Service Delivery Research Project

Office of the Presidency

Transforming hospital functioning: an assessment of the surgical division transformation project at Chris Hani Baragwanath Hospital

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Over a period of five years starting in 2003, a team of clinicians, nurses, administrators, trade unionists and expert consultants implemented a pilot project for transforming the functioning of hospitals in the surgical division of Chris Hani Baragwanath Hospital, a tertiary hospital located in Soweto and servicing a wide catchment area in Gauteng and beyond. The project was unique in its origins, in the important role played by trade unions, and in the systematic way it constructed a new model of functioning based on the principles of decentralisation, integrated management and clinical leadership. The new model was designed to improve patient care, management efficiency, and staff satisfaction and morale, and while it made significant progress in these areas through empowering staff and managers, it also alienated important and powerful constituencies within the hospital and in the provincial health department. In the end, this failure resulted in the transformation project being dismantled, and its lessons ignored.

This paper reflects on the experience of establishing the new model in the surgical division, the rationales for the model, its achievements and how these were achieved, and its demise and some of the reasons for this. The authors were members of the designing and implementing team, and this inevitably colours their perception; however, it is also a strength, as our knowledge of the overall trajectory of the project, as well as the gritty detail of implementation, provides a perspective unavailable to the external researcher. In an effort to mitigate what may appear to be our partisan loyalties to the project, we have drawn extensively on the reports of external evaluators, Doherty (2010) in particular, but also Khalvest Consulting (2009).

The paper begins with an analysis of the surgical division labour process in terms of the relationship between routine and high-skill elements of the process. The public health system, hospitals included, are part of the state sector, which is frequently regarded as a highly routinised bureaucracy operated by hierarchical layers of clerical and administrative staff. The state in fact consists of highly diverse institutions and labour processes, each characterised by a distinctive relationships between standardised

bureaucratic routines based on uniform procedures, and discretionary decision-making which rests on an assessment of a complex set of variables, and which may or may not require a high level of skills. The vertical and horizontal distribution of skills across an institution varies considerably with the functioning and purposes of the institution. Any attempts to improve the functioning of a particular state department or institution needs to take account of the specific purpose, labour process and distribution of skills in that institution.

The paper then analyses the ineffective functioning of Chris Hani Baragwanath Hospital, and describes the transformation model that was implemented in the Surgical Division, and the ways in which it was designed to improve patient care, management efficiency and staff morale. The results of the independent evaluations of the project are summarised. The paper then goes on to discuss in more detail how the project was implemented, how the improvements were achieved, as well as the challenges and resistance faced by the project. Ultimately, the resistance to the project prevailed, and it was dismantled. In this sense, despite its achievements, the project was a failure. The paper concludes with an analysis of the implications of this failure-in-success.

The labour process

There are 27 surgical wards at Chris Hani Baragwanath Hospital, comprising the general, orthopaedic, neuro, paediatric, maxillofacial, plastic, ear-nose-throat and urology subspecialities. Each subspeciality forms a clinical department, with a clinical (medical) head.

Patients enter the surgical wards through a variety of routes. Trauma patients, or patients showing signs of distress, come through casualty and are distributed into the trauma units of general or orthopaedic surgery, or to the relevant subspeciality. Other patients enter via the outpatients department, or through referrals from other hospitals. Surgical procedures are categorised into elective and non-elective -- the latter for conditions which require an immediate surgical intervention, such as trauma or an acute medical condition, the former for surgical procedures which can be safely scheduled for a later date.

The treatment for surgical patients is highly dependent on other sections of the hospital. Surgical procedures are performed in the Theatre section of the hospital, while postoperative patients are sent to ICU for intensive care, drugs are provided by Pharmacy, and diagnosis often requires patients to be sent to Radiography etc. Non-clinical services include laundry, kitchen, transport and other services.

Traditionally, different categories of workers are managed within distinct managerial silos. The doctors in each department (specialists, consultants, registrars, interns) are accountable to the clinical head of department. The nurses (professional nurses, enrolled nurses, nursing assistants) are accountable through a hierarchy of corridor matrons and section matrons to the head matron of the hospital. Cleaners and ward attendants are accountable to a foreman in the cleaning department; porters...; and ward clerks are

accountable to a corridor supervisor in the patient administration department. Chris Hani Baragwanath Hospital is an academic hospital linked to the University of the Witwatersrand, so the doctors are jointly appointed by the University and the Department of Health, and their duties include teaching, supervising trainees (interns and registrars), and research.

It is clear from the above that the clinical labour process is a complex one: it is spread across several different sites (surgical wards, operating theatres, radiography, pharmacy), combines a range of different categories of staff, and is dependent on non-clinical labour processes such as in the laundry or kitchen, as well as administrative processes such as procurement, financial management and human resources management. This complexity is reflected in the structures of management, which are fragmented into parallel silos.

Skills and the labour process

The complexity and variability of illness and disease, and the way these manifest in different individual patients, including the complexities of therapeutic decision making, means that the clinical labour process is highly skills-intensive. This is even more the case at a tertiary academic institution such as Chris Hani Baragwanath Hospital, which is characterised by a high degree of specialisation in specific areas of medicine. This is reflected in the proportion of different categories of staff: at the time of this research, there were somewhat fewer than 2000 nurses, 500 doctors, and about 2200 support workers, clerks, administrators, supervisors and managers.

The complexity, variability and changeability of illness means that the labour process is characterised both by high levels of skill as well as high levels of discretion. The clinician makes decisions about the treatment of the patient, and instructs the nurses accordingly. Most of these decisions are taken on a daily ward rounds, but also when clinicians visit particular patients in the ward. Nurses contribute to decision-making by reporting on the condition and progress of the patient, and drawing the attention of the clinician to significant features. Nurses then implement the course of treatment decided on by the clinician, monitor the effects, and take care of the patients. While nurses do not make most of the clinical decisions, they do exercise a high level of judgement, based on skill and experience, regarding the impact of treatment, whether a patient is in danger, whether a doctor should be called, and so on. There is therefore considerable discretion (judgement, prioritising, choice, decision-making) in the daily work of nursing. Since nurses are in day-long contact with the patients, unlike doctors, they are regarded as the "eyes and ears" of the doctors and have the responsibility to bring to their attention anything they regard as significant for the treatment of a particular patient.

High levels of skill and discretion does not mean that the clinical labour process bears no relationship to the routinised bureaucratic processes that are thought to characterise the modern state. On the contrary, highly specified routines and procedures are central to the practice of modern medicine, from the routines of checking temperature and blood pressure to the checklists of symptoms that aid in making a diagnosis, and the strict protocols governing activities such as hygiene control, undertaking a surgical procedure,

or administering medications. These routines are absolutely essential for gathering the information on which decisions depend; skill and discretion are required in interpreting the information and its patterns and discrepancies, and making decisions about the course of treatment; again, routine is essential for implementing these decisions, and discretion and skill for monitoring and interpreting the patient's response.

The interplay between routine and discretion means that significant aspects of the clinical labour process can be routinised and delegated to less skilled members of the clinical team such as nursing auxiliaries and enrolled nurses in the nursing function, and interns or registrars in the medical function. However, these always work under the supervision or guidance of professional nurses and consultants, and in the nursing function in particular there are strict regulations governing the scope of work of different levels of nurse. Schedule 5 and higher drugs, for example, can only be administered by a professional nurse.

The crisis in hospitals

By the early 2000's it was clear that both the routine procedures and the discretionary decision-making that are vital to the clinical labour process were under severe stress, and in some cases in a state of collapse, in many public hospitals, including Chris Hani Baragwanath Hospital. Routine nursing procedures were no longer followed consistently, recording of data was inconsistent, discipline had broken down, inexperienced or underqualified staff were taking responsibility beyond their scope of practice, infection control procedures had broken down, essential drugs were absent from pharmacies, linen shortages were endemic, to name only a few indices of hospital malfunctioning (Von Holdt and Maserumule 2005; Von Holdt and Murphy 2007).

Three quotes illustrate this point.

> Records are not up to date! We do not have time to take vital data, change dressings, keep records of incidents and mortality and morbidity conferences. We know 'what's not written is not done'. We are trying our best, but it is so difficult. (Professional Nurses, in Von Holdt and Murphy 2007: 328)

> We always have to rush: we wash, we medicate, we move on. You miss some things. You cannot listen to the patient. You cannot be broad and implement things that would improve health care and staff morale. You cannot apply your knowledge and improve the unit. (Professional Nurses, in Von Holdt and Murphy 2007: 330)

> When we go to meetings with supervisors we complain about the shortage of staff, the linen, the cleaners. They tell us, ' Try your best!' They come with no solutions. It is a waste of time, problems remain unresolved. Who do we cry to? We never see the managers. (Von Holdt and Maserumule 2005: 442)

In our analysis, there are three basic causes for this problem: shortage of staff due to underbudgeting, dysfunctional organisational structures which fragment managerial authority and produce incoherent management systems, and a lack of managerial skill. The transformation project at Chris Hani Baragwanath Hospital had no control over the problem of underbudgeting, but focused on addressing the problem of dysfunctional management structures and management skill.

Dysfunctional organisational structures

Centralised control

Hospital managers have very little real authority to manage their institutions. Staff establishments, budgeting, dismissal outside their control and numerous operational decisions have to be referred to provincial head offices. Centrally determined rules and operational interference undermine hospital management and lead to ' severe under development of management systems, structures and capacity at hospital level, and to a distorted management culture'. (Hospital Strategy Project 1996: ii, 29; see also Von Holdt and Murphy 2007: 318-21)

Silo structures of management

The organisational structure of hospitals is fragmented into parallel and separate silos of managerial authority. Thus nurses are managed within a nursing silo, doctors are managed within a silo of clinicians, and support workers are managed by a web of separate silos for cleaners, clerks and porters. This means that no unit of the hospital can be managed as a distinctive operational domain, there are grey areas, conflicts and communication failures between silos, and accountability and authority are fundamentally undermined, creating disempowered managers and a 'managerial vacuum' at the heart of hospital operations (Von Holdt and Murphy 2007: 322-25;see also Hospital Strategy Project 1996...).

Clinical process marginalised by administrative goals

Centralisation of authority in the hands of administrators, and the disempowering effect of silo structures in the hospital, work systematically to marginalise the clinical process and its agents -- the doctors and nurses -- from strategic and operational decision-making. The system fails to respond to the requirements of the clinical process and patient care, but operates instead according to administrative goals and procedures which generate constant failures in the wards and operating theatres. (Hospital Strategy Project 1996:... Von Holdt and Murphy 2007:325)

Lack of investment in management (posts, skills & systems)

Hospital management suffers from a shortage of management posts, skills and systems. There are too few managers for the scale of operations and functions that have to be

managed, and too many of the senior managers in hospitals lack the experience or skills required to coordinate complex operations. The result is deficient management systems. HR, financial, procurement and logistical functions are rudimentary at best.

Autocratic management practices

The general management style in hospitals is an autocratic one, with instructions and decisions passed down from on high with very little consultation. This is at least in part a coping strategy for dealing with the general fragmentation and disempowerment of management authority, as well as a hangover from the apartheid era. Nursing cultures in particular are historically authoritarian (Marks 1994).

These features of hospital management together produce a managerial vacuum at the heart of hospital operations. The fragmentation and dispersal of management authority and accountability means not only that managers and staff avoid accountability, but also that it is extremely difficult to hold them accountable. Those at the top of the management structure issue instructions and decisions, but these have little effect, and not infrequently negative effect, on the clinical process and its support functions. The lack of clear operational domains makes it extremely difficult to manage operations or people effectively. Problems emerge, or are raised, but cannot be addressed except through temporary fire-fighting endeavours or interim solutions. The lack of management systems means that problems recur in old and new forms. Ad hoc solutions do not result in long term change. Throughout the system there is a loss of staff morale as the pressure of staff shortages is exacerbated by weak and ineffective management.

The conclusion of the transformation project designers was that ad hoc and piecemeal changes could not succeed over the medium and long-term; only systematic structural transformation could produce long-lasting, sustainable improvements.

The transformation project: a new management model

The transformation project at Chris Hani Baragwanath Hospital was designed to overcome these structural dysfunctionalities and address the management vacuum by reconstituting managerial authority with a new organisational structure. The principles of the new model attempted to address systematically the dysfunctionalities of the existing organisational structure.

Decentralisation to the hospital CEO

The project required that there be the delegation of managerial authority to the hospital CEO so that he could implement the new management model in the surgical division, make the necessary decisions as the project developed, and take full accountability for its results. This would the role the CEO should play in any hospital in order to take full accountability for the functioning of that hospital. The model in turn required the

devolution of management authority by the CEO to the head of division, so that he could take accountability for operations under his control.

Integration of management functions

The fragmented silo structure of the organisation would be broken, and the silos integrated at the level of the division and again at the level of the ward. The managers of different functions (nursing, medical, HR, finances, systems) would report to the head of division, rather than the head of their silo at hospital level, thereby managing the division as an integrated operational unit. In the ward, the ward manager would have authority over all categories of staff, again breaking the system of parallel silos of staff each accounting to their own supervisor.

Clinician leadership

In order to shift the clinical process from the margin to the centre of all operational and strategic decision-making, leadership of the division was to be invested in a senior practising clinician rather than an administrator. Administrative managers would report to the division head, rather than the other way round, as would the nursing head. Clinical leadership would ensure that patient care was the central concern of all functions, and would be underpinned by strong administrative support.

Increased resources and skills

The new organisational structure would require an expanded managerial and administrative staff to make up for the deficit identified in the existing management structure. External expertise would be required in order to redefine roles and responsibilities and develop the skills of the new management team.

Consultative management

The new management practices would be based on the principle of consultation -- consultation with staff and managers over decisions that affect their work, and consultation with trade unions over matters that affect their members. This would replace the autocratic decision-making style that alienates staff and managers and frequently produces poorly thought-through and inappropriate decisions.

The rationale behind decentralisation, clinician leadership and the integration of management functions ' is to reorient and enable decision-making in the service of patient care' which is affected both by the leadership of clinicians as well as by bringing administrators ' into close contact with the process of health care delivery' (Doherty 2010: x). Enhanced resources and skills would improve management effectiveness. Consultation would ensure that better decisions were made, and that managers and staff understood and accepted them.

At the heart of the new model was a new organogram. Figure 1 shows the old organogram, with its complex of organisational silos. While the organogram implies that only the five directors who oversee the silos report to the CEO, in practice all the clinical heads of departments have access to the CEO, as they are frequently frustrated by the inabilities and lack of insight from this group of managers the decisions and authority of the clinical executives and clinical director. Indeed, the incoherence of the management structure requires repeated negotiations, fractious fallouts, fire-fighting and special dispensations in order to function. Figure 2 shows the new organogram at the level of the hospital as a whole: the institution is divided into five operating divisions, four of them clinical (surgical, mother and child, medical and clinical support services) and one of them non-clinical (non-clinical support services). The divisional heads report directly to the CEO, cutting out the multiple lines of authority and flattening the management structure. This is designed to impose operational order on the fragmented structures of the old organogram. Figure 3 shows the new organogram at the level of the Surgical Division, which was selected by the CEO as the pilot for implementing the new organisational model.

The new model was designed to replace multiple overlapping lines of accountability with a clear single line of accountability, providing certainty and stability to the management of operational domains. The head of the surgical division was a clinician who accounted directly to the CEO for the running of the division. As a clinician he would continue to maintain his surgical practice and teaching and research activities, but would be supported by a team of professional HR, finance and systems managers. The head of nursing for the division would also report directly to thehead of division, thus building and strengthening the relationship between nursing and clinicians, which had been broken by the silo structure.

It was believed that this new model would enhance management efficiency and the effective use of scarce resources, and improved staff morale and effectiveness, enabling both management and staff to focus on improving health care. The project was designed, then, to achieve three outcomes: improved patient care, management effectiveness, improved staff morale.

If we return to our earlier discussion of routine, discretion and skill, the new model with its principles of decentralisation, integration and clinical leadership can be seen to reflect the particular nature of the clinical labour process. The complexity of that process, and the high levels of skill and discretion that are required at the workplace, in the interaction with the patient, on an hour-by-hour basis (moment-to-moment during a surgical procedure) require complex decision-making on an immediate basis. This suggests that a decentralised management structure with management authority and decision-making devolved to the lowest possible level is the most appropriate model. At the same time, the necessity for support functions to actively support the clinical process in realtime suggests an integrated management structure at this lowest possible level will ensure the most effective combination of the diverse processes that go into patient care. Clinical leadership ensures that the head of the division represents both the highest level of expertise in the workplace and has an intimate knowledge of the workings of the clinical

process. Administrative functions are subordinated to the clinical imperative. Routine processes and systems are therefore designed to support and facilitate clinical decision-making, for which they are essential.

While this model may well turn out to be generally applicable, in different configurations, across the public health system, it may be inappropriate, or require at least to be redesigned, for institutions and labour processes with a different combination of routine, discretion and skill.

Impact of the new model

The new management model was implemented intensively over a period of two years (2006-2008), but preparatory work had been done in the general surgery department of the Surgical Division since 2003. During this period a team of implementers began working together, nurses were appointed to the ward manager positions, and the outlines of the new model gained more definition, but progress was slow due to insufficient funding.

In assessing the impact of the new model, we draw on two independent evaluations of the transformation project, one commissioned by the Gauteng Department of Health (Khalvest 2009), and the second commissioned by the Surgical Department in the Faculty of Health Sciences at the University of the Witwatersrand (Doherty 2010). We draw mostly on the latter, as the former was more limited in what it assessed, was contradictory in places, and was marred by hostility towards the consulting organisation which drove the implementation of the project.

Management effectiveness

Independent evaluation of the transformation project concluded that there had been considerable improvements in management efficiency. The creation of an integrated management structure with clear lines of accountability created the ability both to solve pressing problems, as well as to put in place systems which prevented the problems from arising in the first place. Some specific achievements were:

- the daily adjustment of staffing in the wards according to bed occupancy and acuity levels, based on validated norms
- ward staff no longer had to leave wards for a long time to make personnel queries or receive payslips, as these were dealt with in the wards
- 65% reduction of queries about salaries and conditions
- 50% reduction in time taken to appoint staff
- human resources maintains the standard of processing within 24-hours all documents received
- billing system established with increased revenue stream for hospital
- decline in outstanding debts
- improve tracking of expenditure and debt
- generation of accurate information for estimating costs and budgets

- supply chain management system established and able to innovate regarding equipment supply and maintenance contracts and establish rapid response systems with suppliers
- correct items ordered and delivered, rapid payment of suppliers, reduction of shrinkage

(Doherty 2010: xii-xii, 61-2)

Doherty's evaluation was based on interviews with management. A survey of 13% of the divisional staff conducted by Khalvest Consulting suggests that staff more broadly have a somewhat more mixed (but still predominantly positive) view of management effectiveness:

STATEMENT	'STRONGLY AGREE' AND 'AGREE' (%)	'STRONGLY DISAGREE' AND 'DISAGREE' (%)
I am held accountable for my performance	83%	0%
Management is held accountable	69%	0%
Overall management is effective	53%	18% a

Accountability of staff and managers is felt to be extremely high, and this is a key measure of management effectiveness. However, a much lower proportion of staff agree that, overall, management is effective, which may indicate the salience of factors beyond the control of surgical division management, such as equipment and staff budgets.

Management effectiveness in the clinical sphere is included in the discussion of patient care, below.

Staff morale

Doherty (2010: 66) draws from Khalvest (2009) as well as her own interviews to conclude that ' significant improvements in staff morale and Labour relations were the result of transformed management systems and a change in organisational ethos.' The Khalvest staff survey produced significant results regarding staff experiences at work:

STATEMENT	'STRONGLY AGREE' AND 'AGREE' (%)	'STRONGLY DISAGREE' AND 'DISAGREE' (%)
Overall, I have a positive relationship with co-workers	88	6
Employees regularly share and exchange ideas	79	4
Employees in my workplace work together as a team	79	12
Teamwork is encouraged	85	8
The workplace has improved as a result of	65	12

transformation		
Someone shows concern for my well-being	65	6
Employees are valued at work	46	23
Employee relationships with management are based on trust	60	13
I am involved in decisions that affect me	58	24
There is open communication between management and staff	44	26
My workload is reasonable	39	37
I have the necessary equipment I need to perform my work	33	38

These results suggest an extremely positive relationship between employees, and a positive relationship with management. The lowest scores are for work load and equipment, which depend on hospital budgets and are beyond the control of either surgical division or central hospital management; these in turn may account for the otherwise anomalous low score for employees feeling valued at work. While there is also a lower score for communication, there is a high score for involvement in decisions that affect staff. Overall, as Doherty comments, this picture provides a strong contrast with previous surveys in the surgical division prior to project implementation (Rajaram 2006), and across the hospital (Schneider, Oyedele et al 2005; Landman, Mouton & Nevhutalu 2001[1]).

In a more qualitative account of management morale, Doherty (2010: 63) reports:

> ' *There is in fact a completely new level of trust, co-operation and respect,'* said one respondent (D). People interviewed demonstrated a striking enthusiasm and unity of purpose, as well as a sense of relief that interpersonal relations were well-structured and respectful. As one person said, ' *You feel that it's quite nice to work here, there's a difference in the workplace'* (I) while another said, there is ' *more opportunity and freedom to do what I think best'* (I). The same person said ' *we are seeing here... I feel much better respected but the feeling is mutual... we have started to see each other as human beings'* (I). Referring to nurses' satisfaction, one commentator said, ' *Nurses? They seemed to be better. I think there's a lot of allegiance. I sense a lot of allegiance towards the department.'* (C)[2]

Patient care

Measuring the quality of health care is a complex and difficult matter. The quality of health care is influenced by many factors, a number of them beyond the control of the division -- such as, for example, cancellation of theatre lists by Theatre. Moreover, the

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[1] This survey is not mentioned by Doherty 2010.

[2] Doherty uses the code D to refer to a project designer, I to refer to a project to implementor in the surgical division (ie, a manager), and C to refer to commentators who were not directly involved with design or implementation, but he knew the project and the local health system well.

inability of the hospital to provide an integrated information system which could track clinical indicators such as length of stay, wound sepsis rates, bedsore rates, etc, meant that the surgical division was unable to provide hard clinical data regarding quality of care. The absence of baseline data would in any case have made it difficult to establish trends pre-and post-transformation. Nonetheless it is possible to use proxy indicators, and indeed, many hospital quality assurance programmes prefer to use proxy indicators over direct clinical data because of the extraneous factors which may influence the latter.

The Doherty evaluation explored the use of intermediate indicators as proxies, and found them to be convincing indications of improved quality of care (Doherty 2010: 69). Most of these intermediate indicators reflected an improvement in management efficiency and coordination in the wards. Doherty (2010: xiv, 67) lists some of them:

1. Re-establishing the practice of doctors and nurses doing ward rounds together, so that instructions for patient care clear and good communication is fostered. This is supplemented by other practices that encourage communication and team working between doctors and nurses.
2. Ensuring that the instructions for patient care are carried out by creating clear lines of accountability for all nursing staff, with final accountability for the ward resting with the Ward Manager.
3. Clarifying standards of patient care, including the development of standard operating procedures that guide nursing staff and have their buy in -- this is especially important now that there are more enrolled than professional nurses in the wards.
4. Empowering nurse managers to solve patient care problems themselves and raise concerns about medical care and ethical issues.
5. Identifying instances of poor patient care and implementing remedial action, including formal, regular mortality and morbidity conferences of doctors and nurses.
6. Creating rapid and innovative solutions to problems of clinical organisation, including improved cooperation between sub-specialities. Implementing a system in the general and trauma wards whereby a consultant is permanently (in house) on-call for intakes (an unusual arrangement in South Africa).
7. Creating a high-care trauma unit within the division, so that these patients can receive more intensive care.
8. Responding rapidly to concerns raised by patients and their families.
9. Improving the hygiene of the environment by keeping wards clean, attending to leaking toilets and ensuring that paper towels and disinfectant are available in the wards for washing hands.
10. Ensuring that supplies and equipment are ordered and received promptly.
11. Improving staffing levels by developing norms according to bed occupancy and acuity, as well as filling vacant posts rapidly.
12. Interviewing staff for specific posts so that they are able to????.
13. Freeing staff from administrative burdens so that they have more time to spend at the bedside.

One might include others, such as improved stock control in the wards and the implementation of effective disciplinary procedures.

According to the Khalvest staff survey, a good majority of staff believes the quality of health care has improved:

STATEMENT	'STRONGLY AGREE' AND 'AGREE' (%)	'STRONGLY DISAGREE' AND 'DISAGREE' (%)
The level of patient care has improved because of the transformation project	60	13
I have received positive feedback from patients about the services we provide	62	17

The Doherty evaluation provides qualitative evidence that the surgical division management also believes the transformation project had significantly improved patient care:

> This [the project] replaces a health environments that one respondent characterised as, ' complete disorganisation. Each one of us was doing whatever he wanted. I'm talking about the heads of the units. There was no control, outcome control. There were no protocols. There was a complete hiatus between the nursing staff and the doctors. The different specialities did not have contact as such and there was a lot of animosity and a lot of competition.' (I). Now the Surgery Division attempts to provide an ' environment [that] supports attention to details' (D). As one respondent said, ' In an environment where there is order, patient care [doesn't] slip through the cracks. And I've seen it in some of the units where there is less attention to detail and I see the chaos that happens there and I see the morbidity and mortality meetings and when we interrogate adverse outcomes I can see that there was no attention to detail. Someone just skated past and very superficially just had a look, rather than spend time really engaging. So it's those kinds of mindsets that one wants to change, not just by... instructing people to do it, but by giving them an environment where it's easier to do it' (D). (Doherty 2010:68)

This account makes it clear that establishing that the previous ' chaos' made it impossible to establish standardised and effective routines governing patient care, and undermined the kind of complex discretionary decision-making that is integral to health care; on the other hand, ' order' was essential for both.

Management structures of accountability are important, so that staff know what is expected of them and that ' they cannot do whatever they want' (I). Professional accountability through the formal adverse incidents forums is also important: ' Look, in South Africa life is cheap, okay. By doing a decent Morbidity and Mortality, where you have your peers there, sitting there, and they are not out for blood but they are not prepared to accept rubbish, life then becomes expensive' (I). (Doherty 2010: 68)

The Khalvest report quotes a senior university academic commenting that the training programme in the Division was now on a par with that at Johannesburg Hospital, with registrars now happy to rotate through the Division whereas previously there had been resistance: ' The academic scope... has grown significantly. The creation of the [Division] has reduced the overload on the students... the Division has become one of the strongest in the country and created control on what is technically possible, and provided a good opportunity to create multidiscipline [sic] in a single training environment'. (Khalvest consulting 2009:36)

How the project achieved these outcomes

In this section we reflect in more detail on some of the principles of the project, and the processes through which the new model was established and the principles put into practice.

Partnership with trade unions

The partnership between managers, clinicians and trade unions in developing the new model and implementing it was a unique feature of the transformation project. It was in fact the National Education Health and Allied Workers Union (NEHAWU), a COSATU affiliate, that initiated the project in 2000 by approaching the COSATU research and policy Institute, NALEDI[3], and proposing a project to transform Chris Hani Baragwanath Hospital into a ' people's hospital' which both delivered a good quality health service to the community and provided a decent quality of work life for its staff. The CEO at the time was enthusiastic and supported the initial research by NALEDI. Over a period of three years research was conducted and a series of stakeholders discussions led to the support of the other trade unions, the hospital board and the Gauteng department of health, and it was agreed to start a pilot project in the general surgery department of the hospital. A strong partnership was established with the head of this department.[4]

A broad outline of the new model of decentralisation, integrated management and clarifying the lines of accountability emerged through the NALEDI research, the input of the trade unions, and the clinical perspective of the head of department. The distinctive feature about the research was that it established a perspective on management failure *from below*, through intensive interviews and focus groups with cleaners, clerks and nurses. The research identified the fragmented silo structure of management, top-down, bureaucratic and authoritarian management culture, the breakdown of discipline, the lack of skills development and career pathing, the lack of team working, and staff shortages as key problems (Von Holdt and Maserumule 2005). The research results and the proposed new model were then presented back to union members and the surgical department staff more broadly for further discussion and refinement. The different unions were able to make significant contributions from the perspective of different categories of workers,

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[3] Karl von Holdt, co-author of this paper, was a senior researcher at NALEDI at the time and headed this project.
[4] Martin Smith, co-author of this paper.

with NEHAWU particularly important in relation to support workers, and Hospersa and DENOSA assisting to define the role of the nurse as ward manager.

The project was initiated in 2003. The lack of financial support meant it was unable to make much progress, beyond the appointment of ward managers for each of the eight wards, the building of team cohesion through regular weekly meetings of the ward managers, the clinical head, nursing head and administrative head, where operational problems could be addressed in a limited fashion.

At a broader level in the hospital and the provincial department of health, the future of the project remained uncertain. The CEO and his senior management team had been unceremoniously removed, and the new CEO and team were not convinced of the merits of the project. In the department, support was intermittent and lukewarm. Political support from the Premier and the MEC for Health was strong verbally but had no practical significance. Among the trade union organisations, NEHAWU had the most political weight, but it to provided only verbal support. This situation changed with the advent of a new NEHAWU provincial secretary, who adopted the project with passion and engaged the MEC. The result was financial support for a three-day workshop for representatives of all constituencies in the hospital, where the outlines of a transformation plan for the institution as a whole were established.

Promises of financial support to implement this plan led nowhere. The provincial secretary was replaced as a result of internal struggles within NEHAWU and the union campaign to put pressure on the provincial department ran out of steam. However, the head office of the union began to take a new interest in the project, led by a head office official and the union general secretary. When the appointment of a new MECfailed to clarify the status of the project, the union spearheaded the organising of a march to Chris Hani Baragwanath Hospital in support of funding for transformation. The march was a remarkable display of unity across all constituencies, combining toyi-toying cleaners, clerks and nurses with matrons, professors, Deans, community activists and church members. A memorandum was handed over to the MEC demanding project funding, the removal of a senior departmental official regarded as the chief opponent of the project, and the appointment of the clinical director to the vacant post of hospital CEO.

The clinical director was appointed CEO some weeks later. The departmental official remained in place. Funding was made available, a tender was issued, NALEDI established an expert consulting team consisting of the former management team from a large mining company's health services division, put in a bid and was awarded the tender. NEHAWU seconded its head office official to the NALEDI team.[5] The project could now be systematically implemented.

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[5] Moloantoa Molaba, co-author of this paper.

The NALEDI consulting team contained an unusual combination of expertise, including a highly experienced trade unionist and highly experienced health managers with public and private sector experience which, it was hoped, would ensure that the transformation project incorporated the concerns of trade unions and their members as well as the technical and managerial perspectives required to end the 'managerial vacuum' in the surgical division, as well as retain the political support of labour. Indeed, the managerial perspective had already, prior to the bid, been quite decisive in resolving a central issue in establishing the new accountability structure; namely, the reporting relationship between the most senior administrator and the clinical heads at the apex of the divisional structure. Colin Eisenstein[6], the project manager, proposed the appointment of the clinical head as the Head of Division, with administrative managers reporting to him. This reversed the current practice, and made immediate sense to the CEO, the clinical head and the project team -- though it remained controversial with hospital management more broadly and among provincial health officials.

During implementation the role of the trade unions remained an important one. Consultative structures were established, with regular meetings to update unions about progress and problems, and to take into account concerns of unions and their members. This was important for helping to resolve potentially conflictual issues. For example, appointing the ward managers at a higher grade than the rest of the professional nurses, in recognition of their managerial role, was thoroughly canvassed with trade unionists before being implemented. In the normal course of conflictual Labour relations in the hospital, innovations such as this would have been automatically resisted, and bureaucratic procedures used to stall change. In another case, the appointment of a white manager to the Surgical Division proved controversial, and lengthy discussions with shop stewards had to take place in order to allay concerns. The relations of trust established between union shop stewards and the Head of Division, and over time with the rest of the surgical management team, also meant that workplace conflicts, including disciplinary cases, could be resolved relatively easily, rather than being escalated into full-scale confrontations between support workers and nursing managers, as was traditionally the case.

> Now when we get into a confrontation in the ward, say between a nurse and a cleaner, the labour representatives -- to the ward, and the nurse phones the labour relations officer and says we've got a problem, can you organise and we will all come together. The cleaner in the room, and a nurse in the room, and their representatives there... they sort it out amongst themselves, industrial peace and everybody goes on their way. (Doherty 2010:47)

Trust developed from continual communication, as another respondent said: 'Union representatives come in here and chat – we never had that relationship before.' (Doherty 2010: 64)

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[6] Dr Colin Eisenstein, whose depth of experience as well as technical expertise were the critical factor in project implementation, had already worked with the project for a period of six months prior to the tender.

In return, the unions won small gains. Twenty new cleaners were employed, lightening the load of the existing cleaners and ensuring that the wards could be kept clean. The project managed to negotiate a bridging programme for 20 enrolled nurses from the division so that they could qualify as professional nurses. Skills development was a key union concern, and the training programme would also help meet the shortfall in professional nurses. Probably the most important feature for the unions, however, was their own role in defining and establishing the project, and the inbuilt processes of mutually respectful consultation that constituted one of its principles. Indeed, it was this principle that made it possible to negotiate the biggest innovation in labour relations -- and the one with greatest potential impact on Labour relations nationally in the public health sector -- the minimum services agreement during the 2007 public service strike, which is discussed below.

Thus the trade union role in the project operated at two levels -- firstly, in the workplace, through defining a strategic partnership with labour and consulting over gritty workplace issues such as the authority and status of ward managers, disciplinary processes, the role and accountability of cleaners, and so on; and secondly, at a strategic political level in terms of pressurising the government to accept and finance the project. On numerous occasions when the project future was uncertain, or stalled by the lack of departmental support, NEHAWU went out on a limb to support and protect it. Without this, the project would never have happened; however, this was probably a contributing factor to the hostility to the project from various officials and managers, as we shall see below.

Nursing: from silo to empowerment

Transforming nursing practices was probably the single biggest factor in improving clinical efficiency and patient care. The model achieved this by breaking the nursing silo, establishing accountability and a good working relationship between nurses and doctors, empowering the ward managers, who are nurses, to take charge of the domain, and building teamwork among nurses in the wards.

Breaking the nursing silo was the most difficult of these, as the silo is so deeply entrenched in historical practices and in the struggles of nurses to break away from the control of doctors. However, breaking this silo was the key to decentralising management authority in the hospital and integrating management functions at divisional, clinical department and ward levels. Although the CEO made a clear decision that the head of nursing in the surgical division should report to the head of division, and no longer directly to the hospital's head matron, the latter put up fierce resistance. At the same time, the nursing manager in the surgical division had herself to be persuaded of the advantages of decentralisation and integration, and be prepared to challenge the authority of the traditional nursing hierarchy. Over time the matron herself became a staunch supporter of the change, but was suddenly killed in a car accident. Her replacement remained opposed to the new organogram, and all the commitment and strength of character of the surgical nursing manager, and the authority of the head of division, was required in order to maintain the new arrangements. The surgical nursing manager came under huge pressure, being undermined, excluded and punished by the rest of the nursing

management in the hospital. She was, for example, told that the new night call system for the surgical division was not acceptable, and on another occasion that she could no longer make use of agency nurses for the division. In both instances the CEO and the head of division had to force the hospital head of nursing to back down.

The division adopted a flattened organisational structure, with three assistant nursing managers reporting to the nursing manager, and below that 23 ward managers. The close working relationship between the head of division and the nursing manager provided a model for doctor-nurse relationships down the hierarchy, at the clinical Department level and at the Ward level. Joint Ward rounds were reinstated, nurses joined the clinical morbidity and mortality conferences, and regular monthly ward meetings of all the doctors and nurses in each ward were instituted. The new system created stability and order in the wards, allowing nurses and doctors to create working relationships so that each understood what the other required. In contrast to the previous system, nurses made sure that their clinical counterparts were party to discussing any changes they planned to introduce in the functioning of the wards.

The new model aimed to empower the ward managers to take full control of their wards and of patient care. While doctors did not fall under the authority of the ward managers, they were encouraged to keep the ward managers appraised of their movements, and ward managers were encouraged to challenge doctors who did not conform to nursing requirements, for example by drafting illegible operating lists or patient bed letters. Together with the NALEDI consultants the ward managers developed a nursing code of conduct and drafted a set of standard operating procedures for the wards, and also undertook training in labour relations issues. Nursing managers were encouraged to innovate in solving operational problems. For example, there was an ongoing problem that doctors on call were unable to assess a patient's condition on the basis of information provided telephonically by nurses. The nurse managers developed a system for codifying symptoms into a three levels (red, orange, green) to designate different levels of severity, so that doctors could rapidly decide whether it was necessary to see the patient and how urgently this was required.

The new model therefore had a significant impact on the ability of nurses to do their work in a professional way. As one nurse respondent put it the sense of empowerment ' has been beyond my dreams' (Doherty 2010: 25). Establishing stability in the nursing domain enabled the surgical division to reconstitute the routines that are so essential for the clinical process. The bulk of nursing activity is about routines -- gathering information regularly, making sure that it is recorded adequately, maintaining infection-control protocols, ensuring that the clinical instructions regarding medications, drips, dressings, etc are rigorously follow, ensuring that the ward has adequate stock of drugs, medical sundries, linen and so on. It is only on the basis of these routines that diagnosis -- which is where complex discretionary decision-making applies -- can be accurately made and treatment implemented. Routine, however, is not enough -- patient care also requires nurses to engage with the patient, the doctor and the family. Empowerment, authority, and responsibility are necessary for these more skilled and discretionary activities, and that is what the new model aimed to provide.

Human resource management

The decentralisation of human resources functions to the surgical division was designed to bring the functions much closer to the staff, and at the same time effect a shift from personnel administration to active human resource management. The central HR function in the hospital is essentially administrative, and is experienced as faceless, time-consuming and inefficient by hospital staff, partly because the HR function is itself understaffed, and partly because dealing centrally with the needs of around 5000 people use, as one respondent said, ' totally unmanageable' (Doherty 2010:45).

The new decentralised HR office was relocated in the same building as the rest of the surgical division management, and consisted of the divisional head of human resources, three HR officers, and six administrative clerks. It focused on administrative efficiency, active labour relations management, improving discipline, and skills and development. In relation to efficiency, the HR office succeeded in halving the time taken to fill vacant posts, established rapid response procedures for queries and grievances, delivered payslips directly to wards, and instituted regular visits to wards to ensure communication with staff. The increase in efficiency and responsiveness increased staff satisfaction (see above), and led to a 65% reduction in queries. The goal was to ensure that HR met the needs of the surgical division managers and staff, improve staff morale and at the same time reduced to a bare minimum the amount of time staff had to spend outside the wards on administrative routines or queries. As one of the project designers explained,

> Nurses get sick, their children die, they have a motorcar accident, they feel depressed by the HIV load that they've got to deal with, they don't have enough equipment, and you've got to keep motivating them to stay at the bedside and nurse in a meaningful way. You've got to have an HR practitioner who is on their doorstep and walks into that ward on a daily basis and says, ' Here I am, how can I help?' Don't ask the nurse to leave the ward and go to HR. Don't expect them to go and walk up to the fourth floor of a tower block to get their payslip. It's three hours out of their day. Now it's delivered to the bedside. If you don't bring those things down to the smallest level of managerial accountability... you will not succeed in effecting health care services.' (Doherty 2010:45)

A respondent from the HR section put it succinctly: ' we cannot go any other routes than being closer to the employee'. (Doherty 2010: 46)

Active labour relations management has been discussed above.

Regarding discipline, the HR section established rapid, effective and fair disciplinary processes, supported by training of all ward managers and clinical department heads. As noted above, regular engagement with trade union representatives created the scope for the informal resolution of Labour relations and disciplinary problems where appropriate, as well as the acceptance of formal disciplinary processes, with formal warnings issued to wrong-doers. It was important that this be seen to operate impartially at all levels, from

cleaner to clinician. One of the most serious and deeply rooted problems at clinician level is the misuse of the RWOPS, which allows doctors in the public service to supplement their salaries with private practice patients, limited to 20% of their working time. Several clinicians were issued written warnings, and two were left with no option but to resign, which demonstrated a new attention to discipline across the division.

There was limited progress in the area of skills development and career pathing, partly because of delays in appointing the relevant officer, and partly because of insufficient resourcing across the public health system.

Finance and procurement

The intention in decentralising the financial and procurement function to the surgical division was to enable the establishment of the division as a full cost centre with proper activity-based budgeting focused on clinical priorities, real-time monitoring and management of costs, and financial accountability. In addition, the numerous problems with procurement -- ordering and delivery of wrong equipment, unwieldy maintenance procedures, failure to pay suppliers and consequent termination of deliveries -- were to be resolved by establishing a procurement section closely aligned with the surgical management and dedicated to meeting the requirements of patient care.

As with HR, the financial section offices were included in the new offices of the surgical division, and a financial head and deputy head, debtors clerk and creditors clerk, and a supply chain manager and two procurement officers were appointed. Significant progress was made in developing new standard operating procedures, developing concrete budgets related to actual activities of the clinical department, and designing the cost centre accounting system. However, little of this could be implemented because of the inability of the central IT system to deliver disaggregated financial data, the failure of the hospital to finance a cheap stand-alone software system for the surgical division, and the centralisation of budgets in the provincial head office. If the stand-alone software system had been provided, the division would have been able to run its own financial system on the basis of internally developed budgets and with accurate cost management systems as a pilot for cost centre management in public hospitals.

Despite this, the finance section was able to use Excel spreadsheets to track expenditure and commitments to goods and services on a real-time basis of, and to develop and accurate costing system and, on the basis of this, routinely bill referral hospitals for costs of medical materials and days of stay, as well as Bill patients covered by a third party payers such as the Road Accident Fund, Workmen's Compensation Fund, and Correctional Services.

One of the section's most effective interventions was developing a supply chain management unit to manage procurement. This was able to develop an innovative equipment leasing contract in place of the prevailing equipment purchase system, with both financial and maintenance advantages for the hospital. This unit ensured that the divisional equipment budget was focused on clinical priorities, that the correct equipment

was specified and ordered, that it arrived promptly, and that most invoices were paid within 30 days, in contrast to the situation elsewhere with many invoices outstanding at 120 days. This was achieved through the existence of staff dedicated to servicing the needs of the division, and their systematic contact with the clinical staff and their needs. The unit still had to work through the Gauteng Shared Services Centre, an enormously inefficient and frustrating institution, but their ability to focus ensured high levels of success. The head of division spent significant time building relationships with suppliers, so that even when there were payment delays, he was able to phone the relevant company manager or managing director and insist on their avoiding the compromise of patient care by refusing to deliver. This would require him to ' put myself on the line and give a guarantee' – knowing that the CEO would back this up. In all these ways, the supply chain unit was integrated into the clinical process, providing a concrete instance of the transformation project's principal of putting patient care first.

Another success of the procurement function concerned the relatively simple item of crutches:

> We ran into a problem where we couldn't discharge any patients because they were no crutches and the hospital didn't have crutches... So we then put in a system where we had our own crutches and our own store for crutches and our own management of that store so that we could get those patients out so that the beds could be rotated to bring other patients in.... If I discharge you earlier the evidence would tell us there's less hospital-acquired infections, that mobility in the home environment is better, you're forced to be active... (Doherty 2010:57)

Clinical leadership and integrated management

The procurement process described above demonstrates the effectiveness of integrating procurement management into the clinical process under the authority of the clinical head, ensuring that procurement functions according to clinical priorities. An even stronger example is provided by the development of the billing system. A multidisciplinary team involving representatives of finance, HR, nursing and doctors investigated clinical processes in theatre and in the wards in order to develop a costing model for different procedures and a workable system for recording costs. The involvement of nurses in developing administrative procedures was unprecedented in the hospital.

A similar multidisciplinary process was used to manage the renovation of the plastic surgery ward. Central management had arranged this without informing the head of division or the nursing manager, and then instructed the head of plastic surgery to close the ward on short notice. The head of division responded by insisting on a delay, and convening a multidisciplinary team to plan the closure properly, securing space for patients in other wards, adjusting the surgery list, etc.

Integrating support functions into clinical management was not only a matter of the lines of authority and accountability, but also bringing administrative managers and staff into

direct contact with clinical processes and patients' needs in the wards. This was facilitated by decentralisation, which brought administrators out of the central administration block into close proximity with the wards, but also by involving administrators in regular visits to the wards:

> The Professor will come in and say, ' Hey, where are my 50 crutches you promised me yesterday?' Now the guy must explain, here's the Professor, right in front of his desk. Why did you let him down? He needs crutches, his patients can't get out the ward, can't go home. You, order clerk, are responsible for that, let me show you. And they take him to the wards, see these patients, that's the one you didn't order crutches for, explain to the patient. (Doherty 2010:73)

Assessing this and other examples makes it clear that the authority of the head of division, resting on his authority as a specialist surgeon, was crucial to the new model, as it enabled him to exert it his authority internally in the division in the relation to clinical department heads, nursing and administration, as well as externally in relation to the administrative managers in the hospital. His accountability to the CEO rested on a mutual recognition of authority, and allowed for a decisiveness in decision-making, as the divisional head represented the entire division. It is difficult to imagine a head from any other occupational category being able to exert effective authority in either the division all the hospital in this way. Indeed, the biggest failing of the prevailing which interposes a clinical executive -- an administrator with clinical qualifications, usually a doctor -- between the clinical heads and the clinical director, who reports to the CEO, is that the clinical executive lacks authority and seniority, not only in relation to chief clinicians but also in relation to other senior hospital managers, and is therefore reduced to endless rounds of negotiation in which clinical heads not infrequently appeal over his head directly to the CEO. This results in ad hoc problem resolution rather than systemic operational management.

An important element in the new model was the incorporation of all the surgical subspecialities into the surgical division, and the subordination of the sub speciality heads to the authority of the head of division. This made management sense, in that it created divisional coherence, and a single Channel of communication and accountability between the division and the CEO, in place of the previous ' system' in which all of the nine sub-speciality heads had direct access to the CEO. There was some resistance from some of the heads who believed they could get a better deal for their departments through negotiating individually with the CEO, and it took the CEO to refuse to talk to them before they would fully commit themselves to the new structure.

Ultimately, however, the establishment of the surgical division executive committee empowered the clinical heads in the running of the division The clinical leadership became significantly stronger and more independent minded in asserting the requirements of the clinical process in the hospital. The substantive and focused discussions in the executive allowed the clinical head to take real proposals to the CEO, which were almost always accepted because they were well-motivated. So, on the occasion when the surgical executive had developed and equipment budget of R 10m for the year, and the

entire hospital was provided with a budget of only R 10m, the executive took the responsibility for developing a new equipment budget of R 3m; previously the hospital management would have made their own selection from the original surgical budget, which would not necessarily have taken into account the priorities of the division. The executive was also able to strengthen the position of individual clinical heads, for example in the case where neurosurgery wanted to refuse the intake of patients because the CAT scan was out of operation.

It was these experiences that convinced the entire management echelon in the surgical division -- administrators, nurses and clinicians -- that the principle of clinical leadership was the single most important factor in the successes of the new model. As one respondent put it:

> [Administrators]... don't see things from the floor. The clinician sees what's happening... The clinician also comes into contact with the nurses, sees them every day, with the cleaners... The administrator is at the back of the desk... He loses contact with reality... He does not understand what it means, what it is not to have a ventilator. For him a ventilator is a number. For us a ventilator is a patient. So he says, ' Yes, there is a patient,' but he doesn't see the patient. So it's a different approach to everything.

And another: ' A clinician is a person who understands. It must be a clinician.' (Doherty 2010: 23-4)

Strike management and the minimum service agreement[7]

The surgical division's management of the 2007 public service strike rested on all the strengths of the transformation model more generally -- integrated management, clinical leadership and a consultative relationship with the trade unions -- and provided a strong contrast with the rest of the hospital.

Some two weeks before the start of the public service strike, the Surgical Division ExCo made the decision to plan proactively for the likelihood of a strike, rather than wait passively and respond in an ad hoc fashion. At a meeting in mid-May, ExCo agreed that the priority was to reduce the possible impact of a strike on patients and clinical care. It was felt that, in a collective bargaining dispute, both the employer and labour would be inclined to subordinate patient interests to their own bargaining concerns.

ExCo decided to pursue an 'empty bed' policy, meaning that the wards would be emptied of all patients except for emergency cases. Each surgical department would estimate the number of beds it should plan to keep open to cater for emergency cases, defined as 'those patients who are suffering life threatening illness and/or may suffer long term consequences of withholding treatment'. These beds should be rationalised to allow for

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[7] The account in the section is taken from 'The 2007 public service strike and our response: Assessment by the Surgical Division ExCo, Chris Hani Baragwanath Hospital'.

the closing of as many wards as possible, so that optimal use could be made of non-striking staff.

ExCo also agreed that this policy might provide a basis for engaging with the unions on the need to maintain 'essential services' in the SD, and it was decided that such an engagement should be pursued.

The final analysis by management indicated that:
- the SD planned to reduce its number of patients by 30%, closing 218 beds and 7 out of 23 wards;
- a skeleton staff of 60% of the normal nursing compliment would be required, while the number of support workers could be reduced below this (management accepted that the strike would disrupt certain support functions such as cleaning, clerical and administration, and that a skeleton staff could not be expected to maintain normal standards in these areas; the emphasis was on maintaining essential patient care functions);
- under normal conditions the SD is staffed by 251 permanent nursing employees (61%) and 158 agency staff (39%);
- this means that under normal conditions the SD is effectively run by a skeleton staff of permanent employees supplemented by agency staff.

This created a difficult dilemma for the unions which threatened to derail the attempts to negotiate an agreement. Their initial view was that no agency staff would be allowed to work during the strike, as they would be regarded as scab labour. However, this would mean that all permanent employees would be required to remain on duty as skeleton staff, and none could join the strike. Ultimately the unions were prepared to revise their position, and agreed that about 70% of the permanent nursing staff should continue working, supplemented by agency staff. Some 30-35% of support workers would be expected to remain on duty as part of the skeleton staffing. Management and labour agreed to establish a strike committee for SD which would meet regularly to monitor implementation of the agreement and resolve problems. The names and contact numbers of delegates to the strike committee were provided.

This agreement held for the first week of the four-week strike. The surgical division cleared the non-emergency beds, consolidated the emergency beds and closed seven wards. During the first week there were sufficient staff on duty, and the nursing managers permitted staff to attend the picket lines during non-intensive periods of work to demonstrate their solidarity. The situation in the surgical division was notably different from that in the rest of the hospital, partly because of the number of staff on duty, and partly because the reduction of beds reduced the work load. However, the inability of the unions and management to establish any agreement for the rest of the hospital, and more importantly, the escalation of strike confrontation at a national level meant that the agreement could not be sustained. A campaign of intimidation was directed against the nursing staff on duty, and they were allowed to leave for their own safety. Nursing managers and clinicians evacuated most of the remaining patients to

private sector hospitals which had been made available by agreement between the department of health and the private hospitals.

As important, however, was the way the executive committee was able to manage the strike. Four days into the strike, it decided to meet daily to assess what was an increasingly volatile situation, and develop co-ordinated responses as required. The fact that it this structure combined clinical heads, nursing managers, and administrators allowed it to coordinate all resources in a strategic way, and provide leadership throughout what was a dire crisis. It coordinated the emergency evacuation, decided we had to concentrate the remaining beds and patients and which wards to close, and was then able to assess on a daily basis the staffing trends and engaged in thorough and sometimes heated discussion when to start readmitting patients and on what basis. Thus, as the numbers of staff on duty gradually rose some of the closed wards and beds were reopened. This forum was not only crucial for managing the practical aspects of the strike, but also for the sense of teamwork and emotional support it provided. Some comments from ExCo members were:

> It was useful and good that ExCo met every day, it gave one peace of mind. The nursing managers worked very hard, we have a brilliant team, they didn't sleep. (Clinical head)

> We always looked forward to the morning meetings where we could share information and plans. It was psychologically supporting, no matter your physical state it is your mental state that is crucial. It was good to know one could communicate with nurses and clinicians. (Nursing manager)

> The meetings were essential. It was unique for the hospital -- our clinical executive was able to take comprehensive information to central management about what was happening on the ground, whereas generally they never know what's happening. (Clinical head)

> Central management tolerated me coming late to their meetings because of the SD ExCo, because I was able to give a strategic report about what we were doing, not just a list of figures. (Clinical executive)

> Knowing that people would sit and listen helped me a lot, it helped me to ventilate and gave me strength to go out and do the work. (Nursing manager)

ExCo's ability to manage the strike demonstrated the value of an integrated management structure with clinical leadership and clear lines of authority. It is clear that the structure empowered clinical and nursing heads to make and implement decisions and manage their respective domains.

In contrast, despite the efforts and commitment of senior managers in the rest of the hospital, the prevailing fragmentation of management structures could not but a adversely

affect coordination, information flow and the management of the strike. The surgical executive committee observed that:

- 'strike management was coordinated by the hospital-wide strike committee, which had no representation from clinical departments or labour; this severely undermined its ability to coordinate across all hospital structures and institutions;
- in the view of ExCo, at hospital level the strike should have been managed by the hospital executive committee, of which the Head of the SD is a member; this would have enabled a higher degree of coordination, particularly as it could have co-opted Medical Advisory Committee (MAC)[8] representation;
- the MAC failed to play a leadership role in the institution as it did not prioritise issues of patient care and treated the strike as something to be endured, like bad weather, rather than managed;
- information flow and communication of management decisions was very poor, which hampered SD ExCo's ability to manage;
- the Hospital Board was 'fantastically silent' throughout the strike; no one in SD was aware of any intervention or support from the Board, and the general feeling was that it had failed the staff and the community that it is supposed to represent.'

Obstacles and resistance

Lack of support from the department

Despite its relatively successful implementation, the designers and implementers of the new model faced serious obstacles and resistance to its implementation. In large part this had to do with the origins of the project in the trade union movement and its policy institute. While this was a source of strength both in providing political pressure without which the project would never have taken place, and in providing a countervailing base for innovation outside the dysfunctional bureaucracy of the department, at the same time this meant that key officials in the department would see the project as imposed from outside and implicitly a critique of their practices. Essentially the attitude towards the project on the part of the department of health ranged from indifference to hostility, while the attitude of the three health MECs who held office over its duration ranged from intermittent enthusiasm to lukewarm or hostile at various points.

Indifference or hostility was apparent not only in the failure to provide promised resources and the clawing back of significant delegations to the CEO (see below), but also in the tapering off of scheduled meetings for the project team to report on progress and problems to the department. After the march in support of transformation at the hospital, the new MEC warned NEHAWU that his officials were not committed to the project because they saw it as belonging to the union and NALEDI, and saw very little

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[8] MACs exist in most hospitals and consist of the senior clinicians in the hospital; it has an advisory relationship with the senior management and CEO. The existence of this structure is an index of the extent to which senior clinicians are marginalised from the formal lines of management authority and accountability, and have to be brought back in in an 'advisory' capacity.

role for themselves. This led to concerted efforts on the part of the project team to meet with senior departmental officials in an attempt to rebuild relations, to no avail.

Failure to provide resources

After the issuing of the tender and the signing of the tender contract, the department paid very little attention to the project. In particular, the agreement that substantial funding of R 5 million would be allocated to the new staff posts required to populate the new management organogram was never implemented. Six months into the project, NALEDI decided to terminate it on the grounds that none of the posts had been filled so it was unable to proceed further. The CEO persuaded NALEDI to remain, promising that the posts would be made available from the existing staff establishment. This was a central area of conflict within the institution as other departments interpreted this as resources been shifted away from them instead of ring fenced funding as promised to support the implementation. Nonetheless, the first post was only filled one year after the contract began – that is to say, at exactly the termination point of the contract! Needless to say, this immeasurably complicated and slowed down the implementation of the project.

Resistance from senior hospital managers

The second reason motivating NALEDI to terminate the contract, was the explicit refusal of the hospital senior managers to cooperate with the transformation project. Again, the CEO persuaded NALEDI to compromise, believing that further engagement would lead to cooperation. Indeed, a degree of co-operation was established with two of the managers, while the other two continued to resist.

The 2010 evaluation report found that there was concerted resistance to the project from the senior management, and concluded that this was due to management accountabilities as defined by the Department of Public Service and Administration and the Public Finance Management Acts, the lack of clarity on the roles and accountability of senior managers in the face of decentralisation, as well as by personality clashes and the failure of the project team to fully and openly discuss the project and its implications with senior management. (Doherty 2010: xv, 80-3)

In the view of the project designers, the fundamental problem was the compromised delegation of powers to the CEO. Given the degree of innovation and the substantial changes to management structures and lines of authority implicit in the new model, it was essential for the CEO to be empowered to take difficult decisions and carry his senior management team with him, and the CEO was indeed given significant delegations in preparation for the project implementation -- one of which was the authority to appoint his senior management team. However, this delegation was clawed back in practice, as the provincial head office insisted on its own candidate for a critical post being appointed, and refused to remove another, thus fundamentally undermining the CEO's authority with his management team.

Ultimately, the implication of the project was that the clinical director post would become redundant, the clinical executives would be removed from their comfortable, ineffectual and nebulous administrative posts in the administrative block and given serious operational accountabilities under the direction of the divisional head, and the roles of the head matron, HR director and financial director would be substantially altered from operational control to a policy, standards, oversight and advisory function. Understandably, their resistance was substantial despite numerous discussions and workshops with the CEO and management team. No amount of further engagement could have been persuasive in a context of a CEO hamstrung by very senior officials in the department who made it clear where real authority lay.

Racial dynamics

It is not improbable that racial dynamics played a part in resistance to the project, and indeed rumours and anecdotes support this thesis. Of the four key project designers, including the head of division, three were white. All of the senior managers affected by the new model were black, as were some of the most critical senior clinicians and all the provincial head office officials with whom the project had contact. The motivation of the project was explicitly critical of hospital and departmental performance, and of the prevailing managerial structures and practices, and this critique could easily be construed as white criticism of black performance.

Moreover, both conceptually and in practice the new model empowered the senior clinicians who were marginalised from the decision making structures of the hospital and the department by the prevailing organisational structure which relegates them to an ambiguous 'advisory' role and compels them to negotiate in all kinds of informal ways with different levels of management. This shift in authority plays into a series of important tensions in the hospital and the public health sector more generally. Not only are senior clinicians disproportionately white, they are also university professors with considerable professional expertise and authority, and they are willing to 'speak back' to authority with the confidence of this expertise and in the interests of patient care as they see it, in a way that no others in the health department -- and perhaps in the public service as a whole -- are able to. This makes for uncomfortable relationships with senior administrators in the hospital as well as departmental officials, as it disturbs the rationales of postcolonial black elite formation within the state, resting as they do on the assertion of bureaucratic hierarchy and 'face', the devalorisation of white skill and an ambivalence towards professional skills more generally (Von Holdt 2010).

In the case of the surgical division, the head of division made use of his position of authority to challenge senior managers, confront non-performance and insist on administrative support for clinical priorities. His personal style was direct and outspoken. It is clear that this was experienced as abrasive, 'defensive, dismissive or even arrogant' by some senior managers and clinicians (Doherty 2010:81), playing into tensions over race, skill, authority and hierarchy. These dynamics, combined with the explicit critique of the prevailing arrangements by the advocates of the new model, provide at least part of

the explanation for resistance to the model and its implementation in the surgical division.

Loss of support in the hospital

The transformation project initially had substantial support from across the clinical and trade union constituencies in the hospital, as a result of intensive consultation and research processes that had involved all constituencies. However, this support gradually eroded because of the delayed implementation, the additional resources channelled to the surgical division to enable it to pilot new structures and practices, and the declining a figure of the consultative processes. Some clinicians in the broader hospital accused the project of holding resources and failing to report on progress to the rest of the institution. The project team, with all its focus on overcoming the obstacles to implementation, felt that the CEO and the clinicians in the rest of the hospital should take responsibility for this. Ultimately, however, the surgical division became increasingly isolated while the rest of the hospital, overwhelmed by the daily grind of trying to make things work, lost interest or became hostile.

Declining support from NEHAWU

At a political level, NEHAWU's support was crucial for the implementation and protection of the project. At several key points this support ensured that the project would continue. However, by 2008 the union leadership was making it clear that they could not go on fighting for a single project if the government was unprepared to learn the lessons and take responsibility for rolling it out more broadly. In the hospital, too, the shop stewards focused on other priorities. It was probably only the support of the union that prevented departmental officials who were hostile to the project from removing the CEO earlier; when the blow finally came in late 2008, there was no significant resistance.

Summary

In summary then, from very soon after it was first mooted with the provincial department of health, the transformation project faced varying degrees of indifference and hostility from within the department and from senior managers in the hospital. This can be attributed to several factors. The origins of the project in trade union proposals, and the outspoken support and pressure from the unions and various points in the life of a project, did not endear it to officials. The fact that the new model was developed and advocated from outside the bureaucracy, and that it was both implicitly and explicitly critical of the prevailing arrangements and practices, meant almost inevitably that officials would resent the project and see it as imposed from outside. The fact that the majority of designers and advocates were white played into racial dynamics. The new model entailed a substantial loss of power and redefinition of work responsibilities on the part of hospital administrators and managers, inevitably generating resistance. The conceptual and actual empowering of senior clinicians disturbed the power and control of administrators and tensions over race, skill, authority and hierarchy in the post-apartheid state.

All of these factors combined tended to work against the long-term success of the project. The concurrent loss of support in the hospital, and dwindling enthusiasm of the union for continued battles over the project, meant that there was less and less a countervailing force to support the project.

It can be argued that several of these factors might have turned out differently if the project team had been more proactive in attempting to win allies within the department and within the hospital (see Doherty 2010: 74ff, for extended discussion of these failings). The project team may well have erred in using political strategies via the trade unions and the MECs to impose the project on the department, as one commentator believed: 'They saw the power base was with the politicians... rather than with the bureaucracy but as you know with any of these things, if you want to drive through certain projects or certain transformation efforts you have to get the bureaucracy to support that.' (Doherty 2010:77) However, it is not at all clear that there was sufficient will, skill, dynamism or functionality in the department for a momentum towards implementation to be generated. The resort to political strategies was a response to what appeared to be departmental inertia and indifference.

In retrospect, it appears inevitable that the project would ultimately fail, as it challenged too many entrenched interests and too wide a front at the same time. The view of its protagonists -- that if they could ring fence and protect the pilot for long enough, success would make the new model irresistible -- seems naive in light of what actually happened.

The dismantling of the project

In late 2008, the CEO, who was a key advocate of the transformation project, was removed from Chris Hani Baragwanath Hospital. Early in 2009 there was a flurry of political activity, with a new interim health minister and then, after the April elections, a new MEC and new health minister. By mid-year it had become clear that there was no longer sufficient political support for the project to be protected. The head of division went on sabbatical leave.

For the whole of 2009 the surgical division continue to operate on the basis of the new model, but in a kind of and easy limbo in the institution characterised by the lack of support but also no overt attempts to dismantle it. However, early in 2010, when the acting CEO was confirmed as CEO, the project was decisively dismantled in every respect, and it no longer exists in the hospital.

Conclusion

Although the new model was not able to achieve everything that it set out to, it did achieve remarkable successes in improving management efficiency, staff morale and

patient care. It is true that with regards to patient care we lack the clinical data that would prove this beyond doubt; however, the proxy indicators developed in Doherty (2010), and reproduced here, provide substantive proof of the ability to focus on healthcare improvement in the surgical division. It can be asserted that the management efficiency and the improved practices of patient care achieved by the project provide at least the necessary conditions for clinical improvement, even if in this particular case it is conceivable that patient care did not improve. For example establishing standard operating procedures for nursing in the wards, including joint ward rounds, is at least a necessary condition for good patient care, even if the actual practice in one or more wards fails to translate into good care.

In our view, the combination in the model of decentralisation and integrated management under clinical leadership accounts for these achievements. Clinical leadership was critical -- though this remains the most controversial element of the model. The reason clinical leadership is appropriate in the hospital setting is the high level of discretionary and skills-based decision-making entailed in the daily activities of health care provision; the clinical head of division embodies the direct knowledge of these daily activities and the nature of the discretionary decisions involved, and so is best equipped to ensure that the necessary supportive environment is brought into being. The clinical labour process is perhaps unique in the way it makes use of the highest level of skill directly in the interface between the daily work practices and the public in the form of the patient. Clinical leadership therefore grounded the decision-making of the entire division in the concrete requirements of the clinical labour process, and ensured that this took precedence over, and shaped, everything else.

The new model's tied the entire organisational structure and its administrative practices to a focus downwards on clinical care, rather than upwards towards hierarchy, upward mobility and deference to face and rules as tends to be characteristic of the post-apartheid state more generally (Von Holdt 2010). The integration of clinical and administrative functions into a single management team led to the establishing of order, coherence and stability in the division. Effective and predictable routines were re-established -- both in clinical practices as well as in support functions such as HR, procurement and finance -- creating the necessary platform for discretionary decision-making that is not arbitrary, but is founded on consistent and reliable information and the ready availability of the material and human resources.

While the new model is appropriate in terms of the structure of the labour process, it is also extremely powerful as a solution to the dire shortage of management expertise and skill in the South African state. It points towards making use of a considerable skills resource that still exists in the public health sector -- namely, clinical skills that reside in doctors and, to a lesser extent in nurses -- and placing these in positions of authority close to the clinical process, so as to ensure that it is managed appropriately. In societies where the state bureaucracy has access to very high level bureaucratic and management skills, it is conceivable that centralised state institutions can provide the institutional stability and effectiveness, and the material and human conditions, for the clinical process to function effectively. However, in the absence of this, it makes sense to deploy clinical expertise,

where possible, to ensure that institutions function effectively, rather than isolating it in a micro-level clinical process which is continuously destabilised by bureaucratic and management failures at other levels.

The project team argues that this model, while constructive specifically to improve patient care outcomes in a tertiary academic hospital, has broader applicability across the public health care system in, for example, secondary hospitals, district health systems and clinics. Considerable adaption and experimentation would of course be needed in these different settings to take account of the particular skills mixes and the requirements of the clinical process at different levels of the health system, but the principle of clinical focus and leadership, and the integration of administrative with clinical management, could provide a powerful strategy for regenerating the public health system.