DIALHS

Policy Brief

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The **D**istrict **I**nnovation, **A**ction & **L**earning for **H**ealth **S**ystems Development **(DIALHS)** project is a collaborative project of the **Health Policy and Systems & Health Economics Divisions** of the UCT School of Public Health and Family Medicine, the School of Public Health at the University of the Western Cape, the City of Cape Town and the Western Cape Department of Health.
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Does identity shape leadership and management practice?

Experiences of PHC facility managers in Cape Town, South Africa

Introduction

For the majority of people seeking healthcare in South Africa, the first point of entry into the health system is at primary health care (PHC) facilities. Professional nurses manage these health service hubs which are a critical interface between the population and health services. However, little is known about the way they practice management or what support they receive to work effectively. Yet their management is likely to be a critical influence over the experience of patients and influence how the surrounding community perceives the facility. This paper explored how individual managers approach their work, how their identity as nurses or managers (or both) influences their management practice, and what could be done better to support the leadership development of PHC facility managers.

Methods

The study responded to appeal by public health managers of the Mitchells' Plain sub-district of Cape Town wanting to improve support to PHC facility managers as part of the broader DIALHS project. Public health service delivery falls under the Metro District Health System (MDHS) of the Western Cape Provincial Department of Health, and the Health Department of the City of Cape Town. Facility managers report to PHC managers who report to the sub-structure director in MDHS or the sub-district manager in City Health. Using a reflective approach, the researchers explored the daily work of eight PHC facility managers at three community health centres and five clinics through a set of repeated interviews, use of journals and group discussions. The managers' ages ranged from 35-62, their professional nursing experience was between 2 years and 20 years, and years of service in their current position ranged from 1 month to 20 years. Most had science degrees and two had Masters qualifications.

Results

Facility managers deal with a range of issues, from human resources, management of drug and medical supplies, controlling costs and responding to patient complaints.

Daily tasks

A key activity is monitoring service performance and quality of care through routine audits of patient records. Their work focused on managing services to meet patient needs and reaching service targets.

Key Points

- Being a PHC facility manager is dominated by tasks focused on clinical management, underpinned by less visible tasks of managing with and through others in a complex system
- PHC facility management is a dynamic, strategic process occurring in conditions of uncertainty, rather than the narrow focus of mechanistic or administrative functions
- Required management skills include the 'soft skills' of leading organisational change such as communication and motivating others, which go beyond clinical and operational skills
- Nurse training does not adequately prepare facility managers for their strategic tasks or leadership of others

Recommendations

The participating managers had the following suggestions to support mana-gerial and leadership competencies:

- Identify potential nurse leaders early in their careers and expose them to management before appointing them as managers
- Provide newly appointed managers with a formal induction programme accompanied by peer mentorship for sharing knowledge and routine problem solving
- Encourage informal peer support to share experiences (e.g. buddy systems)
- Support reflective practice using journals or staff meetings which allow reflection to develop self-awareness and self-confidence to lead, inspire and motivate

Many became involved in providing services particularly when there were staff shortages. Few facility managers saw broader community engagement or strategic planning as key tasks. Yet this goes against the expectation that they would adopt a community focus and supervise service provision rather than stepping in themselves.

Managing people and relationships

Figure 1 reflects the 32 most critical incidents reported by facility managers over a 4-month period. The majority were incidents of inter-personal conflicts among staff, absenteeism, theft and staff personal problems.

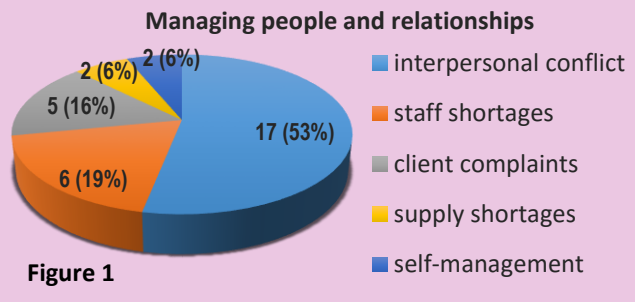

Figure 1

Text box 1 illustrates how staff relationships affect daily work, which facility managers reported was their most difficult challenge. Limitations on their authority and procurement constraints inhibited their efforts to be creative and motivate staff. They also reported confusion brought on by too little policy guidance in areas such as establishing a facility committee, and too many policy initiatives which increased job demands. Professional power imbalances that favoured doctors only further undermined their position and confidence.

Box 1: *In one facility, two nurses were absent; one was on sick leave and the other went for training. The manager called the remaining three nurses…to share the day's tasks accordingly. One professional nurse did not like how the tasks were divided…She just took her handbag, started shouting and left the clinic. She did not report for duty for three days…She underwent a disciplinary hearing when she reported back on duty." (FM03)*

Factors driving facility focus

Professional training and organizational imperatives were the key drivers leading these managers to focus on internal facility service delivery. All the nurse managers valued their clinical expertise and were driven by their commitment to caring for people. For some, this offered greater job satisfaction than management, and stepping in to provide services was seen as a higher priority and a role modelling opportunity. They saw being a nurse as their primary professional identity. Meeting service delivery targets and increased workloads also drove the focus on facility services rather than on the community at large.

Box 2: *"…at the end of the day, targets seem to be the uppermost thing on top of everything."* (FM03)

"The challenge is that your need to meet the targets and if you don't assist clinically you are not going to meet the targets." (FM05)

Variations between managers

Three of the eight facility managers, however, had established a strong leadership identity, in contrast with the other facility managers.

- They believed their managerial role was dominant over their nursing roles and expertise, they were confident in their role as managers and rarely became involved in service provision
- These managers actively addressed relationship issues with staff and/or patients and proactively tackled problems, dealing with misconduct immediately and being visible all the time
- They had better self-management skills
- Discussing staff shortages and delegating working, such as assigning other staff to manage drug supplies and supporting these staff to deal with shortages, was more common with them.
- They established direct, informal relationships with procurement and human resources staff to strengthen services
- Staff meetings were regularly conducted and they shared communication from higher levels

What distinguished these facility managers from their peers was a 'can do' attitude and a work ethic instilled from childhood; personal aspirations beyond nursing - which was seen as a stepping stone to other work because it was the most affordable first option; and some prior managerial experience. Little formal support was provided to any of the managers before or after their appointment, and the current post-graduate training in primary healthcare was inadequate

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