, 2005). The performance of leaders and their followers is thought to be enhanced through strong emotional attachment and collective commitment to higher moral behaviour (Bass & Riggio, 2006; Avolio & Gardner, 2005). Transformational leadership is often defined in contrast to transactional leadership, which involves manipulation and social exchange, when leaders use rewards or negative feedback to obtain the required performance from their followers (Avolio, Bass, & Jung, 1999; Bass, 1990; Bass, 1985).

These two leadership styles are aimed at achieving a goal or an objective. A leader can exhibit both transformational and transactional leadership styles (Bass, 1985), but the two are sometimes viewed as being at the opposite ends of a continuum (Den Hartog, Van Muijen, & Koopman, 1997). These two leadership styles have been examined in some LMICs as outlined in more detail in the ensuing paragraphs, including outside the health sector.

In Morocco, a study using realist evaluation argued that the motivation of healthcare workers is an outcome of a mix of laissez-faire, transactional, transformational and distributed leadership (Belrhiti et al., 2020). Results from the Moroccan research suggests that whereas transactional leadership had a positive influence on the motivation of healthcare workers because of the administrative focus on compliance with rules and procedures in social interactions, transformational leadership worked to generate support and trust between managers and staff, which enhanced their motivation. Laissez-faire leadership behaviour is experienced where staff are given all the decision making and problem-solving authority while managers become facilitators who do not make effort to motivate or satisfy staff needs and is associated with poor relationships amongst staff (Skogstad, Einarsen, Torsheim, Aasland, & Hetland, 2007).

The Brazilian study by Abelha et al., (2018) sought to identify the influence of factors within organisations and individual leader characteristics on the link between transformational leadership and job satisfaction in various healthcare and nonhealthcare organisations. The study used responses from electronic questionnaires administered to postgraduate students in business administration who were working in different public and private companies. It found positive association between transformational leadership and job satisfaction among junior staff. In a separate study, a conducive work environment created by hospital leadership for their nursing staff generated satisfaction through camaraderie, role clarity, training and development, trust, work infrastructure and relationship with doctors in five private Brazilian hospitals (Araujo & Figueiredo, 2019). A Malaysian study (Adi et al., 2013), meanwhile, demonstrated the positive associations between transformational and transactional leadership styles with job satisfaction among nurses.

The ethnographic study by Aberese-Ako et al. (2018) in Ghana, finally, explored the influence of contextual factors on the transformational, transactional and laissez-faire leadership styles of hospital managers in the context of maternal and child health in two public hospitals. The research identified institutional rules and regulations, and financial constraints as barriers to managerial power and leadership styles, leading to low motivation amongst managers and workers. Despite showing the association between leadership styles, some contextual elements and job satisfaction, these Brazilian, Malaysian, and Ghanaian studies only focused on leadership styles exhibited by individual managers rather than the collective practice of leadership across groups of workers.

Comparatively, a cross-sectional study in three regions in Uganda found that health workers were highly motivated, satisfied with their job and worked as a team when they perceived their leaders to be transformational in contrast to when their leaders were seen as transactional or practiced laissez-faire leadership styles (Musinguzi, Conrad, Namale et al., 2018). Additionally, an exploratory study in Malawi found that transactional leadership had negative impact on relationships between obstetric care staff and their managers due to lack of support for staff welfare and staff performance (Chipeta et al., 2016). The study also identified lack of mentorship for junior staff and inadequate supervision as outcomes of poor leadership that frustrated staff leading to low morale, absenteeism, and intention to leave.

Meanwhile, Chigudu and colleagues (2014) undertook a study that identified democratic, pace-setting or moral-charismatic, and authoritative as the most

predominant health system leadership styles in The Gambia, reflecting the characteristics of transformational and transactional leadership. This study also highlighted setting clear visions, the ability to engender shared leadership, and relationships as aspects of leadership at the sub-national level. Importantly, they highlighted the need for empirical research that examines healthcare leadership across all levels of the health systems and considers the intertwining political, socio-economic, and cultural influences over it as important in identifying opportunities for health systems strengthening. The study, thus, shifts away from research focused only on leadership styles within health systems, to acknowledging the influences of the social context in which leadership is practiced and embedded.

Organisational leadership has also been the subject of recent research in South Africa, specifically. Outside the health sector, an organisational study of administrative staff in a South African academic institution used quantitative research to examine the positive impact of participative and directive leadership on organisational culture (Bell, Chan, & Nel, 2014). These scholars used Denison's (Denison & Neale, 1996; Denison, 1984) culture traits (that include involvement, consistency, adaptability and mission) as the measures of organisational culture. The findings showed that participative and directive leadership encouraged workers to engage in open communication and share knowledge with colleagues. The increased participation of frontline administrative workers in decision making that resulted, also further motivated them. Another empirical study supported these findings by demonstrating the impact of transformational and transactional leadership styles on intrinsic motivation amongst managers in a university in South Africa (Chipunza & Matsumunyane, 2018).

Scholars have also used mixed-method research to analyse leadership strategies that could improve service delivery in four regional hospitals in Kwa-Zulu Natal Province (Govender et al., 2018); and quantitative research to examine empowering leadership and performance in a metropolitan municipality (Govender, 2017). The mixed-method study identified participative decision-making as a leadership approach important for improving performance in hospitals because of its potential to promote collaborative problem solving and engagement. In addition, the study teased out transformational leadership style as useful in addressing challenges in hospitals. The municipality study illustrated the association between empowering leadership, workers' effort, their performance, and ability to deliver municipal public services. However, the studies did

not consider how the empowering leadership approach might be connected to organisational context.

Another recent health care study did, however, identify hierarchical structures as a constraint on participative practices and the ability of both managers and frontline staff to contribute to decision-making and the implementation of innovations in South African health care organizations (Brooke-Sumner, Petersen-Williams, Kruger, Mahomed, & Myers, 2019). It also identified participative leadership as critical to building of trusting relationships within these settings.

Cleary et al.'s (2018) study at primary health care level also provides insights on the influence of centralised bureaucratic and rigid hierarchies in the public health system on distributed and relational leadership. The study identified bureaucratic hierarchies as presenting a challenge to developing leadership practices that would improve performance and policy implementation in the South African health system (Cleary et al., 2018). The bureaucratic and rigid hierarchies are derived from the public sector context within which the public health system operates. Furthermore, research exploring the influences of professional and other contextual factors on managerial and leadership practices within primary health care facilities (Daire & Gilson, 2014) demonstrated that identity transition from nursing or clinical role to leadership and managerial roles was shaped by organisational, systemic and professional factors. The organisational and systemic factors were associated with the bureaucratic nature and professional identities in the South African healthcare system.

Some of the studies above reveal a growing focus within the literature on different aspects of organisational and healthcare context that have influence on leadership, moving beyond concern for individual leadership styles. Two recent LMIC articles specifically found that distributing leadership responsibilities leads to collective efficacy and problem solving within hospital settings (Belrhiti et al., 2020; Belrhiti, Giralt, & Marchal, 2018), and that distributing leadership contributes to better interactions between staff because of improved communication flow and staff interactions (Belrhiti et al., 2020). Recent studies on clinical leadership in LMIC public hospitals have also started looking at how leadership is distributed in the healthcare context, and, relatedly, the role of power and interprofessional relationships in shaping leadership practices (Nzinga, McGivern, & English, 2018). This Kenyan study demonstrated that medical professional dominance and parallel leadership by clinicians and nurses impact negatively on distributed clinical leadership.

Despite some research on leadership in healthcare in LMICs, including in sub-Saharan Africa, leadership scholars in Africa have argued that there is need for more research to determine how leadership practices influence efficiency and effectiveness in private and public organizations in Africa (Kuada, 2010). Kuada (2010), for example, also suggests that research in the continent should consider the influence of the centralisation of power, uncertainty and resistance to bureaucracy on leadership in African organisations. The author challenges researchers to analyse the leadership styles and practices that improve organisational performance, while at the same time giving thought to leadership development strategies, learning and creativity to enhance the quality of leadership in organisations. Existing evidence in the educational field, meanwhile, suggests work-based learning and formal leadership learning programmes are critical in enhancing leadership (Bush & Glover, 2004). In their report on the evidence and beliefs about leadership development, these scholars suggest that leadership development should always be firmly rooted within the targeted participant's context.

In summary, the sets of studies and body of knowledge interrogated in this narrative review offer useful insights about the extent of research and the knowledge gap on hospital leadership in South Africa, Africa and other LMICs. Apart from identifying the leadership styles and other forms of leadership exhibited by individual managers, some of the studies also considered their potential influence on aspects of staff satisfaction and motivation. Studies also underscored the role of social context in shaping individual leadership styles. This body of work also highlights the relevance of organisational factors to leadership, or on the influence of these factors on staff motivation and performance. Finally, the review revealed that clinical and distributed forms of leadership in hospital settings is an emerging area of research, with some suggestions that leadership development ought to be embedded in the staff and managerial context.

Yet, to date, empirical research in South Africa and other LMICs has given little focus to understanding the influence of the context of health care organisations over leadership practices, although it is critical for establishing and embedding effective leadership processes over time. Exploring the critical influence of HCOs' context on leadership practices and staff satisfaction and morale remains an important research objective.

2.3 Methodological Gaps in the Empirical Leadership Literature

Research on leadership in public and private sector organisations has also tended to use quantitative designs to establish causal relationships between leadership and other organisational constructs (D'Innocenzo, Mathieu, & Kukenberger, 2014; Dinh *et al.*, 2014; Yukl, 2009; Antonakis, Avolio and Sivasubramaniam, 2003; Avolio, Bass and Jung, 1999; Bass and Avolio, 1993). The existing leadership studies are, however, criticised for not considering the complex and dynamic processes that happen over prolonged periods within the organisational context (Dinh *et al.*, 2014; Yukl, 2009).

Some researchers advocate for the expansion of research methods to address methodological weaknesses to comprehensively understand the context of leadership practices (Drescher & Garbers, 2016). Specifically, there are calls for the use of longitudinal comparative case studies to describe events over time and to search for holistic explanation of processes, within and between cases, using a 'high degree of structure' and 'some level of flexibility' (Dinh et al., 2014; Pettigrew, 1997; Pettigrew, 1990). Therefore, an analytic case study approach that incorporates qualitative methodology is valuable in supporting in-depth understanding of the context of public hospital leadership in LMICs, and to contribute to wider debates on health system reforms.

Few of the health system studies reviewed explicitly analysed the interplay between organisational context, leadership practices and staff satisfaction and morale. This scholarly gap is addressed by this study. Using a qualitative research design, this study applies a holistic and systematic analysis to understand healthcare organisational contextual issues that are likely to influence the social interactions and behaviours of individuals and groups, the nature of leadership practices, and their effects in engendering staff satisfaction and morale (Day *et al.*, 2014; Iszatt-White, 2011; Mowday and Sutton, 1993).

2.4 Chapter Summary

In this chapter, I identified existing gaps in LMIC health sector leadership research through a comprehensive literature review that also informed the conceptual framing (see Chapter Three) for this study. Most studies have focused on the different

leadership styles of individual leaders in formal positions and authority which have impact on performance.

The weak limited available evidence about LMIC healthcare leadership does, however, highlight a growing recognition of the need to consider the situational and contextual factors that may have influence over leadership practices. For example, existing evidence suggests that among other factors, hierarchies and resource availabilities influence leadership. There are also some hints about the possible association of these issues with staff satisfaction and morale in healthcare settings. However, the evidence does not clearly consider the interplay between hospital context, leadership practices and staff satisfaction and morale.

In conclusion, many organisational scholars have suggested the significance of organisational context on leadership as a practice, including an understanding of the dynamic interactions and relationships between the dimensions of context and leadership (Porter & McLaughlin, 2006). They have also highlighted the importance of using qualitative methods, as seen in studies in HICs, to understand leadership (Fitzgerald, Ferlie, McGivern, & Buchanan, 2013). These represent the starting points for this study of the relationship between hospital context and leadership practices that promote or undermine satisfaction and morale of staff in healthcare organisations in South Africa, and, specifically, the Western Cape Provincial health system.

Chapter 3: Definition of Terms and Conceptualizing the Leadership Trinity Framework

3.0 Introduction

Review of relevant theory helped in deciding the important concepts for the study, as well as the possible relationships amongst the related phenomena as they play out in real world settings - and so, also, the information to gather and analyse. Conceptual clarification drew from the different disciplines of relevance to studies of organisational context and leadership. I deliberately use the term *phenomena* to refer to the core issues examined as they have multiple dimensions and are observed and experienced in various ways by different actors. The three central phenomena examined – HCO context, leadership practices and, staff satisfaction and morale as indicators of leadership effectiveness – influence the delivery of quality healthcare services.

In this chapter I, first, highlight the theoretical starting points for the study and its three core phenomena. Second, I present the conceptual understanding of leadership that is central to the study, that it is a situated and collective practice, before, third, defining the conceptual meaning of staff satisfaction and morale, used in this thesis as indicators of leadership effectiveness. Fourth, I outline the understanding of healthcare organisational context as used in the study. Finally, I provide a summary of the chapter with the conceptual framework that guided data collection and analysis.

3.1 Theoretical Foundation for this Study on the Interrelationships between Context and Leadership

In studying and analysing organisations, integrating different but relevant and complementary theoretical insights allows full comprehension of the organisational phenomena under research (Hall & Tolbert, 2005). Two broad theoretical lenses underpinned the study's overall conceptual framework: contingency and complexity theories of leadership.

Contingency theories of leadership posit that situational or environmental factors influence leadership outcomes within organisations (Bolden, Gosling, Marturano, & Dennison, 2003). For this study, they were important in understanding the role of situational and environmental factors over leadership practices in hospitals and the subsequent effect of these practices on staff satisfaction and morale. Fiedler's

contingency theory (1967), for example, suggests that leadership outcomes are dependent on the relations and motivations of the leaders as well as situational factors, such as the leader-member relations, task structure, and leader's position power. Another contingency theory, the path-goal theory of leadership (House and Aditya, 1997; House, 1996; House, 1971), drawing from the expectancy theory of motivation (Vroom, 1964), identifies key leadership roles as the creation of followers' paths towards individual and group goals. The leader adapts behaviours in specific situations to enhance the motivation and satisfaction of individuals or groups of workers in achieving the desired organisational goals. Finally, some contingency theories suggest that focusing on how and the degree by which organisational leaders involve others in decision-making might encourage the development of leadership capacity across the organisation (Vroom and Jago, 2007; Vroom and Yetton, 1973).

In complexity science, complex systems are seen as comprising different independent parts, agents, or groups of agents that interact with each other, gather information about their own environment and behaviour, may have conflicting goals and are self-organizing (Rouse, 2008; Goldstone and Sakamoto, 2003; Levin, 2002; Marion and Uhl-Bien, 2001; Anderson, 1999). Hospitals can be seen as complex social systems, or organisations, that comprise multiple, different departments, subunits, professional groups, and patient groups. These multiple elements adapt and react to each other and function as a whole for the realisation of health care organisational goals (Rouse, 2008; Plsek and Wilson, 2001). A key idea from complexity theory is that leadership is emergent, an outcome of relational interactions between individuals, or actors, occurring over time. These interactions are social, nonlinear, and unpredictable, but shaped by existing rules and regulations within the complex system or organisation (Lichtenstein et al., 2006; Marion & Uhl-Bien, 2001).

3.2 Understanding Leadership as a Situated and Collective Practice

This section articulates the conceptual understanding of leadership as process of social influence that is situated within a given social context. Social relations influence the behaviours of individuals within social settings, such as hospitals, where individuals belong to multiple units and teams (Reicher, Haslam and Hopkins, 2005; Ashforth and Mael, 1989).

The notion that leadership involves social interactions within a specific context has been prominent in organisational literature for some years (Day 2001; Bolden 2005).

For some scholars, then, leadership entails connecting organisational, social and personal processes (Bolden, 2004) to enable complex interactions between people towards the attainment of shared objectives (Yukl, 2006; Day, 2001). Vroom and Jago (2007 p18), specifically, see leadership as *'a process of motivating people to work together collaboratively to accomplish great things'*; in other words, as a process of influencing others. Yet others assert that leadership commonly involves coping with change by combining personal and internal organisational practices to generate values and beliefs (Endrissat and von Arx, 2013; Carroll, Levy and Richmond, 2008), and the external actions of influencing, directing and building individuals, teams, and organisations (Hanson, 2012; Bolden, 2004; Day, 2001). Leadership processes within organisations are, thus, seen as creating organizational culture, generating commitment, motivating workers, and enhancing the cooperation that impacts on employee satisfaction (Hanson, 2012; Day, 2001).

The notion of collective leadership, specifically, has its theoretical and empirical underpinnings in the corporate and private sector where it is conceptualised and measured as a form of distributed influence and control involving collaborations and relationships (Hiller et al., 2006). These collaborations, nonetheless, require individual intentions and behaviour. Findings in a paper on collective decision making, leadership, and collective intelligence (McHugh et al., 2016), suggest that *'the collective'* is interdependent and characterised by how the members are organised and the types of relationships that they develop. The relationships and sense of interdependence within the collective encourages diversity and perspectives among individuals and groups that supports more leadership learning.

'*The collective*' can include individuals, teams, groups, and organisations who interact within a social context (Friedrich, Griffith, & Mumford, 2016; Contractor et al., 2012; Yammarino et al., 2012; Hiller, Day, & Vance, 2006), and are involved in information processing and sharing for improved productivity (Marion, Christiansen, Klar, Schreiber, & Erdener, 2016). Individuals with and without formal leadership roles, particularly within groups with different professional identities, are all part of the collective (White, Currie, & Lockett, 2014; Fitzgerald et al., 2013a; Denis, Langley, & Sergi, 2012; Spillane, 2012; Currie & Lockett, 2011; Denis, Langley, & Rouleau, 2010; Harris, 2009; Harris, 2008).

Collective practices are theorised as those that involve widespread lateral, rather than only individualised or hierarchical, forms of leadership (Marion, Christiansen, Klar, Schreiber, & Erdener, 2016; Contractor, DeChurch, Carson, Carter, & Keegan, 2012;

Yammarino, Salas, Serban, Shirreffs, & Shuffler, 2012). It is, thus, a practice of social influence that entails the distribution of tasks and responsibilities despite the existing hierarchies and power relations in public organisations (White et al., 2014). It is itself, then, an enabler of social interaction between team members, reflecting the ability to share leadership responsibilities rather than ascribing individual roles to a formal leader.

Thus, in HCOs, collective leadership demands a shared approach where individuals consciously and collectively emphasise the need for service delivery through engagement, participation and involvement in organisational activities (Eckert, West, Altman, Steward, & Pasmore, 2014; West, Eckert, Steward, & Pasmore, 2014). Staff develop collective responsibility for promoting hospital cultures of quality care to deliver healthcare services. However, when undertaking tasks or roles in these HCOs as social contexts, actors' behaviours may lead to strains, tensions, and power struggles. The tensions may arise because of the actions and reactions of actors from different occupational backgrounds exercising some form of leadership within the complex hospital setting. Hospitals, as healthcare organisations, are commonly characterised by power distance and professional groups that lead to gaps in relationships (Denis et al., 2012).

3.3 Healthcare Organisational Effectiveness and Staff Satisfaction and Morale

Organisations are studied to understand how and why they are effective or ineffective. Organisational effectiveness refers to the achievement of multiple and frequently conflicting organisational goals, but organisations may be effective in some areas and ineffective in others (Hall & Tolbert, 2005). Hersey, Blanchard, and Johnson (2012), organisational scholars, specifically suggest that organisational context and leadership practices contribute to organisational effectiveness. The notion of organisational effectiveness, as discussed in the institutional theory of leadership, is seen both as an outcome of individual actors and one that is influenced by the interactions and relationships between actors within the organisation's social setting (Shamir, 1999; Biggart and Hamilton, 1987).

In this study, organisational effectiveness is seen as intricately intertwined with leadership because leadership is relevant to the achievement of the types of affective outcomes that enhance organisational performance. Specifically, collective leadership, and leadership practices in general, may have impact on staff satisfaction

and morale (Hersey, Blanchard, & Johnson, 2012). Staff satisfaction and morale are, moreover, particularly important in health settings as they are linked to hospital performance (Mannion, Davies and Marshall, 2005; Scott et al., 2003), quality of healthcare services (Kruk et al., 2018; Harrison and Coppola, 2007), worker intention to remain in HCOs (Franco, Bennett, & Kanfer, 2002), and worker individual intrinsic behaviours or drive rather than extrinsic goal for rewards (Ryan & Deci, 2000).

In any setting, job satisfaction is understood as an attitude maintained and developed from the perceptions of individuals about their work and based on their experiences within an organisation (Oldham and Hackman, 1981; Vroom and Jago, 1988; Locke, 1976). Satisfaction and commitment (Bass, 1985), and motivation (Hersey et al., 2012), are seen as linked to leadership and can therefore be considered as proxies for assessing the outcomes of leadership practices. Contingency and expectancy theories of leadership support the argument that leadership moderates worker satisfaction and morale (Hersey, Blanchard and Johnson, 2012; House, 1996; Fiedler, 1967). For this study, then, staff satisfaction and morale are seen as an indicator of '*leadership effectiveness*' in hospital settings.

3.4 Understanding Health Care Organisational Context

This study is guided by the general definition of an organisation from organisational sociology: '*a collectivity with a relatively identifiable boundary, a normative order (rules), ranks of authority (hierarchy), communication systems, and membership coordinating systems (procedures); this collectivity exists on a relatively continuous basis, in environments, and engages in activities that are usually related to a set of goals; the activities have outcomes for organisational members, for the organisation itself and for the society*' (Hall & Tolbert, 2005, p.5). In this sense, organisations comprise of a collection of interacting actors within a social structure or environment that exhibit collective rather than individual behaviours.

Organisational scholars suggest that organisational context consists of interconnected history, structures, cultures, and processes within which events occur over time (McAlearney, 2006; Pettigrew, Woodman and Cameron, 2001). The inclusion of context in analysis, identification and explanation of patterns in organisational processes, and the ability to demonstrate how processes and context shape outcome, is important in studying organisations (Johns, 2006; Pettigrew, Woodman and Cameron, 2001; Pettigrew, 1987). Organisations contain individuals from different groups, whose expectations and performance are likely to, reciprocally,

influence the context of the organisations - in other words, organisational context determines the interactions between the individuals, but the interactions also shape or create context (Johns, 2001; Johns, 2006; Pettigrew et al., 2001). It is, then, difficult to separate individuals from their context as through their physical, social, and emotional interactions and experiences within their organisation they create meaning and develop understandings that enable them to achieve their goals (Hall, Johnson, & Haas, 2015; Hall & Tolbert, 2005).

Pettigrew (2001; 1987) argues, moreover, that organisational processes are embedded in both outer and inner contexts. The outer context comprises the historical, economic, social, political, competitive, and sectoral environments. The inner context includes the structural, cultural, and strategic environments, which together with the outer context influence the attributes of the organisation. Similarly, McAlearney, (2006) considers the different elements of health care organisational contexts, specifically, as: external environment within which hospitals operate (policy context); the health sector factors responsible for healthcare strategies; organisational factors such as internal structure, culture and human resource functions (organisational context) and; time period that is important in strategic changes within healthcare organisations (historical context).

The importance of organisational context to leadership, specifically, is asserted both by organisational behavioural researchers and leadership scholars. Organisational behavioural researchers conceptualise the context of leadership as the physical and social environment where leadership is observed (Liden & Antonakis, 2009). They argue that researchers ought to consider the role of context in leadership - investigating how it influences relations between the different phenomena or issues being researched to show how causal relations between leadership practices and outcomes vary because of the mediating role of context. They also highlight organisational culture as a component of context that shapes the relationship between leadership behaviour and leadership outcomes, concluding that leadership and culture reciprocally influence one another. The other aspect of context considered by Liden and Antonakis is the team/unit context – which influences leadership even as, at the same time, leaders influence relationships in teams. Also intricately linked to the team context is the overall social environment which significantly shapes individual leadership attitudes and behaviours.

As already discussed (see section 3.2), meanwhile, some leadership scholars identify leadership as a social process deeply embedded in contextual settings (Day *et al.*,

2014; Bolden and Gosling, 2006; Porter and McLaughlin, 2006; Bolden, 2004). Therefore, leadership cannot be completely understood outside the social and cultural context in which it is practiced (Biggart & Hamilton, 1987). In their conceptual review of the relationship between leadership and context, Porter & McLaughlin (2006) acknowledge the absence of a universally accepted definition and description of the elements of context. However, they identified seven major components of organisational context that might influence leadership: culture/climate, goals/purposes, people/composition, processes, state/condition, structure, and time.

Other leadership scholars identify the historical, proximal, and distal contexts that foster leadership (Avolio, 2007). According to Avolio, historical context plays a role in emergence of diverse practices of leadership. The proximal context is critical in leadership and includes the work environment, team and group characteristics, task characteristics, and performance. Meanwhile, distal context constitutes the organisational socio-cultural climate and innovation. The distal context is responsible for the interpretations, decisions, and behaviours of both leaders and followers.

In the present study, healthcare organisational context is defined as comprising internal and external factors within hospitals as social systems that influence how leadership is practiced. I designate hospitals as healthcare organisations whose specific goals are to promote patient care and health through curative and preventative services, teaching, and research. Thus, the following discussion outlines factors that I judged as relevant external and internal contextual features of hospitals as HCO.

3.4.1 External Organisational Context

External context of HCOs refers to the immediate environment or surrounding within which hospitals operate. External organisation components include health sector traditions, legislation, policy and regulatory framework, historical events, and social and economic systems within which an organisation operates (Pettigrew, 1987). The social and economic environment of an organisation creates opportunities and challenges for leadership because public organisations respond to the demands of socio-economic systems that support them (Pettigrew, 1985). The social context entails an understanding of the social density, social structure, and social influence within which an organisation operates (Johns, 2006). Economic conditions determine the environment for leadership and behaviour within organisations (Oc, 2018; Rousseau and Fried, 2001).

The national, provincial, and regional structure of the economy plays an important role in the allocation of resources for the establishment, maintenance, and provision of services in healthcare organisations. Analysis of the socio-economic context leads to an understanding of socio-economic trends on the emergence and distribution of organisational values, norms, attitudes and relationships that may influence the direction of changes within the organisation (Pettigrew, 1985).

The legal framework comprises of policies and regulations developed by national governments, which allow individuals to advance through their system, and may also provide information that is relevant to understanding leadership practices. For example, the experience of individuals who advance in their managerial or leadership positions through the system are determined by established national public and health policies and regulation (Hall & Tolbert, 2005).

Historical events are individual and organisational activities that take place over time within the organisation (Pettigrew, 1990). Pettigrew argues that history is not just events of the past but should be studied as legacies of the past that are alive in the present and are always shaping a continuously emerging future. According to Pettigrew, historical events that are important in leadership practices include time, tenure of leadership, organisation's life cycle or stages, and the leadership succession history.

Leadership practices change over time with changes in organisations (Biggart & Hamilton, 1987). Historical experiences and actions of organisations and the leadership within them plays a role in the ability of actors to intervene by adapting collective behaviours to achieve organisational objectives. The analysis of historical events within and outside an organisation is likely to yield patterns of leadership practices and their consequences by understanding the unpredictable pathways that generate satisfaction and morale.

3.4.2 Internal Organisational Context

Internal context is the actual setting or environment where healthcare organisational activities take place to achieve organisational goals. The internal context of the organisation, broadly, comprises of organisational elements such as culture, structure, demographics/population, and internal power characteristics (Pettigrew, 1987). Organisational and public administration scholars argue that internal organisational context is, in most cases, influenced by the external organisational context during change processes (Pettigrew, 1987). Key elements of internal

organisational context highlighted by Pettigrew, for analysis in the hospital as HCOs, include organisational demographics, processes, structure, and culture.

HCO demographics, for the purposes of this study, refer to the personnel composition and subgroups within subunits. Demographic components include different variables such as age, gender, nationality, race/colour, organisational/job tenure, and educational level or professionalization. Some evidence from organisational sociology indicate that demographic heterogeneity and diversity exert an influence on organisational behaviour, organisational learning ability and, ultimately, organisational effectiveness (Chatman *et al.*, 1998; Cox, Lobel and McLeod, 1991). While demographic diversity may also have negative influences on organisational effectiveness, homogeneous groups have better outcomes because increased diversity and heterogeneity is associated with conflict and power struggles (Chatman *et al.*, 1998; Tsui, Egan and O'Reilly, 1991), increased employee turnover and low social relations and integration (Elfenbein and O'Reilly III, 2007; O'Reilly III, Caldwell and Barnett, 1989).

Within HCOs the heterogeneous staff group may interact with other elements of the healthcare organisation, such as the structures, resources, and human resource processes, impacting on their behaviour and ability to develop collective leadership practices. Healthcare staff are socially differentiated by their knowledge, expertise and authority, which define how they distribute their work and build relationships (Abbott, 1988). This expert knowledge contributes to their professional power and authority (Yukl, 2006), and legitimise the professional identities that play a role in their professional subcultures (Correia, 2017).

These professional boundaries may have consequences for staff satisfaction and morale, and the delivery of better patient care (Powell & Davies, 2012). Professionalisation and professional identity in healthcare in HICs has led to growing debates on the role of healthcare professionals in leadership (McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015; Baker & Denis, 2011; Waring & Currie, 2009; Denis, Lamothe, & Langley, 2001). Therefore, it is important to clarify the nature of healthcare staff professional identities, power, and relationships that are embedded in the different professional groups within hospitals.

Internal context can also be characterised as having both hardware and software elements (Gilson, 2012; Sheikh *et al.*, 2011). Hardware elements comprise of the structure, organisation, technology, and resourcing of the health system, while

software elements are denoted by values, norms, actors, and relationships within the health system. Resource based theory and competitive advantage literature (Barney and Clark, 2007; Barney, 1991) also argues that the internal organisational elements that play an important role in creating value within an organisation include physical, financial, human and organisational resources. In the literature, these elements are further classified as tangible or intangible (Zigan, Macfarlane and Desombre, 2009; Zigan, Macfarlane and Desombre, 2008; Carmeli and Tishler, 2004). Tangible elements comprise of resources that are easily imitated like organisational structures, facilities, equipment, and raw materials. Intangible elements are made up of the culture that underpin functioning of the organisation, relationships between the leadership and staff or amongst staff, communication, professional behaviour, and knowledge within the organisation.

3.5 Chapter Summary

The theoretical framing and definitions presented in this chapter provide the framework and lens for investigating the three phenomena of collective leadership practices, HCO context and staff satisfaction and morale, and the linkages among them. The current research posits that HCO context, leadership practices and staff satisfaction and morale in the health system present a dynamic complex, and the interplay between these phenomena is important in strengthening the health systems and improving health outcomes.

The interplay among the three interrelated constructs is represented in **Figure 3.1**. Hospitals comprise groups of individuals working together within an internal and external social context, and their collective intelligence may engender desirable or undesirable practices that may, respectively, promote or hinder collective leadership across groups of hospital staff, as well as impact positively or negative on satisfaction and morale. To examine internal context, the analysis draws on the concepts of hardware, tangible software, and intangible software.

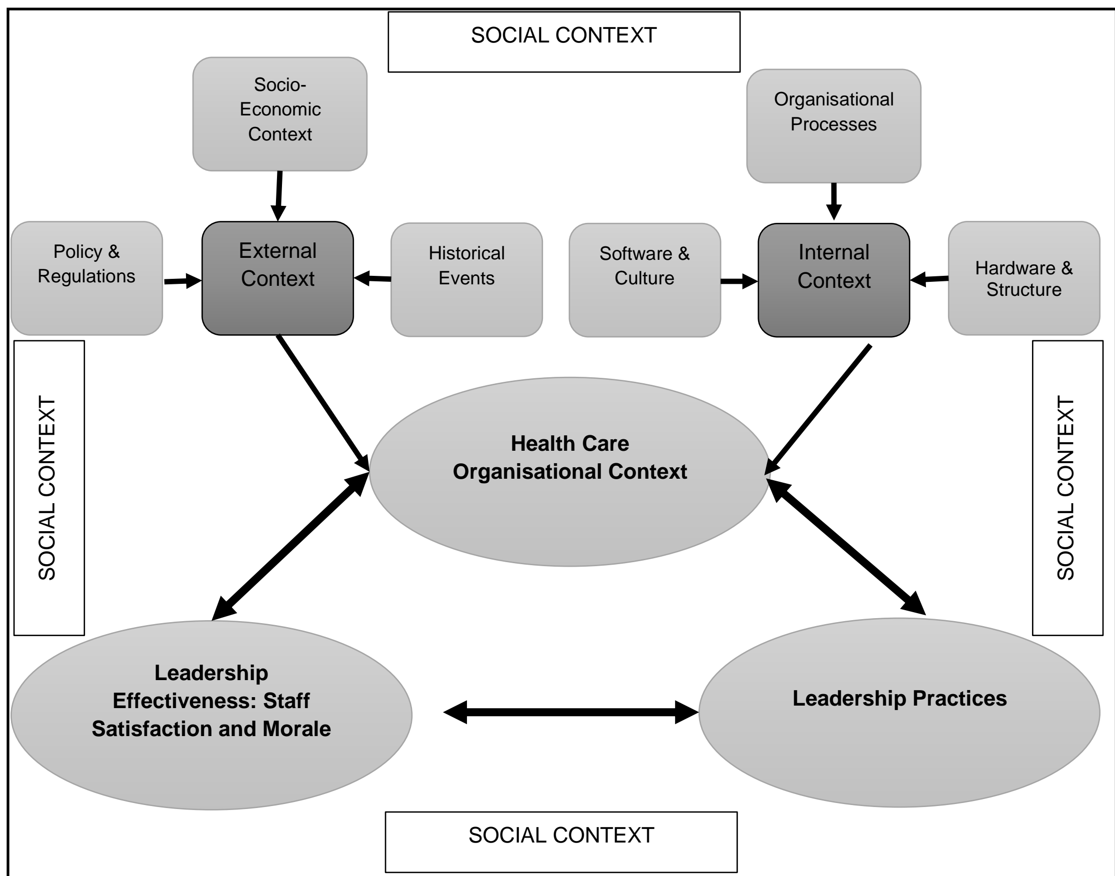


Figure 3.1*: A Framework for Health Care Organisational Context, Leadership Practices, and Leadership Effectiveness: Staff Satisfaction and Morale*

This conceptual model is the prism or thinking tool that informed the data collection and guided the analysis. Echoing calls by other researchers (Liden & Antonakis, 2009), it suggests there is a need to understand the variation in contextual factors that moderate leadership practices, and the consequences for staff satisfaction and morale.

Chapter 4: Research Methodology and Study Design

4.0 Introduction

This empirical research study collected primary and secondary data from two case study hospitals to explore and explain the linkages between health care organisational (HCO) context, leadership practices, leadership effectiveness through staff satisfaction and morale. The phenomena and participants were studied in two hospitals, using a qualitative approach, including observations of the actions of participants *in situ*, to understand the complex dynamics in these settings.

This methodology chapter describes the procedures and techniques that I employed in designing and operationalising the study. First, I outline my philosophical standpoint. Second, I elaborate on the research methods and study design, including the selection and the sampling techniques. Third, I outline the approaches to data collection before, fourth, detailing the techniques I used to analyse the data. Fifth, I describe the measures that I undertook to ensure study rigour and trustworthiness. Sixth, I enumerate ethical procedures and approvals for the study, including reporting on how I ensured privacy and confidentiality of the respondents. Seventh, I explain the methodological limitations to the study, before, finally, providing a summary of the chapter.

4.1 Ontological and Epistemological Standpoints

My philosophical standpoint is constructivism, and so the study is founded on the understanding that the world around us, reality, experiences, artefacts, are constructed through social interactions among people and groups (Kukla, 2000; Berger & Luckman, 1991). This philosophical standpoint shaped my overall line of inquiry, including research questions, theoretical frameworks, and the methods used to gather information, analyse and interpret the data (Yin, 2014; Creswell and Clark, 2011; Kukla, 2000; Berger and Luckman, 1991).

This philosophical standpoint requires consideration of actors' perceptions of their worlds and their experiences, and how they form multiple and conflicting social realities (Creswell and Clark, 2011; Guba and Lincoln, 1994). From my constructivist position, I understand the hospital setting to be a construct of social interaction in which relational processes are observed and given meaning (Jonassen, 1991). In addition, I understand leadership practices as social events in these settings (Berger

& Luckman, 1991), and the emergence of leadership practices as the construction of new knowledge and learning arising from the experiences of individuals and groups of managers and staff (Endrissat and von Arx, 2013; Raelin, 2011; Denis, Langley and Rouleau, 2010; Carroll, Levy and Richmond, 2008).

Given these understandings, it was important to elicit the perspectives of the actors or agents within the hospital contexts, and consider how these contexts influenced them (Barley and Tolbert, 1997; Giddens, 1984). It was also relevant to identify and examine leadership practices and experiences in multiple settings (groups, units, departments) within the study hospitals, taking account both of individual and group experiences. These needs shaped my overall study design and methodological approaches, as explained in the subsequent sections.

In summary, my constructivist standpoint influences how I understand the phenomena of focus in this study and shaped its overall design and methods.

4.2 Research Method and Study Design

In line with my philosophical position I used the qualitative research paradigm, or flexible study design, to conduct the research in the natural hospital setting of social actors (Miles, Huberman and Saldana, 2014; Babbie and Mouton, 2001; Lincoln and Guba, 1985). This supported me to: consider the perspectives of the participants, social actors or health staff; generate in-depth descriptions and understanding of the hospital as a social setting (Miles, Huberman, & Saldana, 2014); and adopt an inductive approach to developing insights about the three phenomena under study (Babbie and Mouton, 2001; Guba and Lincoln, 1994). Therefore, the research also needed reflexivity and careful interpretation of the information gathered from the actors within their HCOs (Creswell & Clark, 2011).

Qualitative research was appropriate in this study because it allows a focus on '*naturally occurring, ordinary events in natural settings'* and generates data on the cases as '*focused and bounded phenomena embedded in its context'* (Miles et al., 2014). All these features of qualitative research were important for this study – in which agents' perceptions, and the way they are influenced by context, was key (Schneider and Somers, 2006; Barley and Tolbert, 1997). As noted in earlier chapters, the currently available organisational and healthcare leadership research is commonly criticised for not applying qualitative approaches and so, for inadequately considering the complexity of the phenomena of focus.

All qualitative research entails gaining access to study participants, as well as applying suitable methods for data collection, and specific approaches in data analysis. In this study, qualitative research approaches enabled the actions of the study respondents to be observed and described in detail, before seeking understanding of their actions in relation to their own knowledge, attitudes, beliefs, history, and their setting. The analytic process led to "*thick and rich description*" (Geertz, 2008) that is detailed and encapsulated the events as they occurred and were perceived by the actors or respondents in their settings (Miles et al., 2014).

4.2.1 Case Study Design

Since the research question focuses on complex phenomena in specific settings, I used an overall case study design with two hospitals as the cases and setting of focus. Applying the case study design as the empirical strategy for this research entailed realistic, complex and detailed examination and analysis of the three phenomena with their various dimensions, and of the hospitals within their situational conditions (Yin, 2014).

Case study research design was advantageous because I sought to ask "*what*", "*how*" and "*why*" questions to capture in-depth and comprehensive description and understanding of the phenomena. In addition, there was a likelihood of complex associations between the phenomena under study and controlling the events, actions and processes in the study was not practical (Yin, 2014).

The study adapted a multiple case study research approach (Yin, 2014) – embracing two district hospitals – to allow for cross-case analysis and analytic generalisations. Similar approaches to data collection were applied in each hospital, and initial analysis focussed on preparing thick descriptions of each hospital's experience, considering different perspectives to understand the contextual influences on staff satisfaction and morale within the hospital as a social system. Subsequent cross-case analysis was undertaken to support analytic generalisation through the comparison of specific experiences across the hospitals (Yin, 2014; Eisenhardt and Gräbner, 2007). Multiple-case selection or sampling, thus, added confidence to the study findings (Miles et al., 2014).

4.2.2 Description of Cases and Study Settings

I opted for multiple case studies, two hospitals, to generate valuable information on the three phenomena. In this scenario, the unit of study was the district hospital, where I studied contextual organisational issues, leadership practices and staff satisfaction

and morale. In the analysis of each case, I developed deeper understanding of the phenomena of focus, and developed a rich description of well-established linkages among them (Miles et al., 2014). The two cases allowed me to produce rich knowledge on the settings that led to insightful assumptions about the leadership practices and morale of the participants.

The Western Cape province has forty district hospitals which are potentially information-rich cases, but only two district hospitals, designated as District Hospital-A (DHA) and District Hospital-B (DHB), were considered within the study. Their selection was judged adequate for the type of inquiry conducted and due to accessibility, time and resource constraints (Sandelowski, 2000; Miles, Huberman and Saldana, 2014).

I used purposive sampling (Miles et al., 2014) to select the two hospitals considering their location within the same province (both a logistical factor and to limit the influence of provincial context as one of the multiple potential contextual factors of relevance), and that they played a broadly similar role in the system at the district. In addition, the hospitals were selected to be based in different neighbourhoods, have different histories, and have different bed capacity and staff size. Therefore, whilst broadly similar in terms of their role in the District Health System, the differences between the two cases allowed inquiry into critical features of their internal and external context as influences over the leadership practices within the hospital. Finally, the hospitals were selected because the Chief Executive Officers and managers of the hospitals were willing to grant access and allow their staff to participate in the study.

The two cases were considered as standalone cases to gather adequate information in each about the interplay between the three phenomena under examination – and also allowing later cross-case analysis. Chapters Six and Seven provide detailed description and analysis of the two cases, and Chapter Eight presents the cross-case analysis.

4.3 Approaches to Data Collection and Data Sources

The case studies utilised multiple sources of empirical evidence that were appropriate to the conceptual framework and phenomena under study. The study engaged emergent approaches to data collection and analysis whereby the qualitative strategies were pre-planned at the start of the study but also unfolded as I gathered information during the research (Creswell & Clark, 2011). The use of a common approach and framework in each hospital provided a base for thick description of the

hospital cases, while at the same time enabled an understanding of the contextual influences on leadership practices within each hospital that later allowed for comparability across cases (Miles et al., 2014).

I used purposive and snowball sampling to identify the respondents. At the same time, being naturalistic research (Lincoln & Guba, 1985), I gathered relevant information through reviews of documentary evidence, non-participant observations, semi-structured in-depth interviews and journaled my personal reflections during the research process in each hospital (Pope & Mays, 1995). The naturalistic approach was to ensure that I observed, described, and interpreted the experiences of the respondents in the hospital as social context. **Figure 4.1** outlines the overarching approaches to data collection at the two hospitals.

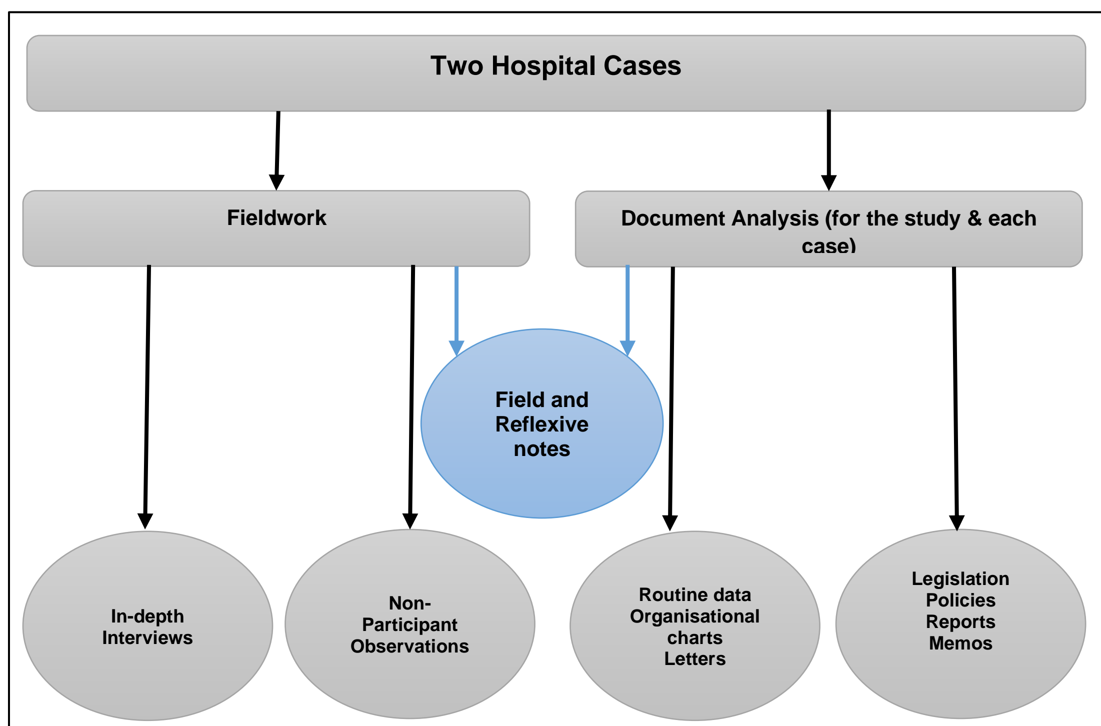


Figure 4.1: *Approaches to data collection*

I gathered data at both hospitals simultaneously to ensure that the entire process was similar in each hospital and to ensure study rigour. I spent equal time at the selected hospitals to allow for a relatively equal distribution of time used for observations and documentation of study-relevant events that occurred in the hospitals. For example, spending morning hours at DHA and afternoon hours at DHB for equal number of days in a week and then alternating the times on alternate weeks by spending morning hours at DHB and afternoon hours at DHA. Sometimes, I spent full consecutive days

at each hospital to follow-up on interviews and relevant information gathered on an earlier day. The approach started with periods of observation in each hospital, to get to know the layout and to be known by both staff and the managers. After a period of familiarisation and introduction to managers and staff, I undertook in-depth one-on-one and group interviews (see sub-section 4.2.3) with selected participants but continued making observations in each hospital case.

4.3.1 Document Reviews

The data collection entailed review of documentary evidence from both inside and outside the hospitals. I carried out document reviews around and during hospital work and observations, and before and after in-depth interviews. Information from document reviews later corroborated findings from empirical data (Yin, 2014; Bowen, 2009). The documents that I reviewed for this study (**Table 4.1**) include wider national and provincial legislation and policy documents, commissioned reports, peer reviewed scientific publications, internal memos, letters, agenda and minutes of meetings, and accessible personnel records outlining staff complement.

One of the objectives of document review was to provide a thick description of the external context of the study hospitals by looking at both national and provincial contexts, in addition to drawing on the details that emerged during in-depth interviews (Bowen, 2009). The review involved internet searches and scrutiny of policy documents and, hospital and Western Cape Department of Health data on budgets and human resources. I also acquired hospital-specific documents and data, with permission from the Chief Executive Officers, from heads of the departments and units such as finance, human resources, quality control, and clinical and nursing departments in each hospital. Overall, the review entailed analysis of the socio-economic system, government policies, Western Cape DoH regulations and other evidence on South African health system and the healthcare leadership processes within the South African and, specifically, the Western Cape.

The analysis of legislative and policy frameworks was important, for example, in understanding the organisation of the National, Provincial and District Health Systems as the broader context of the hospital. Legislation also outlines the frameworks for financing and budgeting of the hospitals, human resources management, quality and standards control, structures and strategies for leadership, and the overall organisation of public healthcare system.

Table 4.1: List of documents reviewed

Document	Description
The Constitution of the Republic of South Africa, 1996, Act 108 of 1996	Constitutional mandate to provincial DoH to provide basic health services
National Health Act 61 of 2003 and its amendments	Legal and legislative framework for the unified health system, used to describe the South African healthcare system
Western Cape District Health Council Act 5 of 2010 and its Amendments Act of 2016	Amendment of the WC District Health Councils Act, 2010, to include members of health sub districts in a district health council
National Health Insurance Act	Healthcare financing framework to ensure all South African citizens and residents receive adequate healthcare services regardless of their earning ability
Public Service Act of 1994	Organisation and administration of the public services, regulation of the conditions of employment, terms of office, discipline, retirement, and discharge of members of the public service, and other employment matters
Skills Development Act, 97 of 1998	Institutional framework and workplace strategies to develop and improve the skills of South African workforce
Skills Development Levies Act, 9 of 1999	Provision for the imposition of a 1% skills development levy
Labour Relations Act, 66 of 1995	Laws governing labour relations – labour peace and democratisation of the workplace
WC Provincial DoH Annual Performance Plans	Strategic plans that link budgets and performance indicators to achieve the goals and objectives of the WC DoH
WC Provincial DoH Annual Reports	Publications of annual financial and non-financial information of the WC DoH for accountability and transparency and linked to efficiency and effectiveness
National Department of Health Systems Priorities: The Ten Point Plan	Strategic plan of the NDoH; a 10-point programme to steward the country towards improving the South African healthcare system and improving access to healthcare
National Development Plan 2030	National strategic plan that aims to eliminate poverty and reduce inequality by 2030, outlines broader plans for the health sector
Human Resources for Health Strategy for Health Sector: 2012/13-2016/17	Strategic vision to develop and employ new healthcare professionals and cadres, improve ways of working and productivity of existing health workforce, to improve retention, increase productivity and revitalise aspects of healthcare education, training, and research.
Negotiated Service Delivery Agreement 2010	A charter that reflects the commitment of key sectoral and intersectoral partners linked to the delivery of identified 12 key outcomes for a long and healthy life for all South Africans
Healthcare 2030: The Road to Wellness (Western Cape Government: Health)	A vision for the WC DoH for access to person-centred, quality care through the perspectives of patients, staff, the community, the DoH, spheres of government and strategic partners.
Commissioned Reports for the Health Sector	A range of reports relevant to Provincial and National healthcare issues, published by different commissioning organisations
Peer Reviewed Journal Articles	Refereed journal articles on issues relevant to the Provincial and South African health systems
Internal memos, letters, charts, personnel records, and meeting agendas and minutes	Specific documents within each hospital – from provincial, sub-structure and internal executive offices

Note: Department of Health (DoH); National DoH (NDoH); Western Cape (WC).

Document analysis was also critical in tracing relevant information on the context and leadership processes in each of the two hospitals. For example, some of the structures and processes, demographic constitution, hospital culture, and leadership strategies were revealed through national and provincial regulation and strategy documents, internal memos and, agenda and minutes for meetings.

4.3.2 Hospitals' Routine Data – Staff Satisfaction Survey

I retrieved routine data from a hospital-wide survey at each hospital that offered important insights for this study. Staff Satisfaction Surveys (SSS) are routinely and regularly conducted in all hospitals in the province by the WC DoH – the first and the second were carried out in 2013 and 2016, respectively. SSS questionnaires are modelled around the National Core Standards (NCS) for health and a National Department of Public Service and Administration (DPSA) Wellbeing Framework for organisational culture. These surveys were commissioned by the WC DoH and were conducted by the Independent Counselling and Advisory Services (ICAS) – a private organisation focusing on employee wellbeing, performance, and counselling services. The aim of the survey as reported, was to assess the hospital's organisational climate among the groups of staff – considering their thoughts and opinions about the organisation, their job, and their work environment.

The tool for each survey year is a common questionnaire that was administered to all categories of staff at each hospital. Subsequent reports were generated for each hospital, sub-structure, and district. The survey consisted of 65 questions with core dimensions relating to opinion of the organisation, communication, leadership, employee satisfaction with the organisation and organisational support structures, trust, team functioning, performance management, growth and development and coping style. There was a qualitative component of the survey that asked a question about the three things which would make the workplace a better place. These quantitative data were already analysed and reported at the time of this study and were therefore available to support interpretations of the phenomena under study.

For this study, I used the 2016 survey findings, the year of fieldwork. In this year, the survey report indicated that there were 102 responses in DHA, a response rate of 23%, compared to 147 responses in 2013 (**Annexure 1**). At 51%, nurses recorded the highest number of respondents in 2016 followed by 30.39% of responses from administrative and support staff. Doctors and allied health staff constituted 16.67% of the respondents. Majority of the respondents, 52.94%, were in salary levels or employment grade 1-6 and 41.18% having been in employment at DHA for 0-5 years.

In DHB, in 2016 the survey report (**Annexure 2**) was based on responses from 455 staff compared to 273 respondents in 2013, a response rate of 59.8%. The highest response rates were reported amongst Nurses, at 53.41%, followed by administrative and support employees at a combined 36.27%, and doctors and allied clinical staff at

10.33%. Most of the survey respondents, 74.07%, were in salary level 1-6, the lowest pay grade within the hospital while 53.41% had been in service for 0-5 years.

The available reports of survey data did not provide data disaggregated by either cadre, level of management, units, or department; and it was not possible to obtain the source data. Importantly, ICAS recommended, as undertaken in this study, that other corroborative data should be obtained and used together with the survey results. The findings specifically considered in this study are related to questions on job satisfaction of survey respondents, the leadership practices, and elements of hospital's context. I used this information with the findings from the qualitative fieldwork to triangulate the perceptions of staff on leadership practices, levels, and sources of their morale and elements of hospital context. Issues related to experience of verbal and/or physical abuse from patients, as reported in the surveys, were not used during analysis as I judged these data as not relevant to my research question.

4.3.3 Non-Participant Observation

Evidence from observations within the study sites enriched understanding of the phenomena under examination (Yin, 2014). Even though Yin argues that the reliability of observational data increases where there are multiple observers, the deliberate and consistent use of an observation topic guide (**Annexure 3**) contributed to the reliability of the data collected for this research. Observations at meetings and during interviews included descriptions of the settings, behaviours of staff and managers and the nature of their interactions. The observations were in blocks of 15-20 minutes, followed by 5-10-minute regular breaks or intervals between the blocks, except for meetings where I made observations for the entire duration of the meetings.

During the study, I made unobtrusive observations to understand and document interactions between staff within hospitals. I made the observations by sitting or standing quietly in selected areas but occasionally held informal conversations with different staff within the hospital. I spent 4-5 hours per day at each hospital to make observation before, during and after interviews. I persistently and strategically observed staff and respondents in their natural work settings such as within the wards, management suites, meeting rooms, offices, and communal spaces like cafeterias and tea rooms, the patient waiting area, and along the corridors or passageways. I also took extensive field notes that described different sections of the hospitals during non-participant observations in meetings. Persistent observations enabled me to have multiple interpretations of words and actions by the respondents.

In some instances, I joined meetings before carrying out interviews in closed rooms and then made further observations in work and common areas. I made 22 observations totalling 88 hours at DHA, and 31 observations totalling 124 hours at DHB because the two hospitals are different in sizes and staff complement, with DHB having twice as many staff and twice as big as DHA. Social artefacts and objects observed within the hospitals form the overall context and setting that play a role in interactions amongst staff.

The information I gathered include descriptions of the meeting rooms or areas, body or physical expressions, behaviour and topics of discussion, and other interactive actions of staff in the hospitals. In addition, I made observations on the physical outlay of each hospital and the portraits, pictures, charts and murals and artworks on walls. The observational data allowed me to note and record different individual and team/group actors, forms and patterns of their interactions and behaviour.

Although there were some difficulties in making interpretations from some observational data, overall, the observations provided background information that assisted in doing and interpreting interviews, and in the process making meaning of the interview responses. Moreover, seeing the workflow and processes enriched the understanding of the wards, units, team, and hospital context. Finally, familiarisation with the staff and the hospital environment during the observational and document analysis allowed free interaction with staff in subsequent study engagements and limited the likelihood of respondents behaving differently than they would in normal situations.

4.3.4 In-depth Interviews

Open-ended In-depth interviews in each case study hospital provided evidence on relationships, history, processes and actions of individuals or groups (Yin, 2014). I initially selected respondents from across different cadres and units within each hospital, and with different levels of experience and from different levels of leadership. This was both to ensure variation in the experience represented and to get a hospital-wide set of experiences. Subsequently, I identified other respondents through a snowballing process (Miles, Huberman and Saldana, 2014; Corbin and Strauss, 2015). This selection strategy elicited rich information that allowed an understanding of the similarities and differences in perspectives, among groups of respondents and managers at each hospital (Babbie & Mouton, 2001; Gioia, Corley, & Hamilton, 2013).

Other than the one-on-one interviews, I carried out joint interviews with a group of three nurses with no leadership positions at DHA, and with two senior clinicians in middle management at DHB as part of the in-depth inquiry. These interviews also gave me the opportunity to observe interactions between staff on the phenomena under study at the selected cases.

Table 4.2 and **Table 4.3** show the breakdown of selected respondents by cadre and level of management at DHA and DHB, respectively.

Table 4.2: Breakdown of respondents in DHA

District Hospital A					
Respondents	Senior Management	Middle Management	Junior Management	No Management Role	TOTAL
Clinical		3	2		5
Nursing	1	5		1	7
Administration	2	2	2		6
TOTAL	3	10	4	1	18

Table 4.3: Breakdown of respondents in DHB

District Hospital B					
Respondents	Senior Management	Middle Management	Junior Management	No Management Role	TOTAL
Clinical	1	6	3	1	11
Nursing	1	5	1		7
Administration	2	4	1	1	8
TOTAL	4	15	5	2	26

In this study, administrative cadre refers to respondents within the executive management team and the departments of finance, human resources and people management, and quality assurance. Clinical cadre or clinicians include doctors and staff from allied health (such as physiotherapists, occupational therapists, and radiographers), while nursing cadre comprises of all categories of nurses. Since leadership is entangled with management and is defined as a social process amongst sets or groups of people in this thesis, for analysis, respondents were categorised in relation to their formal managerial or lack of managerial roles in the hospitals.

In terms of numbers, due to differences in size and capacity DHA (a smaller hospital) had less than half the number of employees than DHB. Although the sample size was relatively small in each hospital, I only stopped interviewing when I had reached

saturation in terms of data collection around the phenomena of focus (see later). Interview material provided information that was rich in breadth and depth from the three cadres and the levels of management considered for the study.

Initial interviewees were the managers with whom the researcher had first contact, largely from the executive management and including the Chief Executive Officers (CEOs) of each hospital. The managers provided background information on the hospitals, including their perceptions on leadership practices, the impact of their leadership and hospital environment on staff and their levels of satisfaction or morale. These key-informants then identified other respondents who could provide more information to help understand the context and the nature of leadership within the hospitals.

However, the sampling criteria ensured variability by aiming to have a broad group of representation and for comparison within and/or between cadres, units, or departments. Including staff from across cadres and levels of management in the research was important for generating reliable information on experiences across the hospitals. The inclusion of non-management staff was also informed by the idea that leadership practices may encourage teamwork and support, which are likely to increase the levels of staff satisfaction and morale. Senior and unit managers who volunteered to be interviewed were requested to explain the significance of the study and encourage other hospital staff within their units or teams to respond to the interviews. In addition, the selection considered respondents who had longstanding work experience at the hospitals, with a deep understanding of the culture and processes within the hospital. The respondents were informed about the basis of their selection.

Due to the tight schedules and nature of hospital work and reported staff shortages, it was difficult to recruit participants during the regular work hours and most staff were unwilling to be interviewed outside their normal work periods. Consequently, I interviewed managers and staff when they had adequate time because many of the interviews were prolonged and lasted for an average of sixty minutes – with some taking place over two days (Babbie and Mouton, 2001; Pope and Mays, 1995).

The interviewing processes took place in offices that were only accessible to the respondents and the researcher during the interview sessions. I conducted the interviews in English, in a conversational manner and open-ended style, using the pre-designed topic guide with the main question and sub questions (see Topic Guide

in **Annexure 4**). Whenever a respondent mentioned a word or phrase that I considered rich and revelatory (Babbie & Mouton, 2001), I probed and encouraged the respondents to explain further, to gain depth over an issue and to gather insights on information that deviated from the general views of other respondents.

I carried out intensive fieldwork in both hospitals over a 4-month period between March and July 2016, and until data saturation (Green and Thorogood, 2018; Fusch and Ness, 2015; Francis *et al.*, 2010; Guest, Bunce and Johnson, 2006). Data saturation was attained when I could not generate newer information from subsequent interviews to create original knowledge through the in-depth inquiry and initial analysis. The interviews aimed at explaining how managers and staff viewed leadership as a source of staff satisfaction and morale to achieve the goal of providing better care. They also sought to elicit the respondents' perceptions and perspectives about both their own knowledge and experience of leadership within the hospitals, and how context influenced aspects of collective leadership such as problem-solving and social judgements.

In-depth interviews and discussions sought staffs' viewpoints on their relationships with others, to understand how these relationships contributed to leadership practices within DHA and DHB. Additionally, the study included the perspectives of respondents on how healthcare leaders influenced the levels of their morale. The interviews explored the understanding of health care leadership practices and gathered data for a better understanding of the aspects of external and internal HCO context and their impact on leadership in the South African health system specifically and, LMICs in general.

I later transcribed the audio-recorded interviews for detailed analysis – 17 hours and 27 hours of recording in DHA and DHB, respectively. The transcriptions of the interview voice recordings yielded 707 pages and 1082 pages of raw interview data from DHA and DHB respectively, double spacing, and 12 font text.

4.3.5 Journaling/Researcher Diary

During the document reviews, observations, and interviews, I noted and journaled how cultural, structural, demographic elements and factors external to the hospitals of relevance influence the leadership practices within the two district hospitals, including the attitudes of staff. The journaling entailed emerging issues for further inquiry in subsequent interviews, while noting personal reflections, thoughts, and opinions on what aspects of leadership and context carried more weight or had

influences on respondent words and actions, and any other information that emerged outside the interview sessions.

The extensive field notes also formed part of memos that guided the study throughout data collection and analysis. The research notes and memos allowed me to fine tune the interview and observational guides during the data collection process. Most of the ideas and information were scribbled during the interviews and observations but later expanded at the end of each data collection day in attempt to understand and make meaning of the information in relation to the phenomena under study. Journaling was critical in detailing my overall experience during the research and expanding on insights about the hospitals.

4.3.6 Data Management, Safety and Monitoring

To manage data effectively, I developed a data inventory chart that entailed all the data sources, including the transcripts from the in-depth interviews, expanded field notes, documents reviewed, journal reflections and memos. The stored data also includes preliminary analytic write-ups, coded data, display matrices from NVivo, preliminary findings presented at local and international conferences, and case report drafts. I generated a data tracking and accounting log to keep details of each type of data collected and the demographic details of the respondents (Pope and Mays, 1995; Green and Thorogood, 2018).

At the end of the fieldwork, I reviewed all the collected data, made copies, and kept the anonymised, transcribed, and reviewed notes from each hospital in separate envelopes and, in external electronic data storage devices only accessible to me. All the raw data and the transcribed material and tapes are securely kept in a secure locked cabinet, to avoid access by unauthorized persons or loss of the data. The data are also stored in a file with different folders on internal storage of a password protected personal computer. I continuously supervised and monitored the study process during the recruitment, sampling, data collection, analysis, and storage to ensure high standards of integrity; using unique codes that anonymise the participants (see section 4.6) to store the information.

4.4 Data Analysis

The analysis of data from DHA and DHB sought to identify dimensions of the three phenomena - hospital context, leadership practices and staff satisfaction and morale – and how they interlinked, drawing on the study's conceptual framework (**Figure 3.1**).

For the themes and sub-themes on positive and negative leadership practices, sources of morale and dissatisfaction, and dimensions of internal and external context, I first identified emergent categories within interview transcripts and the routine data. Then I refined these categories and grouped the organised data from each interview and each hospital around the emergent themes and categories, to illuminate the linkages and sets of relationships between the phenomena.

Data analysis was processual (Pettigrew, 1997) and involved transcription of the interview recordings, reading and re-reading of all interview transcripts from each case, organising transcribed interviews, observational field notes and hospital-specific internal documents as case data sets in the NVivo computer software (Miles, Huberman and Saldana, 2014; Green and Thorogood, 2018). The use of multiple sources of information allowed me to look at the data across different dimensions and develop thick descriptions of the phenomena and the cases.

The analysis period was long to cultivate critical analytic insights from the collected data, both inductively and deductively. The analytic approach was both grounded and thematic to illuminate the broad themes of relevance to the study. I did not use the grounded theory approach but rather applied grounded analysis (Corbin and Strauss, 2015; Glaser and Strauss, 1967). The grounded theory-based analysis involved: intensively reviewing the data to identify repeating themes; using keywords and phrases to code the emergent themes; grouping the codes into relevant concepts; and then categorizing the concepts by identifying relationships between them. These categories and the links found between them became the foundation for cross-case analysis and the discussion thereafter. This was useful in generating theory since leadership practices are processes that involve social interactions, relationships and influence that may generate better levels of satisfaction and morale (Parry, 1998).

To generate the key themes for cross-case analysis (Chapter 8) and discussion (Chapter 9), iterative inductive, deductive and abductive processes enabled the explanation of the relationships between the phenomena in a descriptively rich, deep and thick manner (Miles et al., 2014). The categories of concepts, from in-depth data coding and grouping, were linked to hospital context, collective leadership and staff satisfaction and morale. Based on the data and existing theories, these categories were interpreted and further analysed for surprising research evidence to generate new insights. Overall, the approach led to a systematic and methodological analysis (Timmermans & Tavory, 2012) that produced the best explanations of the interplay between context, leadership practices and staff satisfaction and morale. Cross-case

analysis is presented to offer generalisable learning that draws more formally on theory in the interpretation of the research findings. In these processes, the theoretical framework aided in suggesting and outlining the relationships between staff experience and the phenomena examined (Wuisman, 2005).

The overall analytic approach allowed an understanding of the hospital context, how context influenced leadership practices and moderated staff satisfaction and morale. A single, neat and tidy approach to qualitative data analysis for cases studies does not exist (Miles, Huberman and Saldana, 2014; Yin, 2014). Utilising multiple sources of evidence and incorporating different analytic styles in this research study allow an holistic analysis and interpretation through both inductive, deductive and abductive reasoning (Creswell and Plano Clark, 2011; Langley A, 2011).

4.4.1 Unit of analysis

According to Yin (2014), the unit of analysis represents the '*what*' of the study. That is, the object, phenomena, entity, or process that the researcher is interested in analysing. In this research, each hospital represented the unit of analysis, thus, a two-case or multiple-case study analysis (Yin, 2014). The hospital setting is a social setting that requires descriptions and explanations of interactions amongst groups of individuals. Analysis was further done at individual, group, and organisational levels. Analysis of individual interviews allowed me to investigate respondents' knowledge, attitudes, and beliefs, all of which play a critical role in their day-to-day behaviours and activities within the hospitals. The combined descriptions of and by individuals generated insights about the groups to which respondents belonged (such as cadres and unit teams) as well as about the organisational context of each hospital.

I analysed data by hospital, following similar analytic steps to ensure the replication or reproduction of the analytic steps and to generate initial case reports for each hospital. For each hospital, I first analysed for differences and commonalities in responses between and among respondents to generate categories and terms that I later used in producing themes. Based on the conceptual theory and model for the study, I later analysed the qualitative empirical data for indications of aspects of leadership practices and those of context such as culture, structure and the demographics that signify the internal organisational context of each hospital.

I also coded and analysed the interview transcripts for factors that were linked to the presence or absence of staff satisfaction and morale. Finally, I used the routine data

from each hospital's staff satisfaction survey to corroborate the findings from the qualitative data.

4.4.2 Data Transcription, Coding and Within-Case Analysis

Figure 4.2 shows the iterative process that I followed during the analysis. I read and re-read the transcribed transcripts, before organizing and coding them, both manually and by use of a coding programme - QSR NVivo 10.0 and its latest versions. NVivo is a Computer-Aided Qualitative Data Analysis Software (CAQDAS) that facilitated the grouping, categorising, analysing and storage of the data (Miles, Huberman and Saldana, 2014; Yin, 2014).

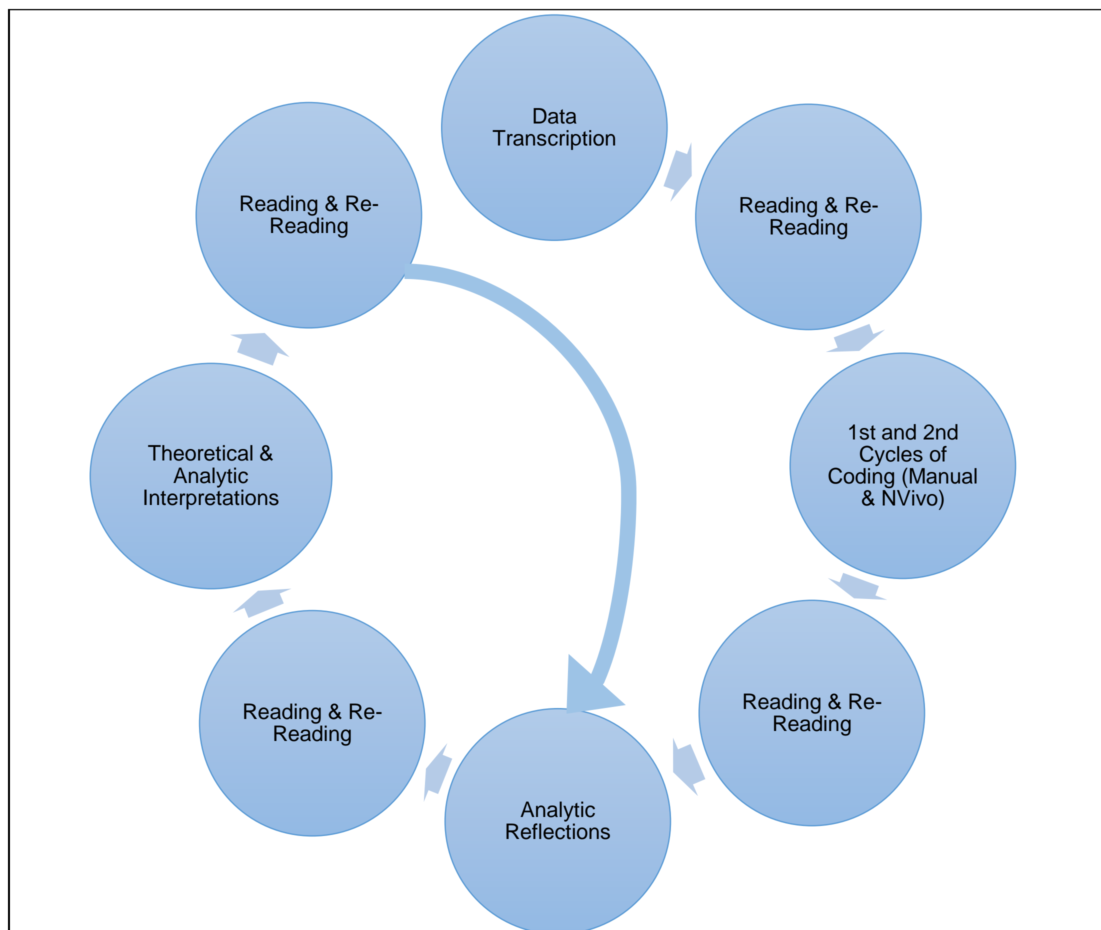


Figure 4.2: *Iterative data analysis process for each hospital case*

The coding and analysis involved identifying, developing, and organising emerging categories and themes. From the transcribed interviews, I identified specifically useful words, quotes, codes, and themes on the different aspects of HCO context and leadership practices. In the process, I identified and analysed the categories and

themes by constant comparison of words to allow the emergence of analytic codes (Miles, Huberman and Saldana, 2014; Yin, 2014).

The first step of coding entailed reading and re-reading of each printed transcript and manually coding using a pencil to allow codes and themes to arise from the gathered data. Using an open coding strategy (Corbin & Strauss, 2015), I created initial codes and categories (Miles, Huberman and Saldana, 2014; Gioia, Corley and Hamilton, 2013; Gioia & Chittipeddi, 1991b) by condensing information in the transcripts word by word, line by line, phrase by phrase, sentence by sentence and paragraph by paragraph.

Afterwards, I uploaded soft copies of the transcripts onto NVivo and reviewed each transcript again to inductively deepen the coding. Observational data and journaled notes were also uploaded onto the analytic software at this stage to allow for uniform coding and categorisation of the entire empirical data set, validate insights from interviews and to illuminate contextual and other study relevant issues. While using NVivo to review the manually and inductively generated codes, I used the conceptual theory and model to generate broad labels and themes, such as the dimensions of external and internal hospital contexts, while at the same time allowing other codes to continue arising from the data – for example leadership practices and sources or morale. The broad labels were critical in generating broad categories that were used in analytic tables to further fine-tune the analysis.

Condensing the coded data to manageable sizes was tedious and challenging but the strategy of displaying data in different tabular matrices and diagrams for each overarching construct or phenomenon proved useful in identifying emerging themes during the analysis. Analytic tables - with rows and columns that disaggregated the data into relevant codes and variables which were related to the overarching phenomena in each case study - were helpful in comparing respondents' views on the common issues and themes from the first and second cycles of coding; to identify similarities and differences in opinions and experiences. The tabular process specifically compared data by respondents, units/departments, cadres and managerial position or level in the hospital hierarchy.

I also coded for attributes of each respondent in the CAQDAS to allow for linking of emerging issues to groups of respondents and for further interpretations. The use of NVivo allowed the display of data through maps that was important in the initial linkages and meaning of the data. Displaying data in matrices enabled the

visualisation of how the constructs and phenomena interlinked; for instance, between individual codes on context and leadership practices, context and morale, and leadership practices and morale. Theory suggests that groupings by race, gender and level of education might generate different views and experiences (Bryman, 2003). However, these descriptive factors were only used in data collection and data organisation during first and second cycles of coding to identify respondents, and they did not reveal significant analytic nuances. Therefore, they were not considered further in the subsequent rounds of analysis.

Using analytic reflections and interpretations of the codes in the analytic tables, I continuously revised and refined the codes as the analysis progressed. To exemplify, codes such as power hierarchies, teamwork, camaraderie, flow of information, human resource processes and professional sub-cultures were generated from this stage of analysis. In addition, codes specifically signalling the leadership practices such as delegative, participative and empowering practices emerged during this process. Relational conflicts, hospital design, intrinsic drive and other sources of satisfaction and morale emerged during this stage of analysis.

During the coding process, I maintained side notes or memos that helped in making sense and meaning of the categories, their specific dimensions and linkages with each other (Gioia & Chittipeddi, 1991). Some of the memos arose during data collection and from the theoretical and conceptual framework that guided the study. The conceptual framework was useful in generating case reports which provided thick description of each hospital, using the inductive codes, that addressed the primary research question (see Chapters Six and Seven).

In the final step, I scrutinised the data and initial codes generated in the previous steps to identify patterns, relationships and categories (Corbin and Strauss, 2015; Glaser and Strauss, 1967). For examples, establishing links between positive leadership practices and staff morale, or negative leadership practices and dissatisfaction and demoralisation of respondents. Making connections and understanding these patterns and categories then formed the second order (Miles, Huberman and Saldana, 2014; Gioia, Corley and Hamilton, 2013; Gioia and Chittipeddi, 1991) basis of the themes and variables that I then linked back to the three constructs of HCO context, leadership practices, and staff satisfaction and morale. Later, I displayed the codes and constructs or dimensions in diagrams linked by lines and arrows to show the relationships between the identified elements of hospital context, leadership

practices and, staff satisfaction and motivation (see figures of illustrations of the relationships in Chapters Six and Seven findings).

Since the study considers three broad constructs with multiple elements, the coding process had multiple iterations. I coded words and phrases several times to capture relevant information that could provide linkages or relationships between the constructs in each case and between the cases. The process was iterative for each specific respondent transcript and the overall coding strategy allowed me to make connections and establish linkages between specific themes or codes to the three broader phenomena.

I included the staff satisfaction survey data from DHA and DHB in the final stages of the analysis as they were important in the approach to the case report and the analytic narrative. Since the routine data had already been analysed and presented as a report, I separately used the conceptual model to code them into the broad categories of HCO context, leadership practices and staff satisfaction and morale (see Chapters Six and Seven). The survey questions and responses were disaggregated in this manner using tables which then provided corroborative evidence to the emerging codes and themes from the analysis of empirical qualitative data.

4.4.3 Cross-Case Analysis

The results and interpretations from the within-case analysis supported comparisons and contrasts between the cases, in cross-case analysis, to generate refined and powerful explanations of the interplay between HCO context, collective leadership and their influence on staff satisfaction and morale. Themes and categories in the final process of coding within-case analysis laid the foundation for identifying analytic issues and units for cross-case analysis. Additionally, analytic explanations and theorisation informed the cross-case analysis between the hospitals and the phenomena under research. I created tables to display data comparing different aspects of hospital context, the hospital histories, and findings relevant to leadership practices, and the sources of morale and satisfaction in each hospital case.

The selection of categories or dimensions for examining within-group similarities and intergroup differences in cross-case analysis led to detailed understandings of relationships between the variables under study (Eisenhardt, 2015). Simultaneously, within-case analysis at each hospital was critical for "*thick*" and "*rich*" description, understanding, and explanation of the events, relationships between phenomena, processes, and actions of respondents in each case. The issues highlighted in the

five main themes presented in the cross-case analysis (Chapter Eight) also emerged during within-case analysis (Chapters Six and Seven).

4.5 Study Rigour and Trustworthiness

I sought generalizability and trustworthiness of the study by conducting a credible, transferable, dependable and confirmable qualitative research process (Lincoln and Guba, 1986; Sandelowski, 1986; Lincoln and Guba, 1985; Guba, 1981). Various approaches undertaken to strengthen the study rigour and trustworthiness included prolonged engagement in each study site, triangulation of data during data collection and analysis, documenting an audit trail throughout the study, and peer debriefing with supervisors and other experts, and member-checking with the managers and respondents (Green and Thorogood, 2018; Eisenhardt, 2015; Yin, 2014; Eisenhardt and Gräbner, 2007). **Table 4.4** summarises the steps I undertook to ensure rigour and trustworthiness.

Table 4.4: Steps for rigour and trustworthiness at each hospital

Criterion	Data collection procedures used	Data analysis steps applied
Credibility	- Prolonged engagement - Multiple sources of evidence (data and respondent triangulation) - Member checking (participants at local conferences) - Peer debriefing and scrutiny (supervisors and colleagues with experience) - Research purpose - Purposive and snowball sampling	- Prolonged analysis - Data and respondent analytic triangulation - Personal researcher reflexivity - Cross-case analysis for patterns and explanation of experiences - Analytic triangulation between respondents, data sources and cases - Peer debriefing and scrutiny (supervisors and colleagues with experience)
Dependability	- Theoretical framework and conceptual model - Case study research design and methods - Audit trail (proposal, data collection tools, transcripts, recordings, analytic approach)	- Analytic maps from NVivo - Stepwise replication and systematic thematic approach to analysis - Coding and recoding for each respondent, data point and case - Personal researcher reflexivity
Confirmability	- Theoretical framework and conceptual model - Different sources of data – document reviews, non-participant observations, in-depth interviews, routine hospital data - Researcher philosophical standpoint	- Analytic triangulation - Personal researcher reflexivity - Audit trail (diagrams, figures, and tables) - Data interpretive analysis to draw policy implications and conclusions
Transferability	- Multiple sources of evidence (data and respondent triangulation) - Theoretical framework - Purposive and snowball sampling	- Thick and rich description of each case - Cross-case analysis between DHA and DHB - Use of theory for explanations

To ensure consistency and confidence in the research findings, or credibility (Guba, 1981; Sandelowski, 1986), I had prolonged engagement in each case, including with each of the respondents. Further, I enhanced the credibility of the analysis through gathering multiple sources of evidence and triangulating data in analysis, limiting methodological and personal biases and deficiencies (Miles, Huberman and Saldana, 2014; Yin, 2014).

The use of multiple sources of evidence also allowed for convergence and replication of emergent ideas in both cases – a process that increased the credibility and transferability of the study (Yin, 2014; Lincoln and Guba, 1985; Guba, 1981). In this study specifically, I used triangulation across respondents and data sources in each hospital; for instance, in-depth interviews and observations (formal and informal time spent with respondents and within hospitals) of the interactions between managers and staff, between staff themselves, and between work teams or units forms respondent data triangulation. Similar approaches to data collection and analysis further enhanced the credibility of the study. For example, I used same sampling technique and topic guides to gather information during in-depth interviews and observations in each case. During the analysis, I triangulated between individual respondents, different levels of management and the different cadres.

Member checking and peer debriefing assured further credibility of the study. To confirm whether I gathered information that were a clear reflection of the respondents' perceptions, actions, attitudes, and beliefs, I constantly checked with them whether my interpretation of the data was reflective of what they relayed during interviews - to allow the voices of the respondents to emerge without distortion. During two conferences or workshops within Cape Town, attended by most of the respondents, I presented preliminary findings from the study to test the emerging analysis and ideas with a pool of similar people. This allowed some of the respondents and staff to check for any factual errors and unpremeditated circulation of inaccurate and sensitive organisational information. Sharing the findings from preliminary analysis with the respondents and other staff corroborated their views and boosted the confidence in the data and analysis.

Peer review and debriefs with research groups and at international conferences enhanced the credibility of the study. The principal supervisor was a sounding board during the entire research study, with the co-supervisor providing analytic guidance, to give credibility and dependability of the research process. Locally, I engaged peers through presentations and discussions of study methodology and findings with

doctoral students and other neutral colleagues within two academic institutions, in addition to other researchers based in different academic institutions in the United Kingdom. Engaging local and international colleagues enabled me to review the analyses, perceptions, and insights from the research. This process was particularly important in deepening my understanding of the data through an inductive analysis, supplemented by deductive and abductive analysis.

However, the observations and responses that I generated from the two case studies are specific to the two hospitals and the period when the research was undertaken. The purposeful sampling may mean the findings are not generalizable to all district hospitals in the Western Cape and South Africa. The study also sought respondents who could offer information to formulate thick, rich, and deep analysis and narrative in the two hospitals. Therefore, it would be spurious to claim that the specific findings from this study are directly transferable to other contexts.

I mitigated the concern about the limited number of cases through purposeful sampling as well as rich description and cross-case analysis that was entirely appropriate to such complex phenomena (Miles, Huberman and Saldana, 2014; Yin, 2014; Eisenhardt and Gräbner, 2007; Lincoln and Guba, 1986; Lincoln and Guba, 1985). In this research study, I did not aim for statistical generalisation of its findings beyond each hospital case, but rather strove for analytic generalisations - through careful cross-case comparison, based on thick case reports and using theoretical insights (Yin, 2014; Lincoln and Guba, 1986). Thus, my study followed a systematic and meticulous approach by using theory to guide data collection and cross-case analysis, thus adding an extra layer of theoretical triangulation for confirmability and transferability.

Additionally, the audit trail that is available for an audit inquiry underlines the dependability and confirmability of the study (Sandelowski, 1986; Lincoln and Guba, 1985; Guba, 1981). Theoretical concepts used in the proposal phase of the study, field notes, raw data in the form of interview transcripts, analytical maps and tables, interpretations, conclusions, and recommendations of the findings are available to attest to the dependability and confirmability of the study and its findings. The research proposal that outlined the study, the interview and observational topic guides, and the output from CAQDAS that I used in this study are available for auditing.

4.6 Research Ethics and Approvals

The approvals of the study were obtained from the executive management of each hospital, University of Cape Town Human Research Ethics Committee, and the WC Provincial DoH. These approval processes and the details of the ethical conduct of the study are discussed in the ensuing sections.

4.6.1 Access and Approvals

Ethical approval for this study was obtained from University of Cape Town's Human Research Ethics Committee (HREC). The initial approval was issued under the reference number HREC REF: 772/2015. The approval had to be renewed annually until the submission of this dissertation. A copy of the approval letter is attached as **Annexure 5**.

Prior to finalising and submitting the study proposal for ethics approval, I contacted the chief executive officers (CEOs) of potential cases, who expressed their interest in the study, indicating that they would grant access to their facilities. I also discussed the details of the study and issues of access to selected units with the CEOs, indicating that interactions with selected respondents would take place during the entire duration of the study – a period which I interacted with staff and respondents, and built relationships with the administrators and staff within selected district hospitals. The two letters from DHA and DHB, respectively, are attached as **Annexure 6** and **Annexure 7**.

I obtained further approval for the study from WC Provincial DoH through their central system for application of approval. Attached as **Annexure 8** is the approval letter reference number WC_2015RP35_449. However, due to the prolonged process of approval by the provincial Health Impact Assessment office, there was a delay in the issuance of the final approval letter.

4.6.2 Anonymity

I explained the hospitals' and individuals' anonymity before the research and during the study process. I concealed the identity of the selected cases by designating them as District Hospital A (DHA) and District Hospital B (DHB) during data collection, analysis, and when sharing preliminary results. In addition, I used unique descriptors for the type of data collected, and numbers denoting the order of interviews as they were carried out. Inasmuch as I anonymised the names of the two hospitals and the study respondents through use of different unique descriptors in presentation of the

findings, I duly informed the participants that readers may deduce the identity of the hospitals based on the rich description provided about the study sites in the findings section.

4.6.3 Informed Consent Process, Privacy and Confidentiality

Carrying out case study research involves extended and close links between the investigator and, in this case, staff in the two hospitals. Therefore, I ensured that the selected respondents and all other staff had freedom of participation in the study, while in the process respecting all individuals and their points of view. During interviews, I asked the respondents for written consent, after formally informing them of the study purpose, study relevance, and their discretionary or voluntary participation. The consent forms served as assurance of privacy and confidentiality of their participation and information that they provided. **Annexure 9** is the information and consent form used in this study. Ethical mindfulness and attention through appropriate engagements was pivotal in generating information from the study respondents.

I discussed the use of audio recorders before the interviews, and only used them at the comfort of the respondents. All study materials and data collection processes were in English and, where participants used words or phrases in other languages, I sought interpretation/translation during transcription of the recorded interviews.

Where controversial but relevant information appeared in the findings, the use of unique identifiers and generalisations within each facility ensured the confidentiality of individuals and teams, to avoid the risk of victimisation and eliminate the fear of job loss. Moreover, the same confidentiality practice will be used in policy briefs, publications, and future conferences to avoid unforeseen consequences from the provincial and national departments of health.

The study did not involve invasive procedures such as collection of body tissues and fluids, administration of chemical or physical substances or, use of laboratory animals and thus did not present any physical harm to the respondents and the investigator. However, despite the selection of mature adults capable of making informed decisions as respondents in this study, there were three cases of unforeseen emotional or social distress during the interviews. When these difficult emotional moments arose, I discussed with the respondents the possibility of referring them to the hospital and the Western Cape’s Department of Health counselling and conflict resolution procedures. However, all the three respondents declined the suggestion and assured

me that they would be fine – a follow up a day or two after the interviews confirmed the respondents' assurance.

4.7 Study and methodological limitations

Gaining access to selected study sites and various respondents could have been a limitation. However, I spent time negotiating access to different units/teams, familiarising myself with the gatekeepers and the two case study sites. This was done concurrently when seeking approval from the Western Cape Province's Department of Health.

All data were collected and analysed using qualitative approaches, which raises the possibility of those with different epistemological positions doubting the trustworthiness and confirmability of these findings. However, as described, I took great care and adopted appropriate practices to ensure study rigour and trustworthiness.

Some respondents were interested in my nationality and professional background. The assumption and understanding that I was not South African (I am Kenyan) allowed these respondents to talk about the previous racial challenges in provision of health services and employment in the hospitals; sometimes giving references to the policy and health system differences between South Africa, Western Cape, and other African countries. I reflectively considered these assumptions and their impact on my interpretive analysis of the experiences in the overall study.

In addition, the assumption by participants that my title (my prior training is as a veterinarian, leading to the title 'Dr') conferred clinical experience and expertise, and my status as a foreign black African national offered some degree of trust and credibility during the fieldwork. Participants viewed the research process as a useful engagement with someone from outside the system who could help in highlighting some of the challenges in the health system. This ensured that they freely gave information. However, the assumptions on my identity and role as a researcher may have elicited social desirability bias (Krumpal, 2013; Fisher, 1993). To minimise the bias, I prodded the participants to be open and share both positive and negative experiences without any fear of reprisal or victimisation.

4.8 Chapter summary

In this chapter, I have discussed the research methodology for the study. The bulk of the chapter focused on the research methods where I chronicled the systematic steps

I undertook to collect and analyse data. This study is a qualitative study that utilised a multiple case study design to examine the interplay between HCO context, collective leadership practices and staff satisfaction and morale. The chapter also discusses in detail the steps that I took to ensure rigour and trustworthiness of the study. I discussed the ethical approvals and steps for privacy and confidentiality, before, finally, outlining the study and methodological limitations.

I have presented a detailed outline of the qualitative approaches applied to establish pathways between the phenomena under study. Such an approach was entirely appropriate given my constructivist perspective and starting points. Consideration of causality in only quantitative form or evidence would have been profoundly unsatisfactory (Gioia, Corley and Hamilton, 2013; Langley A, 2011) as quantitative evidence alone cannot fully reveal the occurrences of processes or social phenomena in social systems (Creswell and Plano Clark, 2011; Bryman, 2003).

Chapter 5: South Africa and the Western Cape – Key Contextual Factors Influencing the Public Healthcare System

5.0 Introduction

To understand the dynamics that play out in the hospitals, it is important to consider the broader national and provincial context, including important historical and current health system features. Thus, in this chapter, I provide brief information on key South African governance and health system features. Then, I discuss the national and provincial policymaking and health policy directions. This leads to a discussion of the Western Cape Provincial health system, before reviewing its existing strategies for leadership development and key human resource management processes commonly important in the daily operations of its hospitals. Finally, I end the chapter with a summary of issues that assist in the analysis of the hospital context, collective leadership practices and, staff satisfaction and morale.

5.1 Key South African Governance, Health and Health Care Features

South Africa is a multi-ethnic and multi-racial constitutional country in the Southernmost part of Africa. At the end of the apartheid regime in 1994, South Africa transitioned into a constitutional democracy including a three-tier system of governance and an independent judiciary (Republic of South Africa, 2019). The three tiers of interdependent and interrelated government structures work across the national, provincial and local levels each of which have their own legislative and executive authority. At national and provincial levels, legislative authority is held by the national parliament, constituted by the national assembly and the national council of provinces, and the nine provincial legislatures. Executive authority, meanwhile, lies with the Cabinet at the National level (President, Deputy President and Ministers) and with the nine Provincial Executive Councils at the provincial level (Premier and Members of the Executive Council). Local government authorities also hold some responsibities in the metroplitan areas.

The decentralisation and devolution of various services to the nine semi-autonomous provinces after the April 1994 election was a core strategy to address the socioeconomic and racial inequalites that impacted on health and health care

(Delobelle, 2013). The colonial and apartheid era had been characterised by racial and gender discrimination, socioeconomic inequalities and violence that had far-reaching effects on the health of South Africa's population and on healthcare provision (Coovadia et al., 2009). The apartheid system was typified by the fragmentation of healthcare services across the four colonial provinces of Cape Colony, Natal Colony, Orange Free State and Transvaal, and the former ten black ethnically-based homelands between 1910 and 1994 (Coovadia et al., 2009). There were also fewer and underfunded healthcare facilities in areas that were predominantly inhabited by black and coloured races, in comparison to predominantly white-inhabited areas (Coovadia et al., 2009).

Since 1994 there has been wide-ranging social and economic policy change to redress the apartheid legacy of social inquality. However, in 2020, twenty-six years later, the country still suffers from socioeconomic disparity. In 2018, for example, the income inequality reflected in the data from the World Bank indicated the South African GINI index as 0.63 (World Bank, 2018), whilst the Gross National Income per capita is $11,923 and Human Development Index of 0.699 (UNDP, 2018) – a reflection of the rich-poor divide and levels of inequality in the country.

Core current demographic and health data are provided in **Table 5.1**. The 2018 mid-year population estimates for South Africa by population group shows that at 80.9%, the Black African population was the largest group as a percentage of the total population. The other groups are identified as Coloured (8.8%), White (7.8%) and Indian/Asian (2.5%). There are eleven offical languages spoken by these population groups. The table indicates little change in key health indicators such as life expectancy at birth, crude birth, infant mortality, under five mortality and crude death rates in recent years, also showing that these rates, including the annual GDP growth rates, are worse than the average rates for other upper middle income countries (see note under **Table 5.1**). The South African infant mortality rate is nearly three time as great as in these other countries. The low annual GDP growth rates in South Africa compared to other upper middle income countries, meanwhile, only exacerbate health inequalities.

Table 5.1: Mid-year population estimates for South Africa, 2015 to 2018 (Source: Department of Statistics South Africa, 2019; World Bank, 2020)

	2015	2016	2017	2018
National Population	54,956,920	55,908,865	56,521,900	57,725,600
Population Density	45.01/km^2	45.79/km^2	46.29/km^2	47.28/km^2
Population aged <15 Yrs	16,596,990 (30.2%)	16,828,568 (30.1%)	15,034,825 (29.6%)	17,029,052 (29.5%)
Population aged >60 Yrs	4,420,000 (8.0%)	4,470,000 (8.0%)	4,600,000 (8.1%)	4,890,000 (8.5%)
Life Expectancy at Birth (Yrs)	Males: 59.7 (***72.0***) Females: 65.9 (***77.3***)	Males: 60.1 (***72.3***) Female: 66.2 (***77.6***)	Males: 60.7 (***72.6***) Females: 67.1 (***77.8***)	Males: 61.1 (***72.8***) Females: 67.3 (***78.0***)
Crude Birth Rate	22.7 (***14.8***)	21.6 (***15.1***)	21.3 (***14.6***)	20.8 (***13.7***)
Infant Mortality Rate	34.4 (***13.4***)/1000 Live Births	33.7 (***12.9***)/1000 Live Births	32.8 (***12.3***)/1000 Live Births	36.4 (***11.8***)/1000 Live Births
Under-5 Mortality Rate	45.1 (***42.6***)/1000 Live Births	44.4 (***41.3***)/1000 Live Births	42.4 (***40.0***)/1000 Live Births	45.0 (***38.8***)/1000 Live Births
Population HIV Prevalence Rate	11.2%	12.7%	12.6%	13.1%
Crude Death Rate	9.6 (***7.1***) Deaths/1000	9.7 (***7.1***) Deaths/1000	9.0 (***7.1***) Deaths/1000	9.1 (***7.1***) Deaths/1000
Annual GDP Growth Rate	1.65% (***4.0%***)	1.62% (***4.3%***)	1.61% (***4.9%***)	1.55% (***4.4%***)

Note: *The bracketd figures in bold italics are comprative data for other upper middle income countries except for the Under-5 Mortality rate that is a global average for all countries as per data from the World Bank* (World Bank, 2020).

Against the background of historical injustices in health and healthcare the first democratically elected government of the African National Congress (ANC), guided by its Health Plan (African National Congress, 1994), moved immediately to re-structure the public health system into a national system with nine provincial departments of health. Subsequent legislation was also implemented to support progressive realisation of the right to health (Republic of South Africa, 2004; Republic of South Africa, 1996). The majority of public healthcare funds are provided from tax funding through the National Treasury's annual budget, and the Division of Revenues Act (RSA National Treasury, 2019a) drives the distribution of the nationally collected revenues between the three tiers of government. Funds from the National Treasury are, then, disbursed to each Province's Department of Finance through a population-

based allocation of resources (McIntyre, Baba, & Makan, 1998), and allocated onward to the various provincial departments and districts. Each province also receives conditional grants, tied to specific functions and activities, including for health care.

At national level, however, the proportion of the public budget spent on healthcare - 11.8% 2016/17, at the time of the study, rising to 12.5 % in 2018/19 (RSA National Treasury, 2019b) - is still below the Abuja Declaration on healthcare expenditure target of 15% of the National budget (African Union, 2001). The private health sector also remains very important within the overall health system. Data from the Income and Expenditure Survey (IES) conducted by Statistics South Africa between September 2010 and August 2011 indicate that over 80% of the South African population continued to rely on the public sector for healthcare services, but over 50% of total spending for healthcare services were within the private healthcare sector or from out of pocket spending (reported in Ataguba & McIntyre, 2018; and earlier papers by Coovadia et al., 2009; Chopra et al., 2009). At the same time, despite the reforms implemented within the public health system since 1994, there are continuing reports of poor quality of care in most provinces, underpinned by poor management, understaffing and other resource constraints (Delobelle, 2013; Harrison, 2009).

5.2 National and Provincial Policymaking and Critical Health Policy Directions

The National Department of Health is the constitutionally mandated regulatory body responsible for all national policies, services and activities within the South African Health System as established in the National Health Act 61 of 2003 (RSA National DoH, 2004). The National Health Act is anchored in the constitution and outlines the framework for provision of basic healthcare rights for South Africans. Building on the 1994 ANC Health Plan, the Act recognised the past socioeconomic injustices and inequities in healthcare services and supported the establishment of a uniform decentralised system based on the principles of equity, efficiency, social justice, good governance, and proper standards.

The National Health Act also provides for the establishment of Office of Standards Compliance by the National Health Council. This office is mandated to monitor and compel hospitals to follow the prescribed quality and standards. It was amended through the National Amendment Bill of 2013 (Republic of South Africa, 2013) to ensure that all public healthcare entities comply with basic standards for provision of healthcare services. Provincial Departments of Health use the national policy

framework as overarching guidelines when formulating provincially-specific policies for the delivery of adequate and equitable healthcare services (RSA National DoH, 2011a; RSA National DoH, 2010).

Most public healthcare facilities have been upgraded and/or rebuilt in preparation for the implementation of the National Health Insurance (NHI) scheme that is outlined in these key policy documents. Despite building and upgrading more than 1,600 healthcare facilities since 1994 and employing more healthcare staff, the figures are still below the WHO recommended distribution and health services indicators (McIntyre & Ataguba, 2017). It is reported that South Africa has over 4200 public healthcare facilities that provide services to 13,800 people per facility, a figure that falls short of the WHO recommended 10,000 per clinic, with a Health Access and Quality Index of 49.7 (Fullman et al., 2018). Further, shortages of health care professionals within the South African healthcare system still persist (Rispel, Blaauw, Ditlopo, & White, 2018).

In recent years, the NDoH has increasingly focused on developing an NHI that is intended to improve the South African health system (RSA National DoH, 2019; RSA National DoH, 2015; RSA National DoH, 2014; RSA National DoH, 2011a). NHI is specifically targeted to bring reforms in the health sector; reforms that will ensure that all South Africans have access to affordable, equitable, efficient and quality healthcare services and at the same time have financial protection from catastrophic health expenditures (RSA National DoH, 2015; Republic of South Africa, 2014; RSA National DoH, 2011a). The NHI policy places emphasis on pooling funds to contract providers.

The NHI policy or Green Paper (RSA National DoH, 2011c) was introduced in August 2012 and the White Paper published for public comments in December 2018 (RSA National DoH, 2019; RSA National DoH, 2015). The policy outlines the efforts by the South African government, over a duration of fourteen years, to create and achieve universal health coverage for all its citizens by introducing a new approach to healthcare financing, re-engineering PHC and strengthening the DHS. The NHI implementation has been piloted in eleven pilot sites across all the nine provinces (RSA National DoH, 2016). Attainment of UHC through the NHI is also emphasised in the National Development Plan 2030 Vision (Republic of South Africa, 2011). The vision aspires to strengthen the South African health system, improve on human resources for health, and review management structures and appointments for

stronger accountability by 2030 where PHC teams provide care to families and communities.

The National Health Act emphasizes the improvement of quality of healthcare services in public hospitals to ensure the quality of health programmes (RSA National DoH, 2014; Republic of South Africa, 2013). The office uses the National Core Standards to monitor quality in the public and private health sectors by ensuring patient rights; safety and clinical governance; and, clinical support services. Other important policy documents that have been introduced to improve on the quality of care are: Batho Pele programme; Patients Rights Charter that outlines the rights and obligations of patients; and the clinical management guidelines. The Patient's Rights Charter is a policy to safeguard the rights of the patients and to guide the interactions between patients and workers and how workers behave towards patients when delivering care. The public service code of conduct outlines expected behaviour and disciplinary procedures for workers in the public service.

Successful implementation of the NHI and revitalisation of PHC requires a dedicated and motivated healthworkforce since South Africa continues to face challenges with its healthcare professionals (Rispel et al., 2018). To address the challenges in human resources and health workforce, especially dissatisfied and demoralised staff, the NDoH developed a human resources for health strategic framework for education, training and development of workers (RSA National DoH, 2011d). The HRH strategy policy document identified eight critical priorites that were aligned and governed by the National Health Act of 2003. These are: leadership, governance and accountability; intelligence planning; workforce for new strategies that ensure value for money; upscaling and revitalisation of education, training and research; interfaces of academic training and service platform; professional HR management; ensuring quality professional care; and, access to health professionals in rural and remote areas. The document emphasizes on a suitable healthcare environment and a strengthened leadership that values and supports its workers.

The national and provincial governments frameworks (RSA National DoH, 2013; Republic of South Africa, 2013; Republic of South Africa, 2011; RSA National DoH, 2011a) outlined above point to the role of leadership in improving health systems. Specifically, the focus on strengthening leadership practices that value and support staff indicates the importance of understanding relationships and collective practices amongst staff in district hospitals.

5.3 The Western Cape province and its Health System

The current study is situated in the Western Cape Province. It is the fourth largest province by size and, with 11.5% of the national population, the third most populated province, as of mid-year 2018 (Department of Statistics South Africa, 2019). Despite having representation of all population groups, the provincial population is predominantly Coloured and Black African, at 49% and 33% of total population respectively. There are three official languages in the Western Cape – Afrikaans, Xhosa and English. Cape Town is the capital of the Western Cape Province and doubles as the legislative capital of the Republic of South Africa.

The province has one urban metropolis district (Cape Town Metro District) and five rural districts. District distribution of the population has remained relatively unchanged over the years (Western Cape Government DoH, 2018a). At 64%, the Metro District has the highest population density in an urban setting – with a concentration of the population in the high density locations or informal settlements in the peri-urban areas which were created during the apartheid regime. These informal settlements are characterised by poor infrasructure and inadequate access to healthcare services. The rest of the population in the province is distributed in five rural districts namely - see **Table 5.2**; West Coast, Cape Winelands, Overberg, Eden/Garden Route, and Central Karoo.

Table 5.2: Population Distribution by District (Source: Western Cape Government DoH, 2018a)

District	Population	Population Density	District Expenditure on DHS (ZAR'000)
West Coast	459 683 (7.1%)	14.4/km^2	3 491 564
Cape Winelands	916 385 (14.1%)	40.3/km^2	7 589 238
Overberg	293 506 (4.5%)	23.9/km^2	2 165 582
Eden	628 623 (9.6%)	26.4/km^2	5 597 323
Central Karoo	76 828 (1.2%)	1.9/km^2	850 440
Cape Town Metro	4 140 565 (63.5%)	1,667.3/km^2	42 751 929

Within the province the deep history of injustices during apartheid still leave significant disparities between areas and different communities (Western Cape Government, 2018). Higher income communities are seen to live in better conditions and have good health indicators, whereas poor communities, such as those within the Cape Town

Metropole areas (see **Table 5.3**) where the case study hospitals are located, have high levels of unemployment, live in poor conditions and have poor access to key health-related services.

Table 5.3: Social Determinants of Health in the Cape Town Metropole Region – Census 2011 (Source: Western Cape Government, 2018)

DETERMINANT	Percentage (%)
Unemployment rate	29.8%
% Population living below R4800 per annum	16.4%
Household with access to potable water on their plot	87.3%
Number of households in informal dwelling (estimate)	20.5%
% Households with access to sanitation (flush toilets)	90.2%
% Households with access to electiricity for cooking	87.6%

The Provincial DoH governs the Western Cape health system, and it is mandated to:

- plan health services in the Western Cape
- provide a full range of individual and public health services to the population of the province
- provide infrastructure and support services to health operations
- provide for public health intelligence, research and training
- ensure effective financial, human resource and asset management
- develop strategic relationships that facilitate the provision of health care and promote health

In addition, the WCDoH, through the Provincial Health Council, functions to: provide for tertiary and quaternary health services; create a platform for training health workers and conduct research; provide for secondary, specialized, emergency and forensic pathology services; ensure the delivery of District Health Services (DHS); and, ensure the delivery of health programmes.

Overall, the primary healthcare services in the WCP are provided in the 479 facilities located in 32 sub-districts and six districts - five rural districts and one urban district. The province also has over 50 ambulance stations with 250 ambulances that provide

Emergency Medical Services (EMS). In addition, the province has 18 mortuaries and 46 response vehicles for Forensic Pathology Services.

Table 5.4 below is a summary of the categories of facilities within the Western Cape Province. Services provided in these facilities include: Aged Care; Baby and Child Health; Chronic Illness; Emergency Services; HIV/AIDS Counselling, Testing and Treatment, Home Based Care, Immunisation, Maternal and Women's Health, Mental Health, Nutrition; Occupational Health Services; Oral and Dental Health; Port and Environmental Health; Rehabilitation Services; Reproductive Health; Sexually Transmitted Infections; and, Tuberculosis Treatment.

Table 5.4: Western Cape DoH Facilities
(Source: https://www.westerncape.gov.za/dept/health/facilities Accessed 13/07/2019)

Facility/Hospital Category	Number of Facilities
Clinics – Community Health and Daycare Centres (CHCs & CDCs)	226
District/Provincially Aided Hospitals	25
Midwife Obstetrics Units	10
Mobile Services	30
Psychiatric Hospitals	4
Regional Hospitals	5
Reproductive Health Facilities	7
Specialised Health Care Facilities	2
TB Hospitals	5
Tertiary Hospitals	3

As in the rest of the country, the Western Cape provincial health system has experienced continuous reform since 1994 (Gilson *et al.*, 2017; Western Cape Government DoH, 2014; Western Cape Government DoH, 2007). In the first wave of reform, inspired by the ANC Health Plan, the post-apartheid provincial government targeted the promotion and maintenance of people's health through strong primary health care and decentralised health services (Gilson, Brady, et al., 2017). A key avenue to delivery of healthcare services were district hospitals (DH) within the district

health system managed by a District Health Management Teams (DHMTs). As elsewhere in the country (Owen, 1995), the DHS was established to address the apartheid legacy of fragmentation and to reinforce a primary health care approach; formal governance and management structures for the DHS are outlined in the National Health Act of 2003. **Table 5.5** below shows that the DHS now captures just under 40% of the total WC provincal health budget.

Table 5.5: Provincial Health Budget against the Total Provincial Budget (Source: National Treasury; StatsSA Website; Western Cape Provincial Treasury; Western Cape Province Annual Reports)

Budget Year	2015/2016 (R'000)	2016/2017 (R'000)	2017/2018 (R'000)	2018/2019 (R'000)
Total WC Provincial Expenditure	51,553,517	55,510,191	59,330,234	64,159,889
Total WC Provincial Health Expenditure	18,737,118	20,078,184	21,496,056	23,099,979
WC Provincial Health Expenditure as a % of Provincial Expenditure	36.3%	36.2%	36.2%	36.0%
Total DHS Expenditure in WC Province	7,352,880	7,953,437	8,737,909	9,341,766
DHS Expenditure as % of WC Provincial Health Expenditure	39.2%	39.6%	40.6%	40.4%

In 2010, a second strategic plan to improve quality of care and tackle the increasing burden of disease was introduced (Western Cape Government DoH, 2007). This Comprehensive Service Plan proposed, critically, further implementation of the DHS, strengthening of the specialist services in regional and central hospitals, and revitalising physical infrastructure of hospitals and services. It included support for the re-distribution of services within the urban Cape Town Metro District, to redress the historical inequities in access. The Cape Town Metro District is sub-divided into four sub-structures, each having two sub-districts (a total of eight, see **Figure 5.1)** (Western Cape Government DoH, 2015).

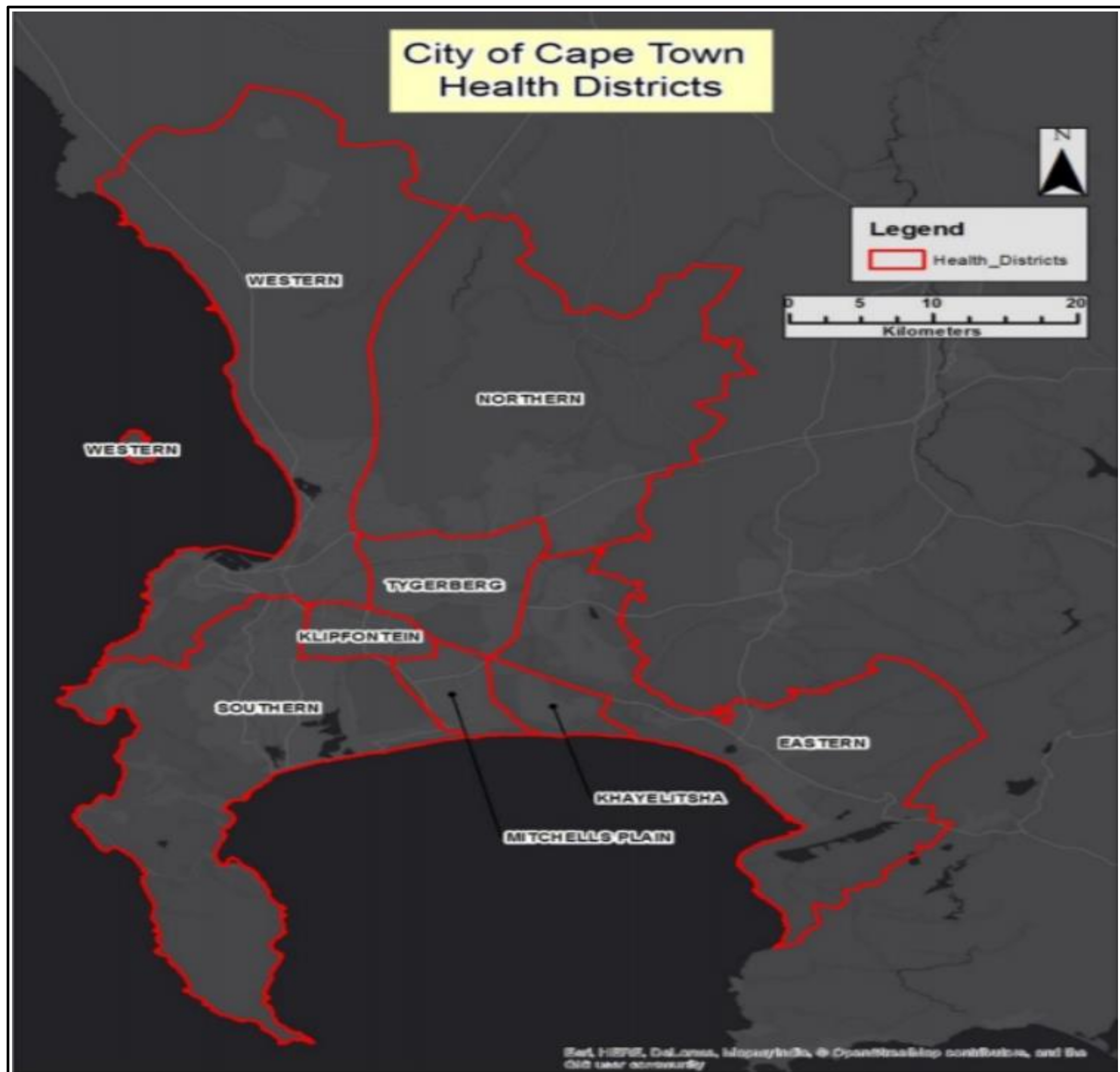


Figure 5.1: Cape Metro Health District boundary (Source: Western Cape Government, 2018)

As part of the 2010 plan new district hospitals was proposed for key under-served areas, alongside the re-classification of some regional hospitals as large and small district hospitals. Whereas small and medium size district hospitals respectively have 50-150 and 150-300 bed capacity, large district hospitals have 300-600 bed space.

District hospitals (DH) provide Level 2 hospital emergency and curative services within districts (Western Cape Government DoH, 2007). They offer in-patient care, outpatient services and, obstetric and paediatric care. In addition, larger DHs offer some general specialist services to improve access to care and bridge referrals to the regional Level 3 hospitals. Overall, the positioning of district hospitals at the centre of the referral system makes them key in delivery of healthcare services in the province. There are now a total of 34 DHs in the province with nine (including Metro TB complex hospital) in the Cape Town Metro Health District, and the rest in the rural districts.

The Metro District Health Services (MDHS) are currently managed by the Chief Director MDHS, who reports to the Chief Operating Officer, alongside the Chief Director Rural District Health Services. The four MDHS substructures are themselves each managed by a director whose main responsibility is to ensure that health services are efficiently and effectively delivered in line with provincial and national frameworks.

According to the 2011 legislation on management of public hospitals (RSA National DoH, 2011b), medium and large DHs should be administered and managed by a CEO, a Clinical Manager and a Nursing Manager. Small district hospitals have a medically trained or registered health profesional to serve in both roles as the CEO and the Clinical Manager. However, in the absence of a health professional, an administrative manager with over 10 years experience in health management may be appointed to serve the role of the CEO. Senior or executive management posts are advertised for by the Provincial HR and DoH who then conducts assessment and psychometric tests based on the job descriptions. A member of the Hospital Board, created under the National Health Act of 2003, must be in the recruitment and selection panel.

Leadership within the hospitals in the Western Cape includes both a departmental and a line-based approach to management, as detailed in Chapters Six and Seven. Some departments have a simple structure while others are more complicated, and Nursing and Clinical Management structures differ. Clinical Management refers to the consultants, doctors, medical officers, interns and the allied health workers. There is a Clinical Manager or Director for Clinical Services and each clinical specialisation is seen as a self-contained clinical unit in the hospital. However, the Nursing Department has a rigid structure that follows the hierarchical lines according to the traditions and practices of the nursing profession (Republic of South Africa, 2005). The Nursing Manager, also referred to as Director for Nursing Services in some District Hospitals, is deputised by 3-5 nursing area managers. Below the area managers are Operation Managers (OPMs) who are responsible for the activities within each ward, their number being determined by the number and size of the wards within the District Hospitals. The Operation Managers supervise the various categories of frontline nurses who work in the wards.

These various managerial structures are nested within the wider public sector bureaucratic environment, and reflect the hierarchical nature of leadership at the

meso and micro levels of the South African health system. The bureacracy and hierarchies are analysed and unpacked in Chapters Eight and Nine of this thesis.

5.4 Strategies for Leadership and Management Development

Inadequate stewardship, leadership and management processes at all levels of the South African health system are identified as major impediments to the provision of adequate and quality healthcare services (Schaay, Sanders, & Kruger, 2011; Coovadia et al., 2009). Evidence indicates that, in addition to a lack of leadership and management development across all professional cadres, the district and provincial offices have failed in creating an enabling organisational environment that nurtures the desired leadership practices (Doherty, 2014). Thus, Doherty (Doherty, 2013) recommended that National and Provincial Departments of Health ought to focus on new approaches to leadership in the health sector; leadership that is *shared and collaborative across professional cadres and organisational boundaries*. The author recommended that the process should involve identification of formal and informal ideal practices that transcend professional and managerial hierarchies.

National policy frameworks give clear priority to health and wider public sector leadership and management development. The Medium Term Strategic Framework (MTSF), a government strategic plan for 2014, amongst other strategic issues, outlines the production and development of human resources for health, improved management practices and a review of management positions and appointments to strengthen accountability mechanisms (Republic of South Africa, 2014). These strategies call for the development of effective leasdership, and suitable reforms for the governance of hospitals; with a focus on provision of strategic leadership to establish social compact through delivery of better health services.

Similarly, Priority 2 in Chapter 10 of the National Development Plan 2030 (Republic of South Africa, 2011) outlines leadership and management as one of the focus areas. In describing the priority on leadership and management, competent leadership and high clinical and technical competence at all three levels are identified as critical in a health system that caters for everybody in the population. Specifically, there is emphaisis on stregnthening leadership and management through the review of management positions and appointments, and effective performance management frameworks as key processes of human resources management. Priority 7 is anchored on the argument that poor leadership is responsible for staff attrition from the public sector.

The WC DoH has itself prioritised the development of leadership skills in individuals and teams. The province's strategic objective goals aspire to transform the leadership and organisational culture and embed good governance and values-driven leadership practices (Western Cape Government DoH, 2017). To achieve this objective, the WCDoH aims to build competent, engaged, caring and empowered employees, and to nurture managers by supporting initiatives for developing leadership capacity in the provincial healthcare system. This strategic goal is anchored both in the National MTSF blueprint and the third provincial strategic health plan, HealthCare 2030 (Western Cape Government DoH, 2014). Of particular interest in this plan is the focus on transformational leadership amongst managers and clinicians. The plan specifically puts emphasis on strengthening leadership by building collective leadership: "*Leadership must be collective and distributed across all levels of the organisation*" (p32). It supports leadership that is "*distributed, dynamic, inspires change, provides strategic direction, builds cohesion and motivates people*" (p32). Such leadership is seen as an approach that will champion organisational values, embrace well developed interpersonal skills, encourage innovation, draw on capability of workers, and be collaborative with workers.

From this broad foundation the WC Health leadership development strategy (Western Cape Government DoH, 2016b; Western Cape Government DoH, 2016c) seeks to achieve the objectives of developing managers across all levels of the organisation and developing leaders and teams that embody organisational values and work towards improved patient-centred care. The first step proposed is to identify needs by conducting skills assessments and analysis of existing gaps. Then, to address the identified gaps, an integrated leadership development approach is proposed that allows individuals and teams to build various competencies through action learning programmes, training and qualifications, coaching, guided individual and team development, and supportive system functions. Operational managers in hospitals are seen as a core target group, through whom to introduce *relational strategies* of working within cross-cadre, cross-functional and cross-level teams. Interpersonal power and collegial relationships, rather than hierarchical authority, underpins this proposed approach to leadership in the hospitals. In addition, the WCP DoH identified the cognitive, functional and social leadership competencies necessary at team and individual levels leading to the creation of the Leadership Behaviour Charter and the Leadership Competency Framework (Western Cape Government DoH, 2016a; Western Cape Government DoH, 2016b;).

5.5 Human Resource Management Processes

Various national and provincial HR policies and processes are applied in hospitals across the WC province to address staff recruitment, retention and performance issues. Nationally, reports indicate that there is poor distribution of health workers between levels of care and between districts (Chopra et al., 2009). This is caused by the shortage of well trained nurses and healthcare professionals result from training shortfalls and the migration of workers from public to private sectors and to other countries (Rispel et al., 2018). To address these inadequacy in HRH, a number of measures and policies have been introduced both at national and provincial levels. These include the National Skills Development Plan 2030 (RSA Department of Higher Education and Training, 2019) the HRH Strategy 2012/13 – 2016/17 (RSA National DoH, 2011d), and Human Resources and Skills Development Strategy in the Western Cape (Western Cape Government, 2003).

Additionally, the Occupation Specific Dispensation (OSD) policies were introduced nationally to address issues relating to salary scales, post levels and pay progression as determined by the Public Service Act, and to meet the demands for scarce skills in particular groups of health workers (DoH Western Cape Government, 2018b; Daviaud and Chopra, 2008; RSA Department of Public Service and Administration, 2008). The policies offer, in effect, incentives to address the challengs of filling vacant posts, worker attrition and migration to private sector and overseas market, and the resultant staff shortages (Ditlopo, Blaauw, Penn-Kekanna, & Rispel, 2014).

In the recent past, within the WCP DoH, implementation of the OSD provisions has affected occupational groups such as: Professional Nurses in some specialties, radiography specialties, operating theaqtre specialists, PHC in rural districts, critical care, medical specialists in emergency and family medicine in rural districts, midwifery, orthopaedics, forensic pathology specialists and technicians, engineers and medical case managers (Western Cape Government DoH, 2018b; Western Cape Government DoH, 2015). Yet despite these efforts to address human resources and management shortages, there are still staff shortages and challenges in selection, recruitment and retention of health workers within the province.

Despite the decentralisation of some accountability for health services to the DHS, key operational decisions are also commonly quite centralised at the provincial level (Chopra et al., 2009). These operational decisions include the ability to select and recruit staff to fill vacant posts. Indeed, within the WC policies to manage staffing

budgets have been introduced, such as the approved post list (APL) and Establishment Control Committee (ECC) to monitor and regulate the recruitment of health workers within the provincial public health system. These measures are linked to the broader public sector financial management policy guidelines that aim to improve efficiency and accountability (Penn-Kekana, Loveday, Blaauw & Schneider, 2004).

The APL and ECC are intended to support decentralised decision-making at hospital and district management levels, whilst setting spending limits in terms of staffing budgets (Gilson, Brady, et al., 2017). The policies stipulate, however, that authorisation must come from the provincial directors before a vacant post can be activated and filled with new clinicians and nurses. There have been reports that despite the decline of the worker turnover rate from 14.1% to 13.2% over a three year period, it is still not easy to fill the required vacant positions due to limited budgetary funds for employing qualified staff (Western Cape Government, 2018).

The performance management and development system, popularly referred to as the Staff Performance Management System (SPMS), is a national HR process that was introduced by the Department of Public Service and Administration in 2003 as a strategy to assess, monitor and improve performance in the South African public sector (Nxumalo, Goudge, Gilson, & Eyles, 2018; Luthuli, 2009; RSA Department of Public Service and Administration, 2008). During quarterly and annual performance cycles, workers and their managers review the personal performance targets which are then used to give financial rewards to best performers and to determine the development plans for those who perform poorly (Elloker et al., 2013). Within the province, the decentralisation of SPMS gives each district and sub-structure the responsibility of managing the process. The WCP DoH maintains the role of policy oversight. Supervisors and managers are regularly trained on how to efficiently carry out the appraisal processes (Elloker et al., 2013). However, in the Annual Report for 2016, the DoH outlined development of a non-financial incentive system as an HR strategy that would be linked to the performance appraisals.

Finally, the WCDoH also introduced measures for worker engagement in organisational culture and change management, towards person-centred quality of care (Western Cape Government DoH, 2016a). For example, with the goal of improving patient care and experience, in August 2013, the WC DoH introduced the C^2AIR^2 (Caring Competence Accountability Integrity Responsiveness and Respect) Club programme or challenge that is applied across all hospitals within the province.

This was initiated by the WC DoH as an organisational culture change intervention across the provincial healthcare system. The C^2AIR^2 Values are linked to provider or worker attitudes towards patient care, and were embedded in other change processes that included support for coaching leaders and, procedures and systems to encourage innovation within the workplace.

The focus of C^2AIR^2 Club challenge was on espousing the departmental values, encouraging leadership for lower level workers, strengthening worker relationships, empowering frontline workers to communicate effectiveley with patients and building problem solving skills that are innovative. Besides satisfied patients who receive quality health services, the programme endeavoured to create competent, healthy, engaged, caring and empowered workers in the WCP DoH and facilities.

5.6 Chapter Summary

In this chapter, I have given a brief overview of the socio-economic and governance background of the Republic of South Africa and the Western Cape Province where the study is situated. I have further described the National, Provincial and District Health Systems and the flow of government funding for the provision of public healthcare services. In the process of identifying and analysing key legislation and policies that have shaped the South African healthcare system, I outlined the specific strategies that are targeted at improving the leadership practices or processes in the public sector at large, and in the Western Cape health system, specifically.

To summarize, South Africa and the Western Cape Province, where the study is situated, have a complex demographic and racial history that influences the continuing efforts to strengthen the health system. The referral system and the provincial health system, meanwhile, highlight the central role of district hospitals in the delivery of healthcare services. Both national and provincial policy and regulatory frameworks have implications for hospital budgeting, staff recruitment and the leadership strategies that hospitals implement. The public health system is part of a broader bureacracy and so individualised, hierarchical leadership practices are common in the DHS and district hospitals. However, the Western Cape Province's policy frameworks support strengthening distributed and collective approaches to leadership. Various national and provincial human resource processes have also been implemented that seek to address staffing budgets and shortages, as well as the interactions or relationships amongst healthcare staff at provincial, district and hospital levels.

The key issues enumerated in this chapter provide the background to, and will be further considered within, the subsequent chapters where I present and discuss the empirical findings of my research.

Chapter 6: Findings from District Hospital A

6.0 Introduction

Chapter Six discusses DHA. After describing and introducing the hospital and its history, I present the critical leadership practices of the hospital. Then, I examine staff satisfaction and morale, as indicators of leadership effectiveness, and the ways leadership practices impact on it. I also highlight the essential features of DHA's context, and how the contextual features reinforce or undermine the experiences and practices of leadership, in addition to their likely impact on staff morale. Lastly, I end the chapter with a summary of the entire case study in relation to the chief study aim of examining the interplay between the three phenomena under study - organisational context, leadership practices, and leadership effectiveness, as indicated by staff satisfaction and morale - in the hospital case. I obtained the information and data analysed in this case study, detailed in Chapter Four, from different documents, observational data, in-depth interviews with staff and managers, and a Staff Satisfaction Survey from 2016 (**Appendix 4.1**).

6.1 Hospital overview and history

6.1.1 Hospital setting and overview

DHA was established in 1888, in an area that had been developed in the late 1700s as a small wine farming area and a garrison town for British traders and civil servants. This area is also served by 4 CDCs and 1 CHC that refer cases to DHA. In addition to the prevalent low socioeconomic status of the surrounding areas, the top three causes of premature death among the population served by DHA are ischaemic heart disease, interpersonal violence and HIV/AIDS (Western Cape Government, 2018).

DHA is currently classified as a Level One DH in the Cape Town Metro Region, Western Cape Province. As summarised in **Box 6.1**, it offers a range of services, including specialist forensic and rape counselling services supported by the only forensic pathologist in Cape Town, has a capacity of 184 beds, employs nearly 600 staff, mostly nurses, and sees an average of 330 outpatients a day and over 3000 emergency patients a month.

Box 6.1: Services and Staff at District Hospital A (Source: Document Reviews and Interview Data)

DHA offers both out-patient and in-patient healthcare services, including 24-Hour emergency services. There are 13 departments within the Clinical, Nursing and Ancillary Services. Within the Department of Clinical Services, there is the Medicine Department that offers diagnostics, treatment and palliative care services and is allocated 72 in-patient beds and three intensive care unit (ICU) beds. Additionally, the Medicine Department has out-patient clinical services which include clinics on diabetes, asthma, rheumatology, HIV/AIDS and Tuberculosis, and endocrine, cardiac, and respiratory complications. Other clinical departments within the hospital are: Surgical Anaesthetics; Paediatrics (four doctors and a team of nurses); the Radiology department that offers X-Ray, Ultrasound, Computerised Axial Topography Scans, and offers support to the Orthopaedic departments; Forensics that offers 24-hour forensic and rape counselling services and is managed by the only Forensic Pathologist in Cape Town; the Palliative Care Department that offers training and support group that guides patients; Psychiatry with 15 beds for mental health; Social Work; Dietetics; Pharmacy; and, Physiotherapy and Occupational Therapy Departments. There are eight wards that are classified as male and female medical wards, male and female surgical wards, paediatric ward, infectious disease ward, psychiatric ward, and the intensive care unit. There is an Accident and Emergency Unit and a General Outpatients services area.

DHA is estimated to have a total of 580-600 workers, comprised of clinical and allied health professionals, nurses and administrative staff, including clerks, support staff, maintenance staff, porters, and groundsmen. The nursing cadre represents over 400 of the workers. Workers, especially nursing staff, have three work shifts – two during the day and one at night - to ensure continuous delivery of services.

6.1.2 The history of downgrading and budgetary pressures

The provincial department's overall plan to address the apartheid legacy and strengthen its health system (Western Cape Government DoH, 2007) involved creating district hospital beds in the Cape Metro District, partly by re-classifying some available hospital bed capacity as well as by building new district hospitals in under-served areas (Gilson et al., 2017; Western Cape Government DoH, 2007). Although DHA had been classified as a Level 3 or Regional Hospital, acting as a secondary referral hospital for its region, it was formally downgraded to a Level 2 small DH in 2009 without reduction in the range of services provided (Western Cape Government DoH, 2007). The downgrade was accompanied by a cut in the nursing staff complement, as well as overspending, and these were perceived by hospital respondents as reflecting a budget reduction, leading to uncertainty and anxiety within the hospital.

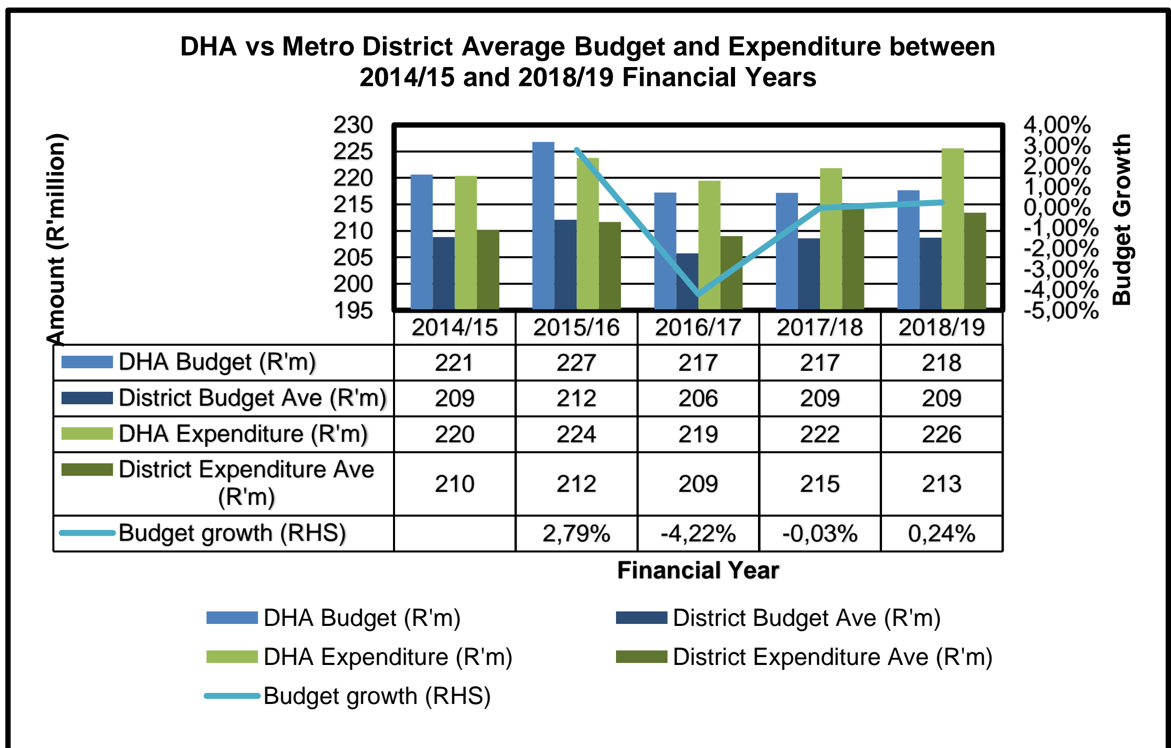
"There is a financial challenge. When the hospital, in terms of finances, when the hospital was downgraded from regional to district, there was not a diminishment of services at this hospital. In fact, despite getting less money, the hospital continued to

deliver the same services and even more services came on. It grew, so all of these and the planned ideas of austerity measures in the last 18 months that has had massive adverse effects on patient care." **DHA-IDI-002 (clinician manager)**

Hospital respondents expressed particular concern that '*high end operations*' meant for larger district and regional hospitals, such as paediatric and intensive care, were being offered at the hospital despite the lack of adequate resources.

"Healthcare demand exceeds our resources. The challenge is resources because with the current fiscal climate, our resources each year, in real terms we are getting fewer resources, but our service demands are increasing." **DHA-IDI-001 (senior administrative manager)**

In real terms, the budget and expenditure data for 2015- 2019, as shown in **Figure 6.1** after inflation, indicate that there was a sudden decline in budgetary allocation and increase in hospital expenditure against the average of the eight Metro District hospitals in the financial year 2016/2017 – the time of data collection. Over time the hospital budget has plateaued, whilst expenditure has increased.



	2014/15	2015/16	2016/17	2017/18	2018/19
DHA Budget (R'm)	221	227	217	217	218
District Budget Ave (R'm)	209	212	206	209	209
DHA Expenditure (R'm)	220	224	219	222	226
District Expenditure Ave (R'm)	210	212	209	215	213
Budget growth (RHS)		2,79%	-4,22%	-0,03%	0,24%

Figure 6.1: *DHA's real Budget and Expenditure against Metro District averages for 2014/15 to 2018/19 Financial Years, 2015/16 prices (Source: StatsSA, Annual Performance Plan 2017/18 and Hospital's department of Finance and Information Management).*

Subsequent external pressures, from 2015 onwards, on hospital budgets included stringent Western Cape Province's DoH controls over staffing. As outlined in a circular obtained from the Chief Executive Officer (CEO) during data collection, if the hospital exceeded its budget for approved posts and agency posts for a month, the hospital leadership was then not allowed to fill other posts in that month (see Chapter Five). In addition, since financial year 2016/2017 the effects of the '*austerity budgets*' borne by the provincial department inevitably had consequences for facilities within the province, although budget allocations actively sought to protect and support district level services.

A third budgetary challenge experienced prior to the study period was poor financial management by the hospital's previous executive leadership. As a result, on appointment, the new CEO had to take tough action to control the budget:

"I think the main successes are that we went from being an organisation that was over budget. We were over budget, but we are now in budget...We were poorly managed from a financial perspective but now we are probably one of the best hospitals in terms of financial management." **DHA-IDI-001 (senior administrative manager)**

However, staff were critical of the actions taken:

"*So, when the new CEO arrived, they knew that there were serious financial challenges. Without consultation, he arrived and without being used to the hospital, in his first month he just cut staff.*" **DHA-IDI-002 (clinician manager)**

6.2 Transitions and experience in hospital leadership

6.2.1 Hospital structures, processes, and leadership transitions

At the time of data collection, in line with broader policy frameworks, DHA was headed by a CEO who was a medical doctor by profession and also held a master's degree in Business Administration. To assist in running the hospital, and as illustrated in **Figure 6.2**, the six heads of departments together with the CEO formed the Executive Management Team (EMT). The departments are: Clinical and Ancillary Services headed by medical services manager; Nursing Services headed by a nursing manager; Finance headed by a Deputy Director; Human Resources (People Management) and Facility Management headed by a Deputy Director; and Quality Assurance headed by a Deputy Director.

Even though some respondents saw the manager for Clinical Services as the chief operating officer of the hospital by default, the EMT saw the Nursing Manager as

second in command to the CEO. This was, in part, attributed to the large number of nursing staff and their critical role in patient care.

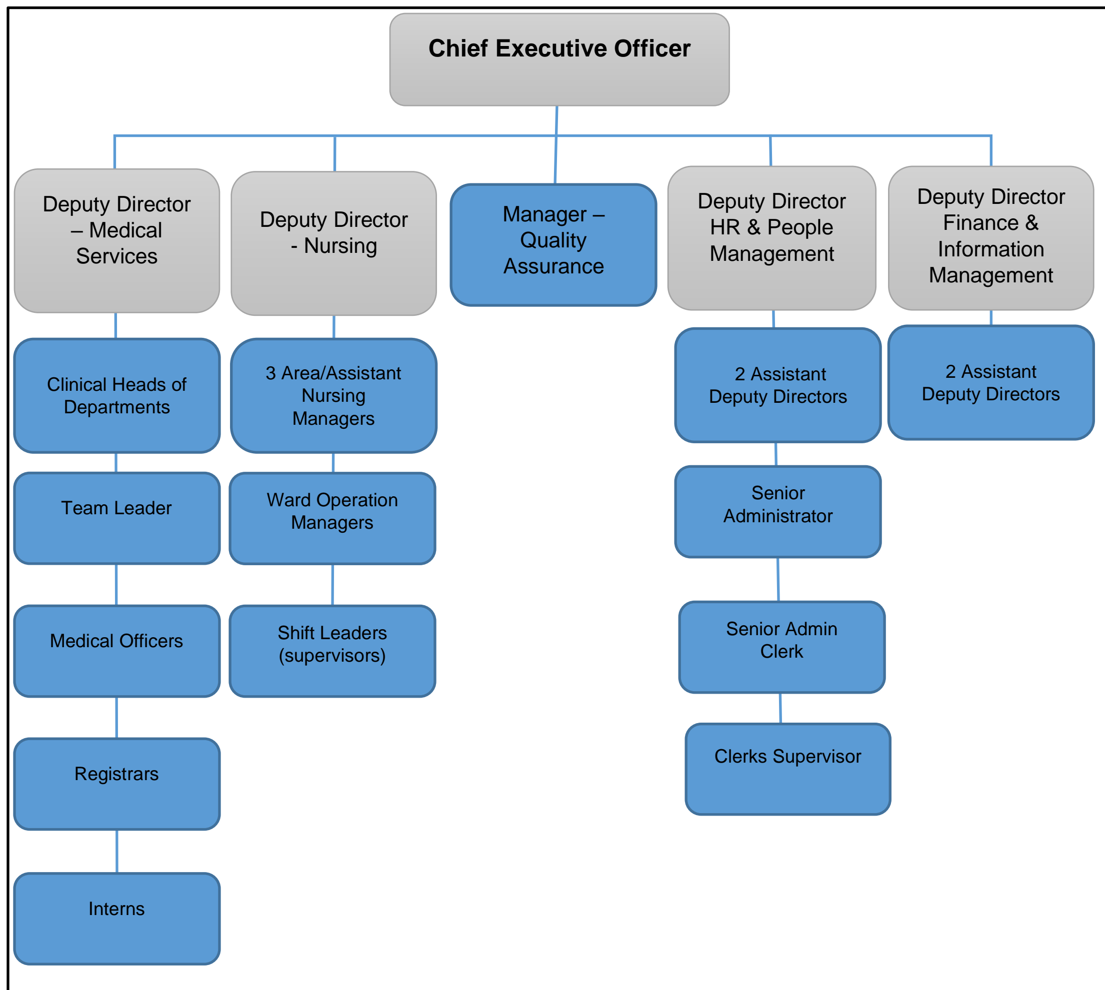


Figure 6.2: *Main DHA staff reporting lines – grey cells represent Executive Management Team; blue cells other staff with formal leadership roles (Source: Interview data and Document reviews)*

The Nursing Manager heads the Department of Nursing Services, which comprises general in-patient services in the surgical, medical, paediatric ward and out-patient services; specialised nursing and out-patient department that offers theatre services, trauma and emergency services and high care services; nursing support services which include infection control; night shift services; and clinical nurse training unit. Each nursing ward is headed by an operations manager (OPM), with support from two registered nurses, two community service nurses, four staff nurses, two enrolled nurses, and interns.

Prior to the study DHA had had three CEOs over a six-year period, and study respondents reported that the immediate previous EMT was dominated by individuals

from the nursing cadre because the CEO had a nursing background. The re-introduction of a CEO with a clinical background was regarded by many as a positive change within the hospital. At around the same time, in 2014, a new Nursing Manager, perceived as having *fresh ideas* was appointed, as well as a new Deputy Director of Human Resources and People Management. The new senior leaders were thought to be offering *strong and dynamic leadership with control* over the hospital, although the changes they introduced also raised some concerns.

"I will say that there's been really some improvement, or I'll say I'm seeing a change because of the change in leadership. So, for me I will say I am quite satisfied with the way things are going since last year, since the appointment of the new leadership that we have. But however, there's always room for improvement." **DHA-IDI-013 (mid-level administrative manager)**

"So, I think everybody now, because we got a new CEO and a new Nursing Manager at the same time two years ago, it was quite something that's quite a big thing okay, and suddenly lots of changes, and that's a big thing." **DHA-IDI-011 (clinician manager)**

The new leadership team's early interventions included changes among clinical heads of department (HoD) to strengthen hospital functioning. For example, one new clinical HoD appointment was made to improve output, teaching, and worker morale.

The routine managerial processes within the hospital included a range of formal weekly, monthly, and bi-monthly meetings. For example, clinical and nursing HoDs had monthly '*transversal meetings*', that were sometimes attended by the EMT, to identify and address challenges for cross-cadre work and relationships between the two cadres. Two-weekly *transversal clinical forum* meetings between clinical and nursing units sought to bridge the gap between clinical and nursing managers and staff, and executive management and the manager for support services. The nursing department also encouraged interactions among operation managers through bi-weekly and bi-monthly meetings.

However, informal processes were also widely regarded as important in building relationships and improving engagements between managers and staff. These informal processes included, daily '*handover meetings'* that I attended as a non-participant observant, '*visibility on the floor and walkabouts'*, having an '*open door policy'*, '*team-building activities*' in and outside the hospital, and staff meeting in *communal tea rooms*. Senior managers emphasised the importance of face-to-face

meetings between staff since DHA is a small hospital by design and regular meetings and interactions with workers '*on the floor*' were highlighted as a constructive form of communication. Besides meetings, hospital used regular short message services (SMS), emails, telephone calls, and communication books and diaries to communicate with staff.

Human resource processes, guidelines, and policy frameworks

Field notes from observations made at meetings between the CEO and the heads of departments indicated that human resources and financial management are guided by the rules and regulations set by the provincial and national governments. Staff selection and recruitment is guided by the broader Public Service Employment Act and the provincial employment policies. Within the WC department frameworks (see Chapter Five), the hospital managed its vacancies carefully as staffing represented around 70% of the total budget.

Human resource recruitment processes ensured equal opportunities within the workplace in line with the national Employment Equity Act, whilst the implementation of the Occupational Specific Dispensation (OSD) policy (see Chapter Five), a remuneration policy, had also specifically impacted on managerial appointments. The OSD policy resulted in some senior or older nursing staff being placed in higher salary bands, effectively promoting them to mid-level manager positions as OPMs. Both processes were criticised by some respondents in terms of their impact on skills' availability within the hospital. At the same time, budget pressures were criticised for limiting the creation of leadership posts, staffing levels, and provision of leadership development opportunities for workers.

Other policies highlighted as influencing hospital experience included the appraisal process (the SPMS described in Chapter Five), which was widely regarded as a highly formalised procedure with a lot of paperwork. Mid-level operation managers and clinician HoDs expressed unhappiness with the procedures and forms, arguing that compliance with them consumed much of their time, and were less likely to improve hospital outcomes. In contrast, the implementation of the provincial C^2AIR^2 Values framework (see Chapter Five), intended to guide culture and behaviour change, was regarded as a success within the hospital - contributing to the hospital being recognised as '*one of the best managed hospitals in the WC, with motivated and empowered critically thinking workers*. The middle manager responsible for C^2AIR^2 related activities also received provincial awards as a *C^2AIR^2 champion*. The champion's responsibilities included organising and planning team building events

that allow workers and managers from across cadres and management levels to interact. For example, the hospital held beauty and fashion modelling and a *Master Chef* themed event for staff.

"What C^2AIR^2 Club is all about, it is all about improving the patient experience but applying the value, the departmental values which is caring, competence, respect, responsiveness, integrity and innovation. So, what I do as part of my programme of that, we normally plan events, like team building events, recently we had one for master chef and the purpose of that was basically to get to know each other." **DHA-IDI-013 (mid-level administrative manager)**

Staff and managerial relationships

Overall, and as discussed further later in this chapter, there was clear evidence from observation and in respondents' views of a link from positive leadership practices to strong relationships and teamwork among staff, between managers and staff, and of a strong communication culture among staff within units and departments.

"There are generally good relations. For example, there is, like, a communal tearoom. Everybody meets up in the tearoom, amongst colleagues, amongst consultants, amongst colleagues and MOs, there is good relations, amongst the doctors and the nursing staff, generally there are good relations and good communication." **DHA-IDI-002 (clinician manager)**

Nonetheless, there were some reports of tensions and conflicts between doctors and nurses, as well as between different levels of management, and between the executive management and frontline staff. Despite their emphasis on informal engagements with staff and being visible, the executive management was sometimes criticized for not being sufficiently available for interactions with staff in the wards or *on the floor*.

All the nursing respondents also specifically noted that DHA did not hold monthly *climate meetings* with different categories of workers, as outlined in the Labour Relations Act. They claimed that there were, then, no appropriate formal platforms to raise and address worker complaints or to provide communication channels and build relationships between senior managers and the lower-level workers.

6.2.2 Leadership practices and experience in DHA

To better understand the pathways or linkages between organisational context, leadership practices and staff satisfaction and morale, I first asked both those in

formal leadership positions and other staff who played more informal leadership roles at the hospital about their practices and experiences of leadership in the hospital. As illustrated in **Figures 6.3** and **6.4**, the observational data and analysis of in-depth interviews revealed experiences and practices that are summarised as either positive or negative, based on respondents' judgements about their likely impact on staff morale (as discussed in later sections and outlined in **Figure 6.5**). The practices contributing positively to morale are shared or delegated practices, empowering others for leadership, approachability, participative and engaging practices, and caring and empathetic practices. Disengaging and hierarchical practices, as well as non-participative practices and favouritism were the leadership practices judged as leading to low morale amongst staff.

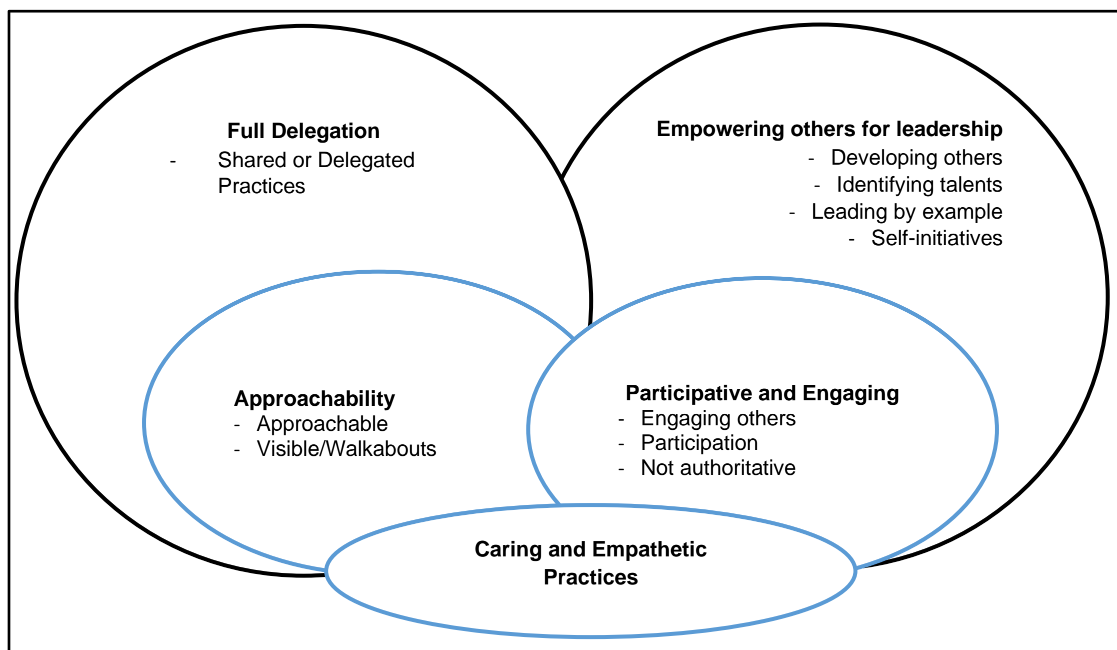


***Figure 6.3**: Positive leadership practices that promote staff satisfaction and morale in DHA (Source: Interview and observational data)*

Overall, shared, or delegated leadership practices and empowering others for leadership - represented in large black circles - emerged as the dominant practices within the hospital. In addition, as represented in **Figure 6.3** and **Box 6.2**, they were accompanied by other practices that entrenched participation by and engagement with staff, were experienced as empowering and as encouraging staff to express care and empathy to each other and their patients - behaviours that staff considered appropriate for provision of healthcare services. The empowering practices were experienced and practiced by respondents from all cadres, as aptly described by a middle manager nurse respondent:

"People work independently when empowered and knowing what their roles are and I don't have to watch over their shoulders to see that the job is done. I am not going to micromanage them … I inspire trust and inspire motivation and you know the people that I work with and a team effort." **DHA-IDI-017 (mid-level nursing manager)**

Empowering practices were reinforced during the morning handover meetings, attended by the researcher, where the CEO engaged nursing and clinical managers by sharing his perspectives on the leadership that he envisioned for the hospital and that would support the middle managers in engaging their staff. It was common to identify lower-level staff with leadership talent and recommend them for leadership development courses or mentoring by the CEO and other managers. These staff were then involved in implementing changes in the hospital, with respondents arguing that these practices contributed to quality of care.

Positive practices were frequently highlighted by respondents from across cadres who considered their managers as usually *delegating and sharing roles*, although this was a little less evident in nursing. In addition to formal delegations of authority - following the management structures outlined in **Figure 6.2** - there appeared to be a more widespread informal practice of sharing roles and responsibilities within different and across levels of management in clinical and administrative cadres. For example, clinical units formally and informally shared leadership roles between the current and previous HoDs, and with junior clinicians:

"I feel the skill of delegation is not an easy one, it needs practice. And my colleague [Former HoD], it is easy for him, but then we are not the same, we complement each other. what we now have is that we have got two people who understand the job better. We've got a better understanding; we are a team." **DHA-IDI-008 (senior clinician)**

Box 6.2: Examples of positive leadership practices that enhance satisfaction and morale (Source: Analysis of interview data, this study)

Developing others to grow into leadership positions through training and other self-initiatives to allow workers to learn by doing was key to empowering leadership practices **in nursing**: *"If you want to actually acquire quality care you need to develop your people by maybe sending them to workshops or trainings or what we also do, you do the ward training but we mostly talking about the training or exposing them to higher positions, so that they can see what is happening. You develop people by asking them their input when you are going to introduce something new than just telling them that we are going to have this thing when their input is not taken into consideration."* **DHA-IDI-009 (nursing operation manager);** And leading by example **amongst clinicians**: *"You need to be what you expect from staff. It is not going to work for me to tell them and do something different. I cannot tell them to come early if I cannot come early. I cannot tell them to work full day if I do not work the full day. I cannot ask them to be efficient if I am not efficient, I need to be the role model that I expect from them."* **DHA-IDI-002 (clinician manager)**

Empowering and developing others for leadership was a feature in **administrative cadre:** *"For the other managers in this institution its less direct mentorship and more working together to develop, not just their leadership skills, but well, mostly to get their leadership and problem-solving skills."* **DHA-IDI-001 (senior administrative manager)**

In **administrative cadre**, respondents viewed self-initiatives such as learning-by-doing as an important practice: *"You learn by doing which is a very good thing because you learn from your mistakes. You would make a mistake and you learn from it. I always think that if you don't make that mistake you are not learning anything."* **DHA-IDI-005 (administrative clerk)**

Shared and delegated practices by **clinicians and administrative staff** as a common and widespread practice: *"He is a good manager, he knows how to delegate, he knows how to get other people to do the work and he's done a phenomenal job in terms of changing the structure of our team and delegating work to other people and allowing other people to take up skills, to take on things that I was not able to release."* **DHA-IDI-008 (senior clinician)**

Engaging others, especially **by the CEO**, was seen as a positive change that was an appreciated practice by most staff: *"Management and leadership wise, I would say that we have a really good manager, our CEO is great, he is brilliant, he listens to you, he's very open, he's smart, he's the change that DHA needed, and he's got a great attitude and I think that everyone else likes it, just like a ripple effect."* **DHA-IDI-007 (mid-level administrative manager)**

Approachability was a critical practice for openness and transparency and to identify **nursing** problems on the work floor: *"Most of the time sisters in the wards handle things but when it's different they call me and let me know or when patients ask for me. Whatever happens I need to give them feedback and when I walk into the passage I need to look around and see what is happening around me. I need to be aware if there's any problems."* **DHA-IDI-016 (mid-level nursing manager)**. Similarly, in **administrative cadre**: *"You see me and Mr. [ABC], we are working together for a couple of years already. The relationship between the two of us is actually very good and it is a working relationship obviously. But I do not see that there is anything. There's no fear involved, you know, a lot of people are afraid of supervisors, not here."* **DHA-IDI-006 (administrative clerk)**

It was reported that DHA was a good place to work at because managers treated others as equals, were empathetic and respectful, and staff cared about each other: For **clinicians,** *"Being empathetic and just being a good human being to your staff and understanding that they are going through tough challenges."* **DHA-IDI-002 (clinician manager)**; and **nurses** *"Whether we have these young nurses who are falling apart because of a boyfriend, or a lot of our staff have debt issues, I'm no financier but you know you sit, and you listen."* **DHA-IDI-017 (mid-level nursing manager)**.

Similar practices were observed among the administrative cadre. For example, in the department of human resources, staff divided their roles amongst themselves, and

the line managers delegated some of their roles to clerks managers also worked together as a team when undertaking special projects.

In contrast, nurse managers tended to delegate according to the formal nursing professional hierarchy. For example, the nursing manager shared his leadership roles with area managers. Whereas assistant or nursing area managers delegated their leadership roles to ward OPMs who assisted them in the management offices, the operation managers delegated their leadership roles to the shift leaders within the wards.

The *transversal meetings* bringing together heads of departments were, however, used to promote collaborative cross-cadre and managerial engagement in problem solving and to share general leadership responsibilities. These meetings also served as a link between executive management and the clinical, nursing and support services. The senior leadership further engaged and interacted with middle managers in discussions of clinical and leadership issues in handover and HoD meetings, demonstrating non-authoritative and engaging practices. These types of interactive practices allowed managers to have first-hand experience of the challenges and personal issues the frontline staff faced on the work floor.

Dispute resolution at departmental level was, moreover, participative, and inclusive, with staff in different departments listening to each other's opinion as teams to come up with solutions - before seeking guidance from their line managers.

"We try and solve everything within the department. So, if I have a problem with them, I will discuss it and manage it here. If I cannot, then I will take it up. Or if they have a problem with me, I will try and first clear it and if they are not happy with me, they then will take it up to my boss." **DHA-IDI-003 (clinician)**

As described earlier, the CEO encouraged other managers to have an *open-door policy*, be *visible* and to undertake *walkabouts* to be accessible and approachable to frontline staff, to build their morale. Respondents appreciated these practices and used the term *visible leadership* to refer to occasions where senior hospital leadership undertook *walkabouts* in different wards and units to observe and interact with the frontline workers. The walkabouts were geared toward improving relationships with frontline workers at the operational level.

Finally, worrying about staff welfare and being fair towards them were generally perceived as caring and empathetic leadership practices. For example, a nursing middle manager suggested that offering the nursing team tickets for a concert was

one way of caring for nurses who were under-recognised in the hospital. Clinician managers and staff also demonstrated care and empathy towards medical officers who worked longer hours and managers often expressed care at a more personal level when staff had other family and life challenges.

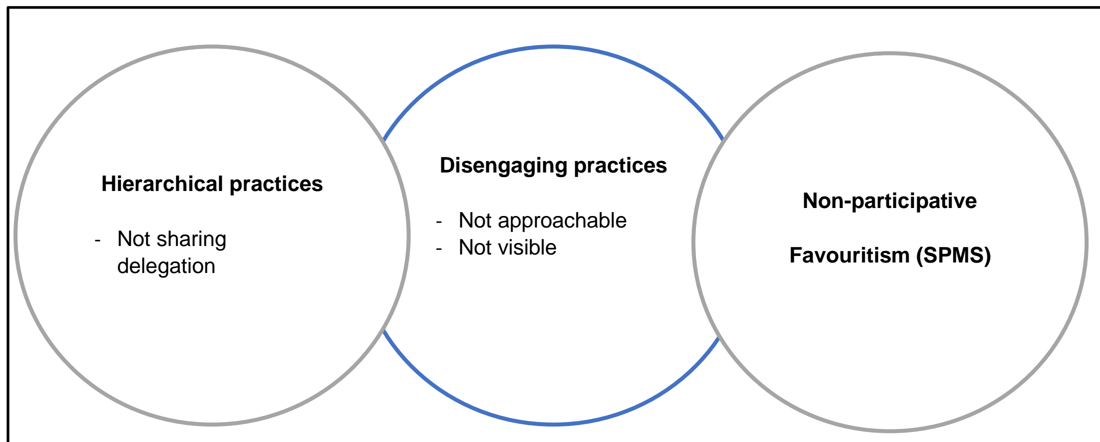


Figure 6.4*: Negative leadership practices that undermine staff satisfaction and morale in DHA (Source: Interview and observational data)*

Despite the widespread reports of positive leadership practice, some negative practices were identified which undermined staff morale and, as **Figure 6.4** illustrates, they were perceived to be inter-linked. Overall, respondents suggested that these sets of practices were more common within the nursing cadre, whereas favouritism and some disengaging practices were experienced among both nursing and administrative cadres.

Failure to develop others, not being visible, as described above, and being unapproachable were disengaging practices that connected to the hierarchical practice of not sharing leadership as well as to being non-participative. Perhaps the most compelling evidence on these negative leadership practices can be seen in the inability of the senior and middle nursing managers to share or delegate leadership outside the formal nursing hierarchical structures. These practices also varied by level of management, as notably asserted by a nurse manager:

"Nobody else makes decisions for me. The wards and the people there that have been historically here in this place do not tell me what to do. I am the manager. I will tell you what to do." **DHA-IDI-004 (senior administrative manager)**

Concerns about limited engagement between senior managers and staff on the floor were, moreover, criticised as reflecting a lack of interest in patient.

"In terms of the clinical manager, as well as the CEO, they are not around, they are not there with us seeing the patients, they don't have meaningful interactions with us where they appear to be interested in patient care." **DHA-IDI-002 (clinician manager)**

Other examples of negative leadership practices as demonstrated across cadres are highlighted in **Box 6.3.**

Box 6.3: Example quotes on negative leadership practices that undermine morale in DHA (Source: Analysis of interview data, this study)

Some **clinician respondents** had previous experience of negative leadership from their previous HoDs whom some saw as *rude, abrupt and despotic*, while others referred to them as *authoritative* and *unapproachable*: *"She was very authoritative and very unapproachable. I never felt like I could come to her and ask her and speak to her or ask for help. I felt intimidated, like she had the management style where I'm the boss you are the worker and that's the boundary."* **DHA-IDI-003 (clinician)**

Hierarchical practices and lack of visibility in **nursing** was a major concern for frontline staff: *"I think I've seen the nursing management in a ward once and that was this week. The nursing manager just sits up there. I have been to other hospitals where you always see the nursing manager in the ward most of the time, overseeing things. It helps a lot because he can pick up other things that are happening on the floor and now if it doesn't happen like that, they will always have unhappy nurses."* **DHA-IDI-018 (nurse)**

Undertaking dual functions as **clinician** and HoD with managerial roles presented conflict of roles that led to leadership challenges in: *"So, in other hospitals I assume, the clinical manager sits in the desk, in an office, but you see Dr XYZ doesn't want to be the clinical manager. She wants to see patients. So, when you do not have a clinical manager, therefore if she is involved in her department, how is she going to know what is happening in other departments? She's not managing she's not leading."* **DHA-IDI-008 (senior clinician)**

Non-participative practices were perceived where **executive management** did not include middle managers and other workers in financial and other policy decisions: *"There is a huge disconnect between management and the physicians, and the clinical staff. Huge disconnect in a sense that managers make financial decisions around the hospital, and they make huge decisions that impact directly on patient care without consulting the physicians that are actually looking after the patients."* **DHA-IDI-002 (clinician manager)**

Favouritism was commonly reported as a negative practice in **nursing wards** where managers respondents perceived their managers as *assigning duties and appraisals based on friendships* between operation managers and other staff: *"She has a lot of favouritism, her friends can just sit, the nurses who are counted. They are assigned to be here; you cannot say you are short staffed up there because how many patients are assigned in the ward, and they will just let them sit and not do the work. She uses a lot of friendship; her friends will just sit."* **DHA-IDI-Group Interview (nurse)**

Figure 6.5, finally, summarises the perceptions and views of the respondents about the possible pathways between the identified leadership practices and staff morale in DHA. The figure demonstrates that staff were likely to be more positive in terms of morale and satisfaction when they experienced leadership practices such as being approachable, enabling delegation, empowering others, allowing participation and engagement, and showing care and empathy. However, disengaging, hierarchical, non-participative and favouritism were negative leadership practices that were

associated with relational conflicts, leadership weaknesses, and inefficient organisational practices and which demoralised staff.

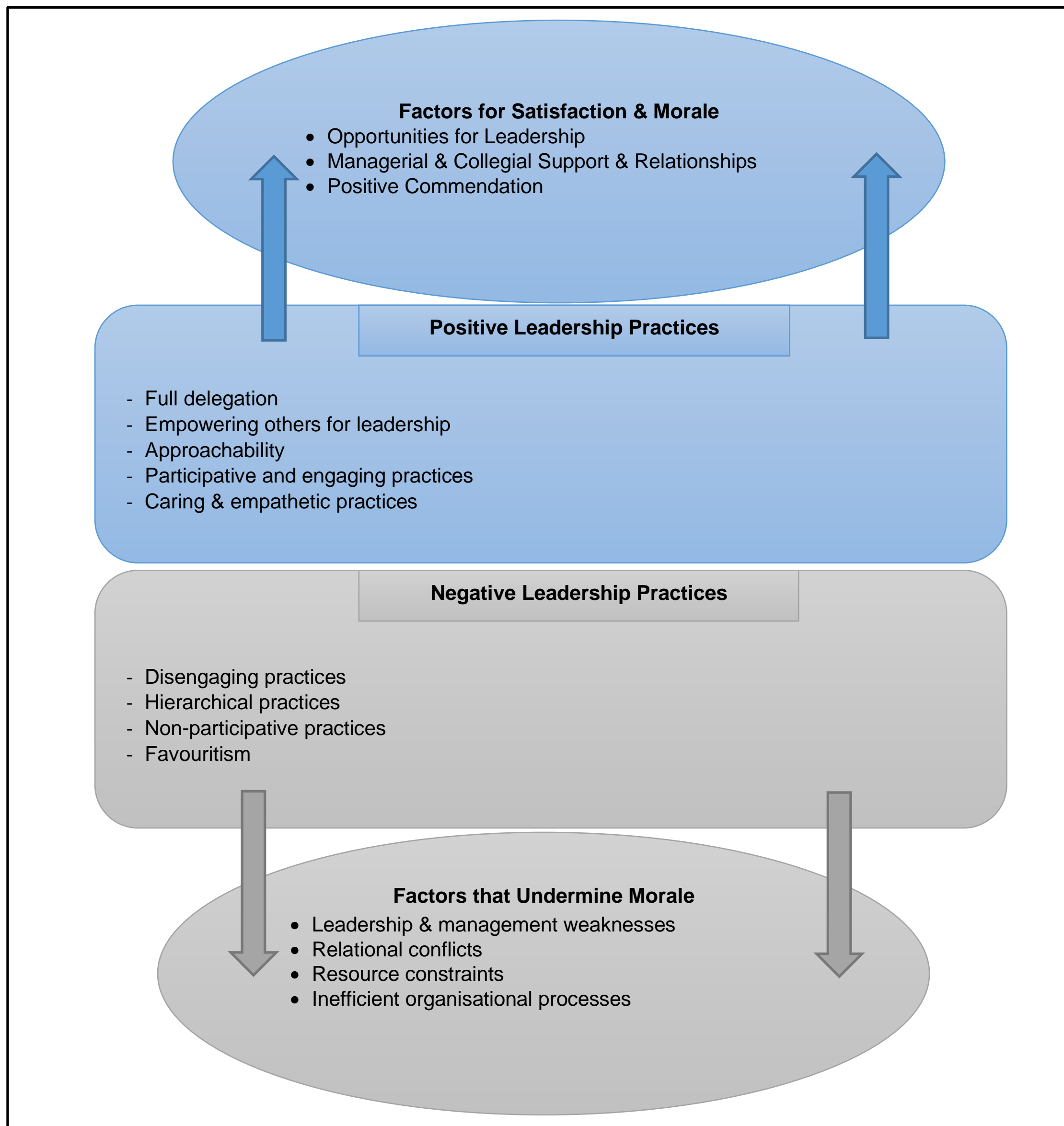


Figure 6.5*: Interlinkage between leadership practices and staff satisfaction and morale in DHA (Source: Interview Data)*

The specific factors that promoted or undermined morale are discussed further in the next section before, finally, identifying the contextual elements that are relevant to both leadership and morale at DHA.

6.2.3 The morale of staff in DHA

Factors that influence staff satisfaction and morale

In this study, as outlined in Chapter Three, I have used staff satisfaction and morale as an indicator of leadership effectiveness. **Tables 6.1 and Table 6.2** summarise the factors identified from interviews and observations as influencing staff and managerial morale at DHA positively and negatively, respectively. Staff morale was enhanced by intrinsic factors (characterised by common goals and experiences, intrinsic drive, hospital work and fighting for change); opportunities for leadership and leadership growth within the hospital; managerial and collegial support and relationships; positive commendation (through appreciation, acknowledgment, positive feedback, and fairness); and the small size of the hospital.

Table 6.1: Factors associated with high or positive staff satisfaction and morale in DHA (Source: Interview and Observational Data)

<table>
<tr><th colspan="2">Sources of staff morale in DHA</th></tr>
<tr><td>Intrinsic factors
• Intrinsic drive and inspiration
• Hospital work or job itself
• Fighting for change</td><td>Positive commendation
• Appreciation and acknowledgement by managers and colleagues
• Positive feedback and open communication from managers and colleagues</td></tr>
<tr><td>Opportunities for leadership
• Opportunities for leadership growth and development
• Developing leadership capacity in others
• Visibility of senior leadership/walkabouts</td><td>Managerial and collegial support and relationships
• Managerial support and relationships
• Collegial support and relationships
• Transparency across levels of management
• Sense of belonging and togetherness</td></tr>
<tr><td></td><td>• Hospital design and work environment</td></tr>
</table>

At the same time, as outlined in **Table 6.2**, the factors that undermined satisfaction and morale of staff and managers included: inadequate service delivery due to poor nursing care; low intrinsic morale (particularly among more junior nurses); few opportunities for leadership; weaknesses in leadership; relational conflicts; unfair commendation practices and inefficient organisational processes; resource constraints; and poor workmanship and infrastructure in the old hospital design.

Table 6.2: Factors associated with low or negative staff satisfaction and morale in DHA (Source: Interview and Observational Data)

Sources of low staff morale in DHA	
Inadequate service delivery - Poor nursing care	**Low intrinsic morale in nursing**
Few opportunities for leadership • Limited leadership role opportunities • Limited leadership development/training • Absent leadership/Lack of visibility of middle and senior leadership on the floor	**Leadership and management weaknesses** • Rigid nursing management style • Inadequate supervision in nursing • Disconnection between levels of management
Relational conflicts • Professional conflicts • Managerial conflicts • Disengagement in nursing	**Unfair commendation practices and Inefficient organisational processes** • Lack of appreciation, recognition, or rewards • Unfair SPMS appraisals • Lack of space to voice opinion
Resource constraints • Staff shortages • High workload • Burnout and depression	**Hospital design** • Poor workmanship and infrastructure

Overall, intrinsic motivation appeared to be a major driver of morale across cadres and different levels of management. Respondents often attributed their high morale to their personal internal drive and inspiration, hospital work or the job itself as well as the ability to fight for change and good patient care (see **Table 6.1** and examples in **Table 6.3**). Accordingly, DHA generated sentimental feelings in clinician respondents: *"I actually love working at [DHA] hospital, this place is very close to my heart."* **DHA-IDI-015 (clinician).** This reflected the general mood of the entire hospital as intimated by an interviewee from administrative cadre: *"[DHA] hospital I would say is the place to be, there's lots happening here."* **DHA-IDI-007 (mid-level administrative manager)**

Nonetheless, there was evidence of low intrinsic morale amongst more junior nurses:

"Sometimes in some wards, there is no motivation, there's nothing there to motivate you to come and to actually do your best. It's just you do your job and go." **DHA-IDI-018 (nurse)**

Table 6.3: Examples of intrinsic factors for staff satisfaction and morale in DHA (Source: Analysis of interview data, this study)

Motivation from fighting for staff and change	*"I feel good, like when I fight for the staff and for their rights."* **DHA-IDI-007 (mid-level administrative manager)**
Motivation from intrinsic drive and inspiration	*"My morale is always good because, I don't want to say it but, I'm a natural leader and I'm also a natural motivator. When I speak to people, I kind of find them listening to me I do not know why, maybe it is my personality, I do not know, but they listen and take in what I say, and my morale has always been good… I mean motivation to do your work is so much more than, I mean honestly if you give me someone who is inspired because of financial incentive, I do not want to work with them. Because someone who is inspired, they want to do a good job, in a team that you get so much out of people like that."* **DHA-IDI-012 (nursing operation manager)**
Motivation from hospital work itself	"The reasons why I chose to stay at [DHA] hospital is, it's a lovely hospital. I really enjoy the patients that are here… I think just the general morale here at the hospital, everyone always delivers big. They always deliver more than what is expected." **DHA-IDI-003 (clinician)**
Motivation from the job itself	*"I feel quite well. Staff and patients, I feel good. I want to come to work in the morning. I do not dread coming to work. In the morning I am up 5 o'clock on my way to work. This is where I want to be. I want to be productive, and I want to provide the service."* **DHA-IDI-004 (senior administrative manager)**

As noted in **Tables 6.1 and 6.2**, leadership practices were another important influence on morale, confirming the experiences outlined in the previous section. Respondents were particularly satisfied and appreciative of the leadership offered by the new management team given their past experiences.

The 2016 Staff Satisfaction Survey results also confirm this influence, recognising a quite low response rate (shown in **Table 6.4**). The survey specifically considered some of the practices already discussed - showing, for example, positive views among a majority of respondents about being respected and valued by managers, managers' handling of dispute resolution and managers demonstrating care to employees. However, fewer respondents were positive about being praised by managers, though the percentage was considerably higher than the provincial average, about management accessibility, and about managerial ability to manage change. Although management visibility was broadly seen quite positively, as discussed earlier, junior nurses did raise concerns about the accessibility of management and managerial supervision:

"We love our jobs but at times we are being like demoralised by the supervision because they are the decision makers of our careers, they are the decision makers of patient care, the quality care." **DHA-IDI-018 (nurse)**

Table 6.4: Leadership practices and collegial relationships in DHA (Source: Annual Report 2016/2017 and Staff Satisfaction Survey in Annexure 1; n = 102)

Specific SSS question	**DHA (%) Strongly Agree/Agree 2016**	**Provincial (%) Strongly Agree/Agree 2016**
Leadership practices		
My line manager respects and values my contribution at work	79%	-
My line manager is able to manage internal conflict effectively	70%	-
My line manager genuinely cares about employee's needs	68%	
In the last 7 days I have received recognition or praise (for example, a thank you) for doing good work from my manager	57%	37%
Management is accessible when I have not been able to receive a satisfactory solution to a problem	42%	-
Managing change		
My manager encourages staff to become part of change	57%	-
My manager manages ongoing change effectively	50%	-
Collegial relationships		
I have good relationships with the people that I work with	88%	84%
I am able to consult my colleagues when I am faced with an unexpected or challenging situation at work	84%	82%

The survey also confirmed that most respondents experienced relationships with colleagues as positive, and this corresponds to findings from the in-depth interviews and observations about the *family-like*, supportive relationships in the hospital - also identified as a positive influence over staff morale (see Table 6.2).

"I love working here, we work as a team, we support each other, we are a family, even people inside the hospital are nice." **Observational DHA-Field Notes**

"We don't just care for the patients, we care about our colleagues, you know and about our colleagues' family." **DHA-IDI-012 (nursing operation manager)**

However, there were also a few reports of professional conflicts, managerial conflicts and disengagement between cadres and levels of management. For example, some middle managers perceived they were seen as *difficult persons* by senior management with whom they had poor relationships.

"Once you defy the management, you are rocking the relationship… Well, you can imagine that if you are not being consulted about the department you are head of you can't have good relations with the management." **DHA-IDI-008 (senior clinician)**

The survey data (**Table 6.5**) indicate that only a small proportion of respondents, and a much lower proportion than the provincial average, had positive views about hospital design features, reflecting its negative influence over morale (**Table 6.1**).

Table 6.5: DHA Physical design (Source: Annual Report 2016/2017 and Staff Satisfaction Survey in Annexure 1; n = 102)

Specific SSS question	**DHA (%) Strongly Agree/Agree 2016**	**Provincial (%) Strongly Agree/Agree 2016**
My building caters for the needs of persons with disabilities	32%	
My building is safe and well maintained	24%	
The restroom/tearoom facilities are adequate	22%	40%

However, the qualitative data show that the small size of the hospital, specifically, was judged to enhance collegial relationships and teamwork.

"I really enjoy working here because it's a small hospital and it is, the people all know each other and we are friendly with each other, we do get along well and it's a nice place that I am situated in." **DHA-IDI-014 (nursing operation manager)**

Human resource management practices were another factor impacting on morale across cadres (**Table 6.1** and **6.2**). Staff morale was promoted when managers acknowledged and appreciated one another, and when positive feedback and open communication that signalled transparency existed amongst managers.

"My work got recognised. Last year I received a cash bonus for work well done you know." **DHA-IDI-012 (nursing operation manager)**

"And they come here, they feel free about telling me no, but I do not like that, and I will tell them also, look here now you are doing nonsense here, there is a problem. We feel we are very open with each other." **DHA-IDI-006 (administrative clerk)**

On the other hand, demoralisation occurred when staff were not rewarded or recognised, perceived that there was favouritism during performance appraisals (the SPMS), or where they lacked space to voice their concerns.

"I feel that people are being neglected, I feel that the true stars are neglected. What I would like to see happening is that we are all on the same page, that my expectations from the system is the same as yours… It is an entitlement and managers do not sort out the problem. Management agrees that this person, every year it's this person that gets it, we all know it's a big problem." **DHA-IDI-010 (nursing operation manager)**

The demoralisation due to lack of recognition was common in the nursing cadre*: "The nurses tell me that they don't feel appreciated. And having C^2AIR^2 Club and giving them a Master Chef episode and giving them a meal doesn't change their morale."* **DHA-IDI-008 (senior clinician)**

Similarly, the Staff Satisfaction Survey data (**Table 6.6)** showed that despite regular evaluations, most respondent judged that the performance appraisals were not conducted in a fair manner and did not promote a high-performance culture – as further reiterated by a clinician HoD in middle management.

"I'm saying again, SPMS is fine for people who aren't doing their jobs because then you get them to pull their socks up. But honestly people who are highly motivated, that stuff does not motivate them. Who are you motivating with a financial reward? Honestly, the guys are not doing what they are doing to get a financial reward, I can promise you that." **DHA-IDI-011 (clinician manager)**

In addition, the survey revealed that although most respondents had a personal skills' development plan, a much smaller proportion felt they had fair access to opportunities for education, training, growth, and development in the hospital. In nursing, for example: *"There are many courses that nurses can actually go for, but they are already demotivated because the ones that have tried to apply were turned down. They don't even send people, even if people want to study further, they have to steal studying"* **DHA-IDI-009 (nursing operation manager).**

Table 6.6: Performance management and skills development issues in DHA (Source: Annual Report 2016/2017 and Staff Satisfaction Survey in Annexure 1; n = 102)

Specific Staff Satisfaction Survey question	**DHA (%) Strongly Agree/Agree 2016**
Performance management	
I have had at least 2 performance appraisals/evaluations in the last year	52%
I felt at ease during performance appraisal	49%
The performance appraisal was conducted in a positive manner	48%
Performance management structures promote a high-performance culture	35%
Skills development	
I have a skills development plan, which meets my specific needs and job requirements	70%
I attended at least one training session in the last year	50%
I have equal and fair access to education and training	45%
I have access to opportunities to grow and develop in this organisation	38%

Finally, as **Table 6.7** notes, less than half of the respondent reported positive views about workloads and resourcing. Despite the generally positive views of the new managerial team, they were criticised by some in relation to resourcing issues.

"There is also inequitable distribution of resources in this hospital where some departments, in terms of staff and equipment, are prioritised. And that is historical, and it continues. The resources in this hospital does not go where they are needed most; the patient care is compromised because of these financial reasons. The inequitable resource allocation has not been effectively addressed and, nursing issues is not being addressed." **DHA-IDI-002 (clinician manager)**

Nurses were particularly frustrated: *"I think the nursing staff, many of whom I've spoken to are not happy for various reasons; one including change of the nursing manager in recent years, the nursing manager has changed and since then I've noticed, I mean there's been a massive cut in nursing staff as well and so since then I've noticed that the nursing staff are not as happy as they used to be, and they often voice their concerns to me on their issues."* **DHA-IDI-015 (clinician)**

Table 6.7: Workload and resourcing in DHA (Source: Staff Satisfaction Survey in Annexure 1; n = 102)

Specific Staff Satisfaction Survey question	**DHA (%) Strongly Agree/Agree 2016**
My workload is manageable	43%
My unit/team has access to sufficient resources to complete their work effectively	43%

Variation between cadres

Although respondents in all cadres reported positive experiences of leadership and positive views on morale, as already noted the available data suggest more negative views and experiences among nurses compared to other cadres. They expressed concerns about poor relationships that lead to conflicts in work teams, low intrinsic morale, resource constraints and poor distribution of staff. Low morale amongst frontline nurses and support staff was certainly resource constraints that led to absenteeism, burnout, and intention to leave.

"There are things that we don't have in the wards that we urgently need, and people are not excited about that because you have to go and borrow somewhere, and you phone around and beg to borrow… I think that is one of the reasons why there are many people going away, maybe looking for other options. People are staying away, getting sick, I am just wondering when is it my turn? When am I going to burn out also?" **DHA-IDI-014 (nursing operation manager)**

The generally hierarchical management style in nursing was a concern, identified as leading to the leadership practices of disengagement and to a disconnect with the frontline workers:

"I don't control the nursing staff. The morale in nursing staff is very low, very poor. Because the challenge within the nursing division from top down, there's huge challenges with the top management of the nursing staff that is adversely affecting the patient and the nursing staff morale." **DHA-IDI-002 (clinician manager)**

Demotivation and low morale in nursing was mainly experienced by frontline staff, as further illustrated by a clinician respondent:

"When you are at a lower level in this hospital and you are a nurse and you're unable to communicate with your management and you don't feel like you're not heard, and you are unable to be inspired and lift now morale." **DHA-IDI-008 (senior clinician)**

In contrast, the positive morale of clinicians and administrative staff was judged as resulting from 'the work' itself, the leadership ability to develop capacity in others and opportunities to share leadership roles, in-cadre management transparency, and support from colleagues and managers. Clinicians had a *good feeling* about working at DHA due to the *generally good relations* amongst them because *they did not feel like they are working on their own*. The morale of the clinicians was observable during ward rounds and in the communal clinician office and tearoom. This positive morale allowed clinicians and administrative respondents to give positive feedback and develop capacity in their colleagues.

"I love to work here, it's very nice and I mean the people are very cooperative and we respect each other… I applied for this post in HR because I love to work with people, and I love to give positive feedback to people, and I like making people happy as well. So, the field that I'm currently in is basically what I want because I am getting satisfaction of what I'm currently doing." **DHA-IDI-006 (administrative clerk)**

Overall morale levels

Overall, however, the 2016 staff satisfaction survey data suggest that most respondents were highly satisfied (**Table 6.8**). The respondents were clear about their jobs and felt they worked in an environment that allowed them to gain satisfaction from work, and these response rates were about the same or slightly higher than provincial averages. The majority also felt that good quality care was provided, and two-thirds or more felt loyalty to the organisation. Indeed, only a third reported that colleagues were looking to leave the organisation soon.

Table 6.8: Staff satisfaction, morale, and commitment in DHA (Source: Annual report 2016/2017; and DHA Staff Satisfaction Survey Results in Annexure 1; n = 102)

Specific SSS Question Linked to Morale	DHA (%) Strongly Agree/Agree 2016	Provincial (%) Strongly Agree/Agree 2016
I am highly motivated to do my job	81%	-
Issues linked to satisfaction from work done		
I am clear as to what I am supposed to accomplish at my work	90%	86%
I understand how my job contributes to the organisation's objectives	88%	86%
I have a measure of control and influence over how my work is completed	85%	79%
I have the skills I need to perform my work effectively	84%	81%
I find the content of my work interesting and stimulating	77%	76%
At work, I have the opportunity to do what I do best every day	76%	-
I have an important role to play in the organisation operations	72%	76%
Issues linked to delivering quality of care		
My colleagues are committed to doing quality work	80%	-
My organisation is committed to providing quality care to patients	75%	78%
Organisational loyalty and stability		
I feel a strong sense of loyalty to the organisation	69%	-
I feel secure in my position at this organisation with the current changes taking place	64%	-
My colleagues are looking to leave the organisation within the next 6 months	35%	34%

6.3 Organisational context and its influence over leadership experience in DHA

Overall, respondents in DHA reported on their experiences of camaraderie and teamwork across cadres with positive consequences for staff morale. However, there was hierarchical distance between senior and junior nurses, and between senior management and other staff, which undermined morale and had some knock-on consequences for cross-cadre engagement.

Section 6.3 examines the contextual factors that influenced these leadership practices, as summarised in **Figure 6.6.** The factors are grouped into internal and external factors, with internal factors further grouped as hardware, tangible software, and intangible software (see Chapter Three). *Hardware* elements comprise of the hospital's design, staff complement, division of tasks between cadres and the management structures. The hospital's *tangible software* includes decision-making procedures, the spread of power and authority, human resource management processes and the hospital's rules and regulations; and the *intangible software* was characterised by teamwork, camaraderie, the processes of information sharing and the sub-cultures within teams and cadres. The following analysis teases out the

interactions among specific factors within these groupings as well as their influence on leadership practices and staff morale and satisfaction, to exhibit the complex interaction between the phenomena.

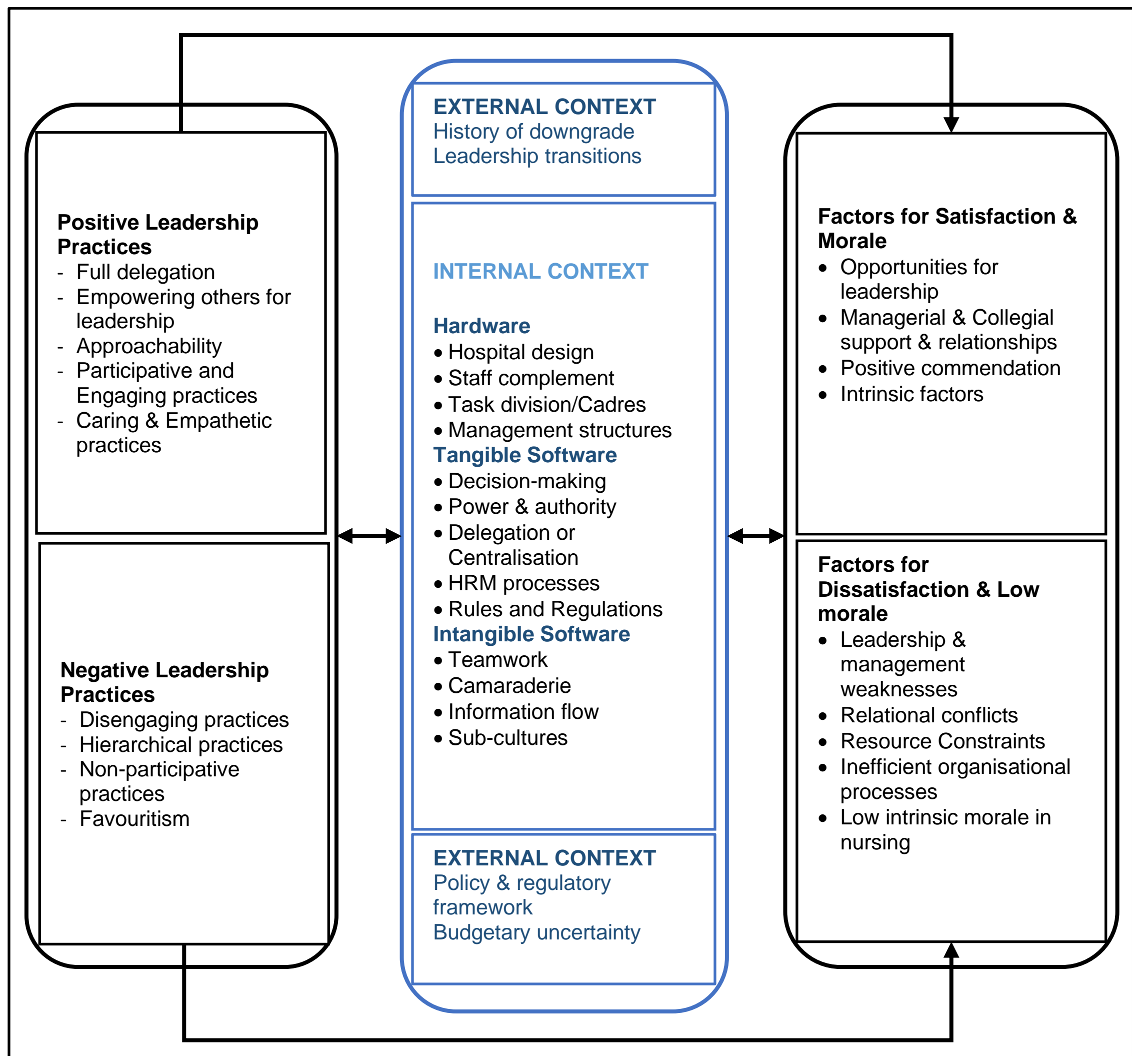


Figure 6.6: *Interaction between context, leadership practices and staff satisfaction and morale at DHA (Source: Interview Data)*

6.3.1 DHA's Internal hospital context

Overall, there was a sense that the strong staff morale as well as experiences of leadership were integrally linked to aspects or features of the hospital's internal context. The core DHA leadership practices of full delegation and empowering others - supplemented by approachable, participative, engaging, and caring leadership – appeared, then, to be intricately connected to the *intangible software* of supportive collegial relationships characterised by *teamwork* and *camaraderie.*

"The doctors and the surgeons and the anaesthetists we all work together really well. There is no hierarchy or organogram. We are all on the same level, whether you are

the CEO of the hospital, whether you are a cleaner of the hospital, we are all on the same level, we eat together, we pray together. So those are the reasons I chose not to leave." **DHA-IDI-003 (clinician)**

The Staff Satisfaction Survey results clearly demonstrate the strong relationships and teamwork within the hospital, including across cadres (**Table 6.9**). Although problems with management were also identified (they were perceived as not having the best interests of staff at heart, **Table 6.9**), this finding was largely contradicted by interview and observational data pointing to the positive leadership practices of senior managers at the time of the study. Indeed, respondents from both clinical and nursing cadres were delighted by the fact that, after having a series of poor managers and leadership in the hospital in a six-year period, the new CEO had a medical and a business background (*tangible software*): *"It's nice to have a doctor back and maybe I can't say doctor because the CEO doesn't have to be a doctor, but it's really nice to have an approachable person up in senior management."* **DHA-IDI-016 (mid-level nursing manager)**. The finding in **Table 6.9** might, then, reflect the history of weak leadership and DHA's prior experience of being downgraded (see section on *external context)* or simply reflect an almost inevitable staff/management divide.

Table 6.9: Organisational relationships and teamwork at DHA (Source: Annual Report 2016/2017 and Staff Satisfaction Survey in Annexure 1; n = 102)

Specific Staff Satisfaction Survey question	DHA (%) Strongly Agree/Agree 2016	Provincial (%) Strongly Agree/Agree 2016
I have good relationships with the people that I work with	88%	84%
I am able to consult my colleagues when I am faced with an unexpected or challenging situation at work	84%	82%
In my unit/component the staff function well as a team	82%	-
Different professions (doctors, health professionals, admin) work well together	62%	-
I believe that senior management in this organisation have the best interests of employees at heart	36%	34%

However, as discussed earlier, there were indications of staff morale problems, particularly among nurses, in DHA. These were, in part, linked to particular types of leadership practices, such as hierarchical practices, disengaging practices, favouritism and non-participative practices, all of which also restricted staff from working cohesively in teams and were themselves underpinned by internal contextual factors, as discussed below. Some Staff Satisfaction Survey data also point to wider concerns about the organisation (**Table 6.10)** that seem likely to reflect past

experience, as discussed further in the *external context* section. Alternatively, given provincial response rates on these issues, there might be a general tendency for staff to be sceptical about organisational management issues.

Table 6.10: Organisational perceptions at DHA (Source: Annual Report 2016/2017 and Staff Satisfaction Survey in Annexure 1; n = 102)

Specific Staff Survey question	DHA (%) Strongly Agree/Agree 2016	Provincial (%) Strongly Agree/Agree 2016
The organisation keeps employees informed about planned changes timeously	37%	34%
The organisation treats its employees fairly	37%	35%
The organisation is open to employee's feedback and ideas	36%	36%
The organisation values and cares for its employees	35%	33%
People in this organisation are transparent (no hidden agendas) and communicate openly	29%	40%
You receive feedback on your suggestions	26%	38%
The organisation puts employees' ideas into practice	22%	39%

Returning to the positive experiences, good relationships, and teamwork among and across cadres *(intangible software)* were widely acknowledged as enabling DHA staff to provide patient centred care, as noted by a nursing operation manager:

"We've got a very good relationship because even doctors when they come here from Groote Schuur, they say wow [DHA] you feel like you are home because there is a relationship between nurses and doctors. We do not have to be putting each other aside. We are working together because you are a doctor, I am a nurse but our goal, what is our goal? Our goal is to make the patient get better. We are here for the patient, that's all." **DHA-IDI-009 (nursing operation manager)**

Certainly, across the hospital and staff mix, current leaders saw teamwork as an essential aspect of the hospital:

"Your team could be your doctors, your nurses or your staff. So, to be the head of the institution, not institution but department, but basically to lead your team, to direct your team, and to keep things in control. But I must tell you, you cannot do this alone, you have to build up relationship with that team for you to be successful." **DHA-IDI-012 (nursing operation manager)**

The teamwork culture *(intangible software)* at the executive or senior management level also enabled the collective development of the hospital's vision *(tangible software)* which itself underpinned the wider teamwork found to be important in providing quality care in the hospital.

“Here is the department’s vision: access to quality care for all. And I think we are still aligned to that vision and have [DHA’s] vision which is, clinical excellence, the best managed hospital in the Western Cape and motivated empowered critical thinking staff.” **DHA-IDI-001 (senior administrative manager)**

The common goal of providing good patient care was, moreover, aligned with the intrinsic motivation of many staff (see **Table 6.1**)*: “It’s a very safe stable environment. It is near where I stay. The patients, the people that work at [DHA] are all passionate and driven towards the same goals. No one is out to get you, no one is competing against you. We all work together for the patients’ sake.”* **DHA-IDI-003 (clinician)**

The hospital vision was also aligned with the broader provincial DoH values (*intangible software)* and hospital values were reinforced by the provincially driven culture change strategy (*tangible software*) through the C^2AIR^2 Principles (see Chapter Five).

“For us to improve our staff morale and just to improve the image of this hospital and portray a good image of this hospital outside, we engage in C^2AIR^2 activities on a regular basis.” **DHA-IDI-004 (senior administrative manager)**

Specific activities were used to promote C^2AIR^2 Principles (*tangible software*) and enhance relationships and collaboration. These activities were spearheaded by an assistant director, seen as a C^2AIR^2 Champion, and included team building events as well as *interactions between staff along the corridors of the hospital*.

Further, positive team working, and camaraderie *(intangible software)* were strengthened by the small size of the hospital and the physical closeness of the units and departments (*hardware*) that allowed cooperation, mutual respect, communication, and good understanding amongst workers when solving problems; especially in common spaces such as *communal tea rooms*.

“What I enjoy in our department is we all understand each other very well. We get along very well, and everything is patient centred. In terms of the hospital on a broader picture, I think the camaraderie, the close-knit relationship between various departments is one that you do not often find at any hospital this size or bigger. Everyone is usually isolated; you know each department is to themselves and here everyone works very well together. So, I think for me that is a big plus about working here, it’s really something that you don’t find often elsewhere.” **DHA-IDI-015 (clinician)**

The stability of staffing in DHA, with clinicians and nursing staff having worked in the hospital for a long time *(hardware)* was also critical in building strong relationships and enabling teamwork. Indeed, the camaraderie and family-like feeling had developed over a long period of time (*external context*) due to the long history of the hospital's existence and established relational practices (see section 6.1) – as enumerated by a clinician:

"There is a family feeling in the hospital, in the sense of camaraderie among staff, a culture that has developed over a long period of time. And the culture has developed despite the management issues that exist." **DHA-IDI-002 (clinician manager)**

An administrative staff member also said: *"I have made a bit of good colleagues, where we have a good working relationship, and it is nice, and some people are really trustworthy."* **DHA-IDI-005 (administrative clerk)**

Camaraderie and teamwork between cadres and different levels of management were also facilitated by leadership practices around the sharing of information (*intangible software*) - at *daily handover meetings*, *weekly meetings* and the *monthly HoD transversal meetings* (*tangible software*). These meetings, which I observed during data collection, represented a clinical forum to promote collaborative problem solving and communication between different clinical and nursing divisions, and support services within the hospital. Communication between managers, and sometimes with lower-level staff, was also deliberately encouraged through what respondents referred to as an *open-door policy* (*intangible software*).

"We are really involved, there's communication. We, all the managers, have our emails, we have our meetings and things like that. We do have a say and if there's anything, like suggestions they have an open-door policy, I can go and talk to my CEO, my manager at any time." **DHA-IDI-012 (nursing operation manager)**

Regular information flow was further supported by *internal phone calls*, *SMS*, *Emails*, and departmental or unit *communication books and night diaries* (*tangible software*). Some other forces supported teamworking within cadres. Staff in the administrative cadre noted, for example, that because of the nature of their tasks (*tangible software*), their work was interlinked which allowed them to function together as a team:

"We are working very well in a team and responsibilities that I give them; they are doing excellently. We need to work together as a team because you can't work on your own in HR, you can drown." **DHA-IDI-007 (mid-level administrative manager)**

Positive professional relationships and teamworking in clinical departments and amongst clinicians were, meanwhile, attributed both to trusting relationships (*intangible software*) which allowed them to share roles, including clinical governance and decision-making responsibilities (*tangible software*), and to empowering leadership (*positive leadership practice*).

"Where we work as a team is that we get everybody to go the extra mile because they feel part of something special. People generally work long full days, but they do not complain… Like we will have monthly socials outside the hospital for team building, monthly team building activities, with various academic activities, you understand. My approach has been to be more inclusive. We have given both MOs leadership, and they seem happy with their leadership. They are like our rock when we are not here. So, when I am not here and they are there I am happy because I know that they will mobilise staff and they will do what is right, because I have empowered them to do that. I'll be careful, I'll never undermine them." **DHA-IDI-002 (clinician manager)**

As previously noted, despite the many positive experiences, some tensions were observed among staff and nursing morale was more variable than among other cadres. Sometimes poor information flow and communication *(intangible software/leadership practices)* between clinicians and nurses about in-patient cases frustrated cross-disciplinary work, as when nursing operation managers were absent during the daily clinical ward rounds. Additionally, teamwork and communication between departments was sometimes weakened by separate reporting channels (*tangible software*). Clinical services and nursing departments have different lines and approaches to communication and problem solving, which also contributed to demoralising professional conflicts between the two cadres.

Some frontline nursing staff specifically attributed poor information flow to the lack of a *comfortable space* (*tangible software*) to express how they felt. They criticised the lack of formal *climate meetings,* which are professional platforms for improving engagement between different categories of nursing staff and the senior management: *"It is a requirement in every hospital to have monthly meetings with different categories. They are called climate meetings for enrolled nurse and auxiliary nurses. They are not doing that here. When are the employees going to voice out their dissatisfactions?"* **DHA-IDI-018 (nurse)**

At ward level, moreover, some nurse respondents felt that the lack of interactive climate meetings *(tangible software)* contributed to the weak supervision and unfair

allocation of roles that undermined teamwork and quality of care: *"There is no teamwork at all and because of that, the health, the wellbeing of the patients are jeopardised and there's not teamwork at all."* **DHA-IDI-018 (nurse)**

Lack of interactive meetings (*tangible software*) also undermined teamwork amongst nursing operation managers.

"We work as a team but when it comes to the people that are in your level, it's difficult to ask from this one that is on top of me, it's difficult to ask from other operational managers. I don't pick up the teamwork in managerial level." **DHA-IDI-009 (nursing operation manager)**

The nursing tradition of staff rotation (*tangible software*) further constrained teamwork and was seen as an *old-fashioned* managerial process of the *strict nursing body*. Similarly, nursing scopes of practice (*tangible software*) limited the engagement practices and retention of competent and efficient staff in key areas such as intensive care, paediatrics, maternal health, obstetrics, and emergency departments.

Although teamwork and camaraderie was evident among nurses, relationships were hindered by the structured and rigid nursing hierarchies (*tangible software*), that only allowed a top-down information flow (*intangible software*) and limited participative and engaging practices. As aptly described by a clinician: *"When you are at a lower level in this hospital and you are a nurse and you're unable to communicate with your management and you don't feel like you're heard, and you are unable to be inspired and lift now morale – then it's very difficult."* **DHA-IDI-008 (senior clinician)**

More generally, management structures (*hardware*) in the hospital were outlined by a layered organogram (**Figure 6.2**) that shows a hierarchical vertical system (*hardware*) within management. At departmental and unit level where tasks are performed by teams in different cadres, deputy directors, line managers and supervisors had the power and authority (*tangible software*) to make some decisions (*tangible software*). Sometimes senior and middle managers allowed other staff in their teams to participate and engage in decision making, regardless of the clear structural divide between senior, middle and junior management. However, this did not always occur. As a clinician noted:

"I feel as a head of department, I finally got a louder voice or authority to make a change. I've always voiced my concerns but at the end of the day, it wasn't me to make the decisions." **DHA-IDI-003 (clinician)**

In addition, despite the decentralisation (*tangible software*) of some decision-making abilities to HoDs, unit managers and supervisors, as outlined in **Figure 6.2**, clinicians were frustrated by senior management's lengthy decision-making processes especially when not consulted. Such decisions included a non-participative financial decision to reduce nursing staff that impacted patient care and led to a disconnect between physicians and senior management.

"Ultimately, most decisions have to be passed by upper management and that's obviously where we often get problems. And it's very frustrating when they do not allow you to initiate the changes that you feel is necessary to improve the service." **DHA-IDI-015 (clinician)**

However, this financial decision was itself driven by wider cross-cutting austerity measures implemented within the Metro DHS and WC Provincial DoH (*external context*) as part of (see Chapter Five and section 6.1.2 of this chapter). This example demonstrates, then, how external, and internal elements of the hospitals interacted to influence leadership practices and morale.

6.3.2 DHA's External hospital context

DHA is over a century old and there were interesting inter-linked aspects of external context that had significant influences over leadership practices and staff satisfaction and morale. These elements of external context and their interactions with internal context and leadership practices are illustrated in **Figure 6.7**.

To begin with, a recent history of instability characterised by leadership transitions and turnover of managers in-between the downgrade of DHA from a regional hospital to a small district hospital in 2009, described in section 6.1.2, resulted in a period of financial mismanagement, followed by budgetary constraints that were exacerbated by subsequent public sector financial austerity. This led to a reduction in the allocation for staffing of clinicians and nurses, without any contracting of service scope.

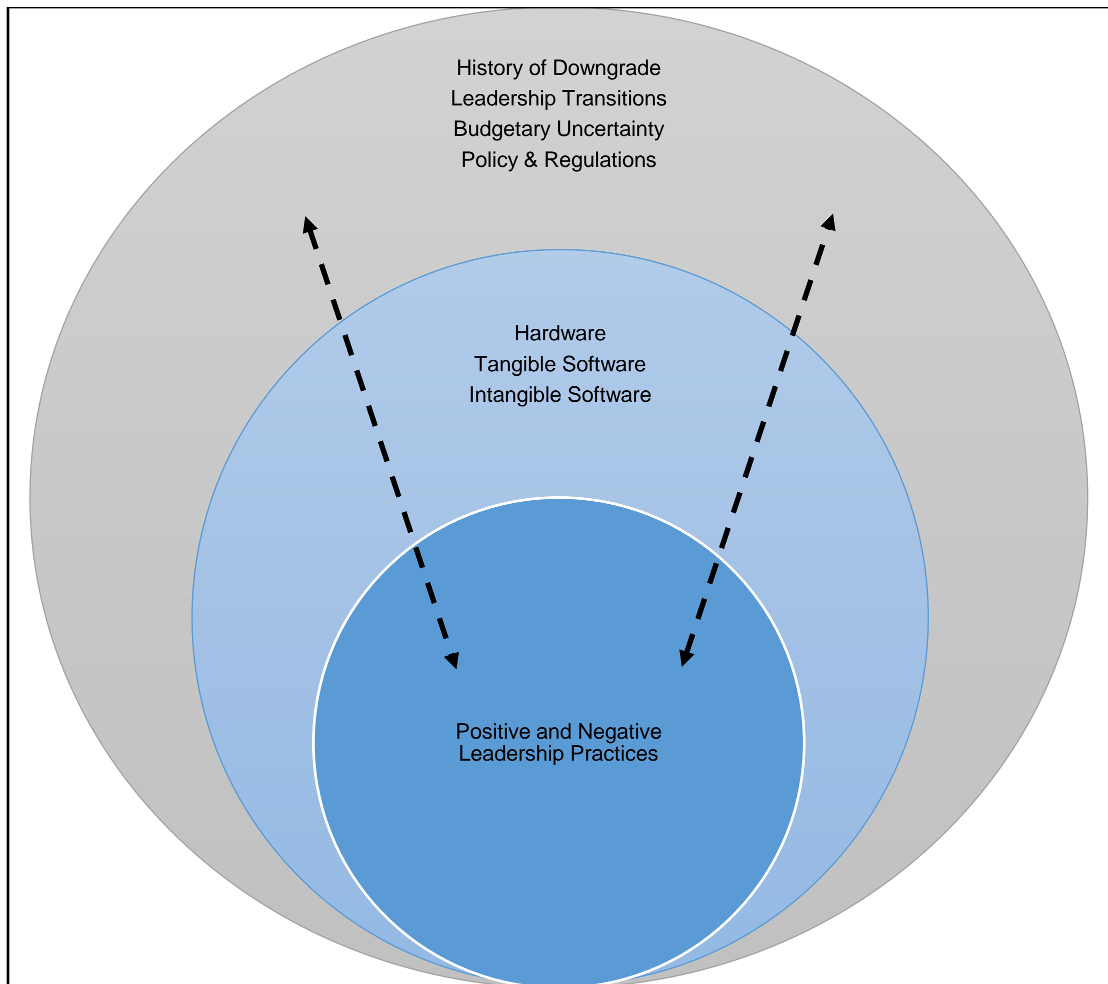


Figure 6.7*: Interaction between external context, internal context, and leadership practices (Source: Interview Data)*

Against the backdrop of the history of downgrade, budgetary uncertainty, and the provincial policy framework, DHA experienced leadership transitions over a six-year period that had generated poor relationships and eroded managerial and organisational trust (*intangible software*) in the period before the study, as highlighted in **Table 6.10**. The leadership transitions in the period before the study were mainly at the senior level - CEOs and deputy directors in different departments. As outlined in section 6.2.1, at the time of the study, DHA had a new leadership team that contributed to staff satisfaction and morale. The new senior management and a mix of experienced middle-level managers (*tangible software*), who survived the leadership transitions (*external context*), had institutional knowledge and were responsible for restoring the managerial and organisational trust (*intangible software*) that had been damaged during the transitions and the hospital downgrade.

"What also helps is the fact that both me and [DR X] have been here for more than six years. So, we have developed largely of experience and institutional knowledge, and we have become, we've also developed a reputation of being very good teachers." **DHA-IDI-002 (clinician manager)**

As compared to nursing leadership that was viewed as rigid in its approaches to problem solving in the hospital, clinical services had managers who had been at the hospital for prolonged time and had better knowledge of the hospital's operations. Senior leadership in departments of nursing and human resources was considered as relatively new and did not have a good understanding of the hospital which influenced how they related and engaged with staff across other departments.

The previous leadership was criticised for their inability to empower staff within the hospital. On the contrary, the new leadership team were seen as having positive leadership practices. For instance, department of human resources and people management had a new manager who was praised for limiting the level of mistakes in contract management and improving the department's service output. Similar comments were generated in not just within other departments and clinical units, but also generally about the hospital.

"There's not much we could do in the first year because there was such a change in the way I manage from previous manager. The hospital was going through financial austerity measures because it was so far over-budget. So, we could not think of DHA hospital management system. We were thinking about surviving and learning to adapt to these new ways of doing things." **DHA-IDI-001 (senior administrative manager)**

Both the new and older leadership within some units and wards were perceived as *strong*, *leading from the front,* and *inspired* other frontline staff, with *experience* and *institutional knowledge.* The reputation of the hospital was reported as largely positive save for the period before the downgrade, with the current senior leadership improving on the reputation:

"I've been through three different CEOs or superintendents as they were called in the old days and I've seen different styles of management since being at DHA, but I think on the whole the management at DHA hospital has been slightly better than at the other places I've worked at." **DHA-IDI-008 (senior clinician)**

And again, as confirmed by a long tenured senior clinician:

"I don't know why the CEOs keep changing. I think in terms of the CEO, about five or six years ago, this hospital had a very good CEO, excellent. And the CEO was part of the reason for recruiting me; she was a brilliant excellent CEO that was hands on, was in touch with all the heads of departments, that was visible in the hospital, where patients did actually come first. And she was inspirational, and she always wanted the best staff." **DHA-IDI-002 (clinician manager)**

To elaborate, the former CEO ensured that DHA recruited efficient workers, consultants and HoDs. However, despite the financial austerity, respondents linked the subsequent changes of leadership to poor financial management, which consequently had impact on how DHA leadership related with staff.

"And the hospital was going through financial austerity measures because it was so far 'over budget'... we were thinking about surviving and learning to adapt to these new ways of doing things." **DHA-IDI-001 (senior administrative manager)**

The hospital also had a legacy of poor financial controls and over expenditure after its downgrade, blamed by some staff on previous managers (see section 6.1.2). Within the first year, the current leadership had to deal with the ongoing change process after the downgrade by streamlining the hospital budget to survive and adapt to the new processes. The previous leadership left the hospital in a situation the respondent referred to as '*over-budget*' whilst the new leadership was expected to conform to the financial austerity measures.

"*Before I came here, I know that DHA was like, if I look at the finance side, it was over expenditure of millions but if you look at DHA now I think the managers currently at DHA are actually doing a flipping, sorry I can't say flipping, but I mean a brilliant job.*" **DHA-IDI-006 (administrative clerk)**

However, because of the introduction of stringent financial measures to curb overspending, some respondents criticised the current leadership for their focus on financial prudence over patient care - *"Whereas the previous management was much more patient-centred, this management is not patient-centred."* **DHA-IDI-002 (clinician manager)**

Even so, most respondents praised the new hospital leadership and its positive leadership practices for moving DHA from a financially poorly managed organisation that went '*over budget*', to being considered as one of the hospitals with better financial management in the province. The achievement was important after DHA's

downgrade and in the face of the hospital's increasing healthcare demands which exceeded the available resources for healthcare services (*socioeconomic context*).

Respondents in senior management found it difficult to explain to staff the financial challenges and that they could only work within the confines of the health systems' financial policy framework, leading to a breakdown in trust between senior managers and staff because of lack of staff participation and engagement hospital's expenditure.

"We can only provide what we can within the frameworks of the department and within the budget allocated to the hospital. I don't have money lying around." ***DHA*-IDI-004 (senior administrative manager)**

The budgetary uncertainty, linked to the broader public sector financial management, led to the reduction of opportunities for leadership and professional development of workers since the austerity measures also targeted skills development strategies for workers that contributed to disengaging leadership practice of not developing others.

"And because of the financial crisis we are in, new posts are not opening up. So, for instance, I will probably stay in this post for a very long time. People working under me will never get to this post unless I must resign, or I must retire." **DHA-IDI-003 (clinician)**

Financial management was influenced by the wider provincial bureaucratic reporting structures. The cross-cutting and extensive bureaucracy in the provincial and district health system meant middle management in the sub-structure, and provincial directors, were the CEO's line managers. All senior and middle-level respondent managers argued that the executive team within the hospital was under the influence of middle managers within the complex bureaucratic structures in the MDHS and the provincial DoH (see Chapter Five), as reflected in the financial decision making that had implications for patient care.

"The managers have a particular budget at their hearts and protected directives. Because of the managers and the department of health being multiple and multilevel, there is lots of middle managers in between, and each middle manager has their own views. So, our CEO would have limits maybe financially as one expectation from his line managers. And those line managers may conflict with the best interests of the patients." **DHA-IDI-002 (clinician manager)**

Another challenge posed by the complex bureaucratic nature of the dual metro and provincial health system was the disruption it presented to the executive team. For

example, the substructure office expected the CEO and other members of the EMT to attend meetings even when bureaucratic memos interfered with their work schedules and internal meetings, thereby reducing the time for engagement practices between executive managers and staff.

Middle-level managers in the hospital were also frustrated by what they perceived as lengthy decision-making in HRM procedures such as selection and recruitment of staff (*tangible software*). However, the senior management had limits to their decision-making in recruitment because they had to adhere to broader recruitment policy guidelines (*external context*) that regulated employment of staff. These regulations were in the form of ECC and APL (discussed in Chapter Five), in addition to the overarching government policy on employment equity, commonly known as BEE (Black Economic Empowerment). Some respondents felt that applying the employment equity policy as the main recruitment criteria was denying the hospital the opportunity to employ adequately skilled workers from other racial groups within the broader population.

In addition, another wider national and provincial policy (*external context*) that was an important aspect of internal context is the staff performance appraisal and assessment system (described them in Chapter Five). As part of the formal leadership roles for managers and supervisors (*hardware*), SPMS was an important HRM process (*tangible software*) influencing the relationships between managers and staff (*intangible software*). Managers and supervisors had the mandate and authority to perform appraisals and assessments of staff under them through the SPMS. However, respondents criticised the outcome and subsequent rewards that were associated with the appraisals.

"People just do it because it's an entitlement and then managers don't sort out the problem. Management agrees that this person gets it every year, we all know that. It's a big problem all over." **DHA-IDI-010 (nursing operation manager)**

The appraisals and the rewards undermined relationships between staff and managers, which had impact on staff morale, because of the perceived managerial favouritism and unfair leadership practices.

"The SPMS is the performance management system, so where they do your assessment for how well you are doing now. And when I look at how much effort I have put into this hospital and how much transformation has happened in my department since I have taken over. I never done it to receive financial benefit but why

should one continue doing that if you do not receive acknowledgement, appropriate acknowledgement where other doctors in the hospital that do much less receive financial reward? Then my goodness, is there discrimination, whether due to colour or whatever, I do not know the reason, but discrimination exists." **DHA-IDI-008 (senior clinician)**

6.4 Chapter summary

This chapter sought to provide a thick analytic description of the experiences in the first case-study hospital, DHA. The chapter has highlighted as influences over leadership experiences, the history of the hospital, the background of downgrading, and the consequences of the leadership transitions and the financial austerity measures that influenced the operations of the hospital after its downgrade. The analysis also unearthed different elements of the hospital's internal context that fostered positive leadership practices and teamwork in the hospital.

A finding of particular interest is that DHA was characterised by camaraderie, togetherness and '*family-like*' relationships that enabled and strengthened teamwork across cadres. These '*family-like*' relationships were also linked to core positive leadership practices that allowed full delegation and empowered others – supplemented by approachable, engaging, participative and empathetic or caring leadership practices. These practices and the interacting features of hospital context were critical in promoting staff satisfaction and morale. In addition, the new executive leadership, particularly the new CEO with medical background and postgraduate qualification in management, purposefully contributed to the teamwork, togetherness, and strong relationships; a culture that had been built over the long existence of the hospital.

Despite the largely positive view of leadership experiences in the hospital, some staff, especially nursing staff, were dissatisfied and demoralised by relational conflicts, weaknesses in leadership and resource constraints. These experiences were underpinned by the hierarchical structures and cultures of nursing, for example. In addition, the hospital's history of being downgraded, coupled with austerity budgets and the wider bureaucratic limits on decision-making were important contextual influences underpinning negative leadership experiences.

The leadership practices experienced in DHA as well as the contextual influences over them are considered further in the cross-case analysis and discussion chapters, together with their implications for policy.

Chapter 7: Findings from District Hospital B

7.0 Introduction

This chapter provides, first, an introduction to the second case study hospital, District Hospital B, and its history. Second, it describes key features of the leadership experiences of the hospital, including a detailed description of common leadership practices. Third, it explores the implications of these experiences and practices for staff morale, using morale as an indicator of leadership effectiveness. Fourth, it considers how contextual factors underpin and influence the experience of leadership within the hospital, as well as their likely influence on staff morale. Finally, a summary of the chapter is presented addressing the central question of this study: how does the DHB context influence leadership practices and moderate leadership effectiveness? Overall, the chapter draws on documentary data, hospital observations, in-depth interview data and the 2016 hospital Staff Satisfaction Survey (see further details in Chapter Four).

7.1 Hospital overview and history

7.1.1 Basic overview

District Hospital B is a new hospital which officially opened in November 2013, replacing an older, smaller, and dilapidated hospital about 10km away. It is in a lower income community within the overall setting of Cape Town. This community was initially formed during the apartheid era, with the re-location of its population from other parts of the city of Cape Town as part of the racial, spatial zoning of that time (Gilson, Elloker, Olckers, & Lehmann, 2014). In 2019 the area had a population of over 900 000 inhabitants, and was characterised by high unemployment, high burden of disease, drug abuse and poor social infrastructure (Western Cape Government, 2018; Gilson et al., 2014a; Elloker, Olckers, Gilson, & Lehmann, 2013). Available data show that the local health services in this area are relatively under-resourced compared to other parts of Cape Town (Western Cape Government, 2018; Elloker et al., 2013).

In fact, DHB was purposefully located in this setting to address the surrounding population's historically poor access to adequate, hospital services (Gilson, Brady, et al., 2017). The construction of the hospital was part of the provincial health department's strategic plan for developing a health system better oriented to the

needs of the population in the post-apartheid era (Western Cape Government DoH, 2007).

Box 7.1. Services and Staff at District Hospital B (Source: Document Reviews and Interview Data)

Specialties offered at DHB are Radiology, Anaesthetics, Surgery, Internal Medicine, Emergency Medicine, Paediatrics, Psychiatry, and Clinical Forensics. There are also Allied Health Services that include Pharmacy, Physiotherapy, Occupational Therapy, Social Work and Audiology. DHB offers both outpatient and in-patient healthcare services. The hospital is currently operating 13 wards with 330 beds at its full capacity. There are 60 Medical adult beds, 60 surgical adult beds, 60 Obstetrics beds, including Kangaroo mother care, 30 Paediatrics beds, 20 Overnight beds, and a 30-bed ward that was moved from another nearby Emergency Centre to the main hospital building. There is an Accident and Emergency Unit and a General Outpatients services area.

DHB is estimated to have a total of 865-890 workers. Nursing is cadre represented by over 500 of the workers. Doctors and specialists about 70 of the total employees when compared to the nursing staff. Workers, especially nursing staff, have four work shifts – two during the day and two at night - to ensure continuous delivery of services.

The hospital is a state-of-the-art facility with 330 beds and a staff complement of just over 800 workers, offering a broad package of services (see **Box 7.1**). In line with provincial policy (Western Cape Government Health, 2014; Western Cape Government DoH, 2007), this package exceeds the standard district, Level 2, hospital service package by offering some regional, Level 3, specialist services. It is, then, in some sense a hybrid hospital combining Level 2 and Level 3 services; reflecting the configuration of hospital beds needed and available within the area of Cape Town. As part of the wider referral system, it receives cases from the CHC and CDCs in its drainage area, offers a 24-hour accident and emergency care unit and refers cases requiring more specialists care on to higher level hospitals within the province.

7.1.2 Commissioning experience

Although the hospital opened its doors in 2013, the process of commissioning had begun in 2012 and continued until 2015, when the full array of services offered at the hospital were finally available. Services that had previously been offered at the older hospital were among the first to be commissioned: the male medical ward, female medical ward, paediatric ward, post-natal ward, and out-patient department (OPD). The paediatric, gynaecology and labour wards were, however, new services, additional to those that had previously been offered. Over the commissioning process, the hospital grew gradually from a 200-bed facility to a 270-bed facility, before attaining its full capacity of 330 beds.

The OPD was initially used as an overnight ward until 2015, when the Emergency Care (EC) unit was finally commissioned. Unfortunately, a fire occurred in the EC not soon after it had been commissioned, reportedly caused by identified design flaws. However, the EC was not, subsequently, re-designed as recommended and this has been linked to the continuing challenges of congestion and poor patient flow. Commissioning officers and clinical consultants who managed these processes were recruited from the decommissioned hospital and other hospitals within the province, with people often working on a part-time basis.

"We had somebody doing the EC, we had somebody doing the psychiatric part, we had somebody doing medicine, we had somebody doing the anaesthetics, there were different people doing things out there. But I was one of the only people that was seconded from somewhere else and was doing it completely full time… We were all new consultants here, so all very junior, all still learning our way and seeing how things must go by and quite inexperienced and then obviously I was thrust in this role, having to commission and being the HOD." **DHB-IDI-026 (clinician manager)**

A large portion of the hospital staff complement moved to DHB from the older hospital; but the larger array of services and bed numbers also required new staff to be employed as well.

"My staff, about 90% of them worked at [OLD HOSPITAL], same with nursing, same with all the other staff. The difficulty in the commissioning was, it came about when we added a new type of service that wasn't done by [OLD HOSPITAL], so now we wanted to open a paediatric ward or a gynaecology or a labour ward, those are the stuff we added." **DHB-IDI-001 (senior administrative manager)**

Ultimately DHB has twice as many staff members as the decommissioned hospital, with continuing tensions between the two staff groups that came together in the new hospital.

"I'm sure you know the whole story, that issues about to amalgamate or closing [OLD HOSPITAL] and open [DHB] and moving staff. I think that was a big impact and I think until now it's a big impact on everyone you know there are people still who are waiting for new [OLD HOSPITAL] to open and go back." **DHB-IDI-016 (clinician manager)**

The DHB commissioning process was also accompanied by important changes in the hospital's leadership, with the new, permanent CEO appointed towards the end of the commissioning period. At other levels, managerial staff were also drawn from the different staffing groups brought into the new hospital – and some concerns were

noted about the weak leadership practices carried into the new hospital. On opening, further concerns were expressed about the high workload at DHB, which was judged to combine with staff shortages and to have compromised quality of care.

"When this hospital opened it was crazy, we didn't have enough medical officers and the workload was high, it was really difficult." **DHB-IDI-023 (clinician)**

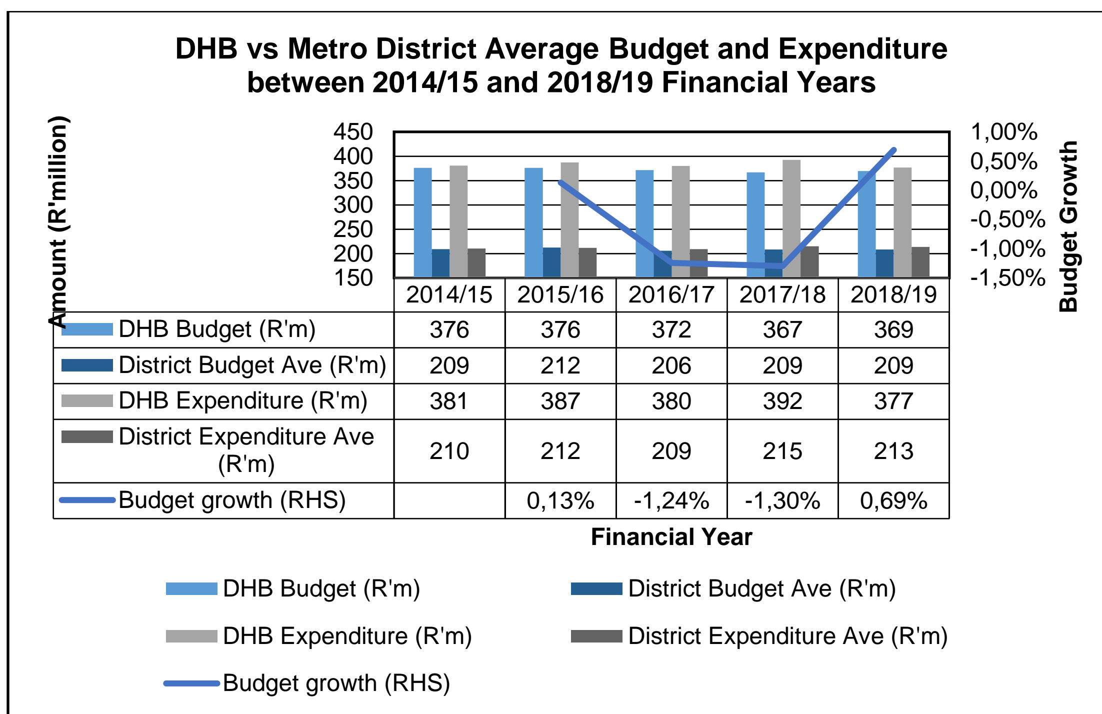
Nonetheless, the very process of addressing some of the general administrative challenges experienced during the hospital's early days was judged by some respondents to itself have helped to build relationships among senior managers within the hospital, providing a more positive foundation for the hospital moving forward. By the time of this study started (3 years later) most clinical respondents argued that the hospital was addressing the operational challenges it had faced during the commissioning.

"My time here has been quite up and down. I think it is getting better. I think like when we first opened it was very difficult and this unit particularly went through some difficult times, especially in terms of leadership. There was a time when we didn't know who our leader was, it was not clear to us." **DHB-IDI-019 (clinician)**

Improved processes also led to retention of workers, and this was noted to provide the platform for improvements in the quality of care. "*So, until I started seeing a significant break of the attrition rate, then one might start thinking, probably stability is coming, slowly creeping, that is why I said, there is a silver lining."* **DHB-IDI-003 (clinician)**

7.1.3 Hospital budget – "More to do with less"

As outlined in Chapter Five, the provincial health budget fell in real terms since the 2016/17 financial year as part of wider national budgetary pressures. However, according to DHB respondents, the hospital has seen an increase of its total expenditure, with permission from Metro Health Services, for extra Level 3 services rendered at DHB. **Figure 7.1** shows the real budget and expenditure trends in recent years; budget and expenditure fluctuated over time - with both budget and expenditure decreases in 2016/17 and 2017/18, the time of this study, compared to the previous year before rising in the 2018/19 financial year.



	2014/15	2015/16	2016/17	2017/18	2018/19
DHB Budget (R'm)	376	376	372	367	369
District Budget Ave (R'm)	209	212	206	209	209
DHB Expenditure (R'm)	381	387	380	392	377
District Expenditure Ave (R'm)	210	212	209	215	213
Budget growth (RHS)		0,13%	-1,24%	-1,30%	0,69%

Figure 7.1*: DHB's real Budget and Expenditure against Metro District averages for 2014/15 to 2018/19 Financial Years, 2015/16 prices (Source: StatsSA, Annual Performance Plan 2017/18 and Hospital's department of Finance and Information Management).*

Concerns about the hospital budget were expressed by many respondents. Some suggested that the hospital budget was inadequate for the range of services being provided, given that it offers some higher level, Level 3, specialist services. Respondents also linked budget shortfalls to the staffing shortages experienced, noting that hospital leadership were unable to employ new staff or fill empty posts over time. This then led to high personnel turnover, with constant and numerous resignations on the grounds of being overworked or burnt out. It was also commonly felt that the budget level had been established before the hospital opened and was simply never enough to meet the growing demands placed on it by the surrounding population (see earlier), given also inflationary pressures. As one more senior manager noted:

"According to the stats, there's influx of 50 000 people per year into the Western Cape or a growth of 3% more patients a year, and the budget in real terms is going down, it's getting less. You have got more to do with less. Because of that it is financial constraints and then the people expect a better service but the resource allocation is every year less so that is placing a big stress and financial constraints onto the health system. Which means there is more and more demand for more nurses and doctors, equipment and medication and blah, blah, blah, but you cannot do what they want

you to do because there's no money." **DHB-IDI-021 (senior administrative manager)**

Overall, then, one respondent graphically summed up the general view: *"I feel [DHB] hospital they have bought a Rolls Royce, but they only have a service plan for a Toyota Tazz 1300, that is what it is, that's the bottom line. And everybody is fighting for this little skeleton and there is nothing, no flesh, there's only bones, that is the problem, that's the bottom line – we're running a service we cannot afford."* **DHB-IDI-025 (mid-level administrative manager)**

7.2 The experience of leadership in DHB

7.2.1 Core structures, processes, and relationships

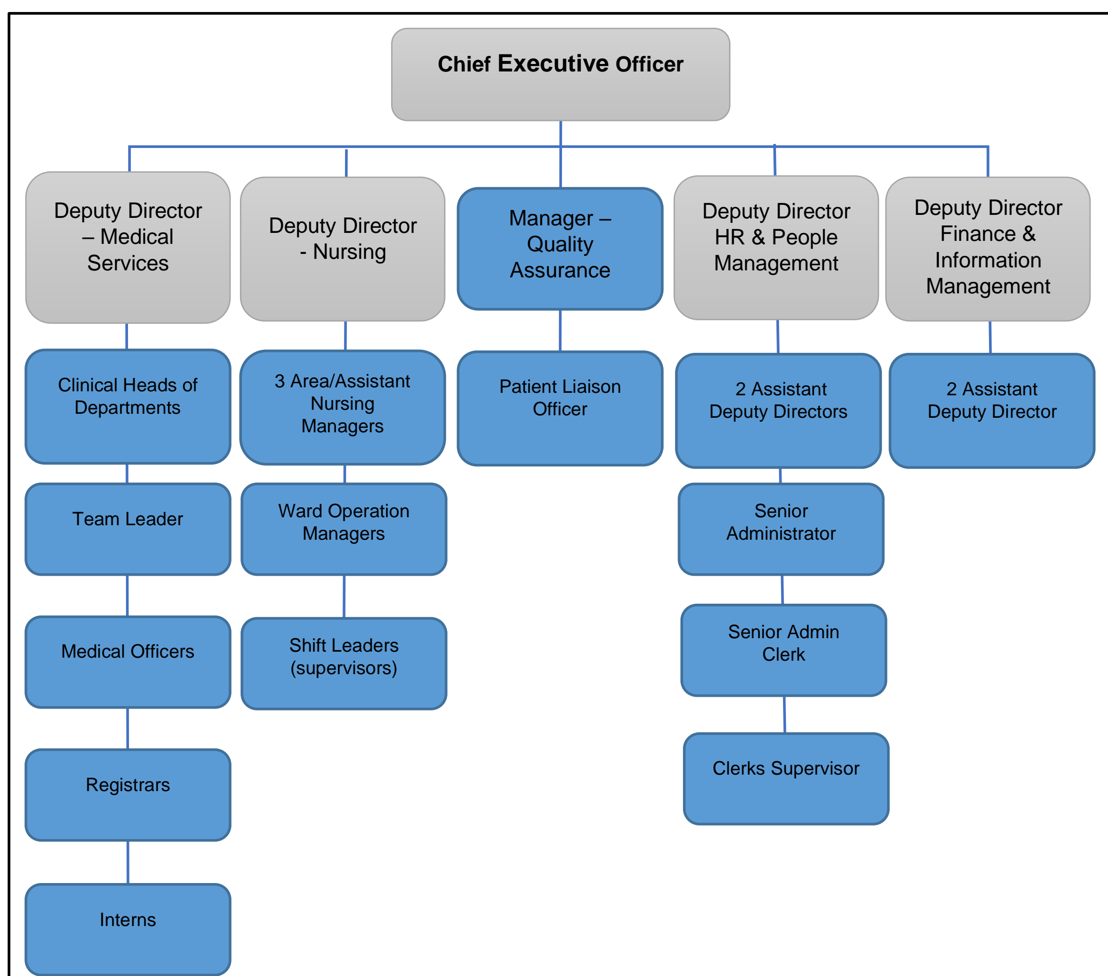


***Figure 7.2**: Main DHB staff reporting lines – grey cells represent Executive Management Team; blue cells other staff with formal management roles (Source: Interview data; Document reviews)*

Following overall provincial and national guidance, DHB is managed by a Chief Executive Officer (CEO), working with a 5-person Executive Management Team (EMT) comprised of the CEO, senior clinician (Deputy Director (DD) Medical Services), senior nurse (Deputy Director (DD) Nursing Services) and the Deputy Directors (DDs) for Finance and Information Management and, Human Resources and People Management.

The DD Medical Services is the de-facto Chief Operating Officer of the hospital, as reported by senior clinician respondents and two other deputy directors. There is also an extended management team (ExtendMT) composed of the five members of the Executive Team, with, additionally, the Quality Assurance Manager, Pharmacy Manager as a representative of Clinical HoDs, Assistant DD in Finance, and the two Assistant DDs (HR and support Services) in Human Resources and People Management. The ExtendMT had been relatively recently established at the time of the study, with the intention of providing a bi-weekly forum for exchanging ideas and collectively addressing challenges within the hospital within a wider managerial team.

It was also common practice for members of the EMT to delegate authority to their colleagues and other more junior managers when they went outside the hospital. The CEO usually delegated to the DD Medical Services, but sometimes also to the DD Nursing or other DDs. Similarly, these DDs delegated roles to senior clinicians (Medical Services) or assistant DDs when away from the hospital. Nonetheless, even members of the ExtendMT felt that the core executive team ultimately made the key decisions. Below the executive management team, as **Figure 7.2** shows, and as is common in South Africa, the management of staff cadres is quite verticalized.

In this study, and as described in the methodology chapter, the term '*clinicians*' refers to doctors and other staff such as physiotherapists, occupational therapists and radiographers. Clinical heads of departments or units are medical specialists who manage the services of their own clinical speciality, including Allied Health, and report to the DD Medical Services. These departmental heads meet weekly with the DD Medical Services to share experience and develop collective responses to common issues. Within their own units they also meet regularly with their staff (medical officers, registrars, interns, allied health workers) to manage work. For example, there were weekly meetings to schedule work in the surgery department and daily planning meetings in departments such as radiology and physiotherapy.

In nursing, the assistant managers for the three nursing areas report to the DD Nursing and themselves manage the nurse ward operation managers (OPMs), who in turn, manage all nursing matters at ward level. Each OPM works with a team of nurses, including staff nurses, professional nurses, nursing assistants, and community service nurses. Amongst these nursing groups there are also supervisors or shift leaders at unit and ward level. As a common practice, nursing staff are regularly rotated through wards and departments to ensure that nurses gain skills in managing patients within different specialties or units.

A range of meetings amongst nursing staff allow operational issues to be discussed and information shared. For example, the DD Nursing has weekly meetings with the assistants and OPMs to discuss issues such as absenteeism, staff shortages and other nursing issues, with information cascaded downwards:

"Our head of nursing, the manager, she does have meetings with different categories of staff. We as operational managers, we have alternate Thursday meetings, when we come back from those meetings, we hand over to the staff what was discussed in the meeting, so they also can talk to the head of department." **DHB-IDI-012 (nursing operation manager)**

The DD Nursing was also meeting with other groups of nurses as she sought to build a professional bond and culture among the entire nursing staff given that different groups had been brought together in the new hospital.

Staff in the central finance and people management departments, meanwhile, met weekly to discuss financial and personnel issues, respectively. Finally, the administrative staff located on the '*hospital floor*' included ward clerks, storekeepers, porters, cooks, cleaners, and security personnel. Although ward clerks work closely with nursing staff, they report to the clerks' supervisor, who is line managed by staff reporting to the Assistant Deputy Director for Support Services within HR and People Management, who, in turn, reports to the Deputy Director within the department. Other administrative staff reported to Senior Administrator for People Management who also reported to the Assistant DD for Support Services.

Finally, a range of more informal processes were instituted to support managers' engagement with staff within the hospital. These included senior managers operating an *open-door policy* to encourage inter-personal interaction with staff:

"If I can be honest with you, I have a very open-door policy with my middle managers. They come in here, so one day they decided to basically, because ultimately they're

responsible for their area it's only when they have, like sitting with a dilemma like XYZ, I've got a problem here or I can't fix this, or can you help me with this, where I sort of really engage them." **DHB-IDI-011 (clinician manager)**

Senior managers in the executive team and the ExtendMT also sometimes conducted '*walkabouts*' within wards, '*on the floor*', to engage with front line staff personally, and see at first hand hospital life. At the time of the study, bi-monthly newsletters were being distributed in the hospital to share information, interesting experiences, and activities in the hospital. In addition, '*town hall*' meetings were being held every two months to allow engagements between senior staff and frontline staff.

During the fieldwork, one of these meetings was used, for example, to introduce the notion of cross-functional teams to staff - the idea that staff from different clinical, nursing, and administrative departments would work in small teams or groups, with the goal of enhancing collective practices among staff. Although inter-departmental meetings were sometimes held - for example, as observed during fieldwork, nurses and clinicians from the obstetrics and gynaecology units met to discuss maternity issues – senior management felt it important to encourage stronger inter-professional teamwork throughout the hospital.

Human resource and financial management

As **Figure 7.2** makes clear the two primary administrative management functions were focused on resource management, with human resource management having the larger dedicated staff complement. However, both functions are strongly regulated by provincial policies and guidelines (see Chapter Five). As already noted, budget constraints were a key concern of staff, but budget levels are essentially set outside the hospital by the provincial department of health. The DD Finance is, then, primarily responsible for managing the budget and supply chain procurement, in engagement with the executive management team.

Staffing levels were another key concern in the hospital. However, again, the hospital works within provincial guidelines - and staff recruitment practices are very carefully managed as part of the provincial department of health's wider efforts to control costs and ensure efficient resource use (Western Cape Government DoH, 2018; Western Cape Government DoH, 2016). At DHB as elsewhere within the Metro District and province, the combined operation of the ECC and APL, as described in Chapter Five, is used to regulate, and influence the budget available for recruitment of new staff to the hospital.

Another human resource management process affecting all staff is the Staff Performance Management System (SPMS), outlined in Chapter Five. In DHB, at the time of the study, it was reported that this process entails supervisors and line managers completing forms on a quarterly basis to assess and rate the performance of workers in each unit, with high performers recognised and rewarded with financial bonuses at the end of each year. Staff improvement needs were also considered during the process, including leadership development needs. At the same time, working within provincial and national guidelines, annual workplace skills plans are developed, funded by the skills levy mandated through the Skills Development Levies Act of 1999 (see Chapter Five).

At the time of the study a strong performance and relational culture was also being encouraged in the hospital through actions to emphasise the provincial C^2AIR^2 principles (also outlined in Chapter Five) - and indeed these principles are graphically represented in ceramic wall murals at the hospital entrance. However, a respondent noted that the ways in which these principles were implemented meant they were not always seen positively by staff:

"There is lack of support for the C^2AIR^2 Club and in fact it should be renamed SCAIR Club." **DHB-IDI-017 (clinician manager)**

Organisational relationships

Two other core features of hospital experience were observed and revealed in interviews. First, supportive collegial relationships and teamwork were clearly identified within multiple departments and groups, including both patient care and administrative teams. At ward level, patient care teams comprise clinicians, nurses, ward clerks and other support staff. Other teams within the hospital include the clinician and allied health worker teams within clinical departments and units, nursing teams at ward level, the finance and HR teams at central level, and the executive and ExtendMT. Second, at the same time, there were also clear and significant experiences of tensions within and between teams, and of fragmentation within the staff pool across the hospital. For example, tensions were reported between the Emergency Centre and other units, as well as between the human resource department on the one side and the clinical and nursing departments on the other side.

Reflecting the hospital's history, some respondents highlighted continuing tensions between those staff who had previously worked in the decommissioned hospital and

the other groups of staff who came to the new hospital. This legacy specifically affected the nursing cadre, with which there was also a divide between senior and junior nursing staff. Finally, respondents noted that it was difficult to develop inter-professional teams, working across the management silos reflected in **Figure 7.2**, whilst front line staff reported a wide divide between them and senior management. Yet, as already noted, senior managers were implementing various activities to try and address these organisational gaps.

7.2.2 The practice of leadership in the hospital

During interviews, respondents' experiences, and perceptions of leadership in the hospital were probed specifically, to allow deeper understanding of the range and influence of leadership practices. Senior staff were asked about their own leadership practices and their perceptions of leadership in general; other staff were asked about their personal experience of leadership in the hospital as well as their general views. Beyond those with formal leadership positions (**Figure 7.2**), some other staff were *champions* - individuals without official managerial appointments or duties but who offer leadership to others. A senior nurse in one department was such a champion because s/he offered support to colleagues and took over the managerial and leadership responsibilities of the department, in the absence of more senior managers. Similarly, a respondent clinician saw herself as the unofficial leader and manager of her unit, while another clinician was reported to offer leadership in a separate clinical unit, because of the support s/he offered to other staff and was identified by other clinicians as inspiring and offering leadership within the hospital.

Figures 7.3 and **7.4** present overviews of the leadership practices identified across interviews and through observation, and as exercised both by those in formal managerial positions and those simply exercising leadership within their teams. Each figure highlights the main practice categories, as well as, where relevant, specific examples. Practices are categorized as positive or negative based on respondents' judgements about how they felt and experienced these leadership practices.

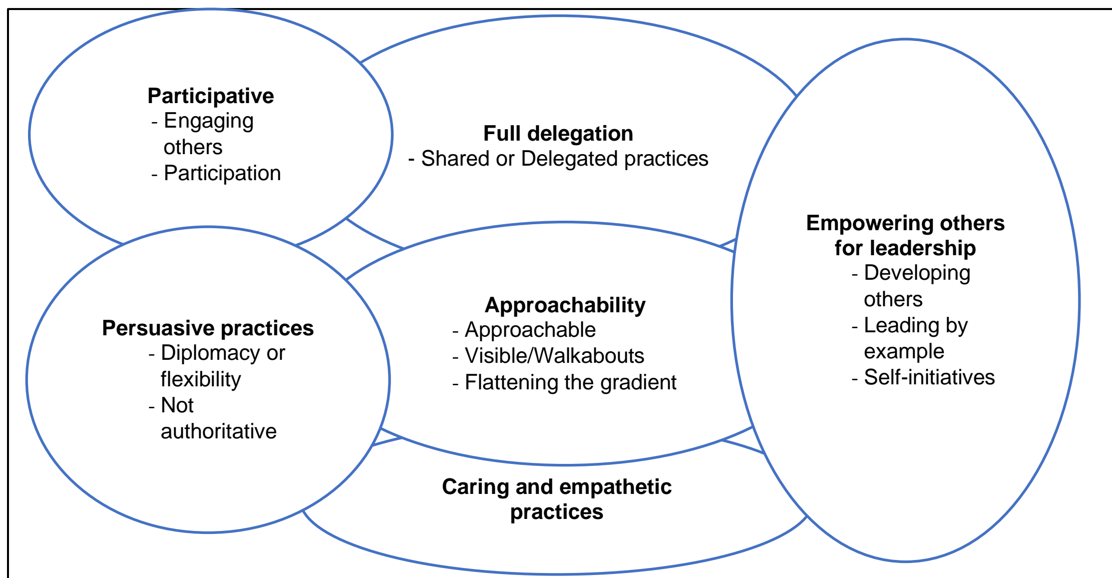


***Figure 7.3**: Positive leadership practices that promote staff satisfaction and morale at DHB (Source: Interview and observational data)*

Leadership practices that were perceived positively (**Figure 7.3**) were those that empowered and engaged others, that spread leadership opportunities to others, that demonstrated approachability, caring and empathy, as well as the ability to be persuasive and diplomatic. Clearly there is overlap between these groups of practices, as the figure shows, and so the practices are likely reinforcing and cumulative in terms of their positive effects. For example, sharing or delegating managerial duties with other staff was considered a practice that led to '*being approachable*' and both were practices that were also seen as empowering because they provided opportunities for developing leadership skills among those not in managerial positions.

Similarly, sharing managerial roles was a '*participative practice*' that allowed for engagement and participation by other staff in decision-making processes and actions within the hospital. Overall, these practices were seen to be important in developing positive collegial relationships, and in underpinning teamwork. Such practices were clearly, although not exclusively, reported by clinician respondents who identified what they saw as '*democratic leadership'* among their managers. For example, during the weekly senior clinicians' meeting, everyone was encouraged to express their opinions and ideas openly, a practice carried into clinical units as a way of encouraging teamwork.

Amongst clinicians the positive experience of leadership practices that empower others was widely discussed. Junior clinicians judged that the ability of their more senior colleagues to engage them and give them opportunities to develop themselves

had a positive impact on how they interacted with other medical officers and interns. This form of leading by example empowered them and involved learning from those in formal leadership positions above and below them.

"*I think I have to empower myself and I get my empowerment from the people that I'm leading, I think we all feed off each other. The skills of leadership I've learnt from other people, I've learnt from the examples that I see in my department, but I've not had any formal you know, I've not been on leadership courses or any sort of training or anything like that, it's that I just feed off other people."* **DHB-IDI-019 (clinician)**

At the same time, senior clinicians recognized the value of allowing challenge from junior clinicians:

"So, you want your followers in the unit to challenge you, but you want them to challenge you for the right reasons not the wrong reasons. Just because you are the boss or the leader does not mean that you are the only one with good ideas, you must be receptive to what other people's ideas are and you must work in an environment where you can be challenged." **DHB-IDI-017 (clinician manager)**

Diplomacy or flexibility were also seen as positive leadership practices, likely to generate staff appreciation and encouraging professionalism:

"*As I say the leadership style, or I think my leadership style is very relaxed, but everybody knows what is expected with them and because I am working with professional people, I don't need to play policeman over them. So, I do not need to be an authoritarian, draconian, you know, person that wields the big stick all the time, I don't need to be that because the professional people have that sense of responsibility and they do what needs to be done*." **DHB-IDI-017 (clinician manager)**

Senior clinicians were also often noted to be accessible, despite their busy schedule and other managers noted this itself contributed to teamwork: *"I mean I think my style is that I think you just need to be approachable. I think, as a leader I'm approachable and I try and make people feel as part of a team and that everyone is important."* **DHB-IDI-019 (clinician)**

Being approachable also meant other staff could raise concerns – such as about budgets or other hospital issues - also demonstrating transparency, or ask for support, with positive consequences for morale. Indeed, being visible and accessible to other workers even gave senior managers what they referred to as '*great internal satisfaction'*.

Finally, caring, and empathetic leadership also supported others and generated positive feedback and appreciation. For example, a senior clinician noted that she had received a note of appreciation from a colleague to whom she had demonstrated sympathy and understanding when arriving late for the ward rounds and another noted the difficulty of being sympathetic among huge demands:

"So {HE'S} been very sympathetic, he's been trying to negotiate on a huge number of psychological traumas amongst doctors. He doesn't always get it right and I think it's because it's a huge balancing act for him to try and keep his managers happy and at the same time keep his group of doctors happy." **DHB-IDI-004 (clinician)**

These positive leadership practices were not, however, only demonstrated or reported by clinicians**.** **Box 7.2** presents experience from other cadres.

Box 7.2: Examples of leadership practices that enhance staff satisfaction and morale in District Hospital B (Source: Analysis of interview data, this study)

It was reported to be a *'usual hospital practice'* to identify, for training, junior administrative staff, clerks and other staff with management potential during quarterly performance reviews, those who were judged as '*innovative, think out of the box and those who thoughtfully contribute during meetings'*.

Administrative respondents noted that their senior managers sometimes shared leadership roles by allocating other managers and staff complex tasks and responsibilities: *"In our component what we will do, if I am not here, the same as you asked me about when our director is not there, I do take up his role. Same goes for all of us, which is according to me something very nice in that it gives the guys exposure. Being a supervisor for a day or for a week just changes your way of thinking and all those things, depending on the person now, but anyhow we do afford people such opportunities."* **DHB-IDI-005 (mid-level administrative manager)**

Leading by example was often identified as important by nurses – for example, a junior ward shift leader argued that "*being punctual, avoiding unnecessary absenteeism, adhering to the nursing dress code and developing a positive work attitude"* demonstrated positive leadership practices for the frontline nurses in her ward to emulate **DHB-IDI-002 (nurse)**

The DD nursing was reported to involve nursing assistant managers in decision-making, in a process that one respondent referred to as being *inclusive and participative,* and entailing *collective discussions and brainstorming.*

Engaging others and encouraging participation was also more widely recognized among nursing managers as important in demonstrating appreciation and as developing teamwork:

"*I think I'm also the type of person that would, if I want this to be done this way, then I would say to people in a very nice way, that you know, although I will get their opinion, I will still deep down want it my way and I've learned to say, let go, this is a team thing and make people feel appreciated, make people feel they also contributed and then it becomes our thing, and everybody feels happy about it and I think that is where I got some of my successes*." **DHB-IDI-015 (senior administrative manager)**

In contrast, leadership practices perceived negatively (**Figure 7.4**) entailed adopting a hierarchical leadership approach, as well as not engaging others (disengaging practices), being critical and behaving badly in relationships (specifically, by divulging

secrets or demonstrating favouritism in the SPMS process). Again, these practices are likely to reinforce each other.

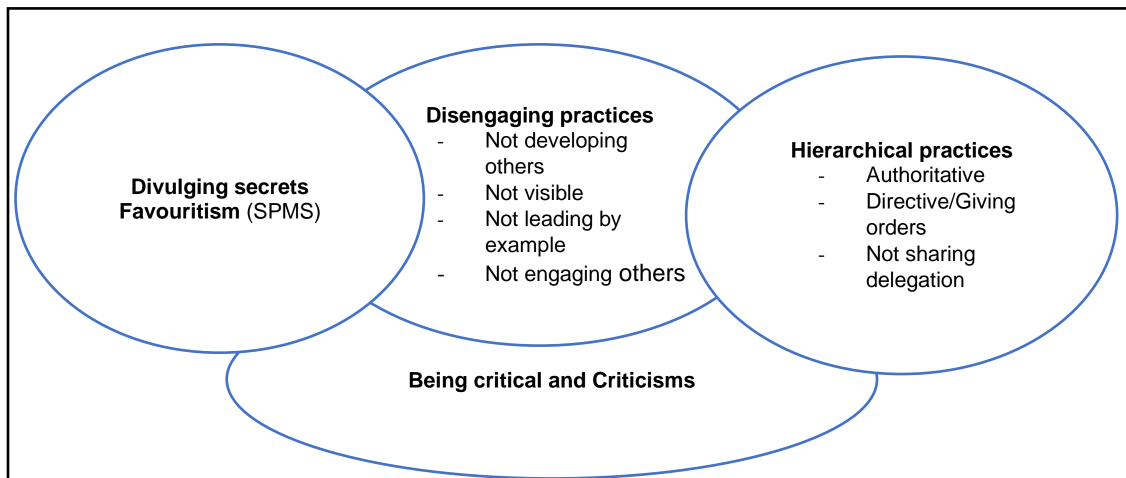


***Figure 7.4**: Negative leadership practices that undermine staff satisfaction and morale at DHB (Source: Interview and observational data)*

Being authoritative, giving orders and not sharing delegation were all regarded as hierarchical practices linked to the inability to engage and develop other staff. Such practices included, for example, what were perceived as unilateral actions and decisions on staff leave requests by managers:

"Okay, I know that the people in unit X struggle, there are quite a few people that do not like the management style that is happening in the {unit}, I think it is very authoritarian, you know it's all of those things. I think that they do not feel supported... They feel that the unit [X] consultants by and large are not supportive." **DHB-IDI-017 (clinician manager)**

Other disengaging practices included failing to support staff development and was experienced both among clinicians:

"They're not interested in developing you as a person, and that's the truth and I accept that. I don't want to fight that, I'm not interested in fighting that, it's too hard, I don't have the energy for it, I would rather put my energy into mentoring someone than into finding out why don't you want to mentor me" **DHB-IDI-004 (clinician);**

and nurses:

"So now because I'm quiet and not very talkative they would just disregard me. And personally, I feel there is so much I can give, I am just waiting for my five years to resign here because I only have my speciality four years now, next year's my fifth

year, then I am moving, I cannot wait… I'm moving because, here I'm not going to grow, the leaders don't identify people that they can take as successes, they only want to do things like this for themselves." **DHB-IDI-014 (nursing operation manager)**

Authoritative leadership was also demonstrated when senior and middle level nursing managers made unilateral decisions and just passed them on for junior nurses and other staff in wards to implement:

"They were, for example, here there was a policy that was implemented without notifying us, staff or {Sr A, Mr B and Sr C} in trauma apparently, they are the one who come with this, ja, policy, that this policy is saying the nurses in overnight ward must go and fetch the patient in trauma for admission." **DHB-IDI-002 (nurse)**

These various practices led to the resignation of demoralised nurses.

"That's why most of the sisters upstairs are resigning, they will resign, I feel they are resigning every day and they will tell me we can't take this anymore, by the time you go home our feet is sore and sore… and the manager will come and shout you, they sit in the office, they don't know what you are feeling on the floor." **DHB-IDI-002 (nurse)**

Divulging secrets, favouritism and being critical were other managerial practices that undermined morale – even among managers:

"I will never share any personal problem that I have. I must lie, sometimes I come on duty and say my geyser is broken, there's water all over the house, I cannot work. Even though sometimes I have got personal problem because I will rather share it to my mum, or my sisters than share it with fellow managers here because at the end of the day it's going to be a laughingstock in the passages." **DHB-IDI-002 (nurse)**

"I had lowered my guard a bit and then not just build a relationship with some staff but then I thought that we will have a common understanding which is impossible and then now a person come up with a story, some sort of attitude, something you didn't expect. So now you feel, you are feeling like betrayed by this person. But then I realised okay, the fault for myself, it was to lower my guard." **DHB-IDI-005 (mid-level administrative manager)**

More specifically, frontline workers who perceived their managers as manipulative and as being biased during performance appraisal described the process as a sign of negative leadership practice:

"You know people want sometimes, when they are in high position, they want you to play according to how they want you to play. And if you are not that type of player then you will not get anywhere, not being rude, not wanting to play the type of play that they want you to be, being a 'B' player, so you will stay a 'B' player. You won't rise in your level." **DHB-IDI-018 (ward administrative clerk)**

In other cases, junior and middle level managers were frustrated by senior managers' failure to get involved in operational work and so role model leadership. For example:

"I think nursing staff's morale is quite low, I think that is why the willingness there, their positivity is a bietjie (bit) low and I think it's because of also, they're overworked, and also positivity around them, everything is shut down, leaders don't lead by example, I don't think I ever see, besides medical and ante-natal, operational managers getting down and dirty." **DHB-IDI-024 (clinician manager)**

7.2.3 Staff morale in DHB

Influences over staff morale

The in-depth interview data also provide specific insights, derived from different questions, about the range of factors driving or undermining staff morale. As **Tables 7.1** and **7.2** show intrinsic motivators and common goals/experiences that were positive influences; managerial and collegial relationships, and the hospital design itself had positive and negative influences; and inadequate services, organizational processes and resource constraints were negative influences. These factors are all discussed further below, drawing on both the qualitative interview data and the staff satisfaction survey data.

Table 7.1: Factors associated with high or positive staff satisfaction and morale at DHB (Source: Interview Data and Observational Data)

Factors that promote staff morale	
Intrinsic factors • Hospital work or job itself • Fighting for change • Intrinsic and spiritual drive • Treatment/patient outcomes • Quality patient care and services	**Common goals and experiences** (previous hospital, patient care, quality care)
Opportunities for leadership • Opportunities to practice leadership • Developing leadership capacity in others	**Managerial and collegial relationships** • Managerial support and relationships • Collegial support and relationships • Transparency between management and units • Understanding – between levels of management
Positive recognition • Appreciation and acknowledgement by managers and colleagues • Positive feedback from managers and colleagues	**Hospital design**

Table 7.2: Factors associated with low or negative staff satisfaction and morale at DHB (Source: Interview Data and Observational Data)

Factors that undermine satisfaction and morale	
Inadequate service delivery • Inadequate patient care • Critical incidents • Complaints from patients	**Resource constraints** • Staff shortages • Absenteeism • High attrition and turnover • High workload • Burnout and depression
Few opportunities for leadership • Limited leadership opportunities • Limited leadership training • Absent leadership	**Leadership and management weaknesses** • Lack of management support • Rigid nursing management style • Managerial conflicts • Disconnection
Relational conflicts • Professional conflicts • Collegial antagonism • Lack of collegial support	**Inefficient organisational processes** • Unfair recognition practices • Slow human resource management processes
	Hospital design • Poor workmanship and infrastructure

Table 7.1 and Table 7.3 (below) also show that intrinsic motivators included the work itself, patient outcomes, and quality of care, even fighting for change towards these goals, as well as personal factors. In contrast, then, the perception of providing inadequate service delivery was a de-motivator (**Table 7.2**).

"Some days you will see stress is everywhere, some you will see the nurses are so stressful, working in a stressful environment, but according to their attitude the patient, but the nursing care in totality, hai (no) the patient won't get the good nursing care they deserve." **DHB-IDI-002 (nurse)**

Table 7.3: Examples of intrinsic factors for staff satisfaction and morale at DHB (Source: Analysis of interview data, this study)

Motivation from empowering others	*"I'm here to grow and develop individuals and see them blossom into mature, competent, professional people – and that's the thing that gives me the biggest kick."* **DHB-IDI-017 (clinician manager)**
Motivation from concern for others	*"I think my staff's morale is quite good because they know that I fight for them... What motivates me is growing and developing individual people and if they are being stifled by people up the line, then I will challenge the people up the line rather. So, I think I've got a fairly happy department"* **DHB-IDI-017 (clinician manager)**
Motivation from the job itself	*"I personally, my morale, because I love my work, I love what I'm doing, I'm passionate about my job, I'll go the extra mile, I'll do my best under difficult circumstances"* **DHB-IDI-015 (senior administrative manager)**
Motivation from intrinsic and spiritual drive	*"And like I said to that other woman, there is 3 things the lord wants from us – to do right, to be a servant and to love your job. That is why my morale will not, I said to her one day when she told me I cannot manage and supervise. Toe se ek vir haar (then I said to her) listen here, with my lord there's no supervision and management ne, you will never demotivate me."* **DHB-IDI-010 (nursing operation manager)**
Motivation from fighting for change and patient care	*"I will always fight for the best for my patients even if it's you know, is against this very difficult systemic problem, I will always fight. But my morale is not low hey, I have a lot of fight left in me."* **DHB-IDI-010 (nursing operation manager)**

Leadership practices promoted morale when they provided opportunities for others to lead and develop leadership experience, when managerial relationships were deemed supportive and, more specifically, when experienced as appreciative and positive (**Table 7.1** and **Box 7.3**). These practices were also integrally linked with positive relationships with colleagues. In contrast, failing to offer opportunities for leadership and related skills development, failing to offer support, conflict with, or being disconnected from, staff, were leadership practices likely to undermine staff morale (see **Table 7.2 and Box 7.3**). Again, these factors were associated to relationships with colleagues. The specific issue of a rigid management style, linked to hierarchical and authoritarian leadership practices, was also raised as a factor undermining morale among nurses.

Box 7.3: Exemplary quotes on negative leadership practices that undermine staff satisfaction and morale at DHB (*Source: Analysis of interview data, this study)*

Clinicians were de-motivated by lack of appreciation due to criticisms and critical practices: *"I think, what makes me feel bad is, sometimes just like I said I don't often feel valued by my manager or by the hospital manager, I don't necessarily feel that the role that I fill is appreciated and that just leaves me a little bit dissatisfied, it doesn't stop me working hard or like doing what I do, it just makes it, I just feel a bit dissatisfied."* **DHB-IDI-019 (clinician)**

Disengaging leadership practices de-motivated **nurses** due to lack of managerial and collegial support: *"I must be alone because I'm pushing just this issue, and for them it's like I wanted for this guy to be fired. I wanted him to improve his behaviour and then all I did was do what I was employed to do, was to manage him, that was last year, end last year, then I really felt like I needed to go, because I didn't get support from my DDN, I didn't get support from my ASD, my area manager, I didn't get support from her also when I literally had to go and phone head office for advice and then, when I did go and followed and phoned people for advice and it came to my DDN's ears, she was so upset she called me in and she wanted to know – I said but how many times during this process have I tried to make appointment with her ?"* **DHB-IDI-014 (nursing operation manager)**

Rigid hierarchical practices in **nursing management** contributed to low morale**:** *"I honestly think that the nursing department is the department that's in most need of help, the way they're being managed, and their morale is low, it's going to affect all others, coz they're central. And I think, if the nursing managers will be open to it and not defensive, need to take a magnifying glass and look what's happening inside the nursing department."* **DHB-IDI-008 (clinician manager)**

The 2016 Staff Satisfaction Survey data broadly confirm the influence of leadership practices and collegial relationships over staff morale (see **Table 7.4**). The survey specifically considered some of the practices already identified, as well as additional issues - such as managing conflict and managing change. Only around half of the respondents judged they had positive experiences around these practices; although for the one question with a provincial comparator, the DHB response rate was higher (more positive) than the provincial average. However, although the response rate was

a little lower than the provincial average, relationships with colleagues were predominantly experienced as positive:

"We work great as a team, we motivate each other and, we've got that good relationship with one another" **DHB-IDI-020 (mid-level administrative manager)**

Respondents made references to the common goal of patient and quality care, and shared workplace experiences (**Table 7.1**) both in the old and the new hospital, as reinforcing the morale boosting relationships.

Table 7.4: Leadership practices and collegial relationships at DHB (Source: Annual Report 2016/2017 and Staff Satisfaction Survey in Annexure 2; n = 455)

Specific SSS question	**DHB (%) Strongly Agree/Agree 2016**	**Provincial (%) Strongly Agree/Agree 2016**
Leadership practices		
My line manager respects and values my contribution at work	61%	-
My line manager genuinely cares about employee's needs	57%	-
My line manager is able to manage internal conflict effectively	54%	-
In the last 7 days I have received recognition or praise (for example, a thank you) for doing good work from my manager	49%	37%
Management is accessible when I have not been able to receive a satisfactory solution to a problem	44%	-
Managing change		
My manager encourages staff to become part of change	56%	-
My manager manages ongoing change effectively	51%	-
Collegial relationships		
I have good relationships with the people that I work with	80%	84%
I am able to consult my colleagues when I am faced with an unexpected or challenging situation at work	77%	82%

More general, hospital-level factors were the other key influences over staff morale. The overall design of the new hospital was both broadly experienced by staff as comfortable, and even as boosting morale, and it was criticized. The rooms within some of the units were judged as small, only able to accommodate a few staff and patients at a time – and the Emergency Centre that had limited space due to design problems.

"The burning out there, especially there in the EC, they are very busy because its unpredictable and I think when it was designed, organograms approved for 13 trollies in EC, now about 30 trollies, so the same 13 nursing staffing must now do 30 trollies' work and it is hectic environment in any EC. So, I think all the EC's will say to you it is a crisis management in the EC environment because of the nature of the EC so the people are very stressed and burnt out." **DHB-IDI-021 (senior administrative manager)**

The EC razed down just before the commissioning and the contractors and designers refused to re-modify the EC to create a more spacious design, leaving what some respondents referred to as a *'dysfunctional unit by design'*.

The 2016 staff satisfaction survey data also highlight largely negative assessments about the specific features of hospital design considered (see **Table 7.5**).

Table 7.5: DHB Physical design (Source: Annual Report 2016/2017 and Staff Satisfaction Survey in Annexure 2; n = 455)

Specific SSS question	**DHB (%) Strongly Agree/Agree 2016**	**Provincial (%) Strongly Agree/Agree 2016**
The restroom/tearoom facilities are adequate	40%	40%
My building is safe and well maintained	46%	-
My building caters for the needs of persons with disabilities	57%	-

Organizational processes were, however, particularly important factors undermining staff morale. Slow human resource management processes delayed appointments, for example, and were then linked to resource shortages. More specifically, the performance appraisal system (the SPMS) was, as noted, identified as being conducted in a way that contributed to feeling unappreciated and unsupported, and many respondents criticised it as being unfair given what they judged was favouritism in performance awards:

"You know there's the thing that's the SPMS, the performance bonus, that they have. If your operational manager does not like you or you are not a player like your operational manager wants you to be, you won't get SPMS." **DHB-IDI-018 (ward administrative clerk)**

Some clinician respondents also suggested that the SPMS process lacked clear objectives and was poorly managed:

"So now I must fill in a form saying what they've achieved for the year when I haven't sat with them at the beginning and said these are your goals for the year ahead. I think then it becomes paperwork as opposed to anything functional. So those kinds of things I do not like. If you want me to do SPMS, tell me what is expected and then let me do it over the course of a year because that is the way it is supposed to be done. Do not ask me to hand in a quickly typed page at the end of the year and expect it to be a summary of the function of that person in the department. So that's the things that I find frustrating." **DHB-IDI-022 (clinician manager)**

These perspectives were again broadly confirmed by the 2016 Staff Satisfaction Survey. As **Table 7.6** shows, less than half of the respondents reported broadly positive experiences with the performance management processes, including in terms of how they were conducted. Similarly, although most staff did have opportunities for skills development, only just over a half felt they had opportunities for personal growth in the hospital, or that these opportunities were fairly distributed. Both sets of issues also connect with concerns about the forms of leadership practices that had negative consequences for staff morale and satisfaction.

Table 7.6: Performance management and skills development issues at DHB (Source: Annual Report 2016/2017 and Staff Satisfaction Survey in Annexure 2; n = 455)

Specific SSS question	DHB (%) Strongly Agree/Agree 2016
Performance management	
I have had at least 2 performance appraisals/evaluations in the last year	52%
The performance appraisal was conducted in a positive manner	48%
I felt at ease during performance appraisal	46%
Performance management structures promote a high-performance culture	41%
Skills development	
I have a skills development plan, which meets my specific needs and job requirements	67%
I attended at least one training session in the last year	60%
I have access to opportunities to grow and develop in this organisation	54%
I have equal and fair access to education and training	54%

Finally, budget constraints and staff shortages were widely criticized, and given high workloads, were connected in respondents' views to absenteeism and high attrition rates among staff. These concerns were confirmed by staff satisfaction survey data (**Table 7.7**).

"People are demotivated, look they are demotivated by the little staff, and you know the short staff and the continuous absenteeism but everybody's contributing to absenteeism, and you know because you are tired today you will, but now we must also understand people have got problems and people's chronic depression… We've got extremely, a very high burden of disease that places a very extreme burden on the staff causing absenteeism and low morale" **DHB-IDI-006 (nursing operation manager)**

"We are having a shortage of staff in this hospital that's why people are leaving every day because they are so unhappy, they are working hard, end of the day they are not appreciated." **DHB-IDI-002 (nurse)**

Table 7.7: Workload and resourcing at DHB (Source: Staff Satisfaction Survey in Annexure 2; n = 455)

Specific SSS question	DHB (%) Strongly Agree/Agree 2016
My workload is manageable	56%
My unit/team has access to sufficient resources to complete their work effectively	51%

Variation between cadres

The interview data provide some indications that the factors influencing morale were experienced differently between cadres. Respondent clinicians tended to cite collegial interactions, support and relationships, leadership practices, including developing leadership and clinical capacity in others, and intrinsic factors as boosting their morale:

"*Within the [X department] we've got excellent consultants that lead us and that inspire us and that actually make us come to work every day because we love working for them. I feel that a lot of stuff in [department X] and in this hospital, it is all about the relationships that you form with people, and it is all about getting respect of others and it is all about being approachable to other people as well. And I think by fostering good relationships with other people you can make your job as a leader much easier because you have those relationships with people, that makes you feel good."* **DHB-IDI-019 (clinician)**

The ability to fight for staff within a unit and to offer leadership opportunities for these staff were other positive influences. However, managerial conflicts with senior and other middle managers, and professional conflicts with nurses undermined their morale, as did animosity, rivalries and distrust between clinicians who moved from the decommissioned hospital and those newly employed in DHB.

Some of the nurses were also intrinsically motivated but like clinicians, experienced animosity and tensions between the new and old employee groups, as well as with clinicians themselves:

"We have found that nurses felt very reluctant to convey certain concerns to doctors because they felt that doctors didn't value their opinion and didn't value them coming and saying I've done this ECG or their concerns about a patient, they would just be shrugged off." **DHB-IDI-007 (nursing operation manager)**

As already noted, rigid management structures and a lack of managerial support were also concerning for nurses, alongside unfair performance appraisals and a lack of senior managerial transparency regarding the financial and human resource

challenges at the hospital. Indeed, the resourcing challenges posed difficulties for nursing staff and strained relations with clinicians due to blames:

"You go and find something where you have to see 10 patients instead of 5 to 6 patients. And then you get hauled over the coals – why – because 2 or 3 of those patients, maybe more, will not receive their full care. Who do they blame? They blame the nurse. But you need to look at the nurse structure and you need to look at the organogram, you need to look at staffing and funding and all those bigger things which management duties are." **DHB-IDI-004 (clinician)**

Administrative staff, finally, reported that their morale was boosted when they felt that other staff appreciated and acknowledged their ability to run the hospital in the face of perceived limited budgetary resources and uncertain hospital environment. Their relationships with the executive management team were also an important influence, positively impacting on morale when demonstrating collegial support and understanding. However, they were undermined by their lack of decision-making ability on budgetary and staff recruitment matters, as well as by tensions with other staff over slow staff recruitment processes. It was reported that it sometimes took 75-90 days to fill vacant posts and as an administrator noted: *"I'm tired of them because every time they just blame HR. The other day I explained to them that there's a lot of processes that takes place after the recruitment and selection has been done inside there."* **DHB-IDI-020 (mid-level administrative manager)**

Middle managers perceived these challenges as resulting from the executive leadership's way of working, but the executive management pointed to the position of the hospital within a broader bureaucratic system. These differences, combined with reflection on the interview data overall suggest that there was likely stronger morale among clinicians compared to nurses or administrative staff, with nurses, in general, apparently experiencing overall weaker morale levels. As a nurse respondent noted:

"The nursing staff, the workload and the absentees, the nursing staff have become so despondent that you as a manager, you must really do something to be able to motivate them and there are times that you just cannot motivate anyone to do something if they already feel downhearted." **DHB-IDI-007 (nursing operation manager)**

Overall staff morale levels

Overall, however, the 2016 staff satisfaction survey data suggest that most respondents in DHB were highly motivated (**Table 7.8**). The majority were also

satisfied with their jobs and felt able to contribute through them to the organization as a whole – perhaps pointing to the important influence of intrinsic motivation over staff morale.

Yet, at the same time, nearly one third of respondents did not agree that their colleagues and organization was committed to provide quality care (a more negative response about their hospital than the provincial average). The questions considering issues of organizational loyalty and stability also highlight signs of low morale, perhaps reflecting the significant recent changes experienced. More than 30% did not feel loyal to the hospital, over 40% felt insecure in the organization and over 50% were looking to leave the organization in the next six months (a higher rate than the provincial average) while over 40% did not feel secure about their jobs in relation to ongoing change management.

Table 7.8: Staff satisfaction, morale, and commitment at DHB (Source: Annual report 2016/2017; and DHB Staff Satisfaction Survey Results in Annexure 2; n = 455)

Specific SSS Question Linked to Morale	**DHB (%) Strongly Agree/Agree 2016**	**Provincial (%) Strongly Agree/Agree 2016**
I am highly motivated to do my job	71%	-
Issues linked to satisfaction from work done		
I understand how my job contributes to the organisation's objectives	83%	86%
I am clear as to what I am supposed to accomplish at my work	82%	86%
I have the skills I need to perform my work effectively	76%	81%
I have a measure of control and influence over how my work is completed	75%	79%
At work, I have the opportunity to do what I do best every day	75%	-
I have an important role to play in the organisation operations	73%	76%
I find the content of my work interesting and stimulating	73%	76%
Issues linked to delivering quality of care		
My colleagues are committed to doing quality work	70%	-
My organisation is committed to providing quality care to patients	68%	78%
Organisational loyalty and stability		
I feel a strong sense of loyalty to the organisation	67%	-
I feel secure in my position at this organisation with the current changes taking place	57%	-
My colleagues are looking to leave the organisation within the next 6 months	46%	34%

7.3 Organisational context and its influence over leadership experience in DHB

As presented in previous sections, the experiences of leadership within DHB were both positive, such as being approachable and empowering, as well as negative, reflected in authoritative and disengaging practices. However, the latter appeared to be the more dominant experience and was revealed in relationships within the nursing cadre, across cadres and between senior management and other staff. It had negative knock-on consequences for staff satisfaction and morale.

This section explores how contextual factors influenced these experiences. As discussed in Chapter Three, context is understood in this study as comprising factors both external and internal - external to the organizational unit of focus (the hospital), and the internal organizational context as combining hardware with tangible and intangible software. More specifically, as **Figure 7.5** shows, the features of DHB's *hardware* (the physical and functional structure) identified as influencing its leadership experiences include the physical design, management structure, staff complement, and the division of tasks between cadres.

The hospital's *software*, meanwhile, can be distinguished between the *tangible* elements, the formal managerial procedures and processes, managerial skills and exercises of power, and the *intangible* features of informal practice and organisational culture. Importantly, these features themselves interact. As discussed further below, for example, management structures and task division among cadres (*hardware*) influence the ways in which authority is spread within the hospital (*tangible software*), and task division among cadres (*hardware*) creates professional sub-cultures within the hospital (*intangible software*).

Figure 7.5 presents an overall summary of the key contextual factors influencing leadership practices within hospital DHB, also indicating the interactions among them. These factors and interactions are now examined further.

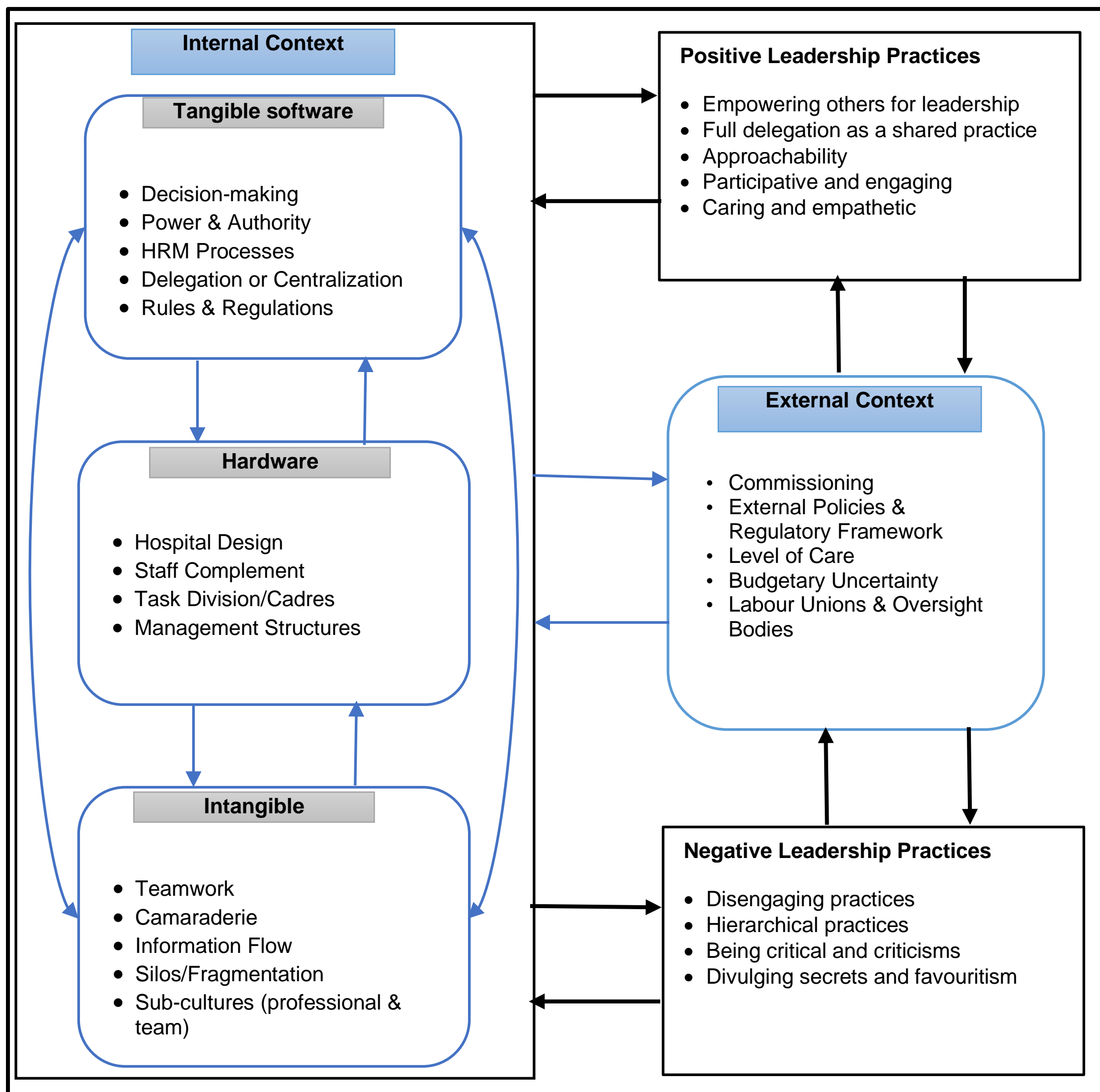


***Figure 7.5**: Interaction between context and leadership practices within DHB*

7.3.1 DHB's Internal hospital context

The hospital's competing leadership experiences, of engagement and team working as well as hierarchy and fragmentation, can partly be linked back to specific sets of leadership practices, as discussed in section 7.2.2. However, at the same time these experiences also reflect key features of the hospital's *intangible software*, as revealed in the staff satisfaction survey data.

Table 7.9 highlights, then, both the strength of relationships among colleagues and, more specifically, teamwork, alongside the existing challenges of inter-professional collaboration and, more clearly, the distrust of senior management.

Table 7.9: Organisational relationships and teamwork at DHB (Source: Annual Report 2016/2017 and Staff Satisfaction Survey in Annexure 2; n = 455)

SSS Specific Question	DHB (%) Strongly Agree/Agree 2016	Provincial (%) Strongly Agree/Agree 2016
I have good relationships with the people that I work with	80%	84%
I am able to consult my colleagues when I am faced with an unexpected or challenging situation at work	77%	82%
In my unit/component the staff function well as a team	69%	-
Different professions (doctors, health professionals, admin) work well together	62%	-
I believe that senior management in this organisation have the best interests of employees at heart	40%	34%

Table 7.10, moreover, illustrates the quite negative staff perceptions of the broader organizational environment – in terms of dimensions likely to influence and/or reflect the senior/junior divide within the organization (in nursing and in the overall staff pool). The perceptions from the survey data indicating that the hospital did not value and care for its employees contradicts the concerns raised in the qualitative interviews. Comparison with available provincial averages show some differences but do not suggest a particular pattern. Other contextual features were also important influences over the hospital's competing leadership experiences.

Table 7.10: Organisational perceptions at DHB (Source: Annual Report 2016/2017 and Staff Satisfaction Survey in Annexure 2; n = 455)

SSS Specific Question	DHB (%) Strongly Agree/Agree 2016	Provincial (%) Strongly Agree/Agree 2016
The organisation values and cares for its employees	43%	33%
The organisation treats its employees fairly	40%	35%
People in this organisation are transparent (no hidden agendas) and communicate openly	36%	40%
The organisation is open to employee's feedback and ideas	36%	36%
The organisation keeps employees informed about planned changes timeously	35%	34%
You receive feedback on your suggestions	30%	38%
The organisation puts employees' ideas into practice	29%	39%

Looking again at *teamwork*, an important foundation for it that was identified by both clinician and nursing respondents was the shared mission *(intangible software*) of providing good patient care. Teamwork was also, more recently, deliberately promoted across the hospital through establishing the shared values (*intangible software*) espoused in the C^2AIR^2 principles:

"… and then there is also what is called, this provincial thing, the C^2AIR^2 Club, although not developed here, it is also an attempt to try to infuse certain values in the staff that this is how you behave when you work here, or when you work for us, that kind of thing. So, things are being done, what one might discuss at length – are they effective? is it working? that is probably to be seen." **DHB-IDI-003 (clinician)**

The flow of information (*intangible software*) and respectful collegial communication (*intangible software*), both reflecting leadership practices, further enabled teamwork. For example, at the time of the study the recent introduction across departments of *'morning huddles'* between clinicians and nurses working in the same department had strengthened communication within cross-professional teams at ward level:

"And another good thing, and we learned from EC – EC started with a huddle to improve communication and they have it every morning, a short meeting to plan things and we decided we will do it once a week on a Tuesday morning 9 o'clock – I think, didn't you see one? And that has improved communication with the nursing staff because it is important to work as a team with the nurses as well, because we're looking after the same patients." **DHB-IDI-023 (clinician manager)**

Among clinicians, meanwhile, the professional sub-culture (*intangible software*) of sharing clinical and leadership roles was specifically identified as important to team working. Clinicians often felt that they were bound to each other by a similar professional background and experience, a shared identity, and specifically referred to the frequent sharing of roles and responsibilities (a sharing of power: *tangible software*) as a team culture.

"I think as clinicians, colleagues, the senior clinicians, we are supportive of one another, the EC, the surgeons, the medicines. I am not going to be hard on my senior colleagues, I am going to understand their limitations, we are going to try and find solutions. As a senior clinician body, we're supportive." **DHB-IDI-008 (clinician manager)**

"We have more or less the same, or rather let me say we have functional team components that suits the way we manage our teams. So, we have all adjusted to what we have been given and some of us have walked into it and been told that this is the number of staff that we have, and we make it work… And I mean, as senior clinicians we sit, and we talk about management issues, and we try and resolve issues together." **DHB-IDI-022 (clinician manager)**

In some cases, clinicians felt bound together by their previous experience of working at the old hospital (*external context*). At the same time, some clinician managers specifically referred to their way of engaging and interacting with junior staff without considering professional or workplace seniority (a leadership practice) as '*flattening the command gradient'*.

"*There's this thing about command gradients, where the bosses are up there, and the juniors are down here – we try and flatten that command gradient or what they call the power distance relationship. So, I work on first name terms with all my medical officers, but if they step out of line too much, I do not have a problem calling them back into line*." **DHB-IDI-017 (clinician manager)**

In some units, WhatsApp lists enabled communication (*intangible software*) amongst the unit team and were used to plan, schedule, and share work. Clinicians often used the term *'camaraderie'* when describing the collegial interactions amongst themselves, which they saw as promoting the participative and engaging leadership practices that contributed to their morale:

"So, you know there's a lot of camaraderie and I like that. When we are all feeling low, we all feel low together and when we all feel good and there is something good to celebrate, we all feel good together." **DHB-IDI-004 (clinician)**

Such camaraderie also enabled clinical teams to act collectively – for example, to solve problems experienced within the units or teams, to share leadership tasks and clinical cases, and to provide a seamless clinical service where patients are transferred to different units according to their clinical care needs and without delays. Sharing responsibility and leadership even allowed managers to take on bigger challenges:

"*We do share responsibility very well because I think also my team is quite aware of the burden that I have as a team leader and they want to take some of that burden away from me and now I feel confident that they can share that burden and they will offer to share the bigger tasks and take those sorts of things on, which is great*." **DHB-IDI-019 (clinician)**

"I believe if you've got good management then they can spread that to your lower levels and that encourages the lower staff to fulfil certain gaps and give them the necessary skills. I think that's a good thing that we've got good management." **DHB-IDI-013 (junior administrative manager)**

Nurses specifically highlighted the experience of working together in the decommissioned hospital (*external context*) as developing a shared identity (*intangible software*) which itself enabled teamwork. Most nursing operation managers and frontline nurses had worked at the decommissioned hospital, and their shared experience was identified as influencing their attitude to work and the lack of loyalty to the new hospital. For example:

"In [OLD HOSPITAL] we used to work hard, from all the nurses that is coming from [OLD HOSPITAL] we are used to working hard, even if there was shortage. In [OLD HOSPITAL] I used to wrap a person alone, a dead person alone, wrap a body alone because there was no staff, because my colleague's maybe on tea then I cannot wait and then I feel like her duties to do when she comes back. We got used of it and be strong and get used of the situation. By the time we came to this hospital it is nothing to us, but for people that are new on this, that is why they resign every day, because they can't take the pressure." **DHB-IDI-002 (nurse)**

In the new hospital, meanwhile, the physical layout of wards (*hardware*) sometimes aided teamwork (*intangible software*) amongst nurses. For example, as demonstrated on the maternity floor, obstetrics, gynaecology, and paediatric wards are close to each other and are interlinked in a circular design, each within a close distance, allowing close working relationships across wards, and interaction among clinicians and nurses. Partly as a result, the maternity floor had its own micro culture of teamwork:

"We work very well as a team, that I must say. Even the nursing staff, like for instance if there is no staff in a postnatal, today the person phone in sick or whatever, the nurses sometimes, some of them would even offer and say I will work in the postnatal staff to cover that… I love working with my team mates here on second floor, we work as a team. If we could only work alone, almost as a hospital on its own without the rest, I would be happy." **DHB-IDI-014 (nursing operation manager)**

Finally, within the administrative cadre, the finance department was noted as working collaboratively with the supply and procurement departments given the connected nature of their roles and tasks (*tangible software*) and relational familiarity with each other (*intangible software*), and the shared goal (*intangible software*) of improving the efficiency of purchasing and delivery of work equipment and supplies. Some respondents identified teamwork among the executive management and other staff in administration as also being derived from their shared experience (*intangible*

software) in managing the early days of the hospital's commissioning and transition (*external context*).

"We work together, from an EMT point of view, because we have weekly meetings and we share the same, common goal, we can actually interact with each other. Say for argument, finance and supply chain, there are key issues around finance, I would table it there when the hospital opened. You had people from all sorts coming from all kinds of hospitals… so now we had to try and bring and instil a culture and a bond, professional bond that will bring the us and the we." **DHB-IDI-015 (senior administrative manager)**

The existing fragmentation and team tensions, meanwhile, were partly because of the inherited tensions between those staff who had previously worked in the decommissioned hospital and other groups of staff who came to the new hospital from other places (*external context,* see later). However, within DHB, the verticalized management of staff (*hardware*, see **Figure 7.2**) shaping leadership practices was *'complex and fragmented',* and was identified as leading to '*working in silos'* - both between units, and wards, as well as between cadres.

"Like I said it is a very fragmented or a cellular facility, so people tend to function in silos, and that silo is a kingdom and people want to protect their kingdom and their turf… I think it would be more departmental and got to do with the relationships that had been built previously you know. So, everybody works on a very cellular function, and everybody says no but it is not their problem, it is not my problem it is your problem. Instead of saying that it is our problem, let us see what we can do as a facility to sort the problem out, it is no, don't involve me in your problem." **DHB-Group Interview-001 (clinician manager)**

"So, the silo management exists in every department and there isn't a forum for us to sit down with all the nurses, a sort of cross platform meeting." **DHB-IDI-008 (clinician manager)**

The hospital's *'big design'* (*hardware)* also isolates different departments and cadres and limits interactions amongst staff and managers, especially senior managers whose offices are in the executive suite that is far removed from other staff and departments: *"And I feel sometimes that maybe all the departments are quite isolated from one another, and we don't often kind of mix and get the opportunity to function as a whole."* **DHB-IDI-019 (clinician)**

Working in inter-professional teams was specifically challenged by power differentials (*tangible software*) and differences in professional sub-cultures (*intangible software*):

"But then, and I don't know if it has to do with the power relationships between doctors and nurses generally, that nurses very easily feel defensive, but it does make things difficult." **DHB-IDI-023 (clinician manager)**

The hierarchical nature of the nursing cadre (*tangible software*), and the rigid scopes of nursing practice (*tangible software*), were other factors separating the cadres. They contributed to verticalized approaches to communication (*leadership practices*) that undermined cross-disciplinary working.

"The operations manager of the ward, the nurses, the lead nurse is the operations manager. He leads the nursing team, so he is their line manager. Then I lead the doctors and I am their line manager. Whenever there is a nursing issue, I cannot really intervene, but I am the consultant of the ward so ultimately, I am clinically responsible but what I do is, when there are nursing issues that cause adverse events, I tell them I will not be called, I will not be subpoenaed, I will not give an opinion because it's a nursing issue." **DHB-IDI-008 (clinician manager)**

HR procedures for handling disciplinary issues (*tangible software*) followed the vertical reporting lines and only further contributed to the silo management that fragmented relationships between clinicians and nurses.

There were also few formal mechanisms to allow meaningful engagements between clinicians and nurses (*tangible software*), and staff shortages (*hardware*) made it particularly difficult for nursing managers to attend the meetings that did exist.

"*We have internal operations meeting, but you see the OPMs attends but the supervisors of the OPMs, they don't come to operations meeting… I believe there should be a cross platform meeting where one of the senior clinicians from each department, the consultant and the OPM from each department, all of us should sit with the head of nursing and the head of our medical – we should have a meeting, even if it's once a quarter*." **DHB-IDI-008 (clinician manager)**

Among nurses, other explanations of the challenges for teamwork included staff shortages (*hardware*) and the practice of staff rotation through different department (*tangible software*). These staffing factors de-stabilised the nursing teams within wards and weakened their team culture. Rigid scopes of practice (*tangible software*) for different nurse cadres also undermined nursing teams and teamwork was more

generally reported as weak where staff within the same cadre or unit did not share common goals and had different expectations on the outcome of their roles within the unit (*intangible software*).

"I feel that certain members of our leadership, their goal is for us, what they expect from us, is very much to see as many patients as possible, get as many patients out and discharged as possible. Whereas other members they want us to be thorough with our patients, do a good job, sort them out clinically and make a good plan for them, to organise the unit properly, to supervise the juniors. So, people expect different things from us and sometimes it's quite difficult and sometimes you even have to change what you're doing at work to please certain different leaders if you see what I'm saying." **DHB-IDI-019 (clinician)**

However, perhaps the most important factor driving fragmentation within nursing, was the quite rigid and hierarchical distribution of power and decision-making within the nursing cadre (*tangible software*).

Nursing operation managers have power and authority within the wards where they supervise all tasks and activities. Delegations within nursing cadre are linked to the professional hierarchies, from the most senior nursing manager (DD Nursing Services) down to the lowest ranked nurse in the hierarchy (Auxiliary Nurse). For example, a nursing operation manager would delegate her duties and authority to shift leaders or the next most senior staff nurse within the ward. The strict adherence to the nursing hierarchies as part of the management structure (*hardware*) shaped leadership practices and hindered teamwork. A nursing operation manager reported that those in higher nursing ranks were reluctant and felt uncomfortable reporting to those in lower categories, which sometimes led to tensions and disagreements amongst nurses and therefore undermining teamwork.

The other key area of fragmentation within the hospital was between senior administrative staff and frontline staff. Across cadres, respondents expressed specific concerns about senior management's leadership and communication practices. Despite their efforts at engaging staff, senior managers were criticized for not meeting staff *on the floor* to see their experiences at first hand. Respondents also reported that senior managers were not approachable, and there was a lack of camaraderie (*intangible software*) between senior managers and staff.

"I do feel that the sense of camaraderie is a bit low but it's because of the gap between management and people on the ground because I'm used to floating in the middle,

I'm used to going from ground to management and I need to be both, and I communicate with people from all levels." **DHB-IDI-024 (clinician)**

Several clinician, nursing and administrative respondents raised specific concerns about the non-clinical background and lack of nursing knowledge of the new CEO (*tangible software*), given their prior, positive experience of clinicians as CEOs. They saw this factor as an impediment to making final decisions on clinical matters:

"I think if the CEO of the hospital was a doctor, the reason why I'm saying that is because he cannot fully make the final decision based on his experience, there is a second person who is the doctor who is making the final decision and then the CEO cannot dispute or cannot say no because he doesn't have enough knowledge about the hospital situation, he's not a doctor or a professional nurse." **DHB-IDI-012 (nursing operation manager)**

"Our CEO was a brand-new person; he was only appointed after we got here. We did not know him at all, and he is an administrator he is not a medical person. Our previous CEOs have all been medical, either nursing or doctor…. You see, and you know we have all had previous CEOs to compare him to, he is not our first, for me he is probably like my 6th CEO. All the others have been clinical, they have all known my name, they have known who works in my department, and they have known what I do. I don't even think, he's never been in my office, our previous CEOs had a bit more diplomacy." **DHB-IDI-004 (clinician)**

At the same time, reflecting their professional power (*tangible software*), clinicians felt they simply had to be involved in decision-making (*tangible software*):

"I think they kind of realise that they have to consult with us actually, they can't impose things coz people, certainly amongst the doctors, and we won't accept that. I don't know what happens at a nursing level, I suspect it's different in the nursing level." **DHB-IDI-017 (clinician manager)**

Yet formal decision-making power within the hospital (*tangible software*) lies, essentially, with the CEO. Both front line clinician and nursing respondents argued that they were unhappy with the centralisation of decisions at the executive level and that the executive team had limited engagement with them. Even members of the ExtendMT noted that:

"We serve on the EXEC but we're a voice around the table but we're not the executive voice if you know what I'm trying to say. It is like, what's that guy's name now on

Animal Farm? George Orwell. So, all animals are equal, but some are more than others." **DHB-IDI-025 (mid-level administrative manager)**

Reflecting this power distribution, the flow of information within the hospital is, then, essentially vertical. Policies, procedures, and feedback on performance are passed downward to lower-level staff, and communication with the executive management is an upward flow – for example, for clinicians, via the deputy director of clinical services. The rule bound nature of the national, provincial and district health systems (*external context*) only exacerbate the flow of information in the hospital.

7.3.2 DHB's External hospital context

Figure 7.6 highlights the critical features of external context that interact with the internal context in ways that had consequences for leadership practices and staff morale within the hospital. First, the commissioning experience (see section 7.1.2) generated important legacies for DHB. Some respondents specifically linked the fragmentation among staff and leadership challenges identified at the time of the study to the process of amalgamating managers and staff from different hospitals. Clinicians who had no prior experience in leadership, for example, had to learn on the job, but the very demanding process left little time for practicing approachable, engaging, and empowering leadership.

Overall, the commissioning process concentrated primarily on establishing and opening units and departments rather than fully engaging and interacting with staff, who were themselves overwhelmed.

"It was one of the most terrible times I think in my working history. There were huge gaps of communication, massive gaps of communication which definitely I mean should you ask anybody else now people might not agree with what I am saying, which will be an indication of what I am referring to as gaps of communication meaning that the project was there, the hospital needed to be commissioned, decisions had to be made and so on and so on. However, support was not there. The commissioning happened at once for all sections and components of the hospital however, some other sections received more support than the others." **DHB-IDI-005 (mid-level administrative manager)**

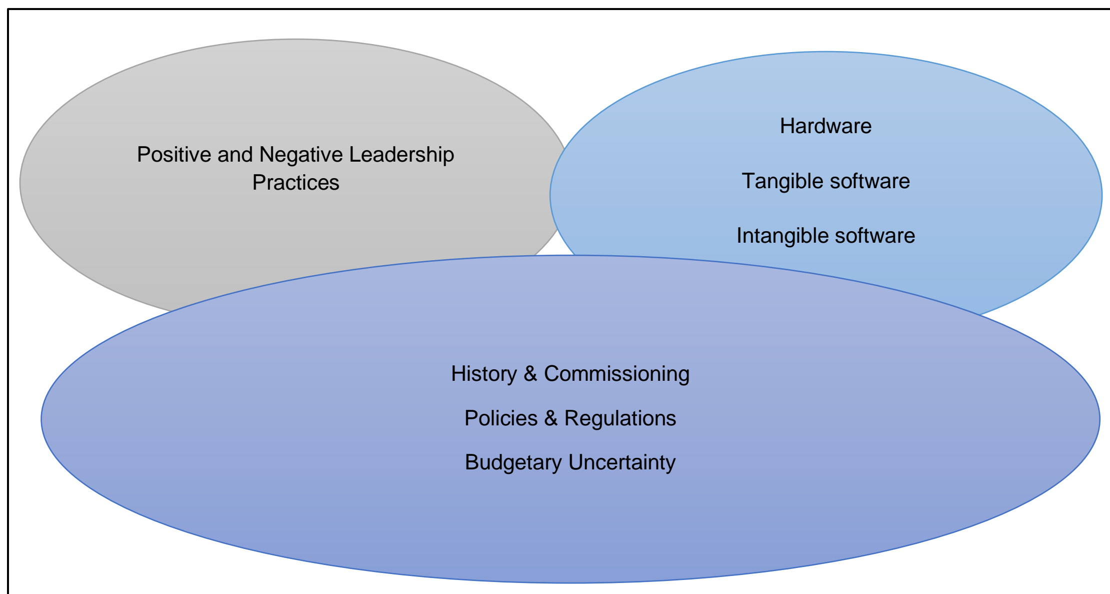


***Figure 7.6**: Interaction between external context, internal context, and leadership practices at DHB*

Many respondents noted that inadequate attention had been paid to change management during the commissioning process and criticised those managing the process as simply not having the skills to manage the amalgamation of different groups of staff and develop good working relationships. The strained relationships between the executive management team and staff at this time were so severe that external factors such as the South African Medical Association (SAMA) got involved to try and resolve the disputes:

"And there was a lot of upset about that, there was a lot of ugly stuff, SAMA got involved so it was trade union representatives, there was a lot of conflicts, a lot of stress, a lot of negativity which was a struggle, but we are over that hurdle now. It was threatening to go to court and the CCMA, and it got really ugly and then the management here kind of backed down you know and said well okay, kind of do it, do it your way sort of thing." **DHB-IDI-004 (clinician)**

Respondents specifically noted that there continued to be tensions between the different groups of nursing managers and staff brought into DHB. These tensions undermined information flow, teamwork, and camaraderie, creating an environment for the more negative leadership practices discussed in section 7.2.2.

"When they have landed here, the [OLD HOSPITAL] group is the biggest group, the other one from [PLACE X] is a smaller group but the [PLACE XX] ones claim ownership of this place, it is ours, we might be 3 but it's ours. You are 200, so what,

do not bring your [OLD HOSPITAL] nonsense here – that kind of thing. There is you against us, they have that problem now." **DHB-IDI-003 (clinician)**

"I don't know what's going on here, but the problem is, look I know we inherited some disastrous nursing managers from [OLD HOSPITAL], disastrous and they're still here, they've come over and they're part of the legacy and they've brought their poison with them." **DHB-IDI-017 (clinician manager)**

Managers spent much time and energy managing these rivalries and processes when they could or should have been building better relationships among staff. Similar experiences affected some of the clinical units, and spilt over into tensions between nurses and clinicians, underpinning the fragmentation among staff, and into the perceived large divide between senior management who the frontline staff expected to build relations with them - as demonstrated by a quote from a nursing respondent:

"I don't know because it's a new hospital, because they were concentrating on bigger things that they needed to sort out downstairs, because they don't have a little clue of what is really happening… I think we have passed that stage of commissioning and they should stop using the excuse that we were busy with the commissioning. They need to put their hands in and come up and see what is happening and connect with the people that's doing the work." **DHB-IDI-014 (nursing operation manager)**

The second critical external influence over DHB experience is that it is located within a broader and hierarchical bureaucracy. The hospital budget is set at these higher-level authorities and as noted earlier, had been a specific concern among staff since it opened, also linked to concerns about staff shortages and attrition:

"For practical purposes we are a regional level hospital, there is no difference between a large metro district hospital and a regional hospital – nothing – we are one and the same thing, okay. But it serves the department of health to differentiate between a large metro district hospital and a regional hospital because it's cheaper." **DHB-IDI-017 (clinician manager)**

The decision-making authority of the executive management team is also set, and curtailed, by higher level policy frameworks and regulations. These bureaucratic policies and regulations, for example, drive human resource management – both the performance management system and recruitment processes – and the scopes of practices governing nursing and clinician duties. A respondent in the extended management team referred to the policy oversight by the next tier of the bureaucracy, the sub-structure office, as *another bureaucratic layer*, with *rigid rules-driven*

approach; perhaps referring to communication processes and the top-down strategy for implementation of policies. The executive management also expressed specific concern about their lack of decision-making authority in relation to the use of allocated funds for recruitment and paying locum staff to mitigate clinical and nursing staff shortages.

The consequences of this bureaucratic hierarchy were, overall, that the hospital leadership was seen by their staff as uncaring and lacking empathy because they did not (and could not) resolve budgetary and staffing challenges. For example, when nationally agreed salary increases could not be paid because of budget limits, this exacerbated tensions between executive leadership and staff and their labour unions. Not surprisingly, then, the limited authority of senior leadership within the hospital undermined their staff's trust in them:

"I feel also lately, I've picked up that there's not a lot of interest from staff as to what management has to say but I think it has to do with the financial constraints that we are having so our staff have been under pressure and management are also under pressure because of these financial constraints." **DHB-IDI-013 (junior administrative manager)**

7.4 Chapter Summary

In conclusion, then, in this chapter, I have presented a detailed description of the leadership practices and their implications for the varying sources and levels of staff satisfaction and morale in DHB. In addition, I have discussed the key features of DHB's context that influence leadership experiences and practices. These include the history of commissioning, budgetary uncertainty, HRM processes, hospital design, decision-making, management structures, and the intangible software of internal context. Some of these features also themselves influence staff satisfaction and morale.

A key finding was how the commissioning process and experience emerged as instrumental in the fragmentation and the tensions between cadres and groups of staff in DHB. The fragmentation undermined relationships in teams and contributed to leadership practices that demoralised staff. Similarly, the organisational processes and the ability or inability to make decisions was critical in shaping staff relationships.

Bureaucracy and budgetary uncertainty, as external context features, therefore, also had a profound impact on elements of internal context such as fragmentation,

camaraderie, teamwork, and professional sub-cultures. In turn, these elements of DHB's context influenced the leadership practices that promoted or undermined staff morale.

Clinician and administrative respondents reported on more positive experiences as compared to the nursing respondents in this case study hospital. Clinicians and administrative staff highlighted the sharing of roles and power within their teams as reflecting both leadership practices and different contextual features, as well as supporting teamwork and having positive consequences for staff morale.

In contrast, respondents from the nursing cadre appeared to be more disengaged than clinical and administrative cadres, with weaker teamwork experiences. Nurses were particularly demoralised by the rigid nursing management style that left them with limited opportunities for delegated or shared leadership. The background of the current CEO and prior managerial turnover are other important aspects of the hospital's context that shaped leadership practices and morale in the hospital.

In sum, then, an important finding that this chapter highlights is how cross-professional and cross-managerial relationships in DHB were undermined by a combination of factors external to the hospital and organisational processes within the hospital. The results in this chapter also show how these factors influenced leadership practices and staff satisfaction and morale. These dynamics are further examined in the ensuing cross-case and discussion chapters.

Chapter 8: Cross-Case Analysis of the District Hospitals

8.0 Introduction

Chapter Eight presents an analysis of experiences across the two hospital cases. It addresses the overall research question: How does organisational context influence leadership practices and affect staff satisfaction and morale, as an indicator of leadership effectiveness, in district hospitals in the Western Cape Province, South Africa? The overarching conceptual framework presented in Chapter Three guided the analysis of the data generated from the two hospitals and the findings presented in this chapter. Specifically, and moving beyond the individual case study experiences, this cross-case analysis focuses on how hospital context mediates the emergence of collective leadership, as a distinct phenomenon. As described theoretically in Chapter Three, collective leadership is broadly a process of distributed influence and control involving collaborations and relationships (Hiller et al., 2006), that shapes the behaviours of individuals situated within a given social context (West, Lyubovnikova, Eckert, & Denis, 2014; Raelin, 2011; Denis, Langley, & Rouleau, 2010).

As summarised in **Figure 8.**1, the chapter considers: first, the potential of the observed leadership practices to support the emergence of collective leadership within the hospitals; second, the external and internal contextual factors that also influenced the emergence of collective leadership; and third, how these particular contextual features may themselves impact on staff satisfaction and morale. Chapter Eight also draws on wider theory on power and identity (professional, managerial or team) to deepen understanding of the interlinkages between hospital context, leadership practices and collective leadership. Power and authority are both features of leadership and context that may influence others or the course of events in the hospitals, including the desire or motivation to act or behave in a particular manner (Yukl, 2006). Theoretical and empirical understanding of professional identity, meanwhile, views leadership as a group process that varies with context and include both individual and collective social interactions (Berghout, Fabbricotti, Buljac-Samardžić, & Hilders, 2017; Daire & Gilson, 2014; Baker & Denis, 2011; Hogg & van Knippenberg, 2003; Hogg, Terry, & White, 1995; Turner, Oakes, Haslam, & McGarty, 1994). Finally, where available, wider South African literature that supports specific analyses is also presented.

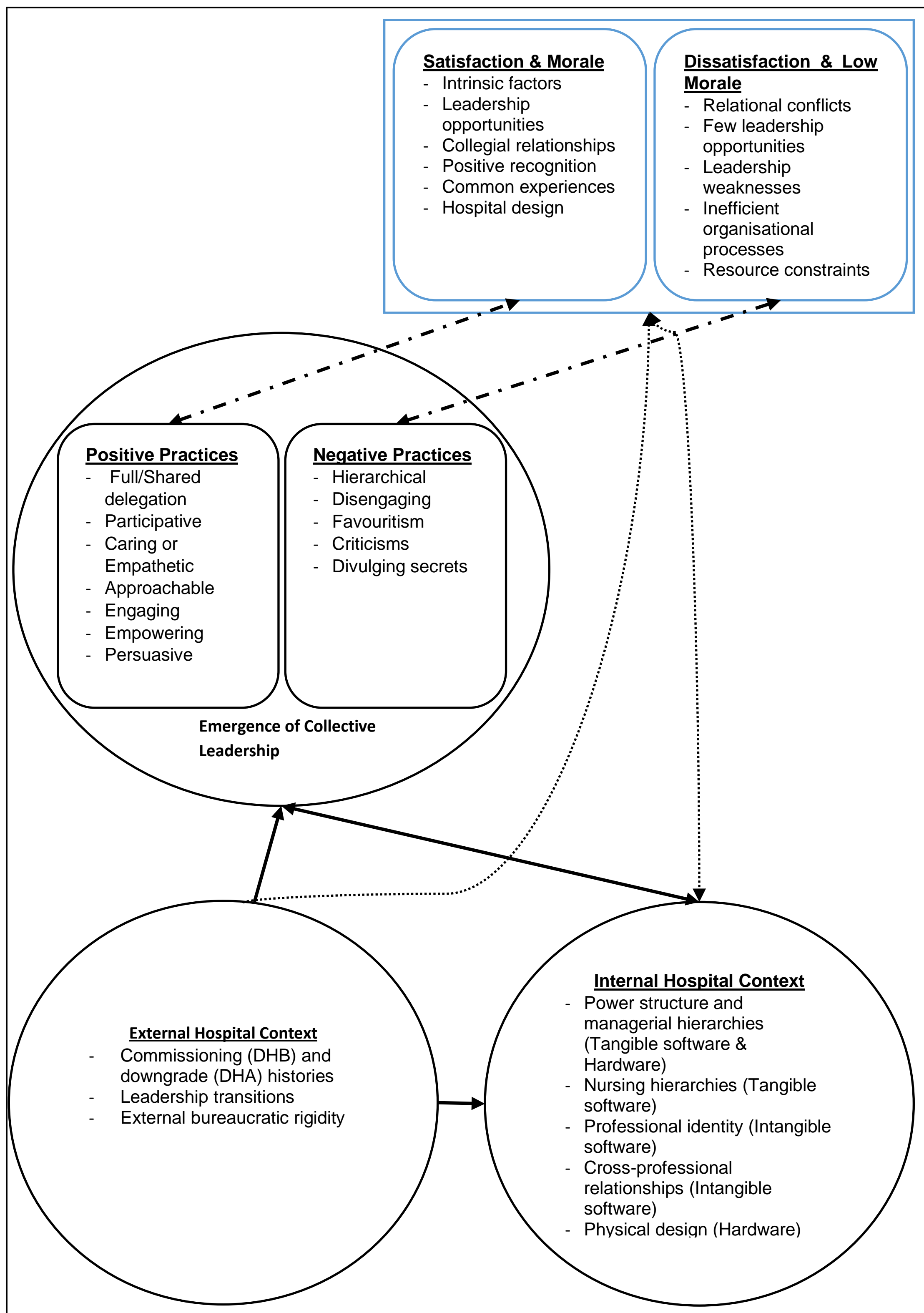


Figure 8.1: Representation of the interplay in cross-case analysis

Note: Figure 8.1 illustrates the pathways between the dimensions of the Leadership Trinity framework (see Chapter Three) that are supported by the cross-case analysis. The external context influenced internal context and was shown to be linked to collective leadership. The dash arrows indicate a probable link between leadership practices and staff satisfaction and morale, and this link is stronger than the possible links between external and internal context, and staff satisfaction and morale which is shown by the dotted arrows.

8.1 Leadership practices and experiences of collective leadership across hospitals

Table 8.1 summarises for both hospitals the categories of leadership practices identified in Chapters Six and Seven as positive and negative. As outlined earlier, these judgments reflect whether, or not, the practices are likely to support staff satisfaction and morale and were derived from the qualitative interview data, notes from observations, and supporting information from staff satisfaction surveys. The Table considers overall experience in each hospital as well as the dominant experiences of leadership practice for each of the three cadre groupings examined in this study.

Table 8.1: Comparison of Leadership Practices in Case-Study Hospitals

Category	District Hospital A	District Hospital B
Overall Positive Leadership Practices	Full delegation/Shared, Participative, Empathetic, Approachable, and Empowering.	Full delegation, Approachable, Participative, Engaging, and Persuasive.
Overall Negative Leadership Practices	*Favouritism, Hierarchical and Disengaging*	*Hierarchical, Disengaging, Criticisms, and Divulging Secrets.*
Administrative Cadre	Empowering, Full delegation/Shared, Caring and Empathetic Practices	Full delegation, Approachable, and *Disengaging Practices*
Clinical Cadre	Full delegation/Shared, Empowering, Approachable, Participative, and Empathetic Practices	Full delegation, Empowering, Approachable, Participative, and Empathetic Practices
Nursing Cadre	*Hierarchical, Favouritism, Disengaging, and Non-participative Practices*	Persuasive*, Hierarchical, Disengaging, Favouritism, Divulging secrets, Being critical and Criticism Practices*

<u>**Note:**</u> Table 8.1 is a comparison of the overall leadership practices in DHA and DHB, outlining the practices as either positive or negative, and by cadre. Italics denotes negative leadership practices as experienced by each cadre grouping.

Leadership practices that were assessed as positive were broadly similar across hospitals. These practices, summarised in **Table 8.2**, include being approachable, participative, and engaging, as well as those that allow sharing with, delegation to, and empowering colleagues and subordinates. These practices resemble what are broadly termed transformational and authentic individual leadership styles - ones that

enhance staff well-being and empowerment, and have a positive impact on staff performance (Kelloway, Weigand, McKee, & Das, 2013; Avolio & Gardner, 2005).

Table 8.2: Understanding Leadership Practices (Source: Observational, Interview and Staff Satisfaction Survey data in DHA and DHB)

Leadership Practice	Description
Full delegation	Sharing and delegating roles and responsibilities to other staff
Empowering	Developing others for leadership, identifying leadership talents, self-initiatives and leading by example
Approachable	Being reliable, accessible, and visible in the unit, ward, or hospital
Participative and Engaging	Interacting with staff, allowing participation and involvement in decision-making
Caring and Empathetic	Concern for staff welfare and fairness
Persuasive	Diplomacy and flexibility when dealing with staff
Disengaging	Inability to develop others, lack of accessibility of visibility to staff, and not leading by example
Hierarchical	Inability to share delegation, instructive, giving orders and authoritative
Favouritism	Assigning duties and conducting appraisals based on friendship
Divulging secrets	Exposing and sharing confidential information or secrets with other staff
Being critical and criticisms	Fault-finding and condemning staff

In direct contrast, negative leadership practices were those which led staff to feel dis-engaged, or subject to criticism or (perceived) biased decision-making, and entailed divulging secrets, not delegating, or sharing roles, or giving orders and being authoritative and instructive (see also **Table 8.2**). These types of individualised leadership behaviours, ones that are corrective and rules-driven, are associated with

what is termed transactional and hierarchical leadership styles (Bass, Avolio, Jung, & Berson, 2003; Avolio & Bass, 2001).

There were also some similarities across hospitals in the experience of cadres. In both hospitals, and despite the generally positive perceptions in DHA, nursing leadership practices were experienced as hierarchical and disengaging, whereas clinicians and administrative staff experienced leadership more positively. **Table 8.3** presents examples of quotes that illustrate how staff perceived these leadership practices in both hospitals.

Table 8.3: Exemplary quotes on leadership practices

Leadership Practice	DHA	DHB
Full delegation	"He is a good manager, he knows how to delegate, he knows how to get other people to do the work and he's done a phenomenal job in terms of changing the structure of our team in delegating work to other people and allowing other people to take up skills, to take on things that I was in a sense not able to release." DHA-IDI-008 Senior Clinician	"In our component what we will do, if I am not here, the same as you asked me about when my director is not here, I do take up his role. Same goes for all of us, which is according to me something very nice in that it gives the guys exposure. Being a supervisor for a day or for a week, just changes your way of thinking." DHB-IDI-005 Mid-Level Administrative Manager
Empowering	"People work independently when empowered and knowing what their roles are and I don't have to watch over their shoulders to see that the job is done. So, I am not going to micromanage them, that I inspire trust and inspire motivation and you know the people that I work with and a team effort." DHA-IDI-017 Nursing Area Manager	"I think I empower myself and I get empowerment from the people that I am leading. I think we feed off each other. The skills of leadership I've learnt from other people, I've learnt from the examples that I see in my department." DHB-IDI-019 Clinician
Approachable	"Management and leadership wise, I would say that we have a really good manager, our CEO is great, he is brilliant, he listens to you, he's smart, he's the change that DHA needed, and he's got great attitude and I think everyone else like it, just like a ripple effect." DHA-IDI-007 Mid-Level Administrative Manager	"You want your followers in the unit to challenge you, but you want them to challenge you for the right reasons. Just because you are the boss, or the leader doesn't mean that you are the only one with good ideas." DHB-IDI-017 Senior Clinician
Participative and Engaging	"We try and solve everything within the department. So, if I have a problem with them, I will discuss it and manage it here. If I cannot, then I will take it up. Or if they have a problem with me, I will try and first clear it and if they are not happy with me, they then will take it up to my boss." DHA-IDI-003 Clinician	"Our head of nursing, the manager, she does have meetings with different categories of staff. We as operational managers, we have alternate Thursday meetings, when we come back from those meetings, we hand over to the staff what was discussed in the meeting, so they also can talk to the head of department." DHB-IDI-012 Nursing Ward Operation Manager
Caring and Empathetic	"Being empathetic and just being a good human being to your staff and understanding that they are going through tough challenges." DHA-IDI-002 Senior Clinician "Whether we have these young nurses who are falling apart because of a boyfriend, or a lot of our staff have debt issues, I'm no financier but you know you sit, and you listen." DHA-IDI-017 Nursing Area Manager	"So [HE'S] been very sympathetic, he's been trying to negotiate on a huge number of psychological traumas amongst doctors. He doesn't always get it right and I think it's because it's a huge balancing act for him to try to keep his managers happy and at the same time keep his group of doctors happy." DHB-IDI-004 Clinician
Persuasive	Not Reported	"I think I'm also the type of person that would, if I want this to be done this way, then I would say to people in a very nice way, that you know, although I will get their opinion, I will still deep down want it my way and I've learned to say, let

Leadership Practice	DHA	DHB
		go, this is a team thing and make people feel appreciated, make people also feel they contributed, and then it becomes our thing, and everybody feels happy about it." DHB-IDI-015 Senior Administrative Manager
Disengaging	"There is a huge disconnect between management and the physicians, and the clinical staff. Huge disconnect in a sense that managers male financial decisions around the hospital, and they make huge decisions that impact directly on patient care without consulting the physicians that are actually looking after the patients." DHA-IDI-002 Clinician Manager	"So now because I'm quiet and not very talkative they would just disregard me. And personally, I feel there is much I can give, I am just waiting for my five years to resign here… I'm moving because, here I'm not going to grow, the leaders don't identify people that they can take as successes, they only want to do things like this for themselves." DHB-IDI-014 Nursing Ward Operation Manager
Hierarchical	"Nobody makes decisions for me. The wards and the people there that have been historically here in this place do not tell me what to do. I am the manager. I will tell you what to do." DHA-IDI-004 Senior Administrative Manager	"I know that people in unit X struggle, there's quite a few people that don't like the management style that's happening in the [unit], I think it's very authoritarian, you know it's all of those things. I think that they don't feel supported." DHB-IDI-017 Senior Clinician
Favouritism	"I feel people are neglected; I feel that the true stars are neglected. But what I would like to see happening is that we are all on the same page, that my expectations from the system is the same as yours." DHA-IDI-010 Nursing Ward Operation Manager	"You know people when they are in high places, they want you to play according to how they want you to play. And if you are not that type of player then you will not get anywhere, not being rude, not wanting to play the type of play that they want you to be, being a B player, so you will stay a B player, you will not rise in your level." DHB-IDI-018 Nursing Ward Clerk
Divulging secrets	Not Reported	"I will never share any personal problems that I have, I must lie… I will rather share with my mum or my sisters than share with fellow managers here because at the end of the day it's going to be a laughingstock in the packages." DHB-IDI-002 Nursing Shift Leader
Being critical and criticisms	Not Reported	"That's why most of the sisters upstairs are resigning every day and they will tell me we can't take this anymore, by the time you go home our feet are sore and sore… and the manager will come and shout at you, they sit in the office, they don't know what you are feeling on the floor." DHB-IDI-002 Nursing Shift Leader "You go and find something where you have to see 10 patients instead of 5 to 6 patients. And then you get hauled over the coals because 2 or 3 patients, maybe more, will not receive their full care. Who do they blame? They blame the nurse." DHB-IDI-004 Clinician

The hospital experiences further suggest that the leadership practices identified as positive in terms of staff morale were also associated with collective leadership, while negative leadership practices were likely to undermine it (**Table 8.3**).

Although relevant leadership practices were identified in both hospitals, there appeared, overall, to be a stronger sense of collective leadership and its value in various spaces of DHA. A senior administrative manager reported, for example, that:

"*I think a lot of our successes is to do with management itself, we do have very good managers and they are experts in their field, and I believe if you've got good management then they can spread that to your lower levels and that encourages the lower staff to fulfil certain gaps and give them the necessary skills*." **DHA-IDI-001 Senior Administrative Manager**

Some unit managers also talked about their preference for small collective teams that would go the extra mile in ensuring quality patient care:

"I would rather have a small team of people who go the extra mile than a lot of people. I cannot carry dead wood, if people are not going to put in and go the extra mile they can go and work somewhere else, seriously. But a small team of people, and they do not have to be competent, they just have to care enough to actually learn, that kind of people." **DHA-IDI-011 Senior Clinician**

Indeed, teamwork, including across cadres, was widely seen as important for performance: as noted by a mid-level nursing manager: "*You have to build up relationships with that team for you to be successful*." [**DHA-IDI-012 Nursing Ward Operation Manager]**. Clinicians at DHA commonly had good feelings about working at the hospital due to the excellent relationships amongst them, so they did not feel like they were working on their own.

"For all the services, we don't have separate doctors in out-patients, separate doctors in teaching, separate doctors, one team doing multiple things because people work together because they are part of something special." **DHA-IDI-002 Senior Clinician**

Finally, the growth and positive outcome of nurturing of collective leadership practices in the hospital was also acknowledged by a mid-level nursing manager, who said:

"I think slowly but surely, we are moving toward an improved staff morale and improved leadership ability amongst all, not just nursing, the allied staff as well." **DHA-IDI-017 Nursing Area Manager**

Similar experiences were also a feature amongst clinicians:

"My approach has been to be more inclusive... we have given medical officers leadership, and they seem happy with their leadership, they are like our rock when we are not here. When I am not here and they are there I am happy because I know that they will mobilise staff and they will do what is right, because I have empowered them to do that, I will be careful, I'll never undermine them." **DHA-IDI-002 Senior Clinician**

In DHB, meanwhile, collective leadership was most clearly experienced among clinicians:

"I think for [unit] we talk together about issues, and we agree on how we are going to do things. It's not necessarily just one person leading but it's the team of senior people providing the direction and then one can see that fortunately we have very good doctors, interns and medical officers so they would then follow that direction and if they don't, we give them feedback." **DHB-IDI-023 Senior clinician**

Indeed, across hospitals clinicians commonly used collective decision-making to solve problems in clinical teams, experiences exemplified by a junior clinician in DHB:

"*We share responsibility very well because I think also my team is quite aware of the burden that I have as a team leader and they want to take some of that burden away from me and now I feel confident that they can share that burden and they will offer to share the bigger tasks and take those sorts of things, which is great.*" **DHB-IDI-019 Clinician**

Despite the positive signs of collective leadership amongst clinicians, however, there were clear signs of the limited depth of collective leadership in DHB's extended management team. The challenges experienced were well expressed, first, by a clinician member of the team:

"To be honest with you at the moment you know it's not a good space for me to be in. I feel very sort of marginalised because whenever I sort of give an idea or something it will sort of it is almost sort of like, okay no or whatever… But sometimes you do feel, I suppose it is just how much I am tramping on your toes man, I think that is the bottom line, and what I was told was [Respondent] they do not want to give you too much of rope because then you might just run, sort of run away with it." **DHB-IDI-011 Clinician**

Another clinician also reported on the wider fragmentation of leadership within the hospital:

"I will reiterate it again that I think the rest of the hospital, when you are leading you need to lead by example and the positivity and trying to work hard together as a team doesn't start on top and that's the problem. It needs to start on top, making sure that the people below you actually feel part of a team – coz now there's different levels, it is not one team. You have got the EMT team, you have got middle management team, you have got different silos of teams but there is not a one team. Everybody is

separated, procurement is a team and if there's no stock it's procurement's fault." **DHB-IDI-024 Clinician**

Many DHB respondents also complained that they experienced leadership as a top-down process of 'passing the buck', rather than one of engagement:

"Sometimes you feel alone you know, not getting the support from the management because they feel you are there, but overall, it is their responsibility and sometimes there's requests coming from substructure that they can answer because all the emails goes to them, and they will pass it out to you but sometimes they do have the stuff and they can just pass it on, so that is like passing the buck I think, if they can just work together more on that." **DHB-IDI-009 Mid-Level Administrative Manager**

A clinician expressed this experience of top-down information flow more forcefully:

"*Don't send me emails saying Richard Branson loves his employees, that for me means nothing, it's patronising, that's what it is. I am not interested in that, you show yourself here, you walk amongst the crowd, you show yourself in the emergency unit when people are lying on the floor because that to me says that you understand what your staff is going through. Don't send an email saying don't put patients on the floor – that's meaningless."* **DHB-IDI-004 Clinician**

The differences between the hospitals in their experience of collective leadership are exemplified by the experiences of two champion leaders, one in each hospital. '*Champion leadership'* is a term that respondents in DHA and DHB used to describe staff who felt empowered by the wider environment of engagement to practice leadership in wards and in the hospital. In DHA this leader noted:

"Over and above my job, I'm a champion for the C^2AIR^2 Club. What C^2AIR^2 Club is all about, it is all about improving the patient experience but applying the value, the departmental values, which is caring, competence, respect, responsiveness, integrity, and innovation. So, what I do as part of my programme of that, we normally plan events, like team building events, recently we had one for master chef and the purpose of that was basically to get to know each other." **DHA-IDI-013 Mid-Level Administrative Manager**

The administrative manager planned team building events that brought staff together to know each other using the provincial C^2AIR^2 values framework. The activities organised by the manager were also judged by colleagues to strengthen existing relationships and camaraderie, in turn supporting teamwork and collective leadership.

In contrast, nursing staff who sought to take initiative as 'champion leaders' for the C^2AIR^2 Club in DHB felt demoralised by the lack of staff interest within the hospital, and criticised the lack of senior leadership support:

"I find there's lack of assertive leadership from the top management, I can give you an example if you want to and it is not personal. For example, we had the C^2AIR^2 Club, the bottom of the barrel, most of the Western Cape is doing extremely well with the C^2AIR^2 Club, but I feel that … the idea was not sold well enough under the doctors, and they decided that they are not puppets, and you know it's a waste of time." **DHB-IDI-006 Nursing Ward Operation Manager**

However, despite the lack of collective engagement in the C^2AIR^2 Club at DHB, there was a champion leader amongst clinicians who had no formal leadership position but was respected by other staff because he inspired them to take over leadership within the hospital. In addition, a nurse was identified as a champion in a section which encompassed three interlinked wards:

"I don't know where I would have been as a young and a new operational manager on this floor, where I would have been if it hadn't been for that woman. She is the one, literally pulling these things together and putting us and giving us that leadership and saying listen here, let us have a meeting, we are going to do this and this and that. Really, she is the one that is really functioning as the area manager on this floor, she does not have the title, she does not get a salary for that job, she's the one that's doing all that the area manager is supposed to do." **DHB-IDI-014 Nursing Ward Operation Manager**

These experiences also, finally, point to the associations illustrated in **Figure 8.1** between leadership practices and hospital context. Positive and engaging leadership practices both enabled collective leadership and nurtured the intangible software of camaraderie and teamwork in DHA (see Chapter Six). In contrast, disengaged and hierarchical leadership practices undermined collective leadership and reinforced fragmented ways of working in DHB (see Chapter Seven). The nature of these recursive associations is further discussed in sections 8.4 and 8.5 of this chapter.

8.2 Hospital histories

In this section I describe some of the key features of hospital history that the cross-case analysis revealed as important influences over the hospitals' continuing experience of leadership (see also section 8.5) and over staff morale at the time of

the study. Table 8.4 summarises the key external contextual issues with the relevant historical internal hardware and software elements considered further in this section.

Table 8.4: Comparison of history and background of DHA and DHB

District Hospital A	District Hospital B
Old hospital structure in a building with limited space	Newly commissioned hospital in a new modern building
Hospital re-classified from Level 3 Regional to Level 2 District Hospital	Hospital functions as Level 2 District Hospital, with some Level 3 Tertiary services
History of togetherness due to staff working for long periods in the hospital	History of tensions due to amalgamation of staff
Senior hospital leadership transitions over six years prior to study	CEO appointed during the commissioning process after resignation of the first CEO

Having been established in 1888, DHA is an old hospital with associated structural challenges of space and maintenance. Previously a Level 3 (regional hospital), in 2009, as part of wider provincial health system restructuring, it was re-classified as a Level 2 District Hospital offering a reduced scope of specialist services and referring more complicated cases upwards. This *downgrading* was also widely associated with budgetary challenges by hospital staff. Nonetheless, the history of stable staffing and well-established relationships in DHA had resulted in the development of family-like collegial relationships between staff (also discussed in detail in section 8.5) which itself represented the internal context (software) supporting collective leadership, as well as nurturing staff morale.

By contrast, DHB is a newly commissioned district hospital that was built and opened in 2013, in line with the wider provincial health system restructuring, which also provides some level 3 specialist care services. Despite being a new hospital, DHB experienced significant structural challenges after it opened that worked against the emergence of collective leadership, and undermined morale. It was criticised by hospital staff for not having the same level of facilities as the old hospital that had previously served the catchment area:

"One of the big challenges that we had is that they closed down the [OLD] high care unit against what everybody said, all of us clinicians complained, we said please do not close down that high care unit, we need it And they shut it down and that's a big problem, it's a big problem in terms of the staff get de-skilled, it's a big problem that we sometimes end up locking the theatre for 12 hours because we can't get a patient shipped across to [the tertiary hospital] because they don't have an available ICU bed and we don't have a bed to put the patient in." **DHB-IDI-017 Senior Clinician**

One of the key areas of the new building, the Emergency Centre, was partially burnt down during commissioning, and both nursing and clinician respondents reported that the contractors and management did not consider their suggestions when redesigning the department. Most respondents argued that the poorly redesigned department had limited space for staff and patients, leading to tensions, stress, and burnout among staff. Some clinicians referred to the department and hospital as a '*dysfunctional unit and family by design*' (**Field Notes**). In addition, the new staff complement of DHB had been brought together from different facilities in the subdistrict, all of whom claimed '*ownership*' of the hospital.

"So, all in all, I think we have been caught in the translation both from the union side the management side and, especially here, staff side because some members of staff came from [Old] hospital another smaller group came from [Facility X], so among staff here, that is one of the problems that they have got, it's you against us. When they landed here, the [Old Hospital] group is the biggest group, the other one from [Facility X] is a smaller group but the [Facility X] ones claim ownership of this place, it is ours, we might be 3 but it is ours. You, you are 200, so what, do not bring your [Old Hospital] nonsense here – that kind of thing. So, there is you against us, they have that problem even now." **DHB-IDI-003 Clinician**

Most of the staff complement came from an older decommissioned hospital and had understood that they were not going to be permanently stationed at DHB but would at some later time go back to the old hospital. The realisation that such a return would not occur was very demotivating.

"Where DHB is a little bit different elephant, first of all, I am sure you know the whole story, that issues about to amalgamate or closing [Old Hospital] and DHB and moving staff. I think that was a big impact and I think until now it's a big impact on everyone you know there are people still waiting for new [Old Hospital] to open and go back." **DHB-IDI-016 Senior Administrative Manager**

Tensions between groups of staff, and with formal hospital leadership, were also fuelled by the poor management of contracts during the commissioning process, which led to mediation between hospital leadership and staff by professional organisations from outside the hospital:

"And there was a lot of upset about that, there was a lot of ugly stuff, SAMA got involved, so it was trade union representatives, there was a lot of conflicts, a lot of

stress, a lot of negativity which was a struggle, but we are over that hurdle now." **DHB-IDI-016 Senior Administrative Manager**

Another feature of hospital history influencing current experience of leadership at both hospitals was the hospital's past leadership. The recent history of DHA had been characterised by rapid turnover of managers, with respondents referring to the experience of an older, good manager in contrast to more recent, less strong managers:

"I've been through three different CEOs or superintendents as they were called in the old days, and I've seen different styles of management since being at DHA… I do not know why CEOs keep changing. About five 5 or 6 years ago, this hospital had a very good CEO who was part of the reason for recruiting me… she was brilliant, hands on, in touch with all departments, visible in the hospital, where patients came first. She was inspirational and always wanted the best for staff." **DHA-IDI-002 Clinician**

At the time of this study, the newly appointed executive leadership team had to confront staff memories of a previous CEO who was highly regarded by long-serving staff for bringing in collaborative practices, focused on relationships, being open to other managers and inspiring frontline staff:

"So, slowly but surely, I think that the bridges are being rebuilt between management and the general staff. Whereas before, it was not a nice thing, it is not an ugly thing but when you went to your senior with an issue and nothing got resolved, you as a person became despondent regardless of what position you're in." **DHA-IDI-017 Nursing Area Manager**

Deliberate managerial appointments had also been made to address past challenges with relationships in departments that were considered as underperforming:

"With the department of [XX], we changed the [HOD]. This was a deliberate move for reasons we won't go into in detail, but the person was underperforming and then we hired a higher performer and our [XX] Department has probably seen a 50% increase in everything; output, teaching, staff morale, it's just a different [XX] Department." **DHA-IDI-001 Senior Administrative Manager**

Overall, then, to highlight the positive leadership in DHA at the time of the study:

"I will say that there's been really some improvement, or I'll say I'm seeing a change because of the change in leadership. So, for me I will say I am quite satisfied with the way things are going since last year, since the appointment of the new leader that we

have. But however, there's always room for improvement." **DHA-IDI-013 Mid-Level Administrative Manager**

In DHB, meanwhile, the commissioning process had been a particularly challenging time for those leading it, since the commissioning managers were inexperienced in change management, with the permanent CEO only appointed towards the end of that period:

"And so that is what the challenges was, there was a lack of experience at managerial level, I'm talking about our level now." **DHB-IDI-001 Senior Administrative Manager**

"I think the EMT, we grew together, there was a time, I must also be honest, that I personally, when all those complaints and stuff came, I became a bit depressed to a point where I actually personally phoned ICAS [counselling] because I felt I'm failing the department, I'm failing the patients, I thought I was doing something wrong you know." **DHB-IDI-015 Senior Administrative Manager**

This situation, and the administrative commissioning procedures, inevitably exacerbated the challenges experienced in bringing together staff from different facilities:

"So, that was a hectic, crazy time. We as management, we were running with commissioning hats, too many meetings and budget meetings and capital meetings and equipment meetings, there was no time to talk to the soft issues of the staff because you were busy commissioning, so then you expected that direct supervisors should do x, y, z and then the direct supervisors are many of them are from [Old Hospital] who didn't bother, there was no loyalty, there was no dedication, but they were your soldiers to make stuff happen." **DHB-IDI-021 Senior Administrative Manager**

Overall, then, inexperience in change management was reflected in the disengaging leadership practices reported from the time of commissioning across departments and units in DHB; these had consequences for supportive relationships and teamwork at the time of the study (see section 8.5).

Generally, the historical context had influences on collective leadership at each hospital, with further consequences for staff satisfaction and morale. On the one hand, the old history of DHA, its re-classification and leadership transitions engendered good relationships and teamwork that built collective leadership and was linked to enhanced staff satisfaction and morale. On the other hand, at DHB, was newly

commissioned and had a history of tensions between amalgamated staff and with the new CEO that, ultimately, hindered collective leadership and largely undermined staff satisfaction and morale.

8.3 Influences of bureaucratic rigidity and managerial hierarchies on leadership practices

In this section, I explain the insights generated from the cross-case analysis about how external bureaucratic rigidity, internal managerial hierarchy, and wider hospital power flows, as well as nursing management hierarchies impacted on collective leadership practices in the case study hospitals. The explanations, where applicable, will also show the possible influences on staff satisfaction and morale. The key comparisons, and similarities across hospitals, are outlined in **Table 8.5** and, subsequently, discussed.

Table 8.5: Summary table of key findings relevant to bureaucracy and managerial hierarchies at both hospitals

Feature	DHA	DHB
External policy and regulations	National and provincial public sector frameworks	
Budgetary uncertainty and HRM processes	Constrained by sub-structure and provincial regulations	
Centralisation/decentralisation	Decision-making at CEO and executive level	
Power structures	Hierarchical and fragmented but lateral amongst clinicians	
Nursing management hierarchies	Rigid but with some flexibility	More rigid and less flexible

8.3.1 External Bureaucratic context

The case study hospitals operate within the same public sector external context. As South Africa has a quasi-federal government system (see Chapter Five), the hospitals are formally managed by the Western Cape Provincial Department of Health but work within both provincial and national health and other public sector policy and regulatory frameworks.

Financial and human resource management in the public health sector are strongly influenced by national government policy frameworks and guidance provided by the national Treasury and the Department for Public Service Administration. The Public Finance Management Act, described in **Box 8.1** below, is an important example of

the overarching frameworks shaping hospital leadership. It seeks to ensure sound financial management for the successful implementation and sustainability of government programmes and projects in the South African public sector (Fourie, 2001). All government departments are also audited annually by the national Auditor General's office, which keeps a close watch on expenditure patterns and practices for accountability (RSA Auditor-General of South Africa, 2004).

Box 8.1: The Public Finance Management Act of 1999 (Source: Fourie, 2002; Fourie, 2001; RSA National Treasury, 1999)

The Public Finance Management Act (PFMA) is a 1999 Act of Parliament. The Act aims to regulate financial management in the national and provincial governments; to ensure that all revenue, expenditure, assets and liabilities of those governments are managed efficiently and effectively; to provide for the responsibilities of persons entrusted with financial management in those governments; and to provide for matters connected with them (RSA National Treasury, 1999). The reforms are formulated to regulate spending in the public sector by linking spending to outcomes (Fourie, 2001). According to the Act, financial decision-making in the public sector is decentralised down to managers of departments who are at the forefront of policy implementation and service delivery, but they are also held responsible (Fourie, 2002). If public managers overspend their approved budget, they are legally held liable and can be prosecuted and sent to jail. Compliance of PFMA is embodied in the staff performance management, where the responsibilities of the staff is outlined.

Provincial treasuries function in line with the National Treasury's planning, budgeting, and reporting guidelines (Roman, 2017). In addition, the provincial treasury is responsible for Annual Performance Plans, audited financial statements and public facilities that they submit to the office of the Auditor General of South Africa (AGSA. AGSA is an independent and constitutionally mandated to audit financial statements of national, provincial, and local governments. They also audit public health facilities in all the provinces. Some provinces devolve PFMA responsibility to managers at ward level using the cost centre approach and frontline staff blame PFMA for the challenges they face in the wards. However other provinces devolve the responsibility to the hospital management level (Deputy Director for Finance), and frontline staff are not conversant with the aim and functions of PFMA. Both DHA and DHB study cases only devolved PFMA responsibility at hospital management level.

Within the Western Cape provincial health system, there are also multiple levels of bureaucracy. The two case study hospitals report to a substructure of the provincial government's Metro District Health Services (DHS) structure (see Chapter Five for further details). The sub-structure co-ordinates and oversees the functioning of the hospitals and other facilities in their area and has its own leadership team that includes the district hospital CEO. This team reports to the Metro DHS office, being guided by it as well as by policy frameworks and policy directives developed by the provincial Department of Health.

A further feature of South African bureaucracy that influences the public health system is its public sector organisational practices - which are widely identified as

conservative, hierarchical, and rigid (Von Holdt & Murphy, 2007). Decision-making in this hierarchical bureaucracy is fragmented and dominated by command-and-control systems where leadership is strictly viewed as an administrative rather than strategic function. Across hospitals, the multiple layers of decision-making and regulatory influences within this bureaucratic environment were having direct impact both on hospital managers and on wider staff morale:

"*We are maintaining service levels while we follow the rules of the department of health. So, I think that is the first thing. When you are in a hospital, a lot of your goals are already set.*" **DHA-IDI-001 Senior Administrative Manager**

"The other issue about management is that there are lots of middle managers. So, you get [the CEO], then Dr W, X, Y and then Dr Z. That is the leadership line of the Western Cape, right. And the problem is, often the hospitals, like its maybe the CEO is under pressure around the decisions that are taken by the head office. The head office, the decisions they make will have huge impacts on patient care, but they don't interact with the patients, they don't speak to us." **DHA-IDI-002 Clinician**

The bureaucratic hierarchies directly influenced how staff felt about their work in both hospitals:

"I feel sometimes debilitated; I feel unmotivated because I feel that it is like you're running in circles. For the fact that there's lot of red tape, the DD must hear what the CEO say, and the CEO must hear what his person in the sub structure say." **DHB-IDI-006 Nursing Ward Manager**

Respondents referred to the substructure office, as *another bureaucratic layer* (**DHB-IDI-025**), working within a *rigid rules-driven approach* (**DHA-IDI-001**) that limited the decision-making ability of the hospitals' executive leadership. In both hospitals, although more strongly represented in DHB, concerns were expressed that critical decision-making processes were strongly controlled outside the hospital. For example, this respondent reflects on the external control over personnel expenditures:

"*There's what is called the APL, the APL is the actual personnel list. Now the actual personnel list is the actual number of posts you have at a facility and who determines this, it is not the CEO. The one who determines this is the chief financial officer and his team at head office, decisions are not made at district level because if they were made at district level there would be far less unhappiness because the CEO would be given an overall budget and told you manage the budget… The decision has already been made and then you as the CEO are told to implement and then how do*

you do that… and if you check most of the unhappiness, I would be surprised if you are going to talk to anyone who's not going to bring up staffing levels as a huge headache." **DHB-IDI-003 Clinician**

Although these processes (outlined in **Box 8.2**) were introduced by the provincial department of health to support cost containment and ensure alignment with the PFMA (**Box 8.1**), their rigid *rules-driven approach* was seen in both hospitals as having negative consequences.

Box 8.2: Decisions on hospital budget and HRM (see Chapter Five)

The hospital leadership can spend their personnel budget within the limits of the Approved Post List (APL) that is used to determine the number of posts and any additional staff. These bureaucratic mechanisms seek to monitor and regulate staffing expenditure in public hospitals, which has been a chronic problem in the South Africa. They are provincial mechanisms linked to the broader public sector reform of financial management (see Box 8.1). For instance, if the hospital leadership exceeds their budget for approved posts and agency staff for any particular month, they are not allowed to fill posts in that month. However, the processes are controlled by the provincial DoH office, and managed by the Establishment Control Committee (ECC). Permission is needed from ECC managers, in positions two levels above the CEO and hospital leadership, to advertise and replace vacant posts. At the beginning of each financial year provincial directorate office and the ECC negotiates with each facility the posts that can be afforded from the hospitals' budget and only uses this APL to hire personnel. The chief director makes the final decisions in the ECC. Personnel posts at DHA and DHB constitute more than 70% of their annual budgets.

The staff appointment delays that resulted were generally blamed on the hospitals' own management:

"And not just the previous financial year like I told you, the other thing was, the hospital, the government policy is that if you have a lady who is pregnant, they don't replace you. That is a policy, government policy. They retain the benefits, but they do not give a replacement body. This previous CEO was patient-centred, they understood the critical need of the service, and they gave us a replacement. The new CEO, there is someone who gave birth here; he has not given me a replacement, because the budget comes first. You understand? So, when the new CEO arrived, they knew that there were serious financial challenges. Without due consultation, he just went he arrived without being used to the hospital, in his first month he just cut staff." **DHA-IDI-002 Clinician**

"I can tell you that today, after so many times nagging and walking and going to HR, I eventually managed to get the signed job offer for the consultant where we did interview in January and this, we often lose the candidates because of some of the things the hospital could do faster, or some people are doing more according to the

rules. And my sub structure I think is very policy, very rigid and rules driven you know." **DHB-IDI-016 Clinician Manager**

Appointment delays were also seen as leading to staff shortages, high workload and low morale that had consequences for the delivery of care:

"There are barriers and then it dampens your morale. For example, take the posts, simple thing. One of the barriers is that when a post becomes vacant, there is now a new process where that post must go to ECC, so we must now wait for approval at the ECC to say yay, that post can be filled. So only after the ECC has approved, now that post can be advertised, that is a process, a period for that advertisement to run, 2 to 3 weeks, then it comes down, you must do your interviews, then you must do other checks, then you can do your selection, then the person can be appointed. In the meantime, the service must continue, nobody cares what's happening." **DHB-IDI-015 Senior Manager**

In DHB, these experiences also threw up barriers to collective leadership. First, they generated concerns about managerial transparency, with consequences for relationships:

"I sometimes feel like our leadership is not very transparent, there's not a lot of like honesty and we don't get a lot of feedback as to what's going on in the hospital, the processes and things like that. And I feel that sometimes that is undermining the role that we play, and they don't feel that it's important to tell the workers on the floor about you know different developments or changes and things like that." **DHB-IDI-019 Clinician**

Tensions about workload and quality of care, particularly at DHB, in turn led managers to withdraw and disengage from their staff because they did not know how to respond to their concerns:

"*You know it's difficult to actually go around and see the struggles of people in the ward, the staff fatigue, the frustration because they're not coping. But you are forced to cope within the ambit of the prescriptions given to you by head office… And there is just no recourse, there is nothing, everybody just shrugs their shoulders and say there is nothing we can do because we busy within financial, we function within financial constraints, that is all you hear, and you have just got to make it work. So that makes it exceptionally difficult because now I do not even feel like I want to go around to the wards coz I know what I am going to hear, and I know I don't have an answer."* **DHB-IDI-025 Mid-Level Administrative Manager**

The impact of these bureaucratic rigidities on staff morale were also compounded by budget challenges in both hospitals. Data presented in Chapters Six and Seven show that the hospital budget and expenditure fluctuated over time but fell in real terms in 2016/17 and 2017/18 (by -4.22% and -0.03%, respectively, in DHA and by -1.24% and -1.30% in DHB). The negative budget growth coincided with implementation of a new provincial strategy of reclassifying levels of care in district hospitals as part of its wider health system transformation (Western Cape Government DoH, 2007), and the generally reported unrealistic budgets.

Despite budget restrictions, both case study hospitals continued to provide a wider package of care than the standard specified for the district hospital level. Re-classified from a Level 3 hospital, DHA continued to provide a wider range of specialist care than expected of its new Level 2 hospital status, whilst DHB offered a wider package of care than expected for a Level 2 hospital because there is no Level 3 hospital serving its population. Respondents commonly referred to the provincial mantra, '*doing more with less*', to signal the hospitals' limited power and authority to make budget related decisions and considered both to have negative impacts on staff satisfaction and morale. As a DHB respondent noted:

"*You know one of the big problems that we've got now are these budget cuts. Because you know they keep on saying to us – we must do more with less. But you reach a point where you cannot, where you are kind of maxed out doing more with less and I think that we have maxed it out. I do not think that we can do much more with what we have got at the moment. And I think that we have reached that point and that is starting to become demoralising. You know we cannot burn people out… because then they are of no value to anybody. When people are burnt out, they are of no value to themselves, they're no value to their families and they're certainly no value to their patients because you can only give what you have and if you have nothing you can't give anything.*" **DHB-IDI-017 Clinician**

The effects were also felt in DHA and linked back to the command-and-control approach to leadership common within the wider bureaucracy:

"I can make an example, almost 2 years ago, we had to cut down on our nursing staff and our nurse manager took away 1 permanent member out of each ward to save the costs of the hospital. We overspent, we were in over-expenditure, he never consulted us but at the end of the day he just made that decision to say that this will be cut 1 down, this ward 1 down, we never had a say. There he acted in the interest of the

hospital budget, they had a budget to save you know, we were crying out for more staff here, he cut down whatever. But at the end of the day, we are here, this is now almost 2 years, but we work with that 1 less staff with the same number of patients and we survive. In the beginning the people were very despondent, very unhappy but we accepted it." **DHA-IDI-012 Nursing Ward Operation Manager**

Wider South African research supports these findings about the impact of external bureaucratic context on hospital experiences. Ethnographic work in the labour wards of two district hospitals illustrated how the PFMA (**Box 8.1**) impacted negatively on mid-level managers' interaction with their staff and on staff motivation and performance (Penn-Kekana, Loveday, Blaauw & Schneider, 2004). PHC-level research, meanwhile, has shown how rigid bureaucratic processes directly impact on lower-level leadership and staff experiences in the Western Cape. PHC facility managers were found to be reluctant to take decisions for fear of acting against bureaucratic rules (Gilson et al., 2014), and supervision was seen as an audit and checking process, rather than one of mentoring, because of the way centrally imposed quality audit processes are experienced in the health system (Cleary et al., 2018).

8.3.2 Structures and processes of power as internal hospital context

The hospitals' internal organograms show that critical decision-making power and positional authority resides in the CEO (see organograms in **Figure 6.2 and Figure 7.2**) and that there are fragmented and parallel leadership structures in administration, clinical, nursing and other support services (Doherty, 2014; Von Holdt & Murphy, 2007). Indeed, as defined in Box 8.3, power relations emerged as a critical element of hospital internal context (representing both tangible and intangible software, as discussed in Chapters Six and Seven) that influenced leadership practices and collective leadership in both hospitals. **Figure 8.2** illustrates the multiple sources of power exercised by different staff groups, as further defined in **Table 8.6.**

Box 8.3: Definition and understanding of power
Power is understood as the social influence of social agent(s) on another person(s) that brings change in their attitudes, behaviour or beliefs, using the work and personal resources available to her or him (Raven, 2008; French, Raven, & Cartwright, 1959). Power is exercised downward when senior staff influence lower level staff; upwards when lower level staff influence senior staff; and laterally when influence is across similar groups or levels of management (Yukl, 2006; Yukl & Falbe, 1991).

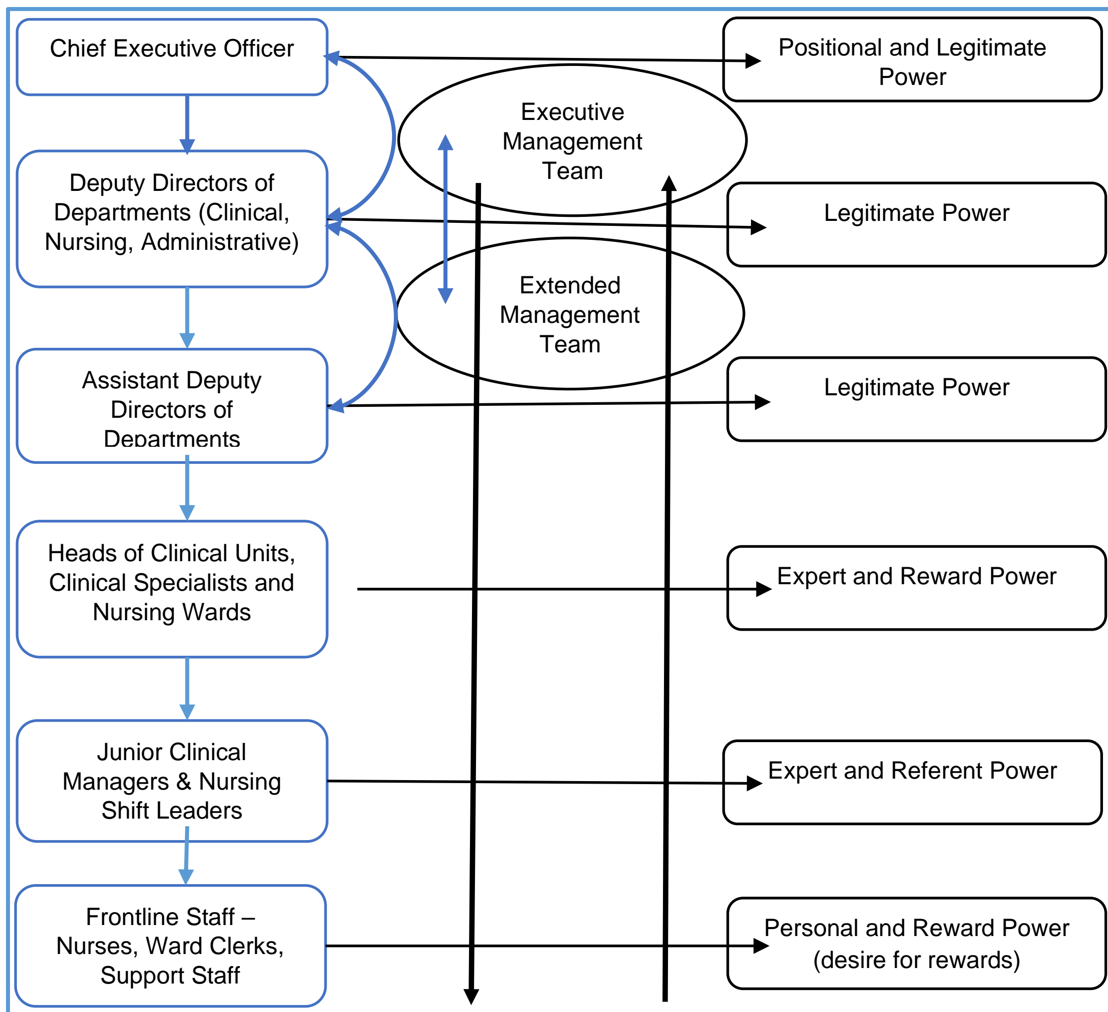


Figure 8.2*: Hospital power structure and hierarchy*

Note: The oval circles and the blue curving arrows show the relationship between the executive management and the extended management team. The Executive Management Team comprises of the Chief Executive Officer and the Deputy Directors of each department. The Extended Management Team includes some Assistant Deputy Directors. The black top-to-down and bottom-to-up black arrows shows the downward/upward direction of power. The blue downward arrows illustrate the management hierarchies from the CEO to the frontline staff. The black arrows from left to right demonstrate the sources of power for each level of management in the hierarchical structure.

The executive management teams exercised downward, or top-down, and legitimate or positional power associated with the formal hierarchical nature of the South African bureaucracy, giving them access and control of information over other staff. This managerial hierarchy worked against the delegation of leadership in several ways. Inadequate authority for leadership and problematic organisational structures have been reported in the South African health system (Doherty, 2014; Doherty & Gilson, 2011). Despite both CEOs' efforts to delegate some of their executive authority to their extended management teams, some members of these teams still felt that they were relatively powerless within the EMT:

"We serve on the exec but we're a voice around the table but we're not the executive voice if you know what I'm trying to say. It is like, what's that guy's name now on Animal Farm? George Orwell. So, all animals are equal, but some are more than others." **DHB-IDI-025 Middle Administrative Manager**

Table 8.6: Definitions of Sources of Power (Source: Raven, 2008; Yukl & Falbe, 1991; French, Raven, & Cartwright, 1959)

Source of Power	Definition
Downward Power	Influence, authority, and control of information by senior managers over middle and lower-level subordinates.
Expert Power	The use of knowledge or superior insight to influence the behaviour of subordinates or those who do not possess similar knowledge.
Lateral Power	Refers to power, influence, and flow of information across similar level of management or professional cadre.
Legitimate or Position Power	Refers to the right of the supervisor or manager to require a change in behaviour and the subordinate is obligated to comply. The subordinate must comply with the orders or requests of the manager who is in a superior position within a formal or informal social structure.
Personal Power	The ability of subordinates to perform roles as they wish to control the outcome of their actions without any influence from managers or superiors.
Referent Power	The ability of the subordinate to identify, model and emulate the behaviours their managers or others.
Reward Power	Ability of the manager to offer tangible rewards or incentives if the subordinate complies and perform their roles. The subordinate also willingly reports their compliance to their managers, and it generates a socially dependent change.
Upward Power	Refers to change in behaviour of frontline staff to gain supervisor or managerial support from middle or senior management

The authoritative practices associated with the exercise of top down or positional power, however legitimate, also undermined relationships with clinicians, as expressed in DHA:

"So often things, decisions get made up in some manager's office, but they actually have no clue about what is really going on the floor, and they often don't include people like myself or the rest of us who are actually working down on the ground in making decisions or choices about what would be best for the hospital or for patients. They do things autonomously because they are the managers, but we often feel that the decisions and choices they make affect us negatively and in turn also affect the patients negatively." **DHA-IDI-015 Clinician**

Indeed, clinicians in both hospitals commonly felt frustrated and demoralised by the exercise of hierarchical power:

“Most decisions have to be passed by upper management and that’s obviously where we often get problems. It’s very frustrating when they do not allow you to initiate the changes that you feel are necessary to improve the service.” **DHA-IDI-008 Clinician**

“They {senior management} cannot sit in their ivory towers, they need to get out of there, they need to be out here. Down there it is all very nice and pretty and it smells nice, and it looks pretty, and you know there is no blood, guts and vomit on their floor.” **DHB-IDI-004 Clinician**

Similarly, the power differences exacerbated the tensions generated by budgetary decisions – as suggested by a respondent in DHA:

“*There is a huge disconnect between management and physicians and clinical staff because management made financial decisions that had direct impact on patient care without consulting staff who look after patient.”* **DHA-IDI-008 Clinician**

Another form of power exercised within the hospitals, largely associated with implementation of the senior performance management (appraisal) system (SPMS), was reward power. Junior staff in both hospitals commonly associated these appraisals, that generated rewards, with non-participative and disengaging leadership practices (such as criticism, lack of adequate feedback, poor communication). They judged that this was due to the lack of adequate training of managers about these processes and how to fairly appraise and offer rewards. They also criticised senior managers for showing favouritism towards specific individuals:

“There are examples but for me like the one example would be staff performance management. It is a very touchy subject, and it is something very difficult for managers to do staff performance reviews. Sometimes some staff feel that every single year the same people get performance bonuses and the same people every year is always; they are just the stars. But what about me, I also really worked hard this year, but I am not getting no recognition because I know that Mrs A, B & C is getting the performance bonus. Staff will be like agh you know what, I do not even care, you guys can just do whatever, say what you want, I do not care, so they do not even like the system, they hate the system, they do not like being reviewed, they do not like feedback because maybe managers are not doing it correctly. And that is why the staff is like – agh I hate this.” **DHA-IDI-007 Middle Administrative Manager**

Similarly, at DHB:

"You know there's the thing that's the SPMS the performance bonus that they have. If you are not, if your operational manager does not like you or you are not a player like your operational manager wants you to be, you will not get SPMS, you understand what I am saying. So, it's the same within the levels." **DHB-IDI-018 Ward Administrative Clerk**

These experiences undermine the potential for collective leadership and led to staff reluctance to participate in performance appraisals, seeing them as '*time consuming compliance systems that did not motivate staff or improve patient care'* **(DHA-IDI-011 Senior Clinician)**.

Other research has also found that the lack of autonomy, lack of collective engagement and lack of collective appraisal during performance assessment led to frustration and subsequently low staff satisfaction and low morale amongst PHC managers in South Africa (Nxumalo, Goudge, Gilson, & Eyles, 2018), and for public sector managers in another sector in South Africa (Makhubela, Botha, & Swanepoel, 2016).

In DHB, frustration with the complex and fragmented top-down power structure and expert power differences between departments, units, wards, and cadres (especially between clinicians and nurses) further hindered collective leadership:

"Like I said, it is a very fragmented or cellular facility, so people tend to function in silos, and that silo is a kingdom and people want to protect their kingdom and their turf. So, the silo management exists in every department and there is not a forum for us to sit down with all the nurses, a sort of cross platform meeting." **DHB-IDI-003 Clinician**

However, at the same time and in contrast to the experiences reported so far, as identified in **Figure 8.2** and **Table 8.6,** the expressions of power observed in the hospitals also included the lateral exercise of power by clinicians, supporting the development of pockets of collective leadership in both hospitals:

"There's this thing about command gradients, you know where the bosses are up there, and the juniors are down here – we try and flatten that command gradient or what they call the power distance relationship. So, I work on first name terms with all my medical officers, but if they step out of line too much, I do not have a problem calling them back into line. But we work very much as a team, we work very much as a family, I think we get on, there is no significant inter-personal conflicts between the

medical officers themselves, or between me and any of them. They know exactly where they stand with me, I know where I stand with them." **DHB-IDI-017 Clinician**

"I don't want to be, I'm the boss you are the subordinate. But I do not also want to be one thing, the subordinates to think that they can walk over you. So, for me effective management is where you can be respected as the leader, but you can still be their friend. But when it comes to work you are still acknowledged and respected as the head of department. That for me is a great leader, where you can lead your department, you can speak to them as an equal, but they respect you and something that you say and identify as an aim, they will work with you to achieve that aim, rather than be disrespected and if you highlight one aim and they work against you." **DHA-IDI-003 Clinician**

Flattening the gradient was the term clinicians used to describe the lateral distribution of power amongst clinicians at different managerial and professional levels in both hospitals. The clinicians shared and delegated leadership practices, and this allowed them also to share expert information and to empower each other. They practiced their clinical roles with engagement and participation of junior clinicians when making clinical and resource sharing decisions in their units and hospital.

In both hospitals, informal *champion leaders* also demonstrated that lateral power may also be important in spreading collective leadership. Staff within and across departments, meanwhile, experienced lateral power when the engagement and participative leadership practices of senior and middle managers supported them to work independently without supervision and collectively together. These experiences were also linked to staff satisfaction and morale in both hospitals:

"I believe if you've got good management then they can spread that to your lower levels and that encourages the lower staff to fulfil certain gaps and give them necessary skills. I think that's a good thing." **DHB-IDI-013 Junior Administration Manager**

"You will find different levels of morale in different departments. It has much to do with the line manager in that department because you have a line manager who promotes good relations, and the morale of the ward is often dependent on the line manager in that area. With certain line managers encouraging a more open energetic atmosphere and certain are being more draconian in their approach." **DHA-IDI-001 Senior Administration Manager**

Finally, there were examples of the use of downward and reward power by middle managers towards lower-level staff which spread or distributed leadership to lower-level staff and in the process built collective leadership in both hospitals:

"You know when you are a leader, like I said in the beginning, you can filter down to your staff what you want them at the end need to portray about the department. If you have morals and you have rules and you have got structure – your department automatically becomes like that because you have standards and if it is on paper and signed and sealed, it's easier." **DHB-IDI-024 Clinician**

and in DHA:

"I think our main successes have been because of teamwork and acknowledging of the team. When I started here it was my priority in the first year to try and get a team of non-rotating staff as much as possible… the main thing was just actually just getting a team of, I called them extra milers, I would rather have a small team of people who go the extra mile than a lot of people. I cannot carry dead wood, if people aren't going to put in and go the extra mile they can go and work somewhere else, seriously." **DHA-IDI-011 Senior Clinician**

8.3.3 Nursing hierarchies

Managerial hierarchy in both hospitals was compounded by hierarchy within the nursing profession, which is itself anchored in key features of the history of professional nursing in South Africa (as summarised in **Box 8.4**). The rigid nursing hierarchies are reflected in the top-down practices of decision-making. Decision-making power lies with the deputy director for nursing in each hospital (formerly the Matron), who directly supervises the three area managers below them in each hospital's hierarchy.

Box 8.4: Nursing identity, hierarchies, and power (Source: Blaauw, Ditlopo, & Rispel, 2014; Rispel & Bruce, 2014; Joyner, Shefer, & Smit, 2014; Ditlopo, Blaauw, Rispel, Thomas, & Bidwell, 2013; Marks, 1997; Rispel & Schneider, 1991).

The rigid hierarchies in professional nursing in South Africa draw from the English 'lady nurses' model that viewed nurses as handmaids. The nursing profession was distinguished by the gender, racial, ethnic and class structures in the colonial and apartheid era. Nursing was considered as a semi-profession because nurses were not educated at the university level. Despite the enactment of the post-apartheid Nursing Act of 1994, professional nursing is still characterised by a colonial hospital mindset signified by structured roles, status, and behaviour that has eroded control and autonomy within the nursing profession, and resulted in tensions between nursing categories and clinicians, low pay compared to clinicians, and demoralisation.

Nursing professional identity developed in response to this history and the imbalance of privileges and prestige relative to the medical profession in hospitals. This imbalance defines current power relations between nurses and clinicians. The professionalisation of nursing in post-apartheid South Africa introduced formal code of ethics, professional associations, legislative governance and licensing, and re-classification of nursing training schools by linking them to universities.

The stratification of levels of nursing through nursing education reforms, the specialisation of nursing knowledge and the division of labour between nursing managers and frontline staff in the 2013 Framework for Nursing Qualifications in South Africa led to fragmentation of nursing practice that has further disempowered the frontline nursing staff.

The negative consequences of the professionalisation of nursing in South Africa include fragmentation of healthcare teams along professional lines; the requirement for a long 4-year degree training period that focus on theory and rigid specialisation process to qualify as a professional nurse; introduction of staff nurse with a 3-year diploma instead of an enrolled nurse with 2-year training and, poor relationships with other healthcare workers and patients. The bureaucratic rules and regulations from the National Department of Health, that focus on performance appraisals as audit measures and assessment of efficiency, and the Occupation Specific Dispensation remuneration policy introduced in 2007, has also minimised the authority and recognition of nurses in South Africa. These consequences have had negative impact in the provision of care in South African public hospitals.

Nursing ward operation managers answer to the area managers and have power and authority within the wards. Among ward nursing staff there is also hierarchy: from specialist registered nurses/midwives with one to two years of experience after training as registered nurses, to registered nurses/midwives trained for four years, then to enrolled nurses trained for two years, and finally to enrolled nursing assistants or auxiliaries trained for one year.

Within the nursing cadre, a failure to delegate reflected this hierarchical approach, as particularly noted in DHB:

"I must say my manager, [a senior nurse manager], *she is trying in a way, but one of her weaknesses is that she wants to do everything herself and that is something you can't do. You need to delegate and you as a leader need to see who is good in doing this, and give people portfolios and responsibilities, it will never be a success if you do it alone. She needs to delegate and that's something, shame, she is struggling with, to delegate and to say you do this, and really to be firm and say I want this feedback and I want that."* **DHB-IDI-014 Nursing Ward Operation Manager**

Other characteristics of nursing leadership practices across the hospitals included lack of visibility and being instructive. Senior nursing managers were rarely seen on the ward floor interacting with nurses or listening to their problems. Although nurses in DHB reported bi-monthly climate meetings with senior nurses, nurses in DHA suggested the lack of such meetings may have led to weak supervision and unfair allocation of roles - leadership practices that further undermined teamwork and quality of care.

"The thing is even if you've got a complaint there are no appropriate platforms where you can raise your complaint that can be taken into consideration and the CEO or whoever must act on it. And those people are learned people who know what is expected from them, it is a requirement in each and every hospital, this is the only hospital I have seen that they do not have those meetings, monthly meetings for different categories. There are meetings, they are called climate meeting for auxiliaries and enrolled nurses and if people are not doing that, when are the employees going to voice out their dissatisfactions?" **DHA-IDI-018 Nurse**

In DHB meanwhile, frontline nursing staff complained that their lack of engagement and participation in formulating a policy on transfer of patients between clinical units and wards, augmented by poor flow of information from nursing managers, made them feel '*unheard*' and reflected the '*uninspiring'* hierarchical sub-culture in nursing (**Field Notes**).

These sorts of authoritative and disengaging leadership practices not only undermined collective leadership within the nursing cadre in both hospitals but was identified by nursing and clinician respondents as generating low levels of staff morale, with possible consequences for the quality of nursing care. A clinician in DHA noted:

"I don't control nursing staff. The morale in nursing staff is extremely low, very poor. The challenge within nursing division is from top down, there's huge challenges with top management of nursing staff that is adversely affecting patient and nursing staff morale." **DHA-IDI-002 Clinician**

Similarly, in DHB:

"I honestly think that the nursing department is the department that's in most need of help, the way they are being managed, and their morale is low, it's going to affect all others, because they are central… if the nursing managers will be open to it and not

defensive, they need to take a magnifying glass and look what's happening inside the nursing department." **DHB-IDI-008 Clinician Manager**

However, despite the widespread negative experience of hierarchical practices in nursing, some individual nurses transcended rigid nursing professional structures to become *champions* who nurtured collective leadership. For example, *champion leaders,* as discussed in section 8.1, used professional nursing experience to interact with other staff, build trusting relations and practice participative and engaging leadership that enhanced the morale of the staff in the wards. These examples demonstrate an experience more commonly found among clinicians in both hospitals, where the flattening of the power gradient and differences was widely acknowledged and generated supportive relationships that also improved the morale of staff in the wards.

Other South African studies have also associated limited participation in decision-making by nurses with nursing hierarchies as well as poor hospital leadership and deterioration in quality of care, especially in rural district hospitals (Penn-Kekana, Loveday, Blaauw & Schneider, 2004). More broadly, a policy analysis study of nurses' participation in policy-making in South Africa has suggested that disengaging nursing leadership practices contributed to the lack of cohesion and lack of collective action amongst nurses when implementing new policies, leading to dissatisfaction and the intention to leave (Ditlopo et al., 2014).

8.4 Professional identities

As outlined in **Table 8.7**, professional identity underpinned professional or team subcultures within each cadre in each hospital, with consequences for collective leadership and staff morale.

Table 8.7: Comparison of intangible software in DHA and DHB (Source: Interviews, Field Notes)

	District Hospital A	**District Hospital B**
Clinicians	Identity reflected in flattened hierarchies & lateral power, enabling collective leadership within cadre	
Nurses	Identify reflected in rigid, professional hierarchies & power relations, limited collective leadership within cadre	
Administrators	Professional background and identity based on qualifications and experience in administration	
CEO	Professional background influences perceived professional identity with consequences for collective leadership within hospital	

Staff in the hospitals routinely referred to themselves and others by their cadres, for example, as administrators, clinicians, or nurses, suggesting that these distinctions mattered in these contexts. In addition, they also used the terms senior, middle, and junior to reflect different managerial levels - giving rise to managerial identities.

A profession is defined as an exclusive occupational group that controls and applies abstract knowledge to particular cases (Abbott, 1988). Professional identity is, therefore, a form of social identity (Hogg & van Knippenberg, 2003; Hogg, 2001; Turner et al., 1994) related to particular professional groups and that has consequences for collective leadership (Daire & Gilson, 2014; Baker & Denis, 2011). Professional identity enabled collective leadership where staff worked together with experiences of camaraderie that improved their satisfaction and morale (see Chapters Six and Seven). However, professional identity also generated tensions, within and between cadres, that undermined collective leadership and, potentially, undermined staff morale.

In South Africa, professional identities in clinical and nursing cadres are reinforced and regulated by their professional bodies respectively, Health Professional Council of South Africa (HPCSA), South Africa Medical Association (SAMA), South African Nursing Council (SANC). These external bodies establish rules and regulations that govern the two cadres, and which influenced the extent of cross-cadre relationships.

In the hospitals, clinicians' professional identity was primarily identified as based on their clinical skills. As a senior clinician in DHA noted:

"We are physicians, we know how to manage patients, but we don't know how to manage people and we don't know how to manage a department." **DHA-IDI-008 Clinician**

Indeed, some acknowledged their lack of managerial or leadership training and skills' limitations (such as in communication) relevant to collective leadership:

"I think one of the most important things that I've learnt in the last 8 years is that when I was trained to be a physician, nobody ever trained me to be a head of department and in fact I didn't have any of the skills required. After 2 years I realised I needed to get other skills – management skills, administrative skills, I need to learn how to email properly, how to communicate properly with higher management, with other managers and so I actually sent myself on a course, on advanced health management course, when I started, the first 2 years I never had a team." **DHA-IDI-008 Clinician**

However, their professional identity did provide the basis for working with other clinicians including, as previously discussed, using lateral power to flatten the gradient (see section 8.3). As noted in DHB:

"I think we as clinicians, colleagues, the senior clinicians, we are supportive of one another, the EC, the surgeons, the medicines, I'm not going to be hard on my senior colleagues, I'm going to understand their limitations, we're going to try and find solutions. So, as a senior clinician body we're supportive." **DHB-IDI-008 Clinician**

Nurses at both hospitals, meanwhile, judged that the provision of quality care strongly influenced their professional identity and occupational choice:

"*So, it is for me really, it's not how I chose the profession. I chose this profession because I wanted to do it, I wanted to render quality service."* **DHA-IDI-018 Nurse**

However, nursing professional identity in both hospitals also seemed underpinned by the rigid hierarchies and power relations of the nursing profession (see box 8.4) - which worked against the types of engaging and participative leadership practices that enable collective leadership. The requirement to follow the chain of nursing command, for example, was experienced as a challenge causing conflict for nurses lower down the chain in both hospitals.

"My problem is with the ward sister and then the nursing manager says he doesn't want to interfere about the way the ward sister is running the ward. I find that sometimes she is so unprofessional. It makes this ward always tense. We always get confrontational especially for someone who is vocal, I unfortunately, I am a very vocal person. So, it makes it, we've got a lot of confrontations and that ended up not being solved." **DHA-IDI-018 Ward Nurse**

"I didn't get support from my DDN, I didn't get support from my ASD, my area manager, I didn't get support from her also when I literally had to go and phone head office for advice and things and then, when I did go and followed and phoned people for advice and it came to my DDN's ears, she was so upset she called me in and she wanted to know – I said but how many times during this process have I tried to make appointment with her but she never, her clerk never came back to me and said okay, there's an appointment for this day, you can come and see me with regards to this issue. So, went I went out to get advice and to get assistance with this issue, she was upset." **DHB-IDI-014 Nursing Ward Operation Manager**

The history and rigid hierarchies in nursing (see section 8.3) also influenced relationships among nurses, especially in DHB:

"You can be friends but working time is working time. But for me if they are friends here but not outside, I have my own friends outside, but we call it a chommie chommie, this chommie chommie with your juniors during working hours is not right, you can be chommie outside, but working time is working time." **DHB-IDI-002 Nursing Ward Shift Leader**

Within the administrative cadre, meanwhile, professional identity seemed to be projected through formal, academic qualifications in management. This aspect of professional identity surfaced in both hospitals and reinforced by job promotion criteria, appeared to be a cause of low morale amongst mid-level administrative staff:

"According to our minimum requirements, you need to have a degree to become a DD. If I do not go study, I will stay as the assistant director even though I have 50 years of experience. And that is just one of the negative things that negatively impacts me because I am sitting with the experience and the knowledge to do the work, but I can't get the position because of the paperwork that is the barrier." **DHB-IDI-020 Mid-Level Administrative Manager**

The final feature of professional identity revealed by the cross-case analysis is how the professional background of senior managers impacted on how they were perceived by other cadres, with consequences for collective working and decisions at the extended management team level. The specific professional backgrounds, a reflection of professional identity, of the CEOs influenced attitudes towards them, the person with overall authority in the hospitals. At DHA, the clinical training (and professional identity) of the CEO, rather than an additional managerial qualification, led staff both to accept him and have confidence in him as 'the CEO'.

As the following quotes illustrate, staff commonly acknowledge him as a doctor whilst also recognising his wider leadership skills:

"We got a new CEO and a new nursing manager at the same time two years ago; it was quite something. And suddenly, lots of changes, and that is a big thing. And we all know, I think all of us have had enough time with Dr [CEO] to realize that his decisions and his leadership models, etcetera are based on sound practice, and I think we've all learnt that and so there's a trust that's developed." **DHA-IDI-011 Senior Clinician**

Indeed, his clinical background seemed to be experienced as conferring approachable, empowering, and empathetic leadership practices that seem likely to have entrenched collective leadership:

"There is lots of opportunity, we have excellent leaders here Dr [CEO] is an excellent leader, [Nursing Manager] also, they motivate us all the time, we get recognition all the time… Dr [CEO], I must take my hat off for doctor, he always comes in the morning when we have a handover meeting, the night staff, the night matrons with the day matrons, then he will join up in that meeting and whenever that handover is done, doctor will pick up maybe, anything and then he will talk about it and he will give us a lesson for that and that is what I like about him. And I can listen for hours to him, a lot of things of what doctor says I actually practice it and you take a thing from doctor, and it inspires you." **DHA-IDI-012 Nursing Ward Operation Manager**

In contrast, at DHB, the non-health professional background and identity of the CEO was judged as problematic for the position, and as an impediment to his authority and decisions on clinical and nursing matters. This led to a lack of confidence in the CEO's ability to bring staff from different cadres together and was itself likely to undermine collective leadership:

"I think if the CEO of the hospital was a doctor, the reason why I'm saying that is because he cannot fully make the final decision based on his experience, there is a second person who is the doctor who is making the final decision and the CEO cannot dispute or cannot say anything because he doesn't have enough knowledge about the hospital situation, he is not a doctor or a professional nurse." **DHB-IDI-012 Nursing Ward Operation Manager**

"One main thing is our CEO, he is more of a businessperson, as much as he is a businessperson, he is not even doing the business function properly, the way he's supposed to. Clinically I would really, in your research, put it, that we want doctors to run the hospitals, that knows why I need certain things, why cannot I allow certain things, we need medical officers to run the hospital and, ja we need medical people, to run the hospitals. He does not have a cooking clue of what is really happening. As much as he tries to understand he cannot relate with our cries, because if we say we need extra nurse because of this and that, he won't be able to go and fight for us there in the head office because he doesn't really have a clue the reason why we need to do 3 hour turns." **DHB-IDI-014 Nursing Ward Operation Manager**

Indeed, most senior clinicians at DHB felt disconnected from the CEO as he lacked clinical experience and knowledge:

"*I think from the senior clinician's perspective it's difficult to have a CEO who's not a doctor. He's not a medical person, he doesn't always understand the importance of things.*" **DHB-IDI-023 Clinician**

"I think that the CEO is probably a good administrator. But he is not a clinician, and one cannot hold that against him, but the problem is there is a huge disconnect between the CEO and the people on the clinical floor, the nurses and the doctors and that sort of thing." **DHB-IDI-017 Clinician**

8.5 Cross-professional relationships in the hospitals

Across the two hospitals, staff worked within teams and units, or in work groups within and sometimes across hospital departments. These heterogenous groups are comprised of people with different occupational spheres of expert power based on their professional qualifications or backgrounds, who nonetheless work together.

Cross-case analysis supported understanding of the nature of these cross-professional relationships and the factors influencing them, as summarised in **Table 8.8**. Overall, there seemed to be a greater depth of cross-professional working, a critical form of collective leadership in hospital settings, in DHA, compared with DHB - although there were some positive cross-professional experiences in DHB.

Table 8.8: Comparison of the factors influencing cross-professional relationships between DHA and DHB (Source: Interview data and Field Notes)

District Hospital A	District Hospital B
Relationships enhanced by close physical proximity and small size of hospital	Relationships hindered by large physical design of hospital
Staff complement working together for long period	Staff complement amalgamated mix from different facilities at commissioning
Positive '*Family-like*' relationships, togetherness, and teamworking	Silo and fragmented relationships and less teamworking, especially in nursing
Professional power differences less prominent	Professional power differences more prominent
Better communication processes associated with camaraderie and togetherness	Poor communication and information flow linked to fragmentation

The experience of cross-cadre relationships within DHA, and its consequences for patient care, was explained by one nursing respondent who compared DHA with experience in another hospital:

"We've got exceptionally good relationship because even doctors from other hospitals say DHA feels like home because there is a relationship between nurses and doctors. So, we work with our doctors, we work like this, we are a small family. So, for me I did not see what they were saying because I did not work in the wards at XXX Hospital where a doctor is a doctor but according to the people, they say a doctor is a doctor at XXX Hospital, a nurse is a nurse. But for me, I did not experience it because we are human beings, we are colleagues. We are working together because you are a doctor, I am a nurse but what is our goal? Our goal is to make the patient get better. We are here for the patient, that's all." **DHA-IDI-009 Nursing Ward Operation Manager**

Good relationships with colleagues were also illustrated by administrative staff who described their relationships with clinicians, nurses, and other administrative staff:

"*Our ability to work as a great team, we motivate each other and, we've got that good relationship with one another."* (**DHA-IDI-006 Mid-Level Administrative Manager**),

"Well, I love to work here, it's very nice and I mean the people, they are very co-operative, and we respect each other man. So, for me that is important you know, we do have respect for each other yes and it is basically also how you treat people. If you treat people, the way you wanted to be treated then you will get respect from them and for me that is very important." **DHA-IDI-006 Administrative Clerks Supervisor**

In contrast in DHB, poor cross-professional relationships across levels of management were associated with the experience of authoritative and disengaging leadership practices. There was distrust of senior leadership who were seen to be managing rivalries rather than building better relationships between staff and mending the fragmentation between clinicians and nurses.

Although, in some units and wards, good teamwork and relationships was acknowledged despite the silos. Staff argued that the collective performance of both clinicians and nurses in work teams was critical for the overall performance of the hospital:

"You know we have such a good relationship that we actually work together and then we decide what needs to be done and then she takes it forward if you can understand. So, I mean we, people do not like speaking to us together because we come forward as a very unified front which is a good thing. I think you need teamwork in any institute and particularly when you face challenges and historically, the majority of our staff

have actually come from [OLD HOSPITAL] so we were all kind of in it together." **DHB-IDI-004 Clinician**

As explained further below, four key factors appeared to explain the differences between hospitals in cross-professional working: hospital histories of staff relationships; hospital size; organisational arrangements and the exercise of clinician power; and the experience of communication and leadership.

For DHA, it seemed that the hospital's history of stable staffing (see Chapter Six and section 8.2), with staff working together for prolonged periods was critical in enabling strong cross-professional relationships. The sense of a long-established *family feeling* was widespread within the hospital:

"DHA is a very good hospital to work at, we care about each other, we care about our colleagues, that is what I pick up here." **DHA-IDI-012 Nursing Ward Operation Manager**

"There is a family feeling in the hospital, in the sense of camaraderie, a culture that has developed over a long period of time." **DHA-IDI-002 Clinician**

The sense of *camaraderie* referred to the friendly work environment with good interactions among different groups of staff. The camaraderie was especially strong among clinicians who had *good feelings* about working at the hospital due to the *generally good* relations amongst them, which made them feel like they were not working on their own – and allowed collective leadership:

"What I enjoy in our department is that we all understand each other very well. We get along very well, and everything is patient centred... the camaraderie, the close-knit relationship between various departments is one that you do not often find at any hospital this size or bigger. For me that is a big plus about working here, it's really something you don't find often elsewhere." **DHA-IDI-015 Clinician**

Clinicians in DHA also attributed teamworking in wards and units to trustworthy relationships, shared roles, strengthened through collective activities:

"Where we work as a team is that we get everybody to go the extra mile, because they feel part of something special, you understand that. So, people generally work long full days, but they do not complain, they are happy because they are only here for a certain time period. Then what I do to facilitate that, we will support them as best as we can. Like we will have monthly socials outside the hospital for team building,

monthly team building activities, with various academic activities." **DHA-IDI-002 Clinician**

In DHB, by contrast, the history of amalgamating staff from the older decommissioned hospital and other facilities within the Cape Metro district, had a continuing impact on relationships. At the time, contractual disputes arose between clinicians, nurses and the hospital's leadership compromised cross-cadre and cross-managerial relationships to such an extent that labour unions and the respective professional bodies had to be involved in dispute resolution processes:

"And there was a lot of upset, there was a lot of ugly stuff, SAMA got involved so it was trade union representatives, there was a lot of conflicts, a lot of stress, a lot of negativity which was a struggle, but we are over that hurdle now. It was threatening to go to court and the CCMA, and it got really ugly and then the management here kind of backed down you know and said well okay, kind of do it, do it your way sort of thing." **DHB-IDI-004**

This history created an environment of tensions, and undermined collective leadership in the new hospital:

"When we landed here, the [old hospital] group is the biggest group, the other one from [Place X] is a smaller group but the [Place X] ones claim ownership of this place, its ours, we might be three but it's ours. You are 200, or what, do not bring your [old hospital] nonsense here – that kind of thing. There is you against us, they still have that problem now." **DHB-IDI-003 Clinician**

Whereas staff at DHA generally felt open with each other, relationships at DHB were riddled with animosity, rivalries, and distrust between staff (clinicians and nurses) from the decommissioned hospital and those who were newly employed at DHB.

"So, doctors felt done in and lied to because they were told this would be cut and paste from [Old Hospital] but this this hospital is not the same as [Old Hospital]. So, your senior people were angry about issues, the junior people were angry about other issues. And then also to understand that some of the people do not want to work here because many people felt, as you are fully aware, any change is a stressful time, who will be my new boss, where will be my office, will I have this, where will I park my care, blah, blah, blah, so just the fear of change is also a big contributing factor." **DHB-IDI-021 Senior Administrative Manager**

"The problem is, I know we inherited some disastrous nursing managers from [old hospital], disastrous and they're still here, they've come over and they are part of the legacy and they've brought their poison with them." **DHB-IDI-017 Clinician**

Even where some camaraderie was evident, its importance in the face of the wider context of difficult relationships was emphasised:

"So, you know there is a lot of camaraderie and I like that. When we are all feeling low, we all feel low together and when we all feel good and there is something good to celebrate, we all feel good together. And that is nice, I do enjoy that. And you know we really can look beyond; you know management is not to blame for everything. When there is a farewell happening, they will come to the party and wish people well, and then you really feel like a team because someone gives a speech and they remind you of how far you have come together even if you were fighting, it is good to do that, it's actually good." **DHB-IDI-004 Clinician**

Physical size was another factor of the structural hardware influencing differences in cross-professional working at the two hospitals. The small size of DHA allows cooperation, mutual respect, communication, and good understanding when resolving problems between colleagues, consultants, medical officers, and nursing staff.

"Yeah, good relations for example there is like a communal tearoom. Everybody meets up in the tearoom, amongst colleagues, amongst consultants, amongst colleagues and MOs, there is a very good relationship, amongst the doctors and the nursing staff generally there are good relations and good communication." **DHA-IDI-002 Clinician**

However, the physically large design of DHB isolated departments and units from each other, which limited the ability to develop cross-unit working and collective leadership:

"And I feel sometimes that maybe all departments are quite isolated from one another, and we don't often kind of mix and the opportunity to function as a whole. I think everyone is working quite independently from each other at the moment." **DHB-IDI-019 Clinician**

DHB is a '*much bigger, busier and more complex hospital*' (**DHB-IDI-023**) than DHA, making it difficult for direct engagement and collective leadership across the levels of management and frontline staff:

"This hospital is so big, in [Old Hospital] if I wanted to manage somebody in the trauma I would walk and take 5 steps and I'm in trauma. With this building it is so big, and it is so fragmented, for me to come to you I must really make a big effort to walk to you, and what is happening is that sometimes people do not want to make the effort for that change or for that person, do you get what I am saying. I don't know if it makes sense to you man, I mean that's where I find the hospital, it's a lovely building but look at the passages, it's so big." **DHB-IDI-011 Clinician**

Organisational silos and professional identities only exacerbated the barriers to cross-professional work, especially in DHB. Loyalties to professional groups and work teams led to '*working in silos*' in the clinical, nursing, and administrative cadres. The silos were commonly experienced as ensuring *fragmented relationships*, undermining collective leadership, and contributed to low morale amongst some staff. Good working relationships in wards were not necessarily reflected higher up in management:

"I think we get on with the nurses in the ward, but if we are in the senior clinician's meeting complaining about the nurses, it's not easy for us to just address a nursing issue directly because [Senior Nursing Manager] will get very defensive." **DHB-IDI-023 Clinician**

Such tensions were experienced in both hospitals because of clinicians exercising their expert power (see section 8.3 and 8.4) in making decisions and instructing nurses on patient care. Clinicians sometimes showed dismissive attitudes towards nurses leading to nurses' reluctance to co-operate or collaborate with them:

"I mean nursing, but that's why I say, nursing traditionally is like that, and we must understand it and there're certain challenges that nursing has that medicine, doctors don't have, and one must understand that as well." **DHA-IDI-011 Senior Clinician**

Nurses also, as reported particularly in DHB, sometimes resisted clinical authority as they felt that their profession was equally legitimate in the hospital:

"We have found that nurses feel very reluctant to convey certain concerns to doctors because they feel that doctors don't value their opinion and don't value them coming and saying I've done this ECG or their concerns about a patient, they would just be shrugged off." **DHB-IDI-007 Nursing Ward Manager**

Across hospitals, therefore, professional identity and professional power differences between clinicians and nurses constrained the possibility of cross-professional

relationships and the ability to engender collective leadership amongst cadres, including the administrative staff:

"There are times when the doctors come in here and then the doctors make you feel like you're inferior towards them and, it's just an eye opener for you to know what's going on in the other departments also and for them to know what's going on there. So then at one or other stage we have to meet each other, we just can't just blame and shame every time." **DHB-IDI-005 Middle-level Administrative Manager**

However, in DHA clear efforts were also made to minimise professional differences and promote collective practices by encouraging better information flow through formal weekly, monthly & bi-monthly transversal meetings between the heads of clinical, nursing, and administrative units (**Field Notes**). The value was illustrated by a nursing manager:

"And I don't have issues coz once you build up a team and everybody know exactly what they are and you have contented workers, you don't have confused people and you give direct and clear guidance and I actually hold meetings at night, it is a staff of 9 and the doctors are invited, the porters are invited, you know and that is my one biggest thing is that I make sure that I am approachable." **DHA-IDI-017 Nursing Area Manager**

Professional differences were also minimised through strong communication practices including unit communication books and night diaries that supported the daily handover meetings from night to day duty managers across the administrative, clinical, and nursing cadres. Transversal managerial meetings between heads of departments (**Field Notes** - researcher attended most of these meetings) were important, and respondents stated that the new CEO encouraged positive communication practices, such as an open-door policy, that brought the heads of clinical, nursing, and administrative units together. These communication practices increased approachability and engagement between and amongst staff to improve cross-professional relationships for collective leadership.

From a leadership perspective, moreover, the deliberate appointment of new managers in some units, by the new executive team (see Chapter Six and section 8.2), also supported the creation of an environment that nurtured collective leadership in DHA:

"If your managers are good leaders and they are setting goals and they motivate the staff and they try to do their best then everyone else wants to do the same there's like

a standard, like you know you set the examples, everybody wants to follow or wants to you know, be the best they can be." **DHA-IDI-007 Senior Administrative Supervisor HR**

Overall, then, a clinician noted:

"We work together really well. There is no hierarchy or organogram. We are all on the same level, whether you are CEO of the hospital, whether you are a cleaner of the hospital, we are all the same level, we eat together, we pray together. So those are the reasons I chose not to leave… It is a very safe stable environment. The people that work at DHA are all passionate and driven towards the same goals. No one is out to get you, no one is competing against you. We all work together for the patients' sake" **DHA-IDI-003**

Communication practices like those of DHA were also observed in DHB. For example, morning *huddle meetings* in some of the units supported cross-professional working, and there were signs of efforts to communicate widely through open door policy, town hall meetings, climate meetings, and internal memos. However, there were no formal regular transversal meetings between the two main occupational groups, reflecting professional differences in DHB:

"Nursing operation managers need to work with the doctors. There is this absolute blank, they do not want to work with the doctors, so the doctors do not get invited to their meetings. The nurses have their own meetings, the doctors have their own meetings and then this one may read the minutes from that one's meeting and that one may read the minutes from this one's meeting, but you cannot work with that. You know you are working in a department where there are patients on the floor, doctors are treating the same patients, nurses are managing the same patients, but you are having two separate meetings – why? It's stupid, we really – at [Old Hospital] I must say, we had combined meetings, I don't know what changed here, but something has changed that has prevented those meetings from actually joining each other and each one wants to tell the other one what to do and then I think professional rank does play a role in it, nobody likes being told what to do." **DHB-IDI-004 Clinician**

Senior leadership in DHB was also perceived to have neglected cross-professional relationships and staff integration during the commissioning of the new hospital, with consequences for the present time:

"But I think one of the biggest frustrations was the animosity that developed between the medical officers and the management structure, and the distrust and that legacy of distrust is still there." **DHB-IDI-017 Clinician**

Poor communication and information flow subsequently exacerbated the fragmentation between senior leadership and other staff:

"They are paying the price because there's that disconnect between management and staff, there's a huge disconnect, people might refuse to see it, but it is a huge gulf that's getting bigger and bigger every day. It's us and them, middle management don't see themselves as part of the management of the hospital they think it's too insulting, because when they criticise the management, they are not talking about themselves." **DHB-IDI-025 Mid-Level Administrative Manager**

"I do feel the sense of camaraderie is a bit low but it's because of the gap between management and people on the ground." **DHB-IDI-024 Clinician**

"There's no interaction with people on the ground, they shy away from interacting with people you know, and they throw policies at staff left, right and centre and think that that's the answer." **DHB-IDI-011 Clinician**

In conclusion, and as illustrated in **Figure 8.1**, the evidence shows that the differences in cross-professional relationships were underpinned by the hospital size and physical design (*hardware*) whereby the small size and design, and a history (*external context*) of working together for long periods enhanced positive relationships in DHA. These positive relationships were strengthened by better communication and information flow (*intangible software*) that limited the power and professional differences (*tangible software*); factors that promoted as a sense of collective leadership in DHA. In contrast, the large physical design (*hardware*) and the amalgamated mix of staff from the decommissioned and other hospitals (*external context*) generated silos and fragmented relationships in DHB. The silos and fragmented relationships, especially in nursing, were also associated with the prominent power and professional differences (*tangible software*) and poor communication or information flow (*intangible software*) that limited opportunities for collective leadership in DHB.

8.6 Chapter Summary

The analysis presented in this chapter highlights the organisational dynamics of hospitals as HCOs. The interacting features highlighted include leadership practices; historical background of the hospitals; bureaucratic and managerial hierarchies and,

the accompanying organisational processes; and professional cultures that influence professional identities and cross-professional relationships amongst the diverse range of professional and occupational groups in the hospitals. The findings also revealed that these features are embedded in the social context of the hospitals.

The cross-case analysis specifically highlighted the role of context in enhancing or undermining collective leadership practices, with possible consequences for staff satisfaction and morale. First, positive, and negative leadership practices were identified that enabled or hindered collective leadership, respectively, and had consequences for staff satisfaction and morale. Second, the external context – socially enacted through bureaucratic rigidity, leadership transitions, and hospital histories – influenced the leadership practices that engender or hinder collective leadership. The interview data also show that this external context directly influenced internal context and may have direct consequences over staff satisfaction and morale in both hospitals. Third, the internal context is characterised by hardware, tangible software, and intangible software features that have a recursive association with leadership practices, have further implications for collective leadership; and may also have consequences for staff satisfaction and morale.

These insights are carried forward into the discussion chapter, and discussed in relation to wider, existing empirical evidence and related theory, to illustrate their significance. The discussion chapter also makes policy suggestions on how to nurture collective leadership, including relevant approaches to leadership development.

Chapter 9: Discussion; Policy and Research Implications, Study Limitations and Directions for Future Research

9.0 Introduction

This thesis has examined the interplay between healthcare organisational (HCO) context, leadership practices and staff satisfaction and morale - as an indicator of leadership effectiveness - in two public, district hospitals in the Western Cape province, South Africa. Ultimately, I wanted to generate policy-relevant ideas about how to strengthen district hospital leadership in ways that strengthen staff satisfaction and morale and contribute to quality care and improved service delivery.

The findings presented in Chapters Six and Seven illuminated each case study hospital's experience of leadership practices, their possible consequences for staff satisfaction and morale as indicators of leadership effectiveness, and the features of organisational context which influenced, and were influenced, by them. The cross-case analysis, Chapter Eight, then drew out commonalities and differences in the two hospitals' experiences. It illuminated the similarities in leadership practices across hospitals and considered which nurtured or constrained the emergence of collective leadership in the hospitals, and how. It highlighted, in particular, the influences of hospital histories, external bureaucratic forces, internal power dynamics and professional identity over the potential for collective leadership – with a particular focus on cross-professional engagement.

This chapter considers, first, this study's particular knowledge contributions. Second, it considers the policy implications of the analysis presented in the thesis. Third, the study limitations are outlined before, finally, presenting the directions for future research.

9.1 Hospital context and leadership practices

9.1.1 Overall experience

My initial conceptual framework (Chapter Three) emphasised the potentially important mediating influence of hospital context over collective leadership, as well as staff satisfaction and morale. As summarised in the revised framework presented in Chapter Eight (**Figure 8.1**), the empirical findings confirmed and deepened understanding of this influence.

First, the findings show a complex interplay among contextual factors within each hospital. Their histories, including past leadership turnover, and wider bureaucratic rigidity (external contextual factors), shaped the hospitals' internal managerial and clinical power structures, professional identities, and cross-professional relationships (internal contextual factors). In both hospitals, for example, the past history of inter-personal relationships and leadership continued to influence staff relationships at the time of the study - working to support relationships in DHA but constraining them in DHB. At the same time, hospital hardware features impacted on hospital software dimensions. The smaller physical footprint of the older DHA encouraged close working relationships, for example, as did the layout of particular wards in the new DHB. In both hospitals, however, the organisational structures (a hardware factor) reinforced various sets of power and professional divides (software factors) - managerial hierarchies, professional power dynamics between clinicians and nurses and hierarchies within nursing – that worked to undermine relationships. Various contextual influences are considered further in section 9.1.2 and 9.4.

Second, these interactions among contextual factors, thus, provided leadership opportunities and challenges in the hospitals, including in terms of the potential for collective leadership to emerge. For example, long-established and close working relationships in both hospitals, but particularly in DHA, provided a foundation of collective leadership that was in some instances further nurtured and encouraged both through other features of internal context (such as physical space) and through what, in this study, I have called positive leadership practices. These practices were also experienced as impacting positively on staff satisfaction and morale. However, tensions and divides in both hospitals, but particularly DHB, undermined collective leadership opportunities and were sometimes driven by leadership practices rooted in, for example, pre-existing hierarchies or hospital histories. These practices were experienced as impacting negatively on staff satisfaction and morale. At the same time, these tensions and divides were also sometimes offset through positive leadership practices, those experienced as participative, empowering, or engaging and that directly nurtured collective leadership and enhanced staff satisfaction and morale. This recursive relationship between context and collective leadership is discussed further in section 9.2.

These findings make an important contribution to the wider empirical literature in illuminating the complex dynamics of these hospitals as health care organisations. Although the lens of complex adaptive systems has gained some traction in health

system research in LMICs (Peters, 2014; Adam & de Savigny, 2012), very few studies have examined specific organisational environments in ways that illuminate this complexity. Perhaps the most relevant study examined Kenyan district hospitals. Reflecting the current study, inadequate financing, limited hospital autonomy and decision-making ability, and ineffective leadership were highlighted as features of these hospitals' organisational dynamics (Barasa et al., 2017). The hardware/software interactions among internal contextual features have, however, been explicitly considered in a few LMIC studies (Roman, 2017; Topp, Chipukuma, & Hanefeld, 2015). For example, work at district level in Kenya and South Africa has examined hardware/software interactions in considering the 'everyday resilience' and, as with my study, has demonstrated software-leadership interactions as an important organisational dynamic within health system settings (Gilson, Elloker, Lehmann, & Brady, 2020; Waithaka et al., 2020; Gilson et al., 2017). But for the most part, the LMIC literature on complex adaptive systems has considered specific health programmes in relation to the wider health system - for example, community health workers (Kok et al., 2017), maternity care (Asefa, McPake, Langer, Bohren, & Morgan, 2020), neonatal mortality problems (Rwashana, Nakubulwa, Nakakeeto-Kijjambu, & Adam, 2014) or health policy change (Agyepong, Kodua, Adjei, & Adam, 2012), rather than, as in this study, organisational settings.

The LMIC literature considering hospital leadership has also rarely recognised the complex dynamics of the organisational environment. A recent scoping review, thus, concluded that there is very little empirical health system literature on leadership in complex organisations (Belrhiti et al., 2018). A few studies have pointed to specific aspects of organisational context that influence leadership – such as governance structures (Aseweh Abor et al., 2008) or hierarchical leadership styles (Fillol, Lohmann, Turcotte-Tremblay, Some, & Ridde 2019). The studies perhaps most similar to mine also illustrate, for example, how culture, norms and structures constrained leadership practice and underpinned the power dynamics impacting on clinical leadership and interprofessional relationships in Kenyan hospitals (Nzinga et al., 2018). Others show how leadership influences staff satisfaction – of nurses in Brazil (Araujo & Figueiredo, 2019) and –considering how distributing leadership supports communication flow and staff interactions - on public service motivation in Moroccan hospitals (Belrhiti et al., 2020). However, within the available literature the interplay between organisational context, leadership practices and organisational

outcomes such as staff satisfaction and morale is generally inadequately examined (Belrhiti et al, 2018).

9.1.2 Context and cross-professional relationships

A particularly important set of insights generated in the current study focus specifically on how internal contextual factors impact on cross-professional relationships within hospitals. In essence, as more widely recognised, hospitals are social environments within which stratified and diverse professional groups must co-operate and work together to provide health care (Nzinga et al., 2018; Daire & Gilson, 2014; ten Hoeve, Jansen, & Roodbol, 2014; Willetts & Clarke, 2014). This study shows the particular importance of professional culture, itself linked to the professional identities of different occupational groups, as a feature of hospital context that influences the development of collective leadership across cadres.

In both hospitals, the professional identity of clinicians was founded on their clinical expertise and this, in turn, provided a foundation for the development of collective leadership *within* this cadre. However, differences in professional knowledge and expertise tended to undermine cross-professional relationships between clinicians and nurses and so, especially in DHB, limited the development of cross-cadre forms of collective leadership. These findings add to the existing South African (Daire & Gilson, 2014) and HIC research (Berghout et al., 2017; Fitzgerald et al., 2013; Baker & Denis, 2011) that has pointed to the role of professional identity in shaping health leadership practices. They also confirm other South African research that has specifically shown that nursing professionals in public hospitals lack clinical autonomy and plan and manage their services based on expert clinical opinions (Joyner, Shefer, & Smit, 2014; Marks, 1997; Rispel & Schneider, 1991).

Some wider LMIC experience has, meanwhile, shown that clinician dominance has sometimes generated conflict and discouraged engagement between clinicians and nurses (Lahana et al., 2019; Nzinga et al., 2018; Hendel, Fish, & Berger, 2007). Wider HIC experience and theory suggests, moreover, that occupational and professional divisions are likely anchored in the institutions that regulate qualifications and membership of these occupations (for example, ten Hoeve et al., 2014; Willetts & Clarke, 2014; Finn, Learmonth, & Reedy, 2010; Finn, 2008). The theory of professionalism explicitly considers how professional expertise shapes identity, confers professional power and creates power distances that could undermine collective leadership by limiting the sharing and distribution of knowledge and expertise between different occupational groups (Abbott, 1988).

Nonetheless, staff in DHA, specifically, tended to see themselves as working collectively, across cadres, towards the common goal of providing patient-centred care. In DHB, meanwhile, the historical legacy of moving different sets of staff into one hospital, rather than professional power, underpinned an important set of identities (staff who came from the decommissioned hospital and those who did not) that generated tensions and undermined collective leadership. These contrasting experiences signal, then, how collective identities influence collective leadership. They add to wider literature that has shown, for example, and in contrast to DHB, how a history of amalgamation and good relationships can generate collective leadership (Fitzgerald et al., 2013; Denis et al., 2001). Wider work also suggests that collective identity may enhance collective leadership, for example, by allowing workers to learn about each other's behaviour through formal and informal engagements (Hiller et al., 2006) or by seeing teammates as sources of leadership (Chrobot-Mason, Gerbasi, & Cullen-Lester, 2016) – further showing the recursive relationship between context and leadership.

The experience of DHB also highlights the limits on cross-cadre working generated by professional silos, as a key driver of staff fragmentation. As found in this study, some HIC studies suggest that senior clinicians are more loyal to their profession than to public hospitals (Zigan, Macfarlane, & Desombre, 2008) - given their expert power to offer patient diagnosis, treatment and decisions based on their professional knowledge, and their ability to interact with the external health system bureaucracy (Spyridonidis, Hendy, & Barlow, 2015; Currie, Koteyko, & Nerlich, 2009). Kenyan research has also identified the phenomenon of '*hybrid management*' (where clinicians hold leadership and management roles), and has shown how such managers are torn between executing their clinical roles and their leadership (McGivern et al., 2015; Nzinga, McGivern, & English, 2019). These Kenyan studies show how, as in the current study, professional power hierarchies give clinicians in leadership roles, hybrid managers, more power over other professions, including nurses (Nzinga, McGivern, & English, 2019; Nzinga et al., 2018). As found in this study, weak preparation for their managerial roles, means that these hybrid managers may not have the skills to promote cross-professional relationships. Distrust amongst members of different professional groups may then, as found in the UK, lead to conflicts (in this case, between clinicians and management) and is likely to compromise the delivery of healthcare services (Fitzgerald et al., 2013). In contrast, leadership practices that build trust across members of different professional groups

have been found to minimise fragmentation and limit the formation of organisational silos (Shamir & Lapidot, 2003).

In the current study, professional identities, silos, and hierarchies also drove tensions between clinicians and nurses, on the one hand, and, on the other hand, hospital administrative staff. Such tensions have, surprisingly, only rarely been identified in LMICs, as for example in Ghana (Aberese-Ako et al., 2018), though more widely recognised in HICs such as Portugal (Franco & Tavares, 2013). In this study, moreover, the professional backgrounds of the hospital CEOs was specifically identified as influencing cross-professional relationships. As reflected in HIC experience, hospital executives with clinical and nursing backgrounds, as in DHA but not in DHB, are commonly perceived to support good performance (Clay-Williams, Ludlow, Testa, Li, & Braithwaite, 2017; Goodall, 2011).

The hierarchy within the nursing cadre was the final key feature of professional identity identified in this study as undermining the possibility for cross-cadre working. Hierarchical and rigid nursing management styles also hindered the development of cohesion in ward teams between levels of management and categories within the nursing cadre. The study adds then to the wider recognition of the challenges of nursing hierarchies for cross cadre working in hospitals (ten Hoeve et al., 2014; Joyner et al., 2014; Franco & Tavares, 2013; Currie, Finn, & Martin, 2010; Penn-Kekana, Loveday, Blaauw & Schneider, 2004; Marks, 1997; Rispel & Schneider, 1991) and for LMIC leadership more generally (Belrhiti et al., 2020; Nzinga et al., 2019; Edmonstone, 2018; Nzinga et al., 2018).

9.2 Hospital leadership practices and organisational performance

9.2.1 Collective leadership

Despite the influence of context over leadership practices and staff satisfaction and morale, the findings of this study (as reflected in **Figure 8.1**) also show that this was a recursive relationship. It offers, then, the potential for leadership practices themselves to impact on hospital software in ways that create space for and nurture collective leadership. This insight is unusual within the still limited body of LMIC health leadership literature, which has only rarely delineated the nature of leadership practices and their consequences. Only two other LMIC empirical studies have explicitly examined collective or distributed leadership in public sector hospitals, and

its interactions with hospital software features (Belrhiti et al., 2020; Nzinga et al., 2018).

By providing empirical evidence from district hospitals in South Africa, this study then adds, first, important empirical insight into what forms of leadership can enhance, or limit, collaboration within and across occupational groups working in LMIC hospitals – and with what impacts on the organisation. In both hospitals, for example, the exercise of shared or delegated, empowering, approachable, participative, engaging and, caring or empathetic leadership practices supported the development of relationships and teamwork within the hospitals, that engendered collective leadership. For example, empathetic practices, identified as collegial concern and senior staff care for frontline staff and the welfare of junior clinicians, were found to enable supportive *family-like* environments. A rare cross-sectional study amongst hospital nurses in Taiwan (Tsai, 2011) similarly linked the expression and perception of care by leaders to positive workplace relationships and interconnectedness.

Further, the current study's findings suggest participative and engaging practices are likely to enhance the collegial relationships that strengthen collective identity and so, may support collective leadership. Although a recent South African study has shown that participative leadership builds trust relationships between managers and staff, it did not consider the consequences for collective leadership (Brooke-Sumner et al., 2019). A realist evaluation on the role of leadership in motivation in Moroccan hospitals has, however, demonstrated that distributing or sharing leadership in networks or interdisciplinary committees and participative decision-making had positive consequences for the self-esteem of staff, which may, in turn, itself enable collective leadership (Belrhiti et al., 2020). Theoretical work also suggests that formal and informal participatory and engaging practices build relationships between staff in a team and are likely to enhance collective leadership by developing a strong and shared sense of identity among team members (Chrobot-Mason, Gerbasi, & Cullen-Lester, 2016; Ibarra, Wittman, Petriglieri, & Day, 2014; Lord & Hall, 2005).

Empowering leadership practices were another approach enabling collective leadership within the case study hospitals. These practices have rarely been explicitly considered in other empirical work within South Africa and other LMICs. Open access between junior staff and middle-level managers created a sense of engagement in the day-to-day activities in the case study hospitals, as also found outside the health sector in Ghana (Abugre, 2012). In addition, as found in a Finnish health care study, the ability to collectively influence decisions, share values, and develop interpersonal

relationships generated a sense of togetherness and emotional connection within teams (Lampinen, Konu, Kettunen, & Suutula, 2018).

Second, this study showed that nurturing collective leadership offered important benefits to the hospitals. Collective leadership was specifically found to support the teamwork important in delivering good quality care. For example, it enables teams to problem-solve and work together to improve services. Of particular importance are the cross-professional teams that are vital in ensuring cooperation, mutual respect, communication, and good understanding amongst workers when providing quality patient care. HIC experience, meanwhile, shows that collective leadership is likely to have positive effects on the intrinsic morale of staff and their intention to provide better patient-centred services (Harrison & Coppola, 2007), as well as to encourage staff to collectively think of solutions to hospital challenges and develop collective approaches to policy implementation within the hospitals (Eckert et al., 2014; West et al., 2014).

The value of collective leadership is also shown in the examples of *champion leaders* identified in both hospitals. Although not assigned to formal managerial roles, these leaders acted as champions by taking over leadership roles in their units, to bring staff together in the absence of formal managers. These colleagues demonstrated, then, the types of leadership practices that encouraged other managers and staff to collaborate and so shared leadership with other team members within their own units and across professional cadres. This *'champion leadership'* was, therefore, associated with the exercise of lateral power (see Chapter Eight) that enabled team-focused decision making, in contrast to the vertical hierarchical leadership associated with formal positional authority (Müller et al., 2018). Although not well recognised within the LMIC health literature, these findings add to healthcare studies from HICs that have noted that informal leadership can be provided by high performing individuals who have a sense of responsibility and influence others when making decisions in their teams (Lawson, Tecson, Shaver, Barnes, & Kavli, 2019; Downey, Parslow, & Smart, 2011), through their integration of formal and informal communication processes (Drescher & Garbers, 2016). Organisational research also suggests that informal leadership emerges in complex collectives or teams, and works to improve information flow in rigid management hierarchies (Marion et al., 2016).

Finally, this study shows that those practices experienced as disengaging, hierarchical, non-participative or as favouritism were likely to undermine collective leadership. Although the existing LMIC empirical research does not explicitly consider

collective leadership, it does show how hierarchical and disengaging practices create disconnections between levels of hospital management in Ghana (Aberese-Ako et al., 2018) or create dis-trust between managers and staff in a Malawian hospital (Chipeta et al., 2016). Studies from HICs more explicitly make the link from, for example, disconnection and disengagement between managers and clinicians, and challenges experienced in working as a collective, as in English hospitals (Fitzgerald et al., 2013).

9.2.2 Staff satisfaction and morale

This study's findings (see Chapters Six, Seven and Eight) add to wider empirical evidence about the factors influencing staff satisfaction and morale, including through its detailed insights about how leadership practices support or undermine morale. A combination of leadership practices and external and internal contextual factors emerged as likely sources of staff satisfaction and morale in this study.

These findings reflect, first, broad LMIC and HIC health sector experience about, for example: the positive impacts on staff satisfaction and morale of specific factors such as positive commendation, recognition and reward during performance appraisal (Perry & Hondeghem, 2008; Willis-Shattuck et al., 2008; Mathauer & Imhoff, 2006; Franco, Bennett, Kanfer, & Stubblebine, 2004; Ryan & Deci, 2000); opportunities for leadership development, and managerial and collegial support (Okello & Gilson, 2015); intrinsic drive or inspiration, fighting for change, the provision of better care (Willis-Shattuck et al., 2008; Ryan & Deci, 2000); and hospital design and physical work environment (Franco et al., 2004).

Similarly, factors that appeared to cause dissatisfaction and low morale amongst health managers and staff in this study also reflect wider evidence. They include: leadership weaknesses that undermine teamworking (Okello & Gilson, 2015) and that limited the growth of collective leadership in case study hospitals; relational conflicts between staff themselves and between staff and their managers (Lahana et al., 2019; Tabak & Orit, 2007), as particularly shown in DHB; and non-participative and hierarchical leadership practices in the hospitals that generate few opportunities for professional and leadership development (Kumar, Ahmed, Shaikh, Hafeez, & Hafeez, 2013). Wider factors that impacted negatively on staff satisfaction and morale in the hospitals also included resource constraints (Okello & Gilson, 2015) and unfair and inefficient organisational processes such as favouritism during performance appraisals (Franco et al., 2002).

Second, this study adds to the currently limited empirical evidence from LMIC hospitals about the influence of leadership practices, specifically, over staff morale. The study, then, specifically addresses the call for empirical research about what characteristics of leadership in complex organisations support better health care (Belrhiti et al, 2018). It has shown which practices were found to enhance or undermine staff satisfaction and morale and how these practices also impacted on collective leadership.

Few other studies have explicitly considered the links between leadership practices, or collective leadership, and staff satisfaction and morale. A previous South African study (Mathole et al., 2018) found, for example, that public hospitals with managers who demonstrated supportive, friendly and approachable leadership styles motivated staff, who provided good care; in contrast, authoritarian practices generated poor relationships and staff were demotivated (Mathole et al., 2018). A survey study in Brazilian hospitals (Araujo & Figueiredo, 2019) also showed that managerial behaviours and attitudes that encourage trusting relationships or offer personal care, support teamwork and health worker motivation. In contrast, a Kenyan study reported how leadership practices impacted negatively on relationships amongst staff in district hospitals (Nzinga et al., 2018). However, perhaps the most comprehensive assessment of these links, and so similar to mine, was conducted in Moroccan public hospitals. It found that leadership practices worked through increasing perceived supervisor support, perceived organizational support and satisfying staff basic psychological needs to impact positively on staff self-esteem and intrinsic morale amongst hospital staff (Belrhiti et al., 2020).

9.3 The (largely) constraining influence of bureaucratic context on hospital leadership

This study's findings show that the wider bureaucracy (external context) and related managerial hierarchies (internal context) of the public sector tend to work against the development of collective leadership in South African public hospitals, with consequences for staff satisfaction and morale. Rigid bureaucratic and managerial structures, and limited managerial authority within the two hospitals, contributed to poor communication systems and a lack of cooperation between departments, teams, cadres, and levels of management. These experiences constrained, though did not fully prevent, the possibilities of creating an environment for collective leadership, and had negative impacts on the satisfaction and morale of staff and managers. These

findings add to the growing concerns about rigid hierarchies and bureaucratic challenges in developing collective leadership in South Africa (Cleary et al., 2018). As Von Holdt & Murphy (2007) argue, the highly centralised and rigidly procedural bureaucracy of the public sector is rooted in colonial and apartheid-era practices. Some wider African literature has also identified similar experiences. A Ghanaian ethnographic study of public hospitals specifically showed how bureaucratic red tape around the procurement of resources resulted in leadership practices likely to undermine collective leadership – such as the use of positional power to monitor staff, with a focus on individual mistakes (Aberese-Ako et al., 2018). Bureaucratic red tape is itself more widely acknowledged to contribute to the demoralisation and dissatisfaction of staff, as in Burkina Faso (Fillol et al., 2019) and Kenya (Barasa, Molyneux, English, & Cleary, 2017; Mbindyo, Gilson, Blaauw, & English, 2009).

The study's cross-case analysis further showed how the broader South African bureaucratic context limits the autonomy of hospital managers in three key areas of decision-making: budgeting and financial management, staff recruitment, and performance assessment. These challenges also exist in public hospitals in other LMICs (De Geyndt, 2017). The findings demonstrate that hospital-level managerial decisions on staff recruitment and provision of resources for care were limited by the wider bureaucratic rigidity around personnel expenditure (see Chapters Six and Seven, and section 8.3.1). They also highlighted the procedural nature of performance assessment, which was found to impact negatively on staff satisfaction and morale.

These findings add considerable texture and depth to the available South African and African evidence. Reporting from a leadership conference, Doherty and Gilson (2011), for example, identified unrealistic budgets and inadequate authority for management in recruitment of staff as hindrances to improving healthcare leadership in South African hospitals. Nxumalo et al (Nxumalo et al., 2018), meanwhile, have shown how the existing bureaucratic context and leadership practices undermine performance assessment at primary health care level in South Africa. In other African settings, limited decision-making autonomy has also been linked to poor personnel management, and poor performance within Ugandan public hospitals (Ssengooba, Atuyambe, McPake, Hanson, & Okuonzi, 2002). In The Gambia, meanwhile, stringent fiscal control at the national and sub-national level coupled with limited financial autonomy at hospital level created sufficient bureaucratic inertia to prevent healthcare managers from working together to mobilise for the distribution of resources to

hospitals Chigudu et al., (2014). Similarly, varying forms of bureaucratic power dynamics were found to be obstacles to district decision-making in a recent and unusually relevant multi-country study in Malawi, Uganda and Ghana (Bulthuis et al., 2020).

9.4 Policy-relevant implications

Deeper understanding of the public hospital context and its influence over collective leadership is not well researched in South Africa and LMICs. Such understanding is important because it can generate policy insights about how to encourage the collaboration among, and empowerment of, staff that is necessary in improving the functioning and performance of hospitals in delivering patient-centred care.

Against the background of past policy recommendations to enhance the managerial autonomy of large public hospitals in LMICs (Ravaghi, Foroughi, Nemati, & Bélorgeot, 2018; Preker & Harding, 2003a; Hanson et al., 2002), the current study suggests that an overarching challenge remains whether existing bureaucratic structures and rigid professional hierarchies will allow the enculturation of collective leadership to motivate managers and staff at the hospital level in the Western Cape and South Africa. Similar concerns have been raised in the very different English setting (Currie, Lockett, & Suhomlinova, 2009).

However, at the same time, as discussed in section 9.2, this study's findings also point to the possibility of working within the existing bureaucratic constraints in ways that create spaces of collective leadership and impact positively on staff morale in the study hospitals. These findings, thus, add to Belhriti et al., (2020) Moroccan study showing how collective leadership can create spaces of engagement and promote staff morale in LMIC hospitals. An in-depth review of the influence of contextual factors on healthcare leadership in public hospitals in HICs similarly reports that while external bureaucratic structures limit the ability to empower staff, due to poor communication practices and transactional leadership styles, organic structures enable transformational leadership styles and cohesion within work teams (Brazier, 2005). Wider research also suggests that a hybrid system encapsulating both traditional hierarchies and collective practices may be necessary in building and strengthening collective leadership (Hiller et al., 2006).

From a policy perspective, then, keeping hospital leadership and autonomy on the policy agenda must be accompanied by considering how to create pockets of collective leadership and engagement within the existing environment of public sector

hospitals in the Western Cape and South Africa, including through new forms of leadership development.

9.4.1 Strengthening collective leadership within hospitals

Given the study's findings, one approach to creating a collective identity and sense of belonging in the case study hospitals could be to induct new staff carefully so that they have a deeper understanding of hospital backgrounds and histories and can work to support intra-organisational relationships between different occupational and professional groups (Chrobot-Mason et al., 2016; Spyridonidis et al., 2015; Currie, Finn, & Martin, 2010; Hogg & van Knippenberg, 2003; Ashforth & Johnson, 2001). Innovative forms of communication are also generally recognised as important in satisfying the different information needs of different disciplines and cadres (De Brún, O'Donovan, & McAuliffe, 2019; Zigan et al., 2008), and these can enhance cross-professional relationships in district hospitals in the Western Cape.

Findings from this study highlight the need for communication channels, in district hospitals across the province, that have clarity and consistency - such as WhatsApp groups, smart applications for remote meetings, and Google groups. Open and direct communication considering all professional and managerial interests is also relevant for collective leadership across managerial and professional groupings. For example, as identified in this study, active engagement and participative practices through town-hall and departmental meetings work to keep staff informed in a regular, continual, clear, and consistent manner and articulate answers to questions that staff generate. Daily huddles as identified in this study are, moreover, widely recognised as key and quite informal communication mechanism. Finally, careful thought about hospital design is also important because, as shown in this study, physical proximity between departments is likely to influence the quality of working relationships positively in district hospitals. The closeness of units and departments enables the exchange of professional ideas, encourages cross-cadre relations and empathetic practices towards one another – factors that build collective leadership (De Brún, O'Donovan, & McAuliffe, 2019; West et al., 2014).

Despite the negative experiences of hybrid managers in this study, other leadership researchers specifically suggest that merging professional and managerial roles may provide avenues for collective leadership and that this may enhance the motivation of clinicians and nurses (Chreim, Williams, & Hinnings, 2007). The exercise of lateral power by clinicians and nurses in district hospitals can also enable an environment that cultivates collective leadership within clinical teams and across cadres, and

relational networks, despite the rigid administrative authority and bureaucratic environment.

Promoting the concept of flattening the gradient to spread power laterally and to lower the power distance between staff is, therefore, important in district hospitals within the province. Flattening the hierarchies can expand the roles and responsibilities of frontline staff and limit their sense of powerlessness as they develop a semi-autonomous functional team comprised of staff from different cadres. Although not well considered in the LMIC literature, cross sectional surveys amongst doctors and nurses in 15 Norwegian hospitals (Krogstad, Hofoss, & Hjortdahl, 2004), and hospital nurses in Taiwan (Tsai, 2011) have shown that tackling rigid hierarchies is likely to improve professional information sharing and cooperation between nurses and clinicians and thus enhance staff satisfaction. Encouraging collective leadership in teams and between cadres may also promote a sense of belonging within the district hospitals (Lampinen, Konu, Kettunen, & Suutula, 2018; Sedgwick & Yonge, 2008). Similarly, wider organisational research indicates that empowering leadership practices counter bureaucratic constraints, increase the collective sense of responsibility in teams, and allow greater flexibility amongst staff (Lee, Willis, & Tian, 2018). These practices and approaches, thus, are likely to engender collective leadership in district hospitals in the Western Cape province.

Re-inventing existing organisational processes that permit participation of staff may itself entrench collective leadership in the case study and across district hospitals in the province. For example, respondents in this study suggested that hospital leadership should consider different approaches of performance management – such as moving from individual appraisals to collective appraisals to create opportunities for collective interactions. Rather than the use of top-down managerial rewards and punishment during appraisals, HIC experience suggests that collective performance management practices are likely to re-distribute rewards, power and team-based incentives and encourage mutual appreciation and acknowledgement, continuous feedback and monitoring of performance to allow for professional integration that promote collective practices and motivate staff (Finn, Learmonth, & Reedy, 2010; Zigan et al., 2008). Organisational research also suggests that collective evaluations of teams enhance trust in colleagues and managers (Boas Shamir & Lapidot, 2003), which may strengthen collective leadership. However, building trust within professional groups might run the risk of developing negative team attributes such as groupthink and conformity (Neck & Manz, 1994; McCauley, 1989; Janis, 1971) or give

dominance to specific individuals (Thylefors, 2012; Lichtenstein, Alexander, McCarthy, & Wells, 2004; Doorewaard & Brouns, 2003). For example, in this study, clinicians were sometimes criticised for the way they exercised power over nurses, as were senior managers in relation to frontline staff.

Tackling the organisational fragmentation and silos that generate rivalries and tensions and discourages teamworking is, therefore, another important action that can be implemented in the case study and other district hospitals. This might be achieved by understanding the contextual causes of conflict as well as by team building activities and training teams in conflict resolution to improve trusting relationships (De Brún et al., 2019; Okello & Gilson, 2015). Social interactions that address professional and managerial identity, tensions, and power challenges in HCOs are recognised as offering the possibility of building relationships between professions (Zigan et al., 2008), and are necessary policy considerations for nurturing collective leadership in the district hospitals.

Finally, it is possible that improved staff satisfaction and morale may itself entrench positive leadership practices, by limiting the perceived negative effects of hierarchies and power distance between senior leadership and lower-level staff in district hospitals within the province. For instance, where rigid hierarchies generate difficulties in building teamwork and camaraderie, such as in nursing, it may be useful to nurture a strong sense of collective leadership among nurses in wards based on their intrinsic morale to offer care. Theoretical insights suggest that this may be helpful because motivated staff have an enhanced sense of self-worth and self-determination (R. M. Ryan & Deci, 2000) and may practice collective leadership, so enhancing collegial support and relationships in the wards (West et al., 2014; Hiller et al., 2006).

9.4.2 Leadership development

The analysis of this thesis, finally, offers ideas or lessons for how to strengthen leadership development activities within LMIC healthcare settings. This is a recognised policy priority for the future of healthcare delivery in South Africa (RSA National DoH, 2014; RSA National DoH, 2011) and other LMICs (Gilson & Agyepong, 2018). Within the Western Cape Province, moreover, teamwork and distributed leadership has been specifically identified as critical in strengthening the provincial health system (Western Cape Government DoH, 2016; Western Cape Government Health, 2014).

Leadership development researchers in HICs have argued that such activities enlarge the collective capacity of people within an organisation to engage in leadership roles and processes (Day, 2001). Collective leadership development, specifically, is likely to enhance the ability of multiple individuals to transfer and share leadership roles both formally and informally (Friedrich et al., 2009), as envisioned in the Western Cape's Department of Health leadership development strategies (Western Cape Government DoH, 2016c). Other benefits of such activities have been identified as: knowledge of leadership roles; increased confidence; improved communication skills; the ability to work and network with others; and, job positivity and satisfaction (Flaig, Alam, Huynh, Reid-Hector, & Heuer, 2020). Wider evidence also suggests leadership development may lead to the spread of positive practices of leadership amongst staff (Welch-Carre, 2017; Norman, Avolio, & Luthans, 2010; Avolio & Gardner, 2005), staff and managerial intrinsic motivation (R. M. Ryan & Deci, 2000) and patient-centred quality care (Little et al., 2001).

A key policy recommendation derived from this study's findings is, therefore, to create more opportunities for leadership development and professional advancement, for both clinicians and nursing staff in district hospitals, that emphasise collective approaches to decision-making and teamworking (as also specifically suggested by Chigudu et al., 2014). These leadership development activities should be founded on the understandings that hospitals are environments for social learning and self-organizing, and that leadership is the ability of an organisation or a group to co-create and make sense together to provide patient-centred care (Gilson et al., 2014a; Weick, Sutcliffe, & Obstfeld, 2005). A focus on a no-blame culture, interprofessional collaboration, professional commitment, and improved information flow between cadres are likely important topics to address (De Brún et al., 2019; Espinoza, Peduzzi, Agreli, & Sutherland, 2018; Song et al., 2017; Tsai, 2011; Chang, Ma, Chiu, Lin, & Lee, 2009) when implementing collective leadership development strategies in the district hospitals.

Shifting the focus from individual strategies of training for leadership skills, to collective approaches to leadership development may also support systemwide capacity development, strengthening the district hospital context or system. Training staff in teams within district hospitals to improve their leadership skills and ability to work as a collective, may also improve their performance to deliver efficient healthcare (De Brún, O'Donovan, & McAuliffe, 2019; Leggat et al., 2010; McAlearney, 2008; Little

et al., 2001). As Day et al. (2014) argue, there is a need to shift from leader development to leadership development.

Leadership development activities should, thus, be embedded in the district hospital context through the use of workplace-based learning (Gilson & Agyepong, 2018; Doherty & Gilson, 2015; Bush & Glover, 2004), which also allows the development of cross-professional collective practices. Organisational researchers view such approaches to leadership development as highly beneficial for collective leadership and collective motivation (Kark, Shamir, & Chen, 2003; Avolio & Bass, 2001). Workplace-based learning, as a strategy for collective leadership development, in district hospitals across the province, may include experiential and action-learning projects, internships, mentoring and coaching systems, innovation fellowships, and sabbatical and reflection periods (Daire, Gilson, & Cleary, 2014; Gilson & Daire, 2011). Action learning, for example, can incorporate regular meetings, reviews and planning sessions within cross-professional teams in the hospitals. Afterwards, the staff can share their experiences with others not present at the meetings and further strengthen social interpersonal relationships (Eva, Cox, Tse, & Lowe, 2019). Shared experiences built on open communication and a history of working together may, in turn, build trust amongst staff from different cadres and strengthen collective leadership district hospitals within the province, and South Africa in general.

9.5 Study Limitations

Discussion of the study's findings and policy implications should be considered together with the limitations of this research. It should be noted that the study did not seek to establish causal relationships between the hospital context and staff satisfaction and morale, collective leadership practices and staff satisfaction and morale, or the pathways between the three phenomena. Instead, the application of a qualitative case study design sought to generate rich insights about healthcare organisational settings, the complex nature of the three phenomena studied and their interactions. Specifically, the analysis established probable associations between different aspects of both external and internal context, and leadership practices and staff satisfaction and morale. Positive and negative leadership practices, respectively, had linkages with collective leadership.

Another potential limitation of the research is the depth and breadth of literature reviewed for the study. The initial qualitative literature review, using systematic and scoping approaches, was extensive and encompassed empirical published articles

on leadership and healthcare leadership from both LMICs and HICs. It yielded an overwhelming journal and grey literature. To make the review feasible as an element within this study, a narrowed focus on leadership and its context in LMICs/Africa was adopted. A narrative approach was deemed appropriate to the primary review aim of distilling the key lines of existing empirical analysis to inform this study.

The study considered only two district hospital cases and could not allow for very long periods of immersive fieldwork. Nonetheless, the trustworthiness of the findings was enhanced by examining two case study hospitals which had different histories, as well as, in each, triangulating multiple data sources, including previously collected quantitative satisfaction survey data. The rigorous within and cross-case analytic process allowed analytic generalisations to be developed (Miles, Huberman, & Saldana, 2014; Yin, 2014; Eisenhardt & Gräbner, 2007). Arguably, moreover, public health sector and district hospitals in South Africa are relatively comparable and share similar characteristics. These findings may, therefore, resonate with other HCOs similar to the case study hospitals, including outside South Africa.

A limitation worth noting is in relation to the survey data, especially in DHA discussed in Chapter 6, which showed a worse picture regarding the phenomena of focus than the qualitative data. Given low response rates in both hospitals, even if higher in DHB, the survey findings might be influenced by small sample sizes. Other data showed clearly that DHA is a smaller hospital with a rich history of good relationships compared to DHB which is a larger newer hospital with poor relationships. The strength of my study is anchored on the evidence offered by a combination of both qualitative and survey data.

Although hinted at in study findings, the data did not support comprehensive examination of some potential dynamics at play in the hospitals that may have implications for collective leadership. For example, demographic issues highlighted by some respondents suggest that there may be a linkage between perceptions of race and gender and collective leadership, with consequences for staff satisfaction and morale. Yet the role of race and gender in leadership has been recognised in other LMIC (Shung-King et al., 2018; Morgan et al., 2016), and HIC literature (Soklaridis et al., 2017; McDonagh, Bobrowski, Hoss, Paris, & Schulte, 2014; Snaebjornsson & Edvardsson, 2013; Schueller-Weidekamm & Kautzky-Willera, 2012; Lantz, 2008).

9.6 Directions for future research

The conceptual, empirical, and methodological contributions of this research to the literature on hospital context and collective leadership offer some directions for future research. First, the study concepts could be further applied in other empirical studies to test the current insights. This would include applying the theories and frameworks underpinning this thesis, such as complexity leadership theory, organisational theory, motivation theories of leadership and collective leadership in healthcare. These theories proved useful in understanding the elements and the interlinkages between the three phenomena. Most research on public sector leadership are not theory driven and therefore the abductive analysis, together with inductive and deductive analysis, used in this thesis offers more than just a report of leadership practices in public hospitals. Future research could also incorporate these forms of analysis to generate more practical, methodological and theoretical evidence on leadership in public sector hospitals and organisations.

Second, the study aimed for thick description of two case study hospitals and the generation of analytic generalisations, rather than a more extensive survey across many hospitals of key issues to support analysis towards statistical generalisation. Future research could increase the case and sample size to include more district hospitals, in both urban and rural settings, and across different provinces. This would enhance the generalisability of the findings across the broader South African health system and may offer avenues for comparisons with other health systems in sub-Saharan Africa. Most of the elements that constitute the *Leadership Trinity* also require further empirical testing and confirmation in larger public hospitals, and in private hospitals.

Third, as the existing research about organisational context and leadership is primarily based on quantitative studies (Stentz, Plano Clark, & Matkin, 2012), this study expands the research methods used in the study of leadership. In-depth analysis and ethnography is rarely used in the study of leadership (Sutherland, 2018) and qualitative realist evaluation approaches are only just beginning to be used understand leadership practices and leadership development in healthcare organisations (McDermott et al., 2017; Kwamie, van Dijk, & Agyepong, 2014; Marchal, Van Belle, Van Olmen, Hoerée, & Kegels, 2012). Further qualitative and mixed studies are, therefore, recommended to consider the linkages within the phenomena in the *Leadership Trinity* – that is, the interplay between healthcare organisational

context, leadership practices and staff satisfaction and morale. The use of longitudinal comparative case studies may, for example, enable researchers to describe events through time (past, present and future) and, search for holistic explanation of processes within and between cases (Pettigrew, Woodman, & Cameron, 2001; Pettigrew, 1990; Pettigrew, 1985) to establish the linkage of hospital context and positive leadership practices to staff satisfaction and morale. At the same time, structured survey work might be able to test the relationships among the phenomena of focus at a larger scale, exploring the links among them and, for example, testing the consequences of removing collective leadership as an interlinking phenomenon.

Fourth, this thesis suggests that conducting research on the links between positive leadership practices and organisational context, such as professional identities and power structures, would be beneficial in understanding how cross-professional relationships can be sustained in hospitals. Study findings demonstrate how collective leadership practices enhance our understanding of the important role of formal and informal relationships in teams within HCOs. Future research that extends the understanding of collective leadership in cross-professional teams may generate deeper insights about how to enact better cross-professional relationships across cadres in hospitals. Such studies could analyse the role and effects of cross-professional and cross-managerial identity and power relationships on collective leadership and their implications for staff satisfaction and morale in public hospitals. Future studies may also need to extend the understanding of collective leadership by intentionally including race and gender in the analysis.

Finally, given the policy implications of this research, future studies could examine the impact of leadership development strategies on collective leadership and, perhaps, their consequences for staff satisfaction and morale. Collective leadership entails social interactions and therefore research on leadership development should also logically consider contextual issues identified in this research in their study designs, methods and analyses to assist in better understanding the leadership development process (Day et al., 2014).

9.7 Chapter summary

The objective of this chapter was to consider the main contributions of this study to the wider LMIC knowledge base, as well as to acknowledge key weaknesses. The chapter also looked at the policy implications and recommendations for strengthening

collective leadership practices in LMIC health systems and presented ideas for future research directions.

Based on in-depth analytic insights drawn from the managerial and staff understandings of organisational context and leadership practices in case study hospitals, the revised study framework presented in **Figure 8.1** illustrates the linkages and pathways between the three phenomena illuminated by this study. It adds to, and opens, debates on collective leadership and their recursive relationship with the socially constructed context of hospitals, and staff satisfaction and morale.

The study identified key features of the internal and external organisational context in district hospitals that are relevant to leadership practices. It has shown how hospital background and history, public sector bureaucracy, power structures and hierarchies, professional identities, and cross-professional relationships, as elements of healthcare organisational context, mediate collective leadership practices and their potential or likely consequences for leadership 'effectiveness' as seen in staff satisfaction and morale.

The thesis also illuminates, on the one hand, the specific types of leadership practices that engender collective leadership and are likely to enhance staff satisfaction and morale. These include those that allowed full or shared delegation, enabled participation, were empathetic, approachable, empowered staff, and were engaging and persuasive. On the other hand, negative practices that undermine collective leadership and had negative consequences for staff satisfaction and morale were identified as hierarchical, disengaging, and practices that led to favouritism, criticisms and divulging of secrets.

The discussion of policy implications focused on how to nurture collective leadership within district hospitals to strengthen staff satisfaction and morale. These include suggestions for practice changes within hospitals as well as new forms of leadership development activities. Although external bureaucratic rigidities and hierarchies might well constrain the impacts of these proposed activities, there is wider support for the idea that spaces of collective leadership can be created within hospitals and despite such bureaucratic features.

Finally, future research ideas are presented to test the study's findings and further develop its conceptual framework, and its policy implications. As noted, a methodological contribution of the study is the use of an approach akin to ethnography to gain insight and understand leadership practices in LMIC hospitals and health

systems. Such approaches have the potential to offer deeper understanding of respondents' argumentation, negotiation and meaning making providing a deeper understanding of leadership practices in health systems.

Chapter 10: Concluding Statements

10.1 The relevance of the thesis for health system development in LMICs

There have been few studies in LMICs examining the influence of hospital organisational context, as enacted social settings, over leadership practices, and the possible consequences for staff satisfaction and morale as indicators of leadership effectiveness. The research underpinning this thesis aimed to examine the interplay between these three phenomena in district hospitals in the Western Cape Province. The research began with the identification and recognition of existing gaps in relevant research, and the development of the *Leadership Trinity* framework to guide the research. To explore and explain the linkages between the three phenomena, a multiple case study approach, using qualitative approaches to information gathering and analysis, was used to address the research questions.

Overall, the thesis has illustrated the relevance and value of the *Leadership Trinity* framework in such inquiry. The positive alignment of enabling features of hospital context with leadership practices that support collective leadership, as demonstrated particularly in cross-professional relationships, is likely to generate positive staff satisfaction and morale, and so support good quality service delivery. However, this balance may be disturbed by features of hospital context (such as rigid bureaucracy and hierarchies) or negative leadership practices, that undermine collective leadership and staff morale, also affecting the quality of healthcare service delivery. There are then possibilities of virtuous or vicious cycles among the phenomena of the *Leadership Trinity* framework.

The thesis' findings provide directions for the actions needed to strengthen hospital leadership in South Africa and other LMICs in ways that also benefit the wider health systems in which they are located. Plans for a National Health Insurance (NHI) system in South Africa, and, more broadly, for Universal Health Coverage (UHC) reforms in other settings, must take cognizance of the study findings. Future health system reform must work to strengthen leadership practices within hospitals, and so promote a virtuous cycle among the phenomena of the *Leadership Trinity* framework. In South Africa, it is critical to adapt existing managerial processes better to support collective leadership as well as to implement new forms of leadership development that purposefully support the emergence of collective leadership within these settings.

Whilst enhancing the extent of managerial autonomy held by public hospitals is also important, it would not be sufficient in itself to generate the changes in organisational dynamics necessary to strengthen hospital performance. Since it is difficult to practice leadership without management processes, at present, there are no clear-cut policy distinctions between leadership and management in the South African public sector and their influences over staff morale and satisfaction. This implies that leadership is entangled with management because formal managers are expected to offer leadership through collective and relational processes that motivate while at the same time planning and controlling resources to achieve organisational goals.

10.2 Epilogue - Researcher reflexive statement

Finally, I outline my overall personal reflections about the doctoral journey and the lessons I learnt. The entire research study and doctoral process was immensely rewarding despite some analytical challenges. During the study, I acknowledged my role as a researcher and a critical tool to the entire research process. Acknowledging my position as a researcher with my own perspectives and ideas enabled the limitation of biases in the description of the phenomena and interpretation of the data (Green and Thorogood, 2018; Wuisman, 2005).

To limit the impact of my assumptions and interpretations on my understandings, I also engaged with senior leadership and other staff to gain trust, build meaningful rapport and to make the respondents comfortable to share rich information with me. In retrospect, I would still undertake a rigorous qualitative research for its rewarding engagement with participants during observations and interviews - backed up with theory and other quantitative evidence.

In my research and personal memos and journals, I acknowledged the analytic and interpretive challenges of undertaking research where my personal perspectives and experiences on essential leadership practices in the public and private sectors in African countries and the general population came into play. These perspectives were predicated and grounded on the growing debate on the critical role of collective leadership practices in the wider private and public sectors. Admittedly, throughout the research process, I conscientiously resisted the urge to adapt or change the emergent findings to reflect my personal opinions. In fact, my position on the general consequences of leadership on satisfaction and morale evolved during the research process.

Coming from a veterinary science background to conduct constructionist social science research was a difficult transformation that reflected in the prolonged analysis phase of the study and which I consider as a personal achievement in the doctoral journey. Limited experience in analysing qualitative data slowed the analytic process. Nonetheless, the prolonged analysis allowed me to fully immerse myself into the data and coding process, generating important insights in analysis.

Indeed, while conceptualising this doctoral research study, I did not know that I was subconsciously starting a journey to deeper consciousness; a journey of self-discovery through the triune of understanding (personal faith), memory (indefatigable hope) and will (charity and love for all). The triune was critical in allowing me the freedom to deeply engage the organisational context, leadership, and motivation literature in ways that I never imagined I would comprehend, and to come up with a coherent thesis. Further, the triune sustained me in a stoic approach and a tenacious mindset to see the successful completion of the doctoral journey – in the end emerging with a deeper understanding and skills in doing holistic self and organisational analysis.

References

Abbott, A. (1988). *The System of Professions: An Essay on the Division of Expert Labor*. Chicago: University of Chicago press.

Abelha, D. M., Carneiro, P. C. da C., & Cavazotte, F. de S. C. N. (2018). Transformational leadership and job satisfaction: assessing the influence of organizational contextual factors and individual characteristics. *Revista Brasileira de Gestão de Negócios*, *20*(4), 516–532.

Aberese-Ako, M., Agyepong, I. A., & van Dijk, H. (2018). Leadership styles in two Ghanaian hospitals in a challenging environment. *Health Policy and Planning*, *33*(suppl 2), ii16–ii26.

Abugre, J. B. (2012). How managerial interactions affect employees' work output in Ghanaian organizations. *African Journal of Economic and Management Studies*, *3*(2), 204–226.

Adam, T., & de Savigny, D. (2012). Systems thinking for strengthening health systems in LMICs: need for a paradigm shift. *Health Policy and Planning*, *27*(Suppl 4), iv1-iv3.

Adi, M. N. M., Noor, H. M., Rahman, A. G. A., & Yushuang, T. (2013). The influence of leadership style on job satisfaction among nurses. *Asian Social Science*, *9*(9), 172–178.

African National Congress. (1994). *A National Health Plan for South Africa*.

African Union. (2001). Abuja Declaration on HIV/AIDS, tuberculosis and other infectious diseases and plan for action. *African Summit on HIV/AIDS, Tuberculosis and Other Infectious Diseases, 24-27 April*. Addis Ababa, Ethiopia.

Agyepong, I. A., Kodua, A., Adjei, S., & Adam, T. (2012). When 'solutions of yesterday become problems of today': crisis-ridden decision making in a complex adaptive system (CAS)—the Additional Duty Hours Allowance in Ghana. *Health Policy and Planning*, *27*(Suppl 4), iv20–iv31.

Anderson, P. (1999). Perspective : Complexity Theory and Organization Science. *Organization Science*, *10*(3), 216–232.

Antonakis, J., Avolio, B. J., & Sivasubramaniam, N. (2003). Context and leadership: an examination of the nine-factor full-range leadership theory using the Multifactor Leadership Questionnaire. *The Leadership Quarterly*, *14*, 261–295.

Araujo, C. A. S., & Figueiredo, K. F. (2019). Brazilian nursing professionals: leadership to generate positive attitudes and behaviours. *Leadership in Health Services*, *32*(1), 18–36.

Asefa, A., McPake, B., Langer, A., Bohren, M. A., & Morgan, A. (2020). Imagining maternity care as a complex adaptive system: understanding health system constraints to the promotion of respectful maternity care. *Sexual and Reproductive Health Matters*, *28*(1), e1854153.

Aseweh Abor, P., Abekah-Nkrumah, G., & Abor, J. (2008). An examination of hospital governance in Ghana. *Leadership in Health Services, 21*(1), 47–60.

Ashforth, B.E., & Mael, F. (1989). Social identity theory and the organization. *Academy of Management Review*, *14*(1), 20–39.

Ashforth, Blake E., & Johnson, S. A. (2001). Which hat to wear? The Relative Salience of Multiple Identities in Organizational Contexts. In M. A. Hogg & D. J. Terry (Eds.), *Social Identity Processes in Organizational Contexts* (pp. 32–48). Pschology Press.

Ataguba, J. E., & McIntyre, D. (2018). The incidence of health financing in South Africa : findings from a recent data set. *Health Economics, Policy and Law*, *13*, 68–91.

Avolio, B. J. (2007). Promoting more integrative strategies for leadership theory-building. *American Psychologist*, *62*(1), 25–33.

Avolio, B. J., & Bass, B. M. (Eds.). (2001). *Developing potential across a full range of Leadership: Cases on transactional and transformational leadership*. Psychology Press.

Avolio, B. J., Bass, B. M., & Jung, D. I. (1999). Re-examining the components of transformational and transactional leadership using the Multifactor Leadership. *Journal of Occupational and Organizational Psychology*, *72*(4), 441–462.

Avolio, B. J., & Gardner, W. L. (2005). Authentic leadership development: Getting to the root of positive forms of leadership. *The Leadership Quarterly*, *16*(3), 315–338.

Babbie, E., & Mouton, J. (2001). *The Practice of Social Research*. Southern Africa: Oxford University Press.

Baker, G. R., & Denis, J.-L. (2011). Medical leadership in health care systems: from professional authority to organizational leadership. *Public Money & Management*, *31*(5), 355–362.

Balabanova, D., Mills, A., Conteh, L., Akkazieva, B., Banteyerga, H., Dash, U., … McKee, M. (2013). Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening. *The Lancet*, *381*(9883), 2118–2133.

Barasa, E. W., Molyneux, S., English, M., & Cleary, S. (2017). Hospitals as complex adaptive systems: a case study of factors influencing priority setting practices at the hospital level in Kenya. *Social Science & Medicine*, *174*, 104–112.

Barley, S. R., & Tolbert, P. S. (1997). Institutionalization and Structuration: Studying the Links between Action and Institution. *Organization Studies*, *18*(1), 93–117.

Barney, J. (1991). Firm Resources and Sustained Competetive Advantage. *Journal of Management*, *17*(1), 99–120.

Barney, J. B., & Clark, D. N. (2007). *Resource-Based Theory: Creating and Sustaining Competetive Advantage* (First). Oxford, UK: Oxford University Press.

Bass, B. M. (1985). *Leadership and performance beyond expectations*. New York, NY: The Free Press.

Bass, B. M. (1990). From transactional to transformational leadership: Learning to share the vision. *Organizational Dynamics*, *18*(3), 19–31.

Bass, B. M., & Avolio, B. (1993). Transformational leadership and organizational culture. *Public Administration Quarterly*, *17*(1), 112–121.

Bass, B. M., Avolio, B. J., Jung, D. I., & Berson, Y. (2003). Predicting unit performance by assessing transformational and transactional leadership. *Journal of Applied Psychology*, *88*(2), 2017–2218.

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

Bell, C., Chan, M., & Nel, P. N. (2014). The Impact of Participative and Directive Leadership on Organisational Culture: An Organisational Development Perspective. *Mediterranean Journal of Social Sciences*, *5*(23), 1970–1985.

Belrhiti, Z., Giralt, A. N., & Marchal, B. (2018). Complex leadership in healthcare: a scoping review. *International Journal of Health Policy and Management*, *7*(12), 1073.

Belrhiti, Z., Van Damme, W., Belalia, A., & Marchal, B. (2020). Unravelling the role of leadership in motivation of health workers in a Moroccan public hospital: a realist evaluation. *BMJ Open*, *10*(1).

Berger, P. L., & Luckman, T. (1991). *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. London: Penguin.

Berghout, M. A., Fabbricotti, I. N., Buljac-Samardžić, M., & Hilders, C. G. (2017). Medical leaders or masters?—A systematic review of medical leadership in hospital settings. *PloS One*, *12*(9), e0184522.

Biggart, N. W., & Hamilton, G. G. (1987). An Institutional Theory of Leadership. *The Journal of Applied Behavioral Science*, *23*(4), 429–441.

Bilhuber Galli, E., & Muller-Stewens, G. (2012). How to build social capital with leadership development: Lessons from an explorative case study of a multibusiness firm. *The Leadership Quarterly*, *23*(1), 176–201.

Blaauw, D., Ditlopo, P., Maseko, F., Chirwa, M., Mwisongo, A., Bidwell, P., … Normand, C. (2013). Comparing the job satisfaction and intention to leave of different categories of health workers in Tanzania, Malawi, and South Africa. *Global Health Action*, *6*(1), 19287.

Blaauw, D., Ditlopo, P., & Rispel, L. C. (2014). Nursing education reform in South Africa–lessons from a policy analysis study. *Global Health Action*, *7*(1), 26401.

Bolden, R. (2004). *What is leadership?* Leadership South West, Exeter: Centre for Leadership Studies, University of Exeter.

Bolden, R. (2005). What is leadership development: purpose and practice? In *Leadership South West*. Leadership South West, Exeter: University of Exeter, Centre for Leadership Studies.

Bolden, R. (2011). Distributed leadership in organizations: A review of theory and research. *International Journal of Management Reviews*, *13*(3), 251–269.

Bolden, R., & Gosling, J. (2006). Leadership competencies: time to change the tune? *Leadership*, *2*(2), 147–163.

Bolden, R., Gosling, J., Marturano, A., & Dennison, P. (2003). *A review of leadership theory and competency frameworks*.

Botma, Y., Botha, H., & Nel, M. (2012). Transformation: Are nurse leaders in critical care ready? *Journal of Nursing Management*, *20*(7), 921–927.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal*, *9*(2), 27–40.

Braithwaite, J., Herkes, J., Ludlow, K., Testa, L. T., & Lamprell, G. (2017). Association between organisational and workplace cultures, and patient outcomes: systematic review. *BMJ Open*, *7*(11), e017708.

Brazier, D. K. (2005). Influence of contextual factors on healthcare leadership. *Leadership & Organization Development Journal*, *26*(2), 128–140.

Brooke-Sumner, C., Petersen-Williams, P., Kruger, J., Mahomed, H., & Myers, B. (2019). 'Doing more with less': a qualitative investigation of perceptions of South African health service managers on implementation of health innovations. *Health Policy and Planning*, *34*(2), 132–140.

Bryman, A. (2003). *Quantity and quality in social research* (First). London: Routledge.

Bryman, A., Stephens, M., & Campo, C. À. (1996). The importance of context: Qualitative research and the study of leadership. *The Leadership Quarterly*, *7*(3), 353–370.

Bulthuis, S. E., Kok, M. C., Amon, S., Agyemang, S. A., Nsabagasani, X., Sanudi, L., … Dieleman, M. A. (2020). How district health decision-making is shaped within decentralised contexts: A qualitative research in Malawi, Uganda and Ghana. *Global Public Health*, 1–16.

Bush, T., & Glover, D. (2004). *Leadership development: evidence and beliefs*. Retrieved from National College for School Leadership website: http://dera.ioe.ac.uk/5094/1/leadership-development-evidence-and-beliefs.pdf

Carmeli, A., & Tishler, A. (2004). The Relationships between Intangible Organizational Elements and Organizational Performance. *Strategic Management Journal*, *25*, 1257–1278.

Carroll, B., Levy, L., & Richmond, D. (2008). Leadership as practice: Challenging the competency paradigm. *Leadership*, *4*(4), 363–379.

Chang, W., Ma, J., Chiu, H., Lin, K., & Lee, P. (2009). Job satisfaction and perceptions of quality of patient care, collaboration and teamwork in acute care hospitals. *Journal of Advanced Nursing*, *65*(9), 1946–1955.

Chatman, J. A., Polzer, J. T., Barsade, S. G., & Neale, M. A. (1998). Being Different Yet Feeling Similar: The Influence of Demographic Composition and Organizational Culture on Work Processes and Outcomes. *Administrative Science Quarterly*, *43*(4), 749–780.

Chigudu, S., Jasseh, M., D'Alessandro, U., Corrah, T., Demba, A., & Balen, J. (2014). The role of leadership in people-centred health systems: a sub-national study in The Gambia. *Health Policy and Planning Planning*, *33*(1), e14–e25.

Chipeta, E., Bradley, S., Chimwaza-Manda, W., & McAuliffe, E. (2016). Working relationships between obstetric care staff and their managers: a critical incident analysis. *BMC Health Services Research*, *16*(1), 441.

Chipunza, C., & Matsumunyane, L. L. (2018). Motivation sources and leadership styles among middle managers at a South African university. *SA Journal of Human Resource Management*, *16*(1), 1–13.

Chopra, M., Lawn, J. E., Sanders, D., Barron, P., Karim, S. S. A., Bradshaw, D., … Coovadia, H. (2009). Achieving the health Millennium Development Goals for South Africa: challenges and priorities. *Lancet*, *374*(9694), 1023–1031.

Chreim, S., Williams, B., & Hinnings, C. R. (2007). Interlevel influences on reconstruction of professional role identity. *Academy of Management Journal*, *50*(6), 1515–1539.

Chrobot-Mason, D., Gerbasi, A., & Cullen-Lester, K. L. (2016). Predicting leadership relationships: The importance of collective identity. *The Leadership Quarterly*, *27*(2), 298–311.

Clay-Williams, R., Ludlow, K., Testa, L., Li, Z. L., & Braithwaite, J. (2017). Medical leadership, a systematic narrative review: do hospitals and healthcare organisations perform better when led by doctors? *BMJ Open*, *7*(9), e014474.

Cleary, S., du Toit, A., Scott, V., & Gilson, L. (2018). Enabling relational leadership in primary healthcare settings: lessons from the DIALHS collaboration. *Health Policy and Planning*, *33*(suppl 2), ii65-ii74.

Collins, D., Njeru, G., Meme, J. M., & Newbrander, W. (1999). Hospital autonomy: the experience of Kenyatta National Hospital. *The International Journal of Health Panning and Management*, *14*(2), 129–153.

Contractor, N. S., DeChurch, L. A., Carson, J., Carter, D. R., & Keegan, B. (2012). The topology of collective leadership. *The Leadership Quarterly*, *23*(6), 994–1011.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: historical roots of current public health challenges. *The Lancet*, *374*(9692), 817–834.

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (Fourth). California: SAGE Publications Inc.

Correia, T. (2017). Doctors' reflexivity in hospital organisations: The nexus between institutional and behavioural dynamics in the sociology of professions. *Current Sociology*, *65*(7), 1050–1069.

Cox, T. H., Lobel, S. a., & McLeod, P. L. (1991). Effects of Ethnic Group Cultural Differences on Cooperative and Competitive Behavior on a Group Task. *Academy of Management Journal*, *34*(4), 827–847.

Creswell, J. W., & Clark, V. L. P. (2011). *Designing and Conducting Mixed Methods Research* (Second). Thousand Oaks, California: SAGE, Publications, Inc.

Currie, G., Finn, R., & Martin, G. (2010). Role transition and the interaction of relational and social identity: new nursing roles in the English NHS. *Organization Studies*, *31*(7), 941–961.

Currie, G., Koteyko, N., & Nerlich, B. (2009). The dynamics of professions and development of new roles in public services organizations: the case of modern matrons in the English NHS. *Public Administration*, *87*(2), 295–311.

Currie, G., & Lockett, A. (2011). Distributing leadership in health and social care: concertive, conjoint or collective? *International Journal of Management Reviews*, *13*(3), 286–300.

Currie, G., Lockett, A., & Suhomlinova, O. (2009). The institutionalization of distributed leadership: A 'Catch-22'in English public services. *Human Relations*, *62*(11), 1735–1761.

Curry, L., Taylor, L., Chen, P. G.-C., & Bradley, E. (2012). Experiences of leadership in health care in sub-Saharan Africa. *Human Resources for Health*, *10*(33).

D'Innocenzo, L., Mathieu, J. E., & Kukenberger, M. R. (2014). A meta-analysis of different forms of shared leadership–team performance relations. *Journal of Management*, *42*(7), 1964–1991.

Daire, J., & Gilson, L. (2014). Does identity shape leadership and management practice? Experiences of PHC facility managers in Cape Town, South Africa. *Health Policy and Planning*, *29*(Suppl 2), ii82–ii97.

Daire, J., Gilson, L., & Cleary, S. (2014). *Developing leadership and management competencies in low and middle-income country health systems* (No. 4). Cape Town, South Africa: Resilient and Responsive Health Systems (RESYST).

Daviaud, E., & Chopra, M. (2008). Daviaud, E. and Chopra, M., 2008. How much is

not enough? Human resources requirements for primary health care: a case study from South Africa. Bulletin of the World Health Organization, 86, pp.46-51. *Bulletin of the World Health Organization*, *86*, 46–51.

Davies, H. T., Nutley, S. M., & Mannion, R. (2000). Organisational culture and quality of health care. *BMJ Quality & Safety*, *9*(2), 111–119.

Day, D. V. (2001). Leadership development: A review in context. *The Leadership Quarterly*, *11*(4), 581–613.

Day, D. V, & Antonakis, J. (2011). *The Nature of Leadership* (Vol. 2nd). Sage Publications.

Day, D. V, Fleenor, J. W., Atwater, L. E., Sturm, R. E., & McKee, R. A. (2014). Advances in leader and leadership development: A review of 25years of research and theory. *The Leadership Quarterly*, *25*(1), 63–82.

De Brún, A., O'Donovan, R., & McAuliffe, E. (2019). Interventions to develop collectivistic leadership in healthcare settings: a systematic review. *BMC Health Services Research*, *19*(72).

De Geyndt, W. (2017). Does autonomy for public hospitals in developing countries increase performance? Evidence-based case studies. *Social Science & Medicine*, *179*, 74–80.

Delobelle, P. (2013). The health system in South Africa. Historical perspectives and current challenges. In C. C. Wolhuter (Ed.), *South Africa in Focus: Economic, Polictical and Social Issues* (pp. 159–205). Nova Science Publishers, Inc.

Den Hartog, D. N., Van Muijen, J. J., & Koopman, P. L. (1997). Transactional versus transformational leadership: An analysis of the MLQ. *Journal of Occupational and Organizational Psychology*, *70*(1), 19–34.

Denis, J.-L., Lamothe, L., & Langley, A. (2001). The dynamics of collective leadership and strategic change in pluralistic organizations. *Academy of Management Journal*, *44*(4), 809–837.

Denis, J.-L., Langley, A., & Rouleau, L. (2010). The practice of leadership in the messy world of organizations. *Leadership*, *6*(1), 67–88.

Denis, J.-L., Langley, A., & Sergi, V. (2012). Leadership in the Plural. *Academy of Management Annals*, *6*(1), 211–283.

Denison, D. R. (1984). Bringing corporate culture to the bottom line. *Organizational*

Dynamics, *13*(2), 5–22.

Denison, D. R., & Neale, W. (1996). *Denison Organizational Culture Survey: Facilitator Guide*. Ann Arbor, MI: Denilson Consulting, LLC.

Department of Statistics South Africa. (2019). Statistical Publications. Retrieved July 13, 2019, from Statistical website: http://www.statssa.gov.za/?page_id=1859

Diaz-Saenz, H. R. (2011). Transformational leadership. *The SAGE Handbook of Leadership*, *5*(1), 299–310.

Dinh, J. E., Lord, R. G., Gardner, W. L., Meuser, J. D., Liden, R. C., & Hu, J. (2014). Leadership theory and research in the new millennium: Current theoretical trends and changing perspectives. *The Leadership Quarterly*, *25*(1), 36–62.

Ditlopo, P., Blaauw, D. B., Penn-Kekanna, L., & Rispel, L. C. (2014). Contestations and complexities of nurses' participation in policy-making in South Africa. *Global Health Action*, *7*(1), 25327.

Ditlopo, P., Blaauw, D., Rispel, L., Thomas, S., & Bidwell, P. (2013). Policy implementation and financial incentives for nurses in South Africa: a case study on the occupation-specific dispensation). *Global Health Action*, *6*(1), 19289.

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

Doherty, J. (2014). *Improving public hospitals through effective clinical leadership: lessons from South Africa*.

Doherty, J., & Gilson, L. (2011). *South African Health Managers Speak Out: Lessons for Innovative Health Management in the Public Sector, 2011.* Cape Town, South Africa: University of Cape Town.

Doherty, J., & Gilson, L. G. (2015). *Workplace-based learning for health system leaders: practical strategies for training institutions and governments*. London.

Doorewaard, H., & Brouns, B. (2003). Hegemonic Power Processes in Team-based Work. *Applied Psychology*, *52*(1), 106–119.

Dovey, K. (2002). Leadership development in a South African health service. *International Journal of Public Sector Management*, *15*(7), 520–533.

Downey, M., Parslow, S., & Smart, M. (2011). The hidden treasure in nursing leadership: Informal leaders. *Journal of Nursing Management*, *19*(4), 517–521.

Drescher, G., & Garbers, Y. (2016). Shared leadership and commonality: A policy-capturing study. *The Leadership Quarterly*, *27*(2), 200–2017.

Eckert, R., West, M., Altman, D., Steward, K., & Pasmore, B. (2014). *Delivering a collective leadership strategy for health care*. London: Centre for Creative Leadership: The King's Fund.

Edmonstone, J. (2011). Developing leaders and leadership in health care: a case for rebalancing? *Leadership in Health Services*, *24*(1), 8–18.

Edmonstone, J. (2018). Leadership development in health care in low and middle-income countries: Is there another way? *The International Journal of Health Planning and Management*, *33*(4), e1193–e1199.

Eisenhardt, K. M., & Gräbner, M. E. (2007). Theory building from cases: opportunities and challenges. *Academy of Management Journal*, *50*(1), 25–32.

Eisenhardt, M. (2015). Building Theories from Case Research. *The Academy of Management Review*, *14*(4), 532–550.

Elfenbein, H. A., & O'Reilly III, C. A. (2007). Fitting In: The Effects of Relational Demography and Person-Culture Fit on Group Process and Performance. *Group & Organization Management*, *32*(1), 109–142.

Elloker, S., Olckers, P., Gilson, L., & Lehmann, U. (2013). Crises, Routines and Innovations: The complexities and possibilities of sub-district management. In A. Padarath & R. English (Eds.), *South African Health Review 2012/13* (pp. 161–173). Durban: Health Systems Trust.

Endrissat, N., & von Arx, W. (2013). Leadership practices and context: Two sides of the same coin. *Leadership*, *9*(2), 278–304.

Espinoza, P., Peduzzi, M., Agreli, H. F., & Sutherland, M. A. (2018). Interprofessional team member's satisfaction: a mixed methods study of a Chilean hospital. *Human Resources for Health*, *16*(1), 30.

Eva, N., Cox, J. W., Tse, H. H. M., & Lowe, K. B. (2019). From competency to conversation: A multi-perspective approach to collective leadership development. *The Leadership Quarterly*, (101346).

Fetene, N., Canavan, M. E., Megentta, A., Linnander, E., Tan, A. X., Nadew, K., & Bradley, E. H. (2019). District-level health management and health system performance. *PLoS ONE*, *14*(2).

Fiedler, F. E. (1967). *A theory of leadership effectiveness*.

Fillol, A., Lohmann, J., Turcotte-Tremblay, A.-M., Some, P.-A., & Ridde, V. (2019). The importance of leadership and organizational capacity in shaping health workers' motivational reactions to performance-based financing: a multiple case study in Burkina Faso. *International Journal of Health Policy and Management*, *8*(5), 272–279.

Finn, R. (2008). The language of teamwork: reproducing professional divisions in the operating theatre. *Human Relations*, *61*(1), 103–130.

Finn, R., Learmonth, M., & Reedy, P. (2010). Some unintended effects of teamwork in healthcare. *Social Science and Medicine*, *70*(8), 1148–1154.

Fisher, R. J. (1993). Social desirability bias and the validity of indirect questioning. *Journal of Consumer Research*, *20*(2), 303–315.

Fitzgerald, L., Ferlie, E., McGivern, G., & Buchanan, D. (2013). Distributed leadership patterns and service improvement: Evidence and argument from English healthcare. *The Leadership Quarterly*, *24*(1), 227–239.

Flaig, J., Alam, A., Huynh, J., Reid-Hector, J., & Heuer, A. (2020). Examining How Formal Leadership Development Programs Positively Influence Hospital Leaders' Individual Competencies and Organizational Outcomes–An Evidence-Based Literature Review. *Journal of Healthcare Leadership*, *12*, 69–83.

Fourie, D. J. (2001). Annual Reports and the Public Finance Management Act. *South African Health Review*, *1*, 117–136.

Fourie, D. J. (2002). The Public Finance Management Act as a reform measure to capacitate public officials. *South African Journal of Economic and Management Sciences*, *5*(1), 219–232.

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health*, *25*(10), 1229–1245.

Franco, L. M., Bennett, S., & Kanfer, R. (2002). Health sector reform and public sector health worker motivation: a conceptual framework. *Social Science & Medicine*, *54*(8), 1255–1266.

Franco, L. M., Bennett, S., Kanfer, R. K., & Stubblebine, P. (2004). Determinants and consequences of health worker motivation in hospitals in Jordan and Georgia. *Social*

Science & Medicine, *58*(2), 343–355.

Franco, M., & Tavares, P. (2013). The influence of professional identity on the process of nurses' training: an empirical study. *Leadership in Health Services*, *26*(2), 118–134.

French, J. R., Raven, B., & Cartwright, D. (1959). The bases of social power. *Classics of Organization Theory*, *7*, 311–320.

Friedrich, T. L., Griffith, J. A., & Mumford, M. D. (2016). Collective leadership behaviors: Evaluating the leader, team network, and problem situation characteristics that influence their use. *The Leadership Quarterly*, *27*(2), 312–333.

Friedrich, T. L., Vessey, W. B., Schuelke, M. J., Ruark, G. A., & Mumford, M. D. (2009). A framework for understanding collective leadership: The selective utilization of leader and team expertise within networks. *The Leadership Quarterly*, *20*(6), 933–958.

Fullman, N., Yearwood, J., Abay, S. M., Abbafati, C., Abd-Allah, F., Abdela, J., … Abraha, H. N. (2018). Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016. *The Lancet*, *391*(10136), 2236-2271.

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *Qualitative Report*, *20*(9), 1408–1416.

Geertz, C. (2008). Thick description: Toward an interpretive theory of culture. In *The cultural geography reader* (pp. 41–51). Routledge.

Giddens, A. (1984). *The Constitution of Society: Outline of the Theory of Structuration*. University of California Press.

Gilson, L. (2012). *Health Policy and System Research: A Methodology Reader* (L. Gilson, Ed.). Geneva: Alliance for Health Policy and Systems Research, World Health Organization.

Gilson, L., & Agyepong, I. A. (2018). Strengthening health system leadership for better governance: what does it take? *Health Policy and Planning*, *33*(suppl 2), ii1–ii4.

Gilson, L., Barasa, Edwine Nxumalo, N., Cleary, S., Goudge, J., Molyneux, S., Tsofa, B., & Lehmann, U. (2017). Everyday resilience in district health systems: emerging insights from the front lines in Kenya and South Africa. *BMJ Global Health*, *2*(2), e000224.

Gilson, L., Brady, L., Naledi, T., Schneider, H., Pienaar, D., Hawkridge, A., & Vallabhjee, K. (2017). Development of the Health system in the Western Cape:experiences since 1994. In A. Padarath & P. Barron (Eds.), *South African Health Review 2017* (pp. 59–69). Durban: Health Systems Trust.

Gilson, L., & Daire, J. (2011). Leadership and governance within the South African health system. *South African Health Review*, 69–80.

Gilson, L., Doherty, J., Lowenson, R., & Victoria, F. (2007). *Challenging inequity through health systems. Final report on the Knowledge Network on Health Systems, WHO Commission on the Social Determinants of Health*. Geneva, Switzerland.

Gilson, L., Elloker, S., Lehmann, U., & Brady, L. (2020). Organizational change and everyday health system resilience: Lessons from Cape Town, South Africa. *Social Science & Medicine*, *266*, 113407.

Gilson, L., Elloker, S., Olckers, P., & Lehmann, U. (2014). Advancing the application of systems thinking in health: South African examples of a leadership of sensemaking for primary health care. *Health Research Policy and Systems / BioMed Central*, *12*(1), 30. https://doi.org/10.1186/1478-4505-12-30

Gioia, D. A., & Chittipeddi, K. (1991). Sensemaking and Sensegiving in Strategic Change Initiation. *Strategic Management Journal*, *12*(6), 433–448.

Gioia, D. A., Corley, K. G., & Hamilton, A. L. (2013). Seeking Qualitative Rigor in Inductive Research: Notes on the Gioia Methodology. *Organizational Research Methods*, *16*(1), 15–31.

Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine Publishing Company.

Goldstone, R. L., & Sakamoto, Y. (2003). The transfer of abstract principles governing complex adaptive systems. *Cognitive Psychology*, *46*(4), 414–466.

Goodall, A. H. (2011). Physician-leaders and hospital performance: is there an association? *Social Science & Medicine*, *73*(4), 535–539.

Govender, K. (2017). Empowering leadership and municipal service delivery: A case study of a metropolitan municipality in South Africa. *International Journal of Public Administration*, *40*(5), 427-433.

Govender, S., Proches, C. N. G., & Kader, A. (2018). Examining leadership as a strategy to enhance health care service delivery in regional hospitals in South Africa.

Journal of Multidisciplinary Healthcare, *11*, 157–166.

Green, J., & Thorogood, N. (2018). *Qualitative methods for health research* (4th ed.). Sage Publications, Ltd.

Gronn, P. (2009). From distributed to hybrid leadership practice. In *Distributed Leadership* (pp. 197–217). Dordrecht: Springer.

Guba, E. G. (1981). Criteria for Assessing the Trustworthiness of Naturalistic Inquiries. *ECTJ*, *29*(2), 75–91.

Guba, E. G., & Lincoln, Y. S. (1994). Competing Paradigms in Qualitative Research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Sage Publications.

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods*, *18*(1), 59–82.

Hall, R. H., Johnson, N. J., & Haas, J. E. (2015). *Organizational size, complexity, and formalization*. *32*(6), 903–912.

Hall, R. H., & Tolbert, P. S. (2005). *Organizations: Structures, Processes, and Outcomes* (Ninth). Pearson Prentice Hall.

Hanson, B. (2013). The leadership development interface: Aligning leaders and organizations toward more effective leadership learning. *Advances in Developing Human Resources*, *15*(1), 106–120.

Hanson, K., Atuyambe, L., Kamwanga, J., McPake, B., Mungule, O., & Ssengooba, F. (2002). Towards improving hospital performance in Uganda and Zambia: reflections and opportunities for autonomy. *Health Policy*, *61*(1), 73–94.

Harris, A. (2008). Distributed leadership through the looking glass. *Management in Education*, *22*(1), 31–34.

Harris, A. (2009). Distributed leadership: What we know. In *Distributed Leadership* (pp. 11–21). Dordrecht: Springer.

Harrison, D. (2009). *An Overview of Health and Health care in South Africa 1994 – 2010: Priorities , Progress and Prospects for New Gains*.

Harrison, J. P., & Coppola, M. N. (2007). Is the quality of hospital care a function of leadership? *The Health Care Manager*, *26*(3), 263–272.

Heerdegen, A. C. S., Aikins, M., Amon, S., Agyemang, S. A., & Wyss, K. (2020).

Managerial capacity among district health managers and its association with district performance: A comparative descriptive study of six districts in the Eastern Region of Ghana. *PLoS ONE*, *15*(1), e0227974.

Hendel, T., Fish, M., & Berger, O. (2007). Nurse/physician conflict management mode choices: Implications for improved collaborative practice. *Nursing Administration Quarterly*, *31*(3), 244–253.

Hersey, P., Blanchard, K. H., & Johnson, D. E. (2012). *Management of Organizational Behavior: Leading Human Resources* (10th ed.). Pearson.

Hiller, N. J., Day, D. V., & Vance, R. J. (2006). Collective enactment of leadership roles and team effectiveness: A field study. *The Leadership Quarterly*, *17*(4), 387–397.

Hogg, M. A. (2001). A social identity theory of leadership. *Personality and Social Psychology Review*, *5*(3), 184–200.

Hogg, M. A., Terry, D. J., & White, K. M. (1995). A tale of two theories: A critical comparison of identity theory with social identity theory. *Social Psychology Quarterly*, *58*(4), 255–269.

Hogg, M. A., & van Knippenberg, D. (2003). Social identity and leadership processes in groups. *Advances in Experimental Social Psychology*, *35*, 1–52.

House, R. J. (1971). A path goal theory of leader effectiveness. *Administrative Science Quarterly*, 321–339.

House, R. J. (1996). Path-Goal Theory of Leadership: Lessons, Legacy, and a Reformulated Theory. *The Leadership Quarterly*, *7*(3), 323–352.

House, R. J., & Aditya, R. N. (1997). The social scientific study of leadership: Quo vadis? *Journal of Management*, *23*(3), 409–473.

Ibarra, H., Wittman, S., Petriglieri, G., & Day, D. V. (2014). Leadership and Identity: An examination of three theories and new research directions. In D. V. Day (Ed.), *The Oxford handbook of leadership and organizations* (pp. 285–301). New York, NY: Oxford University Press.

Iszatt-White, M. (2011). Methodological Crises and Contextual Solutions:an ethnomethodologically-informed approach to understanding leadership. *Leadership*, *7*(2), 119–135.

Jacobsen, C. B., & Jakobsen, M. L. (2018). Perceived organizational red tape and

organizational performance in public services. *Public Administration Review*, *78*(1), 24–36.

Janis, I. L. (1971). Groupthink. *Psychology Today*, *5*(6), 43–46.

Johns, G. (2001). In praise of context. *Journal of Organizational Behavior*, *42*, 31–42.

Johns, G. (2006). The essential impact of context on organizational behavior. *Academy of Management Review*, *31*(2), 386–408.

Jonassen, D. H. (1991). Evaluating constructivistic learning. *Educational Technology*, *31*(9), 28–33.

Joyner, K., Shefer, T., & Smit, E. (2014). Discourses and practices in institutionalised nursing in South Africa: challenges for care. *South African Review of Sociology*, *45*(3), 34–52.

Judge, T. A., Thoreson, C. J., Bono, J. E., & Patton, G. K. (2001). The job satisfaction–job performance relationship: A qualitative and quantitative review. *Psychological Bulletin*, *127*(3), 376–407.

Kark, R., Shamir, B., & Chen, G. (2003). The two faces of transformational leadership: Empowerment and dependency. *Journal of Applied Psychology*, *88*(2), 246–255.

Kelloway, E. K., Weigand, H., McKee, M. C., & Das, H. (2013). Positive leadership and employee well-being. *Journal of Leadership & Organizational Studies*, *20*(1), 107–117.

Kok, M. C., Broerse, J. E., Sally Theobald, S., Ormel, H., Dieleman, M., & Taegtmeyer, M. (2017). Performance of community health workers: situating their intermediary position within complex adaptive health systems. *Human Resources for Health*, *15*(1), 1–7.

Kotter, J. P. (1990). *A Force for change: how leadership differs from management*. New York, NY: Simon and Schuster Inc.

Kotterman, J. (2006). Leadership versus management: What's the difference. *The Journal for Quality and Participation*, *29*(2), 13–17.

Krogstad, U., Hofoss, D., & Hjortdahl, P. (2004). Doctor and nurse perception of inter-professional co-operation in hospitals. *International Journal for Quality in Health Care*, *16*(6), 491–497.

Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., … English, M. (2018). High-quality health systems in the Sustainable Development

Goals era: time for a revolution. *The Lancet Global Health*, *6*(11), e1196–e1252.

Krumpal, I. (2013). Determinants of social desirability bias in sensitive surveys: a literature review. *Quality & Quantity*, *47*(4), 2025–2047.

Kuada, J. (2010). Culture and leadership in Africa: a conceptual model and research agenda. *African Journal of Economic and Management Studies*, *1*(1), 9–24.

Kukla, A. (2000). *Social Constructivism and the Philosophy of Science*. London: Routledge.

Kumar, R., Ahmed, J., Shaikh, B. T., Hafeez, R., & Hafeez, A. (2013). Job satisfaction among public health professionals working in public sector: a cross sectional study from Pakistan. *Human Resources for Health*, *11*(2), 1–5.

Kwamie, A., van Dijk, H., & Agyepong, I. A. (2014). Advancing the application of systems thinking in health: realist evaluation of the Leadership Development Programme for district manager decision-making in Ghana. *Health Research Policy and Systems*, *12*(1), 29.

Labonté, R., Sanders, D., Mathole, T., Crush, J., Chikanda, A., Dambisya, Y., … Bourgeault, I. L. (2015). Health worker migration from South Africa: causes, consequences and policy responses. *Human Resources for Health*, *13*(92).

Lahana, E., Tsaras, K., Kalaitzidou, A., Galanis, P., Kaitelidou, D., & Sarafis, P. (2019). Conflicts management in public sector nursing. *International Journal of Healthcare Management*, *12*(1), 33–39.

Lampinen, M.-S., Konu, A. I., Kettunen, T., & Suutula, E. A. (2018). Factors that foster or prevent sense of belonging among social and health care managers. *Leadership in Health Services*, *31*(4), 468–480.

Langley A. (2011). Strategies for Theorizing from Process Data. *Academy of Management Review*, *24*(4), 691–710.

Lantz, P. M. (2008). Gender and leadership in healthcare administration: 21st century progress and challenges. *Journal of Healthcare Management*, *53*(5), 291–301.

Lawson, T. D., Tecson, K. M., Shaver, C. N., Barnes, S. A., & Kavli, S. (2019). The impact of informal leader nurses on patient satisfaction. *Journal of Nursing Management*, *27*(1), 103–108.

Lee, A., Willis, S., & Tian, A. W. (2018). Empowering leadership: A meta-analytic examination of incremental contribution, mediation, and moderation. *Journal of*

Organizational Behavior, *39*(3), 306–325.

Leggat, S. G., Bartram, T., Casimir, G., & Stanton, P. (2010). Nurse perceptions of the quality of patient care: confirming the importance of empowerment and job satisfaction.". *Health Care Management Review*, *35*(4), 355–364.

Levin, S. A. (2002). Complex Adaptive Systems : and the Unknowable. *Bulletin of the American Mathematical Society*, *40*(1), 3–19.

Lewis, M. (2015). *Better Hospitals, Better Health Systems: The Urgency of a Hospital Agenda* (No. CGD Policy Paper 053). Washington DC.

Lichtenstein, B. B., Uhl-bien, M., Marion, R., Seers, A., Douglas, J., & Schreiber, C. (2006). Complexity leadership theory: An interactive perspective on leading in complex adaptive systems. *Emergence: Complexity and Organization*, *8*(4), 2–12.

Lichtenstein, R., Alexander, J. A., McCarthy, J. F., & Wells, R. (2004). Status differences in cross-functional teams: effects on individual member participation, job satisfaction, and intent to quit. *Journal of Health and Social Behavior*, *45*(3), 322–335.

Liden, R. C., & Antonakis, J. (2009). Considering context in psychological leadership research. *Human Relations*, *62*(11), 1587–1605.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry.* SAGE Publications.

Lincoln, Y. S., & Guba, E. G. (1986). But Is It Rigorous? Trustworthiness and Authenticity in Naturalistic Evaluation. *New Directions for Program Evaluation*, (30), 73–84.

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., Gould, C., & Ferrier, K. (2001). Preferences of patients for patient centred approach to consultation in primary care: observational study. *Bmj*, *322*(7284), 468–472.

Locke, E. A. (1976). The nature and causes of job satisfaction. In M. D. Dunnette (Ed.), *Handbook of industrial and organizational psychology* (1st ed., pp. 1297–1349). Chicago: Rand McNally.

Lord, R. G., & Hall, R. J. (2005). Identity, deep structure and the development of leadership skill. *The Leadership Quarterly*, *16*(4), 591–615.

Luthuli, T. B. (2009). From compliance to performance: a leadership challenge in the South African Public Service. *Journal of Public Administration*, *44*(3), 460–469.

Maboko, D. R. (2012). Nursing leadership in an academic hospital in Gauteng. *Journal of Nursing Management*, *20*(7), 912–920.

Makhubela, M., Botha, P. A., & Swanepoel, S. (2016). Employees' perceptions of the effectiveness and fairness of performance management in a South African public sector institution. *SA Journal of Human Resource Management*, *14*(1), 1–11.

Mannion, R., Davies, H. T. O. D., & Marshall, M. N. (2005). Cultural characteristics of "high" and "low" performing hospitals. *Journal of Health Organization and Management*.

Marchal, B., Van Belle, S., Van Olmen, J., Hoerée, T., & Kegels, G. (2012). Is realist evaluation keeping its promise? A review of published empirical studies in the field of health systems research. *Evaluation*, *18*(2), 192–212.

Marion, R., Christiansen, J., Klar, H. W., Schreiber, C., & Erdener, M. A. (2016). Informal leadership, interaction, cliques and productive capacity in organizations: A collectivist analysis. *The Leadership Quarterly*, *27*(2), 242–260.

Marion, R., & Uhl-Bien, M. (2001). Leadership in complex organizations. *Leadership Quarterly*, *12*(4), 389–418.

Marks, S. (1997). The legacy of the history of nursing for post apartheid South Africa. In A. M. Refferty, J. Robinson, & R. Elkan (Eds.), *Nursing history and the politics of welfare* (pp. 28–44). London: Routledge.

Mash, B. J., Mayers, P., Conradie, H., Orayn, A., Kuiper, M., & Marais, J. (2008). How to manage organisational change and create practice teams: experiences of a South African primary care health centre. *Education for Health (Abingdon, England)*, *21*(2), 132.

Mash, R., Govender, S., Isaacs, A.-A., De Sa, A., & Schlemmer, A. (2013). Assessment of organisational values, culture and performance in Cape Town's primary healthcare services. *South African Family Practice*, *55*(5), 459–466.

Mathauer, I., & Imhoff, I. (2006). Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. *Human Resources for Health*, *4*(24).

Mathole, T., Lembani, M., Jackson, D., Zarowsky, C., Bijlmakers, L., & Sanders, D. (2018). Leadership and the functioning of maternal health services in two rural district hospitals in South Africa. *Health Policy and Planning*, *33*(suppl 2), ii5–ii15.

Matsoso, M. P., & Strachan, B. (2011). *Human Resources for Health for South Africa: HRH Strategy for the Health Sector 2012/13 - 2016/17* (p. 10). p. 10. SAHR2011.

Mayosi, B. M., Lawn, J. E., Van Niekerk, A., Bradshaw, D., Abdool Karim, S. S., & Coovadia, H. M. (2012). Health in South Africa: Changes and challenges since 2009. *The Lancet*, *380*(9858), 2029–2043.

Mbindyo, P., Gilson, L., Blaauw, D., & English, M. (2009). Contextual influences on health worker motivation in district hospitals in Kenya. *Implementation Science*, *4*(43).

McAlearney, A. S. (2006). Leadership development in healthcare: a qualitative study. *Journal of Organizational Behavior*, *27*(7), 967–982.

McAlearney, A. S. (2008). Using leadership development programs to improve quality and efficiency in healthcare. *Journal of Healthcare Management*, *53*(5), 319–331.

McCauley, C. (1989). The nature of social influence in groupthink: Compliance and internalization. *Journal of Personality and Social Psychology*, *57*(2), 250–260.

McDermott, I., Checkland, K., Coleman, A., Osipovič, D., Petsoulas, C., & Perkins, N. (2017). Engaging GPs in commissioning: realist evaluation of the early experiences of Clinical Commissioning Groups in the English NHS. *Journal of Health Services Research & Policy*, *22*(1), 4–11.

McDonagh, K. J., Bobrowski, P., Hoss, M. A. K., Paris, N. M., & Schulte, M. (2014). The leadership gap: Ensuring effective healthcare leadership requires inclusion of women at the top. *Open Journal of Leadership*, *3*(2), 20–39.

McGivern, G., Currie, G., Ferlie, E., Fitzgerald, L., & Waring, J. (2015). Hybrid Manager–Professionals' Identity Work: The Maintenance and Hybridization of Medical Professionalism in Managerial Contexts. *Public Administration*, *93*(2), 412–432.

McHugh, K. A., Yammarino, F. J., Dionne, S. D., Serban, A., Sayama, H., & Chatterjee, S. (2016). Collective decision making, leadership, and collective intelligence: Tests with agent-based simulations and a Field study. *The Leadership Quarterly*, *27*(2), 218–241.

McIntyre, D., & Ataguba, J. (2017). Access to quality health care in South Africa: Is the health sector contributing to addressing the inequality challenge. In *Parliament of South Africa 2017*.

McIntyre, D., Baba, L., & Makan, B. (1998). Equity in Public Sector Health Care Financing and Expenditure in South Africa. In A. Ntuli (Ed.), *South African Health Review 1998* (pp. 29–44). Durban: Health Systems Trust.

McPake, B. I. (1996). Public autonomous hospitals in sub-Saharan Africa: trends and issues.". *Health Policy*, *35*(2), 155–177.

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). *Qualitative Data Analysis: A Methods Sourcebook* (Third). Thousand Oaks, California: Sage Publications, Inc.

Mills, A. (1990). The economics of hospitals in developing countries, Part I: Expenditure Patterns. *Health Policy and Planning*, *5*(2), 107–117.

Mills, A., Rasheed, F., & Tollman, S. (2006). Strengthening health systems. In D. T. Jamison, J. G. Breman, A. R. Measham, G. Alleyne, M. Claeson, D. B. Evans, … P. Musgrove (Eds.), *Disease Control Priorities in Developing Countries* (Second, pp. 87–102). Washington DC: The World Bank.

Morgan, R., George, A., Ssali, S., Hawkins, K., Molyneux, S., & Theobald, S. (2016). How to do (or not to do)… gender analysis in health systems research. *Health Policy and Planning*, *31*(8), 1069–1078.

Mowday, R. T., & Sutton, R. I. (1993). Reproduced with permission of the copyright owner. Further reproduction prohibited without permission. *Annual Review of Psychology*, *44*, 195–229.

Müller, R., Sankaran, S., Drouin, N., Vaagaasar, A.-L., Bekker, M. C., & Jain, K. (2018). A theory framework for balancing vertical and horizontal leadership in projects. *International Journal of Project Management*, *36*(1), 83–94.

Murray, C. J. L., & Frenk, J. (2000). A framework for assessing the performance of health systems. *Bulletin of the World Health Organization*, *78*(6), 717–731.

Musinguzi, Conrad, Namale, L., Rutebemberwa, E., Dahal, A., Nahirya-Ntege, P., & Kekitiinwa, A. (2018). The relationship between leadership style and health worker motivation, job satisfaction and teamwork in Uganda. *Journal of Healthcare Leadership*, *10*, 21–32.

Neck, C. P., & Manz, C. C. (1994). From groupthink to teamthink: Toward the creation of constructive thought patterns in self-managing work teams. *Human Relations*, *47*(8), 929–952.

Newbrander, W., Barnum, H., & Kutzin, J. (1992). *Hospital economics and financing in developing countries*. Geneva: World Health Organization.

Norman, S. M., Avolio, B. J. A., & Luthans, F. (2010). The impact of positivity and transparency on trust in leaders and their perceived effectiveness. *The Leadership*

Quarterly, *21*(3), 350–364.

Nxumalo, N., Goudge, J., Gilson, L., & Eyles, J. (2018). Performance management in times of change: experiences of implementing a performance assessment system in a district in South Africa. *International Journal for Equity in Health*, *17*(1), 1–14.

Nzinga, J., McGivern, G., & English, M. (2018). Examining clinical leadership in Kenyan public hospitals through the distributed leadership lens. *Health Policy and Planning*, *33*(suppl 2), ii27–ii34.

Nzinga, J., McGivern, G., & English, M. (2019). Hybrid clinical-managers in Kenyan hospitals: Navigating between professional, official and practical norms. *Journal of Health Organization and Management*, *33*(2), 173–187.

O'Reilly III, C. a, Caldwell, D. F., & Barnett, W. P. (1989). Work group demography, social integration, and turnover. *Administrative Science Quarterly*, 21–37.

Oc, B. (2018). Contextual leadership: A systematic review of how contextual factors shape leadership and its outcomes. *The Leadership Quarterly*, *29*, 218–235.

Okello, D. R., & Gilson, L. (2015). Exploring the influence of trust relationships on motivation in the health sector: a systematic review. *Human Resources for Health*, *13*(16).

Oldham, G. R., & Hackman, J. R. (1981). Organizational Structure and Employee Reactions: Comparing Alternative Frameworks. *Administrative Science Quarterly*, *26*(1), 66–83.

Osborn, R. N., Hunt, J. G., & Jauch, L. R. (2002). Toward a contextual theory of leadership. *The Leadership Quarterly*, *13*(6), 797–837.

Ovretveit, J. C., Shekelle, P. G., Dy, S. M., McDonald, K. M., Hempel, S., Pronovost, P., … Wachter, R. M. (2011). How does context affect interventions to improve patient safety? An assessment of evidence from studies of five patient safety practices and proposals for research. *BMJ Quality & Safety*, *20*(7), 604–610.

Owen, P. (1995). District health systems development. In D. Harrison & M. Nielson (Eds.), *South African Health Review 1995* (pp. 253–261). Durban: Health Systems Trust.

Parry, K. (1998). Grounded Theory and Social Process. *Leaderhip Quarterly*, *9*(1), 85–105.

Pearce, C. L., Conger, J. A., & Locke, E. A. (2008). Shared leadership theory. *The*

Leadership Quarterly, *19*(5), 622–628.

Penn-Kekana, Loveday, Blaauw, D. B., & Schneider, H. (2004). 'It makes me want to run away to Saudi Arabia': management and implementation challenges for public financing reforms from a maternity ward perspective. *Health Policy and Planning*, *19*(suppl 1), i71–i77.

Perry, J. L., & Hondeghem, A. (2008). *Motivation in public management: The call of public service* (J. L. Perry & A. Hondeghem, Eds.). London: Oxford University Press.

Peters, D. H. (2014). The application of systems thinking in health: why use systems thinking? *Health Research Policy and Systems*, *12*(1), 1–6.

Pettigrew, A. M. (1985). Contextualist Research and the Study of Organizational Change Processes. *Research Methods in Information Systems*, *1*, 55–78.

Pettigrew, A. M. (1987). Context and Action in the Transformation of the Firm. *Journal of Management Studies*, *24*(6), 649–670.

Pettigrew, A. M. (1990). Longitudinal field research on change: theory and practice. *Organization Science*, *1*(3), 267–292.

Pettigrew, A. M. (1997). What is a processual analysis? *Scandinavian Journal of Management*, *13*(4), 337–348.

Pettigrew, A. M., Woodman, R. W., & Cameron, K. S. (2001). Studying organizational change and development: challenges for future research. *Academy of Management Journal*, *44*(4), 697–713.

Pierce, J. L., & Newstrom, J. W. (2011). *Leaders and the leadership process* (Sixth). New York, NY: McGraw-Hill.

Pillay, R. (2008). Defining competencies for hospital management: A comparative analysis of the public and private sectors. *Leadership in Health Services*, *21*(2), 99–110.

Pillay, R. (2010). Towards a competency-based framework for nursing management education. *International Journal of Nursing Practice*, *16*(6), 545–554.

Pillay, Y, McCoy, D., & Asia, B. (2001). The district health system in South Africa: progress made and next steps. *Pretoria: National Department of Health*. Pretoria, South Africa.

Pillay, Yogan, & Barron, P. (2011). The implementation of PHC re-engineering in South Africa. *PHASA Online Newsletter 15 November 2011*, 1–6.

Plsek, P. E., & Wilson, T. (2001). Complexity, leadership, and management in healthcare organisations. *BMJ*, *323*(7315), 746–749.

Pope, C., & Mays, N. (1995). Qualitative research: reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ*, *311*(6996), 42–45.

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

Powell, A. E., & Davies, H. T. (2012). The struggle to improve patient care in the face of professional boundaries. *Social Science & Medicine*, *75*(5), 807–814.

Preker, A. S., & Harding, A. (2003a). *Innovations in health service delivery: the corporatization of public hospitals* (A. S. Preker & A. Harding, Eds.). Washington, DC: The World Bank.

Preker, A. S., & Harding, A. (2003b). The economics of hospital reform: from hierarchical to market-based incentives. *World Hospitals and Health Services : The Official Journal of the International Hospital Federation*, *39*(3), 3–10.

Raelin, J. (2011). From leadership-as-practice to leaderful practice. *Leadership*, *7*(2), 195–211.

Ravaghi, H., Foroughi, Z., Nemati, A., & Bélorgeot, V. D. (2018). A holistic view on implementing hospital autonomy reforms in developing countries: a systematic review. *Health Policy and Planning*, *33*(10), 1118–1127.

Raven, B. H. (2008). The Bases of Power and the Power/Interaction Model of Interpersonal Influence. *Analyses of Social Issues and Public Policy*, *8*(1), 1–22.

Reicher, S., Haslam, S. A., & Hopkins, N. (2005). Social identity and the dynamics of leadership: Leaders and followers as collaborative agents in the transformation of social reality. *The Leadership Quarterly*, *16*(4), 547–568.

Republic of South Africa. Constitution of the Republic of South Africa, Act 108 of 1996. , Government Gazette § (1996).

Republic of South Africa. *Nursing Act No. 33 of 2005*. , Pub. L. No. 33, 1 (2005).

Republic of South Africa. (2011). *National Development Plan 2030: Our future - make it work*. Pretoria, South Africa.

Republic of South Africa. *National Amendment Act No. 12 of 2013*. , Pub. L. No. 529 (2013).

Republic of South Africa. (2014). *Medium-Term Strategic Framework (MTSF) 2014-2019*. Pretoria, South Africa.

Republic of South Africa. (2019). South African Government System. Retrieved July 13, 2019, from https://www.gov.za/about-government/government-system

Rispel, L., & Bruce, J. (2014). A profession in peril? Revitalising nursing in South Africa. *South African Health Review 2014*, *1*, 117–125.

Rispel, L. C., Blaauw, D., Ditlopo, P., & White, J. (2018). Human resources for health and universal health coverage: progress, complexities and contestations. *South African Health Review*, *1*, 13–21.

Rispel, L., & Schneider, H. (1991). Professionalization of South African nursing: who benefits? *International Journal of Health Services*, *21*(1), 109–126.

Roman, T. E. (2017). *Exploring Decision Space: A Case Study of Two South African Central Hospitals*. University of Cape Town.

Rouse, W. B. (2008). Health Care as a Complex Adaptive System: Implications for Design and Management. *Organization Science*, *38*(1), 17.

Rousseau, D. M., & Fried, Y. (2001). Location, location, location: contextualizing organizational research. *Journal of Organizational Behavior*, *22*, 1–13.

RSA Auditor-General of South Africa. *Public Audit Act, No. 25 of 2004*. , Pub. L. No. 27121, 24 (2004).

RSA Department of Higher Education and Training. (2019). *National Skills Development Plan 2030 - An educated, skilled and capable workforce for South Africa*. Pretoria, South Africa.

RSA Department of Public Service and Administration. *Public Service Amendment Act 30 of 2007*. , Pub. L. No. 22, 511 (2008).

RSA National DoH. *National Health Act No. 61 of 2003*. , Pub. L. No. 869 (2004).

RSA National DoH. (2010). *National Department of Health Strategic Plan 2010/2011-2012/2013*. Pretoria, South Africa.

RSA National DoH. National Health Act 2003: Policy on the Management of Public Hospitals. , Pub. L. No. 656, Government Gazette (2011).

RSA National DoH. *National Health Act No. 61 of 2003: Policy on the Management of Public Hospitals*. , (2011).

RSA National DoH. (2011c). *National Health Insurance in South Africa (Green Paper)*. Pretoria, South Africa.

RSA National DoH. (2011d). *The HRH Strategy for the Health Sector: 2012/13 - 2016/17*. Pretoria, South Africa.

RSA National DoH. (2013). *Annual Performance Plan 2014/15-2016/17* (p. 156). p. 156. Pretoria, South Africa.

RSA National DoH. (2014). *Department of Health Strategic Plan 2014/15 - 2018/19*. Pretoria, South Africa.

RSA National DoH. (2015). *National Health Insurance for South Africa: Towards Universal Health Coverage (White Paper)*. Pretoria, South Africa.

RSA National DoH. (2016). *Status of NHI Pilot Districts - Progress Report*. Pretoria, South Africa.

RSA National DoH. *National Health Insurance Bill*. , Pub. L. No. 42598, 60 (2019).

RSA National Treasury. *Public Finance Management Act No. 1 of 1999*. , (1999).

RSA National Treasury. *Division of Revenues Act No 16 of 2019*. , Pub. L. No. 636, 112 (2019).

RSA National Treasury. (2019b). The 2019 Estimates of National Expenditure.

Russell, S., Bennet, S., & Mills, A. (1999). Reforming the health sector: towards a healthy new public management. *Journal of International Development: The Journal of the Development Studies Association*, *11*(5), 767–775.

Rwashana, A. S., Nakubulwa, S., Nakakeeto-Kijjambu, M., & Adam, T. (2014). Advancing the application of systems thinking in health: understanding the dynamics of neonatal mortality in Uganda. *Health Research Policy and Systems*, *12*(1), 1–14.

Ryan, F., Coughlan, M., & Cronin, P. (2007). Step-by-step guide to critiquing research. Part 2: Qualitative research. *British Journal of Nursing*, *16*(12), 738–744.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*(1), 68.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, *8*(3), 27–37.

Sandelowski, M. (2000). Combining qualitative and quantitative sampling, data

collection, and analysis techniques in mixed-method studies. *Research in Nursing & Health*, *23*(3), 246–255.

Schaay, N., Sanders, D., & Kruger, V. (2011). Overview of health sector reforms in South Africa. *Human Development Resource Center, London*.

Schneider, M., & Somers, M. (2006). Organizations as complex adaptive systems: Implications of Complexity Theory for leadership research. *Leadership Quarterly*, *17*(4), 351–365.

Schueller-Weidekamm, C., & Kautzky-Willera, A. (2012). Challenges of work–life balance for women physicians/mothers working in leadership positions. *Gender Medicine*, *9*(4), 244–250.

Scott, T., Mannion, R., Marshall, M., & Davies, H. T. O. (2003). Does organisational culture influence health care performance? A review of the evidence. *Journal of Health Services Research & Policy*, *8*(2), 105–117.

Sedgwick, M. G., & Yonge, O. (2008). "We're it",'We're a team','We're family'means a sense of belonging. *Rural & Remote Health*, *8*(3).

Shamir, B. (1999). Leadership in boundaryless organizations: disposable or indispensable? *European Journal of Work and Organizational Psychology*, *8*(1), 49-71.

Shamir, Boas, House, R. J., & Arthur, M. B. (1993). The motivational effects of charismatic leadership: A self-concept based theory. *Organization Science*, *4*(4), 577–594.

Shamir, Boas, & Howell, J. M. (1999). Organizational and contextual influences on the emergence and effectiveness of charismatic leadership. *The Leadership Quarterly*, *10*(2), 257–283.

Shamir, Boas, & Lapidot, Y. (2003). Trust in Organizational Superiors: systemic and collective considerations. *Organization Studies*, *24*(3), 463–491.

Sheikh, K., Gilson, L., Agyepong, I. A., Hanson, K., Ssengooba, F., & Bennett, S. (2011). Building the field of health policy and systems research: framing the questions. *PLoS Medicine*, *8*(8), e1001073.

Shung-King, M., Gilson, L., Mbachu, C., Molyneux, S., Muraya, K. W., Uguru, N., & Govender, V. (2018). Leadership experiences and practices of South African health managers: what is the influence of gender? - a qualitative, exploratory study.

International Journal for Equity in Health, *17*(1), 1–12.

Skogstad, A., Einarsen, S., Torsheim, T., Aasland, M. S., & Hetland, H. (2007). The destructiveness of laissez-faire leadership behavior. *Journal of Occupational Health Psychology*, *12*(1), 80–92.

Snaebjornsson, I. M., & Edvardsson, I. R. (2013). Gender, nationality and leadership style: A literature review. *International Journal of Business and Management*, *8*(1), 89.

Soklaridis, S., Kuper, A., Whitehead, C. R., Fergusson, G., Taylor, V. H., & Zahn, C. (2017). Gender bias in hospital leadership: a qualitative study on the experiences of women CEOs. *Journal of Health Organization and Management*, *31*(2).

Song, H., Ryan, M., Tendulkar, S., Fisher, J., Martin, J., Peters, A. S., … Singer, S. J. (2017). Team dynamics, clinical work satisfaction, and patient care coordination between primary care providers: a mixed methods study. *Health Care Management Review*, *42*(1), 28–41.

Spillane, J. P. (2012). *Distributed leadership*. John Wiley & Sons.

Spyridonidis, D., Hendy, J., & Barlow, J. (2015). Understanding hybrid roles: The role of identity processes amongst physicians.". *Public Administration*, *93*(2), 395–411.

Ssengooba, F., Atuyambe, L., McPake, B., Hanson, K., & Okuonzi, S. (2002). What could be achieved with greater public hospital autonomy? Comparison of public and PNFP hospitals in Uganda. *Public Administration and Development:The International Journal of Management Research and Practice*, *22*(5), 415–428.

Stentz, J. E., Plano Clark, V. L., & Matkin, G. S. (2012). Applying mixed methods to leadership research: A review of current practices. *The Leadership Quarterly*, *23*(6), 1173–1183.

Sutherland, N. (2018). Investigating leadership ethnographically: Opportunities and potentialities. *Leadership*, *14*(3), 263–290.

Tabak, N., & Orit, K. (2007). Relationship between how nurses resolve their conflicts with doctors, their stress and job satisfaction. *Journal of Nursing Management*, *15*(3), 321–331.

Tangcharoensathien, V., Witthayapipopsakul, W., Panichkriangkrai, W., Patcharanarumol, W., & Mills, A. (2018). Health systems development in Thailand: a solid platform for successful implementation of universal health coverage. *The Lancet*,

391(10126), 1205-1223.

ten Hoeve, Y., Jansen, G., & Roodbol, P. (2014). The nursing profession: public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing*, *70*(2), 295–309.

Thylefors, I. (2012). All professionals are equal but some professionals are more equal than others? Dominance, status and efficiency in Swedish interprofessional teams.". *Scandinavian Journal of Caring Sciences*, *26*(3), 505–512.

Timmermans, S., & Tavory, I. (2012). Theory construction in qualitative research: From grounded theory to abductive analysis. *Sociological Theory*, *30*(3), 167–186.

Topp, S. M., Chipukuma, J. M., & Hanefeld, J. (2015). Understanding the dynamic interactions driving Zambian health centre performance: a case-based health systems analysis. *Health Policy and Planning*, *30*(4), 485–499.

Trottier, T., Van Wart, M., & Wang, X. (2008). Examining the nature and significance of leadership in government organizations. *Public Administration Review*, *68*(2), 319–333.

Tsai, Y. (2011). Relationship between organizational culture, leadership behavior and job satisfaction. *BMC Health Services Research*, *11*(1), 98.

Tsui, A. S., Egan, T., & O'Reilly, C. (1991). Being Different: Relational Demography and Organizational Attachment. *Academy of Management Best Papers Proceedings*, *8*(1), 183–187.

Turner, J. C., Oakes, P. J., Haslam, S. A., & McGarty, C. (1994). Self and collective: Cognition and social context. *Personality and Social Psychology Bulletin*, *20*(5), 454–463.

UNDP. (2018). South Africa Human Development Indicators. Retrieved July 13, 2019, from Human Development Reports website: http://hdr.undp.org/en/countries/profiles/ZAF#

Van Wart, M. (2003). Public-sector leadership theory: An Assessment. *Public Administration Review*, *63*(2), 214–228.

Von Holdt, K., & Murphy, M. (2007). Public hospitals in South Africa: stressed institutions, disempowered. In S. Buhlungu, J. Daniel, R. Southall, & J. Lutchman (Eds.), *State of the nation: South Africa 2007* (p. 312). HSRC Press.

Vroom, V. H. (1964). *Work and motivation*. New York: Wiley.

Vroom, V. H., & Jago, A. G. (1988). *The new leadership: Managing participation in organizations.* Prentice-Hall, Inc.

Vroom, V. H., & Jago, A. G. (2007). The role of the situation in leadership. *American Psychologist*, *62*(1), 17.

Vroom, V. H., & Yetton, P. W. (1973). *Leadership and decision-making*. University of Pittsburgh Press.

Waithaka, D., Kagwanja, N., Nzinga, J., Tsofa, B., Leli, H., Mataza, C., … Molyneux, S. (2020). Prolonged health worker strikes in Kenya-perspectives and experiences of frontline hea. *International Journal for Equity in Health*, *19*(1), 23.

Waring, J., & Currie, G. (2009). Managing expert knowledge: organizational challenges and managerial futures for the UK medical profession.". *Organization Studies*, *30*(7), 755–778.

Weick, K. E., Sutcliffe, K. M., & Obstfeld, D. (2005). Organizing and the process of sensemaking. *Organization Science*, *16*(4), 409–421.

Welch-Carre, E. (2017). *Influence of A Hospital-Based, Internal Leadership Development Program on Leadership Effectiveness*. Creighton University.

West, M. A., Lyubovnikova, J., Eckert, R., & Denis, J.-L. (2014). Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance*, *1*(3), 240–260.

Western Cape Government. (2003). *A framework for developing a Human Resources & Skills Development Strategy in the Western Cape*. Cape Town, South Africa.

Western Cape Government. (2018). *Cape Metro District Health Plan 2018/19 - 2020/21*. Cape Town, South Africa.

Western Cape Government DoH. (2007). *Comprehensive Service Plan for the Implementation of Healthcare 2010*. Cape Town, South Africa.

Western Cape Government DoH. (2014). *Healthcare 2030: The Road to Wellness*. Cape Town, South Africa.

Western Cape Government DoH. (2015). *Strategic Plan 2015-2019*. Cape Town, South Africa.

Western Cape Government DoH. (2016a). *Annual Report 2015-2016*. Cape Town, South Africa.

Western Cape Government DoH. (2016b). *Leadership Competency Framework*. Cape Town, South Africa.

Western Cape Government DoH. (2016c). *Leadership Development Strategy 2016*. Cape Town, South Africa.

Western Cape Government DoH. (2017). *Annual Performance Plan 2017-2018*. Cape Town, South Africa.

Western Cape Government DoH. (2018a). *Annual Performance Plan 2018-2019*. Cape Town, South Africa.

Western Cape Government DoH. (2018b). *Western Cape Government Health: Annual Report 2017-2018*. Cape Town, South Africa.

White, L., Currie, G., & Lockett, A. (2014). The enactment of plural leadership in a health and social care network: The influence of institutional context. *The Leadership Quarterly*, *25*(4), 730–745.

Willetts, G., & Clarke, D. (2014). Constructing nurses' professional identity through social identity theory. *International Journal of Nursing Practice*, *20*, 164–169.

Willis-Shattuck, M., Bidwell, P., Thomas, S., Wynes, L., Blaauw, D., & Ditlopo, P. (2008). Motivation and retention of health workers in developing countries: a systematic review. *BMC Health Services Research*, *8*(247).

World Bank. (2018). *Overcoming Poverty and Inequality in South Africa: An Assessment of Drivers , Constraints and Opportunities*. Retrieved from http://documents.worldbank.org/curated/en/530481521735906534/pdf/124521-REV-OUO-South-Africa-Poverty-and-Inequality-Assessment-Report-2018-FINAL-WEB.pdf

World Bank. (2020). World Development Indicators 2015 to 2018 - Upper Middle Income Countries. Retrieved February 17, 2021, from The World Bank in Middle Income Countries website: https://data.worldbank.org/income-level/upper-middle-income

World Health Organization. (1992). The Hospital in Rural and Urban Districts: Report of WHO Study Group on the Functions of Hospitals at the First Referral Level. In *World Health Organization - Technical Report Series*. Geneva, Switzerland.

World Health Organization. (2007). *Everybody's business -strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: World

Health Organization.

Wuisman, J. J. J. M. (2005). The logic of scientific discovery in critical realist social scientific research. *Journal of Critical Realism*, *4*(2), 366–394.

Yammarino, F. J., Salas, E., Serban, A., Shirreffs, K., & Shuffler, M. L. (2012). Collectivistic leadership approaches: Putting the "we" in leadership science and practice. *Industrial and Organizational Psychology*, *5*(4), 382–402.

Yin, R. K. (2014). *Case Study Research: Design and Methods* (Fifth). Los Angeles: Sage Publications, Inc.

Yukl, G. (2006). *Leadership in organizations* (Vol. 6th). Upper Saddle river, NJ: Pearson-Prentice Hall.

Yukl, G. (2009). Leading organizational learning: Reflections on theory and research. *Leadership Quarterly*, *20*(1), 49–53.

Yukl, G., & Falbe, C. M. (1991). Importance of different power sources in downward and lateral relations. *Journal of Applied Psychology*, *76*(3), 416–423.

Yukl, G., & Lepsinger, R. (2005). Why integrating the leading and managing roles is essential for organizational effectiveness. *Organizational Dynamics*.

Zigan, K., Macfarlane, F., & Desombre, T. (2008). Intangible resources as performance drivers in European hospitals. *International Journal of Productivity and Performance Management*, *57*(1), 57–71.

Zigan, K., Macfarlane, F., & Desombre, T. (2009). The Identification of Important Intangible Resources in Hospitals. *International Journal of Public Adminstration*, *32*(13), 1162–1181.

Annexures

Annexure 1: Staff Satisfaction Survey 2016 Findings for DHA

Western Cape Government Health

Staff Satisfaction Survey Results

June 2016

Introduction

Western Cape Government Health commissioned the services of the Independent Counselling and Advisory Services (ICAS) to analyse the data for their 2016 staff satisfaction survey. The aim of the survey was to assess the organisational climate among this group of employees by way of their thoughts and opinions with regard to the organisation, their job and their work environment.

This report is based on 102 responses received and this represents a 23.0% response rate. This response rate is sufficient to ensure representivity of the findings. However, it would be recommended that corroborative data is considered in conjunction with these results.

A similar survey was conducted in 2013, with 147 respondents. Where available, the results of the 2013 survey are provided in this report for comparative purposes.

The staff satisfaction survey comprised 65 questions. The primary dimensions assessed in the survey were related to opinion of the organisation, communication, leadership, employee satisfaction with the organisation and organisational support structures, trust, team functioning, performance management, growth and development and coping style.

Demographic overview of participants

The greatest number of responses were received by Nurses (51.0%), followed by Administrative employees (23.5%). With regard to salary level, the majority of employees (52.9%) were in the level 1 – 6 category. Representation by age was greatest in the 36 – 50 category (46.1%), followed by employees who were 18 – 35 (38.2%). 41.2% of respondents have been employed for 0 – 5 years. The majority of respondents were female (76.5%). Of the respondents, 0.98% indicated that they were living with a disability.

Occupational category	No.	%
Admin	24	23.53%
Allied	4	3.92%
Doctor	13	12.75%
Nurse	52	50.98%
Support	7	6.86%
No response	2	1.96%
Grand Total	**102**	**100.00%**

Salary level	No.	%
Level 1 - 6	54	52.94%
Level 7 - 8	20	19.61%
Level 9 - 12	27	26.47%
Level 13 - 16	0	0.00%
No response	1	0.98%
Grand Total	**102**	**100.00%**

Age	No.	%
18 - 35	39	38.24%
36 - 50	47	46.08%
51 - 65	16	15.69%
66 and older	0	0.00%
No response	0	0.00%
Grand Total	**102**	**100.00%**

Years of service	No.	%
0 - 5 years	42	41.18%
6 - 10 years	21	20.59%
11 - 15 years	11	10.78%
16 - 20 years	4	3.92%
21 years and over	24	23.53%
No response	0	0.00%
Grand Total	**102**	**100.00%**

Please select your respective sex	No.	%
Female	78	76.47%
Male	23	22.55%
No response	1	0.98%
Grand Total	**102**	**100.00%**

Please select if you have a disability	No.	%
No	99	97.06%
Yes	1	0.98%
No response	2	1.96%
Grand Total	**102**	**100.00%**

Opinion of the organisation

Overall it appears that levels of satisfaction with regard to respondents' general opinion of the organisation were mixed. The 2 highest scoring items in this dimension were with regard the organisation being committed to providing quality care to patients (75.5% agreement) and feeling that the individual had an important role to play in the organisation's operations (71.6% agreement). Both of these items have increased since the previous survey. There were 2 items that did not score favourably on levels of agreement. Only 35.3% of felt that the organisation valued and cared for employees, and 37.3% felt as though the organisation treated them fairly. When an employee perceives that the organisation cares for them and supports them this may serve to fulfil employees' emotional and social needs and in this way, their role within the organisation may actually become an integrated part of their identity. It has also been shown that employees who feel valued and cared for are more likely to expend discretionary energy in the course of their daily work. In this instance, it appears that while employees are proud of and loyal towards the organisation, this may be an intrinsic commitment towards the ideals of being in a helping profession. In order for this level of internal inspiration to be sustained, there needs to be a perception that the organisation returns those same levels of loyalty and pride to the employee.

							2016		2013	
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response	Agree	Disagree	Agree	Disagree
The organisation values & cares for its employees	7.84%	27.45%	27.45%	18.63%	18.63%	0.00%	35.29%	37.25%	37.41%	33.33%
The organisation treats its employees fairly	4.90%	32.35%	23.53%	25.49%	11.76%	1.96%	37.25%	37.25%	32.65%	36.73%
I have an important role to play in the organisation operations	22.55%	49.02%	17.65%	3.92%	2.94%	3.92%	71.57%	6.86%	48.98%	23.81%
I feel a strong sense of loyalty to the organisation	26.47%	42.16%	15.69%	5.88%	5.88%	3.92%	68.63%	11.76%	65.99%	12.93%
My organisation is committed to providing quality care to patients	22.55%	52.94%	13.73%	3.92%	4.90%	1.96%	75.49%	8.82%	71.43%	5.44%

Communication and consultation within the organisation

The primary area of dissatisfaction with communication lay in the organisation's willingness to act upon and provide feedback on the ideas and suggestions received from employees. Only 26.5% indicated that they received feedback on their suggestions and 21.6% indicated that the organisation put their ideas into practice. Less than half of the respondents agreed that they were kept adequately informed about planned changes (37.3%). Communication functions as a key driver of employee engagement and performance and within the Health Care context also functions as a contributor towards customer satisfaction and service delivery. In order for employees' to continue to engage in their work and their working environment they need to be able to contribute towards the advancement of the organisation and consultations with employees form a key component of such an initiative. The absence of such consultations have the potential to result in corridor talk, the vilification of "Head Office" as not understanding the local context of frontline staff, resentment towards to the organisation and a pre-occupation with not being informed which diverts energy from key job requirements. Given the perceptions which have been raised around communication, communication of the results of this survey would be an ideal way of shifting perceptions with regard to not being heard by the organisation. Having said that, any communication of the results should be accompanied by a clear plan as to how areas of concern will be addressed. The following table provides an overview of the results for this dimension.

							2016	2016	2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response	Agree	Disagree	Agree	Disagree
The organisation keeps employees informed about planned changes timeously	9.80%	27.45%	27.45%	17.65%	15.69%	1.96%	37.25%	33.33%	25.85%	43.54%
The organisation is open to employee's feedback and ideas	7.84%	28.43%	29.41%	15.69%	16.67%	1.96%	36.27%	32.35%		
You receive feedback on your suggestions	3.92%	22.55%	31.37%	20.59%	17.65%	3.92%	26.47%	38.24%	23.81%	43.54%
The organisation puts employees' ideas into practice	2.94%	18.63%	34.31%	23.53%	17.65%	2.94%	21.57%	41.18%	20.41%	38.78%

Leadership style

The most favourably rated item on this dimension was with regard to line management respecting and valuing work contributions, with 79.4% agreeing with this. 67.7% of respondents felt that their line manager genuinely cared about employee needs. The lowest scoring item on this dimension was with regard to having received recognition or praise for doing good work (56.9% agreement). 69.6% of respondents indicated that their line manager was able to manage internal conflict effectively. In the day-to-day life of an organisation it falls to the manager to create the work experience of employees, and this extends to more than having mastered the operational basics of their role. A key example may be in relation to perceptions of how managers' manage conflict. Managing conflict may fall within the realm of people management skills and is an integral component of managing both individuals and teams. In the absence of effective conflict management by a manager employees may question the reliability, integrity, and trustworthiness of managers. The absence of these factors may negatively influence not only the performance of employees but their discretionary effort. The results from this dimension are outlined in greater detail in the following table.

							2016	2016	2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response	Agree	Disagree	Agree	Disagree
My line manager genuinely cares about employee's needs	20.59%	47.06%	15.69%	3.92%	9.80%	2.94%	67.65%	13.73%	62.59%	17.69%
My line manager respects and values my contribution at work	22.55%	56.86%	10.78%	4.90%	2.94%	1.96%	79.41%	7.84%	65.99%	12.93%
My line manager is able to manage internal conflict effectively	20.59%	49.02%	13.73%	10.78%	3.92%	1.96%	69.61%	14.71%		
In the last 7 days I have received recognition or praise (for example, a thank you) for doing good work from my manager	19.61%	37.25%	15.69%	12.75%	11.76%	2.94%	56.86%	24.51%	48.30%	31.97%

Team functioning

88.2% of respondents indicated that they had good relationships with the people that they work with. It is further encouraging to note that 84.3% were able to consult with their colleagues when faced with an unexpected or challenging situation at work. The lowest scoring item on this dimension was with regard to different professions working well together, with 61.8% agreeing. 35.3% of respondents indicated that their colleagues were looking to leave the organisation within the next 6 months. What would be useful would be to consider the attrition rate for the last year in order to plan effectively for any potential exits.

							2016	**2016**	**2013**	**2013**
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response	Agree	Disagree	Agree	Disagree
In my unit/component the staff function well as a team	27.45%	54.90%	11.76%	2.94%	1.96%	0.98%	82.35%	4.90%	77.55%	9.52%
I have good relationships with the people that I work with	33.33%	54.90%	6.86%	0.00%	1.96%	2.94%	88.24%	1.96%		
I am able to consult my colleagues when I am faced with an unexpected or challenging situation at work	36.27%	48.04%	10.78%	0.98%	0.98%	2.94%	84.31%	1.96%	78.23%	5.44%
My colleagues are committed to doing quality work	24.51%	55.88%	15.69%	1.96%	0.98%	0.98%	80.39%	2.94%	75.51%	7.48%
My colleagues are looking to leave the organisation within the next 6 months	8.82%	26.47%	31.37%	23.53%	8.82%	0.98%	35.29%	32.35%	29.93%	33.33%
Different professions (Doctors, health professionals, admin) work well together	12.75%	49.02%	24.51%	4.90%	5.88%	2.94%	61.76%	10.78%	58.50%	15.65%

Drivers of commitment and retention

It is encouraging to note the extent to which respondents indicated that they are clear as to what they are supposed to accomplish at work (90.2% agreement) and how their job contributes to the organisation's objectives (88.2% agreement). These items, to a large extent, relate to the support structures that an organisation provides, and it is imperative that employees are clear with regard to what they are supposed to do. 43.1% of respondents' indicated that their unit/team had access to sufficient resources to complete their work effectively. The item with the greatest disagreement was with regard to people being transparent and open in their communication, with 35.3% indicating that this was not the case.

							2016	**2016**	**2013**	**2013**
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response	Agree	Disagree	Agree	Disagree
I am highly motivated to do my job	32.35%	49.02%	8.82%	4.90%	3.92%	0.98%	81.37%	8.82%	68.03%	14.29%
I have a measure of control and influence over how my work is completed	24.51%	60.78%	6.86%	3.92%	0.98%	2.94%	85.29%	4.90%	74.83%	8.16%
I feel secure in my position at this organisation with the current changes taking place	12.75%	50.98%	14.71%	13.73%	5.88%	1.96%	63.73%	19.61%		
I find the content of my work interesting and stimulating	30.39%	47.06%	8.82%	9.80%	2.94%	0.98%	77.45%	12.75%	73.47%	10.88%
At work, I have the opportunity to do what I do best every day	27.45%	49.02%	12.75%	4.90%	3.92%	1.96%	76.47%	8.82%	74.15%	10.20%
I understand how my job contributes to the organisation's objectives	33.33%	54.90%	7.84%	0.98%	0.98%	1.96%	88.24%	1.96%	84.35%	4.76%
I am clear as to what I am supposed to accomplish at work	28.43%	61.76%	6.86%	1.96%	0.00%	0.98%	90.20%	1.96%	82.99%	3.40%
People in this organisation are transparent (no hidden agendas) and communicate openly	4.90%	24.51%	34.31%	19.61%	15.69%	0.98%	29.41%	35.29%	21.09%	31.97%
My unit/team has access to sufficient resources to complete their work effectively	5.88%	37.25%	21.57%	15.69%	17.65%	1.96%	43.14%	33.33%		
My workload is manageable	5.88%	37.25%	20.59%	16.67%	9.80%	9.80%	43.14%	26.47%	46.26%	23.81%

Physical work environment, safety & security

Employees reported varying levels of satisfaction on this dimension. With regard to the physical work environment, 26.5% indicated that the ablution/cloakroom facilities were adequate and 21.6% were satisfied with the restroom/tearoom facilities. There were concerns with regard to the safety of personal belongings, with 28.4% indicating that these were safe. In contrast, 52.9% felt safe at work during the day. At a very basic level the comfort of the physical work environment may be viewed as being an indicator of the extent to which the organisation cares about the comfort of their employees and views them as being valuable enough to invest in their work environment.

								2016	2016		2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
I feel safe at work during the day	10.78%	42.16%	23.53%	9.80%	10.78%	2.94%		52.94%	20.59%		57.14%	19.05%
I feel safe at work during the night	3.92%	29.41%	31.37%	15.69%	8.82%	10.78%		33.33%	24.51%		38.78%	22.45%
My personal belongings are safe at work, e.g. car, bag, etc.	5.88%	22.55%	24.51%	26.47%	18.63%	1.96%		28.43%	45.10%		28.57%	40.82%
The restroom/tearoom facilities are adequate	4.90%	16.67%	15.69%	30.39%	29.41%	2.94%		21.57%	59.80%		29.25%	40.82%
The ablution/cloakroom facilities are adequate	3.92%	22.55%	11.76%	25.49%	26.47%	9.80%		26.47%	51.96%		27.89%	38.10%
My building is safe and well maintained	1.96%	21.57%	21.57%	32.35%	19.61%	2.94%		23.53%	51.96%			
My building caters for the needs of persons with disabilities	6.86%	25.49%	23.53%	23.53%	17.65%	2.94%		32.35%	41.18%			

With regard to having experienced verbal and/or physical abuse from patients in the past year, 36.3% indicated that they had experienced this form of abuse (that is, they disagreed with the item). Approximately 21.6% indicated that they had experienced verbal abuse from members of staff in the last year and 14.7% had been harassed (sexual/racial/emotional). These items point to the level of strain that employees are experiencing in the day-to-day work environment over and above the emotional demands of the actual job that they are engaged in. Of the respondents, 41.2% felt that the organisation took adequate steps to ensure that they were not exposed to violence and aggression at work and 42.2% indicated that the organisation supported and promoted employee health and wellbeing.

								2016	**2016**		**2013**	**2013**
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
I have not experienced verbal and/or physical abuse in the last year from colleagues or employees	12.75%	45.10%	17.65%	13.73%	7.84%	2.94%		57.84%	21.57%		55.78%	20.41%
I have not experienced verbal and/or physical abuse from patients in the last year	7.84%	37.25%	15.69%	18.63%	17.65%	2.94%		45.10%	36.27%		48.30%	31.29%
I have not been exposed to harassment (sexual, racial, or emotional) at work in the last year	18.63%	48.04%	15.69%	7.84%	6.86%	2.94%		66.67%	14.71%			
The organisation takes adequate steps to ensure that I am not exposed to violence and aggression at work	6.86%	34.31%	27.45%	20.59%	8.82%	1.96%		41.18%	29.41%		43.54%	21.09%
The organisation supports and promotes employee health and wellness	9.80%	32.35%	22.55%	18.63%	12.75%	3.92%		42.16%	31.37%			

Performance appraisal and evaluation

A key organisational imperative is organisational performance and often performance management structures are a key component of ensuring that employees are performing effectively. 52.0% of respondents had had 2 performance evaluations in the last year. 49.0% of respondents felt at ease during their appraisal and 48.0% indicated that their appraisal was conducted in a positive manner. In comparison, only 35.3% of respondents felt that the current performance management structures promoted a high-performance culture. This may suggest concerns regarding the performance, or lack thereof, of other employees (that is, a perception that they work harder than others). This raises the question as to the purpose of performance management in the organisation and what the outcomes of the process should be, not only for the employee, but for the organisation as well.

								2016	2016		2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
I have had at least 2 performance appraisals/evaluations in the last year	8.82%	43.14%	13.73%	12.75%	16.67%	4.90%		51.96%	29.41%		51.70%	22.45%
I felt at ease during the appraisal	8.82%	40.20%	22.55%	8.82%	9.80%	9.80%		49.02%	18.63%		45.58%	17.01%
The appraisal was conducted in a positive manner	7.84%	40.20%	29.41%	3.92%	8.82%	9.80%		48.04%	12.75%		48.98%	14.97%
Performance management structures promote a high-performance culture	3.92%	31.37%	25.49%	15.69%	15.69%	7.84%		35.29%	31.37%		43.54%	24.49%

Services provided by administrative components, e.g. HRM/Staff Office

The lowest scoring item was with regard to being satisfied with the childcare facilities, with only 14.7% of individuals indicating that these were to their satisfaction. In terms of the support services, the area of least agreement was with regard to receiving prompt responses to queries, with only 31.4% agreeing. Only 42.2% of respondents indicated that management were accessible to them when they had not received a satisfactory resolution to their problem. This once again positions the organisation as not taking a vested interest in their employees.

								2016	2016		2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
The support service is efficient in providing assistance when required	6.86%	32.35%	26.47%	19.61%	12.75%	1.96%		39.22%	32.35%			
The support service is accessible to staff to assist with enquiries	5.88%	37.25%	25.49%	19.61%	10.78%	0.98%		43.14%	30.39%			
The support service office responds promptly to my enquiries	6.86%	24.51%	34.31%	21.57%	9.80%	2.94%		31.37%	31.37%			
Management is accessible when I have not been able to receive a satisfactory solution to a problem	4.90%	37.25%	26.47%	14.71%	13.73%	2.94%		42.16%	28.43%		34.01%	28.57%
I am satisfied with the childcare facilities provided by the organisation (only where facilities are available)	0.98%	13.73%	14.71%	0.98%	2.94%	66.67%		14.71%	3.92%		26.53%	24.49%

Education and training

The majority of respondents (84.3%) indicated that they had the requisite skills for performing their work effectively. 50.0% of respondents had attended a training session in the last year and 38.2% indicated that they access to opportunities to grow and develop in the organisation.

								2016	2016		2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
I have the skills I need to perform my work effectively	26.47%	57.84%	8.82%	3.92%	1.96%	0.98%		84.31%	5.88%		74.83%	8.16%
I have a skills development plan, which meets my specific needs and job requirements	13.73%	55.88%	15.69%	5.88%	6.86%	1.96%		69.61%	12.75%		67.35%	10.20%
I have equal and fair access to education and training	5.88%	39.22%	19.61%	15.69%	17.65%	1.96%		45.10%	33.33%		50.34%	29.25%
I have access to opportunities to grow and develop in this organisation	3.92%	34.31%	17.65%	21.57%	18.63%	3.92%		38.24%	40.20%		47.62%	28.57%
I attended at least one training session in the last year	10.78%	39.22%	15.69%	16.67%	14.71%	2.94%		50.00%	31.37%		56.46%	20.41%

Perceptions of change

A 2008 Towers Perrin study of 90 000 employees concluded that a top engagement driver globally was employees' belief that senior management had their best interests at heart. Only 36.3% of employees agreed with this statement on the survey. 56.9% felt that their manager encouraged staff to become part of change and 50.0% of respondents indicated confidence in their line manager's ability to manage change effectively. These results indicate that there is doubt with regard to the change management abilities of leadership structures in the organisation.

								2016	**2016**		**2013**	**2013**
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
I believe that senior management in this organisation have the best interests of employees at heart	6.86%	29.41%	24.51%	14.71%	21.57%	2.94%		36.27%	36.27%		31.97%	32.65%
My manager encourages staff to become part of change	7.84%	49.02%	16.67%	14.71%	7.84%	3.92%		56.86%	22.55%		46.26%	21.77%
My manager manages ongoing change effectively	9.80%	40.20%	24.51%	12.75%	9.80%	2.94%		50.00%	22.55%		47.62%	20.41%

Individual Wellness

69.6% of respondents felt in control of their overall wellbeing. Given the healthcare context within which employees function, and the potential for burnout, steps need to be taken to ensure that employees are able to manage their wellbeing. 20.6% indicated that they frequently struggled to stay out of debt.

	Never	Sometimes	Often	Always	No response
I struggle to stay out of debt	48.04%	28.43%	5.88%	14.71%	2.94%
I feel in control of my overall wellbeing	7.84%	15.69%	29.41%	40.20%	6.86%
Number of chronic conditions	Average of 1				
Number of losses experienced (e.g. death of a loved one, divorce, loss of a job)	Average of 2.74				
Number of traumatic incidents traumatic incidents experienced (threat to life or safety e.g. armed robbery, motor vehicle accident)	Average of 1.19				
How many units of alcohol do you consume per day (a unit is equivalent to one beer, a glass of wine or one tot measure of spirits)	Average of 0.39				

Analysis of qualitative data

There was 1 qualitative question that was asked on the survey, 'what are the 3 things which will make the place at which you work a better place?' There were 217 responses received to this question. These responses were analysed according to themes. These themes were derived based on the content of the comments received. The table below provides an overview of the categories that were developed:

Upgraded infrastructure, assets, facilities, and space creation	26
More staff members/employee capacity	18
Employee learning, development, growth, and job opportunities	15
Facilities tearoom, kitchen and canteen	13
Housing and Transport subsidies	12
Improve style and management of meetings and regular employee forums for employee input (staff/management involvement)	12
Transparency and fairness and honesty and equality	10
Improve work tools, equipment, and stock supply	9
Facilities, improve ablution facilities	7
Communication etiquette and improve access to information	6
Improve morale within teams and encourage a culture of working together	6
Improve supply chain and procurement processes and less red tape	6
Improved safety and security	6
Supportive environment	6
A culture of respect	5
Coffee machine vending machine staff amenities	5

Recognition	5
Cleanliness and better working conditions	4
Prioritise wellness and health promotion for staff members	4
Facilities Aircon	3
HR support	3
Improve/change Leadership enhance strategic intent and create visibility and more trust)	3
Patient centred approach to care	3
Upgrade technology	3
Community Involvement	2
Corruption Nepotism and favouritism in recruitment selection and promotion. Unfair labour practice	2
Facilities parking	2
Less management victimisation and abuse of authority	2
Recreational Facilities (gym)	2
Remuneration	2
Review of working hours	2
A culture of empathy	1
Access to childcare facilities	1
Employee engagement and work commitment	1

Facilities (Furniture)	1
Improve (respect/etiquette/empathy/people competency) management practices and management style	1
Improve budgeting	1
Improve employee/manager relations	1
Improve Performance reward tool (SPMS) motivate with incentives and promotions	1
Language and cultural barriers	1
Qualified/competent management	1
Racial Discrimination	1
Respect confidentiality and reduce gossip	1
Review of staff attitudes	1

The most frequent comment was with regard to the physical work environment (25.4%) of the respondents. Some of the issues that were raised included the need for building renovations, upgraded ablution facilities, storage space, bigger workspaces, shaded parking, parking bays, and more ergonomic planning of workspaces. Respondents also noted the need for maintenance of existing infrastructure, such as fixing lifts, replacing light bulbs, air-conditioning, and fixing broken furniture. With regard to the comfort of their physical working environment, respondents further identified the need for fresh air, fresh water, water coolers, quieter working environments and clean toilets and hygienic work environments.

17.6% of respondents indicated the need for more human resources. The examples provided with regard to the type of staff required included, nurses, doctors, allied health workers, specialists, administrative and cleaning staff. The need for more staff was linked to service delivery in order to ensure that the patient-staff ratio became more manageable. More staff members were needed to meet Victoria Hospital's operational needs of the site, as well as to reduce the extent to which employees were feeling overworked and overloaded. A small number of respondents indicated that adequate staffing would reduce the absenteeism rate in the organisation.

14.7% of respondents raised 2 primary issues raised with regard to training and development. These were the need for growth and greater job opportunities within the organisation and a general need for more training to be provided to employees. Employees indicated a willingness to improve on their current skills so as to

enhance engagement, motivation levels and work commitment. Issues raised also included views around promotions, career advancements and succession planning efforts. A small number of respondents also indicated that there needed to be equal and fair access to education and training.

Linked to the responses with regard to tearooms, kitchens and canteens (12.7%) was the need for recreational space and room to partake in leisure activities during break periods. A number of respondents also identified vending machines and healthier food options in their areas.

Staff Satisfaction Survey: The Way Forward

Based on the findings outlined in this survey the following issues require further attention:

- The results of this survey need to be communicated to employees, with senior management representation at Victoria Hospital. There needs to be ownership of the survey by key stakeholders and a commitment towards addressing the issues which employees are raising.
- There needs to be a commitment to fostering a culture of support and care for employees with an increased focus on people issues. Management in particular needs to be more accessible to staff and might benefit from training on people issues and interpersonal skills in order to foster the culture shift.
- While employees are indicating a need to be heard, it is also evident that there are concerns with the quality of communication that they are receiving from their managers. What is also evident in the qualitative comments is that employees are looking to provide their input on change and innovation for the organisation. So, not only should the structures be provided for employees to contribute their thoughts, but these would need to be acknowledged and considered.
- There are various communication campaigns that should be considered for the employee population: what is the value proposition for being a WCGH employee at Victoria Hospital; how do employees address their burning issues outside of a survey; create awareness on the training and development policies that are available.
- Where required, address the structural issues addressed in the survey, for example, the need for fresh air, the need for fresh water and the need for general cleanliness of the facilities.
- Avenues for emotional support (group or individual) should be given attention. One component of this would be to continue to encourage employees to make use of the EWP.
- There were key issues raised in the qualitative comments with regard to values such as fairness, accountability, equality, trust, and honesty. These are the intangible issues that influence employee levels of motivation and discretionary effort. Leadership in the organisation need to be perceived as being congruent in relation to the values of the organisation.

Annexure 2: Staff Satisfaction Survey 2016 Findings for DHB

Western Cape Government Health

Staff Satisfaction Survey Results

June 2016

Introduction

Western Cape Government Health commissioned the services of the Independent Counselling and Advisory Services (ICAS) to analyse the data for their 2016 staff satisfaction survey. The aim of the survey was to assess the organisational climate among this group of employees by way of their thoughts and opinions with regard to the organisation, their job and their work environment.

This report is based on 455 responses received and this represents a 59.8% response rate. This response rate is sufficient to ensure representivity of the findings. However, it would be recommended that corroborative data is considered in conjunction with these results.

A similar survey was conducted in 2013, with 273 respondents. Where available, the results of the 2013 survey are provided in this report for comparative purposes.

The staff satisfaction survey comprised 65 questions. The primary dimensions assessed in the survey were related to opinion of the organisation, communication, leadership, employee satisfaction with the organisation and organisational support structures, trust, team functioning, performance management, growth and development and coping style.

Demographic overview of participants

The greatest number of responses were received by Nurses (53.4%), followed by Administrative employees (23.1%). With regard to salary level, the majority of employees (74.1%) were in the level 1 – 6 category. Representation by age was greatest in the 36 – 50 category (43.3%), followed by employees who were 18 – 35 (39.3%). 53.4% of respondents have been employed for 0 – 5 years. The majority of respondents were female (78.7%). Of the respondents, 3.30% indicated that they were living with a disability.

Occupational category	No.	%
Admin	105	23.08%
Allied	32	7.03%
Doctor	15	3.30%
Nurse	243	53.41%
Support	60	13.19%
No response	0	0.00%
Grand Total	**455**	**100.00%**

Salary level	No.	%
Level 1 - 6	337	74.07%
Level 7 - 8	65	14.29%
Level 9 - 12	50	10.99%
Level 13 - 16	3	0.66%
No response	0	0.00%
Grand Total	**455**	**100.00%**

Age	No.	%
18 - 35	179	39.34%
36 - 50	197	43.30%
51 - 65	79	17.36%
66 and older	0	0.00%
No response	0	0.00%
Grand Total	**455**	**100.00%**

Years of service	No.	%
0 - 5 years	243	53.41%
6 - 10 years	91	20.00%
11 - 15 years	40	8.79%
16 - 20 years	33	7.25%
21 years and over	48	10.55%
No response	0	0.00%
Grand Total	**455**	**100.00%**

Please select your respective sex	No.	%
Female	358	78.68%
Male	97	21.32%
No response	0	0.00%
Grand Total	**455**	**100.00%**

Please select if you have a disability	No.	%
No	440	96.70%
Yes	15	3.30%
No response	0	0.00%
Grand Total	**455**	**100.00%**

Opinion of the organisation

Overall it appears that levels of satisfaction with regard to respondents' general opinion of the organisation were mixed. The 2 highest scoring items in this dimension were with regard the organisation being committed to providing quality care to patients (68.1% agreement) and feeling that the individual had an important role to play in the organisation's operations (73.4% agreement). The latter has item has increased since the previous survey. There were 2 items that did not score favourably on levels of agreement. Only 42.6% of respondents felt that the organisation valued and cared for employees, and 40.2% felt as though the organisation treated them fairly. When an employee perceives that the organisation cares for them and supports them this may serve to fulfil employees' emotional and social needs and in this way, their role within the organisation may actually become an integrated part of their identity. It has also been shown that employees who feel valued and cared for are more likely to expend discretionary energy in the course of their daily work. In this instance, it appears that while employees are proud of and loyal towards the organisation, this may be an intrinsic commitment towards the ideals of being in a helping profession. In order for this level of internal inspiration to be sustained, there needs to be a perception that the organisation returns those same levels of loyalty and pride to the employee.

								2016			2013	
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		Agree	Disagree
The organisation values & cares for its employees	7.91%	34.73%	20.00%	21.76%	15.60%	0.00%		42.64%	37.36%		43.96%	30.04%
The organisation treats its employees fairly	6.37%	33.85%	19.34%	25.05%	15.38%	0.00%		40.22%	40.44%		39.56%	30.40%
I have an important role to play in the organisation operations	26.37%	47.03%	13.63%	6.37%	6.59%	0.00%		73.41%	12.97%		49.45%	28.21%
I feel a strong sense of loyalty to the organisation	25.05%	42.42%	16.48%	9.01%	7.03%	0.00%		67.47%	16.04%		62.27%	16.48%
My organisation is committed to providing quality care to patients	23.74%	44.40%	14.73%	9.67%	7.47%	0.00%		68.13%	17.14%		72.89%	10.99%

Communication and consultation within the organisation

The primary area of dissatisfaction with communication lay in the organisation's willingness to act upon and provide feedback on the ideas and suggestions received from employees. Only 30.6% indicated that they received feedback on their suggestions and 29.5% indicated that the organisation put their ideas into practice. Less than half of the respondents agreed that they were kept adequately informed about planned changes (35.2%). Communication functions as a key driver of employee engagement and performance and within the Health Care context also functions as a contributor towards customer satisfaction and service delivery. In order for employees' to continue to engage in their work and their working environment they need to be able to contribute towards the advancement of the organisation and consultations with employees form a key component of such an initiative. The absence of such consultations have the potential to result in corridor talk, the vilification of "Head Office" as not understanding the local context of frontline staff, resentment towards to the organisation and a pre-occupation with not being informed which diverts energy from key job requirements. Given the perceptions which have been raised around communication, communication of the results of this survey would be an ideal way of shifting perceptions with regard to not being heard by the organisation. Having said that, any communication of the results should be accompanied by a clear plan as to how areas of concern will be addressed. The following table provides an overview of the results for this dimension.

							2016	2016	2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response	Agree	Disagree	Agree	Disagree
The organisation keeps employees informed about planned changes timeously	6.15%	29.01%	20.22%	27.25%	17.36%	0.00%	35.16%	44.62%	36.63%	34.80%
The organisation is open to employee's feedback and ideas	5.71%	30.33%	21.32%	22.64%	20.00%	0.00%	36.04%	42.64%		
You receive feedback on your suggestions	4.18%	26.37%	23.74%	27.03%	18.68%	0.00%	30.55%	45.71%	25.64%	41.03%
The organisation puts employees ideas into practice	5.05%	24.40%	24.18%	27.03%	19.34%	0.00%	29.45%	46.37%	23.81%	36.63%

Leadership style

The most favourably rated item on this dimension was with regard to line management respecting and valuing work contributions, with 60.9% agreeing with this. 56.7% of respondents felt that their line manager genuinely cared about employee needs. The lowest scoring item on this dimension was with regard to having received recognition or praise for doing good work (48.6% agreement). 54.1% of respondents indicated that their line manager was able to manage internal conflict effectively. In the day-to-day life of an organisation it falls to the manager to create the work experience of employees, and this extends to more than having mastered the operational basics of their role. A key example may be in relation to perceptions of how managers' manage conflict. Managing conflict may fall within the realm of people management skills and is an integral component of managing both individuals and teams. In the absence of effective conflict management by a manager employees may question the reliability, integrity, and trustworthiness of managers. The absence of these factors may negatively influence not only the performance of employees but their discretionary effort. The results from this dimension are outlined in greater detail in the following table.

							2016	**2016**	**2013**	**2013**
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response	Agree	Disagree	Agree	Disagree
My line manager genuinely cares about employee's needs	18.46%	38.24%	13.19%	17.36%	12.75%	0.00%	56.70%	30.11%	57.51%	24.54%
My line manager respects and values my contribution at work	18.68%	42.20%	13.63%	16.04%	9.45%	0.00%	60.88%	25.49%	57.88%	22.71%
My line manager is able to manage internal conflict effectively	16.26%	37.80%	19.56%	15.82%	10.55%	0.00%	54.07%	26.37%		
In the last 7 days I have received recognition or praise (for example, a thank you) for doing good work from my manager	14.51%	34.07%	12.31%	19.34%	19.78%	0.00%	48.57%	39.12%	39.19%	46.89%

Team functioning

80.4% of respondents indicated that they had good relationships with the people that they work with. It is further encouraging to note that 76.9% were able to consult with their colleagues when faced with an unexpected or challenging situation at work. The lowest scoring item on this dimension was with regard to different professions working well together, with 61.5% agreeing. 45.7% of respondents indicated that their colleagues were looking to leave the organisation within the next 6 months. What would be useful would be to consider the attrition rate for the last year in order to plan effectively for any potential exits.

								2016	2016		2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		Agree	Disagree
In my unit/component the staff function well as a team	24.62%	44.18%	12.75%	12.53%	5.93%	0.00%		68.79%	18.46%		72.89%	10.62%
I have good relationships with the people that I work with	33.85%	46.59%	11.43%	5.27%	2.86%	0.00%		80.44%	8.13%			
I am able to consult my colleagues when I am faced with an unexpected or challenging situation at work	25.49%	51.43%	11.87%	5.49%	5.71%	0.00%		76.92%	11.21%		84.98%	6.23%
My colleagues are committed to doing quality work	22.64%	47.25%	16.04%	7.91%	6.15%	0.00%		69.89%	14.07%		78.39%	7.33%
My colleagues are looking to leave the organisation within the next 6 months	18.46%	27.25%	25.71%	17.36%	11.21%	0.00%		45.71%	28.57%		31.87%	41.76%
Different professions (Doctors, health professionals, admin) work well together	12.53%	49.01%	17.80%	10.77%	9.89%	0.00%		61.54%	20.66%		57.88%	17.95%

Drivers of commitment and retention

It is encouraging to note the extent to which respondents indicated that they are clear as to what they are supposed to accomplish at work (81.7% agreement) and how their job contributes to the organisation's objectives (83.3% agreement). These items, to a large extent, relate to the support structures that an organisation provides, and it is imperative that employees are clear with regard to what they are supposed to do. 50.6% of respondents' indicated that their unit/team had access to sufficient resources to complete their work effectively. The item with the greatest disagreement was with regard to people being transparent and open in their communication, with 38.9% indicating that this was not the case.

							2016	2016	2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response	Agree	Disagree	Agree	Disagree
I am highly motivated to do my job	27.25%	43.96%	12.75%	8.35%	7.69%	0.00%	71.21%	16.04%	71.79%	15.38%
I have a measure of control and influence over how my work is completed	21.54%	53.41%	13.41%	7.03%	4.62%	0.00%	74.95%	11.65%	69.96%	11.72%
I feel secure in my position at this organisation with the current changes taking place	13.19%	43.52%	17.58%	14.51%	11.21%	0.00%	56.70%	25.71%		
I find the content of my work interesting and stimulating	21.54%	51.43%	14.73%	7.47%	4.84%	0.00%	72.97%	12.31%	73.99%	12.09%
At work, I have the opportunity to do what I do best every day	24.84%	50.55%	13.63%	6.81%	4.18%	0.00%	75.38%	10.99%	73.26%	9.16%
I understand how my job contributes to the organisation's objectives	27.03%	56.26%	9.67%	4.40%	2.64%	0.00%	83.30%	7.03%	75.09%	8.79%
I am clear as to what I am supposed to accomplish at work	26.81%	54.95%	10.99%	3.74%	3.52%	0.00%	81.76%	7.25%	84.25%	7.33%
People in this organisation are transparent (no hidden agendas) and communicate openly	8.35%	27.91%	24.84%	19.56%	19.34%	0.00%	36.26%	38.90%	28.94%	39.93%
My unit/team has access to sufficient resources to complete their work effectively	10.55%	40.00%	22.20%	15.38%	11.87%	0.00%	50.55%	27.25%		
My workload is manageable	12.31%	43.74%	16.04%	14.73%	13.19%	0.00%	56.04%	27.91%	54.58%	24.91%

Physical work environment, safety & security

Employees reported varying levels of satisfaction on this dimension. With regard to the physical work environment, 41.8% indicated that the ablution/cloakroom facilities were adequate and 40.2% were satisfied with the restroom/tearoom facilities. There were concerns with regard to the safety of personal belongings, with 40.2% indicating that these were safe. In contrast, 2.9% felt safe at work during the day. At a very basic level the comfort of the physical work environment may be viewed as being an indicator of the extent to which the organisation cares about the comfort of their employees and views them as being valuable enough to invest in their work environment.

								2016	2016		2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
I feel safe at work during the day	14.51%	48.35%	13.85%	13.85%	9.45%	0.00%		62.86%	23.30%		57.51%	21.25%
I feel safe at work during the night	8.13%	35.60%	25.71%	16.70%	13.85%	0.00%		43.74%	30.55%		40.29%	30.40%
My personal belongings are safe at work, e.g. car, bag, etc.	7.03%	33.19%	22.64%	20.00%	17.14%	0.00%		40.22%	37.14%		35.16%	36.63%
The restroom/tearoom facilities are adequate	7.47%	32.75%	16.70%	20.22%	22.86%	0.00%		40.22%	43.08%		38.10%	44.32%
The ablution/cloakroom facilities are adequate	8.13%	33.63%	18.46%	19.78%	20.00%	0.00%		41.76%	39.78%		37.36%	38.10%
My building is safe and well maintained	8.79%	37.36%	21.32%	16.70%	15.82%	0.00%		46.15%	32.53%			
My building caters for the needs of persons with disabilities	8.79%	48.57%	19.12%	13.41%	10.11%	0.00%		57.36%	23.52%			

With regard to having experienced verbal and/or physical abuse from patients in the past year, 35.8% indicated that they had experienced this form of abuse (that is, they disagreed with the item). Approximately 27.7% indicated that they had experienced verbal abuse from members of staff in the last year and 25.3% had been harassed (sexual/racial/emotional). These items point to the level of strain that employees are experiencing in the day-to-day work environment over and above the emotional demands of the actual job that they are engaged in. Of the respondents, 53.4% felt that the organisation took adequate steps to ensure that they were not exposed to violence and aggression at work and 59.8% indicated that the organisation supported and promoted employee health and wellbeing.

								2016	**2016**		**2013**	**2013**
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
I have not experienced verbal and/or physical abuse in the last year from colleagues or employees	16.04%	41.98%	14.29%	14.73%	12.97%	0.00%		58.02%	27.69%		68.13%	17.22%
I have not experienced verbal and/or physical abuse from patients in the last year	12.75%	37.14%	14.29%	17.36%	18.46%	0.00%		49.89%	35.82%		57.14%	27.47%
I have not been exposed to harassment (sexual, racial, or emotional) at work in the last year	17.80%	42.86%	14.07%	13.41%	11.87%	0.00%		60.66%	25.27%			
The organisation takes adequate steps to ensure that I am not exposed to violence and aggression at work	10.99%	42.42%	19.78%	16.48%	10.33%	0.00%		53.41%	26.81%		56.78%	21.98%
The organisation supports and promotes employee health and wellness	12.53%	47.25%	17.80%	14.95%	7.47%	0.00%		59.78%	22.42%			

Performance appraisal and evaluation

A key organisational imperative is organisational performance and often performance management structures are a key component of ensuring that employees are performing effectively. 51.9% of respondents had had 2 performance evaluations in the last year. 45.7% of respondents felt at ease during their appraisal and 48.4% indicated that their appraisal was conducted in a positive manner. In comparison, only 41.1% of respondents felt that the current performance management structures promoted a high-performance culture. This may suggest concerns regarding the performance, or lack thereof, of other employees (that is, a perception that they work harder than others). This raises the question as to the purpose of performance management in the organisation and what the outcomes of the process should be, not only for the employee, but for the organisation as well.

								2016	2016		2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
I have had at least 2 performance appraisals/evaluations in the last year	9.45%	42.42%	16.26%	18.68%	13.19%	0.00%		51.87%	31.87%		43.22%	35.16%
I felt at ease during the appraisal	7.47%	38.24%	23.96%	17.58%	12.75%	0.00%		45.71%	30.33%		38.10%	32.23%
The appraisal was conducted in a positive manner	8.35%	40.00%	24.84%	16.04%	10.77%	0.00%		48.35%	26.81%		33.70%	31.87%
Performance management structures promote a high-performance culture	6.37%	34.73%	25.05%	16.48%	17.36%	0.00%		41.10%	33.85%		33.33%	30.04%

Services provided by administrative components, e.g. HRM/Staff Office

The lowest scoring item was with regard to being satisfied with the childcare facilities, with only 25.3% of individuals indicating that these were to their satisfaction. In terms of the support services, the area of least agreement was with regard to receiving prompt responses to queries, with only 42.4% agreeing. Only 43.7% of respondents indicated that management were accessible to them when they had not received a satisfactory resolution to their problem. This once again positions the organisation as not taking a vested interest in their employees.

								2016	2016		2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
The support service is efficient in providing assistance when required	7.25%	39.12%	21.76%	19.12%	12.75%	0.00%		46.37%	31.87%			
The support service is accessible to staff to assist with enquiries	5.27%	44.18%	20.00%	19.12%	11.43%	0.00%		49.45%	30.55%			
The support service office responds promptly to my enquiries	5.05%	37.36%	24.62%	20.00%	12.97%	0.00%		42.42%	32.97%			
Management is accessible when I have not been able to receive a satisfactory solution to a problem	5.49%	38.24%	22.42%	18.90%	14.95%	0.00%		43.74%	33.85%		45.05%	27.84%
I am satisfied with the childcare facilities provided by the organisation (only where facilities are available)	8.57%	16.70%	12.09%	4.84%	8.35%	49.45%		25.27%	13.19%		17.95%	45.79%

Education and training

The majority of respondents (76.5%) indicated that they had the requisite skills for performing their work effectively. 59.8% of respondents had attended a training session in the last year and 53.9% indicated that they access to opportunities to grow and develop in the organisation.

								2016	2016		2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
I have the skills I need to perform my work effectively	25.93%	50.55%	11.43%	5.49%	6.59%	0.00%		76.48%	12.09%		79.49%	8.79%
I have a skills development plan, which meets my specific needs and job requirements	15.16%	52.31%	13.63%	10.55%	8.35%	0.00%		67.47%	18.90%		62.64%	15.75%
I have equal and fair access to education and training	13.19%	40.88%	20.22%	13.41%	12.31%	0.00%		54.07%	25.71%		52.38%	23.81%
I have access to opportunities to grow and develop in this organisation	12.75%	41.10%	17.80%	13.19%	15.16%	0.00%		53.85%	28.35%		52.38%	26.01%
I attended at least one training session in the last year	15.16%	44.62%	10.11%	15.60%	14.51%	0.00%		59.78%	30.11%		53.11%	29.67%

Perceptions of change

A 2008 Towers Perrin study of 90 000 employees concluded that a top engagement driver globally was employees' belief that senior management had their best interests at heart. Only 40.2% of employees agreed with this statement on the survey. 56.5% felt that their manager encouraged staff to become part of change and 51.4% of respondents indicated confidence in their line manager's ability to manage change effectively. These results indicate that there is doubt with regard to the change management abilities of leadership structures in the organisation.

								2016	2016		2013	2013
	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	No response		Agree	Disagree		**Agree**	**Disagree**
I believe that senior management in this organisation have the best interests of employees at heart	7.69%	32.53%	19.78%	19.12%	20.88%	0.00%		40.22%	40.00%		41.03%	30.77%
My manager encourages staff to become part of change	10.99%	45.49%	15.38%	14.07%	14.07%	0.00%		56.48%	28.13%		49.82%	23.08%
My manager manages ongoing change effectively	8.79%	42.64%	19.34%	13.19%	16.04%	0.00%		51.43%	29.23%		43.22%	21.98%

Individual Wellness

58.2% of respondents felt in control of their overall wellbeing. Given the healthcare context within which employees function, and the potential for burnout, steps need to be taken to ensure that employees are able to manage their wellbeing. 31.9% indicated that they frequently struggled to stay out of debt.

	Never	Sometimes	Often	Always	No response
I struggle to stay out of debt	36.70%	31.43%	13.19%	18.68%	0.00%
I feel in control of my overall wellbeing	16.26%	25.49%	22.86%	35.38%	0.00%
Number of chronic conditions	Average of 0.92				
Number of losses experienced (e.g. death of a loved one, divorce, loss of a job)	Average of 1.32				
Number of traumatic incidents traumatic incidents experienced (threat to life or safety e.g. armed robbery, motor vehicle accident)	Average of 1.13				
How many units of alcohol do you consume per day (a unit is equivalent to one beer, a glass of wine or one tot measure of spirits)	Average of 0.80				

Analysis of qualitative data

There was 1 qualitative question that was asked on the survey, 'what are the 3 things which will make the place at which you work a better place?' There were 1012 responses received to this question. These responses were analysed according to themes. These themes were derived based on the content of the comments received. The table below provides an overview of the categories that were developed:

Category	Count
More staff members/employee capacity	167
Improve morale within teams and encourage a culture of working together	63
Employee learning, development, growth, and job opportunities	55
Upgraded infrastructure, assets, facilities, and space creation	53
Communication etiquette and improve access to information	50
Improve style and management of meetings and regular employee forums for employee input (staff/management involvement)	50
A culture of respect	41
Improve work tools, equipment, and stock supply	39
Transparency and fairness and honesty and equality	39
Improved safety and security	37
No CAIR Club completion	34
Improve absenteeism and better leave and time keeping management	28
Improve Performance reward tool (SPMS) motivate with incentives and promotions	25
Improve supply chain and procurement processes and less red tape	24
Recognition	22
Improve/change Leadership enhance strategic intent and create visibility and more trust)	19

Remuneration	18
Review of staff attitudes	18
Suggestions concerning the CEO	16
Cleanliness and better working conditions	15
Facilities Aircon	15
Corruption Nepotism and favouritism in recruitment selection and promotion. Unfair labour practice	14
Facilities tearoom, kitchen, and canteen	13
Improve (respect/etiquette/empathy/people competency) management practices and management style	13
Employee engagement and work commitment	11
Reduce workload	11
A culture of empathy	10
Facilities (Furniture)	9
Qualified/competent management	9
Visible, approachable open, supportive management	9
Upgrade technology	8
HR support	7
Recreational Facilities (gym)	7
Clarify job function and responsibilities (align with skill)	6

Patient centred approach to care	6
Review of working hours	6
Accountability and improve management of poor performance	4
Housing and Transport subsidies	4
Improve budgeting	4
Prioritise wellness and health promotion for staff members	4
Supportive environment	4
Fewer office politics and better conflict management	3
Less management victimisation and abuse of authority	3
Racial Discrimination	3
Trust	3
Facilities parking	2
Facilities, improve ablution facilities	2
No issues, happy with the environment	2
Access to childcare facilities	1
Designated smoking area	1
Employee value proposition	1
Improve employee/manager relations	1

Job security and satisfaction	1
Monitoring and evaluation and adherence to SOPs and policies	1
Respect confidentiality and reduce gossip	1

36.7% of respondents indicated the need for more human resources. The examples provided with regard to the type of staff required included, nurses, registered nurses, doctors, specialists, administrative staff and cleaning staff. The need for more staff was linked to service delivery (for example, a specialist health professional was requested based on the needs of patients and the community), to making the patient-staff ratio more manageable, to the need for meeting the operational needs of the site, as well as to employees feeling overworked and overloaded. A small number of respondents indicated that adequate staffing would reduce the absenteeism rate in the organisation.

13.8% of respondents indicated that the morale within teams needed to be uplifted. The vast majority of comments indicated that people needed to work together and become more involved in working towards shared goals at Mitchell's Plain District Hospital.. There were a few instances where additional detail was provided and some of the comments provided included the need for staff to be more empathetic and friendly towards each other. Some respondents indicated a need for team building activities to improve the current levels of team spirit.

12.1% of respondents indicated the provision for more learning, development, growth, and job opportunities. Employees indicated a willingness to improve on their current skills so as to enhance engagement, motivation levels and work commitment. Respondents expressed views around promotions, career advancements and talent mapping effort, indicating that opportunities for career advancement would be ideal.

11.6% of respondents commented about the physical work environment. Some of the issues that were raised included the need for entirely new buildings, tearooms, rest rooms, upgraded ablution facilities, storage space, bigger workspaces, shaded parking, parking bays, and more ergonomic planning of workspaces. Linked to the responses with regard to restrooms was the need for recreational spaces and/or activities. For example, the provision of a gym, canteen, DSTV, games and so forth. While not markedly significant, there were also requests for onsite ATMs. Respondents also noted the need for maintenance of existing infrastructure, such as fixing lifts, replacing light bulbs, air-conditioning, and fixing broken furniture. With regard to the comfort of their physical working environment, respondents further identified the need for fresh air, fresh water, water coolers, quieter working environments and clean toilets and hygienic work environments.

11.0% of respondents indicated that communication needed to be improved. The comments made were with regard to a need for better and more frequent communication across multiple relationships: manager and employee, between colleagues, across departments, across disciplines and from senior management

to employees. An additional 5.0% of respondents requested a call for better meeting forums so that information could be shared appropriately and timeously. However, on the other hand there were a small number of respondents who felt that the current meetings that were held were unproductive. One of the areas that employees noted they needed more information was in relation to planned changes. This was also linked to a need to be heard, where employees have noted that they are either not given the opportunity to provide feedback, or that their feedback is not taken seriously.

Staff Satisfaction Survey: The Way Forward

Based on the findings outlined in this survey the following issues require further attention:

- The results of this survey need to be communicated to employees, with senior management representation at Mitchells Plain District Hospital. There needs to be ownership of the survey by key stakeholders in the organisation, and a commitment towards addressing the issues which employees are raising.
- There needs to be a commitment to fostering a culture of support and care for employees with an increased focus on people issues. Management in particular needs to be more accessible to staff and might benefit from training on people issues and interpersonal skills in order to foster the culture shift.
- There were key issues raised in the qualitative comments with regard to values such as fairness, accountability, equality, trust, and honesty. These are the intangible issues that influence employee levels of motivation and discretionary effort. Leadership in the organisation need to be perceived as being congruent in relation to the values of the organisation.
- Communication structures need to be considered carefully. While employees are indicating a need to be heard, it is also evident that there are concerns with the quality of communication that they are receiving from their managers. Any intervention would need to be managed and structured in order for it to be effective, as it is likely that some employees are already disempowered and despondent and may not respond to open and unstructured invitations to share their views. What is also evident in the qualitative comments is that employees are looking to provide their input on change and innovation for the organisation. So, not only should the structures be provided for employees to contribute their thoughts, but these would need to be acknowledged and considered.
- There are various communication campaigns that should be considered for the employee population: what is the value proposition for being a WCGH employee; how do employees address their burning issues outside of a survey; create awareness on the training and development policies that are available.
- Where required, address the structural issues addressed in the survey, for example, the need for safety and security, fresh air, the need for fresh water and the need for general cleanliness of the facilities.
- Work sessions should be held with senior leadership of each District to address the issues raised and agree on the best way in which these issues can be addressed. Some of the questions that need to be considered: what do these results mean in the context of what the organisation has to deliver (strategy; annual priorities) and the skills set required to manage that; what the barriers are to creating high-performance teams and/or departments; what are the enablers that may be leveraged to improve the way in which results are delivered for the organisation.
- Avenues for emotional support (group or individual) should be given attention. One component of this would be to continue to encourage employees to make use of the EWP.
- The role of performance management in the organisation should be evaluated. There were qualitative comments made with regard to the system being ineffective and lacking fairness and objectivity. It was also noted that there were employees who were often absent or not performing optimally, but that these issues were not addressed by management. These are critical issues that need to be addressed constructively and managers should be equipped to deal with difficult conversations with employees.

Annexure 3: Observation Topic Guide

The Leadership Trinity: Examining the Interplay between Organisational Context, Leadership Development and Leadership Effectiveness in the Health Sector - A Multiphase Mixed-Method Case Study of District Hospitals in the Western Cape Province, South Africa.

Topic Guide for Observations

The observational data will be obtained, unobtrusively, from meetings and during interviews. The aim is to observe and note/journal how cultural, structural, and demographic elements of relevance influences the leadership behaviour and processes within the two district hospitals. The observational data and field notes are useful in understanding the complex settings and the relationships between workers in district hospitals.

The investigator will explain the value of the study and give appropriate feedback on the results and its practical consequences. The observations will be made in three blocks of 20 minutes with 10-minute regular intervals between the blocks. The investigator to take detailed field notes to record what is observed.

The investigator will aim to minimise the "Hawthorne Effect" by getting used to the hospital environment and freely interacting with workers to limit their likelihood of behaving differently than they would in normal situations.

Notes for observation by the investigator include:

- Describe the settings: the work environment, layout, and office spaces that may indicate aspects of the culture within the district hospitals or the position within the organisational/hierarchical structure (interviewee office space)
- Passively recorded behaviours of managers and workers, including how they interact, relate, and communicate with each other. This should also include a description of those involved in the actions.
- How workers display their leadership skills in meetings and in their duties
- Observe and document leadership processes and actions within hospitals, including different individual and team/group actors, forms of their interactions and their leadership behaviour.
- Observe for anxieties and depression

Annexure 4: Interview Topic Guide

The Leadership Trinity: Examining the Interplay between Organisational Context, Leadership Development and Leadership Effectiveness in the Health Sector - A Multiphase Case Study of District Hospitals in the Western Cape Province, South Africa.

Topic Guide for In-depth Interviews

Note: Each Interview will last 45-60 minutes. The goal will be to interview 10-15 respondents (unit managers, supervisors, and workers) from purposefully selected units/departments. The investigator will ask probes and follow up questions on points raised by the health workers. The topic guide is to be used during the exploratory qualitative first phase of the study.

Key Research Question: How does organisational context influence leadership development and moderate leadership effectiveness in district hospitals in the Western Cape Province?

Research Sub-Questions:

a. What are the district hospital managers and workers understanding of organisational context and leadership development?

b. What are key features of the internal and external organisational context in district hospitals that are relevant to leadership development and effectiveness?

c. What are the pathways through which organisational context influences leadership development and leadership effectiveness in district hospitals?

d. Can organisational context be adapted in ways that enhance leadership processes and effectiveness in district hospitals?

Research Objectives:

i. To identify and explore the leadership processes in district hospitals as health care organisations within the Western Cape Provincial health system.

ii. To understand different aspects of internal and external organisational context of relevance to leadership development and the exercise of leadership in district hospitals.

iii. To examine the relationship between organisational context and leadership effectiveness by measuring levels of job satisfaction and motivation of health workers (as indicators of leadership effectiveness).

iv. To elicit and explain the perspectives of hospital managers and workers on the different aspects and effects of health care organisational context on leadership

development and leadership effectiveness in district hospitals within the Western Cape Provincial health system.

v. To identify implications for health care policy and management by making recommendations on relevant aspects of organisational context that can be modified or adapted to improve leadership development and effectiveness in district hospitals.

Research Purpose: To explain and understand the interplay between organisational context, leadership development and leadership effectiveness using multiphase approaches to case studies in two district hospitals in the Western Cape Province. The multiphase approach will involve overlapping but sequential qualitative and quantitative data collection and analysis, separately and together in discussions and interpretations.

1. **Introduction: 5-10 minutes**

- Greetings and thanking interviewee for accepting to participate in the study.
- The principal investigator to introduce himself and note respondent's age, gender, cadre, marital status, and date of joining the hospital. Ask respondents about family and interests or leisure to break ice.
- Assure respondent by being friendly and making light anecdotes and jokes about general issues not related to study. Get more involved and concerned about respondent welfare to make them loosen up and feel confident to talk to you.
- Introduce and explain the research objective and purpose of the study.
- Explain the consent details and request respondent to sign the consent form.

2. **Research Topics: 30-45 minutes**

Aim is to explore the respondents' insights and thoughts on what their understanding to identify and explore the leadership processes in the district hospital as a health care organisation within the Western Cape Provincial health system. The interview will explore managers and workers understanding of external and internal context of district hospitals, including how context and leadership influence their feelings and how their feelings affect their work and interactions.

i. Feelings about leadership processes and development within the District Hospital

- Can you tell me how long you have been working at this hospital? Where did you work before? Have you always worked in Cape Town, or worked anywhere

else? What is your position and responsibilities at this hospital? Have you held such a position elsewhere? How do you compare this hospital with others that you have worked in or within the province?

- Why did you choose your cadre or type of health profession in the first place? (For other staff: - why did you start working in health facilities?). Do you work as teams and how do you share responsibilities in those teams? What is the form of leadership in your team?
- How is the hospital organized and operated on a daily basis? Please share the main successes and challenges faced by the hospital so far. What kind of relationship does the hospital leadership have with the health workers? Do you have good or bad experiences with them?

From here discuss more specific context and leadership development related questions or issues

- What is your own understanding of the term leadership or leadership development? Please give examples of actions that indicate leadership processes in this hospital. Are there ways in which leadership is encouraged or developed at this hospital? Please give examples, if any, of such programmes. Do you feel empowered and skilled to act as a leader?
- Over the course of your working life, have you had any opportunities to manage or lead a group of people? (Investigator to probe if there have been any programmes or trainings for leadership; and whether how they feel now about leadership in the hospital is different from other places in which they have worked).
- How do you find this hospital as a place to work? Do you share responsibilities and actions with your colleagues or other workers in your unit/department? How is decision making distributed amongst the workers? Are you involved in problem-solving activities? How does it compare with other places in which you have worked?
- Is there any form of training or programme to improve your problem-solving skills or leadership capability? How does this training interact with your work environment? Are you involved in any collaborative supervisory roles? Please elaborate on your relationship with your colleagues and supervisors. How fast or slow is the advancement to higher positions within this hospital?

- Tell me situations or incidences when you have felt good or bad about working at this hospital.
    - o Probe: does being in a leadership role influence how you feel about your work? What are the kinds of influences?
    - o Probe: do you consider the rules, regulations, guidelines, values, beliefs, and relationships with colleagues as positive or negative influences on your ability to develop leadership skills and boost your morale here at the Hospital? Do you have the power to make independent decisions? Is their support from your professional colleagues?
        - ▪ Kindly give me an example of how and why the hierarchies, regulations, values, and colleagues have influenced your morale (when you feel/felt good or bad about working here and developing as a leader).

ii. How leadership influences motivation and job satisfaction

- What would you describe as effective or poor leadership? Give me an example. Do your feelings about your leadership roles or development, if any, and working here at this district hospital, affect your daily duties? Can you give concrete examples?
    - o Please elaborate to me if the issues you have mentioned influence how you interact with patients or other people within the hospital.
    - o Do the managers and leaders ahead of you offer solutions that inspire you to perform your duties? How regular do you interact with the manger or leader ahead of you in the hospital?
    - o Do they affect your relationships with colleagues? How? Does that have consequences for your assigned activities in the hospital? Or for patients? Can you give concrete examples?
    - o Does the possibility of advancement or promotion to higher position influence your morale to work at this district hospital? How do you feel about working as a team with different roles?
    - o Do they affect your own relationships with patients? How? Can you give concrete examples?

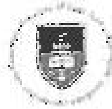
iii. Levels of motivation and job satisfaction

- Can you tell me how the factors that you have mentioned about the leadership processes, development, and the hospital environment, affect your personal feelings and morale?
- Please tell me whether you judge you have high or low morale working at this hospital. How do you make that judgment?
- Finally, do you judge that your feelings about your work here at DH-A/DH-B, and district hospital as a place to work, are similar or different to the colleagues with whom you work with most closely? In what way? Can you give concrete examples? (To get some sense of wider motivation and job satisfaction in this hospital).

3. Summary: 5-10 minutes

- Do you feel you have expressed your feelings adequately about the organization of the hospital? What key information, with regard to the hospital's organization and the morale of the workers, would you like to put across?
- Are there any other key thoughts that you would like to express in relation to our discussion? Please provide any suggestion that you think may improve how the hospital is organised (demographics, structure, and culture) to enhance leadership capabilities and the happiness/morale of managers and health workers?
- Appreciation for participating in the study. Thank you once again for your time and for providing me with such information. I wish to remind you that this information is confidential; there is no link between your name, and the issues discussed.

Annexure 5: UCT Human Research Ethics Committee Approval Letter



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
Email: sumayah.ariefdien@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

10 November 2015

HREC REF: 772/2015

Prof L Gilson
Health Economics Unit
Public Health & Family Medicine
Falmouth Building

Dear Prof Gilson

PROJECT TITLE: THE LEADERSHIP TRINITY: EXAMINING THE INTERPLAY BETWEEN ORGANISATIONAL CONTEXT, LEADERSHIP DEVELOPMENT AND LEADERSHIP EFFECTIVENESS IN THE HEALTH SECTOR- A MULTIPHASE MIXED-METHOD CASE STUDY OF DISTRICT HOSPITALS IN THE WESTERN CAPE PROVINCE, SOUTH AFRICA (Doctoral-candidate-Dr D Okello) PHASE ONE

Thank you for your response letter addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved-PHASE ONE** of the above-mentioned study.

Approval is granted for one year until the 30th November 2016.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please quote the HREC reference no in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsbility of the principal investigator.

Yours sincerely

Signature Removed

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

Hrec/ref:772/2015

Annexure 6: Approval Letter from District Hospital A

Dr M. Moodley

CEO: Victoria Hospital

Tel: 021 799 1234

Melvin.moodley@westerncape.gov.za

09 October 2015

DR Dickson R O Okello

PHD Student

Health Policy and Systems Division

University of Cape Town

Permission to conduct research at Victoria Hospital Wynberg

Research Title: The Leadership Trinity: Examining the Interplay between Organisational Context, Leadership Development and Leadership Effectiveness in the Health Sector - A Multiphase Case Study of District Hospitals in the Western Cape Province, South Africa.

Dear Dr Okello

Thank you for expressing your interest in conducting research at Victoria Hospital. Victoria Hospital will be willing to grant you access to the facility and will participate in your study.

This is subject to the following 2 conditions:

1. Ethics approval by the University of Cape Town Human Research Ethics Committee
2. Permission from the Health Impact Assessment Unit of the Western cape Department of Health

Regards

Dr M Moodley

CEO: Victoria Hospital

Signature Removed

Victoria Hospital, Alphen Hill Road, Wynberg, Cape Town, 7800

Annexure 7: Approval Letter from District Hospital B

MITCHELLS PLAIN HOSPITAL

Email : hans.human@westerncape.gov.za
Tel : +27 - 21 377 4305
Fax : +27 -21 377 4887
Postal Address: Private Bag X 9
Mitchells Plain, 7789
Street address: 8 AZ Berman Drive
Mitchells Plain, 7785

Dr Dickson R O Okello
PhD Student
Health Policy and Systems Division
University of Cape Town

Dear Dr Okello

REQUEST: RESEARCH ON LEADERSHIP DEVELOPMENT AT MITCHELLS PLAIN HOSPITAL

Our meeting of 6th October 2015 has reference.

This serves to confirm that you have been granted permission to conduct your proposed study on organisational context and leadership in district hospitals, at Mitchells Plain Hospital.

The afore-mentioned is subject to approval from the respective Research Ethics Committees of the Department of Health and University of Cape Town.

Yours sincerely

Signature Removed

MR H HUMAN
CHIEF EXECUTIVE OFFICER
MITCHELLS PLAIN HOSPITAL

DATE: 12.10.2015

Annexure 8: Approval Letter from Western Cape Department of Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2015RP35_449
ENQUIRIES: Ms Charlene Roderick

University of Cape Town
Anzio Road
Observatory
7935

For attention: **Dickson Drookello**

Re: **THE LEADERSHIP TRINITY: EXAMINING THE INTERPLAY BETWEEN ORGANISATIONAL CONTEXT, LEADERSHIP DEVELOPMENT AND LEADERSHIP EFFECTIVENESS IN THE HEALTH SECTOR - A MULTIPHASE CASE STUDY OF DISTRICT HOSPITALS IN THE WESTERN CAPE PROVINCE, SOUTH AFRICA.**

Thank you for submitting your proposal to undertake the above mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Victoria Hospital	**M Moodley**	**Contact No: 021 799 1201**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the estimated completion date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

Signature Removed

DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 9/3/2016
CC: **K GRAMMER** **DIRECTOR: SOUTHERN/ WESTERN**

Annexure 9: Informed Consent, Privacy and Confidentiality

Consent Form for Interviews

INFORMATION SHEET AND CONSENT FORM FOR RESEARCH PARTICIPANTS

The Leadership Trinity: Examining the Interplay between Organisational Context, Leadership Development and Leadership Effectiveness in the Health Sector – A Multiphase Case Study of District Hospitals in the Western Cape Province, South Africa.

This is to request you to participate in a research study to be conducted by me Dr Dickson R. O. Okello, a doctoral student at the Health Policy and Systems Division, University of Cape Town. The research will explain how healthcare managers and workers consider the role of organisational context in healthcare leadership development; and what elements they deem essential to the development of effective leadership by measuring job satisfaction and motivation levels. The research will also gather and explain information regarding the perceptions of healthcare managers and workers on the role of leadership development on their motivation; and how it influences their effectiveness and the implementation of relevant policies.

You are being requested to volunteer for this study because you are an employee or worker at this district hospital.

Study Purpose – The study aims to examine and understand the interplay between organisational context, leadership development, and leadership effectiveness.

I will use multiphase and mixed methods approaches to case studies to achieve this study purpose. These will include interviews with managers as key informants and, with other staff for in-depth information. I will also observe how workers interact and carry out their activities that reflect their leadership capabilities and levels of motivation.

Procedures – If you agreed to participate in this study, I will ask you to participate in an interview on the research question and objective. However, you are not required to participate, and there will be no negative consequence if you choose not to participate.

If you choose to participate, you have the right to respond or not to the questions asked and whenever you feel uncomfortable, you can choose not to answer a question. The interview process will be one-on-one with the investigator and will last for 45-60 minutes depending on your response and information that you feel free to give. If you agree, a tape recorder will be used to ensure an accurate recording of your views and thoughts. I will later transcribe the tape. If you refuse to allow tape recording, there will be no negative consequences for you. I will then only take notes by hand. You are allowed to respond to the questionnaires and deposit them, anonymously in a sealed envelope, in the questionnaire box at the front desk.

Potential Risks and Harm – There will be no physical risk to the participants in this study. There is a risk that you may share confidential and personal information and you may feel uncomfortable discussing some topics. Negative emotions, interpersonal and social differences may arise during the interviews. I will stop the proceedings when you experience negative emotions concerning the topic of discussion. Social and interpersonal conflicts that are experienced will be addressed through moderation. You are not at risk of losing your job or be subjected to any form of sanctions.

Potential Benefits to Participants and/or Society – There is no reward or payment for participating in the study. The study is likely to benefit you by using the knowledge gained to provide useful suggestions for managerial and policy actions to improve your morale to develop as a leader and work at the hospital. Information obtained from the study can also be used to enhance the relationship between the managers and the health workers.

Rights of Participants – The decision to participate in the study is voluntary and you can choose whether to be involved or not. You may decline to answer a question but still be involved in the study. Withdrawal of the consent any time when you feel to discontinue participation will bear no penalty of any kind. I may provide you with a summary of the study results upon request.

For any questions and concerns about the study contact Human Ethics Research Office at the Faculty of Health Sciences at the **University of Cape Town at +27 21 650 4015.**

Confidentiality – Your identity will not be revealed to anyone and all the information that you provide will be anonymously coded with letters and numbers to protect your identity and maintain high standards of confidentiality. Your identity can only be used or disclosed with your permission or if required by law. The tape recordings will be securely locked and kept by the researcher after transcription.

For further concerns and queries about the research please contact:

Dr Dickson R. O. Okello
Tel: +27 74 663 4017
E-mail: dickson.drookello@gmail.com
OR
Prof. Lucy Gilson (Supervisor)
Tel: +27 83 743 9108
E-Mail: Lucy.Gilson@uct.ac.za

CONSENT FORM FOR THE STUDY

Participant Declaration

I (**Name**) ____ declare that I have read and understood the information about the study and my role and hereby voluntarily consent to participate in this study as an interview respondent at my own volition and I can withdraw at my own discretion without any obligation or reprimand. I will respond to issues on the organisation of the hospital, the leadership processes and, how they motivate/demotivate me to work. I agree ☐/disagree ☐ (please ✓tick one) for the interview to be audio-recorded.

Signature: ___________________________ **Date:** ________________________________

Investigator Declaration

I (**Name**) ____ declare that I have explained to detail the information on this document about the research to (**Participant's name**) ____. I am convinced that he/she has understood all the information and has made an informed decision to participate. She/he has the right to withdraw from the study at any time without any form of coercion or intimidation. The conversation was conducted in English.

Signature:________________________________ **Date:**________________________________

Consent Form for Observations

University of Cape Town

INFORMATION SHEET AND CONSENT FORM FOR OBSERVATION

The Leadership Trinity: Examining the Interplay between Organisational Context, Leadership Development and Leadership Effectiveness in the Health Sector – A Multiphase Case Study of District Hospitals in the Western Cape Province, South Africa.

Dr Dickson R. O Okello is a doctoral student at Health Policy and Systems Division. He is conducting a research study to find out more about the relationship between organisational/hospital context, leadership development and leadership effectiveness in district hospitals. The researcher will sit in certain places within the hospital and observe what goes on in those places. Your participation in this study is entirely voluntary. Please read the information below and ask questions about anything you do not understand, before deciding whether to participate or not.

The purpose of this study is two-fold. First, it aims to examine and explain the interplay between organisational context, leadership development, and leadership effectiveness. Second, it contributes to understanding the influences of the hospital context on leadership development and effectiveness.

If you agree to be in this study, the following will happen to you: the researcher will observe your everyday activities without interference. The observation may last from a few minutes to several hours. The researcher may ask you questions and take written notes, but not videotape you, about your activity while observing. The researcher will also attend some meetings to make observations but not participate or interfere with the proceedings of the meeting.

Participation in this study may involve some risks or discomforts. These include the following:

a. Observing natural behaviour may involve collecting and storing personal information relating to individuals or groups and this creates a potential for the loss of confidentiality because such data, if disclosed to third parties, may cause harm or distress. Your name will not appear in the observation notes, nor will it appear in the analysis thereafter. If the observation notes and analysis are read by other audience, neither your name nor the name of the hospital will be available to the readers.

b. The researcher may make you uncomfortable while observing as you carry out your routine activities. If the presence of the observer makes you uncomfortable, you may terminate the observation at any time at no risk. Simply tell the researcher that you do not wish to be observed anymore.

c. The researcher or observer may present an impediment to safe behaviour (for example by obstructing a corridor or crowding an office) or create distraction. You are free to ask the researcher not to interfere with or obstruct your activities and interactions.

This is an interview and observation research study that may have some unknown risks that are currently unforeseeable. You will be informed of any significant new findings during the study.

Alternatively, you can choose not to participate.

There will not be any direct benefit to you from participating in this study and you will receive no compensation for participating. The investigator, however, may learn more about the leadership processes and your motivation, and other district hospitals may benefit from this knowledge.

Your participation in this research is entirely voluntary. You may refuse to participate or withdraw or refuse to be observed at any time without penalty. There will be no cost to you for participating in this study.

The researcher named above has explained this study to you and answered your questions.

If you have other questions or research-related problems, you may contact the research supervisor **Prof. Lucy Gilson - Tel: +27 83 743 9108; E-Mail: Lucy.Gilson@uct.ac.za**

If you are affected as a direct result of participation in this research, you may contact **Human Research Office at the Faculty of Health Sciences at the University of Cape Town at +27 21 650 4015** for more information about this, to inquire about your rights as a research participant or to report research-related problems. You have received a copy of this consent document.

AGREEMENT TO PARTICIPATE

By signing this consent form below, you are stating the following:

i. The details of this case study have been explained to me including; what I am being asked to do and the anticipated risks and benefits;

ii. I have had an opportunity to have my questions answered;

iii. I understand that my participation is voluntary, and I agree to participate in the research as described on this form, but I am free to withdraw at any time without giving reason;

iv. I grant the researcher the permission to observe my activities and meetings within the hospital, but not to videotape the proceedings;

v. I have been given a copy of this document for my records;

vi. I may ask more questions or stop participating at any time without penalty

_________________________ _________________________ _____________________

Participant's Name **Signature** **Date**