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BOOK OF ABSTRACTS

Groote Schuur Hospital

Western Cape Government
BETTER TOGETHER.

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ABSTRACTS

A beginner's guide to using the Enneagram in a leadership journey

Ms Wendy Wilson[1]

[1]*Riversdale Provincial Hospital Pharmacy, Riversdale, South Africa*

Brief bio of my qualifications to present! Qualified as a pharmacist in 1988. Pharmacy didn't inspire me, and in my 30s I studied and worked in zoology, qualifying with a Masters in zoology. Life circumstances led me back to pharmacy, and I was appointed as the pharmacy supervisor, Riversdale Hospital in 2012.

Conferences attended:

SAAHIP conferences 2014 – 2019. 2017 and 2019: presented two podium talks at each conference. Presenting two talks at SAAHIP conference 2020 (one on Enneagram leadership).

Leadership Conferences 2016 and 2018

International Enneagram Conference 11-13 Oct 2019

Medical manager of Riversdale Hospital nominated me for the "recognition of boundary spanning leadership" award in 2019

INTRODUCTION

My journey has been a steep, bumpy ride. Being a competent professional, and generally "nice" person, did not equip me to be a competent leader. However, a passion for my work and deep-seated gut feeling that I was moving in the right direction, kept me going. I fell many times, but I didn't fail to get up, learn a lesson, and carry on.

I had a reasonable amount of self-awareness, but this was limited to knowledge of me functioning independently, in a physical and emotional environment over which I had some control. I was now in charge of a team that needed to step out of its comfort zone. I needed to facilitate new ways of team work and collaborate with other healthcare professionals.

My knowledge of my behaviour in this type of complex environment was extremely limited, and I found myself floundering. It took me five years to get over the worst. A large part of my self-awareness journey, and ability to lead a great team, has been Enneagram related.

ENNEAGRAM

This is a brief guide to the Enneagram without going into exhaustive detail. The Enneagram refers to nine personality types. It is much more than a personality profile - it investigates the core motivations, defense mechanisms, and fears of each personality type.

It is stereotyping, rather it shows us how small we have made our own boxes, and how understanding ourselves can set us free. No type is better or worse than another, each has unique strengths and weaknesses. Understanding of these leads to increased self-awareness, and improved ability to work in a team.

Anecdotes of my experiences with the personality types (mostly humorous and self-deprecating):

The pharmacy team of 11 has diverse Enneagram types. I am a type 5. I don't like asking for things, so I never put anything on the pharmacy wish list, I delegated this responsibility! I continually praise a Type 2 (Helper), while balancing this with a Type 8 (Active controller) who has different strengths. I need to "protect" a Type 9 (Peacemaker) because she does not openly express her conflicts. Etc etc

Knowing the Enneagram types helps me build on the strengths in our team. I am the captain of our ship, the team sails just fine without me, I clear the path ahead, and provide a buffer against the challenges.

A Leadership Journey

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In the literature I found some common principles and thoughts shared by various leadership experts like Solomon (The Bible), John Maxwell (Intentional leadership), Richard Barret (The new leadership Paradigm) and Rick Warren (Purpose driven live). Some of these common principles and thoughts are:

- Choose to be internally defined
- Leadership is a thing of the heart
- It's about personal and spiritual purpose
- Vision driven
- Values based
- Authenticity
- Vulnerability
- Leaders are not born – they are made
- Becoming and being yourself
- Being the best FOR the world not the best IN the world

In the article "Leadership: Uncommon sense" (Anderson, n.d.) Bob Anderson makes the case for a paradigm shift as a prerequisite for leadership in the future. From the "problem-reacting" structure to the "outcome-creating" structure for leadership and life. He suggests that there are eight disciplines that promote and sustain a shift into the outcome-creating stance of genuine leadership of which five of these are inner disciplines – the work that the leader does within himself.

Becoming a leader is synonymous with becoming yourself. Central to becoming a true leader is to find out what it is you're about, and be that. "Success in the knowledge economy comes to those who know themselves — their strengths, their values, and how they best perform." (Drucker, 2017)

Leadership is about influence and power is the potential or capacity to influence. It's been said that "culture eats strategy for breakfast". I am committed to values-based leadership and have based my leadership style on some of Richard Barret's models. "Values are the anchors we use to make decisions so we can weather a storm. They keep us aligned with our authentic self. They keep us true to ourselves and the future we want to experience" (Barret, 1998). I found that being authentic, living my values and convictions, leading by example and building trust are techniques that have been helpful in my leadership journey thus far.

According to Barret's "New leadership paradigm" the three new principles of successful business in the consciousness age is:

1 .cultural capital

2. cultural transformation begins with personal transformation

3. measurement matters

By focusing on these three principles I believe that we can become a successful organization that achieves our organizational purpose of: "to do the greatest good for the greatest number, creating the greatest value for all".

A Leadership-as-practice approach to Leadership development within the Emergency Medical Services

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[1]*WCGH Emergency Medical Services, Cape Town, South Africa*

Middle management are the cornerstones when it comes to mobilizing and engaging their teams. They close gaps to ensure strategic plans flow effortlessly from them, to staff who experience patient interaction and living the purpose of EMS. These interactions define the EMS brand and ultimately our success. Middle managers are the number one driver of employee engagement. Research shows unquestionably that employee engagements drives the customer experience, which in turn impacts organizational growth and strengthens working relations with staff and management.

In recognition of this management/leadership gap, EMS introduced an inhouse programme focused at imparting the critical skills and knowledge that the complex pre-hospital environment demands of the middle manager. The programme – inspired by the talk at the inaugural leadership conference – involved the embedding of junior management candidates within the entangled messy practice that is the world of management. Adopting a leadership-as-practice approach, the programme emphasises the embodied and tacit skills so vital in leading a critical, constitutionally mandated emergency medical services.

Going by the title 'the Leadership Laboratory' and using a dynamic and innovative candidate selection process, 8 - 12 candidates are selected. For 12 months candidates rotated through all the elements of the organisation (including HR, SCM, Fleet, Operations etc) absorbing both through formal mentoring / lecturing sessions as well as the everyday practice world of a functional EMS.

Assessment was both formative and summative with pedagogic guidance sourced from the EMS training college and the EMS executive management team. An extended faculty included senior and experienced EMS managers as well as subject matter experts from each component within the provincial EMS organisation – this even included organised labour as both faculty and examiners. The results were surprising and unexpected and exceeded expectations on several fronts. The programme – now in its 4th intake continues to shape and evolve with the needs of the organisation and illustrates the importance of an entangled contextual construction of leadership and leadership development.

Assessing how the Community Capacity Enhancement methodology has assisted the adaptation from supply-driven to demand-led service delivery approaches in the Western Cape Government

Mr Denver Moses[1]

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BACKGROUND AND CONTEXT

Governments often fail to understand that an emphasis shift from form to function is an essential building block of legitimacy. The Western Cape Government (WCG) has in recent years been grappling with the anomalies of a bureaucracy where principals and actors have the option of either reforming and adapting the prevailing system, or simply retaining its status quo. Indicators such as the number of civic protests linked to service delivery shortcomings suggest that change is both necessary and desired. Based on this suggestion, introducing methodologies that challenge legacy systems is necessary if demand-led service delivery is to be integrated with institutional change that is geared to overcome state capability traps. Implementing this change is made more difficult through contextual challenges such as continuously revised mandates and more recently a prevailing climate of austerity.

PROBLEM STATEMENT & AIM

The United Nations Development Program-authored Community Capacity Enhancement (CCE) methodology has been pilot-tested as a training course geared to give WCG officials the tools to enable communities to actively participate in deciding their own targets or processes. This study will review the process that has been followed in implementing CCE in WCG since 2016 and then highlight successes and areas of improvement.

METHODOLOGY

Within the Western Cape, the CCE course is conducted over 5 days. Data was obtained from particicipants who completed the course. The evaluation process evolved since project initiation in 2016. It started with a simple post course evaluation and has since been expanded to include as pre course evaluation. The data was analysed in order to identify areas of course improvement, extent of personal shifts and perceived value in the workplace. The assessment of the data frmed the basis for a semi-strutured interview guide that was used to interview selected course attendees (n=10) for deeper analysis of the impact of the course.

FINDINGS & CONTRIBUTION

Probing questions elicited details of whether the CCE tools made a difference in the work and lives of attendees. This revealed impacts that were not being captured by the current assessment indicators. A research output will be proposed revised assessment indicators that will broaden the scope of the current CCE evaluation process.

Keywords:

Community Capacity Enhancement; service delivery; tools; commuties; impact; Western Cape Government.

The EMS safety forum as a model of Shared leadership

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The question of leadership and of leadership practices remains one of the most compelling and (arguably) the most important field of inquiry in contemporary times. The seemingly innumerable and intractable challenges facing corporations and the societies in which they exist, have highlighted the need for such a focus. We see all too frequent examples, in both the public and private sector, where a failure in executive leadership has held severe and far reaching consequences for both the organisation and the society at large. (Grootes, 2016)

Against this background, the provision of an essential and constitutionally mandated service to an extremely unequal and largely disenfranchised population, can appear insurmountable. To do so within the self-constraining environment that is government service, with its many competing priorities and volatile socio-political climate is certainly not for the fainthearted. Add in the ever present threat of staff attacks, ensuing labour volatility, along with the suffocating bureaucratic austerity and the scale of the problem begins to come into view.

By adopting the principles and practices of shared leadership, the western cape emergency medical services have achieved common purpose and shared understanding on an issue which has the potential of causing division and polarising stances.

The formation and evolution of the EMS safety committee illustrates the importance of addressing power gradients and institutional structures when tackling complex problems.

This presentation recounts the journey and progress of the EMS Safety committee and in so doing reflects on the lessons and insights gained around the themes of leadership, trust and power. It illustrates the importance of newer leadership paradigms within the complexity of health service provision and its social determinants within a post-apartheid South Africa.

Recognised by the department as an example of boundary spanning leadership, the EMS Safety Committee demonstrated how innovation, creativity and shared understanding is possible within a large, hierarchical, highly bureaucratic state emergency service. The result is greater autonomy, ownership and agency enabling staff and stakeholders to live a whole of society approach.

From Beautiful to Powerful: Integrating interrelated, competing aspects in decision-making processes

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Sustainability is an organizational imperative that requires leaders to straddle, and integrate competing, interrelated dimensions in decision-making processes. Integrating across organizational boundaries is essential for sustainability, but difficult to achieve. We continue to explore and learn how competing, interrelated dimensions are actually integrated in practice.

This paper forms part of a study that explored the integration of economic and social-ecological dimensions in decision-making processes. The paper explores how organizations integrate these interrelated, competing aspects in decision-making processes, especially where one dimensions is predominant.

Drawing on theory from paradox, ambidexterity and organizational identity literature, on a backdrop of corporate sustainability, the paper explores this question in a century old mining company. The case study, based on qualitative interview data finds that underlying identity, cognitive and process tensions constrain integrative decision-making in contexts where economic dimensions are predominant in practice.

This paper contributes to the scholarly conversation on organizational purpose by identifying how an integrative purpose can be crafted to enable both/and decision-making frames that facilitate integrative decision-making on different levels of the organization, under certain conditions.

I argue that leaders need to create the spaces where integration can lead to creative and more sustainable solutions. This is achieved by first understanding multiple different perspectives, and then exploring integrated options whilst suspending premature convergence on a single - often pre-determined - solution.

I conclude that leaders who seek more sustainable outcomes need to unlearn taken-for-granted assumptions about how to lead, learn how to become permeable, and embrace the discomfort of including seemingly opposing perspectives in integrated decision-making processes.

Holacracy - a novel approach to leadership and power within the Emergency Medical Services

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The delivery of acute health services in a country that has a history of inequity and disenfranchisement of the most vulnerable in society is a notable challenge. Not simply because of the logistics and scope of the system required to do so but also because of the political and historical context within which these have to be delivered.This challenge is made all the more so as we grapple with an ever increasing demand, a burdened workforce and an ever constricting fiscal environment. What follows is a slow denudation of the meagre performance gains that appear to be resistant to all efforts of reversal. As a result, EMS teams and managers adopt a defensive culture of blame 'allocation' with the inevitable conflict and low staff morale. It is within this context that the challenge of delivering access through an efficient, coordinated and motivated, purpose driven workforce.

The traditional approach has been to create highly structured, heararchical organisations with strict delegations of authority and scope of managerial tasks and practices. This results in consistent and compliant organisation but at the cost of agility and efficiency along with the many inevitable organisational drag such structures bring.

Rethinking this design, a team of creative and innovative organisational design practitioners set out to create a more effective and agile set of organising practices that privilege, accountability, purpose and agency to create interdependent, autonomous EMS teams. Using the principles of Holacracy* and the entangled and embedded nature of our being-in-the-world, the teams are disclosing new and sustainable models of leadership and of organising.

The journey itself has been both exhilarating and frustrating for organisation and team alike. Now in its 2nd intake, the team has grown to 80 staff strong and the results (both qualitative and quantitative are encouraging. The path ahead is arduous and long but it is certain that the organisation is on the cusp of realising a new way of being that may hold the key to a modern, effective and agile state service.

** Holacracy is a method of decentralised management and organisational governance, in which authority and decision-making are distributed throughout a holarchy of self-organizing teams rather than being vested in a management hierarchy.[wiki]*

Reflections on leading strategically and from the heart during COVID-19

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Purpose: The practice of public service leadership is generally regarded as the weakest link in public governance. A number of scholars call for more self-aware, visionary, inspirational, affiliative, democratic, adaptive, ethical, compassionate, and caring public leaders that endeavour to enhance the quality of life of their citizens. These leadership behaviours and styles build positive organisational cultures in which public officials excel in delivering public services. Adaptive, innovative and inspirational leaders are regarded as exemplary in their leadership practice. Inspirational leadership emphasises a leader's competence in inspiring followers, articulating a compelling vision, building group pride, and bringing out the best in their people (Goleman & Boyatzis, 2014). The adaptability competence emphasises a leader's effective adaptation to shifting priorities, complexity, uncertainty, rapid change, multiple demands and changing overall strategy, goals or projects to cope with unexpected events or that fit the situation (Goleman & Boyatzis, 2007). The purpose of this paper is to examine the inter-relationships between public leadership styles and contextual organisational factors as potential mediators in defining workplace culture and climate in ten African countries (including South Africa) using a qualitative research design.

Design/methodology/approach: The paper is based on data from interviews (n = 500) conducted by 100 UCT MPhil (Development Policy and Practice) students from 2015–2019 in ten African public sector organisations using the Dynamic Inquiry (DI) method (London and McMillen, 1992). DI is a qualitative conversational interview methodology that facilitates deep insight into organisational culture to uncover emotional realities by tapping into subjective experience. Ken Wilber's (2000) integral theory and four quadrants model is applied to explore the complex interplay of contingency factors (extracted from thematic inductive analysis) in examining the relationship between leadership styles and organisational culture.

Findings: The qualitative analysis indicates a strong association between leadership styles and organisational culture in public sector organisations, and impact on public officials' motivation in African public institutions. The participants' experiences are framed into two contrasting sets of leadership styles informed by specific leadership behaviours, viz. resonant leadership (visionary, democratic, inspirational, coaching, affiliative), which draws strongly on socialised power, and dissonant leadership (commanding and pace-setting), informed by strong personalised power. Leaders' emotional intelligence competencies of self-awareness, empathy, adaptability and inspirational leadership emerge as dominant themes in leadership styles and its impact on organisational culture and climate.

Practical implications: The paper will provide guidance to leadership development programmes and reflective practitioners with useful conceptual and developmental approaches to develop leadership styles, behaviours and emotional competencies within public organizations.

Originality/value: The paper helps to build a body of research that contributes to overcoming the paucity of evidence on the African continent on the relationship and impact between leadership behaviours and styles and organizational culture and performance in public institutions.

Keywords: Leadership behaviours, leadership styles, organizational culture, emotional intelligence, resonant and dissonant leadership, adaptability, empathy, inspirational leadership

Post-Heroic Leadership within the Emergency Medical Services

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The state of our public sector institutions has received much attention, as has the state's ability to deliver on the promises made by a post-apartheid democracy. The challenge of delivering on a restitutive constitutional mandate amidst the socio-political climate, growing labour volatility, and suffocating bureaucratic austerity, is daunting. Within this context, the focus quickly shifts to the question of leadership and of the executive leader's fitness to hold office.

However, insights from systems thinking and complexity science is beginning to shape our understanding of organisational leadership. For my own part, there is a growing realisation that the power and influence that accompanies such senior offices cannot (and should not) be vested in any single individual, nor can the accompanying complexity be contingent on the limited talents of a solitary protagonist.

This paper therefore sets out to challenge the assumption of a unitary command (the 'heroic' leader) and attempts to escape the all too compelling narrative of embodied leadership. Through adopting a grounded theory approach and a semi-structured interview, the paper explores EMS practitioners' perspectives on leadership and on how it manifests within their daily routines. It poses questions aimed at surfacing how these observations may disclose insights into the emergence of leadership within the flow of practice. These insights are then used towards a theory for post-heroic leadership within the Western Cape Emergency Medical Services.

Drawing on Weick's work on theorising as disciplined imagination as well as that of Morgan's use of metaphor in organisational studies, the theory of Modal Leadership is presented as an alternative framing of leadership's generative dynamic. Using the metaphor of the jazz ensemble, the theory privileges context, relationships and practices as the foundational principles of an emergent quality to leadership and posits leadership as a mutually constituted outcome of relational interactions.

Building on seminal work within the field of sociology, it explores the notion of agency and historicity as contained within the Bourdieusian concepts of habitus and field. In addition, it examines the role of power and its spatiality by incorporating Victor Turner's anti-structural elements of communitas and liminality. Combining these ideas with the thematic foundations to surface through nine core aggregate dimensions, the theory encourages a temporal sensitivity to the role that leadership's spatiality and relationality plays in the production of action. Modal Leadership Theory (MLT) thus enables the system's expression of the agency and improvisational skill lying dormant within.

Quiet Leadership

Dr Anthony Hawkridge[1]

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The traits of extraversion and introversion are fundamental to human personality theory. The labels were popularized by Carl Jung (b. 1875), although their common meaning and psychological usage have diverged to a certain extent from those originally intended. In theory, whether we are extraverted, introverted or something in-between goes to the heart of who we are, strongly influences how we live, interrelate, work and love, and shapes how we conduct ourselves in gatherings, discussions and exchanges with co-workers.

Introversion has been defined as a state of being concerned chiefly with one's own mental life. Introverts are classically seen as being more detached or thoughtful, and as individuals whose energy tends to grow through contemplation and diminish during interaction. Their nervous systems are more responsive to all forms of stimulation. Introverts are most prolific and at ease in settings that are less energizing. They enjoy lone activities such as reading, writing or meditating and value time spent by themselves, rather than with sizable groups of individuals. Introverts are easily overwhelmed by too much social stimulation. They would rather be in a tranquil external milieu, choose to focus on one pursuit at a time, prefer to study the status quo before they join in and are inclined to assess situations critically before speaking.

Introverts make up a third to a half of the workforce. Susan Cain (b. 1968) has argued that contemporary Western society underestimates the competencies of introverts, leading to a dissipation of their ability, drive and contentment, and that the general public is prejudiced against introverts. She maintains that, with individuals being schooled from their early years that to be outgoing is to be contented, introversion is now considered "somewhere between a disappointment and pathology". Capable introverts are often ignored for leadership responsibilities because "they didn't fit the mold".

Where introverts do develop into leaders, they tend to do so out of dedication and "almost in spite of themselves". It has been suggested that introverted leaders often produce sounder outcomes, that most outstandingly resourceful individuals tend to be introverts and that most original thinking occurs alone, and not in groups.

The intention of this talk is to reflect on how we, as a large Department, are "introvert-friendly", whether we may be missing valuable opportunities to benefit from introverts' particular talents and abilities by not recruiting, appointing or adequately developing them, and what we could and should do about it.

Reflecting on the transition from a private service provider for adult intermediate care to a NPO service provider in the Klipfontein/ Mitchells Plain Sub-structure

Mrs Fatima Peters[1], Mrs Patti Olckers[1]
[1]*Metro Health Serives, Cape Town , South Africa*

BACKGROUND

The Western Cape Department of Health strives to provide access to quality person centred care at all service delivery platforms. With the ever-increasing burden of disease and shrinking budget, managers must be astute and proactive at all times about inefficiency in service delivery.

A private provider was contracted for a five- year period (2012-2017) to provide adult intermediate care services in the Klipfontein/Mitchells Plain substructure (KMPSS). Some concerns were highlighted during governance visits and via patient complaints about the quality of care. Furthermore, it was noted that all other community based services (including intermediate care) in the Metro was outsourced to NPOs at a reduced cost.

What did we intend to do?

A decision was made during 2017 to move away from a private provider for the intermediate care services and move to a NPO driven service.

The KMPSS team was tasked to safely phase out the private provider model of intermediate care by the end of the contract term which was 31 August 2017 and phase in a new NPO service provider who will provide access to quality intermediate care services in KMPSS.

How did we achieve our goals?

Key implementation principles was applied to achieve our desired goal:

- Leadership
- Reflective, adaptable and flexible practice
- Incremental, phased in approach
- Person-centred approach

WHAT DID WE ACHIEVE?

The team managed to safely transition the adult intermediate care services from the private provider model to an NPO driven service. Since the transition the complaints have been reduced and compliments have increased. There are currently no governance concerns, implying improved quality of care. There is a stronger and more optimal relationship between the intermediate care services, the acute and specialist hospitals and the home and community based services, thus strengthening the continuum of care. Lastly, there has been a cost reduction where in 2017/18 it costed R752 per bed per day and in 2019/20 it costs R680 per bed per day. Since the transition there has been a saving of just over R6million.

CONCLUSION

Reflections from the team indicate that the key to the successful transition was leadership. The leadership described is leadership that was strategic and purposeful with enough room for creativity and flexibility. Leadership that was distributed, supportive and enabling. Leadership that was value-based, and collaborative.

Sequel to the NTSS Leadership Development Journey

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The problem that existed within the Northern-Tygerberg Sub- Structure was that many operational and middle managers were appointed without having been adequately equipped for the transition that came with the implementation of the Comprehensive Service Plan 2010 and the added responsibilities that came with it.

Although progress was made in the form of a succession planning programme to develop the current operational managers, these efforts had proven to not be sustainable. This was due to the absence of a formal leadership development strategy, adequate local level support and an appropriate sub-structure level platform to drive leadership development.

In 2018, we shared the NTSS journey and lessons learnt, while touching on some results and the next steps to follow. The purpose was to find sustainable mechanisms to achieve the original objective of developing leaders across the platform who would boldly transform the local and broader systems through innovation and inspire others to come along.

During 2019 the NTSS Leadership Development (LDP) Support Forum was established. Based on participant feedback, this platform is found to be of value in the form of providing support and sustaining the transfer of training to the workplace. Project teams presented their projects to the forum, attended by managers and various course participants. The LDP Support Forum further presents a platform for networking, sharing ideas and evaluating the implementation potential of innovations for quality improvement. The high-level attention given to project teams has motivated them to keep up their momentum and efforts to apply their acquired skills.

Nineteen leaders have been exposed and developed since 2018 to 2019 using the Management Sciences for Health (MSH) Challenge Model. Greater insight into the health system context has been gained. 2018 presented the opportunity to identify what not to do in 2019, which in turn will inform strategy for 2020.

The outcomes of the ideal clinic status, patient satisfaction and staff satisfaction reports, as well as compliments and complaints, have been considered in structuring the 2020 quality improvement strategy. Twenty potential leaders will be identified to address the areas that require improvement, with the support from quality improvement change agents and with the intention of developing their leadership and quality improvement competencies.

Tackling the behemoth: addressing emergency department overcrowding at Groote Schuur Hospital

Dr Kenneth Crombie[1]
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CONTEXT

The Emergency Unit (EU) at Groote Schuur Hospital, Cape Town, South Africa, was experiencing severe overcrowding leading to a number of adverse outcomes including compromised patient care and staff burnout.

PROBLEM

In 2018, this tertiary level emergency unit was operating at over 180% capacity with a patient's average length of stay in the EU of almost 24 hours. The congestion led to multiple complaints, adverse incidents and staff burnout. Various previous efforts had not addressed the problem.

AIM STATEMENT

To improve patient flow through the EU thus improving patient experience, quality of patient care and improving the working environment and job satisfaction of the EU staff.

INTERVENTION

Hospital management prioritized the decongestion of the EU as a key annual objective plan for 2019, thus recognizing it as a hospital-wide challenge being expressed within the EU.

The EU developed a departmental strategic plan to improve the working environment of the EU. A part of this plan was to identify and solve challenges around input, throughput and output elements relating to patient flow.

Change management strategies were utilized in addition to remodeling leadership structures and giving ownership back to the staff. Daily opportunities for feedback from all the EU staff allowed for rapid problem recognition, delegation and resolution.

Reorganization of the in-patient care team structure complimented these interventions.

MEASUREMENT OF IMPROVEMENT AND RESULTS

Over a 12-month period, there was a decrease in mortality, average length of stay, percentage occupancy and number of client complaints. In addition, there was a subjective improvement in staff morale.

CHALLENGES AND LESSONS LEARNED

Key to these improvements was hospital management ownership of the problem and the motivated EU and in-patient care teams using a cohesive, multi-faceted approach. The use of digital platforms assisted in the implementation of many of the improvement strategies.

The importance of organisational culture in the management of a CRE Outbreak

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INTRODUCTION

In April 2019 Red Cross War Memorial Children's Hospital (RCWMCH) experienced an outbreak of Carbapenem-resistant Enterobacteriaceae (CRE) related infections. The outbreak was known to be happening across the province and the country. We had a small CRE outbreak 15 – 18 months previously at RCWMCH, in which one patient had died (primarily due to major co-morbidities), but the outbreak was contained at that time.

DISCUSSION

At the onset we initiated contact precautions to prevent the spread of CRE to other patients and amongst staff. Many challenges arose that necessitated continuous re-assessment of our containment plan. Some of these challenges related to laboratory challenges with initial testing have high sensitivity but low specificity together with a long turnaround time. These issues were addressed with NHLS managers. Other challenges related to physical infrastructure issues specifically being able to isolate CRE-infected, CRE-exposed (or potentially exposed) patients from other patients and making particular plans for CRE-exposed patients in different geographic areas of the hospital. Unfortunately, this outbreak coincided with a seasonal "surge" of patient load, and this created high stress for the hospital as we had to prioritize the active management of this outbreak.

It became emotionally challenging to have to prioritize the needs of individual patients versus the needs of the hospital as a whole. A team approach was necessary to gather information; make decisions regarding where CRE-exposed patients should be managed; implement all necessary IPC practices; optimize utilization of available resources and review all hospital practices for potential impact on spread of CRE (e.g. restricting access to patients by visitors, volunteers and medical students).

CONCLUSION

Understanding the contextual realities of different wards in the hospital was a key lever to containing the spread. Boundary spanning leadership, team work and effective communication were extremely important in managing this outbreak. Giving all role-players a voice and actively listening to staff across all categories and particularly those at the frontline was crucial. The usual power dynamics had to give way for a collaborative management approach with mutual trust. There is still a lot of work to be done, but lessons learnt from the management of this outbreak have been used to create a strong Antibiotic Stewardship Committee for the institution and will be used to look at processes for managing other IPC issues in the hospital.

The Swartland Hospital Fire Disaster: Learnings from a Burnt Platform

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A devastating fire in March 2017 destroyed the Swartland Hospital building, causing a potential catastrophic disruption in health service delivery in the Swartland Sub-district. While construction is still underway to restore a basic package of services to the hospital premises, reflecting on the system responses and personal experiences provide insights into adaptive leadership, boundary spanning collaboration and the transformative capacity of an organisation after an unprecedented shock. This presentation will showcase these critical learnings:

The immediate disaster response was characterized by a series of events that included an emergency evacuation, the establishment of new service points, the subsequent reconfiguration of an entire health service network and determining infrastructure solutions for the short and long term. The uncertainty about successful short term infrastructure reinstatement within reasonable time-frames posed a significant threat to the access to safe and efficient health services and staff morale. Drawing from these experiences, will provide insights into how an organisation managed to ensure uninterrupted health services in an unpredictable, precarious and fragmented environment through adaptive leadership.

Cross-border thinking and multi-stakeholder collaboration became important mechanisms to maintain the clinical service delivery platform. This meant eliciting resources within the institution itself, deviating from traditional geographic care and referral pathways by involving neighbouring health facilities and strengthening cooperation with key co-partners like Emergency Medical Services, the Facilities, Infrastructure and Maintenance Directorate, other governmental departments, private companies and communities. The collateral consequences for institutions at the periphery of the epicenter of the disaster was significant and resulted in secondary risk for the broader organisation. By discussing relationship building and co-ownership as critical enablers in this crisis, the universal importance of organisational interconnectedness will be demonstrated.

Narratives of the personal experiences from the people in the organisation reveal the immeasurable impact on individual and team well-being that resulted from the fire at Swartland Hospital. Exploring these varying perspectives will provide a clearer understanding and appreciation of how people were able to persevere, absorb, adapt and transform in a broken, uncertain and insecure working environment. This event remained a catalyst for staff to critically review and improve practices and service models, build relationships and collaborate to ultimately enhance personal and system resilience.

For any institution, like the Western Cape Government Department of Health, on a journey to become a learning organisation the learnings from the Swartland Hospital fire disaster may influence perceptions about adaptive leadership, interconnectedness and transformative institutional culture.

Values-driven leadership for health sector well-being

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BACKGROUND

In South Africa, the health sector is groaning under high levels of staff burnout, service fragmentation, and a culture of poor collaboration. Within this environment we initiated a project to care for the carer. We wanted to create a safe space for people to address everyday challenges within a values-driven leadership framework. The goal was to bring rural health care workers together in a multi-professional collaborative environment and understand how their values determine their leadership style.

THE PROJECT

Values-driven Leadership for Healthcare Professionals stems from a programme developed by African-based business schools in association with the Academy of Business in Society (ABIS). The world-renowned Giving Voice to Values approach of Mary Gentile from the Darden School of Business informs the programme's learning philosophy and method. The base programme promotes responsible leadership, sustainable development and good business conduct in an African context. The healthcare version enhances personal, relational and organizational well-being in healthcare settings.

IMPLEMENTING THE PROJECT

Funding was obtained and CPD points for ethics approved through Stellenbosch University. With the lead facilitator, Prof. Arnold Smit, and Dr Zilla North and Prof. Louis Jenkins, 4 regional weekend workshops were conducted during 2019 in the Garden Route district. The 2.5-day workshops were structured around 4 modules: Giving voice to values, Dealing with values-based dilemmas, Professional support frameworks, and Values-driven leadership in action. Attendee numbers were capped at 16 to enable trust and relationship building to maximize the impact to each participant.

OUTPUTS

During the four workshops, 64 people had the opportunity to identify, frame and develop action plans for their values-based dilemmas at work. In the process they learned about the connection between values-driven leadership on the one hand and personal, relational and organizational well-being on the other. By doing several practical exercises and mastering several helpful processes they learned how to voice their values, identify their dilemmas, engage with their rationalisations and rescript their way towards values-driven action.

IMPACTS

Nurses, doctors, allied health workers, and managers from six regional and district hospitals, and clinics met up in a multi-racial, multi-gendered, multi-professional environment. Feedback from workshop attendees indicated that people felt empowered to voice their values, solve real problems, and recognize themselves as leaders in the workplace. We are building communities of learning in the context of relationships, which was not there before. The plan is to repeat another 4 workshops in 2020, including a training the trainer workshop.

Why the abused becomes the abuser and how to break the cycle of violence

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This presentation follows on from my presentation at the last Leadership conference, entitled *"Protecting Ourselves the Dark Side of our Profession"*.

The Medical Profession (as are many other professions) is unfortunately plagued with a fair amount of bullying, intimidation and other forms of abusive behaviour towards both junior and senior staff - the proverbial elephant in the living room. This kind of behaviour is not unique to the profession, and is encountered across many aspects of society – including high schools, universities, the military, many corporate structures, and even within social and religious structures, including the home.

A common theme of the above 'disconnected' social systems, is that it is often the very people who are themselves abused who then evolve into the abusers of the next generation, or the next 'intake' of junior staff.

What is it – what are the underlying psychological mechanisms – that lead the abused to become the abuser, or the oppressed to become the oppressor? If one wishes to ever eliminate this kind of destructive workplace behaviour, then one must first endeavour to understand it.

This presentation focuses on the psychological factors at play within the workplace (which parallel the factors at play in the setting of domestic abuse) and within the minds of both the abused and the abuser, and provides an understanding of how and why the abused person evolves into the abuser (facilitating the perpetuation of the cycle of violence), explains why it is so difficult to root this behaviour out of the workplace, and also explains what one can do about it.

This presentation is my second choice for acceptance, the first being "Emotional Intelligence in Clinical Leadership", already submitted.

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