INVESTIGATION INTO HEALTH CARE FACILITIES IN KWAZULU-NATAL: A SPECIAL FOCUS ON PROFESSIONAL ETHICS

SUMMARY REPORT

MARCH 2018

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AN	Assistant Nurse
ANC	Ante Natal Care
ARV	Anti-Retroviral
CCG	Community Care Giver
CEO	Chief Executive Officer
CCMDD	Centralised Chronic Medicine Dispensing and Distribution
COHSASA	Council of Health Service Accreditation of Southern Africa
COMSERVE	Community service
CTOP	Choice of Termination of Pregnancy
CSSD	Central Sterile Supply Department
GO	General Orderly
HAST	HIV, AIDS, STI and TB
HCT	HIV Counselling and Testing
HIV	Human Immuno Virus
EMS	Emergency Medical Services
ICRM	Integrated Chronic Disease Management
ICU	Intensive Care Unit
KINC	KwaZulu-Natal Initiative on New-born Care
MMC	Medical Male Circumcision
MASEA	MEC's Annual Service Excellence Awards
MEC	Member of the Executive
MOPD	Medical Out-Patient Department
MNCWH	Maternal, Neonatal, Child & Women Health
MDR-TB	Multi Drug resistant Tuberculosis
MDT	Multi Drug Tuberculosis
OPD	Out-Patient Department
OSS	Operation Sukuma Sakhe
NHI	National Health Insurance
NIMART	Nurse Initiated and Managed Antiretroviral Therapy
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PN	Professional Nurse

SHS	School Health Services
SOPD	Surgical Out-Patient Department
STI	Sexual Transmitted Infections
TB	Tuberculosis
UTT	Universal Test and Treat
VCT	Voluntary Counselling and Testing
WBOT	Ward Based Organization Team(s)
XDR	Extreme Drug Resistance

1. INTRODUCTION

1.1 Background and Purpose

Following a number of complaints by citizens and in the media, the Public Service Commission (PSC) decided that its research in KwaZulu-Natal would be focused on the Health Sector for two years (2016/17 & 2017/18). A quick pilot study on clinics, which were the subject of complaints, was done so that problems were understood within their context and research tools were tested. In large measure the pilot showed that the major issues were around professional ethics. The research study on Health Care in KwaZulu-Natal was thus conceptualized using the lens of professional ethics, i.e. looking at the institutions' approach to ethics and how the institutions perceive their own impact on citizens. In its first year (2016/2017) the study focused on hospitals with some involvement of Districts. Hospitals of different levels of care were sampled in all 11 Districts. In the second year of study, more facilities were included in the sample and focused engagement with selected Health District Offices was done.

During this research, the PSC team has been engaging Health Care facilities' management teams on their monitoring and evaluation methodologies, their approach to Batho Pele and citizen satisfaction, as well as the facilities' own assessment of whether they are fulfilling their mandate. Both in terms of engaging facilities at management level and in terms of inspections, the project in KwaZulu-Natal has sought to investigate whether professional ethics and citizen satisfaction is a pre-occupation of these facilities at the level of: professional conduct, systemic responsiveness to citizen's needs, and the general professional culture within these institutions. The overall impression of the research thus far is that, despite the best intention of the Constitution of the Republic of South Africa on professional ethics (particularly as reflected in section 195), there are serious challenges. The system can be improved to be more deliberate in terms of: inculcating a thriving culture of professional ethics, in policies that are more responsive, in decisions that are quicker and geared towards impacting lives on a daily basis. The bureaucratic system needs to be less rigid than it currently is with routine processes to review delegations and it is in need of discretionary points that are geared towards quicker interventions. The bureaucratic pipeline is not kind within itself, with lower-level management not receiving professional attention they deserve (even by way of responses to their concerns) from the higher level provincial structures.

1.2 Mandate of the PSC

In terms of Section 196 of the Constitution, the PSC has a mandate to promote the Constitutional values set out in section 195 and to propose measures to ensure effective and efficient performance within the Public Service. By inspecting service delivery sites, the PSC generates appropriate information required to assess public service performance and advice on improvements. Furthermore, the PSC promotes the Bill of Rights by ensuring that all the state institutions effectively and efficiently execute their mandates, thus facilitating equal distribution of services to all citizens. Furthermore, inspections are mandated by the Public Service Commission Act, 1997, Section 9, which provides that "the Commission may inspect Departments and other organizational components in the Public Service and has access to such official documents or may obtain such information from Heads of those Departments or organizational components as may be necessary for the performance of the functions of the Commission under the Constitution or the Public Service Act." The Public Service Commission thus conducts the inspections in its own accord, as a methodology into solving Public Administration complaints, and as part of broader research that is geared to understand service delivery challenges, with specific focus on efficiency and enquiry into professional ethics.

1.3 Methodology

The inspections were conducted in all 11 Health Districts. Sampling was done within the Province such that in each district a hospital, and in some Districts also a clinic, were selected. This was done taking into account the variables such as: type of the institution, locality, and population the facilities serve. Letters addressed to the District Managers and Hospital Chief Executive Officers (CEOs) of hospitals, informing them about the inspection visit were sent to respective institutions. A semi-structured questionnaire was used to solicit the information. The facilities were requested to prepare a short presentation on the following:

- types of services the facility provides,
- resources they have,
- quality of service,
- areas of excellence, as well as,

- challenges experienced by the facility

During each engagement with management in site, the purpose of the visit was narrated accordingly, where it was emphasized that PSC places emphasis on the human factor aspect of the interaction between public administration (and public servants) with the citizens, as well as the quality of service that is rendered to the citizens. In this regard the PSC explained that it expected to be informed by the institution as to what are the challenges experienced and what are the areas of excellence in their view in terms of the impact of the institution in the community it serves. They needed to highlight what is supposed to be the impact, in terms of required standards and prescripts and the reasons why it is not feasible, if that is the case. A walkabout, a fulfillment of a guided inspection was then conducted. During such an inspection, the CEO and the team would take PSC Team to various components of the hospital. There are spaces which the PSC team specified it has to see. These were: the reception area, the filing rooms, a typical ward representing each type of service rendered, and public ablution facilities. The PSC team emphasized that areas earmarked for professional seclusion would be respected. As such the inspection team would not be intrusive in consultations, theatres, or any areas mooted as secluded.

Focus group discussions were held with Health District Offices to discuss their role as District Offices in the pipeline of health provision, their assessment of capacity and management quality in the facilities over which they have jurisdiction, strengths and challenges in the District's fulfillment of the mandate of the Department. Specific insight into Monitoring and Evaluation, as well as a perspective on emergency services was also the subject of discussion. This was also because in the facilities presentations, M&E specialists gave a lot of data relating to intervention targets and how well the institutions were doing in meeting them. The district level engagement was crucial as it gave insight into co-ordination and support at a level closest to the facilities. A focus group with some officials at provincial level was held as well as a visit to one of the two laundries that were popularly cited by the facilities as serving the hospitals.

The methodology of this research had limitations in that not too much time was spent engaging the citizen directly outside of observations and the fact that the whole research was instigated by increasing spontaneous voicing of dissatisfaction. While engagements with the institutions were led by management and various levels of practitioners could

be engaged, this too posed a challenge as it is not clear that people would have said everything they would have expressed about management issues. Nevertheless, while limitations can be pointed out about such an approach, it was observed to be the strength of the methodology to raise pertinent questions of impact of institutions with many of those involved in one room.

The methodology was bottom up, in that inspections and focus group discussions were first conducted at facility level, and then Districts were engaged after issues had been identified at facility level. Facilities were given the draft report for comment so that they were satisfied that facts were correctly represented for the time of the inspection. The District Offices that had been selected into the sample as well as the Department at Provincial level were given the same opportunity. Many responses were brief, heeding the call to check veracity of the information, while a small number confused the opportunity as a right of reply to what they deemed to be criticism.

2. RESEARCH ENGAGEMENT WITH HEALTH FACILITIES AND FINDINGS

2.1. Introduction

Like in other provinces, KwaZulu-Natal adopts a comprehensive health care system with various levels of care – from primary to tertiary health care. At the centre of the bureaucratic pipeline is a District Management system which oversees and supports facilities and serves to co-ordinate various access points to health care. Some services, including those that are about technical and infrastructural resources support are co-ordinated from the provincial level. In terms of geographic jurisdiction, Health District Offices are somewhat in alignment with District Municipal boundaries. This enables each District to be able to take stock of what is in that municipal jurisdiction and the various levels of care each facility offers. Primary health care facilities (such as clinics) are allocated under a supervision and support by local hospitals. Thus during this study, a conversation with hospital management teams highlighted their own level of care and the other primary health care facilities (e.g. community health centres or clinics) which they support.

Some hospitals are hugely aware how their location near provincial boundaries affect who is attracted into their facilities. This awareness however, does not mean that their referral systems are flexible in line with transport routes preferred by their patients. Thus the District Health System is a bit rigid in principle, to a point where people make up addresses to ensure convenient access in line with proximity to institutions. Nevertheless, it appears that for urgency some hospitals cannot adhere to the rigid referral systems and indeed they have to exercise understanding. Thus for example Madadeni hospital opens it to a dilemma of referral leniency, which it was unclear whether is supported by the system as a whole. During the research they described the situation in the following manner:

> The hospital [Madadeni] provides services to Newcastle, Danhauser and Emandlangeni communities. It also services Umzinyathi district as well as Dundee and Nquthu referrals. Normally Zululand District refers patients who need higher level of care to Ngwelezane hospital; but for orthopaedic services Zululand also sometimes refers to Madadeni hospital. Uthungulu Health District also refers psychiatric services to Madadeni Hospital, whilst Volkrust refers to Witbank; but patients also cross the provincial border and come to Madadeni because of proximity.

Such fuzziness creates even more complications in Districts such as Harry Gwala where provincial boundaries complicate the need to follow-up through social workers on cases involving psychiatric patients and TB.

The following is a listing of facilities that were sampled for this research. This excludes the clinics which were investigated as part of the pilot study that was done in the initial stages of PSC's focus the Department of Health. A separate report on the pilot study was issued in June 2016. This report is based on research which included the following facilities:

1. Madadeni Hospital
2. Nkonjeni Hospital
3. East Griqualand (EG) and Usher Hospital
4. Addington Hospital
5. Mseleni Hospital
6. Nkandla Hospital
7. Stanger Hospital
8. Ladysmith Hospital
9. Dundee Hospital
10. Northdale Hospital
11. Umzimkhulu Hospital
12. Edendale Hospital
13. Prince Mshiyeni Memorial Hospital
14. Montebello Hospital
15. KwaMagwaza Hospital
16. Osindisweni Hospital
17. Church of Scottland Hospital
18. Manguzi Hospital
19. Vryheid Hospital
20. Niemeyer Memorial Hospital
21. St Andrews Hospital
22. St Margaret Hospital
23. Emmaus Hospital
24. Amandlalati Clinic Hospital
25. Tholusizo Clinic Hospital
26. Rorke's Drift Clinic Hospital
27. KwaPata Clinic Hospital
28. Jolivet Clinic Hospital
29. St Mary's Hospital
30. Mshiyeni Provincial Laundry

In all these facilities presentations were requested for management teams to discuss the services rendered by the facilities, what they consider to be their areas of excellence, what their challenges are, and any other issues they may which to raise relating to service delivery. It was explained that the main lens of the Public Service Commission is professional ethics and Batho Pele. In addition the Public Service Commission conducted and inspection in which the following were the main areas of observation:

- Patient flow
- Signage
- Functioning and capacity of the various units at the time of inspection

Brief conversation was held, during the inspection, with unit heads on status/quality of work and crucial procedures (such as disciplinary procedure).

2.2. Type of services rendered

Various hospitals offer services in line with what their level in the Health Care model. However, the history and location of each facility sometimes influences services offered. For example, because of its location, Stanger Hospital offers both the range of services that Regional and District Hospitals offer. Even though it is now a regional hospital, it cannot shun the duties of a District hospital because there is no District hospital for the immediate community. Yet it is located in big transport networks where the need for higher level interventions has long created the need for it to be a regional hospital. Northdale, on the other hand sees itself as a District hospital which, but by virtue of pressure it offers some regional services. Some hospitals were initiated by missionaries for specific areas of intervention which they continue to offer as long as their Boards maintain a link with that history and for as long as their management can attract the support for that specialized intervention. Madadeni Hospital was founded as a mental hospital. It is ironic though that today one of its biggest challenges is the availability of psychiatrists, and as such it experiences huge challenges in rendering mental health care services.

The following is a comprehensive list of services offered within hospital facilities, with the actual combination of services in various facilities pegged according to whether it is a District, Regional or Tertiary facility:

Medical Services		
Clinical and Casualty Services	**Mental Health care**	**Other Specialisations**
• **Admissions Wards:** Burns Unit, Isolation Ward, Medical Wards, Orthopaedic Wards, Surgical Wards, Paediatric Wards, Urology Ward, Maternity ward • **Outpatient Department Services:** Medical, Surgical, Paediatrics • Emergency and accidents (Casualty) • **Clinics:** Gateway Clinic, Voluntary Counselling and Testing (VCT) Department, Dental Clinic, Ophthalmic Clinic / Eye Clinic, Orthopaedic Outpatient, Wound / Stoma Clinic	• Child mental health services, • Psychiatric outpatient services, • Psychiatric inpatient services	• TB Services (Outpatients and Wards • MDR Unit • Oncology • Renal unit – 12 beds (but no specialist; reliance on Greys hospital)

Other Support Services	
Hospital Support and investigations	**Comprehensive Support Specialisations**
• Radiology Services: C.T. Scan, X-Ray and Ultrasound • Blood Bank, • Medical Laboratory, • Pharmacy, • Physiotherapy, • Occupational Health Unit – OHU	• Crisis Care Centre/ 'Thuthuzela' – deals with domestic violence and rape victims • Adult (ART) services • Clinical Psychology • Dermatology

• Audio visual and speech therapy • Dietician • Urology Services • Intensive Care • Internal Medicine • Male Medical Circumcision (MMC) • Maxillo Facial Services • Operating Theatre • Forensic services • Mortuary	• Ear, Nose and Throat (ENT) Specialization • Echocardiogram • Family Medicine (adult) • Peritoneal Dialysis • Social Work Services

2.3. Areas of Excellence and Challenges: Issues as Raised by Facilities themselves

Areas of excellence

In large measure the question of excellence in service delivery of performance of facilities was found to be a difficult question for many institutions to engage with. In the name of 'areas of excellence' articulation of specific duties in specific units of hospitals was done. But it was not clear what was excellent about what is going on or the measure of excellence. This is not to say that there is no appreciation of the work done by the hospitals or the huge task undertaken under resource constraints that were described to the Public Service Commission. However, management should be clear in terms of what excites them as good performance of the hospital, especially in relation to where **they make a difference – i.e. impact**. Excellence should not be a difficult conversation when management is given the opportunity to flaunt quality of their service.

The following was a citation of what management teams in different hospitals considered to be 'areas of excellence': These were:

- Renovation of buildings or installations of specific infrastructure, e.g. boiler or parking extension
- Awards/accolades given to certain units
- Ratings of various clinics in line with Office of Service Standards
- Restructuring of work so that clinics are given the attention they deserve. For example, availability of pharmacy assistants that are placed at clinics to reduce incorrect dispensing of medication
- Acquisition of technology such as digital pens by Community Care Givers (CCGs)
- Co-ordination with other departments (such as SAPS, social workers) through specialised trauma clinics

This discussion of areas of 'excellence' mixed 'areas of improving the establishment' with 'areas of institutional recognition' which could indirectly mean there is impact. The discussion of the content of survey forms and how the facilities know how the people feel about their service was rather stiff. It was observed that a discussion of excellence in relation to 'difference made is community' or 'responsiveness to patients' had to be eked out and solicited in discussion. This was in contrast to a fluent discussion of challenges. It is not excellence devoid of challenges that the PSC was looking for. In fact articulation of challenges related to interventions would have shown a more impact-driven commitment. For example, where issues of Community Care Givers were discussed, which imply co-ordination with other departments (such as the Department of Home Affairs, Department of Social Development), a more nuanced picture could have been painted around social issues, the Departments' response rate, as well as the ability (or inability) by CCGs to follow-up.

Challenges

The PSC was made aware of a number of challenges faced by the hospitals and their management teams:

- Infrastructure: congestion in specific areas such as Outpatient Departments (OPDs), poor ventilation in waiting areas and consultation rooms
- Poor ventilation generally, which may pose infection risks
- Inadequate bed capacity or bed spacing not meeting acceptable norm (some hospitals have visible challenges with bed capacity in certain units)
- Insufficient office space for personnel in administrative units: Some hospitals scrounge for administrative space and medication storage space.
- No hospital in the study sample was found to have sufficient archival space. The issue of archives seems to be a problem left for hospitals to contend with.
- HR-recruitment and retention of skills is not given an approach sensitive to various context of facilities. A generic moratorium on so-called non-critical staff affects hospitals differently and there is no scope to make a special case – even where security issues are pressing such as where State patients are kept in a psychiatric hospital. A general frown on re-employing people who previously left the Department also affects the system where few are willing to join certain professions especially in remote areas far from urban centres. These recruitment issues ultimately affect service delivery.
- The deployment of rural allowance, to attract professionals to rural hospitals, is not done systematically (at least there is such a perception voices by some facilities), nor is the question of building accommodation appropriately linked to recognition of challenges in attracting professionals in these rural areas.

- Even critical posts are supposed to be ratified centrally by the department at provincial level. Yet no facility management team is clear on how the Ratification Committee sits or works to decide about the distribution of resources or responses to the requests of institutions. Some institutions are unclear whether non-response to their requests means that some posts, which they regard as critical, are in the non-critical list of the Department. These are such posts such as: Deputy Matrons, Public Relations Officers, and Health and Safety Officers. But more than what list posts belong to, the assessment of whether the facility can still function without a certain level of capacity (in other words, the basic level of capacity to allow for delivery) is not done. Hence the non-filling of 'non-critical posts' ends up affecting the work of critical professions in different settings.
- The acquisition, maintenance or certification of medical equipment after it had been repaired is not co-ordinated with due regard for sustaining service delivery. Some hospitals will simple not be able to deal with certain conditions because equipment acquisition or maintenance cycles are at odds with delivery. While the province has been cited in the media for this problem with regards to oncology issues, other areas of health practice are also affected by laxity in maintenance of echo-cardiograms, cataract sets, and complete urology telescopic sets, etc. Practitioners in supply chain are completely oblivious of service delivery challenges and urgency as they affect their procedures and protocols.
- Some hospitals do not have an in-house laundries, even for purposes of managing urgent flow of linen during critical peak times as the stock from central laundries is awaited. Generally, laundry is done in centralized places within the province and these provincial laundries are far from the hospital.

2.4. Some Analysis of Issues Raised and Observed

- **Lack of Professional Ethics Forums for ALL employees:** Some hospitals have unique challenges emanating from servicing big transient populations and dealing with urgent referrals for which support staff is under-prepared. Yet whenever the subject of professional ethics is raised facilities responded by referring to clinical debriefing sessions which is the business of clinical employees, especially after a crisis has happened. No reference was made to making all employees of facilities understand their obligations to **professionalism** as a constant or occasional initiative of facilities. Support staff are not considered for this intervention at all. Yet, the Public Service Commission itself has struggled at times to be received through the hospital via telephone lines to raise issues that the public would raising while at corridors of the hospitals. A hospital as big as

Addington, Stanger or Northdale, for example, coping with a lot of people and facing different challenges, would need to develop better modules and creative smaller meetings on professional ethics – for all its employees. The culture of professionalism needs constant attention. Debriefing sessions over specific matters is a fire-fighting approach to professional ethics and it only involves certain employees.

- **A deliberate comprehensive approach to professional ethics and ethical dilemmas:** The reference to registration to professional bodies cannot be the only approach the Department adopts to deal with professional ethics. In many instances there is little discussion on what the professional bodies actually do for facilities, except to deal with matters in the event that those are brought to their attention. Support staff must also be part of active cultivation of professionalism. In many hospitals, HR units do not see the need to work with PROs to improve responsiveness to patients. HR units see their delineated roles as processing employee issues and recruitment only. The best they proffer in relation to professional ethics is that they do induction of employees when they are first employees. Besides professionalism, ethics modules in a health care environment surrounded by complex religious and cultural issues, are needed to deal with **ethical dilemmas**. For example there are issues related to a clash between belief systems of professionals and some services provided (e.g. termination of pregnancy). Many did not denounce a possibility of the youth being aloof to using local facilities because of general timidity and sharing Churches with some local professionals. Nevertheless some did cite some initiatives to tone down those issues including 'Happy Hour' initiatives for the youth and location of Choice of Termination of Pregnancy Clinics where privacy is enhanced.

- **Patient flow, Public Relations and Service Inspections within facilities can be improved:** Expected waiting times are not always visible in all relevant units within health care facilities. Some units will display waiting times; yet as patients progress in the service pipeline there is no commitment to displaying waiting times expected. The Public Service Commission found many pharmacies within hospitals defaulting in this regard, and yet pharmacies tended to be where long queues are witnessed – especially in urban hospitals with dense populations. People are not regarded as worried about time spent in the facilities (both hospitals and clinics). While there are hospitals that are doing a very good job in dedicating capacity to receiving patients (directing them to various units, triaging, streamlining the elderly or those needing speedy attention), there remained a significant number of facilities where patients direct themselves and streamlining of queues is fuzzy. In many institutions, PROs and M&E practitioners do not do

walk-abouts to ensure that the service quality, the institutional layouts, and patient management are fulfilled. The PROs faces are only to be found on walls, duly pasted with their contact numbers. Generally it is an arms-length approach to public relations which they adopt on their part. Pressed on this issue, one of the PROs told the PSC team that he communicates with the patients via emails. This was a painful response which illustrated that although facilities lament lack of capacity, they sometimes underuse quite significantly the current capacity they have. A PRO of a busy hospital that attends to an average ordinary citizen that hardly affords food, let alone data, sees his job being 'to attend to emails'.

- **On infrastructure**, the PSC made observations that were far from pleasing:
  a) Some hospitals have serious issues which could impact on their efficiency on core business. These are such issues as: a theatre requiring attention of an air-conditioning unit, damp wall in a TB hospital.
  b) Why would an impression be created that one is rushed to urgent medical help in a hospital, when long-standing problems of dysfunctional lifts reverse the urgency completely as no urgency is possible beyond a certain point (such as what is happening in Addington hospital, for example)?
  c) What makes a whole Health Care System (with local and remote management levels) persevere with such lack of hygiene in relation to public toilets as was evident in some facilities?

  Understandably because of limited resources, some infrastructural problems may take time to resolve. However, there is **a need to assess what elements of the infrastructural problems make a hospital border on not yielding value for its current public purse investment.**

- The **non-responsiveness of certain portfolios/structures at a Provincial level affects facilities negatively**: The major issues related to equipment, financial delegations, and specific challenges of a hospital must be escalated to relevant units at provincial level – and such escalation must be documented. The amount of challenges, red tape and professional hurdles that institutions are coping with is worrying. One of the CEOs narrated a story of how she had to stage a sit-in at the corridor of the provincial offices for her to get a response on requests that she had been escalating for a very long time with no response. Another manager told a story of the amount of time spent on the phone persuading the department to resolve the question of recruitment of a medical manager because the usual response of that "Ratification Committee had not sat", which was the only response they had been receiving for months, was showing that the Province had no empathy with coalface issues. To some extent one wonders **as to whether the provincial approach to management is simply compliance and**

enforcement. Are there structures where challenges are analyzed and are managers' analyses and proposed solutions processed in order to make service delivery a reality?

- **Vehicles:** Part of the resources that require rationalization in line with context are vehicles. These are important in order to reach out to primary health care facilities and to communities – where mobile clinics are the main mechanism to reach out to some communities. The Public Service Commission was disappointed to hear of habitual situations where employees have to fix cars in order to make service delivery possible. While some of the situations may not be avoided, it would be assuring to professionals affected know that the distribution of resources is in accordance with geographic context and social needs.

- The sum-total of lapses in professionalism that are cited in different parts of the main report could imply some kind of **professional prejudice in handling the ordinary citizen**. Many hospitals cite the fact that they serve largely the uninsured population. This is appreciated of public health care system, but there are moments when the laxity and lack of regard for efficiency in some institutions can be interpreted as borne out of this fact – citizens that are indigent and less assertive of their rights. Different identified in different facilities that justify this disconcerting reading are:
  - A need to bring the public service standards on par with excellent service standards, regardless of clientele served;
  - A sufficiently integrated approach to chronic illnesses while allowing for specialization. What is referred to as a HAST clinic in the facilities usually leaves much to be desired on confidentiality of information and integrity of patients, even though in theory this is supposed to not be an issue;
  - Decent transportation of people, including conditions in which people wait for inter-facility referrals
  - uncoordinated emergency services,
  - support and professional supervision to Community Care Workers .

3. ENGAGEMENT WITH DISTRICTS AND THE PROVINCE

A District model of decentralization is adopted in the Health sector in South Africa. This does not mean that health becomes a key mandate of Local Government. It simply means that the Provincial Department of Health makes its decentralized presence in line with District Municipal boundaries. As has been pointed out in the Introduction, the research included the participation of some District Offices during the inspection of facilities where they provided important contextual data about the District. Besides this, the PSC engaged directly with half of the Districts in the Province posing direct questions relating to:

- The role of Health District Office in the health delivery system
- Quality of management within their institutions
- An approach to Monitoring and Evaluation
- Co-ordination with Emergency Services

A focus group discussion was also health with representatives of various units in the Province. Not all units targeted could be present at this focus group discussion. This was a limitation. However, the fact that in the absence of some units little can be said about how they operate, says something about the scant level of integration in the Department of Health. The situation of 'silos within a sector' was evident.

3.1 Emergency Services: Ambulances

EMRS: There is a host of issues related to emergency services and ambulances. Some of these issues emanated from facilities' frustrations and some were teased out by the PSC with EMRS managers during visits at District. The following was observed:

- There are Health District Directors who have successfully forged a good relationship with managers of EMRS in their Districts. However, this cannot be said for many Districts. Some EMRS managers are aloof and feel that they are not accountable to the District situations even for impact purposes. This remains a challenge because the service provided is interlinked and communities do not understand the formal performance reporting lines.

- Some EMRS managers were able to articulate some approach to how they provide services with fairness to geographic coverage of the district. This includes linking some 'pressure point' facilities to direct liaising with vehicle dispensing personnel. Obstetrics emergencies are prioritized and provided for separately in many instances, but the vehicles are sometimes not coping with demand. However, some projected a complicated system of vehicle dispensing and no regard for turnaround time whatsoever. It is one thing to relate the challenges of terrain and distances, but to show no mind application to the question of turnaround time was worrying. Many clinics (in this report – see KwaPata, Tholusizo, Rorke Drift) lament the sense of disillusionment over EMRS.
- There are real issues of no regard for the type of environment served in some instances. This includes lack of induction to the geographic orientation and landmarks of the area for new employees, who also feel unsafe looking for patients in areas they do not understand. The department hardly considers unique situations in its approach to (integrated) Human Resource induction, although when this was discussed during this research some Districts suggested this is their role. This is an area where the Health District management and EMRS management could forge a stronger relationship of support and firmer utilization of community structures such as War Room champions, local councilors and local headmen (izinduna).

3.2 District Level Support for Managers of Facilities

The reason why Districts were engaged on the question of quality of management was to see whether they interface with the strength and weaknesses of management capacity they have in different facilities. It was discovered during research that there are CEOs and operational managers who simply do not understand what management is – beyond responding to circulars of the department. Many such managers could not infuse impact in responding to the question of 'areas of excellence' when it comes to their facilities role in society. They do not see the link between good administration and making a difference; they do not regard the lobbying various stakeholders, and creating good morale in their institutions as part of their management duties. Most of them are clinicians who do not understand the overall responsibility of their positions.

It was also discovered that there are managers who are a pillar of strength of specific institutions – institutions with lots of challenges – but which are thriving because of

managers' ability to forge relationships with various stakeholders, their Boards, other government departments, and who have created a working team out of their management teams. Management Teams of Vryheid Hospital, Church of Scotland Hospital, and St Andrews Hospital are amongst a few who must be cited as examples of good practice.

It was rather disappointing that in many districts the probing on quality of management was understood as probing for qualifications of managers, or a mere discussion of recruitment processes of managers. Further probing had to be done to elicit the role of Districts in analyzing and giving support to management. It became clear that District Offices take a hands-off approach to management, and if there is any support to speak off it is about occasional meetings related to core business of the department and its processes. The fact that good clinicians would need support to be good managers is not taken as an area of intervention by many Districts. There is a perception in facilities that doctors are preferred for jobs as CEOs. Whether this is a wrong or right perception there does not exist a formal view and initiative to intervene in the name of management support.

Human Resource units are not ready for this kind of intervention (i.e. workshops on management issues), nor are they found to be ready with support on professional ethics workshops for various types of employees in the health pipeline. Human Resource departments do not act as trained specialists that can assist facilities undertake a professional culture change-management. The main response to questions of professionalism is: "Batho Pele workshops are done during induction of employees". Some facilities' managers have inherited difficult issues of mismatch between skills and demands to specific positions. This relates to positions such as PROs, M&E managers, and Quality Assurance managers who are either under-performing or do not see the value of co-ordination. Specialist support from Human Resource units is a dire need. But there is no culture of communication between human Resource practitioners and managers in hospitals.

3.3 District Approach to Support and Oversight

There is no clear approach to support and oversight provided by Districts. They merely send things that come from Head Office and enforce without lobbying for their facilities

and rationalizing what they have for immediate efficiency. There are many issues that require active District Level support, for example:

- Cross-boundary/border issues relating to patient care – in some Districts there are complications between provincial boundaries where patients prefer to go to institutions closest to them or where they believe there is better care. Yet there are hospitals where management believes District is handling the matter, but they have not been invited to the special inter-District engagements of the matter (see for example St Margaret's report). To some extent this point relates to the issue of management capacity development that was raised earlier. However, the current point must not be missed: Does a District have an approach to supporting and solving issues raised by institutions, particularly in relation to efficiency and impact? What is that approach?
- Relationships with municipalities in relation to essential services, or a plan to amass options to ensure that there is no crisis where essential resources are critically erratic in availability (e.g. municipal relationships, tanks, boreholes, all supported between relationships with specific technical service providers)
- Rationalizations of emergency services – such that service standards and fair coverage to the Districts is possible, partnerships with other community leaders, as well as induction/orientation of EMRS employees to the geography of the District.
- Some institutions are plagued by connectivity issues. These affect Human Resource practice as things must be sent between different offices and systems for processing service terminations are increasingly becoming electronic. District and Provincial intervention to ensure systems yield efficiency is necessary

In fact the question of 'freedom to manage' as opposed to 'rule by compliance enforcement' is at the core of management approach in the Department of Health, especially at District level. Thus it is worth repeating the questions: Does a District have an approach to supporting and solving issues raised by institutions, particularly in relation to efficiency and impact? What is that approach? Whenever these questions were raised, Districts' main response is an official response of what they do in principle. One District that was clearly aggrieved by the constructive criticism in this PSC's report at draft stage ventured to summarize its role:

> Through data analysis and performance reviews district offices give support on development of facility plans for the implementation of services as per the department annual performance plan, facilitate development of facilities remedial plans to address issues of below standard performance and also facilitate development of facility service implementation plans which are in line with the government business for priority programs.
>
> The district office plays an important role in developing and maintaining multi-stakeholder relations and engagements. The Operation Sukuma Sakhe, Integrated Development Planning sessions are important platforms for engaging stakeholders in the district. The issue of water availability to hospitals and clinics is handled between district health, district municipality and provincial treasury. Major breakthrough were achieved as a result of district office intervention.

The "breakthroughs" remained unnamed. The stakeholder engagements were not related to solving any cited issues relevant to that particular district. In fact the PSC was particularly worried about many issues in that district and had to raise them urgently with the department before the end of the research. The main issue, in typical district responses, is: plans are created, structures sit routinely, and achievements are generic and log-framed with little articulation of real life solutions of issues unique to their regions.

3.4 Systemic Efficiency driven from District and Provincial Context

The intensity of problems in certain hospitals is symptomatic of the fact that challenges affect institutions differently depending on the context. Thus proposed solutions must consider the context (dense urban populations, rural contexts and farm-dweller populations, connectivity issues, difficult nature of roads, location near provincial and country borders). The moratorium on non-critical staff for a hospital such as Mzimkhulu, which has no other laundry and is located in a region of acute water scarcity, has a debilitating effect. In spite of them not being replaced for their normal duties, non-critical staff members are required to assist to fetch water and to ensure assistance at the laundry for essential utilities to take place. It is worse in situations where, like in St Margaret Hospital, the specialization makes them deal with communicable diseases. While there is reason behind generic solutions, such as a moratorium on appointments, a blanket approach in their implementation may be harmful to service delivery.

The question of a provincial approach to Management as well as Monitoring and Evaluation of Health Care remains unclear. In the first instance, the slow pace of dealing with issues affects institutions differently. The slow, centralised and protracted pace on appointments (since the moratorium on appointments by institutions) and sluggish SCM processes, combined with the necessary certification requirements for equipment – all work together to have a huge impact on big hospitals that attract a high volume of patients (Northdale, Addington, Stanger and Edendale are examples in this report). As has been pointed out above the same issue affects hospitals in rural Districts differently. It is unclear how a hospital specializing on TB (such as St Margaret) can have evidence of moist and mould on its walls and remain with a CEO who has not been appraised of where the facility is in the infrastructural plan. The blanket approach on moratorium of non-critical human resources even affects a central laundry, which thrives on the personnel currently classified under 'non-critical'.

There is no evidence that the Provincial Department adopts a foot-soldier approach to Monitoring and Evaluation and Quality Assurance. Monitoring and Evaluation is a matter of statistics submitted to the Province. In fact in a focus group with some units at provincial level the issue of remote engagement with Districts was an overriding revelation. Some concrete ideas need to come through on issues like: waiting times, criteria guiding the responses of the Infrastructure Unit, approach to professional ethics, co-ordination strategy on essential services (EMRS, Provincial Laundry), and even a definitive approach on M&E and Quality Assurance.

3.5 Provincial Laundry

A provincial laundry was also inspected by the PSC. It must be acknowledged as a limitation that only one provincial laundry was visited – the one located next to Prince Mshiyeni Memorial Hospital. At a time when the PSC intended to co-ordinate its research visits such that the laundry located in Dundee would also be visited, it was brought to the attention of the PSC that it was closed for renovation. Before the laundry was inspected, there had been hints of appreciation of its service and also complaints that had been voiced by facilities, particularly on material sent to laundry not coming back in its original condition. Some institutions lamented sending relatively newer material and finding the return laundry with much older linen. Some institutions pointed out that the reason why they 'hang on' to their small on-site laundries, despite Human Resource dwindling, is that

they need to cope in case there are delays in the central laundries. Indeed some facilities do not wish to join the queue to central laundry at all. The inspection of the laundry yielded the following:

- There is coping anxiety generally as the laundry runs on a thin **staff compliment** (there were 48 vacant posts at the time of the PSC inspection). Due to a moratorium on staff appointments, posts are not being filled. Current employees are aging and as they leave the situation will be worsened. However, at the time of the inspection the manger had been promised some approvals of appointment, but these were awaiting HoD approval. Seven administrative staff members are overstretched and they do work that is supposed to be handled by vacant posts. Coping mechanisms must be balanced against pressure to deliver and managing risks (sterile clean linen must be produced; labor issues must be respected too). As part of coping, instead of ironing everything which is what is supposed to happen, some items can be folded while coming out of hot driers.
- **Management strain:** There are no floor supervisors at the laundry; the laundry manager goes to supervise at floor level himself. The laundry was experiencing a particular phase of strain during the PSC visit as some institutions that are normally serviced by Dundee Laundry were being serviced at Prince Mshiyeni Laundry due to renovations at the Dundee Laundry.
- There are **no SCM Committee** associated with the laundry. Procurement happens through Head Office and these processes themselves have had their own delays.
- There are **occupational health risks** with lack of floor supervision as well. Some employees did not comply with safety measures, such as wearing of masks when handling soiled linen, as well as wearing safety shoes. During inspection this was also observed by PSC team and when engaged the employees complained that some people should not be in that floor anyway, as they reported issues of failing to cope with masks. As far as they are concerned the issue is pressure because of no sufficient appointments in the establishment. As such the occupational rules that they used to follow before, which included frequent breaks for breathing purposes, stocking of milk which

used to be provided as a way to purge certain bacteria[1], and flexibility to exchange with employees from other floors in line with personal strains – all got thrown away over time with no visible approach to occupational health approaches. Dwindling human resource capacity has also led to less time to separate linen according to how soiled it is. Some linen occasionally comes with sharp objects which poses a risk on employees and can break machines. The unhappiness on employee issues extends to the fact that the Prince Mshiyeni Hospital does not see any need to include laundry employees into their Wellness Clinic.

- **Operationally** there is a schedule regulating which hospitals are coming by what date. There is an area for off-loading dirty linen, which is packed in different trailers for different hospitals and marked as such. The vehicles have a fumigation area where disinfectants are sprayed to ensure that the vehicle is ready to take back the clean load that would have been sent previously. Inside the laundry there are different floors, each cascading floor dealing separately with washing, drying, and ironing. The seven administrative staff members are spread between dealing with operational issues of accepting and dispensing with linen, HR issues of employees, finance/budgeting issues, coordinating other duties associated with repairs and logistics.
- **Current issues** that the mangers has been dealing with include: making plans to ensure supply of water since the elevated reservoir is no longer working; improving connectivity of the institution by working with SITA; dealing with security issues – both for the whole facility and for parking; dealing with staff morale partly emanating from remunerative structure that gives no room for further recognition of hard work, especially after people have reached notch 4. Some of the problems cannot be solved by a single manager trying to cope with many issues. For example the laundry has only one generator, which can only cope with lights and cannot cope with machines when there is power failure. Disinfectant machines must also be sourced urgently as there is only one machine functioning currently.

[1] This reportage is as was rendered by the people affected. Whether there is medical truth in the perceptions created is not clear to the PSC team

4. CONCLUSION AND RECOMMENDATIONS

Through this work the Public Service Commission has been appraised of major issues relating to capacity of the Department of Health in KwaZulu-Natal, many of which require strategic thinking at leadership and management level. However, the main revelation of this report is on the issue of dwindling professional agency of the existing capacity within the department – including the capacity of management and various structures to be responsive to the challenges within the professional pipeline. The Department of Health is not demonstrating responsiveness and professionalism in handling the citizen and in dealing with needs of its practitioners at coalface level because cultivation of professional ethics is not a 'deliverable' against which to measure performance. Responsiveness is not even seen as a 'fair question' to ask in many facilities, Districts and Provincial Health Care pipeline. Lack of responsiveness and professionalism does not only frustrate the citizen, but it also adversely affects and demoralizes those professionals who dare to remain in the service. The following issues surmised from engagements that have been discussed in this report demonstrate this core finding of lack of agency, professionalism and responsiveness in the professional pipeline of public service in this sector. Below they are pointed out as conclusions to which a recommendation is attached per issue:

A balance between administrative efficiency and citizen convenience must be struck in referral systems: The District level referral system is sometimes at odds with the transport routes of patients. This creates a situation where patients are forced to misrepresent their location in order to maneuver around reach of facilities.

⇨ The system should ensure sufficient discretion to allow patients access to convenient facilities. Administrative accounting and seamlessness should be tailor-made to enable patient convenience.

Provincial Laundry Service Rationalization must be clear: Some on-site laundries are too small, input and output area designs almost overlap. Some, such as in some hospitals in Harry Gwala District, have water challenges which require serious intervention of the Department of Health – particularly for those hospitals that deal with TB. Access and service standards to a laundry could be developed to take into account whether a hospital has its own resources for laundry, the hospital specialization, and how far a facility is from the provincial laundry. The need for the service is primary consideration and the department must ensure that the service is resourced as per need.

Operational norms, standards and procedures must be in place to deal with specific issues such as fumigation of vehicles that deliver dirty laundry and collect clean laundry.

⇨ Service standards for enrolment into a provincial laundry by hospitals, for laundry specifications for on-site laundries, for operations, and for laundry occupational health for employees (with relevant inspection protocols) must be developed.

Infrastructure unit of the province should articulate a clear set of prioritization criteria for intervention, especially if there are financial capacity issues: There are instances in the province where serious issues (which could potentially affect the life of patients) have not been acted on, and some hospitals feel that either urban status or proximity to Pietermaritzburg accounts for whether requests are taken seriously or not. The fact that CEOs of hospitals are not receiving responses that inform them of where their issues are in prioritization is not a reflection of sound professionalism.

⇨ Criteria and considerations, on the basis of which infrastructure prioritization takes place must be transparent. It must be clear whether a faulty air-conditioning unit in the theatre accounts for inclusion in the priority list, or whether there is money ring-fenced for specific projects and contingencies.

The matter of rationalization of Human Resources capacity in the context of financial constraints deserves a live approach beyond the current blanket moratorium on filling of non-critical posts: There are hospitals where the non-filling of non-critical posts affects the attraction of critical appointments to those hospitals. Coupled with remoteness of some facilities these matters exacerbate the ability for institutions to attract employees and they further cause non-efficiency and strain in the working environment. Currently there are different responses on whether there is a Rationalization Committee on appointments – with some Health District Offices believing that this committee exists and others believing that it does not exist. Similar to the matter on infrastructure, there is a need to look into local situations within facilities – for big densely populated hospitals to have less administrators, potters, and security personnel can strain the working of a facility.

⇨ Within adopted parameters to manage resources, which Executive Authorities and Senior Management must retain the right to exercise, there must be scope to motivate Human Resources on a case-by-case basis in the interest of saving lives. If a case-by-case method is too cumbersome, the Department must look into developing the reviewable minimum standards for provision of various

categories of personnel. Such standards must be accompanied by an obligation, on the part of the Department, to respond to a hospital expressing unique circumstances.

Monitoring and Evaluation, Quality Control, and Public Relations Officers must have an approach to work that promotes the human element of the Health Care System: In many presentations and conversations with unit managers there is too much emphasis on meeting targets at all cost. It is important for health practitioners to exude a sense of concern about real challenges against which they rate their achievements. Sometimes the presentations on excellence/ achievements appeared as though they are about meeting targets issued to professionals. This is the case even at District level M&E discussions. This is a worry in a department that deals with 'care'. It makes one wonder how CCGs, for example, present their counselling work in communities under such pressure to meet numeric targets.

⇨ The Department of Health must work into the Monitoring and Evaluation professional practice qualitative methods of monitoring and evaluation, methods such as inspections. M&E practitioners, Quality Control managers and PROs must design strategies to monitor user-friendliness of their institutional systems - from layout, daily work schedule, dealing with emergencies, and information system within service points.

Something must be done to empower Clinic Committees to understand why they exist: Currently many are dysfunctional and not visible. They do not provide much support or ask for accountability from Clinic Management. This is more the case for Clinics, although some hospitals also confessed to have the same challenge of Boards who meet for the sake of meeting only occasionally.

⇨ The Department must empower facilities oversight committees and Boards through modules that emphasise their role on oversight and requesting accountability of institutions, in addition to their role as enablers of institutions within their society.

Staff attitudes are a major issue despite the Batho Pele policy being in place for some time. There is a need to formulate user-friendly language when inducting staff into their roles and as a basis for continuous engagement on values. Whereas Batho Pele emphasized the relationship with the client, the Department of Health, which is in

desperate need to swing the mind-set of the employees in all units within the Public Administration pipeline must think about other ways to effect mind-set change and a different culture in its institutions. This requires active management that is willing to depart from a diagnosis of key problems of professional culture in their institutions. The following set of issues could be the basis to check what the major problems are. They could also be used to create a point of emphasis in the change-management strategy of each institution. Thus any manager could select amongst these and other desirable elements those that they want to work on for their facilities or specific units within them.

⇨ The ten points outlined here on institutional culture change-management were selected from observing issues that emanated in the pilot report before this study and from inspections conducted during this study. They are offered to assist managers with starting points or a list of issues to pull together as starting points as they structure their institutional culture change interventions. Needless to say, depending on whether coalface professionals are engaged or support units such as HR, Finance, Registry, the selection and order of these points of emphasis may change. In a diagnostic mode these need to be posed as questions; in an intervention mode they must be ideals against which promotion and intervention is designed.

Ten points to structure diagnosis and change-management on institutional culture:

(a) Be solution-oriented
(b) Be happy to serve all equally
(c) Complete your tasks
(d) Refer wisely (make considered referrals relevant to the matter)
(e) Ensure client-information confidentiality
(f) Represent your institution well
(g) Co-ordinate diligently (follow-up, handover, report back to client)
(h) Exercise fairness
(i) Refuse corruption
(j) Analyze each situation and give professional opinion, not personal opinion.

Clear District Support must be evident on both institutional matters and core business.

The importance of decentralizing Departmental support to a level closer to the facilities is underscored. However, there needs to be clarity on the nature of support and what the Districts can actually do besides being conduits for messages of enforcement from Province and National levels. As it stands many Districts merely state what the Departmental stance is on issues and hardly articulate what their own analysis and lobby is for their jurisdiction. Other than the 'stance of the department' on pre-planned interventions, there is little 'ad hoc' interventions/abilities in Districts. There is hesitation to intervene in problems that present themselves as not previously anticipated. There is a need to evolve the role of the District in Department-to-Department co-ordination. For example, can the Department of Education make a request for assistance with children needing speech therapy in Primary Schools and hope that the District could devise a plan to attend to such a request in a particular District? Can a Health District co-ordinate a meeting of affected Hospitals, the Municipality and Provincial Health in a water-scarce District such as Harry Gwala to explore mechanisms to supply water for hospitals?

⇨ There is a need to evolve the role of the District in both in core business and institutional diligence (employment practices, logistics), such that the Districts have clout to intervene on behalf of their institutions and citizens. This pertains to issues such as –

(a) Districts interacting more with facilities on professional ethics promotion;
(b) Department-to-department referrals in relation to core business;
(c) Department making requests to other departments on behalf of its institutions;
(d) How do districts analyze their District context and make representations on it – e.g. explore arrangements for referrals to neighboring District institutions for citizens who find transport routes permitting easier access to health institutions of the next District; on provincial cross-boundary issues for social work cases to be followed up; on acquisition of equipment and human resources;
(e) Co-ordinating health care stakeholders efficiently, including Emergency Services, Boards, Clinic Committees;

(f) District M&E visiting facilities; and

(g) Districts supporting facility managers with necessary management skills development.

Needless to say, the Departments at Provincial level and at National level must create an environment for empowered Districts. As things stand the Districts have been reduced to sending messages from Province and National level to institutions and they perform little action to demand that these two 'higher levels' respond in ways appropriate to District needs. This cannot be seen as optimal use of decentralization of a government sector. The Department of Health is a department that purports to 'perform care' to citizens on a daily basis. It cannot afford to have its administrative and management practitioners completely suffocating in a rigid, hierarchical, *a priori* kind of planning systems that portray 'higher level' structures as holding commanding authority without an obligation towards *de facto* solutions relevant to area-specific contingencies.