# MENTORSHIP IN HEALTH SERVICES LEADERSHIP

by

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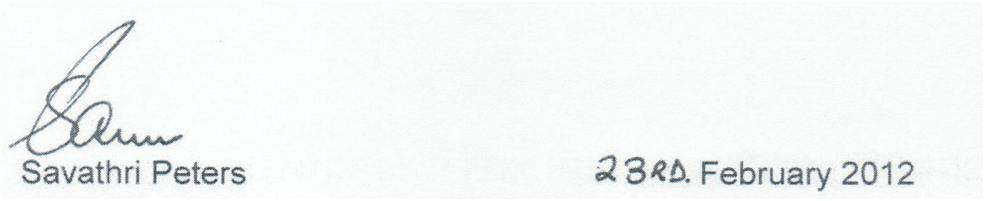
# DECLARATION

I declare that **MENTORSHIP FOR HEALTH SERVICES LEADERSHIP** is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution

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# MENTORSHIP IN HEALTH SERVICES LEADERSHIP

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## ABSTRACT

The objectives of this study were to identify leadership competencies required by health services leaders, determine the role of mentorship in leadership development and, make recommendations for succession planning in the public health sector. A quantitative approach using an exploratory and descriptive design was used, with the intention of conducting a census survey. Respondents were managers in positions 11 and upward.

Findings revealed that experience assisted managers in improving the technical competencies of human resources, financial and strategic planning, but not that of leadership skills and behaviour, and communication and relationship management, which required development in the form of mentorship. It is recommended that leadership development for future leaders be embedded in succession planning, based on policy guidelines.

Limitations of this study were that a response rate of 30% was achieved and due to the narrow geographical coverage, the findings could not be generalised.

**Key words**
Leadership, management, leadership competencies, mentorship and succession planning.

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## List of abbreviations

| | |
|---|---|
| DPSA | Department of Public Service and Administration |
| EFQM | European Foundation for Quality Management |
| HPCSA | Health Professionals Council of South Africa |
| SANC | South African Nursing Council |
| SETA | Sector Education and Training Authority |
| WHO | World Health Organization |

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# CHAPTER 1

# Overview

## 1.1 INTRODUCTION

Leadership positions in public health care settings, especially at middle and senior management level in South Africa prior to 2000, were most often held by medical personnel. However, a review of the organisational structure of some provinces in South Africa now shows that a variety of professionals occupy leadership posts up to the most senior levels. Nurses in particular occupy a number of senior positions. This was an observation made in the North West Province in 2003 and 2004 where positions held by nurses ranged from district managers to directors within the Provincial Department of Health. At least one premier was a nurse from 2004 to 2008 (THE NURSE heading the FREE STATE 2004:22).

From personal experience at a middle management level it was found that some competencies required by health services leaders were not optimally executed. The stresses encountered by the researcher in rapidly attempting to acquire proficiency in a new management position, and meeting the demands of a leadership position were taxing. In retrospect, the researcher deduced that some form of preparation prior to accepting a leadership position would have facilitated easier adaptation.

Current literature on leadership, whether in the corporate or public sector, provides evidence of the significance of preparing personnel for leadership positions through well structured programmes, such as succession plans and mentorship programmes (*Training and learning development …* [S.a.]).

## 1.2 OVERVIEW OF THE CHAPTER

This chapter commences with the background to the problem. It then deals with an outline of the problem and states the research problem. The research process is

discussed briefly as the details are discussed in the relevant chapters. Concepts used in this study are also defined.

## 1.3 BACKGROUND TO THE PROBLEM

The researcher had the experience of moving from an operational post in nursing education, i.e. that of a nurse educator, to that of a manager of a nursing education institution.

The lack of specific leadership skills in the operational role of a nurse educator was a personal experience. This limitation was evident on assumption of a leadership role as a manager. The core competencies related to managing academic programmes were easily managed. The knowledge and experience of having worked with nursing education programmes, and specifically in preparation for accreditation served the researcher well. The researcher was able to guide staff with regard to academic standards required in the implementation of academic programmes.

However, managing an institution in the public sector that was accountable to the Provincial Department of Health demanded a wide range of competencies. Among these were conflict management and negotiation skills involving a range of stakeholders, strategic management, human resources management, financial management and management of the transport fleet, to name but a few.

On taking up the appointment, the researcher was confronted by the following major challenges:

- Guiding academic staff to put in place plans to meet the requisite academic standards to maintain accreditation with the South African Nursing Council (SANC), or face the threat of closure as a training institution.
- Negotiating with labour organisations and students that were not only politically astute but were involved in interpersonal conflicts with academic staff. The situation of polarity of stakeholders was compromising the teaching and learning environment. The researcher was faced with the task of bridging the divide between students and academic staff and ensuring that the process of

transformation continued despite the prevailing environment of distrust at the time. This had to be done without being perceived as being biased.

- Addressing a three year backlog of performance assessments of staff. The institution had no formalised structures to deal with this process.

Through working in collaboration with peers, networking, research, seeking guidance from senior personnel within the Department, and being involved in training programmes that were arranged by the Department of Health, the researcher was able to make significant changes in initiating transformation within the institution. However, certain problems which could have been handled proactively were handled reactively. Although these were learning experiences, having the essential competencies could have enhanced efficiency. Therefore, in retrospect it is apparent that some preparation would have made the transition from an operational position to a leadership and management role a smoother one.

Job advertisements in the printed media outline specific competencies as requirements for positions of deputy director and higher within the public sector (Business Times Careers 2007:41). However, it has been noted that nurses and nurse educators are rarely given the opportunity to be involved in the activities that contribute to the above functions. The demands of daily schedules and the staff shortages, especially in public sector institutions in South Africa, leave staff with little time, if any, to get involved in structured programmes for self development. This is probably true of other professionals too. The following studies reinforce the fact that preparation of future leaders contributes to self confidence and efficiency.

Nurse leaders have a role to play in preparing future nurse leaders. According to Haase-Herrick (2005:118) nurse leaders are obligated to develop future leaders, and to make opportunities available for succession planning. Providing opportunities for gaining experience allows nurses to accomplish the skills that are needed in leadership positions. This is supported by Sherman (2005:125) who quotes Kouzes and Posner (1995) in stating that the “true legacy of leaders is to create institutions and develop people who will adapt to a leadership role”.

Bradford and Sutton (2003:108-117) describe successes in various organisations and the two points that stand out are the fact that middle management need to develop a

relationship with senior management in order to be part of the leadership process, and that having a mentor is critical. This relationship, which could be seen as mentorship, is a support mechanism for succession planning. Leadership effectiveness is therefore dependent on support and career opportunities for growth (Upnieks 2003:145).

Sherman (2005:130), in a study amongst staff nurses in the United States of America (USA), identified their concerns about the level of support needed to move into leadership roles, and mentorship was identified as the key support mechanism. In this particular study, mentorship and education were identified as the key components in the transition from a functional employee to becoming a leader.

What emerges from these studies is that mentorship has a significant role to play in leadership development.

Mentorship also plays a significant role in developing confidence and facilitating career development in nurses as shown in the study by Washington, Erickson and Ditomassi (2004:166-167). In this study, which involved a sample of minority nurses in the USA, a number of respondents stated that mentors influenced their careers, self concept and confidence. This fact is reinforced by a similar study on a sample of Hispanic nurses who stated that mentors helped them to move ahead and a lack of mentors was often a barrier to leadership progression (Villaruel & Pergallo 2004:173). MacDonald and Gallant (2007:58) further explain that a mentoring relationship provides the mechanism for sharing knowledge, shaping professional nursing identity and developing the talents of nurses.

The above studies illustrate a linkage between succession planning and mentorship. Whilst the former provides a pool of potential leaders, the plan is meaningless without opportunities for development. All of the above studies demonstrate a positive relationship between mentorship and leadership skill development and confidence building in personnel that take up leadership posts.

According to the Department of Public Service and Administration (DPSA 2006), in their guide on mentorship, “South African government departments are implementing mentorship programmes as part of the broader plan to improve quality in the public sector”. As noted in the introduction of the above-mentioned guide, even at the most

senior level of government in South Africa, it is recognised that a lack of skills hinders individuals' abilities to fulfil their responsibilities. Therefore according to the Department of Public Service and Administration (2006:6), mentorship is regarded as a means of transforming the public sector.

Both international and national sources appear to support the significance of mentorship in preparing leaders to function efficiently. This study aims to expand these findings.

## 1.4 STATEMENT OF RESEARCH PROBLEM

In South Africa, training programmes in basic and post basic courses in nursing incorporate mentorship. Therefore the significance of mentorship in skills development is recognised. Examples of these are the enrolled nurses' and post basic nursing programmes being run by the Health and Welfare SETA (Sector Education Training Authority), in partnership with nursing colleges in the public sector.

However, mentorship in health services leadership does not appear to be commonly practised, or if it is practised, then it is not widely publicised. The fact that the DPSA has made available, on its website, a guide for mentorship, reinforces the idea that the need for structured mentorship programmes for leadership development is recognised as a way to improve the quality of practice in the public sector in South Africa.

In view of the background discussion, it is apparent that problems are experienced by nurses being placed in leadership positions without the necessary training and support. This adversely affects their role in practising as managers of health institutions, districts and heads of specific portfolios in the public sector, which often places them at a disadvantage when compared to health services leaders from other backgrounds, such as the corporate sector.

By the nature of the responsibilities carried out by nurse educators and nurses in hospitals or health care centres, little time, if any, is allowed for them to focus on issues governing their institutions. Curriculum implementation, which involves facilitation of teaching and learning both in the classroom and in areas of experiential learning, takes up more than a hundred percent of nurse educators' time, whilst nurses in hospitals find that direct patient care and unit management leave little time for anything else.

Therefore, when opportunities arise for them to take on responsibilities at middle management levels or higher they are dependent on support staff, which may not be to their advantage if the support staff themselves are lacking in skills. Although this introduction elaborates the background of nurses, this is probably also applicable to other professionals.

From the researcher's own experience and observation of colleagues at meetings dealing with strategic issues, the researcher found that nurses were among those personnel in leadership positions who lacked the confidence to expound on financial and strategic management issues. However, those managers with an adequate background were able to participate with confidence. These included managers who had experience in other departments or had come in from the private sector, and in particular, those who had come from a corporate environment, where they were exposed to strategic and business planning and information management amongst other things.

The fact that nurses are appointed to posts at higher levels supports the fact that nurses have the potential for leadership. However, qualities of leadership need to be combined with technical skills to foster efficiency in both strategic and operational management. Financial and human resources management and information management are among those that demand that a leader be *au-fait* with planning, implementation and monitoring to ensure efficiency, as well as compliance with legislative requirements.

To summarise, it is apparent that health services' leaders are not adequately developed before assuming positions of leadership that require a wide range of competencies.

From this problem statement the following research questions arise:

- What are the leadership competencies required by health services' leaders from middle management positions and upward?
- What role do mentorship programmes play in preparing upcoming leaders in health care institutions?
- What is the relationship between succession planning and the development of competence in potential leaders?

## 1.5 PURPOSE OF THE STUDY

This study therefore aims to add to current research on the significance of mentorship as a means of leadership development, and to make recommendations for succession planning.

## 1.6 RESEARCH OBJECTIVES

The research objectives are to:

- Identify the specific leadership competencies required by health services' leaders from middle management positions and upward.
- Determine the role of mentorship programmes in preparing personnel for new leadership positions.
- Make recommendations for succession planning.

## 1.7 SIGNIFICANCE OF THE STUDY

This study seeks to confirm that mentorship is an indispensable process in preparing future health services' leaders, who provide a readily accessible pool of leaders for succession planning. High quality health services leadership and management are essential components in the quest for effective management of institutions, the appropriate development of staff and optimal delivery of quality patient care. The institutions that were part of the research will have access to the research findings and will have the option of utilising the findings in their skills development activities, if appropriate.

If the findings reveal that health services' leaders were never exposed to mentorship programmes, then the researcher will acquire their views about the significance and the feasibility of implementing such programmes. In the process, programmes for succession planning will also be explored. The rationale for this study is to establish the worth and value of mentorship programmes in developing future leaders, especially in the South African public health sector.

## 1.8 DEFINITION OF KEY CONCEPTS

The following concepts are clarified for the purpose of this study.

**Empowerment**: This refers to the process of interaction between leaders and followers that involves power sharing and participative decision-making. In the process the followers' potential and competencies are recognised and opportunities are created for them to discover and utilise their expertise (Jooste 2003:217). In this study the role of mentorship and succession planning in empowerment will be illustrated.

**Leadership**: Is a complex process by which a person influences others to achieve a mission (Jooste 2003:25). Investigation into health services leadership would therefore cover personnel in various posts that carry responsibility for sections of institutions or entire institutions.

**Leadership skills**: This is illustrated by Kerfoot (2002:233) who quotes Ulrich (1996:218) in stating that leadership "is a composite of building the perceptions you want, and having the competence to have those perceptions believed, because you have the competence to get the job done". This 'competence' involves a wide spectrum of skills ranging from soft skills such as interpersonal and communication skills to strategic management, human resources management, financial management, risk management and quality management. Strategic management, human resources management and financial management are classified as technical skills (Goleman 1998: 94)

**Mentor**: Is defined as a trusted friend and advisor (Washington et al 2004:166). The characteristics involve role modelling and one who facilitates the ability of a mentee to discover him or herself. Barondess (1997:347) further states that "a mentor must be able to offer guidance for a new and evolving professional life, to stimulate and challenge, to encourage self realisation, to foster growth and to help to make more comprehensible the landscape in which the protégé stands." It is within this last mentioned context, as applied to professionals with the potential for leadership roles, that this research endeavours to place mentorship.

**Middle management**: Personnel who occupy posts at deputy director level in the public sector in South Africa. These are posts at levels 11 and 12 in the public sector. However, not all personnel at these levels have managerial roles to play e.g. certain medical practitioners. However, other medical practitioners at this level do hold management positions and were included in this study.

**Stewardship**: Service in which something is left as good as, if not better than before you touched it (Haase-Herrick 2005:115). The role of leaders in the health care sector is looked at from this perspective in that development of personnel is as significant as all other management issues.

**Succession planning**: Identification of potential leaders and putting in place development programmes to prepare them for transition into such posts.

## 1.9 CONCEPTUAL/THEORETICAL FRAMEWORK

According to Burns and Grove (2005:121, 128), "a theoretical framework is an abstract, logical structure of meaning that guides the development of the study", whereas a conceptual model consists of abstract related concepts that explain phenomena of interest. Specific theoretical frameworks for studies on mentorship were not readily available in the literature reviewed.

However, the predominant concepts in this study are leadership, leadership competencies, mentorship and succession planning. The models described in section 2.5.6, deal with the approach used in the implementation of mentorship programmes. Therefore no specific theoretical framework was used, but the various models of mentorship are discussed and the common themes from the models, as discussed in section 2.5.9, are extrapolated.

## 1.10 RESEARCH METHODOLOGY

This chapter introduces research methodology and the details of research methodology will be discussed in chapter 3.

Research methodology outlines how data is collected or generated and analysed including the problems, solutions and effects (*Writing up Research. Methodology and Research Design* 2007). Burns and Grove (2005:211) also explain that research methodology is related to research design in that it gives the outline and direction for the study. This study makes use of the quantitative approach whilst using an explorative and descriptive design.

- **Quantitative research** is the investigation of phenomena that lend themselves to measurement and quantification. The information gathered and analysed through this method assists in understanding the phenomenon generally (Polit & Beck 2008:16; 763). In this research the objective was to identify the role of mentorship in the development of leadership competencies.
- **Exploratory research** seeks to identify different aspects of phenomena and determine the relationships between them (Polit & Beck 2008:20; 273).This research aimed to establish the relationship between mentorship and leadership development.
- **Descriptive design** attempts to give an accurate portrayal of people or situations and the frequency with which certain phenomena occur (Burns & Grove 2005:239). This study attempts to describe the role of mentorship in assisting the protégé to adjust to positions of leadership.

The plan for the research was to obtain information by means of a survey and to make recommendations for succession planning. A survey is “non-experimental research that focuses on obtaining information regarding activities through questionnaires” (Polit & Beck 2008:322). This is supported by Mouton (2006:15), who states that a survey is a study which is quantitative in nature and which aims to provide a broad overview of a representative sample of a large population.

### 1.10.1 Population

According to Polit and Beck (2008:337), population refers to an entire aggregate of individuals that meet definite criteria or the entire set of individuals having common characteristics.

In this study, the population was constituted by managers of health institutions in the public sector, who occupied posts from level 11 (deputy director) and upwards. They

were based in the Gauteng Department and Northwest Departments of Health. The institutions include hospitals, nursing colleges, district health services and provincial office health directorates.

#### *1.10.1.1 Sample*

A sample is a portion of the population or a subset that compose the population (Polit & Beck 2008:339). As this study focused on health service leadership in the public health sector of two provinces in South Africa, every manager in positions from level 11 and upward from consenting institutions, was contacted to ensure that respondents were representative of the population. This method of selecting respondents conforms to the criteria for the census method rather than sampling. The census method will be explained in more detail in chapter 3.

### 1.10.2 Data collection

Data collection is influenced by both the type of research and the source of data. Therefore the instrument used to collect the data needed to be the best instrument that would yield optimum data to support the validity of the study. This point is reinforced by Polit and Beck (2006:290) when they state that "data that will be analysed statistically must be gathered in such a way that they can be quantified".

#### *1.10.2.1 Data collection instrument*

Data was collected in a structured manner using a data collection instrument which was a formal written document used to collect and record information (Polit & Beck 2008:371). In this study self-administered questionnaires were used.

One of the advantages of using a questionnaire is the ability to collect information in retrospect (Polit & Beck 2008:424). This may have been the situation with a number of managers who were in their posts for longer than two years. The major disadvantage of a questionnaire is that it is not possible to verify the accuracy of the responses (Polit & Beck 2008:424). This may be the situation if respondents feel that they are compromising themselves in any way.

#### *1.10.2.2 Process of data collection*

The questionnaires were dispatched to the respective managers, after permission to proceed with the study and permission to gain access to the relevant managers was obtained.

Self-administered questionnaires and a self addressed envelope were posted to respondents involved in the pre-test. For the main study the feasibility of on-line data collection was explored and was found to be a practical option for data collection. The wide geographical spread of the institutions made personal contact with all respondents difficult. If those within easy access were contacted personally the consistency of data collection would have been compromised.

#### *1.10.2.3 Validity*

Validity is the "degree to which the research instrument measures what it is intended to measure" (Polit & Beck 2008:459). This was reinforced by the reliability of the instrument which was confirmed, through statistical analysis of data accumulated through pre-testing. The process of pre-testing validated the use of the instrument (Burns & Grove 2005:377). There are, however, different aspects of validity to consider, viz. face validity and content validity. These aspects are discussed in chapter 3

#### *1.10.2.4 Reliability*

According to Polit and Beck (2008:456), reliability is the consistency with which an instrument measures what it is designed to measure. Polit and Beck (2006:324) also define an instrument as being reliable "if its measures accurately reflect true scores". The various aspects of reliability are discussed in chapter 3. One method of ascertaining an instrument's reliability is by pre-testing the instrument. Pre-testing was done in one institution and two directorates in the provincial Head Office in Gauteng Province.

## 1.11 PERMISSION TO DO RESEARCH

Permission to conduct the research was obtained from the executive Heads of the Departments of Health of the Northwest and Gauteng Provinces. The respective Heads of Departments of Health were furnished with copies of the research proposal and a provisional data collection instrument. A copy of the consent to proceed with the research and further requests to conduct the research were submitted to the managers of the respective regions, institutions or departments within each provincial department of health.

## 1.12 DATA ANALYSIS

According to Burns and Grove (2005:733), data analysis is conducted to reduce, organise and give meaning to data. Therefore the process needs to be planned systematically in order to avoid errors. Data analysis comprises numerous steps, although not all steps are used in every study (Burns & Grove 2005:452-454). Results are presented as descriptive statistics.

The assistance of a statistician was solicited to identify the most appropriate inferential statistics to use in the final analysis.

## 1.13 ETHICAL CONSIDERATIONS

The nature of the study was fully outlined to the respective Executive Authorities in each province selected for this study during the process of acquiring permission to conduct the research. The following ethical principles were adhered to during this study:

- ***Right to confidentiality and anonymity***

Confidentiality is the management of private information shared in such a way that anonymity is maintained. Anonymity refers to the fact that the participants' identity cannot be linked to responses (Burns & Grove 2005:188). A commitment was made to omit the names of participants in the research instrument and the final research report. A copy of the findings will be made available to participating institutions.

- ***Obtaining informed consent***

Informed consent comprises the elements of disclosure of information, comprehension, competency and voluntarism (Burns & Grove 2005:193). All participants were given adequate information so that they could make an informed decision as to whether to participate or not.

- ***The right to protection from harm***

According to Burns and Grove (2005:190) the above is based on the principle of beneficence and therefore the researcher is obligated to protect subjects from discomfort and harm and bring about the greatest possible balance of benefits in comparison to harm.

The researcher made a commitment to the protection of the information received and therefore respondents were assured that they would not be compromised in any way. Respondents were also made aware of the fact they would be making a contribution to the body of knowledge in leadership development and the outcomes of the research would be made available to the participating departments of health for possible incorporation into leadership development programmes.

## 1.14 TIME FRAME

Target date for completion of this research was February 2012.

## 1.15 LIMITATION OF THE STUDY

The wide geographical area covered by this study may have been a limitation, in that direct contact with respondents was not be possible in the time set for this study. The outcomes of the study could only be generalised to the two provinces that were part of the study.

## 1.16 ORGANISATION OF THE REPORT

Chapter 1 covered an introduction to the study, while chapter two deals with the relevant literature reviewed to give this study scientific direction. Chapter 3 discusses the research methodology in detail, and chapter four presents an analysis of the data. The final chapter presents the findings, conclusions, recommendations and limitations.

## 1.17 CONCLUSION

Whilst there is almost limitless information on leadership and what entails leadership, there are also varied approaches to the subject. Studies on mentorship and its role in leadership and leadership development are well recognised, as identified in the literature review. However, for leadership development there does not appear to be definitive programmes in place that make mentorship an integral part of succession planning. Therefore this study aims to highlight the link between the concepts of mentorship, leadership development and succession planning.

In summary, this chapter covered the background to the research problem, defined the concepts and outlined the approach to the research.

# CHAPTER 2

# Literature review

## 2.1 INTRODUCTION

Mentorship can be traced to ancient Greek mythology. Mentor, a friend of Ulysses, took care of Ulysses' son Telemachus during the siege of Troy and for many years thereafter. Mentor was seen as the transition figure in Telemachus's life as he matured. This mythology illustrates the traits associated with mentoring today, i.e. a wise, experienced and trusted counsellor actively involved in guidance and maturation of a younger person (Barondess 1997:347).

The need for mentorship in developing proficiency is recognised in many walks of life and takes many forms, not necessarily a formal programme. E.g. potters and artists will, in most cases, be able to identify their 'mentors', and in the academic field, mentors for new teachers are well recognised.

In nursing, which is one of the health services professions, the need for mentorship is well documented. However, in most instances mentorship is applied to the trainee or to the graduate entering the field. There does not seem to be much evidence of preparation of nurses or other health services professionals for leadership through mentorship. However, there are a number of formal programmes ranging from short certificated courses to degree and diploma courses in leadership that are well advertised.

This chapter expands on the concepts identified and establishes a framework for this study. Literature sources were reviewed with the objective of increasing understanding and broadening the perspective of related concepts.

## 2.2 PURPOSE AND SCOPE OF LITERATURE REVIEW

The purpose of the literature review was to identify the specific leadership competencies required by health services' managers in senior leadership positions, and to review and interpret research studies conducted on the role of mentorship on leadership development in order to establish the relationship between the two processes. The literature review was also done with a view to identifying theoretical models used in mentorship programmes. According to Burns and Grove (2005:95), the purpose of the literature review is to convey what is known about the topic. This will help in the development and implementation of the study.

The sources of readings that have been reviewed and referenced in this chapter were from books, journal articles, which were sourced with the assistance of the librarian, and websites dealing with the subject of leadership and related concepts. Theoretical literature resources cover concept analysis, models, theories and conceptual frameworks that support a selected research problem or purpose (Burns & Grove 2005:94).

## 2.3 MANAGEMENT

Health services personnel are appointed to management positions from the most junior to the most senior post. Whilst a major portion of the responsibilities expected of managers from middle management positions and upward are related to management of institutions, departments or directorates, efficiency, dynamism, adaptation to change and empowerment of personnel is largely dependent on leadership qualities. The efficiency in executing leadership functions is what sets managers apart from their counterparts in other institutions or departments.

### 2.3.1 Definition

Management relates to exercising executive, administrative and supervisory direction of a group or organisation (Ricketts 2009:1). The administrative functions tend to be task oriented and efficiency is dependent on specific skills that managers require. These are outlined below.

### 2.3.2 Management skills

A manager needs to have knowledge of and proficiency in the specific area of work. Hence, in the South African health care sector, one sees a greater number of hospital managers with some form of professional health services qualification.

A manager needs to be able to work with people as well as with ideas and concepts (Ricketts 2009:3). A manager, however, that does not possess leadership skills will find it difficult to move an organisation forward. The dependency of a manager on effective leadership skills irrevocably links management and leadership. Discussions on leadership follow.

## 2.4 LEADERSHIP

Definitions of leadership are as varied as there are authors on the subject of leadership. The following sections will list a few definitions of leadership and review effective leadership competencies.

### 2.4.1 Definition

The following definitions of leadership serve to reinforce the fact that leadership is complex.

“Leadership is a process by which a person influences others to accomplish an objective and directs the organisation in a way that makes it more cohesive and coherent.” (*Concepts of leadership* 2010). This definition is reinforced by Bennis (2004), who goes further to emphasise the complexity of the leadership process.

Muller, Bezuidenhout and Jooste (2006:392) on the other hand, quote Charlton (2000:3) who states that “The nature of leadership is about enabling ordinary people to achieve extraordinary things in the face of challenge and change and, to constantly turn in superior performance to the long-term benefit of all concerned.”

These definitions are consistent on one feature of leadership, that of influencing others with the ultimate objective of a positive impact on an organisation.

Therefore, the view that leadership is a universal phenomenon, in which there is increased investment, will be taken (Bolden 2004:3). This study will place emphasis on leadership skills or competencies.

### 2.4.2 Leadership competencies

Leaders in health care settings clearly face organisational, economic, social and political challenges in an environment that is technologically complicated (Bondas 2006:332).

According to Goleman (1998:94), leadership competencies involve technical skills such as accounting, business planning, cognitive abilities, emotional intelligence and strategic vision. This is reinforced by Tornabeni (2001:4) who identifies strategic planning, resource allocation and financial management skills, which can be gained through formal studies, as essential.

Exeter University on the other hand expands on these to divide the competencies into soft skills such as communication, problem solving and people management, and technical skills such as information processing, project management and customer service delivery skills (Bolden 2004:15). Bolden (2004:17) goes on to quote the European Foundation for Quality Management (EFQM) Business Excellence Model in which leaders are expected to develop a vision, mission and values, be a role model of a culture of excellence and become personally involved in ensuring an organisational management system.

Clearly the demands that are placed on leaders are enormous and excellence in the performance of organisations is dependent on the quality of leadership development in place. This is reinforced by Bondas (2006:332) who states that “the eternal task of a nurse leader is to ensure a balance between optimum patient care, family friendly environment, employee attraction and effective organisation”.

Such competencies cannot be acquired merely by years of experience in any specific field. It is evident that formal and informal preparation is essential for personnel in leadership positions.

From the above discussion it is evident that the major categories of competencies required of managers in health care settings in leadership positions, are strategic planning, financial management, communication and people management and customer service delivery skills. The last mentioned is highly dependent on a leader being able to manage and develop the human resources available or, to develop a strategy to attract and retain the most appropriate talent. A manager in a leadership position needs to facilitate optimum output of his or her institution, department or district within the available resources, and therefore has to utilise competencies in each of the above areas effectively. These will be itemised in the research instrument, which will be discussed in chapter 3.

Bondas (2006:333) quotes Duffield (2001) who describes the lack of formal preparation for the transition and development of clinical nurses into management positions, and also explains that effective clinical leadership requires competencies in research, knowledge of patient care, understanding of multi-professional roles, priorities and stakeholder expectations. Bondas (2006:333) also quotes McKenna (2004) who emphasises the fact that nursing leadership impacts on the quality of care and organisational culture. As much as the aforementioned article focuses on nurses, the same could be applied to other health care professionals or personnel that take on management positions in which leadership roles need to be executed. Hence, health service leaders need to reflect on the meaning and impact of leadership on care and organisational culture. The effect of role models, mentorship and networking on nurturing healthy leadership cannot be ignored (Bondas 2006:334).

All of the literature reviewed points to the fact that leaders need to have the essential technical skills as well as soft skills, and in addition to these, they need to be visionary. For individuals to possess such competencies, they need to possess, if not, develop certain characteristics.

#### *2.4.2.1 Clarification of the competencies required by health services leaders*

As mentioned in the section above, the core competencies required of health services managers in leadership positions are strategic planning, financial management, communication, people management and customer service delivery skills. Each of these competencies encompasses specific skills in which a leader will need to be

proficient, so that he/she functions effectively in any health care setting. In reviewing each of the above it will be noted that the concepts are often designated by other terms, but the skills that are needed and ultimate goal are the same. From this point on the constructs 'health services managers' and 'health services leaders' will be used interchangeably as there is a significant overlap in the definitions (Bolden 2005: 11)

- **Strategic capability and leadership**

Boleman and Deal (1991) as quoted in *Concepts of leadership* (2010) discuss strategic capability under the structural framework which emphasises strategy, environment, implementation, experimentation and adaptation. The DPSA identifies strategic capability and leadership as a core competence of a senior manager. The Department of Public Service and Administration (2003:8), specifically in the appendix, breaks down strategic capability and leadership into the specific skills or criteria that can be used for assessment. These focus on the leader as a role model who is able to impact positively on the team and simultaneously develop effective plans for implementation of the institution's strategy.

These were reinforced in the Consultative Forum for Senior Managers held in the Mpumalanga Province of South Africa in 2007 (DPSA 2007:9) in which leading with communication strategies, problem solving, leading in the cultural context and leading knowledge and learning and service delivery innovation were highlighted. The main dimensions of strategic capability and leadership discussed were: strategic planning, governance and management, annual performance reporting, leading people, strategy and task execution management.

It is apparent that the international expectations of leadership competencies are the same as those expected of leaders in the South African public sector.

- **Financial management**

According to the Department of Public Service and Administration, "Annexure E" (DPSA 2003:1), senior managers in the South African public sector are expected to implement financial planning, budgeting and forecasting. They are expected to monitor financial risks, and prepare relevant financial documents. This was reiterated at the Consultative

Forum for Senior Managers in the South African Government in 2007 (DPSA 2007:26). Financial planning and performance, and financial budgeting and execution were identified as the main dimensions of financial planning required of managers in the public health.

Various pieces of legislation govern financial management in the public health sector in South Africa. Two of the most significant are the Public Finance Management Act Number 1 of 1999, as amended, and the National Treasury Regulations (South Africa: 1999). Personnel in leadership positions in the health sector need to be skilled in a range of competencies to be effective in financial management. Planning a budget follows development of a strategic plan, as the monies requested are related to specific outcomes that need to be achieved (Muller et al 2008:417).

In addition to the above, a health services leader is legally obligated to ensure effective financial management. A major area of accountability is monitoring and control of expenditure and ensuring that management processes are within the legislative framework, and that they are transparent (Muller et al 2006:420, 434).

- **Communication and people management competencies**

According to Sullivan (2001:70), the interpersonal competence that is required to bring people together to conduct assessments of organisational effectiveness and make decisions, needs "collaborative skills". This author also emphasises the importance of team interaction rather than the leader functioning as an individual. Skills in leadership are often demonstrated in behavioural traits. Lindstrom and Tracy (2001:43) reinforce the above by indicating that senior executives in health care must have the ability to work well with large and diverse groups of people. They expound on this to emphasise "a willingness to listen and appreciate divergent world views" as a mark of an effective leader.

*Communication and people management* requires more than being able to listen to differing viewpoints. A leader must be able to balance his/her views with that of a team and make the best decision in the interests of the organisation. It is important for a leader to be able to read an organisational culture so that when an approach is decided upon, a leader will be able to identify whether to move ahead or not, i.e. he/she will be

able to determine whether there will be buy-in from the team (Lindstrom & Tracy 2001:45).

This was supported by the DPSA (2007:28) in their Consultative Conference for Senior Managers, in which the core competency of people management and empowerment was discussed. People skills and communication strategies, and problem solving and analysis in people skills were identified as indicators for measurement of success in this competence. The link between human resources planning and employee relations management was also highlighted.

- **Human resources management**

According to the DPSA (2006:27), in the report on *Human Resource Development for the Public Service. Strategic Framework. Vision* (2015), human resources management encompasses people management and empowerment. This competence at the level of operations in the public sector tends to be complex. It encompasses organisational development, human resources development and management of labour relations. Muller et al (2006:231) describe human resources management as "encompassing all management decisions and actions that affect the nature of relationships between the organisation and employees".

Human resources management involves planning for, and the utilisation of personnel. Therefore a health services leader has to develop expertise in recruitment and selection, talent management, facilitating training and development and management of performance. Talent management is an approach in succession planning that ensures retention of talent in an organisation. It promotes growth and development of personnel with the potential for leadership and therefore facilitates promotions from within an organisation (Hill 2012). All the aforementioned skills need to link in to the effectiveness of the organisation in achieving planned outcomes, within the material and financial resources that are available. Booyens (2008:179-204) discusses a range of other issues such as managing conflict and cultural diversity that add to the complexity of human resources management.

- **Customer service delivery skills**

A health services leader is expected to pursue the goals of the organisation, ensuring that resources are fully utilised, or, that there is no unnecessary expenditure on resources, and in the process, effecting changes that are innovative whilst maintaining stability within the organisation. In this way the needs of both internal and external customers are met. Therefore, whilst planned outcomes have to be met, the needs of personnel have to be factored in (DPSA 2006:51). The goals and targets to be achieved in service delivery are often very difficult to measure and this clouds the characteristics of what is expected in terms of good leadership.

- **Change management**

As the workplace is dynamic and is directly influenced by the external environment, change management is recognised as a core competence. According to the DPSA (2006:47), leaders need to work with changes to vision, planning and strategy, and changes in organisational and structural design. They have a responsibility to monitor and evaluate the impact of change.

Jooste (2003:297-303) discusses change management in conjunction with strategic planning. According to this author, a leader needs to understand the characteristics and process of change and identify strategies to deal with change. One of the factors identified by this author, who quotes Dienemann (1998:149), is the significance of a leader communicating the reasons for change very clearly and institutionalising the change by clearly outlining the relationship of the change to the success of the institution.

It is evident that the competencies required of health services managers are complex and while a number of years of experience in a post can contribute to proficiency, accountability and responsibility are expected immediately personnel take on posts. This study will attempt to explore leaders' experiences in executing their responsibilities in the above mentioned areas. Competencies of leadership cannot be discussed without reviewing the characteristics of effective leadership.

### 2.4.3 Characteristics of leadership

As with the definition of leadership, a number of authors describe a variety of characteristics of leadership. However, Van Dyk, Van der Westhuizen and Jooste (2003:34) appear to capture the essence of leadership characteristics, which are described as follows:

- **Focus**

Leaders keep track of the outcomes and build capacity in others to achieve. E.g. having a strategic plan in place is inadequate without a monitoring and evaluation strategy.

- **Authenticity**

By being themselves, leaders allow for followers to be confident in knowing what to expect. This characteristic builds a relationship of trust between a leader and his/her followers.

- **Courage**

Leaders face challenges and have the courage to admit when things go wrong. A courageous leader wins the respect of his followers because openness is generally valued.

- **Empathy**

Effective leadership is characterised by the ability to listen empathically and hence reinforce the credibility of the information proffered by others. Therefore, by making others feel part of the team, they promote consensus building and this keeps the team together.

- **Timing**

Leaders know when to make critical decisions.

Muller et al (2006:398) discuss the attributes, qualities and skills of leadership and, in addition to the above, add strategic thinking and change management.

Competencies of leadership are illustrated in the leadership strategies discussed below.

### 2.4.4 Leadership strategies

Leadership strategies, however, need to vary to suit the situation and this is illustrated in the four frame approach described by Boleman and Deal (1991) as quoted in *Concepts of leadership* (2010). These are:

- **Structural framework**

Leadership style focuses on analysis and design with an emphasis on structure, strategy, environment, implementation, experimentation and adaptation.

- **Human resource framework**

The leader in this context is a catalyst and servant who supports advocates and empowers. Belief in people is communicated and the leader is visible and accessible. Therefore participatory management is characteristic and decision making is decentralised.

- **Political framework**

These leaders build linkages between stakeholders. Persuasion and negotiation are characteristic of the communication style.

- **Symbolic framework**

Leadership style is one of inspiration. Leaders using this style give interpretation to experiences and communicate a vision.

From the above descriptions of leadership it is clear that a number of common threads run through all. That leadership styles are situational, is constantly reinforced. The issue

of technical expertise combined with soft skills such as empathy, being inspirational and communicating a vision also stand out. Therefore, these competencies of leadership were included in the research instrument.

Nursing leadership, one of the key leadership roles in health services, is seen as challenging and complex, and requires diverse expertise and knowledge. Many nurse leaders find themselves confronted with situations in which they need adequate knowledge and skills in generic management processes, health services management and clinical expertise. In a study in New Hampshire, Allen (1998:18) selected twelve nurse leaders and identified factors that influenced their successes. Although personal qualities and experiences played an important role, all of the participants cited significant people and mentors as playing a pivotal role. According to the participants in the study, mentors created the opportunity for them to grow and succeed, and they were coached and taught.

The above study established a clear link between leadership and the role of mentorship in exercising the leadership trait of “influencing others”.

## 2.5 MENTORING AND MENTORSHIP

A common concept that runs through the literature sources reviewed is that mentorship is an established way of preparing an individual for a specific position or with specific competencies. Literature sources confirmed that mentoring is an age old process that holds as true today as it did in ancient Greek and ancient African societies. This section will explore the definition of mentorship, the relationship between mentorship and leadership and a few models of mentorship. In the literature reviewed, the person that is senior or is in the teaching role is described as the mentor, whereas, the person who is mentored is referred to as a mentee or protégé. Therefore, the latter two concepts will be used interchangeably.

### 2.5.1 Definition

Traditionally, mentoring is seen as a relationship between a senior and junior member in an organisation that is directed toward the up-lifting of the junior member (Fowler & O’Gorman 2005:51). Fawcett (2002:950) also explains that nursing mentors are

experienced nurses who help those less experienced in their field to advance their careers. According to Woodrow (1994:813), the effectiveness of mentorship relationships depend on the qualities of the mentors and the needs of the protégés. Owens and Patton (2003:199), quote Thompson (2000), who states that mentoring is a professional responsibility as well as an opportunity for growth.

Bozeman and Feeney (2007) as quoted in *Concepts of leadership* (2010), define mentoring as "a process for informal transmission of knowledge, social capital, and psychosocial support perceived by the recipient as relevant to work, career, or professional development; mentoring entails informal communication that is sustained over a period of time, between the person who is perceived to have greater knowledge, wisdom and experience (mentor) and a person who is perceived to have less (protégé)".

According to *Training and learning development* … ([S.a.]), any training programme in an organisation that links mentorship with the objectives of the organisation is highly effective. In this article the authors explain the elements of a training programme, and describe a mentor as one that facilitates the experiences of a mentee. The authors see mentoring as similar to coaching, in that a mentor facilitates and coaches and does not tutor or lecture.

Block and Korow (2005:134) further define nursing mentorship as a relationship between two nurses that is characterised by mutual respect, compatible personalities and a common goal of growing the nurse toward personal and professional growth.

The major concepts covered in the above definitions were the relationship between a more experienced member and a junior member, transmission of knowledge, wisdom and experience, development of an individual and linking the training programme to the objectives of the organisation. The following section, therefore, explores the relationship between mentorship and leadership.

### 2.5.2 The role of mentorship in leadership development

Allen (2002:440) identifies the first systematic investigation of nursing mentorship that was conducted by Connie Vance in the United States. The author concluded that mentor connections played a key role in the succession of leadership in the profession.

In this study nurses identified peer to peer models as well as expert to novice models of mentorship. Allen (2002:440) went on to describe the significance of a mentor and the characteristics of a mentor, which will be discussed later under the models of mentorship.

Villarruel and Peragello (2004:173-180), in a descriptive study on leadership, explain the experiences of Hispanic nurses in Michigan and Miami. Again the importance of mentors, who served as role models, was a common theme, and the authors explained that mentors served as support and assisted with the development of skills. However, the limitation of this study was the fact that this study was conducted only on recruited Hispanic nurses.

Barondess (1997:347) in an article "On Mentoring" describes mentorship as a multifaceted and complex relationship. Barondess (1997:347) quotes a study carried out in New York that illustrates the success of mentorship. In this study 25 doctors who had mentors were interviewed with the following results:

- 88% said it enhanced their personal development.
- 72% reported that it helped them deal with stress.
- 81% themselves became mentors.

He recommended that cross sectional and longitudinal studies should be conducted to evaluate the effects of structured and supporting mentor roles on health professionals.

In an article on *Mentoring and Baby Boomers* ([S.a.]), the author states that to be effective "mentoring needs to be done strategically and creatively". The article further expands on the positive effects of mentoring in that there is a "positive correlation between a positive mentoring experience and an increase in productivity, employee retention and job satisfaction". However, it is clear that mentoring has to be strategically placed and acknowledged by senior staff in an organisation.

Mentoring, like leadership, is a complex process that involves both technical expertise as well as numerous communication skills. It is also apparent that mentorship and coaching, though perceived to be different "is increasingly converging, making them less distinct in practice" (Deans, Oakley, James & Wrigley 2006: i). These authors

postulate that coaching and mentoring are different styles on a continuum and therefore the prevailing situation determines which competencies are required. Coaching is viewed as task oriented, skills focused, directed and time bound, whereas, mentoring is seen to focus on open ended personal development (Deans et al 2006:4). However, according to Deans et al (2006:10), coaching and mentoring have moved from being task centred to addressing the more personal and emotional aspects of the person's life. The principles and process of mentoring give clarity to the concepts discussed thus far.

### 2.5.3 The principles of mentoring

The following model is an illustration of a simple approach to a structured mentorship process. The emphasis is on basic principles that could be incorporated into guidelines for mentorship programmes.

Mentoring often involves a number of meetings with focused discussions that are guided by specific goals for each session. This illustration reinforces the premise that the mentor is more experienced and knowledgeable. Clutterback (2001:106), as quoted by Deans et al (2006:11), outlines an ideal mentoring session in the following illustration.

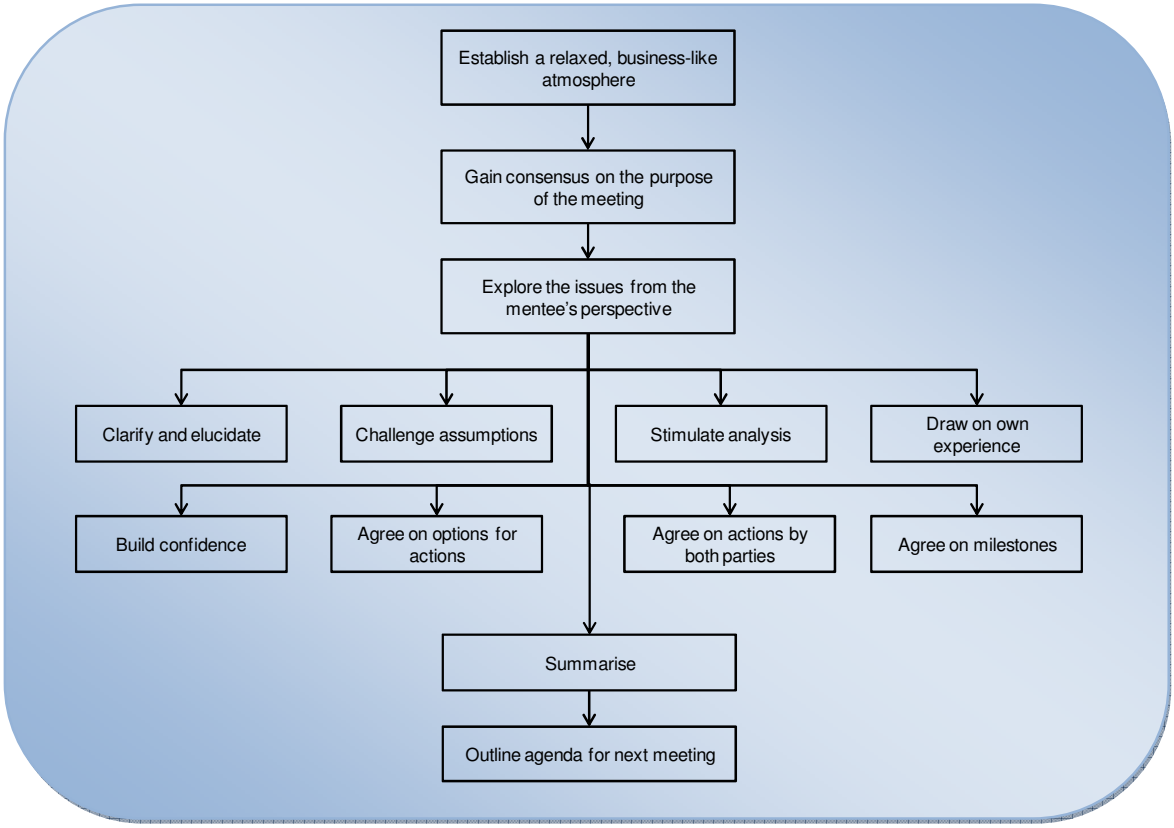



**Figure 2.1 Components of a mentoring session**

(Clutterback 2001:106)

The key principles of a mentoring session, therefore, are as follows:

- There is an agreement in place to clarify the objectives and expectations and to establish ground rules and authentication.
- Conversation is structured, constructive and meaningful.
- It is empowering.
- It creates a trusting relationship and a safe space.
- It is flexible in style and approach.

The above outlines a fairly structured approach to mentoring and this is reinforced in the processes discussed below. The principles guide the process of mentorship.

### 2.5.4 The process of mentorship

The process of mentorship described by the University of British Columbia in *Possible Mentorship Models* (2008) is similar to that used in South Africa (DPSA 2006:7-19), in that a one to one process is used. Both institutions suggest that a single mentor enter into a mentorship contract with a single protégé. However, in the South African scenario a mentor may have more than one protégé for whom he/she is responsible. Guidelines are required to work out the number of hours of contact that a mentor will have with a mentee.

Both the University of British Columbia and the South African public sector use a formalised programme, which is a one year contractual relationship, based on the following principles:

- Firstly mentors are recruited and a mentee has the chance to select names from the potential mentors.
- The mentor must not be the person evaluating the mentee i.e. the line manager cannot be a mentor.
- In the South African model both mentor and mentee have line mangers to whom they report. In addition, the mentor is expected to report and get support from the mentorship programme manager.

The mentor, according to *Possible Mentorship Models* (2008), is expected to give career advice and support as well as give formative assessments at regular intervals.

#### *2.5.4.1 The mentorship process as described by the DPSA*

The DPSA guide sets out the framework and the specific phases of a mentorship programme. In essence, the framework covers the programme objectives and the principles of mentoring. The objectives focus on the fact that mentorship is an effective vehicle for non-formal training that succeeds in maximising efficiency and improving the quality and overall effectiveness of human resources development (DPSA 2006:7). Lifelong learning is one of the principles that are highlighted. The phases of the programme are outlined as follows:

- **Preparation**

- A needs assessment is conducted to establish the skills required by the mentee and the resources available.
- The department is prepared for running the mentorship programmes.
- Supervisors are briefed on the intention and process of the mentorship programme.
- The objectives of the mentorship programme are communicated to trade unions and professional organisations. This forms part of the stakeholder consultation.
- Training of mentors and mentees has to be conducted in the theory and practice of mentoring in the public sector.

- **Selection**

- Criteria for protégé and mentor selection have to be developed.
- An analysis is conducted to determine if prospective protégés and mentors meet the selection criteria that are developed, and that they are then selected accordingly.

- **Agreements**

Agreements related to the mentorship programme are concluded. These cover the following:

- Formal mentorship agreements.
- Negotiated performance agreement for mentor and protégé
- Specific remuneration packages.
- Performance criteria, performance incentives and renewal of options/close-out as well as the assessment process (DPSA 2006:20).

- **Implementation**

This phase involves the agreements that a mentor and mentee enter into with regard to performance agreements. Each enters into a performance agreement with his/her respective supervisor. This allows for monitoring of both the mentor and the mentee.

- **Termination**

This involves formalised termination and debriefing sessions as well as an evaluation of the programme (DPSA 2006:17-19).

#### *2.5.4.2 An informal approach to mentorship*

Owens and Patton (2003:198-204) describe the phases of mentorship that occurred via e-mail, the outcomes of mentorship and strategies and that could promote this approach. The authors explained what had to exist before the relationship commences i.e. characteristics of mentor and protégé and behavioural expectations of both parties. The rest of the article outlines the development and ultimate termination of the mentoring relationship. The entire experience was mutually satisfying and although the protégé developed independence, the relationship terminated in "pleasurable companionship". The authors therefore recommended the following strategies to promote successful informal mentoring relationships as listed hereunder.

- Take a chance on another person.
- Employ creative methods of communication.
- Honour the mutual contract.
- Periodically evaluate the goals.
- Utilise adult learning principles and move towards a peer relationship.
- Leave room for independence and error.
- Be willing to push expectations.
- Express sincere gratitude for professional nurturing and praise.
- Make time to enjoy companionship.

The above study was carried out in Ohio. This approach, however, differs from that of the DPSA and the University of British Columbia, which are structured; whereas, a collegial relationship is a less structured process that requires a great deal of trust and a high level of maturity. Public sector institutions may find that a structured approach is more practicable.

### 2.5.5 The role of mentorship

If mentorship is integral to the preparation of future leaders in health services, then it needs to fit into a programme of leadership development. This is supported by Block and Korow (2005:136), who quote a study carried by Hale (2004) in which there was evidence to support a strong relationship between mentorship and nurse retention. Of significance is the fact that the respondents who underwent mentorship were self-confident, had job satisfaction, were competent and demonstrated professional growth and improved leadership skills. The article reinforces a positive relationship between self confidence and mentorship. The authors also describe the Macmillan Mentorship Programme used in the United Kingdom, in which mentors helped new nurses in the transition to specialist practice. This programme comprised experiential learning, reflective practice and effective mentorship.

On self report questionnaires mentors and mentees from Block and Korow's (2005:136) study gave positive feedback. Of significance were the models that emerged from this study namely:

- The *structural model* that comprised the environment, people and events.
- The *process model* that comprised mentoring characteristics, dimensions and strategies.

The authors reinforced the fact that mentorship fosters a positive work culture. However, they also acknowledged the need for financial and human resources for successful mentorship programmes.

Not only does mentorship contribute to the development of future leaders and to staff retention, but it also addresses the shortage of nurses as described by Thomka (2007:22-26). In this study, which was carried out in the United States, the lived experiences of mentees on mentorship programmes are explained. In the abstract, Thomka explains that mentorship is being increasingly recognised as a way to address the shortage of health care professionals. The author goes further to explain its role in retention of intellectual capital and succession planning within health services. In this study the experiences were informal, developed over a period of time, and were the result of proximity of the mentee to the identified mentor. All expressed a desire to

emulate the mentor and pass on the knowledge and skills learnt. The implications of this study as outlined by the author are that health services leaders are to:

- Engage in reflection to determine the gaps in leadership development and ensure succession.
- Identify and remove barriers to mentorship.
- Create a positive environment for learning.
- Ensure that mentoring relationships develop.

To have a consolidated approach to mentorship, principles and processes of mentorship need to be augmented with an appropriate model for mentorship.

### 2.5.6 Models for mentorship

The performance management system and integrated development plans that form part of the policy guidelines (DPSA 2003:6-7) in the South African public sector can only be successful in contributing to organisational success if it involves mentorship. Mentorship focuses on talent management in institutions that place value on human resources. Mentorship, however, cannot be implemented unless there is some form of structure in place. This is where mentorship models play a significant role. What then are the various models for mentorship that have been used?

#### *2.5.6.1 A collegial mentoring model*

The following is a discussion of the peer mentoring model that is described as the "Collegial Mentoring Model for Nurse Educators" (Thorpe & Kalischuk 2003:5-13). Of significance in this article is the reinforcement of the statements made in the introduction to this chapter, i.e. that there is very little literature that pertains to mentoring of trained nurses. There is a lot of focus on students in training. The authors quote, among others, Angelini (1995) who presents a structural and a process model of mentorship in nursing. The structural model involves interplay between the environment, people and events. Mentoring is seen as a multidimensional, dynamic and interactive process. In this model, peers and nurse mangers are important to the process of mentoring trained nurses.

The significance of this literature source is the fact that the authors expound upon the fact that, although there are many descriptions of mentorship, there are few writings on the actual interactions in mentorship relations and what is actually learned. The focus of the present study is to identify the relationship of mentorship and leadership development in health services.

Thorpe and Kalischuk (2003:5-13) brand the Mentor-protégé Model as outdated and refer to the Collegial Model as friendship based. Communication is open and takes place over a longer period with a positive outcome. The *collegial mentoring model* comprises a micro and a macro realm that are described as follows:

- **Macro realm**

This covers the socio-cultural, political and economic environment and is conceptualised as having a background comprising societal aspects, and a foreground comprising personal and professional factors. The pressures placed on the authors, who themselves entered into a collegial mentorship relationship, increased the need to be successful, but also helped them to recognise their isolation. This resulted in their need to share. Over time, they valued their relationship for the support and guidance received from each other.

- **Micro realm**

The micro dimension is apparently the essence of this model as the concepts of caring, connecting and communicating, which are integral to this model, occur in this realm. The following processes take place in this realm, namely:

- *Making time for togetherness*

Priority is given to time commitment that is highly qualitative and ultimately results in "creative energy" and increased productivity when they return to work.

- *Creating ambience*

The authors refer to this as creating a safe, nurturing, and aesthetic environment. This is achieved by going out to tea or coffee and is likened to the Japanese tea ceremony, which is a calming social experience. It provides an opportunity to share frustrations and discuss ideas on changing the way things are done, offer support on personal and professional issues, and give and receive encouragement. According to the authors this sparks a collaborative relationship.

- *Promoting being-ness*

In this context each individual has the opportunity to be who he/she is at that moment. The authors emphasise that this is only possible when safety and trust is established. This is recognised as contributing meaningfully to the mentoring relationship.

- *Caring, connecting, communicating*

Communication is as important to mentorship as it is to nursing. It is seen as fostering a relationship that links personal and professional lives. Connecting refers to reaching out to another person. Caring involves encouraging and supporting each other.

All three processes are seen as inseparable and cannot be realised without making time for each other.

- **Outcome**

The outcomes of this model are described as personal and professional development that results in:

- Enhanced general well-being
- Increasing synergy
- Gaining new insights
- Envisioning the bigger picture
- Making sense of experiences
- Finding ways of succeeding

- Creating a balance
- Increasing creativity and productivity

The limitations of the study were that such a model required commitment to a relationship over time, and work and time pressures could have been serious obstacles. Secondly, the focus is very narrow and there is a potential for personal and professional jealousy.

However, the authors quote Johnson (1999), who explains that mentorship occurs within boundaries and that the onus is on the individual to take the initiative. The merit of this model is recognised by the fact that success cannot be achieved independently and that the outcomes of such a model have the potential to enhance employee retention.

Mentorship, however, is not only about following a structured programme, but requires patience, enthusiasm, a sense of humour and respect, and needs to advocate for the mentee. Mentorship is seen as a long term, labour intensive relationship that requires mutual respect, common interest and a desire to grow professionally (Fawcett 2002:950-954).

Allen (2002:440-444) reinforces the above in stating that successful mentoring comprises mutual trust and respect, an environment of understanding, empathy and cooperation, and mutual sharing of information through good communication skills. The emphasis here is on sharing of skills.

The significance of the *collegial mentoring model* is the degree of trust that has to exist in the relationship. Such a model cannot be built into performance management contracts and hence it is left to the initiative of individuals. Therefore a *collegial mentoring model* for mentorship cannot be part of structured or formal programmes within health services institutions.

The STEER model, described hereunder, bridges the gap between mentorship and coaching.

#### *2.5.6.2 The STEER model*

This model is task oriented and originates from the world of sport (Deans et al 2006:31). It comprises the following steps:

- **S**pot training needs.
- **T**ailor training content to meet the needs of the individual.
- **E**xplain and demonstrate how the task should be done.
- **E**ncourage the individual while he/she is learning.
- **R**eview progress during and on completion of training.

This model is clearly very task-oriented and more suited to coaching.

The following two models that are described by Deans et al (2006:34 -35) are more congruent to leadership development. These models appear to incorporate both learning and caring into the process. As much as the models speak to coaching they are applicable to mentoring. Reviewing processes involved in coaching one can see that they are applicable to mentoring, and hence the view that mentoring and coaching are on either end of a continuum is logical Deans et al (2006:34-35).

#### *2.5.6.3 Transformational coaching model*

According to Turner (2004) the core of this model is transformation. The three aspects of this model are as follows:

- ***Transforming who people are, or Triple loop learning***

Empowering people to change their viewpoints of themselves in order to help them to learn to grow and reach their desired goals.

- ***Coaching people to learn to do new things, or Double loop learning***

Enabling people to re-shape their thinking with the objective of helping them break through barriers and to learn to do things differently.

- ***Coaching for incremental improvement, or Single loop learning***

"Coaching people to continuously improve their current practices or to do what they are already doing better" (Turner 2004).Figure 2.2 illustrates this process.

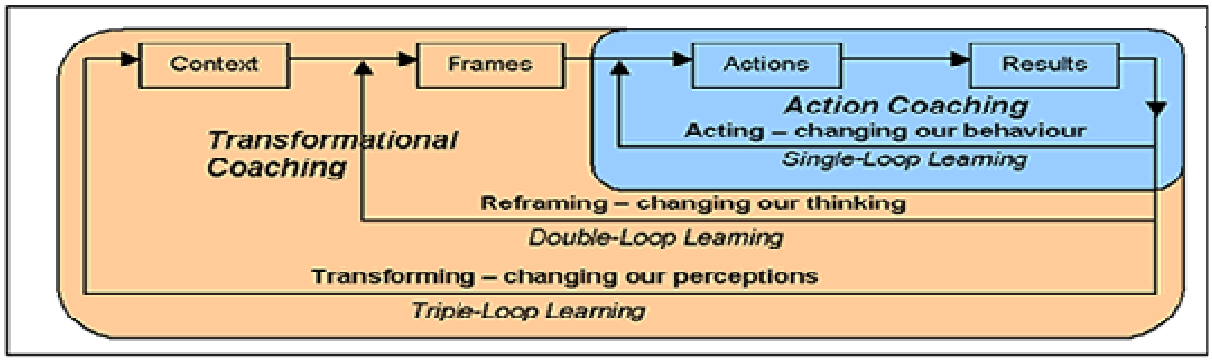



**Figure 2.2 Transformational coaching model**

(Turner 2004)

The key component of this model is the positive influence of the mentor on the mentee. While this correlates with the outcomes of the Collegial Mentoring Model, it links up with the competencies required of health care leaders, i.e. the soft skills of inspiring and motivating but also the technical expertise related to human resources management and development. In addition the issue of organisational development for optimum output is inherent in this model (Turner 2004).

#### *2.5.6.4 POSITIVE coaching model*

Deans et al (2006:35) describe this model as one that uses a more psychological approach. POSITIVE is an acronym for Purpose, Observations, Strategy, Insight, Team, Initiate, Value and Encourage.

- **Purpose**

The protégé is encouraged to gain clarity on his/her goals and the mentor/coach uses a number of communication skills to facilitate this process.

- **Observations**

The protégé is encouraged to think about what is going on around him/her. The objective being, that the protégé will be able to see his/her own position from a holistic viewpoint.

- **Strategy**

The coach helps the mentee/protégé to develop a goal plan.

- **Insight**

The goal, together with the emotions it invokes, is explored. In this way the mentee gets a clear picture of what he/she really wants.

- **Team**

A support network is essential to encourage the mentee on his/her goal path.

- **Initiate**

The process of coaching commences.

- **Value**

Weekly or short term tasks are set to help the protégé to achieve long term goals. Regular feedback assists the mentee to value progress (Deans et al 2006:35).

- **Encourage**

Motivation and support is consistent.

The Positive Coaching Model and the Transformational Coaching Model are similar in that they both facilitate the process of the individual learning through gaining insight and exploring the programme of mentorship. The principles of mentorship according to Clutterback (2003) are also incorporated into the *transformational coaching model* of mentorship.

In summary, the models on mentorship discussed above illustrate a number of common characteristics:

- Learning through insight.
- Relationships that bring about change.
- Feedback from the mentor or colleague.

As these main themes emerge from the above models, the theories that apply to mentorship need to be explored.

### 2.5.7 Theories that support leadership development and mentorship

Allen (1998:19) explains the Social Learning Theory according to Albert Bandura (1994), which describes how behaviour is moulded through reciprocal interaction of a person's cognition, behaviour and environment. In this context, learning is seen as interactive in that an individual has a measure of control. Successful performance also contributes to an individual's ability to succeed, and learning takes place through observation and imitation of others. Lastly, reassurance from peers or seniors contributes to the experience of success, which is experienced psychologically.

The impact of learning processes is also reinforced in the integrated framework for leadership development (Bolden 2005:18). Here Bolden explains that in the process of leadership development, learning transfer occurs i.e. provided that all the organisational processes are in place to facilitate leadership development. Bolden (2005: 18), describes leadership development as an interactive learning process.

Wagner (2005:89) describes a mentorship model based on Watson's Caring Theory, Newman's Theory of Expanding Consciousness and Roach's Model of Caring. The caring models highlight the concepts of compassion and empathy. However, the issues of competence figure quite prominently and the need to pass on the skills. Hence learning and caring are interwoven.

In all the noted models, the concepts of 'learning' and 'caring' are common threads that run throughout. This then leads to the characteristics of an effective mentor.

### 2.5.8 Characteristics of an effective mentor

The following descriptions of the characteristics of mentors, by an undergraduate student, reinforce the fact that theories of caring and learning support the process of mentorship.

- "Mentors create opportunities and open doors.
- Mentors know your strengths and abilities. They don't set you up to fail. They challenge you to go beyond what you think you can do.
- Mentors set an example.
- Mentors want you to succeed and help you learn from your mistakes.
- Mentors want you to become independent. The training you receive and the associations you build, often through your mentor, enable you to eventually function independently – whatever your ultimate career path" (Kappel 2008).

The above characteristics are reinforced in the following excerpt:

- "Mentors listen, guide and are practical.
- Mentors educate, provide insight and are accessible.
- Mentors criticise constructively and are supportive.
- Mentors are specific. Mentors care. Mentors succeed.
- Mentors are admirable."
  *(Characteristics of a good mentor* ... [S.a.]).

### 2.5.9 Common themes embedded in the models discussed

At the level of leadership development, what then is the ultimate goal of mentorship? An analysis of the common themes identified in the models described will attempt to answer this question.

**Table 2.1 Comparison of mentoring models**

| Model | Themes | Themes common to all models |
|---|---|---|
| Collegial Mentoring Model | • Multi-dimensional interactive process<br>• Environmental influences<br>• Communication, sharing and interpersonal relationships<br>• Caring | • Communication, sharing and interpersonal relationships<br>• Caring |
| STEER Model | • Identification of need<br>• Development of a plan to meet needs<br>• Encouragement of the mentee (caring interpersonal relationship) | • Encouragement of the mentee (caring interpersonal relationship) |
| Transformational Coaching Model | • Empowerment of personnel to reach their potential<br>• Positive influence of mentor<br>• Coaching and guiding mentee to optimise output | • Coaching and guiding mentee to optimise output |
| Positive Coaching Model | • Guidance of mentee to clarify goal using communication skills<br>• Guidance to develop<br>• Guidance and support to reach optimal levels (caring) | • Guidance of mentee to clarify goal using communication skills<br>• Guidance and support to reach optimal levels (caring) |

The threads that run through all models are guidance of mentees, demonstration of caring that the mentee reaches full potential and utilisation of communication skills to get the mentee to optimise output. Caring, teaching and supporting appear to be the key concepts in all models.

## 2.6 SUCCESSION PLANNING

The literature that has been reviewed describes leadership development as it occurs through mentorship. According to Zaphyr ([S.a.]) leaders need to find potential new

leaders through the development of current employees. This process allows for a pool of personnel that could be available for selection for future promotion. As people are the intellectual capital of organisations, organisations need to place value on people and devise ways of retaining their talent and therefore a structured method of accomplishing this is through succession planning.

### 2.6.1 Definition

Succession planning is a process by which personnel with potential are identified for key posts within an organisation (Hirsh 2000). In essence it is a process of developing pools of people, with potential, who are adaptable and form part of the capital resource. However, to be of benefit to the organisation, succession plans need to fit into the competency framework of an organisation.

Rothwell (2006) relates succession planning to succession management, which is a process of preparing people to meet an organisation's need for talent over a period of time. It is regarded as a way of ensuring effective performance of an organisation and part of the larger talent management programme. Succession planning serves a twofold purpose in that vacancies in an organisation can be readily filled and the staff is assisted in developing their potential so that they become marketable. According to the Institute for Employment Studies, succession plans are part of a wider set of resourcing and development processes (Hirsh 2000). It is clearly a very practical means of developing people and ensuring that they are correctly placed to achieve optimum results.

### 2.6.2 Purpose of succession planning

Succession planning is seen to contribute to the following:

- Improved job filling.
- Active development for long term success.
- Growing a talent pool.
- Fostering a corporate culture by building corporate resources.

Therefore, succession planning should be linked to the broader human resource policy of recruitment and retention. Development of staff should be about growing people to meet their own and the organisation's needs. Hence a sound performance management system would assist leaders to identify potential talent for leadership. These principles are outlined in *Talent management* ([S.a.]).

### 2.6.3 Process of succession planning

According to Rothwell (2006), succession planning is systematically planned as follows:

- The head of an institution or organisation clarifies his/her expectations.
- A competency model is developed which clearly describes the standards and capabilities required of specific positions.
- A full circle assessment (360°) is conducted in which individuals are assessed against the standards in order to identify the gaps.
- A performance management system, with clearly outlined objectives, is developed.
- An assessment of the potential for success with increased responsibilities is conducted, with a focus on the future.
- Individual members and supervisors establish a plan for development.
- Integrated development plans are implemented.
- A talent inventory is established. In this way the individual's performance is matched against his/her potential.
- Accountability for succession planning is established.
- Results are evaluated.

In addition, effective succession planning is dependent on the steps outlined below, as discussed in the *Succession planning 101 ...* (2006). This paper reinforces the linkage between leadership development and mentorship, and makes provision for succession planning. Leadership development plans do not guarantee that succession plans automatically follow. There needs to be a structured programme, for succession planning that is developed and implemented.

### 2.6.4 Ensuring effectiveness of succession plans

Having a succession plan in place is not adequate. It must, of necessity, be planned and implemented in a structured manner. Succession planning needs to be included in an organisation's competency framework and workforce planning strategy if positive results are to be seen. Potential leaders are engaged and involved in assessment and development programmes (*Succession planning 101 ...* 2006).

The following guidelines can assist to overcome obstacles in the process.

- **Assess the problem**

Determine the talent lack in the organisation. In the process the following is identified: turnover rate, replacement costs, critical skill gaps, and problems such as key positions remaining vacant for extended periods of time.

- **Obtain buy-in and create a plan for success**

Align strategic succession management with the business strategy to gain wider acceptance. Develop skills and knowledge to address business strategies, and to develop the leadership. This becomes an effective way of looking inward to the talent pool in the organisation rather than incurring costs in recruiting.

- **Become more strategic**

A more strategic approach would be to focus on risk analysis and leadership development in non-executive positions, particularly in two areas: technical and professional. In the process, personnel with leadership potential and expertise in specific operational areas would be identified for development. In this way a talent pool would be established. However, the data base of potential leaders would have to be reviewed and updated regularly to align with the needs of the organisation.

Employees in any organisation are the most expensive item. Thus, HR needs to become more strategic as the guardians of human capital. The implication is that there

must be structured plans to match the right people to the right jobs, ensure key positions have succession plans, and decrease the rate of turnover.

- **Strengthen your employee data**

It is essential to have an accurate data base from which to draw talent in an organisation and to have the right performance management system. This facilitates the integration of performance results with other data for a complete profile of each employee.

Once a comprehensive talent inventory is compiled, it becomes relatively easy to identify skills gaps at a departmental and individual level. Leaders within organisations can then systematically identify people with the qualifications and competencies needed to fill those gaps.

- **Integrate talent management functions**

Talent management is not only made up of talent acquisition but has to be integrated into learning management, employee performance management, and compensation management. This reinforces the fact that succession planning cannot take place in isolation but becomes part of the broader leadership development plans and organisational competency framework.

- **Consider integrated systems as part of the solution**

The use of technology, where available, makes the process more manageable.

- **Don't just diagnose – prevent**

Communication is critical. It is important to update the groups who can mitigate the key risks and enforce positive change. Employees themselves become an integral part of reducing the risks of talent shortages according to *Succession planning 101 …* (2006).

The above processes and steps paint the picture of ideal organisations. However, it is clear that succession planning, mentorship and leadership development have a

significant role to play in any organisation, not just from a human resources planning perspective but also in asset management and risk mitigation.

## 2.7 CONCLUSION

It is an undisputed fact that the positive outcomes of mentoring relationships on leadership development and succession planning lead to the retention of staff. The fact that the studies were carried out internationally, in some instances with limited groups, lends credence to the general theme of this study and the aim is to explore its relevance to the South African public sector.

The studies on informal and collegial models for mentorship indicated positive outcomes and there is a possibility that these could form part of recommendations for implementation in the South African situation. The following quotation, though referring to one category of health services professional, substantiates the above-mentioned statement:

"The mentorship process encourages development of leadership skills and advances a protégé's vision, not only for individual success, but also for the future of nursing as a profession" (Owens & Patton 2003:43).

From the literature reviewed one feature stands out clearly and that is, that mentorship has a positive impact on leadership development. Mentorship focuses on developing the individual for personal success and advancement of the profession and in so doing contributes to the organisational need for succession planning. Both succession planning and mentorship follow a process of assessment, designing a plan for development or entering into a contractual agreement respectively, and evaluation.

The main components that have been covered in this chapter are:

- Leadership and leadership development.
- Mentorship and its role in leadership development.
- Succession planning and the contribution of leadership development to organisational stability in that retention of talent is part of the process.

# CHAPTER 3

# Research methodology

## 3.1 INTRODUCTION

Research methodology refers to the methods used to address the research questions including the methods used to collect, analyse and organise the data (Polit & Beck 2008:328).

The purpose of this study was to add to the current research on the significance of mentorship as a means of leadership development in the public health sector and to establish the outcome of formal or informal mentorship programmes to which health service leaders may have been exposed. The concepts that are discussed in this chapter are: the research design, the research methodology, the research instrument and the ethical principles that were considered during the study.

## 3.2 RESEARCH DESIGN

Research design refers to the plan that is developed in order to answer a number of questions to address the research problem (Mouton 2006:2; 5). In this quantitative study, explorative and descriptive research was undertaken using a questionnaire as the instrument in a survey.

### 3.2.1 Quantitative research

Denzin and Lincoln (1998) as quoted by Golafshani (2003), explain quantitative research as research that emphasises the measurement and analysis of causal relationships between variables. The information, therefore, that is collected results in formal measurement, which is analysed by statistical procedures (Polit & Beck 2008:16). In this study, the main concepts that were explored were mentorship and leadership development and the role that mentorship had on the latter.

Quantitative research allows the researcher to familiarise him/herself with the problem or concept to be studied. In quantitative research, it is important to be able to combine concepts or phenomena into common categories so that it can be applied to similar situations. Therefore, there is a need to develop an instrument to be administered in a standardised manner. Hence the instruments that are most commonly used in quantitative research are questionnaires and structured interviews.

### 3.2.2 Exploratory research

Exploratory research enables insight and understanding of an issue. This study attempted to gain an understanding of how leadership development occurs in public sector health services and what role mentorship played in the process. Therefore, the spectrum of respondents that were selected comprised experienced and less experienced leaders, who may or may not have been exposed to mentorship. The aim, therefore, was to explore the success with which leaders implemented the essential leadership competencies in execution of their roles, and to identify the role that mentorship may have played. In the process, the opinions of leaders, who were not exposed to mentorship, was also elicited.

### 3.2.3 Descriptive research

According to Polit and Beck (2008:274), descriptive research falls under the category of non-experimental research, the purpose of which is to observe, describe and document different aspects of situations.

A descriptive study establishes the association between variables (Polit & Beck 2012:226). This study sought to verify the relationship between mentorship and leadership development that was identified in the literature review. The study ensured that an accurate description was given, of the experiences of leaders who were, or, who were not exposed to mentorship and whether or not this had a bearing on their leadership competencies. This complied with the principle of a descriptive study, which according to Polit and Beck (2008:275), “seeks to describe what exists in terms of frequency”.

Both the exploratory and descriptive studies in this research fell into the class of ex-post facto research, which meant obtaining the facts after an event has occurred. The objective of such a study was to understand the relationship between phenomena, which in this study was mentorship and leadership development (*Experimental, quasi experimental and ex post facto research* ([S.a.]).

However, according to Polit and Beck (2008:276), there may be difficulties experienced in inferring the causal relationship between variables, in this case mentorship and leadership development, because of lack of control. The authors go on to explain that other factors that may compromise interpretation of results are that the groups selected for the research may have other factors that influence them, such as individual personalities.

Nevertheless, in this study, the appropriate design that was identified was exploratory and descriptive, since it was more practical.

### 3.2.4 Survey

A survey is a descriptive study that utilises questionnaires or personal interviews to collect data from an identified population (Burns & Grove 2009:245). Polit and Beck (2008:767), on the other hand, state that a "survey obtains information regarding prevalence, distribution and interrelationships of variables within a population." The authors expand on this definition to explain that a survey is based on self reports, where respondents answer questions through personal interviews or self administered questionnaires. The last mentioned method of data collection was used in this study.

Some researchers consider surveys to be shallow in that they do not add to the depth of scientific knowledge (Burns & Grove 2009:245). Polit and Beck (2006:241), however, rate surveys as highly flexible, applicable to many populations and emphasise the fact that surveys can focus on a wide range of topics. The authors, however, also reinforce the fact that information collected tends to be superficial.

The reason that a survey was selected was to reach a population that was widely distributed geographically. Moreover, the information collected would add to an already existing body of knowledge on the relationship of mentorship and leadership

development, and contribute to ideas on practical ways for implementation of mentorship in health institutions in the public sector.

## 3.3 QUANTITATIVE RESEARCH APPROACH

This section expands on the concepts in quantitative research that were introduced in chapter 1. It also indicates how these concepts relate to the study that was undertaken.

### 3.3.1 Population

Polit and Beck (2008:337) refer to population as an aggregate of individuals that meet definite criteria. It is to this group that the results could be generalised. The population is divided into the target population, i.e. the specific group that the study is aimed at, and the accessible population, i.e. that which can be realistically reached.

The population selected for this study was the managers in the Departments of Health in the Gauteng and Northwest Provinces of South Africa. As the purpose of the study was to identify the effect of mentorship on health services leadership a heterogeneous group of personnel in leadership positions was selected. The reason for this was that personnel holding leadership positions come from a range of backgrounds. The criteria for selection were managers in the respective health departments who occupied posts from level 11 and above. This included managers of institutions such as hospitals and nursing colleges, district health services and specific directorates and sub-directorates in the selected departments of health. The total population in the provinces tends to vary. At the time of the study the total population was approximately 551. This was the estimated population as the data obtained on personnel from level 11 an upward was not accurate. For instance many staff members at level 11 do not hold management positions such as a physician who is head of a specialty. However, other physicians in managerial posts on the same level were selected for the study. The population of 551 comprised 397 personnel from the Gauteng Department of Health and 154 personnel from the Northwest Department of Health that were in management positions. These included managers in institutions, districts and directorates with the exception of staff in the offices of the Heads of Departments and the Member of the Executive Committee (MEC) for Health, i.e. the last two mentioned were not included in the study. This data was obtained from the human resources directorate in each province.

### 3.3.2 Sample versus census

A sample, as defined in chapter 1, is a portion of the population or a subset that compose the population (Polit & Beck 2008:339). However, in this study the census method was used for data collection.

"Census and sampling are methods of collecting data about the populace. For better governance, every government requires specific data and information about the populace to make programs and policies that match the needs and requirements of the population. Census refers to periodic collection of information from the entire population. It is a time consuming affair as it involves counting all heads and generating information about them. There are stark differences between census and sampling though both serve the purpose of providing data and information about a population. Regardless of how accurately a sample from a population may be generated there will always be a margin for error, whereas in the case of a census, the entire population is taken into account and as such, it is most accurate. It is obvious then that when a whole population is taken into account, data collection is by means of the census method, whereas when a small group that is representative of the entire population is used, it is called a sample." (*Difference between census and sampling* 2011). However, a census may be conducted on a delimited population and in this instance it was managers that were accessible by virtue of the fact that consent was obtained to conduct research in the relevant institution, district or directorate in two different provinces in South Africa.

From the population of public staff members employed at post level 11 and upward, the target population was health care personnel in the leadership positions from middle management upwards. In order to ensure that the collected data was as representative as possible of the target population, every personnel member employed in a management position, at post level 11 and upward of the consenting institutions, were approached to participate in the study. This approach conformed to the characteristics of a census, which is referred to as a study of every member of a given population (Gray 2009:220).

As soon as permission to conduct research was obtained from the Provincial Departments of Health in the two provinces that were part of this study, the Human

Resources Management Departments of the different health care institutions were contacted to obtain the names of managers in positions level 11 and upward. This information identified the level and the job title of personnel. The job titles gave an indication of the job description of the particular staff member. Thereafter institutional managers and managers of districts were contacted to obtain permission (Annexure $B_1$) to conduct research in their areas of control. Unfortunately, some Chief Executive Officers (CEOs) did not respond despite follow up communication. Once permission was obtained from the CEOs of institutions (Annexure $B_2$), their personal assistants or secretaries were requested to furnish the researcher with the names, job titles and contact details of managers from level 11 and upward. As the contact details of every management member, of the institutions that the researcher was granted permission to access was available, these managers then constituted the total accessible population, which amounted to 153 managers, 144 from Gauteng and 39 from the Northwest Province. In the Northwest Province consent was obtained from two out of four districts and two out of four chief directorates. In Gauteng Province consent was obtained from one out of three central hospitals, three districts (although one did not participate at all), three chief directorates and five regional and district hospitals

The identifying details of the institutions and districts have been blocked to protect the anonymity of participants in the research.

### 3.3.3 Data collection instrument

A questionnaire is a printed self report form designed to obtain written responses from subjects (Burns & Grove 2005:398). Polit and Beck (2008:414) state that a questionnaire is a "method of obtaining information from respondents through self administration of questions in a paper and pen format." This method of data collection was selected because it was easier to reach a large number of participants. The self administered questionnaire was developed based on the three-fold focus of this research viz. leadership competencies, mentorship and succession planning. The questionnaire was developed based on the literature review, and where existing questionnaires were identified with information that could be utilised, permission was obtained to use the questionnaires with modifications (Annexure C). A detailed description of the questionnaire is given later in this chapter.

Since this is a structured method of data collection, questions were specific with pre-designated responses. In keeping with the structured approach, the questionnaire comprised a fixed number of questions that had to be answered in a specific sequence. Although this type of data collection does not allow for qualification of responses it allowed the researcher to compute percentages in terms of levels of leadership competencies and the effect of mentorship on leadership.

#### *3.3.3.1 Advantages of questionnaires*

According to *Questionnaires* ([S.a.]), the following were described as advantages of a questionnaire:

- Standardised data that is gathered is easy to analyse.
- Data can be gathered from a large number of respondents in a relatively short period of time.
- It is possible to compare the results to similar studies that have been conducted.
- The anonymity allowed to respondents is likely to produce more honest answers.
- If online surveys are used they are relatively inexpensive.
- One person can administer the whole process if they have the necessary skills.

#### *3.3.3.2 Disadvantages of questionnaires*

The above article identified the following disadvantages of questionnaires:

- If questions are misinterpreted the responses may be inaccurate.
- The sample size has to be relatively large so that the responses can be used to represent the population.
- Response rates may be poor thus compromising the study.
- The whole process of designing, producing, distributing, and analysing the questionnaires may make them expensive and time consuming.
- The responses received may not be adequate to answer the research question and may need to be followed up by focus group interviews, which will then change the approach of the research to that of a mixed research.

There is the possibility that the researcher may not have considered all the possible responses to the questions posed and this may impact on the understanding of the issues being researched (Polit & Beck 2008:369).

#### *3.3.3.3 Developing the data collection instrument*

A number of literature sources were reviewed in terms of identifying examples of data collection instruments and three examples were identified as the most suitable for application in this study. All three instruments linked very closely to the researcher's understanding of mentorship and leadership based on the extensive literature review. Consideration was given to the likelihood that there would be health services leaders with wide experience and others with limited experience at leadership level. The researcher, therefore, developed questions that would be simple to understand and that were relevant to health services' management.

The questionnaire that was developed was a modification and selective combination of the American College for Healthcare Executives (*ACHE) Health Care Executive Competencies Assessment Tool* (2010), A Competency Assessment Tool for Leadership in Health Care Administration (Robbins, Bradley, Spicer & Mecklenburg 2001:188-200) and the *Department of Justice Leadership Competency Assessment Tool* (2010). Concepts that were identified in the literature review were included in the questionnaire.

The assessment tools identified above were all part of self assessment tools that could be used by leaders to identify their need for further development. As the focus of this study was leadership development, the researcher found that competencies and the associated skills that were identified in these assessment tools were consistent with the literature on leadership competencies, and with the researcher's own experience of the competencies that are demanded of leaders in health services in the public sector.

#### *3.3.3.4 Design of the questionnaire*

The questionnaire (Annexure D) comprised three sections. A covering letter (Annexure E) was attached before despatching to potential respondents. The covering letter and

the section for data collection were informed by common concepts indentified through the literature review and the work experience of the researcher.

- *Covering letter*

The researcher was introduced to the participant in the covering letter (Annexure E). The letter outlined the purpose of the study and introduced the format of the questionnaire. The principles of voluntary participation, informed consent, confidentiality and anonymity were reinforced.

- *Section 1 of the questionnaire*

Section 1 covered the biographical data and an overview of the respondent's position within the health services. The objective of obtaining this information was to gain a clearer understanding of the target population and what positions the respondents held.

- *Section 2 of the questionnaire*

This section sought to obtain information on the respondent's leadership competencies. The approach that was used was that the respondent was expected to do a self analysis.

- *Section 3 of the questionnaire*

Section 3 dealt with mentorship. It covered the respondent's personal experience of mentorship, knowledge of existing mentorship programmes and his/her opinion of the effect of mentorship programmes on the competence and confidence of leaders.

**Table 3.1 Design of questionnaire**

| **Sections** | **Questions : rationale and sources** |
|---|---|
| Section 1: Biographical Data | Questions 1.1 and 1.2 requested the respondent's gender and age.<br><br>Questions 1.3 to 1.5 sought information on position, experience and type of institution in which the |

| Sections | Questions : rationale and sources |
|---|---|
| | respondent worked.<br><br>The information obtained was used to describe the research sample. The researcher was also able to establish the relationship between experience and leadership competencies and the role of mentorship. |
| Section 2: Leadership Competencies – communication and relationship management | Questions 1.1 to 1.7 requested the respondent to analyse their skills in communication and relationship management.<br><br>As leaders in health services in the public sector constantly deal with internal and external stakeholders, communication is an inherent competence in the role of a leader. Success of leaders in lobbying for resources and in motivating teams to function effectively is highly dependent on competence in communication and relationship management. This is the personal observation and experience of the researcher.<br><br>However, the significance of this competence is supported by Bolden (2005:15) in which he speaks about communication, problem solving and people management This also links with leadership strategies as described by Boleman and Deal (1991) as quoted in *Concepts of leadership* ( 2010). |
| Section 2: Leadership Competencies – leadership skills and behaviour | Questions 2.1 to 2.9 elicited leadership skills and behaviour from the respondent.<br><br>Leadership competencies as mentioned earlier are as wide and as varied as there are authors on the topic. However, Goleman (1998:94) speaks to a leader needing strategic vision, Tornabeni (2001:4) describes customer service and delivery skills and Bondas (2005:17) describes a leader as a role model of a culture of excellence and one who ensures organisational management. |
| Section 2: Leadership Competencies – human resources planning | Questions 3.1 to 3.3 required respondents to analyse their skills in human resources planning.<br><br>Leaders in health services in the public sector are highly dependent on human resources to ensure service delivery. However, efficient use of human resources is linked to other resources, the objectives of the particular institution and on the ability of the leader to apply technology.<br><br>Bolden (2005:17) identifies people management and |

| Sections | Questions : rationale and sources |
|---|---|
| | technical skills as leadership competencies. |
| Section 2: Leadership Competencies – financial planning | Questions 4.1 to 4.5 expected the respondents to analyse their financial management skills in this section.<br><br>Service delivery in health institutions in the public sector is dependent on human resources and finances. As much as the public sector institutions are not profit driven, health services leaders are accountable for the finances allocated from government funding.<br><br>Goleman (1998:94) identifies accounting and business planning as leadership competencies. The researcher recognised that health services leaders needed skills in analysis of expenditure trends to manage and monitor budgets. |
| Section 2: Leadership Competencies – strategic planning | Questions 5.1 to 5.5 prompted the respondent to analyse his/her strategic planning skills. |
| Section 3: Mentorship | This section requested the respondents to give information on personal experience with mentorship, knowledge of mentorship programmes and opinions on the significance of mentorship.<br><br>All the literature reviewed pointed to the positive role of mentorship on leadership development.<br><br>The data collected assisted the researcher to relate this information to the literature on the subject. It also provided the researcher with the rationale for developing practical guidelines for mentorship that could be used in public sector heath institutions in South Africa. |

#### *3.3.3.5 Validity and reliability*

The instrument used to collect data needs to be valid and reliable so that the data collected is credible and will be subject to scientific scrutiny.

- **Validity**

Whilst validity, as mentioned earlier, refers to the degree to which an instrument measures what it is supposed to measure, it contributes to appropriate interpretation of

the data collected (Polit & Beck 2008:768). Burns and Grove (2005:380) state that "the validity of an instrument determines the extent to which it actually reflects the abstract construct being examined." The aspects of validity are face validity, content validity and construct validity. In this study, the first two aspects of validity are discussed, as ascertaining construct validity was not possible within the time frame available.

- *Face validity*

Face validity refers to whether an instrument "looks as though it is measuring the appropriate construct" (Polit & Beck. 2008:458). This is regarded as one of the ways of ensuring that respondents are willing to complete the instrument. However, according to Burns and Grove (2005:381), while face validity is important, it is more appropriate to look at content validity.

Face validity was achieved by compiling the questionnaire and obtaining the opinion of colleagues and more specifically, the supervisors of this study.

- *Content validity*

Content validity examines whether all elements that are relevant to the construct are being measured. Content validity is initiated from the commencement of development of the instrument, when what is measured is determined.

In this study content validity was ensured based on the extensive literature review and by acquiring the views of experts, in the form of review by the researcher's supervisor and co-supervisor.

Burns and Grove (2005:380) explain that the validity of the instrument is a "reflection" of how thorough the researcher is. However, they do acknowledge that validity is assessed in degrees and may vary in different situations.

In this study, the questionnaire was developed through the literature review and then submitted to the supervisors of the researcher to evaluate the individual items.

- **Reliability**

Reliability as discussed in chapter 1 refers to the degree to which the instrument consistently measures what it is intended to measure (Burns & Grove 2005:377). According to these authors, an instrument is reliable if it elicits the same response from an individual, when administered at different times. Reliability is also established if the instrument is administered by different data collectors, using the same sample, and the results that are obtained are comparable. It is apparent that a reliable instrument lends credence to a study. Therefore, testing of the instrument was crucial. In this study the reliability and validity of the instrument was established through reviewing the instrument with experts, who in this case were the supervisors of the study, and by administering the instrument to a group of respondents from the sample as part of the pre-test.

Reliability testing of the instrument was done statistically on the pre-test data to determine the reliability coefficient. According to Burns and Grove (2005:377) a reliability coefficient of 1.00 is a reflection of perfect reliability. Reliability testing according to Burns and Grove (2005:379) focuses on stability, homogeneity and equivalence.

**Stability** refers to the fact that the factor to be measured remains the same for subsequent tests. Stability was tested in this study.

**Equivalence** refers to two versions of the instrument or a comparison of two data collectors using the same instrument and the same sample. This is referred to as “interrater reliability” (Burns & Grove 2005:378). Equivalence was not established in this study.

**Homogeneity** refers to the “correlation” of the items in the instrument. It examines the extent to which all items in the instrument measure a construct consistently. This is a test for internal consistency. This was done statistically in this study and the services of a statistician were used.

#### *3.3.3.6 Pre-testing of the questionnaire*

Pre-testing is the collection of data before the actual test, and is used to test the instrument developed as well as work out time frames required for the test (Burns & Grove 2005:377).

Pre-testing of the instrument was initially done by obtaining expert opinion in the form of the researcher's supervisors.

The sample that was selected for the pre-test was from a health institution in close proximity to the researcher as well as two directorates in the Provincial Department of Health in the same province.

A total of thirty seven questionnaires were despatched and seventeen respondents returned completed questionnaires.

The group selected for pre-testing was not part of the main survey. The respondents that returned the questionnaires did not have any specific comments. However, generally it was identified that skills of managers improved over a period of time in the post.

The analysis of the data collected for the pre-test confirmed the reliability of the instrument.

### 3.3.4 Acquiring permission

An application was made to the ethics committee of the University of South Africa to obtain ethical clearance (Annexure F and G). Thereafter, letters were written to the policy and planning directorates of the Gauteng and Northwest Provinces' Departments of Health and Social Development, requesting permission (Annexure $A_3$ and $A_4$) to conduct research within the respective provinces. Responses were positive (Annexure $A_1$, and $A_2$). Furthermore, within each province permission was obtained from each CEO, District Manager or Chief Director of institutions, directorates and districts before accessing the managers within these clusters (Annexure $B_1$ & $B_2$).

### 3.3.5 Data collection

Data collection refers to the "gathering of information to address a research problem" (Polit & Beck 2008:371).

After obtaining the authorisation from the respective research committees of the provinces and the relevant accounting officers of districts, directorates and institutions in each of the provinces selected for the study, the instrument was despatched to 153 managers via e-mail or fax. The institution and directorates that were part of the pre-test were excluded. These managers were identified by their job titles submitted by the relevant institutions. The job titles confirmed whether the staff member was in a management position or not.

A covering letter was sent with the self administered questionnaire. (Annexure E). The purpose was to introduce the researcher to the respondents and assure them of confidentiality and anonymity. The research instrument did not make any provision for the respondent's name, effectively ensuring anonymity. The process of ensuring confidentiality and anonymity is elaborated on, under ethical principles.

Some intuitions and districts in both provinces did not respond despite numerous follow ups. For the respondents selected, the majority responded after a second or a third reminder or a phone call. The challenge of the overwhelming work pressures were inevitably cited as a reason for delayed responses. It was also interesting to note that health services leaders, in professions other than nursing assumed that the research was targeted at nurse leaders only. The researcher had to reinforce the fact the all health care professionals were intended to be part of the study. These included managers of clinical and non-clinical departments such as human resources departments.

### 3.3.6 Data analysis

Data analysis is the "systematic organisation and synthesis of research data." (Polit & Beck 2008:415).

Statistical analysis was used to describe the data collected and identify the outcome of the study. The data will be presented in tabular and graphical form in chapter 4. The services of a statistician were enlisted to carry out detailed statistical analysis of the data collected.

### 3.3.7 Ethical principles

Ethics deals with a code of practice that spells out what is the right thing to do. The following are the ethical principles in research.

- **The principle of beneficence**

This is the basic ethical principle in research involving people in which the researcher commits to doing no harm. Beneficence comprises the following two dimensions:

- *Freedom from harm*

This encompasses protection of respondents from all types of harm i.e. physical and psychological. If at any time during a study a researcher identifies that participants are being injured the researcher is obligated to terminate the study immediately (Burns & Grove 2005:190).

- *Freedom from exploitation*

Participants in a research project need to know that the information provided will not be used against them (Burns & Grove 2005:190).

In this study the principle of beneficence was upheld by assuring the respondents of their anonymity in the study, and that none of the information provided would be traced back to them. Findings of the research will be made available to respondents who request the information' by making copies of the final research available to the relevant departments of health. Respondents will have the option of utilising the recommendations of the research as part of leadership development programmes.

- **The principle of respect for human dignity**

This principle includes the right to self determination and self disclosure as discussed hereunder.

- *Right to self determination*

This involves recognising the fact that participants are independent people who control their own activities. As such they have the choice of participating voluntarily in research and should be protected from any form of coercion (Burns & Grove 2005:188).

- *Right to self disclosure*

It is the participants right to have full knowledge of the nature of the research. In this way, the participant has the necessary information to make an informed decision before giving consent to participate (Burns & Grove 2005:188).

In this study, participants were given an information letter that explained the nature of the research. Hence, participation in the research was regarded as consent and participants responded voluntarily. Participants had the option of withdrawing at any time during the research. At least three participants telephoned and indicated that they withdrew due to commitments.

- **The principle of justice**

The principle of justice involves the right to fair treatment and the right to privacy.

- *Right to fair treatment*

The right to fair treatment includes, among others, the fair selection of participants. Participants should be selected according to research principles and not for the convenience of the researcher or because the researcher favours a particular group of participants. Those participants that decline to participate or withdraw should not be prejudiced in any way (Burns & Grove 2005:190).

- *Right to privacy*

This covers confidentiality and anonymity, i.e. participants have a right to expect that information shared with the researcher is kept in the strictest confidence and that the information is not traceable to them (Burns & Grove 2005:190).

The researcher in this study assured participants of the confidentiality by ensuring that the research instruments did not have identification on them. The linkage to e-mail addresses was not included in the instrument that respondents had to complete. A commitment was made to omit names of participants in the research instrument and the final research report. A copy of the findings was to be made available to the participating institutions. Respondents were also assured that all data collected would only be available to the researcher and the researcher's supervisor.

- **Informed consent**

Informed consent means that the participants have enough information to make a well thought out decision to participate in the research. Information that participants need is the purpose of the research, for what purpose the data provided will be used, the fact that their privacy will be ensured and that they have a right to withdraw from the study.

In this study, the participants were given information in the form of a "Participant Information Letter" (Annexure E). They did not have to sign consent but were informed that participation in the study was accepted as consent. At least three contacts responded to say that they would rather not participate in the study.

## 3.4 CONCLUSION

This chapter dealt with the research design in depth. As this was a quantitative study using an exploratory and descriptive approach, these approaches were discussed as it applied to this study.

The concepts of population, sample versus a census, and data collection were further expounded. The data collection instrument, which was a questionnaire, was discussed in depth. The advantages and disadvantages of a questionnaire were reviewed and thereafter the process of developing the questionnaire was explained.

The concepts of validity and reliability were discussed as it applied to the study, and the process of testing the validity and reliability of the research instrument was discussed. This involved explaining how the pre-test was conducted.

The rigor of the scientific process was established by following the principles involved in conducting quantitative research through a survey.

Chapter 4 will expand on the analysis of the data collected in the pre-test and test samples.

# CHAPTER 4

# Reporting of research findings

## 4.1 INTRODUCTION

The purpose of this research project was to identify the relationship between mentorship and leadership in health services. In order to draw a conclusion it was essential to identify people in leadership positions that would become the target population for the study. This study was confined to the public health sector in two provinces of South Africa. Data was obtained from health services managers in leadership positions in two Provincial Departments of Health.

Self-administered questionnaires were sent out to health services managers in posts from level 11 (Deputy Director) and upwards. This chapter will explain the data analysis methods and thereafter cover the analysis of the data, the findings and the interpretation of the data obtained.

## 4.2 ANALYSIS OF DATA

One hundred and fifty three questionnaires were distributed to the total target population in an attempt to do a census. However, 46 questionnaires were completed and returned, giving a response rate of 30%. Despite repeated telephonic and e-mail reminders (a minimum of three times) sent out over a period of 11 months, the response remained poor. The pressure of work was cited on more than one occasion as the reason for none or poor response. This limited the sample size which could have prejudiced the results.

The reliability of the questionnaire was determined using the Cronbach's Coefficient Alpha test. The Cronbach's Coefficient Alpha is used to measure internal consistency or reliability of an instrument. The alpha coefficient ranges from 0 to 1 and a reliability score of 0.70 or higher validates the reliability of an instrument. These concepts are

explained by Choudry (2010). In the analysis of leadership competencies the alpha coefficient ranged from 0.86 to 0.93, thereby reinforcing the reliability of the instrument.

The statistical analysis method that was used was the Analysis of Variance (ANOVA). ANOVA comprises statistical procedures that compare group means by analysing the comparison of variance estimates. In these procedures the observed variance of a particular variable is divided into components. According to Plonksy (2012), two independent estimates of the population variance can be obtained from the sample data and a ratio is formed. One is sensitive to treatment effect and error between group estimates and the other to error within group estimates. The ANOVA procedures test the difference between two or more means and examine the ratio variability between two conditions and the variability within each condition as explained by Arsham (2011).

In this study the Analysis of Variance was applied to the data collected from respondents that related to self analysis of leadership competencies over a period of time. Hence a comparison was made between the data that was submitted by respondents for the first year in office and the current year.

Descriptive data in the form of frequencies and percentages were generated which are presented in tables, pie graphs and bar charts. Percentages were rounded off to two decimal points.

The information was further subject to a paired t-test to determine the significance of the findings. This will be further elaborated on under the relevant section.

The completed questionnaires were submitted to a statistician at the Data Management Services of South Africa (DMSA) for the purpose of data processing and analysis. The questionnaire consisted of the following three sections:

- Section 1: Biographical information.
- Section 2: A comparative self assessment of leadership competencies over a period of two or more years.
- Section 3: Respondents' perspective on mentorship for leadership development.

The results will be presented in accordance with these three sections and subsections.

## 4.3 RESULTS

The results will now be presented based on the data accumulated by means of a questionnaire.

### 4.3.1 Biographical information

The biographical information accumulated dealt with gender and age. In order to obtain more information on the profiles of the respondents this section expected respondents to indicate the current positions they held, the number of years in the current positions and the employing institution.

#### *4.3.1.1 Gender*

Of the 46 completed questionnaires that were returned 17 (37.77%) were males and 28 (62.22%) females. One respondent omitted to answer this question.

Leadership positions in the public health sector are occupied by a range of health care professionals. This study did not determine the professional qualification of the respondents. However, one of the largest groups of health care professionals is nurses. According to South African Nursing Council (2010) "Statistics on the Geographical Distribution of Nurses per Population per Province", it is evident that nursing is still a female dominated profession with a total of 107,029 (92.9%) out of 115,244 registered professional nurses being female (SANC 2010:1). Of the 162,261 health professional registered with the Health Professionals Council of South Africa (HPCSA) (2011), as at December 2011, 43,712 were medical and dental practitioners. Of the total number of health professionals registered with the Health Professionals Council of South Africa, 85,485 (52.68%) were female and 76,776 (47.32%) were male (Daffue 2012). These two councils were selected to review the gender representation because nurses, physicians and allied health workers constitute the largest number of health practitioners.

From the data acquired for this study, it is evident that more than a third of the respondents were males, illustrating that men feature strongly in senior management

positions in the public health service. This may be attributed to the fact that historically, leadership positions were dominated by males, but with the implementation of the Employment Equity Act, more females have aspired to leadership positions, therefore almost two-thirds (28; 62.22%) of the respondents were female. However, the distribution of females in senior management positions does not appear to be consistent with their distribution within the professions.

It was important to determine the gender of respondents as it is a well known fact that leadership styles differ between males and females and this could affect their mentorship roles and skills. The perception of differences between males and females impacts on the success of males rather than females succeeding in managerial positions as discussed by Puliaeva (2002). However, Eagly and Carli (2003:807-834), discuss in detail their meta analysis of a range of published and unpublished works in which leadership styles of women were found to be transformational and inclined toward the reward component of transactional leadership while men tended to demonstrate transactional leadership inclining toward authoritarian leadership. Hence the type of leadership demonstrated by females is consistent with currently accepted leadership styles. However, through data captured by a Multifactor Leadership Questionnaire (MLQ) in 45 studies, Eagly and Carli (2003:807-834), concluded that the prejudice toward women tends to label women as communal (demonstrating warmth and selflessness) while men were seen as agentic (assertive and instrumental). The latter is perceived as being consistent with success and management skills. This placed women in management positions, in a situation of being doubted and held to higher standards of competence. As much as these differences were not the focus of this study, it could shed light on the disproportionately high distribution of males in leadership positions in the public health sector.

#### *4.3.1.2 Age*

As posts level 11 and upward are considered to be middle to senior management, it was important to establish the age of respondents, as this would link to their experience in the health care sector, whether at operational or management positions. Table 4.1 illustrates the age distribution of respondents.

**Table 4.1 Age distribution of respondents (n=46)**

| Age | n | % | Cumulative n | Cumulative % |
|---|---|---|---|---|
| **<30 years** | 2 | 4.35 | 2 | 4.35 |
| **31-40 years** | 5 | 10.87 | 7 | 15.22 |
| **41-50 years** | 18 | 39.13 | 25 | 54.35 |
| **51-60 years** | 17 | 36.96 | 42 | 91.30 |
| **> 60 years** | 4 | 8.70 | 46 | 100.00 |

The majority of the respondents (35; 76%) fell in the age group of 41-60 years. Only two (4.34%) respondents were less than 30 years and four (8.69%) were above 60.

The greater majority of respondents were in the middle adult years, which implies that most incumbents would have worked for between 15 to 20 years before getting into middle or senior management positions. This would possibly bring experience in the health sector, but not necessarily experience in leadership, to the post currently occupied. If one compares this to the number years in the current position one will note that although 39 of the respondents were above 41years old, only 18 were in their posts for longer than six years.

#### *4.3.1.3 Current position*

The significance of establishing the current positions of the respondents was to elicit information on leadership competencies from real life experiences rather than opinions or knowledge gleaned from literature.

Table 4.2 illustrates the number of respondents in each of the positions.

**Table 4.2 Positions held by respondents (n=43)**

| Current position | N | % | Cumulative n | Cumulative % |
|---|---|---|---|---|
| **Chief Director** | 0 | 0 | 0 | 0 |
| **Director** | 14 | 32.56 | 14 | 32.56 |
| **Deputy Director** | 29 | 67.44 | 43 | 100.00 |

Fourteen (32.56%) Directors and 29 (67.44%) Deputy Directors responded. Three respondents omitted this question or filled in an additional response not covered in the questionnaire. No Chief Directors responded. This could be attributed to the fact that they had given permission to conduct the study in their institutions or regions and therefore did not find it appropriate to participate.

#### *4.3.1.4 Number of years in current position*

The respondents were required to indicate how long they had been occupying the current position. This was important to establish as it would give the researcher an idea of their management experience.

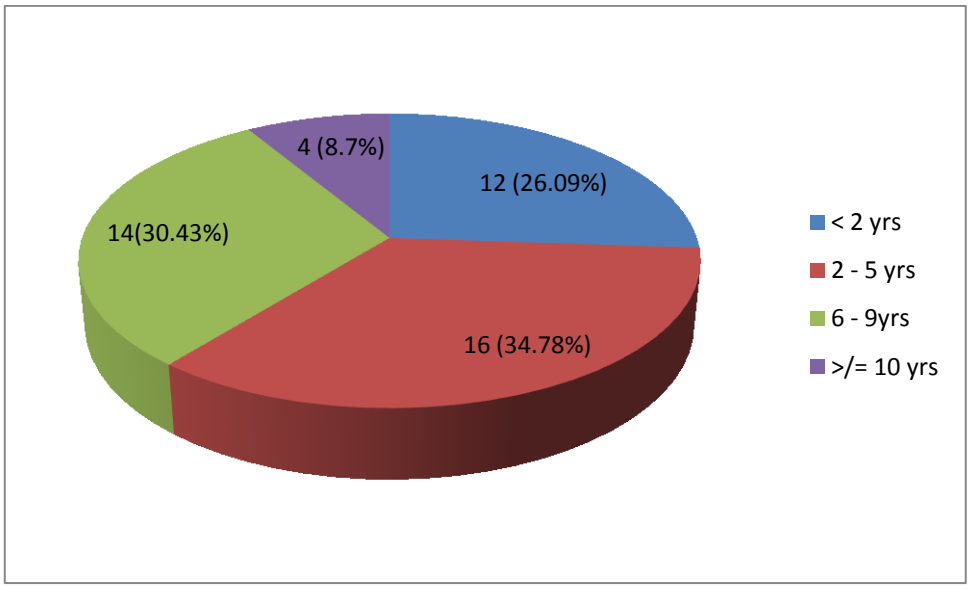



**Figure 4.1 Number of years in current position (n=46)**

Twelve (26.09%) respondents have been employed in their current positions for less than two years, 16 (34.78%) for between two and five years, 14 (30.43%) for six to nine years and four (8.7%) respondents have been functioning in their current position for more than 10 years. It is therefore apparent that the majority (34; 73.91%) of the respondents have two or more years experience in their current positions. It can therefore be deduced that the information proffered by respondents is a reflection of the leadership and management situation in their specific health care sectors at the time of the study.

It is noted that all respondents indicated the number of years in the current position, even though three (6.52%) did not identify their positions in the previous question.

#### *4.3.1.5 Employing institution*

In order to complete the profile of the respondents, they were requested to indicate the type of public sector institution they were employed in.

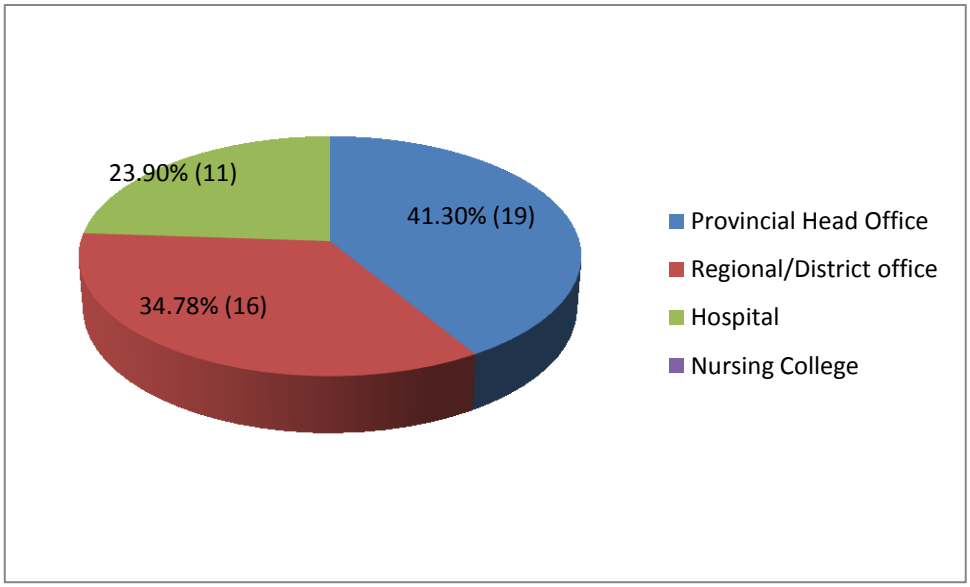



**Figure 4.2 Institutions that health services managers were employed in (n=46)**

Nineteen (41.30%) respondents were from the Provincial Head office, 16 (34.78%) were from regional or district offices and 11 (23.90%) were from hospitals. No respondents were from the nursing colleges as the colleges in one province formed part of the pre-test sample. The directorate, to which the colleges reported in the other province, did not give the necessary permission to conduct the research.

### 4.3.2 Self analysis of leadership competencies

Respondents were asked to assess themselves on leadership competencies over a period of time. They were asked to rate themselves as *"novice, competent or expert"* in terms of leadership competencies on assumption of their posts i.e. in the first year of occupying their management position, and to assess themselves again on the same competency at the present time. Those that were in their positions for less than two

years were not expected to answer the second portion of these questions. Forty five respondents answered this section. The five main leadership competencies that were assessed are:

- *Communication and relationship management*
- *Leadership skills and behaviour*
- *Human resources (HR) planning*
- *Financial planning*
- *Strategic planning*

In the statistical analysis of the data for the above noted five sections of the questionnaire, the ratings of 1, 2 and 3 allocated to the response alternatives "*novice", "competent*" and "*expert*" respectively was converted to percentages as a means of quantifying the responses:

- *Novice*: 0%
- *Competent*: 50%
- *Expert*: 100%

The conversion to percentages was a linear transformation of the ratings of one to three as listed on the questionnaire. Calculations on the percentages allowed for better clarity of the outcome of the analysis as compared to working with a proportion of three. This was the recommendation of the statistician at the Data Management Services of South Africa.

The average for each competency was assessed for the first year in the post and again in the current year. Each of competencies were analysed in terms of the respondents' self assessment as far as the relevant skills are concerned. The average rating for each skill was calculated using the means procedure, i.e. the sum of all the scores of the respondents was divided by the number of respondents (Polit & Beck 2012:386). For example in question 9, which is *Build collaborative relations*, there were 45 respondents (n=45) and the total score for this skill was 2000 i.e. *novice* (10 x 0), *competent* (30 x 50) and *expert* (5x100) in the first year in the post. Therefore the mean for this skill in the first year in the post was 44.44%. The overall mean for the competency was

calculated by dividing the sum of the means of the skills by the number of skills in the competency.

#### *4.3.2.1 Comparison of self assessment ratings of respondents in the current year in the position to that of the first year*

Frequency ratings of all the skills under each of the competencies in the first year and the current year were calculated. Thereafter the averages obtained for each competence in the three rating categories will be discussed.

##### *4.3.2.1.1 Communication and relationship management*

Assessment of communication was significant to this study as most of the other leadership competencies are dependent on effective communication. The American College for Health Care Executives, defines this competence related to leadership as "the ability to communicate clearly and concisely with internal and external customers, to establish and maintain relationships, and to facilitate constructive interactions with individuals and groups" *ACHE Health Care Executive ...* (2010).

Table 4.3 illustrates the frequency of ratings for each skill under *communication and relationship management*. Not all the respondents provided all the information for the two assessment periods, resulting in the n-value varying between 42 and 45.

**Table 4.3 Comparison of frequency ratings of *communication and relationship management* over time (n=45)**

| Communication and relationship management | | Year 1 | | Current year | |
|---|---|---|---|---|---|
| | | n | % | n | % |
| Build collaborative relations | Novice | 10 | 22.22 | 2 | 4.76 |
| | Competent | 30 | 66.67 | 21 | 50.00 |
| | Expert | 5 | 11.11 | 19 | 45.24 |
| Identify stakeholder expectations | Novice | 9 | 20.00 | 0 | 0.00 |
| | Competent | 31 | 68.89 | 20 | 46.51 |
| | Expert | 5 | 11.11 | 23 | 53.49 |
| Practice shared decision-making | Novice | 5 | 11.11 | 0 | 0.00 |
| | Competent | 32 | 71.11 | 14 | 32.56 |
| | Expert | 8 | 17.78 | 29 | 67.44 |
| Communicate and model the vision of the institution | Novice | 10 | 22.22 | 0 | 0.00 |
| | Competent | 28 | 62.22 | 23 | 54.76 |
| | Expert | 7 | 15.60 | 19 | 45.24 |
| Foster an inclusive workplace that manages diversity and individual differences to achieve the vision of the institution | Novice | 10 | 22.73 | 4 | 9.52 |
| | Competent | 26 | 59.09 | 18 | 42.86 |
| | Expert | 8 | 18.18 | 20 | 47.62 |
| Provide results of data analysis to senior staff | Novice | 10 | 22.22 | 2 | 4.76 |
| | Competent | 29 | 64.44 | 24 | 57.14 |
| | Expert | 6 | 13.33 | 16 | 38.10 |
| Use mediation, negotiation and conflict resolution to maintain labour peace | Novice | 11 | 24.44 | 5 | 11.90 |
| | Competent | 26 | 57.78 | 22 | 52.38 |
| | Expert | 8 | 17.78 | 15 | 35.71 |

From table 4.3 it is clear that between 20 and 22.44 percent of the respondents considered themselves as novices in six of the listed skills in the first year of assumption of the position. *Shared decision-making* was the only skill in which respondents considered themselves to be *competent* (32; 71.11%) or *expert* (8; 17.78%), at the time of taking office as a manager.

The average for each of the skills under *communication and relationship management* were calculated and it is apparent that there was a general improvement of 25% in the skills over a period of time demonstrating a shift from *novice* to *expert* level. This is illustrated in figure 4.3.

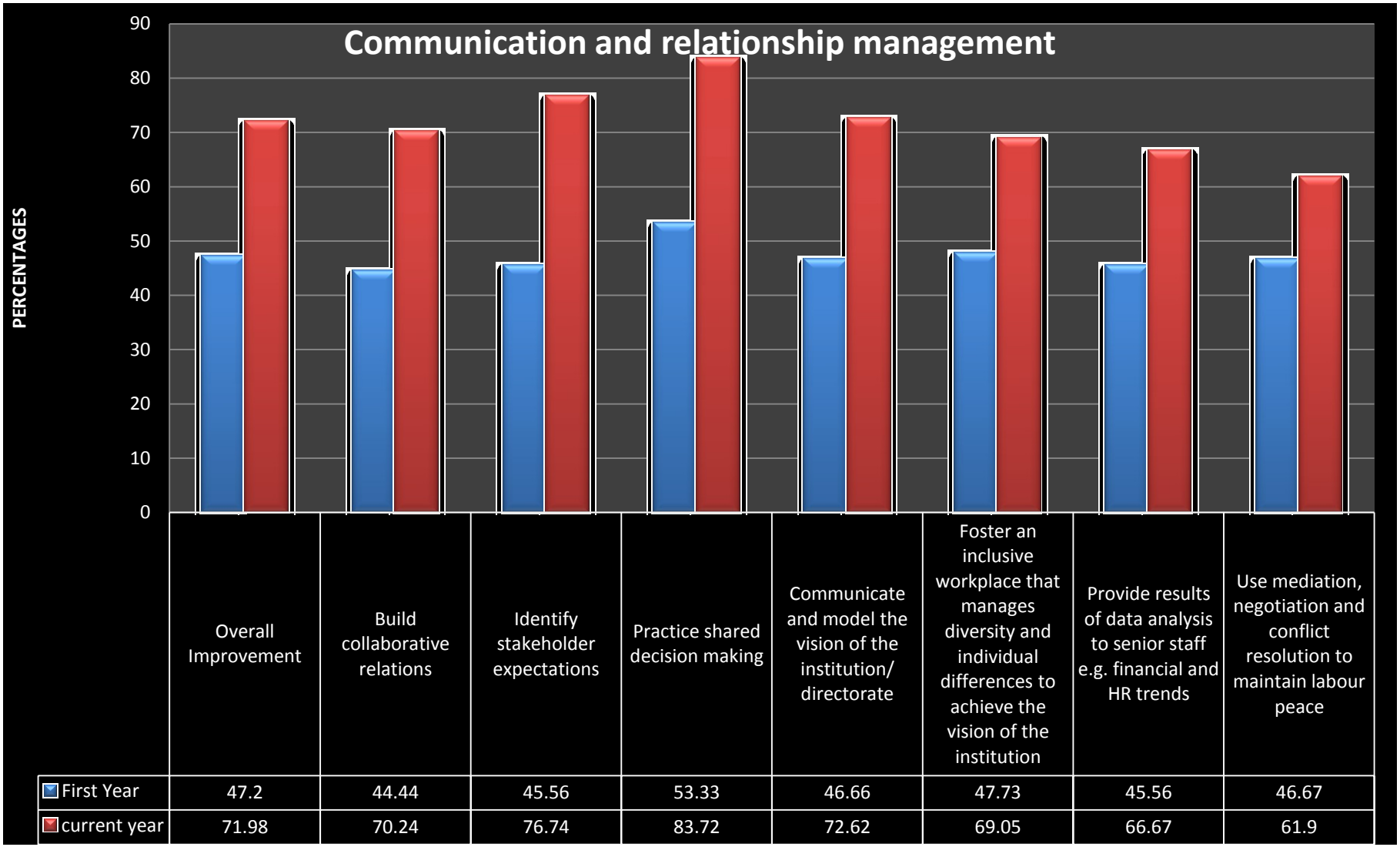



**Figure 4.3 Comparative analyses of the average ratings for skills improvement in *communication and relationship management* (n=45)**

Substantial progress was made in acquiring more advanced competency in the following skills: *identifying stakeholder expectations* (31.18%), *practising shared decision-making* (30.40%) *communicating and modelling the vision of the institution/directorate* (26.00%), *building collaborative relationships* (26.00%), *fostering an inclusive workplace that manages diversity and accepts individual differences* (21.32%), *provide results of analysis to senior staff* (21.11%) and *using mediation and negotiation and conflict resolution to manage labour peace* (15.23%). The question arises, whether this improvement was solely gained through acquiring experience or were there other facilitating factors which cultivated the different skills?

A health services leader has to lead health care workers who are highly trained and experts in their own area. Therefore if a manager, e.g. a hospital CEO wishes to be successful, he or she will need to use participative leadership (Rubino 2006:10). This is supported by the ratings of respondents on the skill of *practising shared decision-making* which reflected an improvement of 30.40%. Roussel (2009:204) explains that in implementing participative management, the interpersonal and conceptual skills that are demanded of managers inevitably increase. This could explain the general improvement in all the listed skills discussed above. In addition to this, the health care environment is dynamic, i.e. there are challenges to be met, such as targets for the millennium development goals and on the other hand there is a host of legislation that controls corporate functions within the heath care services. As skills and behaviours can be learned (Rubino 2006:18), it is assumed that health services managers would have been exposed to practical learning opportunities and formal and informal developmental programmes whilst in office.

#### *4.3.2.1.2 Leadership skills and behaviour*

*Leadership skills and behaviour* is core to leadership positions. However, measurement of such a competence is not possible without identifying the specific skills that make up this competence. As mentioned in chapter 2 (2.4), the definitions of leadership are varied. However, the feature that stands out is the ability to influence others with a positive impact on the organisation. Table 4.4 illustrates the frequency ratings of nine skills pertaining to *leadership skills and behaviour*. Not all the respondents provided all the information for the two assessment periods, resulting in the n-value varying between 43 and 45.

**Table 4.4 Comparison of frequency ratings of *leadership skills and behaviour* over time (n=45)**

| Leadership skills and behaviour | | Year 1 | | Current year | |
|---|---|---|---|---|---|
| | | n | % | n | % |
| Develop a strategy to achieve vision and mission | Novice | 12 | 26.67 | 0 | 0.00 |
| | Competent | 26 | 57.78 | 26 | 59.09 |
| | Expert | 7 | 15.56 | 18 | 40.91 |
| Apply legal and regulatory standards | Novice | 13 | 28.89 | 4 | 9.09 |
| | Competent | 24 | 53.33 | 23 | 52.27 |
| | Expert | 8 | 17.78 | 17 | 38.64 |
| Foster an environment of trust | Novice | 8 | 17.78 | 3 | 6.82 |
| | Competent | 28 | 62.22 | 26 | 59.09 |
| | Expert | 9 | 20.00 | 15 | 34.09 |
| Advocate for and participate in health care policy initiatives | Novice | 17 | 37.78 | 5 | 11.36 |
| | Competent | 25 | 55.56 | 24 | 54.55 |
| | Expert | 3 | 6.67 | 15 | 34.09 |
| Create an organisational climate that encourages team work | Novice | 4 | 9.09 | 0 | 0.00 |
| | Competent | 29 | 65.91 | 21 | 48.84 |
| | Expert | 11 | 25.00 | 22 | 51.16 |
| Encourage high level commitment to the purpose and value of the institution | Novice | 9 | 20.00 | 2 | 4.55 |
| | Competent | 23 | 51.11 | 22 | 50.00 |
| | Expert | 13 | 28.89 | 20 | 45.45 |
| Promote and manage change | Novice | 11 | 24.44 | 0 | 0.00 |
| | Competent | 23 | 51.11 | 26 | 59.09 |
| | Expert | 11 | 24.44 | 18 | 40.91 |
| Promote continuous organisational growth | Novice | 9 | 20.00 | 0 | 0.00 |
| | Competent | 25 | 55.56 | 22 | 50 |
| | Expert | 11 | 24.44 | 22 | 50 |
| Plan strategy for overcoming obstacles | Novice | 13 | 28.89 | 1 | 2.27 |
| | Competent | 23 | 51.11 | 26 | 59.09 |
| | Expert | 9 | 20.00 | 17 | 38.64 |

The above table demonstrates an improvement in the nine listed leadership skills over the two periods of assessment indicating the positive influence of experience on the respondents' competence. This improvement is clearly illustrated in figure 4.4 when the means of the listed skills and the leadership competency are calculated. Table 4.4 shows that over 50% (n=45) of the respondents rated themselves as *competent* in the leadership skills listed in the first year of assumption of the position. However, in the current year of assessment there is an average increase of about 25% (n=45) in the rating of *expert* level. The demand for optimal performance in health care services could be a motivating factor for this trend. Sinioris (2010:1) states that "leadership is the single most important driver of overall organisational performance". This author also explains that the complexity and dynamism of health care services demands effective leadership. Health services managers are faced with severe pressures to deliver cost effective quality care. Health services are changing continuously in terms of the burden of disease. Resources to manage the changes are limited and these, among other factors, impacts on the success or failure of leaders in the health sector.

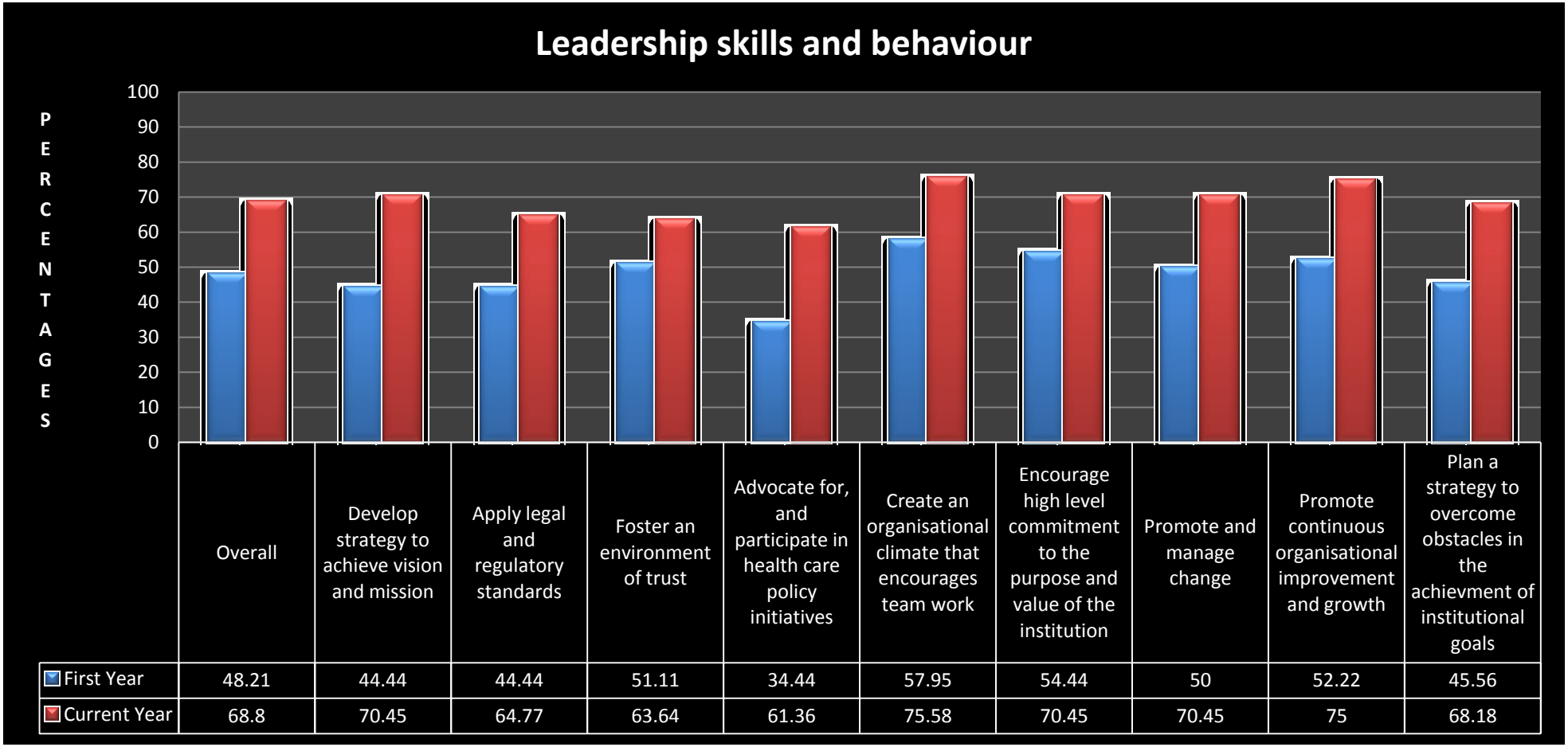



**Figure 4.4 Comparative analysis of the means of *leadership skills and behaviour* over time (n=45)**

From the above illustration it is evident that respondents developed from an average rating of *novice or competent* in each of the items to near *expert* resulting in a 20.59% overall improvement in *leadership skills and behaviour* competence.

The percentage increase for each of the nine listed skills under *leadership skills and behaviour* are as follows:

- *Develop a strategy to achieve vision and mission*: 26.01%
- *Apply legal and regulatory standards*: 20.33%
- *Foster an environment of trust*: 12.53%
- *Create an organisational culture that encourages team work*: 17.63%
- *Advocate for and participate in health policy initiatives*: 26.92%
- *Encourage an increased level of commitment to the purpose and value of the institution:* 16.01%
- *Promote and manage change:* 21.00%
- *Promote continuous organisational improvement and growth*: 23.00%
- *Plan a strategy for overcoming obstacles to the institutional goals*: 23.00%

From the above it is clear that the greatest improvement is in the skill of *advocate for and participate in policy initiatives* (26.92%) followed by *developing a strategy to achieve the vision and mission* (26.10%). This could be explained by the fact that the mission of an organisation describes the purpose for which an organisation exists. All health institutions are expected to develop strategic plans which are congruent with the strategic plan of the National Department of Health in South Africa. This has been the experience of the researcher in the health institutions worked in. Roussel (2009:290) explains that "articulation of a mission statement" is key to strategic planning. Hence constant practice in the skill of developing a strategy to achieve vision and mission could explain this level of improvement.

The skill of *fostering an environment of trust* shows the lowest rate of improvement (12.53%) followed by *encourage a high level of commitment to the purpose and value of the institution* (16.01%) and *create an organisational climate that encourages team work* (17.63%). Leadership skills can be technical or behavioural. The skill of *fostering an environment of trust* is a behavioural skill requiring interpersonal influence and

control (Moe, Pappos & Murray 2007:12). This is perhaps an indication that fostering an environment of trust requires mentorship as an approach to leadership development.

*4.3.2.1.3 Human resources (HR) planning*

Health services leaders, inevitably have to manage teams that are either responsible for programmes or the management of institutions. Roussel (2009:335), states that staffing or *human resources planning* is one of the priorities in delivering health care and Contino (2004:4) quotes Kouzes and Posner (1999) in stating that "genuine caring for people is at the heart of effective leadership". In this discussion the author referred to involvement of staff in training for leadership and training is integrated in human resource planning Knowledge of *human resources planning* impacts on the effectiveness of operations as health services delivery is dependent on human resources. Table 4.5 portrays the frequency ratings for the specific HR skills. The 45 respondents who answered this section all responded to the three listed skills.

**Table 4.5 Comparison of frequency ratings of *human resources planning* over time (n=45)**

| **Human resources (HR) planning** | | **Year 1** | | **Current year** | |
|---|---|---|---|---|---|
| | | **n** | **%** | **n** | **%** |
| Build and manage HR and work situations based on institutional goals, budget and staffing needs | Novice | 13 | 28.89 | 4 | 9.30 |
| | Competent | 27 | 60.00 | 21 | 48.84 |
| | Expert | 5 | 11.11 | 18 | 41.86 |
| Assess current and future HR needs based on institutional goals, budget and staffing needs | Novice | 11 | 24.44 | 5 | 11.63 |
| | Competent | 27 | 60.00 | 16 | 37.21 |
| | Expert | 7 | 15.56 | 22 | 51.16 |
| Use efficient and cost effective approaches to integrate technology to improve workplace effectiveness | Novice | 13 | 28.89 | 7 | 16.28 |
| | Competent | 30 | 66.67 | 17 | 39.53 |
| | Expert | 2 | 4.44 | 19 | 44.19 |

According to Roussel (2009:338), planning for staffing requires knowledge of the organisation as well as judgement, experience and being thoroughly *au fait* with the requirements of the organisation. From table 4.5, it is evident that between 24.44 and 28.89 percent of the respondents initially considered themselves as *novices* in the three listed skills. However, the respondents' competency in the listed HR skills improved as the ratings of *novice* reduced over time. This improvement is consistent with the progress made in view of *communication and relationship management* and *leadership skills and behaviour* previously discussed. A 25% general improvement in *human resource planning* skills was detected when the means for the skills and the competency of *human resource planning* was calculated. This is graphically illustrated in figure 4.5.

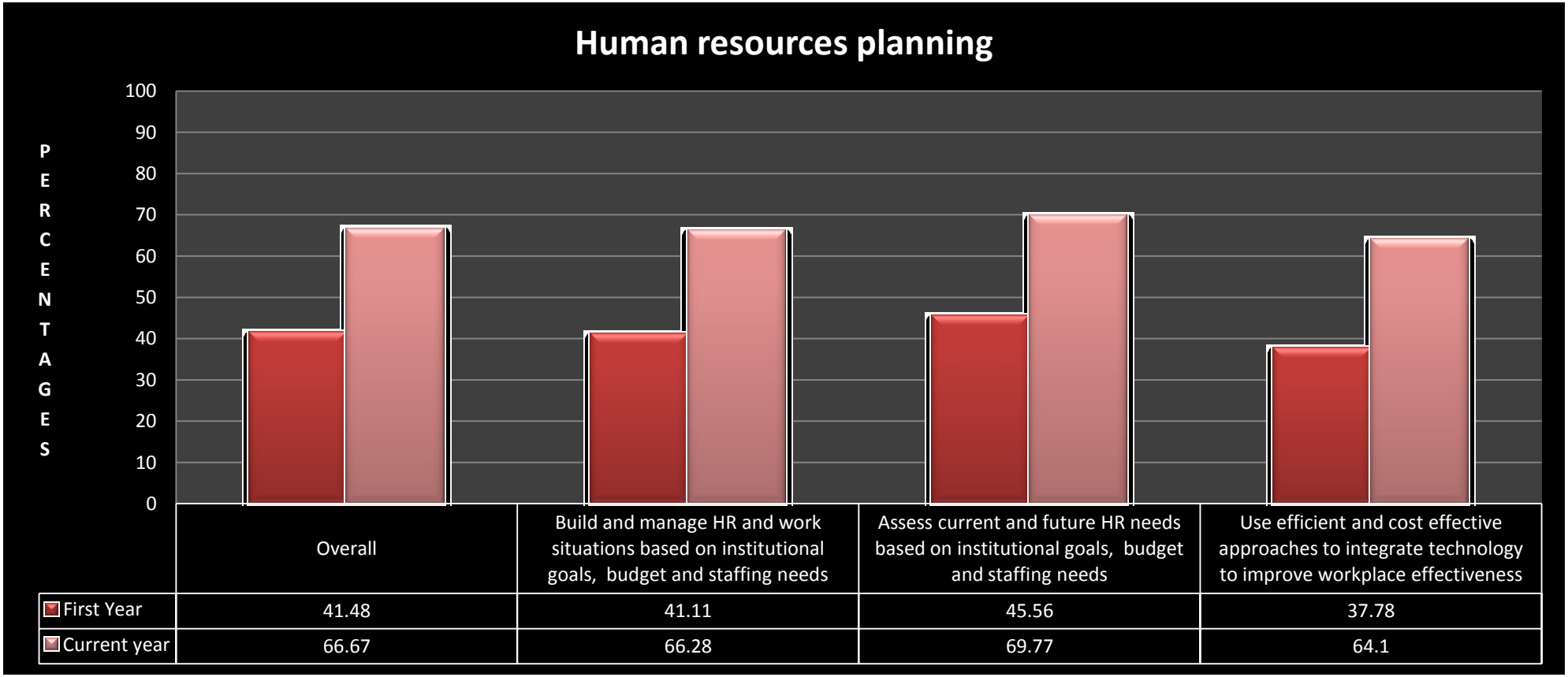



**Figure 4.5 Comparative analysis of the means of skills in *HR planning* (n=45)**

From the comparative analysis of the overall means, for the competency of *human resources planning,* there is an improvement of 25.19% over time. Each of the skills also shows a substantial improvement i.e. *build and manage human resources and work situations based on institutional goals, budget and staffing needs* increased by 25.17%, *assess current and future human resources needs based on institutional goals, budget and staffing needs* by 24.21%, and *use efficient and cost effective approaches to integrate technology to improve workplace effectiveness* by 26.32%.

*Human resources planning* is regarded as a technical competency and as such, health services leaders have many policy guidelines and legislation on which to base planning. In the public health sector in South Africa each Provincial Department of Health has to plan and manage resources within a financial year cycle. In terms of the Public Finance Management Act, Act 1 of 1999, as amended (South Africa: 1999), managers need to plan for budget requests and on receipt of a budget, they have to plan the acquisition of resources accordingly. Human resources are a significant component of all the resources required for a health services institution to function effectively. Accountability demanded of managers for the allocated resources requires managers to work within certain limitations. In addition to this, health services managers develop plans for staffing according to an organisational structure. Any changes usually have to be motivated and will normally be reviewed by numerous Provincial Office structures before it is approved.

The above discussion illustrates the structured framework within which *human resource planning* is implemented in the public health sector in South Africa. Hence the improvement in the three listed skills could be attributed to experience guided by policy frameworks, and probably to formal training programmes whilst in the current post.

#### *4.3.2.1.4 Financial planning*

Health services delivery requires resources, and the major resource is sufficient finances, as all other resources are dependent on the planning for, availability and management of finances. Therefore it was important to assess *financial planning*. Table 4.6 illustrates the frequency of ratings on each skill in *financial planning.* As not all the respondents answered all the items in both sections, the n-value ranges from 43 to 44.

**Table 4.6 Comparison of frequency ratings of *financial planning* over time (n=44)**

| Financial planning | | Year 1 | | Current year | |
|---|---|---|---|---|---|
| | | n | % | n | % |
| Understand principles of financial management | Novice | 8 | 18.18 | 1 | 2.33 |
| | Competent | 27 | 61.36 | 21 | 48.84 |
| | Expert | 9 | 20.45 | 21 | 48.84 |
| Prepare, justify and administer budget | Novice | 11 | 25.00 | 4 | 9.30 |
| | Competent | 24 | 54.55 | 18 | 41.86 |
| | Expert | 9 | 20.45 | 21 | 48.84 |
| Monitor expenditure | Novice | 7 | 15.91 | 0 | 0.00 |
| | Competent | 30 | 68.18 | 23 | 53.49 |
| | Expert | 7 | 15.91 | 20 | 46.51 |
| Identify cost effective approaches to management | Novice | 10 | 22.73 | 3 | 6.98 |
| | Competent | 26 | 59.09 | 21 | 48.84 |
| | Expert | 8 | 18.18 | 19 | 44.19 |
| Manage procurement and contracting | Novice | 16 | 37.21 | 6 | 14.29 |
| | Competent | 21 | 48.84 | 20 | 47.62 |
| | Expert | 6 | 13.95 | 16 | 38.10 |

In comparison to the first three competencies discussed, there is a marked improvement in *financial planning* skills. This could be due to the fact that financial planning is governed by a well defined regulatory framework and monitoring and evaluation is guided by a system of checklists and regular reports. Hence structured guidelines are in place as reference sources for health services mangers in leadership positions.

According to the Public Finance Management Act No. 1 of 1999 as amended (South Africa: 1999), managers are expected to have systems in place for financial and risk management and internal control. Section 38 (1) a (i)) and section 39 of the Act holds a manager accountable for ensuring that expenditure is in line with the budget allocated and that steps are taken to prevent unauthorised expenditure.

Figure 4.6 illustrates the improvement in each skill and the overall competency over time.

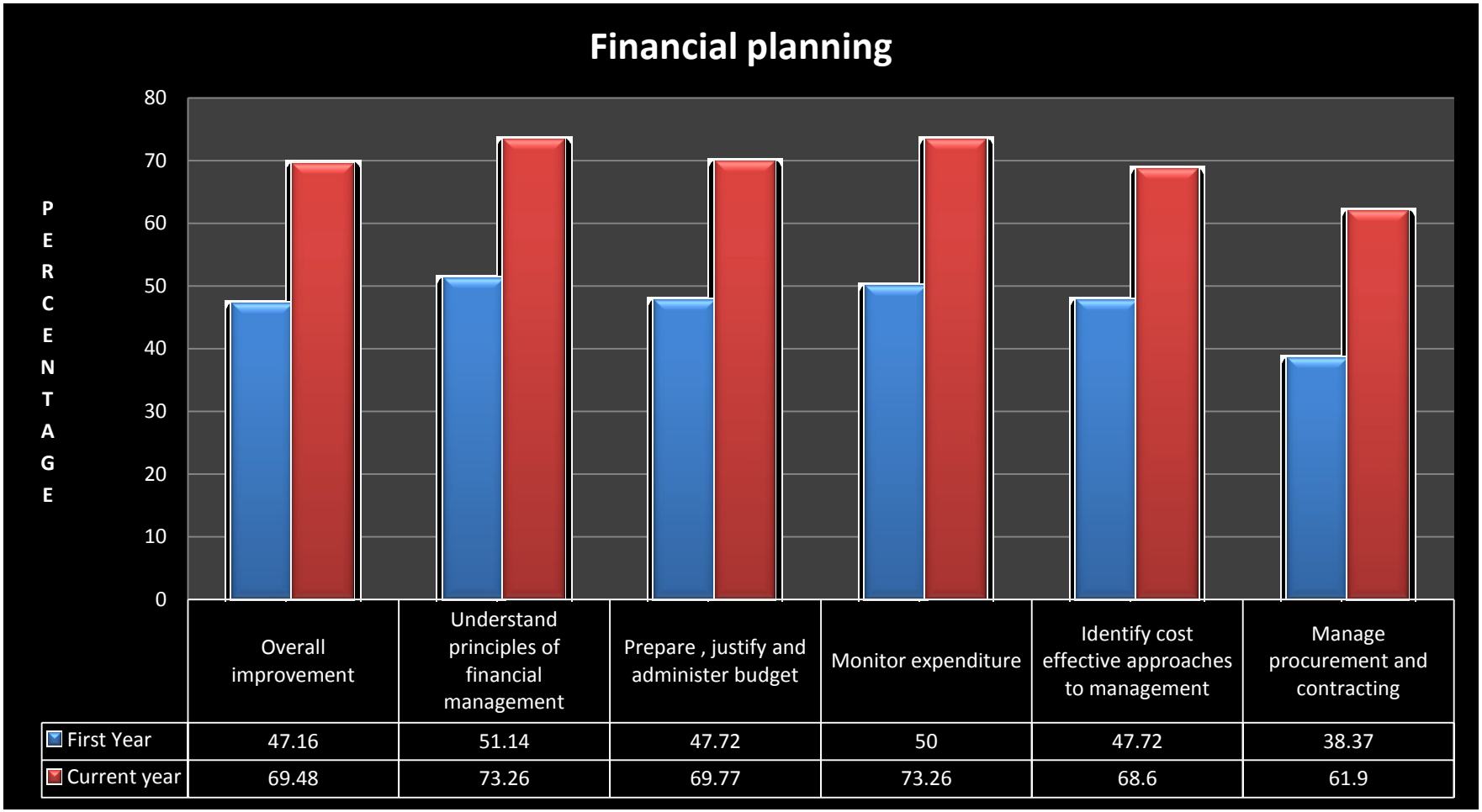



**Figure 4.6 Comparative analysis of means pertaining to *financial planning* skills (n=44)**

The overall improvement in *financial planning* is 22.32%. This improvement is consistent for all the skills listed under *financial planning.* An improvement of 22.12% is noted in understanding the principles of financial management. An increase of 22.05% in *preparing, justifying and administering the budget* is evident, 23.26% in *monitoring expenditure*, and 20.88% in *identifying cost effective approaches to management*, while *managing procurement and contracting* improved by 23.53%. As discussed in the analysis of table 4.6, it is clear that the regulatory framework provides for a structured approach to financial management. However, it is noteworthy that the skill of *identifying cost effective approaches to management,* showed the lowest improvement (20.88%).

The lower percentage improvement in the skill of identifying cost effective approaches to management, could be attributed to the fact that health services management is unique in that it comprises a range of specialists such as physicians, nurses, radiographers amongst others. Each group contributes to the achievement of the main purpose of the service which is embedded in the vision. For example the vision of the Gauteng Department of Health is "To be the best provider of quality health and social services to the people in Gauteng". However, the cost of resources to meet patient care is often in excess of the budgets allocated. Rising health care costs is an international trend as noted by Yoder-Wise (2011:230) who stated that the "rises in health care pricing have out priced general inflation". In addition to this, the complexities of the changing disease profile in South Africa places a huge demand on health services and puts pressure on the limited budgets as explained by KPMG (2011). KPMG is an auditing firm that was formed as a merger between Klynveld Main, Goerdeler and Peat Marwick.

This statement is supported by the discussion that the Minister of Health, Dr Aaron Motsoaledi had on Radio 702 breakfast show on the 22nd January 2012, in which he mentioned the cost of Anti-retroviral Drugs as being 4.4 billion ZAR in the 2010/11 financial year. Furthermore the national health expenditure grew by 15.3% from 21.7 billion ZAR in 2010/11 to 25.7 billion ZAR in 2011/12 as discussed in *Healthcare in South Africa [S.a.].* Hence health services managers may have experienced real problems in achieving a rating of expert in the skill of identifying cost effective approaches to management, and instead attained an average rating of 68.60% after two or more years in office. The average for the first year in office was 47.72%. This rating

places the respondents at 18.60% above *competent*. (Competent was rated at 50% by the statistician*).*

*4.3.2.1.5 Strategic planning*

As cited in chapter 2, Goleman (1998:94) and Tornabeni (2001:4), describe strategic planning as one of the important technical skills that leaders must possess. It was therefore important to assess this skill to give the researcher an idea of whether health services leaders viewed themselves as leaders that were able to get involved in long term planning. Table 4.7 illustrates the frequency rating of skills noted under *strategic planning*. Not all of the respondents answered all the items in this section resulting in the n-value ranging from 43 to 45.

**Table 4.7 Comparison of frequency ratings of *strategic planning* over time (n=45)**

| **Strategic planning** | | **Year 1** | | **Current year** | |
|---|---|---|---|---|---|
| | | **n** | **%** | **n** | **%** |
| Facilitate development of a strategic plan for the institution | Novice | 15 | 33.33 | 2 | 4.55 |
| | Competent | 26 | 57.78 | 24 | 54.55 |
| | Expert | 4 | 8.89 | 18 | 40.91 |
| Develop business/operational plan for the institution | Novice | 10 | 22.22 | 1 | 2.27 |
| | Competent | 28 | 62.22 | 23 | 52.27 |
| | Expert | 7 | 15.56 | 20 | 45.45 |
| Monitor and report on the implementation of the business/operational plan | Novice | 8 | 17.78 | 1 | 2.27 |
| | Competent | 30 | 60.67 | 23 | 52.27 |
| | Expert | 7 | 15.56 | 20 | 45.45 |
| Analyse policy issues and strategic planning with long term perspectives | Novice | 17 | 37.78 | 6 | 13.64 |
| | Competent | 24 | 53.33 | 23 | 52.27 |
| | Expert | 4 | 8.89 | 15 | 34.09 |
| Anticipate potential risks and facilitate risk management | Novice | 16 | 37.21 | 4 | 9.30 |
| | Competent | 23 | 53.49 | 22 | 51.16 |
| | Expert | 4 | 9.30 | 17 | 39.53 |

In comparison to the other competencies, more than 50% (n=45) of the respondents rated themselves as *competent* or *expert* on strategic planning skills on assumption of their posts. It would have been helpful to understand the type of training that the various health professionals had undergone and whether or not leadership preparation was integrated into their programmes. However, as health services managers are a

heterogeneous group in terms of their professional qualifications, it is therefore, not within the scope of this project to analyse the curriculum outcomes of the various professional training programmes.

Health institutions in the public sector of South Africa are guided by a National Department of Health Strategic Plan which clearly spells out the strategic goals, priorities, targets and indicators (National Department of Health 2010). This strategic plan is easily accessible and each Provincial Department of Health and the respective institutions develop a strategic plan that is congruent with that of the National Department of Health. As the priorities are directly related to health care delivery, personnel in health care institutions continuously have exposure to the implementation and evaluation of strategic priorities, In addition to this, institutions are expected to report on the achievement of targets at Provincial levels. Reporting is expected on a quarterly basis in a financial year. This could be the explanation for the fact that over 50% of the respondents appeared to be best prepared for this competency in the first year in office. This is reinforced in figure 4.7 which demonstrates the means for each skill as well as the overall competency in *strategic planning*.

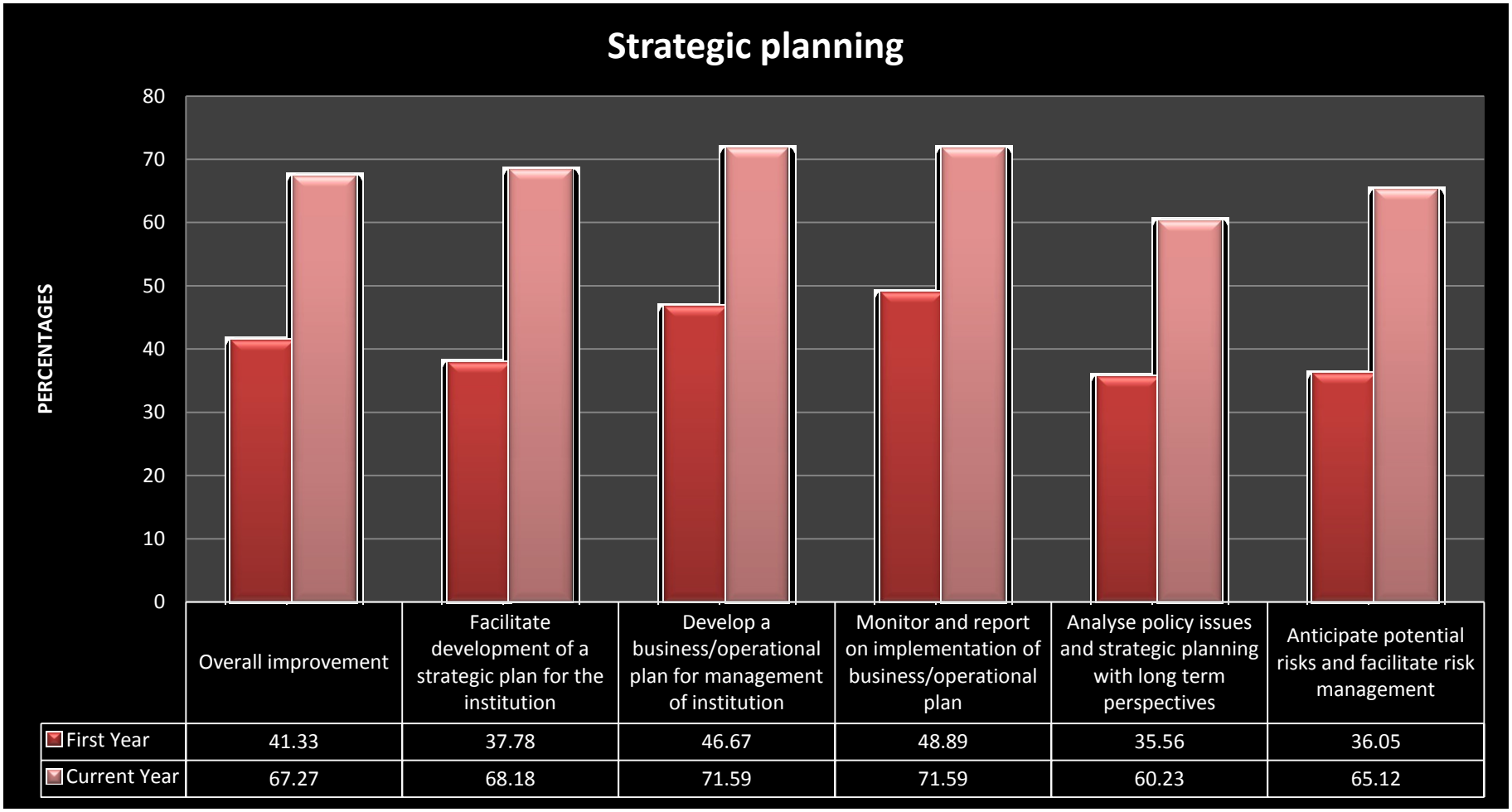



**Figure 4.7 Analysis of *strategic planning* skills (n=45)**

Figure 4.7 distinctly shows an improvement in all the skills listed under *strategic planning.* There is an overall improvement of 26.00% in the competency of *strategic planning* and the following improvements in the individual skills:

- *Facilitate the development of a strategic plan for the institution*: 31.60%
- *Develop a business/operational plan for management of the institution*: 25.00%
- *Monitor and report on implementation of business/operational plan*: 22.70%
- *Analyse policy issues and strategic planning with long term perspectives*: 24.67%
- *Anticipate potential risks and facilitate risk management*: 29.07%

The National Treasury Department of South Africa publishes "Treasury Guidelines for Preparation of Expenditure Estimates for the Medium Term Expenditure Framework" annually. National and provincial departments are expected to report financial performance against targets and where additional financial resources are requested, it has to be aligned to previously identified outputs (*Treasury Guidelines ...* 2009).

The skills listed above could be attributed to the regulatory framework in terms of the Public Finance Management Act No. 1 of 1999 as amended (South Africa 1999). A health services manager has to have a strategic plan in place to motivate for a specific amount in terms of the budget. Financial requests are linked to specific health outcomes and outputs that need to be achieved. In so doing, a manager is also expected to give evidence of achievements for the previous or current financial year in which the bid is being made. This is governed by the Public Finance Management Act, Act 1 of 1999 as amended (South Africa 1999). As noted in the analysis of the skills above, the greatest improvement is in the skills of *facilitate the development of a strategic plan for the institution at* 31.60% and *anticipating potential risks and facilitating risk management* (29.07%). This reinforces the link between *strategic planning* and financial management. According to Yoder-Wise (2011:311), the success of a strategic plan is developing a business plan which is integrated with a financial plan.

### 4.3.3 Test for the significance of leadership skills improvement

A paired t-test was conducted to establish the significance of the overall improvement in the ratings on the leadership competencies. A t-test assesses whether the means of two groups are statistically different from each other. In analysing the differences between

the two groups, a judgement is made on the difference between their means relative to the spread or variability of the scores. Once the t-value is computed it is compared to a table of significance to test whether the ratio is large enough to establish a significant difference between the two groups. As a general rule, a risk level is set at 0.05 which implies that five times out of a hundred there would be a statistically significant difference between the means of the two groups (Trochim 2006). In addition to this, there is a need to establish the degree of freedom (DF) which is equal to the number of paired observations minus one (DF=n-1) (Polit & Beck 2012:415). Thereafter the p-values are checked in a standard table of significance. The p-value refers to the probability that the results obtained are due to chance. Probability ranges from 0 to 1. A p-value of ≤0.05 implies significance at less than or equal to a 5% level and a p-value of ≤0.1 implies significance at less than or equal to a 10% level (Trochim 2006). The smaller the p-value, the less significant the assumption that there is no difference between the two groups (Hogg & Tanis 2010:359).

The results of the t-test for the overall improvement in the competencies in the first year in office and the current year is presented in table 4.8

**Table 4.8 Results of paired t-test on leadership competencies**

| Leadership competency | DF | t-value | p-value |
|---|---|---|---|
| Communication and relationship management | 41 | -7.56 | <0.0001 |
| Leadership skills and behaviour | 42 | -5.99 | <0.0001 |
| Human resources (HR) planning | 41 | -6.27 | <0.0001 |
| Financial planning | 41 | -5.96 | <0.0001 |
| Strategic planning | 42 | -7.86 | <0.0001 |

The results of the t-test confirmed the improvement in the five listed leadership competencies. The significance levels for the listed competencies as illustrated by the p-values are less than 5%.

The rationale for obtaining information on the respondents' self rating on leadership competencies in the first year in office was to establish whether they were adequately prepared in the leadership competencies generally required of health services leaders.

It was also essential to establish the current ratings as this would serve as a baseline to identify whether or not there was a need for leadership development programmes.

As the above results only focused on the self assessment ratings, further analysis needed to be done to identify which, if any leadership competencies, were lacking if a respondent did not participate in a mentorship programme. Section 4.3.4 discusses the effect of mentorship programmes on leadership competences. From the discussions on the various competencies it was apparent that health services managers were either prepared or developed competency in the technical competencies of leadership. It was in the behavioural competencies that further development was required Refer to 4.3.2.1.2. According to Hutton and Moulton (2004) as quoted by Rubino (2010:11), “behavioural competencies are an accurate determinant of success as leaders”.

### 4.3.4 The effect of mentorship on leadership competencies

One of the objectives of this study was to determine the role of mentorship programmes in the development of potential leaders. From the literature review, the leadership competencies required of health services leaders from middle management positions and upward were identified, and the above results indicate how the respondents rated their improvement in the different skills since taking office more than two years ago.

The following section deals with the effect of mentorship programmes on leadership competencies.

#### *4.3.4.1 Relationship between leadership competencies and non-participation in a mentorship programme*

Of the 46 respondents, only ten (21.74%) participated in a mentorship programme before taking on their leadership role.

Respondents who answered positively to question 67, which related to whether they had participated in a mentorship programme, were not expected to answer questions 68 to 75. However, two respondents who answered positively to question 67, also answered questions 68 to 75 and were therefore left out of the analysis.

An independent, two sample t-test was conducted to test which leadership competencies were lacking if a person did not participate in a mentorship programme before taking on their leadership position. In an independent, two sample t- test, the sum of the number of respondents that participated in a mentorship programme and the number that did not participate minus two, allows the statistician to compute the difference of freedom (DF) value (Polit & Beck 2012:412). The outcome of the test is shown in table 4.9.

**Table 4.9 Relationship between leadership competencies and non-participation in a mentorship programme (n=35)**

| Competencies | First year in post | | | Current assessment | | |
|---|---|---|---|---|---|---|
| | DF | t-value | p-value | DF | t-value | p-value |
| Communication and relationship management | 43 | 2.62 | 0.0123* | 41 | 2.02 | 0.0502 |
| Leadership skills and behaviour | 43 | 3.37 | 0.0016* | 42 | 2.7 | 0.01* |
| Human resources (HR) planning | 43 | 2.08 | 0.044* | 41 | 1 | 0.3239 |
| Financial planning | 42 | 1.77 | 0.0841 | 41 | 1.37 | 0.1789 |
| Strategic planning | 43 | 1.61 | 0.1143 | 42 | 0.68 | 0.5012 |

*Less than five percent level of significance

At a less than 5% level of significance, *communication and relationship management*, *leadership skills behaviour* and *human resources planning* were lacking in the first year at post if a respondent did not participate in a mentorship programme before taking on his/her post. It is noted that the p-values for these competencies are below 0.05, and at a significance level of <10%, *financial planning* is lacking in the first year in office (p-value of <0.1). At a ≤ 5% level of significance, *communication and relationship management* and *leadership skills and behaviour* are still lacking after two or more years in the post.

It can therefore, be deduced that mentorship programmes could assist in preparing health services managers for leadership positions in the following leadership competencies:

- *Communication and relationship management*

- *Human resource planning*
- *Leadership skills and behaviour*
- *Communication and relationship management*

This reinforces earlier findings that for health services managers to improve in behavioural competencies they need to be exposed to a structured development programme. Thus, leadership development plays an important role in the preparation of personnel for leadership positions. The literature review in this study has cited numerous international studies that attest to the success of mentorship programmes in leadership development. Allen (2002:440) described the peer to peer model of mentorship as playing a significant role in the succession of leadership, Villarruel and Peragello (2004:173-180) explained the success of mentors in assisting with the development of Hispanic nurses, while Barondess (1997:347) described the success of mentorship for a group of 25 doctors.

#### *4.3.4.2 Relationship between leadership competencies and participation in a mentorship programme*

Before taking on leadership positions, 10 (21.73%) of the respondents, enrolled for, or participated in different forms of mentorship. It was evident that respondents made use of different forms of mentorship in an attempt to enhance their capacity and competence. Refer to table 4.10 for the types of mentorship programmes and the number of respondents that participated in each type of mentorship programme.

**Table 4.10 Summary of respondents who participated in different mentorship programmes (n=10)**

| **Type of mentorship programme** | n | % |
|---|---|---|
| Formal | 7 | 70.00 |
| Informal | 8 | 80.00 |
| Collegial Mentorship Programmes | 6 | 80.00 |
| Supportive role models acted as mentors | 6 | 60.00 |

Eight (80%) out of the ten respondents who enrolled in a mentorship programme indicated that the mentorship programme was useful and that it did contribute to confidence in their current position. Table 4.11 provides the views of respondents who

did not participate in any mentorship programmes before assuming a leadership position.

**Table 4.11 The effect of non-participation in a mentorship programme on taking on leadership positions (n=36)**

| Item | Yes | | No | |
|---|---|---|---|---|
| | n | % | n | % |
| Do you think that the lack of a mentorship programme affected you negatively | 22 | 61.11 | 14 | 38.89 |
| Do you feel that if you had been prepared through mentorship you would have been more confident on assuming a leadership position | 28 | 80.00 | 7 | 20.00 |

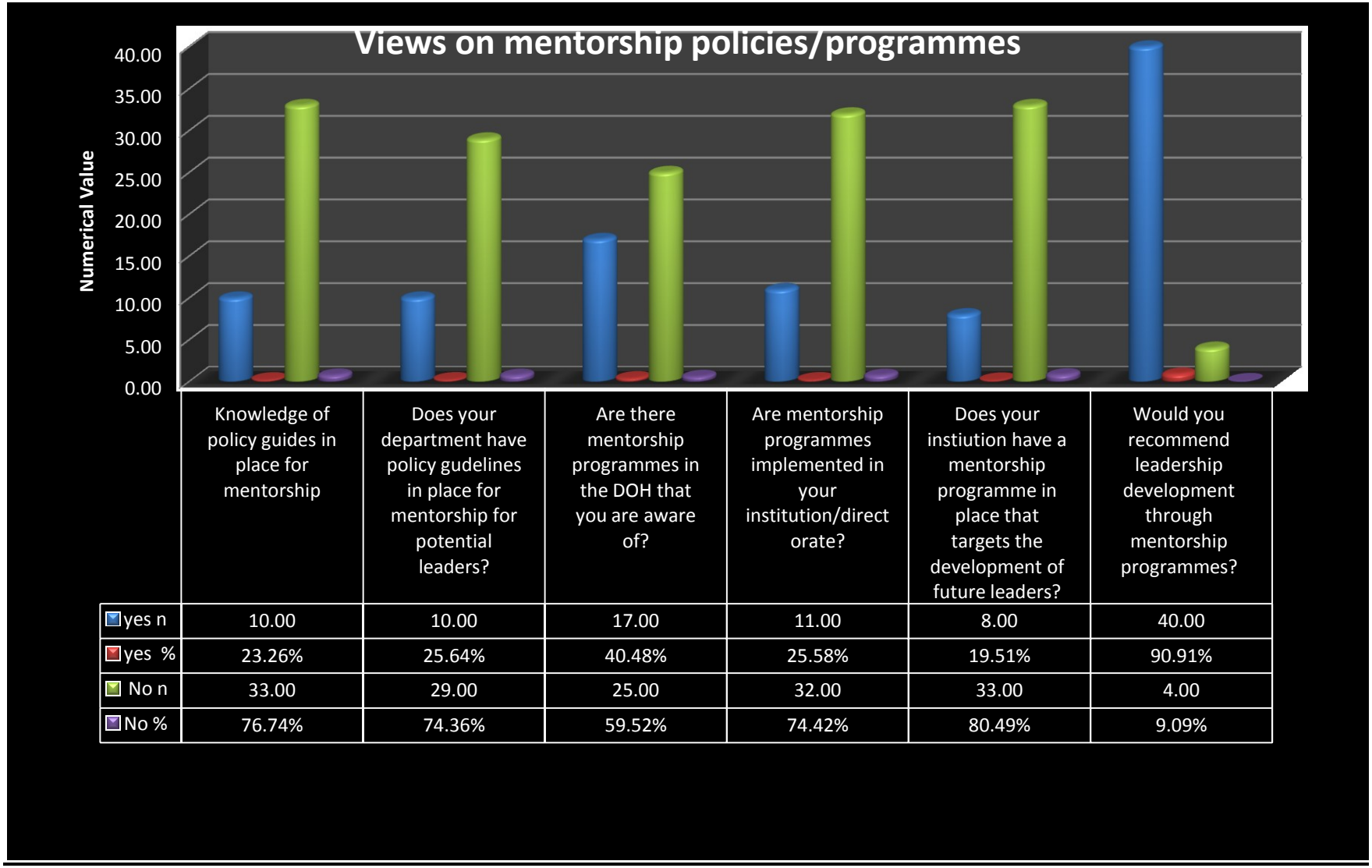
As all the respondents did not answer this section fully, the n-value ranged between 35 and 36.

Twenty-two (61.11%) out of thirty-six respondents who responded to the first question in table 4.11, reported that the lack of mentorship programmes could have affected them negatively.

Thirty-five respondents reacted to the second question, of which 28 (80.00%) were of the opinion that a mentorship programme could have contributed to them being more confident in their leadership post. There is a consistency in the responses of the respondents that participated in some form of mentorship programme and those who did not, in that in both groups 80% of the respondents valued the role of mentorship in leadership development. These findings reinforce the view engendered by the literature.

#### *4.3.4.3 Knowledge of mentorship policies in the workplace*

Respondents were asked to indicate whether they had knowledge of policy guidelines in relation to mentorship that were in place, whether their institutions had mentorship programmes and whether their institution had mentorship programmes that targeted future leaders. Not all the respondents answered all the items and hence the n-value ranged from 41 to 43.




| | Knowledge of policy guides in place for mentorship | Does your department have policy gudelines in place for mentorship for potential leaders? | Are there mentorship programmes in the DOH that you are aware of? | Are mentorship programmes implemented in your institution/direct orate? | Does your instiution have a mentorship programme in place that targets the development of future leaders? | Would you recommend leadership development through mentorship programmes? |
|---|---|---|---|---|---|---|
| yes n | 10.00 | 10.00 | 17.00 | 11.00 | 8.00 | 40.00 |
| yes % | 23.26% | 25.64% | 40.48% | 25.58% | 19.51% | 90.91% |
| No n | 33.00 | 29.00 | 25.00 | 32.00 | 33.00 | 4.00 |
| No % | 76.74% | 74.36% | 59.52% | 74.42% | 80.49% | 9.09% |

**Figure 4.8 Views on the existence of policies/programmes on mentorship for health services leadership (n=44)**

The data contained in figure 4.8 demonstrates the respondents' views that there was a lack of policy guidelines on, and the absence of mentorship programmes for leadership development at institutional level within the health institutions participating in this study.

It is noted that the majority of respondents (33; 80.49%) indicated that there were no mentorship programmes in place that targeted the development of future leaders. This implies that there may not be a talent pool within institutions to select leaders from. Respondents were asked if they would recommend leadership preparation through mentorship programmes. Forty-four respondents answered this question, of which 40 (90.91%) answered 'yes', indicating that there was an overwhelming support for mentorship programmes in the departments that were part of this study. As the researcher in this study used the existing DPSA guide on mentorship as a reference source (DPSA 2006), it may be that the respondents were not informed about this guide, or that the guideline was not implemented at institutional level.

Section 4.3.4.4 discusses respondents' views on the filling of leadership positions and the role of mentorship programmes.

#### *4.3.4.4 Filling of vacant leadership positions*

It was important to ascertain what the current situation is with regard to the filling of leadership positions, and in so doing, to establish the role of leadership development in facilitating this process. Preparation of personnel for leadership positions in health care settings is recognised as crucial to the success of health services leadership. As Ngatia and Kimotho (2009), indicate that "those leading and managing health systems are not sufficiently prepared to succeed in leadership roles".

Table 4.12 illustrates respondents' views on filling of leadership posts and whether or not they rated mentorship as significant to leadership development.

Once again the n-values for the items illustrated in table 4.11 are variable because respondents did not answer all the questions. Hence the n-value ranged from 41 to 43.

**Table 4.12 Views on the filling of vacant leadership positions (n=43)**

| Question | Yes | | No | |
|---|---|---|---|---|
| | N | % | n | % |
| Does it take more than 6 months to fill a leadership position? | 37 | 86.05 | 6 | 13.95 |
| Are candidates for leadership positions selected from internal candidates? | 17 | 40.48 | 25 | 59.52 |
| Are candidates for leadership positions selected from external candidates? | 21 | 51.22 | 20 | 48.78 |
| Would a mentorship programme for potential leaders in your department prevent a leadership gap? | 34 | 82.93 | 7 | 17.07 |

Information captured in table 4.12 indicates that the greatest majority (37; 86.05%) of respondents noted that it takes more than six months to fill a vacant leadership post in their institution or district. According to the respondents' views, there was a 10.74% difference in favour of external candidates being selected for filling leadership position, in contrast to internal candidates. It is important to note that the greater majority (34; 82.93%) of respondents were of the opinion that a mentorship programme for potential leaders would prevent a leadership void when positions become vacant. This finding is congruent with the literature on the need for leadership development programmes.

The literature review conducted for this study, referred to a number of these studies/sources that emphasised the importance of leadership development through mentorship. In a recent study conducted by the African Medical and Research Foundation (AMREF) in July 2009, with human resources managers as respondents, 75% of these managers indicated their lack of knowledge about HR functions, and 70% (n=96) identified the need for training in leadership skills such as team work and collaboration, communication and interpersonal skills and leadership and advocacy (Ngatia & Kimotho 2009).

Preparation of potential leaders implies having succession plans in place. One of the objectives of this study was to make recommendations for succession planning. This will further be elaborated on in chapter 5.

## 4.4 CONCLUSION

This chapter covered the statistical analysis of data that was collected from 46 respondents who completed and submitted questionnaires. The findings indicated that a number of leadership competencies and their related skills of health services leaders improved over a period of two or more years. However, *leadership skills and behaviour* and *communication and relationship management* still showed a lack of improvement over a period of time in those respondents that were not exposed to mentorship programmes. Health services leaders in the public health sector in the two provinces in which this study was conducted appear to have improved over time in the leadership competencies that are regarded as technical competencies and which are well regulated by policies and protocols. The need for development programmes in behavioural competencies was established. It was apparent that respondents were unaware of the existence of mentorship policies or programmes that were being implemented in their specific health sector. However, there was overwhelming support for leadership development through mentorship programmes.

# Chapter 5

# Conclusions and recommendations

## 5.1 INTRODUCTION

Chapter one provided an overview of the study which outlined the background to the problem, which was, that health services leaders are not adequately developed before being promoted or appointed to a management position. Literature reviewed on the subject demonstrated the importance of mentorship for leadership development. Hence the purpose of the study was to ascertain whether the preparation of health services leaders in management positions in the two selected provinces of South Africa, were aided by mentorship programmes. Pertinent terms were defined and the approach to the study, including the research design and methodology, were briefly discussed.

The specific objectives of the study were to:

- Identify the specify leadership competencies required by health services leaders from middle management positions upward
- Determine whether mentorship programmes exist in health care settings, and if so, the role they play in preparing personnel for leadership positions
- Make recommendations for succession planning

Chapter two dealt with the literature review. The broad concepts of leadership, management and mentorship were reviewed. Definitions, characteristics and principles of these concepts were further explained. Furthermore leadership competencies were discussed in fair detail as this was the core of this study. Five of the leadership competencies identified by means of the literature review were incorporated in the research instrument used for data collection. These leadership competencies are *communication and relationship management, leadership skills and behaviour, human resource planning, financial planning and strategic planning,* and they will be elaborated on in section 5.2.2.

Thereafter mentorship and the relationship of mentorship to leadership development were explored. In the process, a number of models of mentorship were explored and explained. Insight was gained, on the similarity of mentorship to coaching as illustrated in the STEER model. In the analysis of the models common themes emerged, which led to the need to explore specific theories that applied to mentorship. The common themes were *guidance of mentees and demonstration of caring so that the mentee reaches full potential*. Hence the key concepts that emerged were *caring, teaching and supporting*. Although this study was not based on any specific theoretical approach, the theories that were identified, that could be best applied to leadership development through mentorship, were Bandura's *Social learning theory* and Watson's *Theory of caring*.

Lastly the literature that was reviewed on mentorship for leadership development appeared to consistently focus on the significance of succession planning in an organisation's plan for leadership development. Therefore the definition and the processes involved in succession planning were explored.

Chapter three discussed the research methodology. This study used the quantitative approach with a descriptive and an exploratory research design. The various concepts in quantitative research methodology were discussed. The data collection instrument, in this instance, a self administered questionnaire, was discussed in detail. As this tool was a modification of other tools, identified through the literature, it was essential to establish the validity and reliability of the instrument. A pre-test was conducted and the validity and reliability of the instrument was confirmed through statistical analysis.

Chapter four dealt with the analysis of the data that was collected from respondents in the two provinces in South Africa that were part of the research project. The data received, inter alia, covered the self assessment by respondents in view of their initial leadership competencies and improvement thereof over a period of time. The respondents' views on the role of leadership development through mentorship were also obtained.

This chapter discusses the findings, conclusions and recommendations emanating from this research project.

## 5.2 SUMMARY AND INTERPRETATION OF RESEARCH FINDINGS

The results are based on the findings of the data collected from the respondents in health services management positions. The results will be discussed in accordance with the three sections of the questionnaire, which are:

- Section 1: Biographical information
- Section 2: A comparative self assessment of leadership competencies over a period of two or more years
- Section t3: Respondents' views on mentorship for leadership development

Despite several follow up actions during the data collection process, a response rate of only 30 % was achieved i.e. only 46 out of the 153 questionnaires that were sent out were completed and returned.

Each section as outlined in the data collection instrument will be discussed. The findings and the conclusions drawn and the recommendations will be put forward.

### 5.2.1 Biographical information

The biographical information submitted by the respondents assisted the researcher to determine the general profile of managers in leadership positions in the health sectors that were part of this study.

#### *5.2.1.1 Gender*

This study showed that more than a third (17; 37.77%), of the respondents from the two provinces were male. It was established that the distribution of females in leadership positions was not consistent with their distribution among registered health care professionals in the period 2010 to 2011. According to the South African Nursing Council (SANC 2010:1), 92.9% of registered professional nurses were women and according to the Health Professionals Council of South Africa (HPCSA) 52.68% (85,485) of registered health professionals as at December 2011, were female (Daffue:2012).

Literature review illustrated the fact that the leadership style of men, i.e. assertive and instrumental, is generally equated with managerial success and women tend to be held to higher standards of competence (Eagly & Carli 2003:807-834 ). These authors pointed out the fact that the leadership style of women inclined toward transformational leadership and the reward component of transactional leadership.

According to Torpman (2004:895) as quoted by Muller, Bezuidenhout and Jooste (2011:431), transformational leadership is characterised by, among others, concern for the developmental needs of followers and stimulation of learning. As such, the assumption is that this type of leadership would have been predominantly practised in the health sectors that were part of this study, as the majority (28; 62.22%) of the respondents were women. However, leadership styles in practice versus gender and the relationship thereof to leadership development programmes was not the focus of this study. The significance of gender distribution, in health services leadership to leadership development, therefore, was not established. This could be a recommendation for further research.

#### *5.2.1.2 Age*

The greater majority (39; 84.78%), of respondents were in their middle to later adult years, implying that they would more than likely have had 15 – 20 of years experience in the health sector before being appointed to their current management positions. They would have brought operational rather than leadership expertise to the positions they occupied. Ngatia and Kimotho (2009) discuss the urgent need to “skill and retool” those charged with leadership and management in the health sector. The authors go on to explain that one of the reasons for limited development of leadership and management capacity is that it is commonly assumed that “a good health care professional is also a good manager”, implying that competency in an area of specialty is often equated with competency in leadership and management. The authors also indicate that some professionals promoted to management positions “have learned on the job but others have been total disasters”. To illustrate their findings, they quote a director, who was a medical practitioner by profession, as saying that doctors need training in leadership and management and that it should be incorporated in their training in class and in the field.

This reinforces the experience of the researcher as outlined in section 1.3 in that the researcher was competent in nursing education but lacked competence in the technical skills needed to manage an institution on taking office. Hence if leadership development programmes are implemented whilst health care professionals are practising in their area of speciality rather than only when they are appointed to management positions, it will contribute to overall increased competency of leadership in the health services. Such a process of leadership development would be consistent with organisational processes for succession planning.

### 5.2.2 Leadership competencies

One of the objectives of this study, as discussed earlier, was to identify the specific leadership competencies required by health services managers from middle management and upward. A number of different approaches to discussing leadership competencies were identified in the literature review. Goleman (1998:204), described leadership competencies which he identified as being the technical skills of accounting, business planning, cognitive abilities, emotional intelligence and strategic vision. Tornabeni (2001:4) identified strategic planning, resource allocation and financial management, whilst Bolden(2005:15), speaks of soft skills such as communication, problem solving and people management and technical skills of information processing, project management and customer delivery skills.

Having identified these competencies through the literature review it was important to identify the level of competency of health services managers in specific leadership competencies. As the study was conducted in the public health sector in two provinces in South Africa, the Senior Management Services Handbook (DPSA 2003) was consulted. This is a manual developed by the Department of Public Service and Administration, a national department in the Government of South Africa that monitors all other public sector departments in the country. The reason for consulting this manual was that the researcher assumed that this manual would set out the goals and expectations of health services managers in leadership positions. Specific competencies, that health services managers could rate themselves on, were selected. These competencies were:

- *Communication and relationship management*

- *Leadership skills and behaviour*
- *Human resource planning*
- *Financial planning*
- *Strategic planning*

Each of these competencies was further broken down into measurable skills that contribute to achieving the overall competence. Respondents were requested to rate themselves on each of these skills, as either *novice, competent* or *expert.* This was a comparative self assessment i.e. an assessment of themselves in their first year in office as a manager, and then a current self assessment if they had been in office for more than two years. The rationale for this exploratory approach was to establish the existence of, or the need for leadership development programmes.

#### *5.2.2.1 Communication and relationship management*

Respondents that rated themselves as *novice* in the seven listed skills in *communication and relationship management* in the first year of office ranged from 20.00% to 22.4% (n=45). However, there was a 25% overall improvement in these skills over a period of time. There was an improvement of 26.00% in the skill of *building collaborative relations* , 31.18% in *identifying stakeholder expectations*, 30.40% in *practising shared decision- making*, 26.00% in *communicating and modelling the vision of the institution/directorate*, 21.32% in *fostering an inclusive workplace that manages diversity and accepts individual differences,* 21.11% in *providing data analysis results to senior staff and 15.23% in the use of mediation, negotiation and conflict resolution to maintain labour peace.*

On self assessment ratings, it was clear that there was an improvement over time, which could be attributed to experience or to development programmes that respondents attended while in their current positions. However, when a two sample t-test was conducted to identify whether there was a difference in skills, between respondents who were exposed to mentorship programmes and those who were not, in the group that did not participate in any form of mentorship programme, it was found that at a 5% level of significance, competency in *communication and relationship management* was lacking in the first year in office and at a 5% level of significance this competency was still lacking after two or more years in the position of a health services

manager. *Communication and relationship management* falls into the category of behavioural skills and therefore the degree of structured guidelines in the way of legislation, policies and protocols and checklists for reporting is limited.

In a health care environment that is complex and dynamic, technical skills, although important, are not an adequate determinant of leadership success (Moe et al 2007: 12). In analysing the skills under *communication and relationship management* it is clear that to be effective in this skill a leader has to be aware of clients' and followers' expectations and facilitate team work to achieve the goals of the institution. In so doing he/she needs to ensure that all team members collaborate with each other and despite differences work together. What has just been described is consistent with emotional intelligence. According to Hagenow (2001:33), "emotional intelligence is an absolute pre-requisite to health care leadership".

Emotional intelligence comprises "the ability to understand and manage oneself and the ability to understand and relate well to others" (Roussel 2009:52). It is this second dimension that Goleman (1998:101) identifies as empathy and social skills, which he explains as an individual's ability to manage relationships with others. He reinforces this fact by stating that for effective relationship management, a leader must be able to empathise and use social skills (Goleman 1998; 201).

As *communication and relationship management* is a behavioural competency, improvement is dependent on practising new behaviours and unlearning old ones.

It is apparent that this competency would best be developed in individuals through a leadership development programme such as mentorship. Deans et al (2006:34-35) describe two models for mentorship that incorporate learning and caring into the process. These are the Transformational Coaching Model and the POSITIVE Coaching Model. In both these models individuals learn through gaining insight and receiving regular feedback from the mentor and the support given places emphasis on the caring aspect of the process of mentorship. The basic principle of learning through mentorship is that "external observation and feedback" are essential. It involves "talking, exploring alternatives and reflecting on behavioural options" (Roussel 2009: 66).

#### *5.2.2.2 Leadership skills and behaviour*

*Leadership skills and behaviour* is core to the role of a leader. However, it is also important that a leader has a sense of self awareness as it impacts on their effectiveness as leaders, as well as their followers (Huber 2010:6). Analysis of the ratings of the respondents on the various skills in leadership indicated that over 50% (n=45) rated themselves as competent in the first year in office and a 20.59% overall improvement in *leadership skills and behaviour* was gained in the current self assessment. The rate of improvement in each of the skills, over time, showed a fair degree of variation as indicated hereunder:

- *Develop a strategy to achieve vision and mission*: 26.01%
- *Apply legal and regulatory standards*: 20.33%
- *Foster an environment of trust*: 12.53%
- *Advocate for and participate in health care policy initiatives*: 27.92%
- *Create an organisational climate that encourages team work* : 17.63%
- *Encourage an increased level of commitment to the purpose and value of the institution* : 16.01%
- *Promote and manage change*:20.45%
- *Promote continuous organisational improvement and growth*: 23.00%
- *Plan a strategy for overcoming obstacles to achievement of institutional goals*: 23.00%

In looking at the nine listed skills under leadership skills and behaviour, one can see that there is an improvement of 20% and more in the technical skills and a less than 20% improvement in the behavioural or interpersonal skills. The lowest rate of improvement was in the skills of *foster an environment of trust* (12.53%), followed by *encouraging an increased level of commitment to the purpose and value of the institution* (16.01%) and *create an organisational climate that encourages team work* (17.63%). These findings reinforce the assumption that technical skills tend to improve because of the structured guidelines and monitoring and evaluation processes that are in place in the South African public health services. For example, the skill of *developing a strategy to achieve the vision and mission* is aligned to strategic planning which is

highly structured from the commencement of planning through to evaluation and monitoring in terms of progress toward achievement of institutional goals and priorities.

However, the skills of *fostering an environment of trust*, *encouraging an increased level of commitment to the purpose and value of the institution and creating an organisational climate that encourages team work* showed the lowest rate of improvement at 12.53% , 16.01% and 17.63% respectively. These skills are interpersonal or social skills that cannot be changed by merely attending a formal lecture but potential leaders would more likely benefit from a leadership development programme through mentorship.

The overall ratings on self assessment in *leadership skills and behaviour* showed an improvement of 20.59% as indicated above. However, when a two sample t-test was performed to identify possible significant differences between those respondents that participated in mentorship programmes and those that did not, it was found that in the group that did not participate in mentorship programmes, certain skills were lacking in the two periods of self assessment. Statistical analysis showed that at a less than 5% level of significance leadership skills and behaviour were lacking on assumption of office and still at a less than 5% level of significance, *leadership skills and behaviour* were lacking after two or more years in their current positions. This finding pointed to the need for a more formal approach to leadership development such as mentorship, as opposed to learning on the job.

#### *5.2.2.3 Human resource planning*

*Human resource planning* is a significant part of a health services manager's responsibilities. Contino (2004: 52 – 64) indicates that nurse leaders need to be cognizant of "fiscal accountability, quality enhancing management strategies and personnel management". As much as the author focuses on nurse leadership, this can be applied to health services leaders in general. She goes on to elaborate, that in view of personnel shortages, it is important to work with human resource professionals who are able to give feedback to managers on the turnover rate and the existing vacancies. Muller et al (2006:236), also indicate that "the successful chief executive officer sees human resources as an asset that needs to be managed more conscientiously". The link or the interrelationship of strategic planning to *human resource planning* is

emphasised in that achievement of organisational goals is dependent on an adequate and efficient workforce.

From the data accumulated on *human resource planning*, it was found that between 24.44% and 28.89% (n=45) of the respondents considered themselves *novices* in the first year in office. However, on current assessment i.e. after two or more years in office there was a 25.19% general improvement in *human resource planning*. The improvement in each of the skills, over time, is as follows:

- *Build and manage human resources and work situations based on institutional goals, budget and staffing needs* : 25.17%
- *Assess current and future human resources needs based on institutional goals, budget and staffing needs* : 24.21%
- *Use efficient and cost effective approaches to integrate technology to improve workplace effectiveness*: 26.32%

*Human resource planning* is a technical competency and as such there are many guidelines in place for health services managers to use as references or policy frameworks to aid in planning. The South African National Department of Health (DPSA 2006: vii) quotes the World Health Organisation's (WHO) definition of human resource planning as "... the process of estimating the number of persons and the kinds of knowledge, skills, and attitudes they need to achieve predetermined health targets and ultimately health status objectives" (WHO 1978). This statement reinforces the linkage of human resource planning to strategic planning. The National Department of Health of South Africa developed *A National Human Resources Plan for Health (*DPSA 2006), which is a policy guideline that is used by the Provincial Departments of Health to formulate their own human resources planning strategies. In addition to this a number of legislative frameworks guide *human resource planning* in the provincial health sector in South Africa. To name but a few, these are: The National Health Act, Act No. 61 of 2003 (South Africa 2003), which provides the framework for health legislation (DPSA 2006:26). Other policy guidelines are the Skills Development Act, Act No. 55 of 1998, policy on internship, policy on commuted overtime, policy on community service for health professionals (DPSA 2006:25 -27). Furthermore in terms of the Public Finance Management Act, No 1 of 1999 as amended (South Africa 1999), managers are

mandated to plan for budgets based on outputs and resources available to meet these outputs. In addition they have to account for the expenditure by regular monitoring.

In view of the above discussion it clarifies the finding of an improvement in all the skills under *human resource planning*, including an overall improvement of 25.19%. Managers may also have undergone training after appointment to their current positions. However, it is important to note that when a two sample t-test was performed to test the differences between respondents that were exposed to mentorship and those that were not, it was found that at a less than 5% level of significance *human resources planning* was lacking in the first year in office.

#### *5.2.2.4 Financial planning*

On analysis of the data on *financial planning* it was found that there was an overall improvement of 22.32% after two or more years in office. In addition to this there was a consistent improvement in all the skills in *financial planning* as follows:

- *Understand the principles of financial management*: 22.12%
- *Prepare, justify and administer budget* : 22.05%
- *Monitor expenditure*: 23.26%
- *Identify cost effective approaches to management* : 20.88%
- *Manage procurement and contracting*: 23.53%

The skill of *Identifying cost effective approaches to management,* showed the lowest rate of improvement at 20.88%. One can understand this in the light of the realities of management in meeting strategic goals which involve a range of specialists as well as specialised equipment and other resources needed for the delivery of health care, that are often way more that the fiscal resources available. As noted in section 4.3.2.1.4 the changing disease profile in South Africa places huge pressures on the limited budgets (KPMG 2011).

However, the regulatory framework that guides *financial planning* and management in the public health sector in South Africa could explain the improvement in all the skills and an overall improvement in *financial planning*. Financial management is regulated by the Public Finance Management Act, Act 1 of 1999 as amended (South Africa 1999)

and the treasury regulations in specific provinces. Moreover, it is possible that health services leaders may have attended formal courses on taking office in their current positions. *Financial planning* being a technical skill can be easily learnt through lectures and workshops.

#### *5.2.2.5 Strategic planning*

Over 50% (n=45) of the respondents rated themselves as competent in strategic planning, on taking office in their current positions. This was an indication that there was a level of preparedness and confidence in this leadership competency as compared to the others. In addition there was an overall improvement in the competency of 25.94% over time, and an improvement of 22.70% to 30.04% in the five listed skills of strategic planning as indicated hereunder:

- *Facilitate the development of a strategic plan for the institution*: 30.04%
- *Develop a business/operational plan for the management of the institution*: 24.92%
- *Monitor and report on the implementation of the business/operational plan*: 22.70%
- *Anticipate potential risks and facilitate risk management*: 29.07%

As discussed in section 4.3.3.1.5 *strategic planning* is closely linked to *financial planning*. Therefore there are adequate structured guidelines in place in the public health sector in South Africa to assist managers with *strategic planning*. The legislative requirements that expect monitoring in terms of the Public Finance Management Act , Act 1 of 1999, section 39 ( South Africa 1999), also apply to monitoring of strategic plans as it relates to outputs achieved in line with the expenditure of the allocated budget.

### 5.2.3 Mentorship and leadership development

Self-assessment of leadership competencies provided an understanding of how health services leaders viewed themselves. Overall there was a general improvement in all the competencies as discussed in the previous sections. However, the significance of the overall improvement in the leadership competencies was then established through a

paired t-test. The results confirmed that the improvement was significant at a significance level of less than 5%.

As one of the objectives of this study was to determine whether mentorship programmes existed in health care settings, and if so, the role they play in preparing personnel for leadership positions. It was essential to determine the effect of participation versus non-participation in mentorship programmes on leadership development. As the number of respondents comprised a fairly small sample, an independent two sample t-test was performed to identify which leadership competencies were lacking if respondents did not participate in a mentorship programme. The results indicated that at a <5% level of significance, *communication and relationship management, human resource planning* and *leadership skills and behaviour* were lacking in the first year in office if the respondents had not participated in mentorship programmes prior to taking office. After two years or more in office, there was still a lack of competency in *communication and relationship management* and *leadership skills and behaviour* at a 5% level of significance.

This result reinforced the fact that whilst it is easier to acquire expertise in technical leadership competencies, it is more difficult to develop expertise in the competencies that are often regarded as “soft skills”.

### 5.2.4 Respondents views on mentorship and leadership development policies or programmes in the workplace

Ten (21.73%) of the respondents were exposed to different forms of mentorship programmes, before being appointed to their current positions. The majority (8; 80%) of these ten respondents stated that the programmes were useful and contributed to confidence in their current positions. In addition to this the majority (28; 80%) of those that did not participate in mentorship programmes felt that they would have been better prepared for leadership positions if they had undergone leadership development through mentorship.

Respondents were requested to indicate whether they were aware of the existence and implementation of mentorship programmes for development of future leaders, in their institutions and in the respective Departments of Health. The majority (33; 80.49%) of

respondents indicated that their institution did not have mentorship programmes that targeted the development of future leaders. All questions that related to whether there were policy guidelines in place for mentorship in the respective Departments of Health also elicited negative responses from the majority of respondents (59.52% to 76.74%). The greater majority (40; 90.91%) of respondents recommended mentorship programmes for leadership development based on their views that such programmes were not available at their institutions.

Finally respondents were asked their views on the filling of leadership posts. The majority (37; 86.05%) indicated that it took six months or more to fill a vacant management post. The difference between respondents' views on whether candidates for leadership positions were selected from internal or external candidates was marginal. Seventeen (40.48%) indicated that internal candidates were selected and 21 (51.22%) indicated that external candidates were selected.

Once again, the majority (34; 82.93%) of respondents indicated that a mentorship programme would prevent a deficiency in leadership skills and competencies. This last mentioned point is aligned to mentorship programmes for leadership development and succession planning.

## 5.3 CONCLUSION AND RECOMMENDATIONS

From the analysis of the data accumulated from the questionnaires that were completed and returned, it was apparent that health services leaders in the two provinces that were part of this study were competent, either at the time of taking office or after two years or more, in leadership competencies that are classified as technical skills, but lacked competency in those skills that are behavioural, or are regarded as soft skills**.**

### 5.3.1 Conclusion

Conclusions drawn from the analysis of data accumulated under each of the sections of the questionnaire will be noted before recommendations are made.

#### *5.3.1.1 Biographical information*

Although two-thirds of the respondents were female, it was not within the scope of this study to determine the predominant leadership style in practice. The majority (35; 76%) of the respondents fell in the age group 41-60 years, which implied that they would have had a number of years experience in the various professions that they represented. However, the impact on leadership competencies on assumption of the positions that they held was variable as discussed in section 5.3.1.2.

#### *5.3.1.2 Leadership competencies*

When the average for each of the leadership competencies was calculated, as illustrated in figures 4.4, 4.5, 4.6, 4.7 and 4.8, respondents were less than competent in all the leadership competencies on taking office. However, there was an overall improvement in these competencies over a period of time.

The first objective of this study was to identify the specific leadership competencies required by health services managers from middle management positions and upward. The competencies of *communication and relationship management, leadership skills and behaviour, human resources planning, financial planning and strategic planning* were identified through the literature review

#### *5.3.1.3 Mentorship and leadership development*

The results of the two sample t-test showed that the competencies of *communication and relationship management, human resources planning* and *leadership skills and behaviour* were lacking in the first year in office if the respondents had not received the benefits of mentoring. In the same group, analysis of in self assessment ratings after two or more years in the post indicated a lack in the skills of *communication and relationship management* and *leadership skills and behaviour*.

The second objective was to determine whether mentorship programmes existed in health care settings and if so, the role that they played in preparing personnel for new leadership positions. The respondents who participated in mentorship programmes indicated that it was useful and contributed to the confidence that they felt when taking

on their leadership roles. Those respondents who had not participated in a mentorship programme, felt that they would have been better equipped had they been prepared for leadership through a mentorship programme. From the respondents views it is apparent that neither are mentorship programmes implemented at institutional or directorate level nor are there mentorship programmes for the development of future leaders.

Respondents attested to the importance of mentorship programmes for leadership development. As it generally takes more than six months to fill a leadership post the respondents felt that a mentorship programme for leadership development would prevent this delay in filling leadership posts.

From these findings it is apparent that mentorship programmes for leadership development are not generally in existence in health care facilities that were part of this study. It is also apparent that succession plans for leadership positions are not in existence. Leadership gaps, in the view of respondents, would not have occurred, had there been succession plans because institutions would have drawn from a pool of potential leaders who had been prepared through leadership development programmes.

#### *5.3.1.4 Literature review related to the current status of leadership development*

The need for capacity building of personnel in leadership positions is reiterated by various authors and researchers on the issue of leadership competencies in the health sector in Africa and South Africa in particular.

Ngatia and Kimotho (2009) quote Thabo Mbeki (2006) as saying that Africa needs to invest resources into “reconstruction of credible and competent leadership capacity”. The authors also state that numerous government leaders consistently cite the fact that, personnel managing health systems are not adequately prepared to succeed in leadership positions. They stress the need to “re-tool and re-skill health sector leaders in order to assist them to “plan, organise and maximise the use of available resources to reach their goals and mission”. The authors also stress the need to narrow the gap in skills and competencies in health leadership by ensuring that leadership and management training is part of the curriculum of health professionals.

As recently as August 2009, Collette Clark, speaking on "Building public service leadership capacity", indicated that South Africa has to "establish a leadership pipeline in the public service with targeted training programmes to predict and identify leaders of tomorrow" *Building public service leadership capacity* (2009). Leadership development and succession planning appear to be irrevocably linked.

In a study carried out on hospital managers in six provinces in 2006, 94.9% of 116 hospital managers in the public health sector indicated that they needed further management development. It was significant that they had attended formal management development programmes and yet rated themselves as unprepared for their current responsibilities. According to the researcher in this instance, the managers appeared to gain from informal approaches to development such as mentorship. It is also significant that this researcher identified the fact that many of the managers were above 50 years old and noted the implications for "natural attrition". The researcher noted that as much as development of the current leadership was important, "development of individuals with management potential as part of broader career management and succession planning" was essential for a sustainable and stable health sector leadership Pillay (2008).

### 5.3.2 Recommendations

As health services managers are a heterogeneous group in terms of their professional qualifications, a recommendation for curricula review to include preparation for leadership positions is beyond the scope of this study. However, health professionals that render services in the public health sector often belong to teams and the largest group of health professionals are nurses who are often the most stable in terms of continuity of service in specific institutions. This being the case it recommended that the provincial Departments of Health that were part of this study develop and implement policy guidelines for succession planning. In so doing the issues of leadership development and mentorship would be integrated into the process of succession planning.

Rothwell (2006:2-6) outlines steps to succession planning, which could be modified and combined with policies and programmes currently in place in the South African public sector. These steps will be summarised, compared with the present South African

public health sector and a relevant recommendation will be made. Information provided pertaining to the recommendations is sourced from policy guidelines available from the South African National Department of Health's website and from the researchers own experience in the public health sector.

#### 5.3.2.1 Succession planning and leadership development

| | **Steps to Succession planning (Rothwell 2006:5-7)** | **Alignment with the South African public health sector** | **Recommendation** | **Responsibility** |
|---|---|---|---|---|
| 1 | Clarify senior leaders' expectations and preferences for succession plans | The National Human Resources for Health Plan outlines "leadership guidance in development and implementation of appropriate leadership training programmes for the health sector (NDoH 2006:63) | Policy guideline on succession planning be developed at provincial Departments of Health | Human Resources Development Directorates in collaboration with Policy and Planning Directorates |
| 2. | Establish Competency models | The Senior Management Services Handbook (DPSA: 2003) identifies the competencies required of manages in leadership positions. | The competency framework should be adapted to suite institutional managers in the public health sector | Human resources departments and skills development units at institutional level |
| 3 | Conduct multi –rater, full-circle assessment | Is only applied to executive authorities in some provinces. | Guidelines for full –circle assessment should be developed at provincial level in consultation with relevant stakeholders and then be devolved to institutions for application | Human Resources Management Directorates in provinces |
| 4. | Establish an organisational | A system of performance | The system should be | Institutional managers in |

| | Steps to Succession planning (Rothwell 2006:5-7) | Alignment with the South African public health sector | Recommendation | Responsibility |
|---|---|---|---|---|
| | performance management system | management is implemented in all public health institutions. | periodically reviewed for effectiveness in identifying individuals eligible for promotion | collaboration with the human resources departments. |
| 5. | Assess individual potential for success at higher levels of responsibility | Other than personnel appointed in acting positions or deputising in the absence of a manager, no system is in place for such a process | The full-circle assessment could be developed and used for the purpose of identifying candidates with leadership potential | Human Resources Management Directorates in provinces. To be implemented at institutional level |
| 6. | Regularly review ongoing individual development plans | This is part of the performance management development plans in place in public health institutions currently | Individual personnel should be encouraged to pursue development programmes and these must be supported by managers | Institutional managers and skills development committees |
| 7. | Implement individual development plans | individual personnel identify developmental needs that are fed into the skills development plan of the institution | Personnel development plans should be reviewed to identify potential individuals for leadership development. This is the step in which selected individuals should be engaged in mentorship programmes for leadership development | Institutional managers, skills development committees, selected personnel |
| 8. | Develop a talent inventory | None | Personnel that are selected for mentorship programmes could be kept on a data base at institutional and provincial level. | Human resources departments at institutional and provincial level |

| | Steps to Succession planning (Rothwell 2006:5-7) | Alignment with the South African public health sector | Recommendation | Responsibility |
|---|---|---|---|---|
| | | | Policy guidelines could be developed to develop a talent inventory for the public sector | |
| 9. | Establish accountability for succession planning | None | Individuals who succeed at achieving development objectives could be rewarded through recognition<br>It is recommended that policy guidelines be developed for managers to monitor and evaluate programmes for succession planning | Institutional managers |
| 10. | Evaluation of the results of succession planning | None | An audit of the time that it takes to fill management posts should be conducted quarterly. This will be an objective indictor of the success or failure of succession planning | Human resources departments |

According to Weiss and Drake (2007:33), the Veterans Health Administration in New York manage a career development data base that allows nursing leaders to identify future nurse leaders for succession planning. This is perhaps a route that could be followed in South Africa as well. Ngatia and Kimotho (2009) also recommend that a "health leadership and management career path for health workers responding to country specific needs should be part of continuous professional development".

#### *5.3.2.2 Mentorship*

In 2006, the Department of Public Service and Administration published "The Public Service Mentorship Programme Step by Step Guide" which serves the purpose of implementing mentorship facilitation across the broader public sector. This policy should be adapted for each provincial Department of Health as the structures recommended in the guide may variable. In a concerted effort, healthcare institutions should be oriented and trained on how to implement the guideline. Furthermore, a monitoring system should be put in place by health authorities to assess the effectiveness of implementing this programme, so that the necessary support and guidance could be provided.

### 5.3.3 Recommendations for future research

In this study it was found that the majority (28; 62.22%) of respondents were women. However, the leadership style in practice and its relationship with leadership development was not explored. Secondly the literature review pointed out the fact that health services leaders have different professional backgrounds. In this study it was established that the respondents viewed themselves as competent in strategic planning skills. This study was not able to establish the level of preparation for leadership that took place at undergraduate or post graduate level in the various professions. The literature also points to the fact that a certain level of emotional intelligence is essential for individuals to enter into mentorship programmes. Therefore the following is recommended for future research:

- Investigate the leadership management styles in practice and the relationship to leadership development.
- Initiate a multidisciplinary collaborative review of health professionals curricula with a view to recommending the integration of preparation for leadership.
- Assess Emotional intelligence in health services leaders and design a programme for development of emotional intelligence.

## 5.4 LIMITATIONS OF THIS STUDY

A number of limitations impacted on this study. These are as follows:

- The response rate was low (46; 30%).
- The study was conducted in two out of nine provincial Departments of Health and therefore cannot be generalised.
- The research instrument on the self assessment of leadership competencies required respondents to answer two columns related to the first year in office and then again in the current situation, this may have led to the fact that questions were not answered consistently by all respondents.

## 5.5 CONCLUSION

This study was conducted in two provincial departments of health with the objective of identifying the relationship between mentorship and leadership development. Questionnaires were despatched to managers and respondents conducted a self assessment of leadership competencies over a period of time and shared their views on mentorship programmes and policies.

Analysis of the data accumulated from the completed questionnaires identified varying level of preparedness for their positions as health services managers, with *strategic planning* being rated the highest. Statistical analysis confirmed respondents self assessment of an improvement in the listed leadership competencies over time.

However, when further statistical analysis was conducted to identify whether non-participation in mentorship programmes impacted on leadership competencies, it was identified that that the competencies of *communication and relationship managemen , human resource planning* and *leadership skills and behaviour* were lacking in the first year in office and after two years or more the competencies of *communication and relationship management and leadership skills and behaviour* were still lacking.

Respondents who were exposed to mentorship programmes before taking office cited that such experience made them more confident in their current positions and those respondents that were not exposed to mentorship programmes indicated that they would have been better prepared if they were exposed to leadership development through mentorship before taking office.

This study also established the link between succession planning, leadership development and mentorship and hence recommendations were made accordingly.

The value of this study was identifying the integration of succession planning, leadership development and mentorship and noting that it could be implemented in the South African public health sector.

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## Annexure $A_1$

## Permission to conduct research: Gauteng Department of Health

## Annexure $A_2$

## Permission to conduct research:

## Northwest Province – Department of Health

## Annexure $A_3$

## Letter requesting permission to conduct research in the

## Northwest Department of Health

## Annexure $A_4$

## Letter requesting permission to conduct research in the

## Gauteng Department of Health

## Annexure B

## Permission to conduct research granted by a CEO

# Annexure C

## Permission granted by ACHE to use questionnaire

# Annexure D

# Questionnaire

# Annexure E

# Participant information letter

# Annexure F

# Request for Ethical Clearance from University of South Africa

# Annexure G

# Ethical Clearance from University of South Africa

# ANNEXURE B

Umnyango wezempilo no Kuthuthukiswa Komphakathi
Lefapha la Maphelo le Tshebeletso le Ntshetsopele ya Sechaba
Department of Health and Social Development
Departement van Gesondheid en Maatskaplike Ontwikkeling

TSHWANE/METSWEDING REGION
Enquiries: Ms M Mosito
+27725602528
Email:Motlalepule.Mosito@gauteng.gov.za

## TSHWANE METSWEDING REGION RESEARCH ETHICS COMMITTEE

## CLEARANCE CERTIFICATE

**Meeting: 02/2010**

**PROJECT NUMBER: TMREC 2010/59**

**PROJECT:**

| | |
|---|---|
| Title: | Mentorship in Health Service |
| Researcher: | S Peters |
| Supervisor: | Prof MC Bezuidenhout |
| Department: | Health Studies, University of South Africa (UNISA) |
| Degree: | MA (Health Scrvice Management) |

**DECISION OF THE COMMITTEE**

**Approved**

**Date: 26 October 2010**

.....
Dr KE Letebele-Hartell
Chairperson Tshwane Metsweding Research Ethics Committee

.....
Mr M Pitsi
Acting Chief Director: District Health Services
Tshwane Metsweding Region
2010.11.03

**NOTE:** Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedure as approved by the committee.
**ALL CORRESPONDANCE TO INCLUDE PROTOCOL NUMBER**

# ANNEXURE C

**From:** Reed L. Morton, PhD, FACHE, CJSS [RMorton@ache.org]
**Sent:** Monday, August 30, 2010 5:47 PM
**To:** Savathri, Peters (GPHEALTH)
**Subject:** RE: Permission to use ACHE assessment tool in a research study

Dear Mrs. Peters:

The competency assessment is in the public domain. If you modify it then it won't be the ACHE Competency Assessment rather the S Peters Competency Assessment. However, if you cite it as a source then the matter of satisfying thesis requirements will reside with your faculty adviser and what in my academic experience was a person whose title was "The Graduate Examiner."

Good luck in conducting your research and completing your thesis and degree.

**From:** Savathri, Peters (GPHEALTH) [mailto:Peters.Savathri@gauteng.gov.za]
**Sent:** Saturday, August 28, 2010 1:59 AM
**To:** Reed L. Morton, PhD, FACHE, CJSS
**Subject:** Re: Permission to use ACHE assessment tool in a research study

Dear Dr Morton

I am a student at the University of South Africa, resident in South Africa

I am currently studying towards my Masters in Health Services Management.
My topic for research is Mentorship in Health Services Leadership .
During my literature search I identified your publication on "ACHE Health Care Executive Competencies Assessment Tool 2010" as a valuable tool that I could adjust for use in my research instrument.

I am requesting authorization to utilize your assessment with modifications in my research. Acknowledgement of the source will be included in my research

I look forward to a positive response from you

Mrs S Peters

Principal
Chris Hani Baragwanath Nursing College
Contact Nos.:027 11 983 3009
027 71 674 1800

# Annexure D

**QUESTIONNARE NO:**

| | | |
|---|---|---|
| 1 | 2 | 3 |

MENTORSHIP IN HEALTH SERVICES LEADERSHIP

Completing this questionnaire indicates that you consent to participate in this study and that you acknowledge that you have read the outline in the information sheet.

Section 1

Please select the appropriate answer and place an **X** in the relevant field in the answer column.

**Section 1:Biographical Data**

| **Question 1.1** | **Gender** | **Answer** | **Columns for official use** | | |
|---|---|---|---|---|---|
| | **Male** | **1** | | | |
| | **Female** | **2** | | | **4** |
| | | | | | |
| **1.2** | **Age** | | | | |
| | <30 yrs | **1** | | | |
| | 31 – 40 yrs | **2** | | | |
| | 41 – 50 yrs | **3** | | | |
| | 51 – 59 yrs | **4** | | | |
| | ≥ 60 yrs | **5** | | | **5** |
| | | | | | |
| **1.3** | **Current position** | | | | |
| | Chief Director | **1** | | | |
| | Director | **2** | | | |
| | Deputy Director | **3** | | | **6** |
| | | | | | |
| **1.4** | **Number of years experience in current post** | | | | |
| | < 2yrs | **1** | | | |
| | 2 – 5yrs | **2** | | | |
| | 6 – 9 yrs | **3** | | | |
| | ≥ 10 yrs | **4** | | | **7** |

| Question | | Answer | Columns for official use | | |
|---|---|---|---|---|---|
| **1.5** | **In which of the following institutions/sections are you employed** | | | | |
| | Provincial Head Office | **1** | | | |
| | Regional/District office | **2** | | | |
| | Hospital | **3** | | | |
| | Nursing College | **4** | | | **8** |

## Section 2: Leadership Competencies

**This** section is a self assessment of leadership competencies over a period of time. **Column A of each subsection represents a self assessment in the first year of assumption of your post. Column B of each subsection is a current self assessment.**

**Key: 1:** Novice **2:** Competent **3:** Expert

**Competence 1: Communication and relationship management**

**Please place an X in the appropriate block in both column A and column B for each item.**

| **NB: Answer columns A and B** | **Column A ( During year 1 in your post)** | | | **For Official Use** | | | | **Column B ( Current self assessment)** | | | **For Official Use** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.1 Build collaborative relations | 1 | 2 | 3 | | | 9 | | 1 | 2 | 3 | | | 38 |
| 1.2 Identify stakeholder expectations | 1 | 2 | 3 | | | 10 | | 1 | 2 | 3 | | | 39 |
| 1.3 Practice shared decision making | 1 | 2 | 3 | | | 11 | | 1 | 2 | 3 | | | 40 |
| 1.4 Communicate and model the vision of the institution/ directorate | 1 | 2 | 3 | | | 12 | | 1 | 2 | 3 | | | 41 |
| 1.5 Foster an inclusive workplace that manages diversity and individual differences to achieve the vision of the institution | 1 | 2 | 3 | | | 13 | | 1 | 2 | 3 | | | 42 |
| 1.6 Provide results of data analysis to senior staff e.g. financial and HR trends | 1 | 2 | 3 | | | 14 | | 1 | 2 | 3 | | | 43 |
| 1.7 Use mediation, negotiation and conflict resolution to maintain labour peace | 1 | 2 | 3 | | | 15 | | 1 | 2 | 3 | | | 44 |

**Key: 1:**Novice **2:**Competent **3:** Expert

**Competence 2: Leadership skills and behaviour**
**Please place an X in the appropriate block in both column A and column B for each item.**

| **NB: Answer columns A and B** | **Column A ( During year 1 in your post)** | | | **For Official Use** | | | | **Column B ( Current self assessment)** | | | **For Official Use** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.1 Develop strategy to achieve vision and mission | 1 | 2 | 3 | | | 16 | | 1 | 2 | 3 | | | 45 |
| 2.2 Apply legal and regulatory standards | 1 | 2 | 3 | | | 17 | | 1 | 2 | 3 | | | 46 |
| 2.3 Foster an environment of trust | 1 | 2 | 3 | | | 18 | | 1 | 2 | 3 | | | 47 |
| 2.4 Advocate for, and participate in health care policy initiatives | 1 | 2 | 3 | | | 19 | | 1 | 2 | 3 | | | 48 |
| 2.5 Create an organisational climate that encourages team work | 1 | 2 | 3 | | | 20 | | 1 | 2 | 3 | | | 49 |
| 2.6 Encourage high level commitment to the purpose and value of the institution | 1 | 2 | 3 | | | 21 | | 1 | 2 | 3 | | | 50 |
| 2.7 Promote and manage change | 1 | 2 | 3 | | | 22 | | 1 | 2 | 3 | | | 51 |
| 2.8 Promote continuous organisational improvement and growth | 1 | 2 | 3 | | | 23 | | 1 | 2 | 3 | | | 52 |
| 2.9 Plan strategy for overcoming obstacles to achievement of institutional goals | 1 | 2 | 3 | | | 24 | | 1 | 2 | 3 | | | 53 |

**Key: 1:**Novice **2:**Competent **3:**Expert

**Competence 3: Human Resources (HR) Planning**

**Please place an X in the appropriate block in both column A and column B for each item.**

| **NB: Answer columns A and B** | **Column A (During year 1 in your post)** | | | **For Official Use** | | | | **Column B ( Current self assessment)** | | | **For Official Use** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.1 Build and manage HR and work situations based on institutional goals , budget and staffing needs | 1 | 2 | 3 | | | 25 | | 1 | 2 | 3 | | | 54 |
| 3.2 Assess current and future HR needs based on institutional goals , budget and staffing needs | 1 | 2 | 3 | | | 26 | | 1 | 2 | 3 | | | 55 |
| 3.3 Use efficient and cost effective approaches to integrate technology to improve workplace effectiveness | 1 | 2 | 3 | | | 27 | | 1 | 2 | 3 | | | 56 |

**Key: 1:**Novice **2:**Competent **3:**Expert

**Competence 4: Financial Planning**

**Please place an X in the appropriate block in both column A and column B for each item.**

| **NB: Answer columns A and B** | **Column A ( During year 1 in your post)** | | | **For Official Use** | | | | **Column B ( Current self assessment)** | | | **For Official Use** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.1 Understand principles of financial management | 1 | 2 | 3 | | | 28 | | 1 | 2 | 3 | | | 57 |
| 4.2 Prepare , justify and administer budget | 1 | 2 | 3 | | | 29 | | 1 | 2 | 3 | | | 58 |
| 4.3 Monitor expenditure | 1 | 2 | 3 | | | 30 | | 1 | 2 | 3 | | | 59 |
| 4.4 Identify cost effective approaches to management | 1 | 2 | 3 | | | 31 | | 1 | 2 | 3 | | | 60 |
| 4.5 Manage procurement and contracting | 1 | 2 | 3 | | | 32 | | 1 | 2 | 3 | | | 61 |

**Key: 1:**Novice **2:**Competent **3:**Expert

**Competence 5: Strategic Planning**

**Please place an X in the appropriate block in both column A and column B for each item.**

| **NB: Answer columns A and B** | **Column A ( During year 1 in your post)** | | | **For Official Use** | | | | **Column B ( Current self assessment)** | | | **For Official Use** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5.1 Facilitate development of a strategic plan for the institution | 1 | 2 | 3 | | | 33 | | 1 | 2 | 3 | | | 62 |
| 5.2 Develop a business/operational plan for management of institution | 1 | 2 | 3 | | | 34 | | 1 | 2 | 3 | | | 63 |
| 5.3 Monitor and report on implementation of business/operational plan | 1 | 2 | 3 | | | 35 | | 1 | 2 | 3 | | | 64 |
| 5.4 Analyse policy issues and strategic planning with long term perspectives | 1 | 2 | 3 | | | 36 | | 1 | 2 | 3 | | | 65 |
| 5.5 Anticipate potential risks and facilitate risk management | 1 | 2 | 3 | | | 37 | | 1 | 2 | 3 | | | 66 |

## Section 3: Mentorship

Mentorship has undoubtedly been recognised nationally and internationally as an effective way to develop leadership. This following section deals with your personal experience with and or opinions on mentorship in leadership development.

**Please place an X in the appropriate block in both column A and column B for each item.**

If you were exposed to a mentorship programme, answer questions 2 to 7, and if you were not exposed to any mentorship programme, answer questions 8 to 9. **All respondents should please answer questions 1; 10 – 17**

**KEY: 1: Yes 2: No**

| **ALL respondents to answer questions 1** | | | | |
|---|---|---|---|---|
| | YES | NO | For official use | |
| 1. Did you participate in a mentorship programme before taking on a leadership position? | 1 | 2 | | 67 |
| **If your answer to question 1 is YES answer questions 2 to 7 and then proceed to question 10.<br>If your answer to question 1 is NO go on to question 8 and complete the questionnaire** | | | | |
| Were you exposed to the following types of programmes? | | | | |
| 2. Formal structured programme | 1 | 2 | | 68 |
| 3. Informal programme | 1 | 2 | | 69 |
| 4. Collegial mentorship relations | 1 | 2 | | 70 |
| 5. Supportive role models acted as mentors | 1 | 2 | | 71 |
| 6. Was your mentorship experience beneficial? | 1 | 2 | | 72 |
| 7.Did it contribute to confidence in your current position? | 1 | 2 | | 73 |

| | | | | |
|---|---|---|---|---|
| **Answer questions 8 and 9 only if you were <u>NOT</u> exposed to a mentorship programme** | | | | |
| | YES | NO | | For official use |
| 8.Do you think that the lack of mentorship affected you negatively in adjusting to a leadership position? Please motivate your answer below | 1 | 2 | | 74 |
| 9.Do you feel that if you had been prepared through mentorship you would have been more confident on assuming a leadership position ? | 1 | 2 | | 75 |
| | | | | |
| **The following questions should be to be answered by <u>ALL</u> respondents** | | | | |
| 10. Do you have knowledge of any policy guidelines in place for mentorship? | 1 | 2 | | 76 |
| 11. Does your department/institution have policy guidelines in place for mentorship for potential leaders | 1 | 2 | | 77 |
| 12. Are there any mentorship programmes in the Department of Health that you know of? | 1 | 2 | | 78 |
| 13. Are mentorship programmes implemented in your institution/directorate? | 1 | 2 | | 79 |
| 14. Does your institution have a mentorship programme in place that targets development of future leaders? | 1 | 2 | | 80 |
| 15. Would you recommend leadership preparation through mentorship programmes? | 1 | 2 | | 81 |
| 16. From you experience or knowledge does it usually take more than 6 months to fill a vacant leadership position? | 1 | 2 | | 82 |
| 17. In your opinion are candidates for leadership positions selected from internal candidates? | 1 | 2 | | 83 |
| 18 In your opinion are candidates for leadership positions in your institution, generally selected from external candidates | 1 | 2 | | 84 |
| 19. In your opinion would a mentorship programme for potential leaders in your department prevent a leadership gap when positions are vacated? Please motivate your answer below. | 1 | 2 | | 85 |

20 Any additional information you wish to provide in terms of the value of, or lack of mentoring for leadership positions

_____

Thank you for taking the time to fill out this questionnaire

# Annexure E

## Participant Information Leaflet

32 Bloubos Street
Mayberry Park
Alberton
1448

Dear Respondent

Mentorship in Health Services Leadership

I am a manager in a health institution and I am in the process of doing my M Cur Degree with UNISA.

The purpose of my study is to establish the relationship between mentorship and leadership development in health services. The objective is to compile guidelines for application of existing policies that could strengthen the practical application and contribute to a structured approach for succession planning.

This letter requests your participation in this study; you will be asked to complete a questionnaire that involves self analysis over a period of time.

Completed questionnaires may be sent back via e-mail or faxed to 011 983 3001. In order to maintain anonymity you will not be asked to sign a consent form.

**The implication of completing the questionnaire is that informed consent has been obtained from you. Your participation in this study is voluntary and you can refuse to participate or withdraw at any time, without giving a reason.**

All data collected will be kept confidential, stored for the required time and only made available to the research supervisor and co-supervisor. The outcome of the research will be published in professional journals and the researcher commits to ensuring that confidentiality will be maintained.
You are free to contact the researcher at any time for questions of clarity.

Thank you for deciding to participate in this study. As a result or your cooperation, a guideline for application of mentorship programmes in developing future leaders and a recommendation for a guideline to succession planning in health services will be developed. The objective is to have a pool of potential leaders available and maintain organisational stability in health service institutions.

Kind Regards

_____ _____

Mrs S Peters Date

# Annexure F

## DOCUMENT 5

### SUMMARY SHEET FOR THE ETHICAL CLEARANCE OF POSTGRADUATE STUDENT PROPOSALS FOR THESES/DISSERTATIONS

The Higher Degrees Committees in Departments in the College of Human Sciences are reminded that they should make their students aware of the policy for research ethics of UNISA available at:
http://cm.unisa.ac.za/contents/departments/res_policies/docs/ResearchEthicsPolicy_apprvCounc_21Sept07.pdf

In judging postgraduate student proposals, Higher Degree Committees should comment on the methodological, technical and ethical soundness of the proposal and ask students to complete the following summary sheets. Difficult or special cases should be referred to the Ethics Subcommittee of the College of Human Sciences under the chairmanship of Prof Kuzvinetsa Peter Dzvimbo, the Deputy Executive Dean: College of Human Sciences (Tel: 012 429 4067; E-mail: dzvimkp@unisa.ac.za).

### CANDIDATURE DETAILS

**A1 FULL NAME OF CANDIDATE**

| |
|---|
| **Mrs Savathri Peters** |

**A2 ACADEMIC AND PROFESSIONAL QUALIFICATIONS**

| |
|---|
| **B A Honors; B A (Cur) Nursing; Diplomas in Nursing Education; Psychiatric Nursing; Midwifery and General Nursing** |
| |

**A3 THESIS/DISSERTATION TITLE**

| |
|---|
| **Mentorship in Health Services Leadership** |
| |
| |

**A4 PERSONAL PARTICULARS**

| | |
|---|---|
| (a) student number: | 581 993 8 |
| (b) current address: | 32 Bloubos Street, Mayberry Park, Alberton 1448 |
| (c) e-mail: | Lynettepeters2004@hotmail .com |
| (d) telephone number(s) | 011 9833009 (W); 0716741800 (C) |

**A5 PROMOTER(S)/SUPERVISOR/(S)**

| | |
|---|---|
| (a) Initials & surname: | Prof. M C Bezuidenhout |
| (b) Contact details: | 012 429 6303 |
| (c) Department: | Health Studies |
| | |
| (a) Initials & surname: | Prof A D H Botha |
| (b) Contact details: | 012 429 8814 |
| (c) Department: | Health Studies |

## B PROPOSAL SUMMARY SHEET

### B1 ABSTRACT OF THE PROPOSAL

**Leadership positions in the public health sector in South Africa are demanding in that incumbents in these positions are expected to be competent in a wide range of skills ranging from corporate governance to clinical management and academic expertise. Personnel often move into these posts with little experience or guidance prior to occupying the post. Leadership development appears to be a key factor in the preparation of future leaders.**
**The role of mentorship in leadership development is well recognised in the public as well as the private sector. Numerous studies that have been conducted on leadership development reinforce the positive role of mentorship.**
**The purpose of this study is to explore and describe the significance of mentorship on leadership development and to make recommendations for succession planning in public sector health services institutions.**

### B2 RESEARCH OBJECTIVES

1. **Identify the specific leadership competencies required by health services' leaders from middle management positions and upward.**
2. **Explore the specific needs of health services leaders from middle management position and upward with regard to mentorship training.**
3. **Determine whether mentorship programmes exist in health settings and if so, the role they play in preparing personnel for new leadership positions.**
4. **Make recommendations for succession planning**

### B3 RESEARCH DESIGN

**This study will use a quantitative approach with an an explorative and descriptive design**

### B4 HOW SHOULD THIS STUDY BE CHARACTERISED? (Please tick all appropriate boxes.)

| | | |
|---|---|---|
| Personal and social information collected directly from participants | Yes x | No |
| Participants to undergo physical examination* | Yes | No x |
| Participants to undergo psychometric testing** | Yes | No x |
| Identifiable information to be collected about people from available records (e.g. medical records, staff records, student records, etc.) | Yes | No x |

***For medical or related procedures, please submit an application to a medical ethics committee.**
****Please add details on copyright issues related to standardized psychometric tests**

### B5 WHAT IS THE AGE RANGE OF THE INTENDED PARTICIPANTS IN THIS STUDY?

**30 to 60+ years**

**B5.1 If the proposed participants are 18 years and older, is the informed consent form for participants attached?**

| Yes x | No | Not applicable |
|---|---|---|

**B.5.2 If the proposed participants are younger than 18 years, are consent and assent forms attached?** (In order for minors -younger than 18 years of age- to participate in a research study, parental or guardian permission must be obtained. For minors a youth assent form is required.)

| Yes | No | Not applicable x |
|---|---|---|

**B5.3 Description of the process for obtaining informed consent (if applicable)**

**Respondents will be informed that their willingness to fill in the questionnaires will be regarded as consent to participate in the research.**
**They will also be informed that participation in the research is voluntary and that confidentiality and anonymity will be ensured.**

**B6. DESCRIPTION OF THE RISKS POSED BY THE PROPOSED STUDY WHICH RESEARCH PARTICIPANTS MAY/WILL SUFFER AS WELL AS THE LEVEL OF RISK** (please consider any discomfort, pain/physical or psychological problems/side-effects, persecution, stigmatisation or negative labelling)

**The only risk may be psychological when participants have to self reflect on past and current competencies in the execution of their responsibilities.**

**B7. DESCRIPTION AND/OR AMOUNTS OF COMPENSATION INCLUDING REIMBURSEMENTS, GIFTS OR SERVICES TO BE PROVIDED TO PARTICIPANTS (IF APPLICABLE)** (Will the participants incur financial costs by participating in this study? Will incentives be given to the participants for participation in this study? )

**None**

**B8. DESCRIPTION FOR ARRANGEMENT FOR INDEMNITY (IF APPLICABLE)**

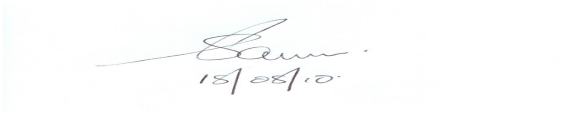
**Not applicable**

**B9. DESCRIPTION OF STEPS TO BE UNDERTAKEN IN CASE OF ADVERSE EVENTS OR WHEN INJURY OR HARM IS EXPERIENCED BY THE PARTICIPANTS ATTRIBUTABLE TO THEIR PARTICIPATION IN THE STUDY**

**Not applicable**

## C CANDIDATE'S STATEMENT AGREEING TO COMPLY WITH ETHICAL PRINCIPLES SET OUT IN UNISA POLICY ON RESEARCH ETHICS

I, Mrs Savathri Peters declare that I have read the policy for research ethics of UNISA and that this form is a true and accurate reflection of the methodological and ethical implications of my proposed study. I shall carry out the study in strict accordance with the approved proposal and the ethics policy of UNISA. I shall maintain the confidentiality of all data collected from or about research participants, and maintain security procedures for the protection of privacy. I shall record the way in which the ethical guidelines as suggested in the proposal has been implemented in my research. I shall work in close collaboration with my promoter(s)/supervisor(s) and shall notify my promoter(s)/supervisor(s) in writing immediately if any change to the study is proposed. I undertake to notify the Higher Degrees Committee in writing immediately if any adverse event occurs or when injury or harm is experienced by the participants attributable to their participation in the study.



## D OBSERVATIONS BY THE HIGHER DEGREES COMMITTEE OF THE DEPARTMENT

D1. Is the proposal of an acceptable standard?

**YES** ☐
**NO, IT SHOULD BE REFERRED BACK TO THE CANDIDATE** ☐

COMMENTS:_____
_____
_____
_____
_____

D2 Are all reasonable guarantees and safeguards for the ethics of this study covered?

**YES** ☐
**NO, IT SHOULD BE REFERRED BACK TO THE RESEARCHER** ☐

COMMENTS:_____
_____
_____
_____
_____

We have reviewed this completed Summary Sheet and are satisfied that it meets the methodological, technical and ethical standards as set in our Department and that it is in compliance with the UNISA policy on research ethics.

| | |
|---|---|
| Signed: | |
| Name: | |
| Date: | |

# ANNEXURE G

UNISA university of south africa

**UNIVERSITY OF SOUTH AFRICA**
**Health Studies Research & Ethics Committee**
**(HSREC)**
**College of Human Sciences**

## CLEARANCE CERTIFICATE

Date of meeting: **7 October 2010** Project No: **581 993 8**

Project Title: **Mentorship in health services leadership**

Researcher: **Ms S Peters**

Supervisor/Promoter: **Prof MC Bezuidenhout**

Joint Supervisor/Joint Promoter: **Prof ADH Botha**

Department: **Health Studies**

Degree: **MA Health Studies**

**DECISION OF COMMITTEE**

**Approved** [√] **Conditionally Approved** [ ]

Date: **7 October 2010**

**Prof GH van Rensburg**
**RESEARCH AND ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES**

**Prof MC Bezuidenhout**
**ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

**PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES**

University of South Africa
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PO Box 392, UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150