University of Fort Hare

Together in Excellence

Clinical governance implementation challenges in the Department of Health, Mpumalanga, South Africa

by

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Declaration

I, Patrick Hawkins Maduna, student number 201928136, hereby declare that this thesis, submitted in fulfilment of the requirements for the degree of Doctor of Nursing, is my original work and has not been derived from, or submitted to, any other organization before submission to the University of Fort Hare.

Also, I am aware that plagiarism is using someone's work and presenting it as one's own, without permission and acknowledgment of the source and that this is a punishable academic offense. I have used Harvard Referencing for citation and referencing. Each significant contribution to and quotation in this study from the work or works of other people has been attributed, cited and referenced.

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Abstract

Clinical governance (CG) is the system through which health authorities are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence flourishes. South Africa is one of the countries where CG has not been successfully implemented. This study sought to explore the CG implementation challenges in the Mpumalanga province, South Africa. The study objectives included the seven pillars of CG.

The study was a qualitative and exploratory, using purposive sampling technique to select study participants. A total of twenty-two (22) individuals were selected for the study. Semi-structured interviews were used for data collection. Each interview was transcribed verbatim by the researcher. Confidentiality was ensured through the coding of interviewee names. The content analysis technique was used for data analysis, using the study objectives as themes.

The study found general lack of understanding of the concept of CG, poor performance of clinical audits, sub-standard clinical performance and effectiveness, poor clinical risk management, poor patient and public involvement in patient care, lack of evidence-based practice and research, inadequate training and development of healthcare workers, and sub-standard health information management across the department.

The researcher recommends that the CG policy be prioritised by the Mpumalanga DOH, that systems be put in place to facilitate policy implementation, and that the

departmental staff establishments at all levels, prioritise healthcare professionals in key leadership positions.

In conclusion, there are numerous challenges that confront the Mpumalanga Department of Health regarding the implementation of clinical governance, requiring urgent attention.

Key Words: Clinical governance, clinical audit, effectiveness, risk, involvement, training, research, information

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Dedication

I dedicate this thesis to my wife. Without her, I would have given up along the way. To my beloved children and my grandchildren, I hope that this work will inspire them to achieve much more academically than I have.

List of Abbreviations and Acronyms

ACGME	Accreditation Council for Graduate Medical Education
ACSQHC	Australian Commission on Safety and Quality in Health Care
ALOS	Average Length of Stay
ALS	Advanced Life Support
ANC	Ante-Natal Care
APP	Annual Performance Plan
BAC	Budget Advisory Committee
BUR	Bed Utilization Rate
CBS	Community Based Activities
CCTV	Closed-Circuit Television
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CG	Clinical Governance
CHI	Commission for Health Improvement
CIHI	Canadian Institute for Health Information
CIPP	Context / Input / Process / Product model
CLANZ	Clinical Leaders Association of New Zealand
COGTA	Department of Cooperative Governance and Traditional Affairs
CPD	Continuing Professional Development
CPG	Clinical Practice Guideline
CPS	Construction Procurement Standard
CSP	Community Service Pharmacist

CRM	Clinical Risk Management
DCST	District Clinical Specialist Team
DDG	Deputy Director General
DHB	District Health Board
DHMT	District Health Management Team
DHS	District Health System
DMU	Health system decision-making unit (Canada)
DPME	Department of Planning, Monitoring, and Evaluation
DPWRT	Department of Public Works, Roads and Transport
EBP	Evidence-Based Practice
ECA	Emergency Care Assistant
ECC	Emergency Communication Center
ECD	Early Childhood Development
ECP	Emergency Care Practitioner
ECT	Emergency Care Technician
EMS	Emergency Medical Services
GAVI	Global Alliance for Vaccines and Immunisation
GoU	Government of Uganda
GP	General Practitioner
HAST	HIV/AIDS, Sexually Transmitted Infections and Tuberculosis
HCP	Health Care Providers
HCSS	Health Care Support Services
HCW	Health Care Worker
HFM	Health Facility Management

HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HOD	Head of Department
HPCSA	Health Professions Council of South Africa
HPRS	Hospital Patient Record System
HPTD	Health Professional Training Grant
HQSC	Health Quality and Safety Commission (New Zealand)
HSEP	Health Sector Evolution Plan (Iran)
HSS	Health Systems Strengthening
HST	Health Systems Trust
ICT	Information Communication Technology
IPCC	Infection, Prevention and Control Committee
IDP	Integrated Development Plan
ILS	Intermediate Life Support
IPPF	International Planned Parenthood Federation
IOM	Institute of Medicine (Washington)
ISHT	Integrated School Health Team (South Africa)
ISP	Integrated Strategic Planning
IUMS	Iranian Universities of Medical Science
IUSS	Infrastructure Unit Support System
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LMIC	Low- and Middle-Income Countries
MCWH	Maternal, Child and Women's Health
MCM	Medical Council of Malawi
MDG	Millennium Development Goals

MTT	Ministerial Task Team
MOA	Memorandum of Agreement
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOHME	The Iranian Ministry of Health and Medical Education
MTSP	Medium-Term Strategic Plan
MTT	Ministerial Task Team (South Africa)
NAO	National Audit Office (United Kingdom)
NDOH	National Department of Health (South Africa)
NDP	National Development Plan 2030 (South Africa)
NHA	National Health Act (South Africa)
NHI	National Health Insurance
NHS(SA)	South African National Health System
NHS(UK)	United Kingdom National Health System
NICE	National Institute for Clinical Excellence
NMCM	Nurses and Midwives Council of Malawi
NPM	New Public Management
NZ	New Zealand
OHSA	Occupational Health and Safety Act (South Africa)
OSD	Occupation Specific Dispensation
PERSAL	Personnel and Salary System
PHC	Primary Health Care
PHCIS	Primary Health Care Information System
PHCN	Primary Health Care Nurse
PMDS	Performance Management Development System

PPE	Personal Protective Equipment
PPI	Patient and Public Involvement
PPTS	Planned Patient Transport Services
PSI	Patient Safety Incidents
PTC	Pharmaceutical and Therapeutics Committee
QAP	Quality Assurance Program (Uganda)
QIP	Quality Improvement Project
RACS	Royal Australian College of Surgeons
R&D	Research and Development
RCT	Randomized Controlled Trials
RMCH	Reducing Maternal and Child Mortality through the strengthening of Primary Health Care
RPHC	Re-Engineering of Primary Health Care (South Africa)
RTC	Regional Training Center
SAC-1 PSI	Severity Assessment Category 1 Patient Safety Incident
SANC	South African Nursing Council
SAPC	South African Pharmacy Council
SCM	Supply Chain Management
SDG	Sustainable Development Goal
SOP	Standard Operating Procedure
TB	Tuberculosis
TNMC	Tanzania Nursing and Midwifery Council
ToC	Theory of Change
TUMS	Tehran University of Medical Sciences
UNC	Universal Health Coverage

UK	United Kingdom
UNDP	Ugandan National Development Plan
UNEP	United Nations Environment Programme
WBOT	Ward-Based Outreach Team (South Africa)
WHO	World Health Organization
WISN	Workload Indicators of Staffing Need

Definition of terms

Clinical Governance	There are numerous definitions of CG that countries have adopted and adapted for themselves. For purposes of this study, CG may be described as a systematic approach to ensuring the quality of patient care in health districts and health establishments
UK National Health System	The NHS is the national healthcare system for the UK that covers each constituent country of the UK and is primarily government-funded and overseen by the DOH and Social Care. The UK NHS provides health care to all legal residents of the UK, with most services free at the point of use
NHS Trust Board	An NHS Trust Board is a health authority within the National Health Service in the UK, that serves either a geographical area or a specialized function. NHS trusts were established under the UK National Health Service and Community Care Act 1990.
Hospital Board	This refers to a group of individuals appointed by health authorities to be responsible for the safe and efficient running of a hospital.
Clinical Audit	This refers to a process of quality improvement that is aimed at improving patient care and clinical outcomes using a systematic review of care against set clinical norms and standards criteria.
Clinical Effectiveness	Clinical effectiveness is a process that seeks to provide the best care using various methods including clinical audit and EBP.
Clinical Risk Management	Refers to a process used by healthcare organizations to identify potential patient care and safety risks and reduce them through risk management intervention strategies such as staff training and education.

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Chapter 1

1.1 Introduction and background

Clinical governance (CG) is the heart of ensuring a health system that is characterized by service delivery that is effective, safe, accessible, and available to those who need it. The service should have minimum wastage of resources, a productive health workforce; a well-functioning health information system; equitable access to essential medical products, vaccines, and technologies; a health financing system, and leadership and governance that involves ensuring that strategic policy frameworks exist and are combined with effective oversight and accountability (World Health Organisation, 2007:vi). Roncarolo et al. (2017:636) observe that across the developed and developing world, health systems and governments are engaged in developing new institutions, mechanisms, and processes intended to assure and improve the quality of health care. In support of that notion, Dodwad (2013:138) notes that policy- and decision-makers in various countries continue to try to improve the quality of healthcare provision by implementing appropriate policies.

In the early 2000s, O'Neill (2002:6) observed that sociologists and journalists had already pointed to signs of a deepening crisis of public trust that was directed at public institutions. Silimperi et al. (2002:67) noted how the quality of health care had received increasing political and public health attention over the previous decade. As a result, significant efforts were already underway to improve the quality of health care worldwide. However, Freeman and Walshe (2004:1) posit that it is much easier to design a national strategy for healthcare quality improvement than to implement it and make it work.

The delivery of high-quality services and the improvement of performance remain challenges for healthcare delivery systems, with numerous governments worldwide making considerable efforts in achieving the ambitious goal of quality health care (Roncarolo et al. 2017:636). The public, on the other hand, continues to demand better quality services from governments (Veenstra et al. 2017:1).

Besides curbing healthcare costs, improving productivity, and improving organizational performance and healthcare services of the required higher quality, countries have tried hard to satisfy both healthcare providers and the public (Dilley, Bekemeier and Harris, 2012: S58-S71). Over time, concerns about the quality and safety of healthcare services have gradually increased people's expectations from the healthcare system concerning performance, excessive costs, and medical practice errors. These have resulted in policy and decision-makers adopting innovative approaches to overcome these issues (Gauld and Horsburgh, 2015:2).

In South Africa, several legislative instruments were put in place obligating the State to ensure access, quality, coverage, and safety of health care for its citizens (Republic of South Africa, 1996:12). In this regard, section 195 of the Constitution of the Republic of South Africa, Act No.108 of 1996 provides the principles that all employees of government are required to observe, to ensure good CG. The government is obliged to provide a structured uniform health system for the country, in compliance with the National Health Act No. 61 of 2003. Section 25(2)(f) of the act requires the provinces to plan, coordinate, monitor and evaluate health service delivery, with a specific emphasis on CG, care and support services. Appropriate service norms and standards, applicable to different categories of health establishments, were promulgated for provincial departments of health to comply with during service delivery (National Department of Health, 2018:21-32).

In South Africa, CG is defined as a framework that helps managers and clinicians (such as nurses, doctors and physiotherapists) to improve the quality of their services and safeguard standards of care, continuously, thoughtfully and in a coordinated fashion, by creating an environment in which excellence in clinical care will flourish. In the South African context, therefore, CG refers to anything that will help to improve and maintain lofty standards of patient care. By 2015 when it was realized that South Africa was not going to achieve the health-related Millennium Development Goals, CG was placed high on the country's agenda (Connell, 2014:10).

In South Africa, health service delivery happens within set constitutional and legal parameters. The constitution places an obligation on the state to ensure access to health care for all South Africans. Section 195 provides principles, which oblige all employees of the government to observe and comply with. This has a huge implication for the way clinical service delivery should be administered and governed.

The national health system of South Africa is structured in line with the WHO health systems building blocks. The National Health Act, 2003 (Act No. 61 of 2003) obliges the government to provide a structured uniform health system for the country. Section 25(2) (f) of the Act, obliges the provincial departments of health to plan, coordinate and monitor health services and evaluate the rendering of health services. Through the National Health Act Regulations: Norms and Standards Regulations applicable to different categories of Health Establishments, the Act obliges provincial departments of health to provide CG and healthcare support services following set national norms and standards (National Department of Health, 2018:21-32)

The health workforce is an essential element of the South African National Health System (NHS). For this reason, it was important for the researcher to review South

African legislation that is applicable to the workforce to establish what role these played as enablers or barriers to the implementation of CG. The Occupational Health and Safety Act, (Act No 85 of 2003) provides for the creation of a safe working environment for employees in the health sector. Provincial departments of health, as employing authorities, must ensure that health establishments are safe for all health workers. The Nursing Act (Act No. 33 of 2005) regulates the nursing profession and provides for matters connected therewith. This Act established the South African Nursing Council (SANC) to maintain professional conduct and practice standards for the practice of the profession. The Health Professions Act, (Act No. 56 of 1974) (as amended) which established the Health Professions Council of South Africa (HPCSA) and the relevant professional boards, provides for control over the education, training, registration, and practice of health professions registered under this Act (medical practitioners, dentists, psychologists and other related health professions). This includes community service by these professionals and for all other matters incidental thereto. The Pharmacy Act, (Act No. 53 of 1974) (as amended) was specifically enacted to provide for the establishment of the South African Pharmacy Council (SAPC) and the training and registration of pharmacists, trainee pharmacists, pharmacy students, unqualified assistants, and pharmaceutical technicians; to provide for the control of the practice of the pharmaceutical profession and to provide for matters incidental thereto.

To ensure that all the above policies are implemented, and to reduce poverty and inequality by 2030, the South African government put together the National Development Plan (NDP). The plan sets out nine long-term health goals for South Africa, the first five of which relate to the wellbeing of the population while the other four describe the required systems and provide indicators and action points. The attainment of these goals, the setting up of the required systems, the activation of the

action points, and the achievement of the performance indicators are dependent on strong clinical care, management, and governance.

In 2011, re-engineering of primary health care (RPHC) was introduced in South Africa, targeting primary health care delivery (Pillay and Barron, 2011). According to this strategy, the stewardship for CG was placed under District Clinical Specialist Teams. The main task of the DCSTs was to provide CG at the district level and ensure quality in service delivery and effective management of health resources to enhance health outcomes. The DCST innovation or stream was part of the strategy to re-engineer primary health care (PHC). At the same time, Ward-Based Outreach Teams (WBOTs), Integrated School Health Teams (ISHTs), and contracted General Practitioners (GPs) were introduced to support the DCSTs. To obtain expert professional guidance on the DCST composition, roles, and responsibilities, the minister appointed a ministerial task team (MTT) in 2011, consisting of health academics and clinicians (Gray and Vawda, 2014:46).

Scaling up the implementation of the DCST stream was guided by ten recommendations set out in the ministerial task team (MTT) report (Ministerial Task Team, 2012: ii-v). Among the identified responsibilities of the DCSTs was ensuring the implementation of the four tiers of CG, *inter alia* ensuring clinical effectiveness; clinical risk management; professional development and management; and people-centred accountability (Gray and Vawda, 2014:47). In the carrying out of their responsibilities, DCSTs were to be assisted and supported by existing hospital specialists, provincial specialists, members of District Health Management Teams (DHMT), Primary Health Care (PHC), and Maternal, Child and Women's Health (MCWH) managers, sub-district coordinators, frontline healthcare providers (HCP), Integrated School Health Teams (ISHT) and Ward-Based Outreach Teams (WBOT) (Oboirien et al. 2018:3-4).

In 2014, the national Minister of Health in South Africa, expressed concern about the challenges facing the country's healthcare system despite numerous national and provincial interventions that had, since 1994, been implemented to attain quality health care (Moyakhe, 2014). The high number of patient safety incidents (adverse events) that have resulted in a high litigation rate is an example of the extent to which health service delivery has deteriorated in the country. This is further illustrated by the country's poor performance as reflected in the 2015 country report where South Africa did not achieve the health-related MDGs 4, 5, and 6, between the years 2000 and 2015 (Statistics South Africa, 2015:xxiv-xxvi).

According to this report and in respect of the MDG 4, the under-five and infant mortality rates were at 34.3 and 23.6 per 1000 live births in 2013 - higher than the set targets of 20 for under-five mortality and 18 for infant mortality respectively (Statistics South Africa, 2015:xxiv-xxvi). The proportion of one-year-old children immunized against measles in 2013 was 91.2, which was significantly lower than the set target of one hundred. The immunization coverage under one year of age rate was low (87) against an agreed target of 100 (Statistics South Africa, 2015:xxiv-xxvi). Lastly, it was reported that the life expectancy at birth was 61.2 years – much shorter than the agreed target of 70 years. For MDG 5, a maternal mortality ratio of 141 deaths per 100 000 live births in 2013 was reported, against a set target of thirty-eight. An antenatal care coverage of 92.9% was reported for 2014 against a set target of 100%. In respect of MDG 6, South Africa underperformed resulting in an HIV prevalence among men and women aged 15 to 45 years standing at 15.6% in 2015, condom use at last high-risk sex being 75.9%, the proportion of the population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS being only 80% and incidence of tuberculosis (TB) being 860 per 100 000 population against a set target of less than 253 per 100 000 population.

The inferior performance by South Africa in the MDGs implies serious challenges in the health system and highlights the need for appropriate interventions in the post-2015 development agenda. In this regard, it is hoped that through the implementation of the Sustainable Development Goals (SDGs), South Africa will attend to the unfinished 2015 business and ensure the achievement of its national developmental goals of reducing poverty and inequality by 2030 (Statistics South Africa, 2015:17). Underperformance on MDG or SDGs reflects poor CG at all health service delivery levels in the country.

This study focused on the views of health programme managers, clinical managers, and clinical specialists on their experienced challenges in the implementation of the CG in South Africa.

1.2 Problem statement

In aligning itself with other member states, South Africa adopted the World Health Organisation (WHO) health systems framework and designed its national health policy using the six WHO health systems building blocks. The implementation of the SA NHS is district-based and uses a primary healthcare approach. In 2011, South Africa introduced the reengineering of primary health care (RPHC) to improve health service delivery. CG became a key to RPHC implementation. A new cadre of healthcare specialists grouped and referred to as district clinical specialist teams (DCSTs) was assigned the stewardship for CG. The primary task of DCSTs was to provide CG in health establishments within districts. They ensure quality service delivery and effective management of health resources to enhance health outcomes. This the DCSTs would do by enhancing clinical effectiveness, clinical risk management, professional development and management, and people-centred accountability.

WBOTs, Integrated School Health Teams (ISHTs), and contracted general practitioners (GP) were also introduced to support the DCSTs. Provincial Health Management, District Health Management Teams (DHMT), PHC and Maternal, Child and Women's Health (MCWH) managers, sub-district coordinators, and frontline healthcare providers, were mandated to support the DCSTs.

In Mpumalanga province and the rest of South Africa, the implementation of the four pillars of the RPHC programme, namely DCSTs, WBOTs, ISHTs, and contracted GPs, has not been successful. DCST support at provincial, district and health establishment levels is not strong, resulting in poor outcomes of clinical auditing, clinical performance and effectiveness, clinical risk management, training and development, EBP and research, patient and public involvement, and information management during patient care.

By exploring the implementation barriers and challenges of the pillars of CG, the researcher sought to find the reasons and recommend appropriate strategic interventions to improve the situation. The researcher further hoped to explore the development of a framework for good governance, as the next step.

1.3 Aim and objectives

1.3.1 Study aim

To explore barriers and challenges in the implementation of CG in Mpumalanga province, with a view towards the development of a framework for good governance.

1.3.2 Study objectives:

The objectives of this study were to:

1.3.2.1 check if clinical audits are conducted in the health establishments.

1.3.2.2 find out about clinical performance and effectiveness.

1.3.2.3 establish how clinical risks are managed by the health teams.

1.3.2.4 ascertain the extent of the patient and public involvement in patient care.

1.3.2.5 find out about evidence-based practice and research.

1.3.2.6 check if training and development of healthcare workers is done.

1.3.2.7 establish how health information is managed in the department, and

1.3.2.8 elicit the views and suggestions of participants about improving CG in Mpumalanga.

1.4 Research questions

1.4.1 What are the barriers and challenges in conducting clinical audits in the department?

1.4.2 What are the barriers and challenges in clinical performance and effectiveness in the department?

1.4.3 What are the barriers and challenges in clinical risk management in the department?

1.4.4 What are the barriers and challenges in evidence-based practice and research within the Department?

1.4.5 What are the barriers and challenges in patient and public involvement during clinical service delivery?

1.4.6 What are the barriers and challenges in the training and development of healthcare workers on CG?

1.4.7 What are the barriers and challenges in information management in the department?

1.4.8 What are your views and suggestions that might help improve CG in Mpumalanga?

1.5 Significance of the study

No study on CG implementation in Mpumalanga, South Africa has been conducted up to now. There is therefore a gap in the body of knowledge in this regard. Chitha (2015) conducted a study on the implementation of CG protocols in district hospitals in Eastern Cape, South Africa. This study did not look at the various pillars of CG but focused on district hospital management and performance. Chitha (2015) found that there was a patchy and non-systematic implementation process with an inadequate institutionalisation of some activities within the district hospital. This study on the other hand, focussed on the implementation of the seven pillars of CG in Mpumalanga. Through this study, the researcher hoped to establish the experiences of senior managers and clinicians within the Mpumalanga DOH regarding barriers and challenges experienced with the implementation of CG. The root-cause analysis of the responses of study participants should assist the department to work out necessary interventions that will have a positive impact on the quality of health service delivery in Mpumalanga.

Furthermore, the study will assist the department to strengthen its commitment to a needs-based, patient-centred, equitable healthcare delivery system using an integrated network of healthcare services provided by dedicated and well-skilled health workers (Mpumalanga Department of Health, 2017). This would contribute significantly to the reduction in the high number of reported SAC-1 Patient Safety Incidents (PSI) and the high rate of litigation against the department.

As a result of this study and the interrogation of the seven pillars of CG, the researcher hopes to assist the Mpumalanga DOH to improve the implementation of CG generally and improve service delivery and patient care. A culture of evidence-based practice will hopefully be instilled, and the Department's research output will improve.

1.6 Structure of the study.

1.6.1 Chapter 1

Chapter 1 consists of the research context, background, statement of the problem, assumptions, objectives, research questions, delimitations, the significance of the study and the summary of the study.

1.6.2 Chapter 2

Chapter 2 focusses on the theoretical framework guiding the study.

1.6.3 Chapter 3

Chapter 3 is a review of the related literature on the implementation challenges of CG.

1.6.4 Chapter 4

Chapter 4 explains the research methodology used to investigate the problem. This gives a detailed description of the research approach, sample selection, data collection, and analysis, as well as the ethical considerations.

1.6.5 Chapter 5

Chapter 5 is devoted to the presentation of the data.

1.6.6 Chapter 6

Chapter 6 gives a comprehensive analysis, interpretation and discussion of the empirical findings and concludes with a summary and the recommendations.

1.6.7 References

A list of references is presented in this section based on the prescribed Harvard referencing style.

1.7 Chapter summary

This chapter introduced the concept of CG and gave a background to its implementation in both developed and developing countries. It gave a synopsis of CG in South Africa, mapping out legislation that support its implementation as well as the challenges of mediocre performance. A problem statement about CG in South Africa is presented. The study purpose, aim, objectives and research questions are listed. The significance of the study is explained. The last part of the chapter gives a layout out of the thesis.

Chapter 2 Conceptual and Theoretical Frameworks

2.1 Introduction

This chapter presents the conceptual and theoretical framework that the study is based on and is divided into the following sections: introduction, conceptual framework, theoretical framework, legislative framework, the last section being a chapter summary. Theoretical and conceptual frameworks are designed to guide the paths of research studies thus offering the foundation for establishing the credibility of such studies (Adom, Hussein and Agyem, 2018). It is argued that though these terms seem similar, they differ from each other in concept and their roles in the research inquiry. Chukwuere (2021), however, holds that the application and selecting process of the theoretical and conceptual frameworks for a research inquiry remain confusing and challenging. For this study, the researcher used a conceptual framework for an in-depth understanding of the concept of CG. He looked at how other countries conceptualize CG and created the framework on which the study will be based. For an appropriate theoretical framework, the researcher studied various theories that relate to public policy implementation and selected aspects that would assist him to explore barriers and challenges in CG implementation.

2.2 Conceptual Framework

A conceptual framework may be described as a structure that the researcher believes can best explain the natural progression of the phenomenon under inquiry (Camp, 2001). It is linked with the concepts, empirical research and important theories used in promoting and systemizing the knowledge espoused by the researcher (Peshkin, 1993). The concept of CG has, since the late 1990s, emerged as an important theme in the search, by various countries, for ways and means to improve both the quality and the safety of health care. CG has, however, proved difficult to implement by

health organizations globally (Pomey, Denis, and Contandriopoulos, 2008). A conceptual framework is regarded as an analytical tool with several variations and contexts. Miles and Huberman (1994:18) define a conceptual framework as a visual or written depiction of the main things to be studied (key factors, concepts, or variables) and the relationships among them. In this study, the researcher considered the CG framework (Figure 2.1) within the context of the seven variables: education and training, clinical audit, clinical effectiveness, research and development, openness, risk management, and information management to establish barriers and challenges, if any, in the implementation of CG in Mpumalanga province.

The CG conceptual framework (Figure 2.1) represents a synthesis of the literature on how most countries explain CG. This maps out the components or pillars of CG and their relationship to the concept. Scally and Donaldson (1998:62) define CG as a framework through which NHS organizations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

South Africa on the other hand, defines CG as “a framework that helps managers and clinicians (such as nurses, doctors, physiotherapists) to improve the quality of their services and safeguard standards of care, continuously, thoughtfully and in a coordinated fashion, by creating and environment in which excellence in clinical care will flourish” (Connell, 2014:10). Though these definitions differ, they do have similarities regarding the participants, health authorities, objectives and goals of the type of health care that is achieved. Other countries such as Australia, Canada, New Zealand and Iran, have adopted the UK definition of CG as stated by Scally and Donaldson (1998:62). All countries are united regarding the seven pillars of CG which constitute the variables of clinical governance in this study.

From this framework, it will be noted that CG is a distinct collection of health activities. It is important to further note that there is currently no formal study on CG that leads to a recognized qualification and yet lately, CG has been elevated to a position of extreme importance to ensure good quality of patient care (Singh, 2009: 189-197).

Figure 2.1: Clinical Governance Conceptual Framework

Source: Scally and Donaldson (1998)

Several countries are in the process of developing CG frameworks, for adoption by their respective governments. Currently, there are varying interpretations of the concept of CG in the literature resulting in associated difficulties in its implementation (Singh, 2009: 189-197). For this study, the researcher used the universal CG conceptual framework of the UK (Figure 2.1).

2.3 Theories and Theoretical Framework

The theoretical framework may be defined as the structure that supports the theory of a research study. It introduces and describes the theory that explains why the research problem under study exists (Labaree, 2009). Fox and Bayat (2007: 29)

define a theoretical framework as ‘a set of interrelated propositions, concepts and definitions that present a systematic point of view of specifying relationships between variables to predict and explain phenomena’. Osanloo and Grant, (2016:13) aver that the theoretical framework is one of the most important aspects of the research process and that without it, the structure and vision for a study are unclear, just like a house that cannot be constructed without a plan.

Over the past two decades, studies of health systems by several global stakeholders grew rapidly into a significant domain (Van Olmen, et al. 2012:1). Through its world health review reports the WHO (2000 and 2007), Van Lerberghe (2008), and Bennett, Ozawa, and Rao (2010) contributed significantly to the development of health systems. The GAVI Alliance, the Global Fund to fight AIDS, TB, and malaria (Global Fund) and the World Bank are other stakeholders who also contributed to the strengthening of health systems.

Concurrently, health systems research has become better defined, with more attention to quality and rigorous scientific methods, facilitated by factors inclusive of an emerging global health workforce crisis, global concerns of weak health systems that were hampering the achievement of organizational objectives, and growing adverse effects of these concerns on health systems (Hafner and Shiffman, 2013:45). Van Olmen, et al (2012:2) argue that there was still a persisting lack of consensus on how health systems could be conceptualized and effectively strengthened. Van Olmen, et al (2012:9) states that health systems have evolved through several frameworks over the years, all influenced by political and economic factors. An analysis of some of these health systems frameworks that evolved in the last decade revealed the following:

2.3.1 WHO Health Systems Strengthening Theory

Health system strengthening refers to the improvement of the health care system of a country. WHO Health Systems Strengthening theory framework resulted from the fact that several countries continued to be faced with several health systems challenges ranging from (i) lack of a clear and concrete health system strengthening agenda; to (ii) absence of clear links between outcome-based programmes and those programmes that have health systems as their core business; (iii) lack of assurance of a country's capacity to respond to current issues and identification of future challenges; to (iv) a need to ensure that institutional assets (staff, resources, and convening power) at each level of the government, are used most effectively.

Through the Framework for Action (World Health Organisation, 2007), the WHO tried to clarify and strengthen health systems in a changing world and ensure that there is continuity in the values that underpinned the Alma Ata Declaration of Health for All of 1978, as well as the principles of Primary Health Care. Consultations before 2007 emphasized the importance of the WHO's institutional role in health systems, resulting in the development of two important strategic documents, namely, the WHO General Programme of Work of 2006-2015 and the Medium-Term Strategic Plan of 2008-2013 (MTSP), which both focused on what needed to be done to support the member states and partners in this regard. To support member states, the WHO developed a single framework with six building blocks (Figure 2.2), which, if adopted by member states, would ensure:

- Good health service delivery that would result in effective, safe, and quality personal and non-personal health interventions for those who need them, when and where needed, using existing resources,

- A well-performing health workforce in enough numbers, appropriate mix, fair distribution, competent, responsive, and productive under given circumstances and environments,
- A well-functioning health information system that will ensure the production, analysis, dissemination, and use of reliable and timely information on health determinants, health systems performance, and health status,
- A well-functioning health system that will ensure equitable access to essential medical products, vaccines, and technologies of assured quality, safety, efficacy, and cost-effectiveness and their scientifically sound and cost-effective use,
- A good health financing system that will raise adequate funds for health service delivery, ensuring the protection of users from financial catastrophe or impoverishment associated with having to pay for them and
- Leadership and governance that will ensure the existence of strategic policy frameworks combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system design, and accountability (World Health Organization, 2010).

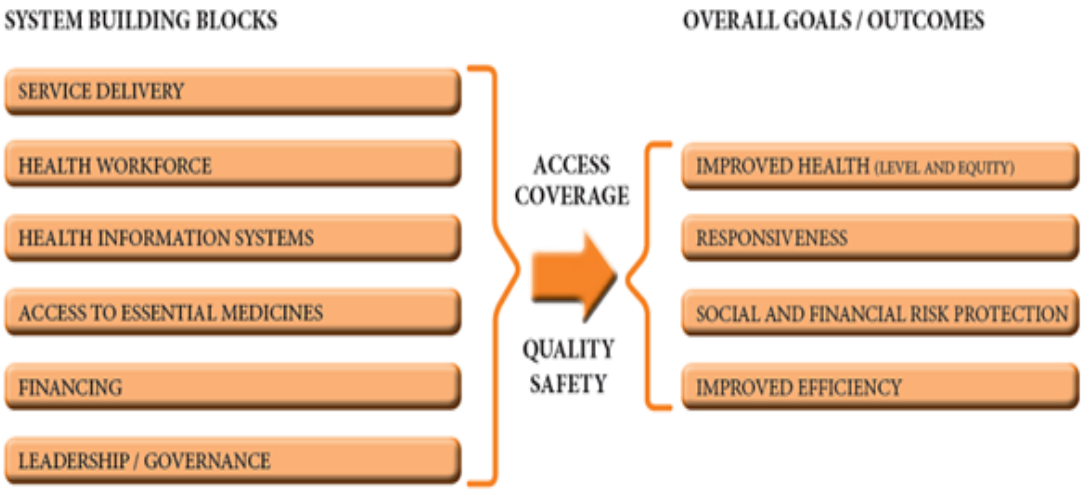


Figure 2.2: WHO Health System Framework
Source: World Health Organization (2010).

This framework continues to be used by WHO member states, including South Africa. The researcher considers this framework relevant to this study in that CG is central to the building block of service delivery, with support from the other pillars.

2.3.2 Systems Thinking in Health

In welcoming a flagship report from the Alliance for Health Policy and Systems Research, which offered a fresh and practical approach to strengthening health systems through systems thinking, the Director-General of the WHO stated that strong health systems were fundamental to the improvement of health outcomes (De Savigny and Adam, 2009:16). As an improvement on the WHO six building blocks for health systems strengthening of 2007, this innovative approach suggested Ten Steps to Systems Thinking, which showed how the wisdom of diverse stakeholders could be better captured in designing solutions to system problems. The systems thinking approach links intervention design and evaluation more clearly, both to each other and the overall health system framework, and places people at the centre of any intervention. The first four Intervention Design Steps include the convening of stakeholders (Step 1), collective brainstorming (Step 2), the conceptualisation of effects (Step 3), and adaptation and redesigning (Step 4). This is followed by six Evaluation Design Steps that include: determination of indicators (Step 5), choice of methods (Step 6), selection of appropriate design (Step 7), development of plans (Step 8), setting a budget (Step 9), and sourcing of funding (Step 10) (De Savigny and Adam, 2009:16). By establishing whether these steps were followed during the introduction of CG in South Africa, the researcher hoped to check what effect this had had on the implementation of CG in Mpumalanga.

2.3.3 Health Integration Theory

Integrated Theory of Health suggests that health behaviour change can be improved by fostering knowledge and beliefs, increasing self-regulation skills and abilities, and enhancing social facilitation. Using a theoretical framework improves clinical management by focusing on assessments, directing the use of best-practice interventions, and improving patient outcomes. Additionally, using theory fosters improved communication with other disciplines and enhances the management of complex clinical conditions by supplying holistic, comprehensive care (Ryan, 2009). To ensure a fundamental shift in the way health services are funded, managed, and delivered, the WHO developed a framework for integrated people-centred health services. The framework supported member countries' progress towards universal health coverage (UHC) through a shift away from disease-oriented towards people-centred health systems (World Health Organisation, 2016:4). In this regard, WHO recommended five interwoven strategies that needed to be implemented:

- Engaging and empowering people and communities

Through this strategy, community and individual resources are unlocked for action at all levels. This enables communities to become actively involved in co-producing healthy environments, empowers individuals to make good decisions about their health, and provides carers with the necessary Training and Development to optimize their participation in the health of their dependents (World Health Organisation, 2016:4). In this way, the underserved and marginalized groups of the population are accessed to benefit from quality services that are co-produced according to their specific needs.

- Strengthening governance and accountability.

This strategy requires a participatory approach to policy formulation, decision making, and performance evaluation at all levels of the health system, from policymaking to the clinical intervention level (World Health Organisation, 2016:6). For this strategy, good governance, which is transparent, inclusive, reduces vulnerability to corruption, and makes the best use of available resources and information to ensure the best possible results, is required. Good governance must be reinforced by mutual accountability among policymakers, managers, providers, and users and by incentives aligned with a people-centred approach (World Health Organisation, 2016:6).

- Reorienting the model of care.

This strategy seeks to ensure the design, purchase, and provision of efficient and effective healthcare services using innovative models of care that prioritize primary and community care services. The strategy suggests a shift from inpatient to outpatient and ambulatory care and from curative to preventive care. Using this strategy, health organizations are investing in holistic and comprehensive care, including health promotion and ill-health prevention strategies that support people's health and well-being (World Health Organisation, 2016:6).

- Coordinating services within and across sectors.

This strategy requires that services be coordinated around the needs and demands of people. This is achieved by integrating healthcare providers within and across healthcare settings, developing referral systems and networks at all levels of care, and creating linkages between health and other sectors (World Health Organisation, 2016:8). The strategy encompasses intersectoral action at the community level to

address the social determinants of health and optimize the use of scarce resources, including, at times, through partnerships with the private sector. Coordination does not necessarily require the merging of the different structures, services, or workflows, but focuses on improving the delivery of care through the alignment and harmonizing of the processes and information among the different services.

- Creating an enabling environment

This fifth and last strategy requires the creation of an enabling environment that brings together all stakeholders to undertake transformational change (World Health Organisation, 2016:9). This involves a diverse set of processes that will change leadership and management, information systems, methods to improve quality, reorientation of the workforce, legislative frameworks, financial arrangements, and incentives. A strong CG framework should embrace these five strategies of this framework. In this study, the researcher hopes to establish if these strategies were considered when CG was introduced in South Africa in 2012.

2.3.4 Health Systems Dynamics Theory

By 2012, the attention to health systems (HS) and health system strengthening (HSS) had re-emerged at the forefront of the global debate on health for a while already (Van Olmen et al. 2012:7). The health systems dynamics framework sought to allow the description of health systems at all levels (national, provincial, or local) (Figure 2.3). In this regard, Van Olmen et al (2012:7) aver that the emphasis of this framework was on the healthcare system and that it focused on its central axis between governance, human resources, service delivery, and population and the interactions between all elements (Figure 2.3). The central axis of the framework transforms the main inputs of financial resources, supplies and infrastructure and health information

into outcomes and goals. As such, the framework looks at performance, while also considering the influence of the other factors in and outside the system.

The framework positions a health system as part of society, thus implying a leading role for the population, on the receiving end as patients and via representation and other means, in the governance of the health system.

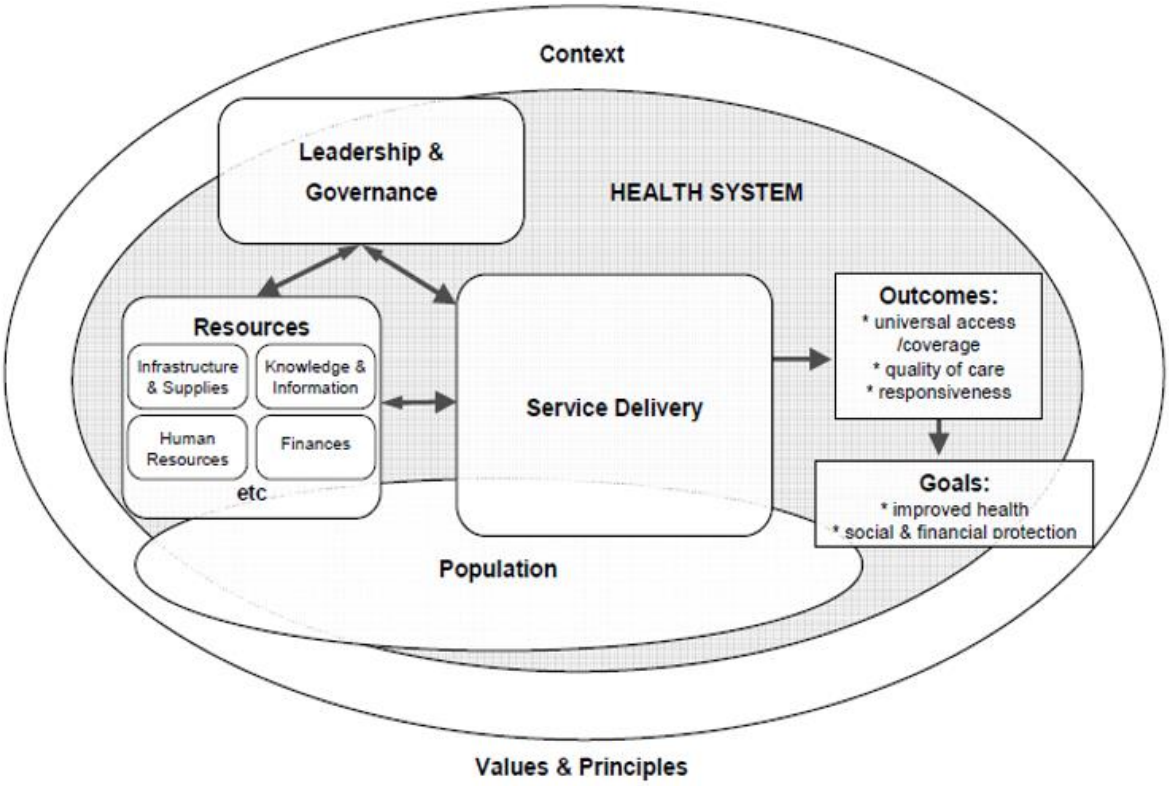


Figure 2.3: Health systems dynamics framework
Source: Van Olmen et al (2012)

2.3.5 Health Investment Theory

The health investment theory provides a standardized methodology for the assessment of the performance of health systems strengthening (HSS) programs. The framework outlines the steps of conducting formative and process evaluations of HSS programs, the assessment of system-wide effects of such programs on elements of the health system, and the plausible effects that influence health outcomes, as defined in the programme's aims and objectives (Itamar et al. 2012:1).

This framework is commonly utilized by funding organizations such as the Global Fund, to establish whether there was value for money in their investments.

2.3.6 Health Systems Theory in South Africa

In South Africa, the National Health Act provides for the public policy on the delivery of health services for its citizens, implemented and administered by the DOH at the national, provincial, and district levels (Republic of South Africa, 2004:28-53). South Africa has a national health system that is delivered through a district health system (DHS), using the primary health care (PHC) approach. It is for this reason that the Department of Health, upon realizing serious poor health outcomes about the MDGs towards 2015, decided to introduce a re-engineering of RPHC to improve the situation. RPHC focussed on three pillars: ward based PHC outreach teams (WBOT), integrated school health teams (IHST), district clinical specialist teams (DCST), and contracting of general practitioners (GP) (Figure 2.4).

The DCSTs were charged with the stewardship of CG focussing on clinical audits; clinical performance and effectiveness, patient and public involvement in CG, information management, clinical risk management, training and education of HCWs on CG and EBP, and research. The RPHC intervention strategy aimed to ensure health service accessibility, universal health coverage, provision of quality patient care, and patient safety (Pillay and Barron, 2011:23; WHO, 2007:3).

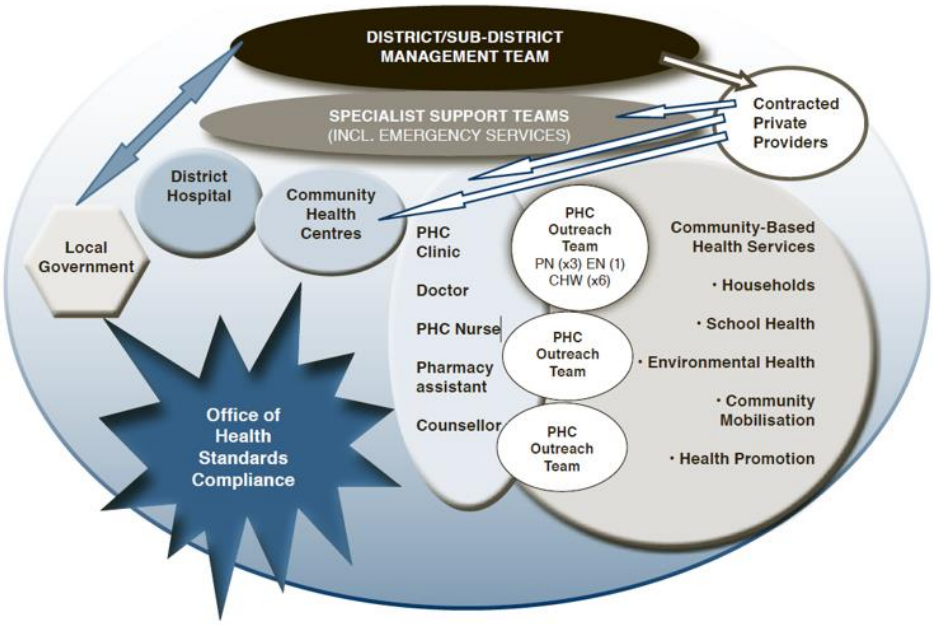


Figure 2.4: Primary healthcare model within the district health system
Source: National Department of Health (2011)

2.3.7 Health Quality Theory

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defined quality in health as the degree to which patient care services increase the probability of desired outcomes and reduce the probability of undesired outcomes given the current state of knowledge (Fromberg, 1988:66). This definition was subsequently adopted by the Institute of Medicine (IOM) in Washington, which defined health quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Donaldson, Corrigan and Kohn, 2000:4-5). From the above, quality in health can be simply defined as the degree of adherence to set standards and the achievement of expected health outcomes, based upon prevailing knowledge, practices, and circumstances.

However, according to Cleary (2003), the patient's perception of quality is in terms of accessibility and affordability of health care, promptness of delivery, early diagnosis, and treatment, with the expectation of returning early to productivity. From the above,

it can be deduced that patients expect to be treated with empathy, respect, and concern. The perception of healthcare providers, on the other hand, is that healthcare quality is based on the parameters of providing care in line with established guidelines and protocols, availability of resources, self-satisfaction with outcomes, and acquisition of knowledge, skills, and competence (Gregory et al. 2005:48-57).

It is the responsibility of health organizations to ensure that public funds for health care are spent responsibly, efficiently and effectively. This will ensure the safety of the public and prevent sub-optimal care. In this process (Kapoor, 2011:207), health organizations must endeavour to meet the requirements of healthcare providers and recipients cost-effectively. Kapoor (2011:207) further argues that quality also does relate to structure, processes, and outcomes of the health system, in which structure refers to the facilities and the human resources, processes representing the various clinical, supportive, and administrative interactions between healthcare providers and healthcare users, while outcomes reflect the changes in the health status of the healthcare users.

According to the IPPF (International Planned Parenthood Federation) (2015:2), quality of care is central to the provision of health services that are characterized by respect, protection, and fulfilment of the most basic human right to the highest achievable standard of health. In this regard, relationships between healthcare providers and users and health care that is provided in line with the needs, values, and preferences of users, as well as the display of compassion and empathy, are fundamental for the quality of care.

The IPPF's Technical Working Group recognized the importance and value of a conceptual framework to unify, guide, and improve quality assurance practices in healthcare provision (IPPF, 2015:3). The framework was regarded as a useful tool to

help structure a situational analysis review of the quality of care and measure and improve the quality of care through ongoing assessments of services and activities against set norms and standards (IPPF, 2015:3).

The seven key components of the quality-of-care framework (IPPF, 2015:6) are safe and confidential environment, comprehensive integrated services, well-managed services, highly skilled and respectful personnel, a secured supply chain management system, adequate financial resources and effective communication and feedback systems. These seven components are briefly described below:

- Safe and confidential environment: The service delivery points should be set up at appropriate locations within the health establishment, which are secure for both healthcare providers and users. These service points should, also, ensure privacy and confidentiality (IPPF, 2015:7). Regarding CG and care, the healthcare organization must ensure that health establishments are in place and that healthcare units are established within such health establishments to ensure the safety of both users and service providers. However, limited resources in public health establishments in South Africa limit the extent to which CG and care can be provided.
- Comprehensive integrated services: The IPPF (2015:8) recommends that healthcare services be given at a specific location holistically, supported by a robust referral system and feedback mechanisms. The Western Cape Government (2012:2), who applied this principle, averred that for instance, the TB-HIV service integration occurred along a continuum, from encouraging referral between services to intensified screening for co-infection to full-service integration in one location, provided by a single team and that this improved the quality outcomes of the programme.

- Well-managed services: To provide healthcare users with the highest quality services, professional competency must be combined with outstanding personal attention and care (IPPF, 2015:8). The services must be compatible with the needs and demands of the users including user follow-up and safe and reliable referral for those healthcare services not offered at the service point.
- Highly skilled and respectful personnel: To ensure high-quality services for users, all healthcare points in a health establishment must be equipped with adequate personnel to perform the prescribed service package for that service point (IPPF, 2015:9). All staff members must be respectful and non-judgemental to all service users. All the necessary support, in terms of training, coaching, mentoring, supervision, and motivation, must be provided to healthcare providers.
- Secured supply chain management system: To ensure the provision of high-quality healthcare services for users, an effective supply chain is required to ensure a reliable supply of enough quantities of high-quality medical commodities and supplies (IPPF, 2015:10). Health authorities must ensure that the healthcare users receive the right product, in the right quantities and in the right condition, to the right place, at the right time, for the right cost during health service delivery.
- Adequate financial resources: Availability of adequate funding constitutes a key part of ensuring quality services for clients. Without enough resources, there will not be effective delivery of high-quality health services. In this regard, IPPF (2015:10) argues that a high-quality service must have the right team, with the right training, good infrastructure, and the right equipment and commodities. The IPPF (2015:10) further aver that these resources must be administered

using effective fiscal management, profitable approaches, and in an environment of financial sustainability.

- Effective communication and feedback systems: In this regard, the IPPF (2015:11) suggests for high-quality health care, all health service delivery points must be client-focused and should have well-functioning monitoring and evaluation systems. Service users must have a way of giving feedback at the service delivery point as well as within the community. Service providers, on the other hand, must respond to the feedback in a timely and appropriate manner. In this sense, therefore, such community engagement will ensure that the services provided are responsive to community needs, which in turn can foster quality assurance and improvement, responsive planning, and programming, create demand and empowerment and promote rights (IPPF, 2015:11).

2.3.8 Universal Health Coverage Theory

The World Health Organisation (2014:7) describes Universal Health Coverage (UHC) as ensuring that all citizens of a country have equal access to needed health services (including prevention, promotion, treatment, rehabilitation, and palliation) of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. This definition highlights three related objectives: equity in health services access, decent quality health services, and financial risk reduction and protection of high-risk groups and individuals (National Department of Health, 2015: viii). In its argument for the acceleration of UHC, the World Health Organisation (2013:16) suggests three dimensions of UHC consisting of population coverage, service availability and quality, and financial protection (Figure 2.5).

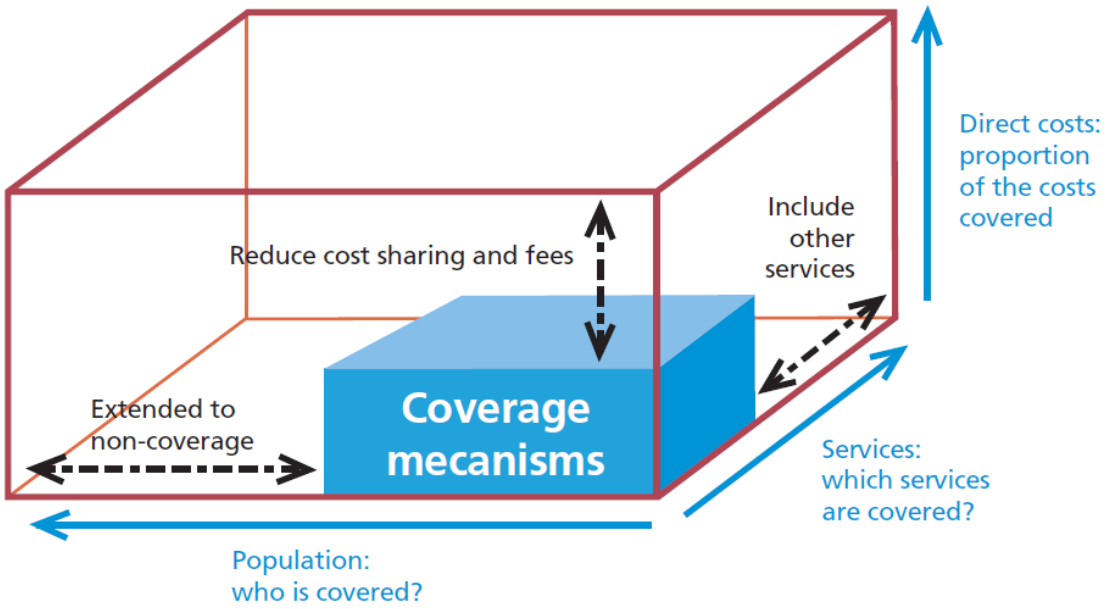


Figure 2.5: Towards Universal Health Coverage
Source: National Department of Health (2015)

In this argument, it is suggested the primary aspiration of UHC is to ensure that all citizens can obtain the health services they require and that those services are of superior quality. WHO suggests that decision-makers should realize progress along individual axes in Figure 2.5 is not adequate and that the services that are rendered should be of the expected quality for communities to have confidence in the system. World Health Organisation (2013a:18) further stresses the importance of human rights and equity in formulating strategies to accomplish the aspirations of UHC in each country. In this regard, everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (World Health Organisation, 2013a:7). This requires a strong and efficient health governance system that involves all relevant stakeholders, supported by all the various components including infrastructure, medicines and medical products, health workers, health information systems, and health financing (World Health Organisation 2013a:7).

In South Africa, UHC is introduced by initially focussing on health financing, referred to as National Health Insurance (NHI). In this regard, it is hoped that the NHI will transform health financing in pursuit of financial risk protection (Department of Health, 2015:1) by eliminating fragmentation and strengthening fund pooling for service purchase, thus creating a unified system that will help in the achievement of the UHC and SDGs. In this sense, NHI represents a substantial policy shift that requires significant health systems governance and management change. The National Health Insurance Bill (South African government, 2019) seeks to address the UHC dimension (World Health Organisation, 2010) that deals with direct costs (financial risk protection) whereby a national insurance fund is established with clearly stated powers, functions, and governance structures.

There is general agreement on the definition of Universal Health Coverage (World Health Organisation, 2013a; Friebel et al. 2018; Berman, Azhar & Osborn, 2019. South African Department of Health, 2015): viii) also concurs. Based on this, the researcher opines that South Africa's National Health Insurance policy is a misnomer and should be called the National Policy on Universal Health Coverage. This would make it easy to compare South Africa's UHC policy with those of other countries in terms of their respective implementation strategies. In any case, the National Health Insurance policy (Department of Health, 2015:29-38) devotes a full chapter to the reorganization of the healthcare system and services under NHI (UHC) inclusive of (i) rearrangement of service delivery into primary health care (PHC), general and specialized hospital services as well as emergency medical services (EMS), (ii) improved leadership and governance at all levels (provincial, district, and facility) with stipulation of clear roles of management, (iii) enhancement of health workforce strategies to increase the production of health professionals, (iv) improved access to medical products and technologies, and (v) improved information management and

research for monitoring progress in UHC implementation. From the above, it became clear to the researcher that the implementation of UHC in South Africa can only happen if a strong CG system is in place. This is confirmed by the World Health Organisation (2014) in the action plan on Health Systems Governance for Universal Health Coverage.

2.3.9 Clinical Governance Theory

According to the World Health Organisation (2010:86), leadership and governance are key in ensuring that strategic policy frameworks exist and that they are combined with effective oversight, coalition-building, regulation, attention to system design, and accountability. The three main categories of stakeholders who are crucial in health systems leadership and governance. These include the government departments and agencies (at the central, provincial and local levels); the healthcare providers (public, private and not-for-profit); and trade unions and professional associations. Networks of care or of services and the citizens become service users when they interact with health service providers. In this regard, the WHO supports member countries to exercise effective health systems governance using the framework of the SDG agenda. As a member country, South Africa has adopted the WHO's six building blocks for strengthening its health system and has highlighted leadership and governance as the most important pillar of its strategy.

The implementation of CG as a strategy should be in line with the theory of change (ToC) framework, which identifies the need for quality patient care, the inputs, processes (activities), outputs, outcomes, and expected impact of the intervention (World Health Organization, 2010). The ToC framework involves relationships among and accountabilities of role players in the patient healthcare value chain. The ongoing evaluation of CG as a programme requires compliance with the ToC framework.

From the theories and theoretical frameworks above, the researcher developed the framework that the study would be conducted based on. Figure 2.6 maps out a four-stage process map through which the CG policy should be formulated, implemented, monitored and evaluated. The framework juxtaposes the WHO six health systems building blocks with the social systems theory framework (input, process, outputs, outcomes and impact).

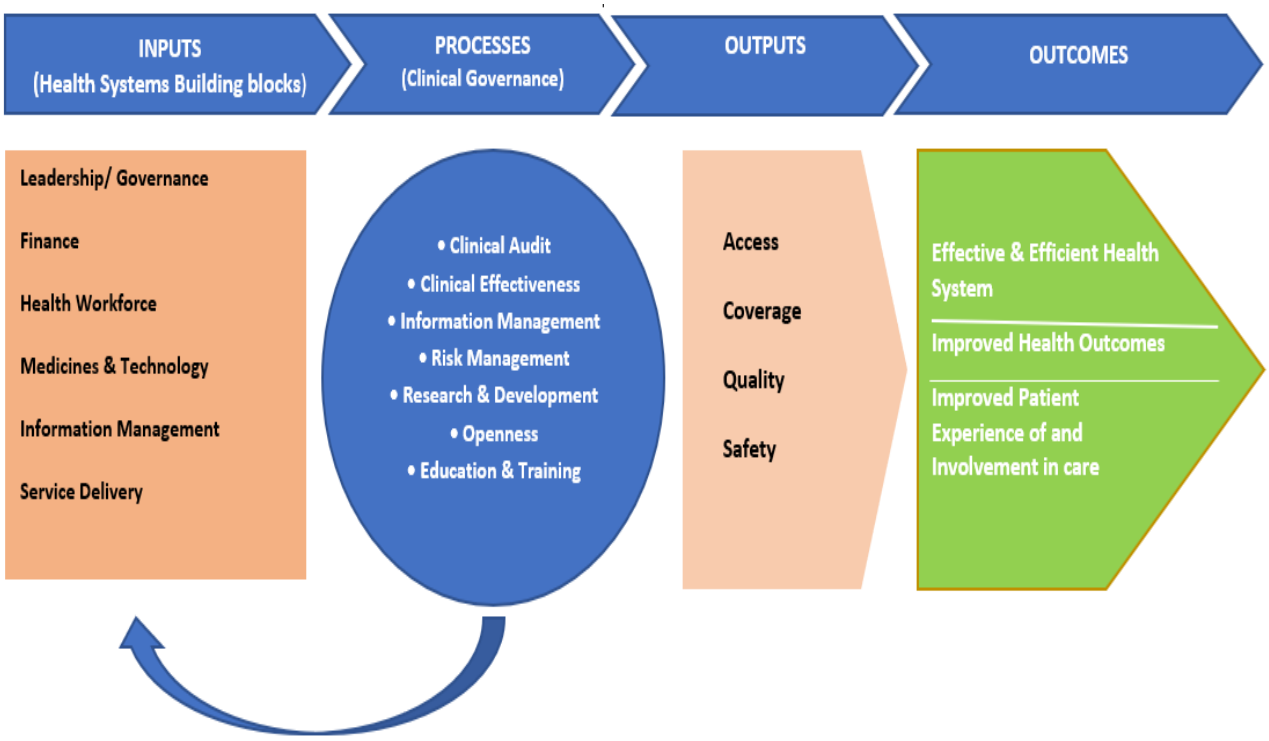


Figure 2.6: Theoretical Framework for Service Delivery
Adapted from the WHO Health Systems Framework

2.3.9.1 Inputs

In this theoretical framework, the researcher regarded the WHO health systems building blocks as important resources or inputs that are required for CG to take place. Each pillar of CG requires that a formal unit be established within the health department, supported by able leadership and governance, adequate financial resources, dedicated personnel**,** tools and systems, information management system, and service delivery guidelines and policies. In interacting with the

participants, the researcher would establish if all these conditions had been met for the successful implementation of the CG policy.

2.3.9.2 Processes

CG is the core of the framework, with each element being considered an important activity. As indicated in the conceptual framework, each element of CG has a specific role to play in the implementation of the policy. As this study was about process evaluation, questions were asked about implementation challenges and barriers in respect of each pillar of CG.

2.3.9.3 Outputs

In respect of outputs, the framework is aligned with the WHO health systems framework where access, coverage, quality, and safety are the expected effects of successful CG. For purposes of this study, however, this was less emphasis on this stage of evaluation.

2.3.9.4 Outcomes

As per the WHO health systems framework, the outcomes of the intervention will include an effective and efficient health system, improved health outcomes, and improved patient experience of and involvement in care. Once again not much emphasis was placed on this evaluation stage.

For this study, the researcher used the first two stages (input and process) of the framework to explore CG implementation barriers and challenges. Participants would have to give their experiences on whether the required input and process measures were adequate for the formulation of the CG policy formulation and the implementation thereof.

2.4 Policy and Legislative Framework

For the researcher to evaluate the implementation of any programme in the public sector, in-depth knowledge of all applicable legislation is important. CG is crucial for efficient and effective health service delivery. The following pieces of legislation are relevant.

2.4.1 The Constitution of the Republic of South Africa Act No. 108 of 1992

The Constitution places an obligation on the state to ensure access to health care for all South Africans. Section 195 of the Constitution makes provision for principles, which call upon all employees of the government to observe. According to the Constitution, every South African has a right to healthcare services, including reproductive health care (Republic of South Africa, 1996:11). By implication, all HCWs are expected to ensure that the right care is provided to the right patient at the right time by the right clinician who has the right skills and that such care is provided in the right way, using the principles of good governance.

2.4.2 National Health Act 61 of 2003

The National Health Act (NHA) obliges the government to provide a structured uniform health system within the country (Republic of South Africa, 2004). Section 25(2)(f) of the Act, obliges the provincial departments of health to plan, coordinate and monitor health services and evaluate the rendering of health services, inclusive of CG and support services. Through the National Health Act Regulations: Norms and Standards Regulations applicable to different categories of health establishments, the Act obliges provincial departments of health to provide CG and health support services in compliance with the set national norms and standards (National Department of Health, 2018:21-32).

2.4.3 The Occupational Health and Safety Act No. 85 of 2003

This act (Parliament, South African, 2003) provides for the creation of a safe working environment for employees by employers. The Act obliges a province, as an employer, to ensure that health establishments are safe for all CG and support service providers. This is in support of those employees of the province who are charged with CG.

2.4.4 The Nursing Act No. 33 of 2005

This act (South African Nursing Council, 2005) regulates the nursing profession and provides for matters connected therewith. The Act establishes the South African Nursing Council (SANC) to maintain professional conduct and practice standards for nurse practitioners within the ambit of all applicable laws. This Act is relevant for this study in that those professional nurses who are employed by the Mpumalanga DOH in its health establishments and as part of the DCSTs, are always expected to practice professionally and ethically.

2.4.5 The Health Professions Act No. 56 of 1974

The Health Professions Act (Republic of South Africa, 2006) establishes the Health Professions Council of South Africa (HPCSA) and professional boards and provides for control over the education, training, and registration for and practicing of health professions registered under this Act (medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals) and for matters incidental thereto. CG is dependent on these professions, making this Act relevant for this study.

2.4.6 Pharmacy Act No. 53 of 1974

The Pharmacy Act, 1974 (Act No. 53 of 1974) (as amended) provides for the establishment of the South African Pharmacy Council (SAPC) and the training and registration of pharmacists, trainee pharmacists, pharmacy students, unqualified assistants, and pharmaceutical technicians, to provide for the control of the practice of the pharmaceutical profession and to provide for matters incidental thereto. Pharmaceutical professionals play a vital role in CG, thus making this Act relevant for this study.

2.4.7 National Development Plan 2030

The National Development Plan 2030, (Chapter 10 Promoting Health) sets out nine long-term health goals for South Africa, the first five relating to the wellbeing of the population while the other four describe the required systems and provide applicable indicators and action points. The attainment of these goals, the setting up of the required systems, the activation of the action points, and the achievement of the performance indicators are dependent on strong CG. Consideration of this plan is, therefore, crucial in this study.

2.4.8 National Health Insurance Policy

National Health Insurance (NHI) policy seeks to improve access to quality, affordable personal healthcare services for all South Africans based on their health needs, irrespective of their socioeconomic status, thus moving South Africa towards universal health coverage (UHC). For this transition from the current health financing system, a robust and efficient system of CG is needed. In undertaking this study, therefore, it is important to assess the knowledge, attitude, and practice of the participants about the new UHC policy.

2.5 Chapter summary

In this chapter, the researcher developed the study framework. This was done through an intensive review of the literature where commonalities among various country positions on the pillars of CG were considered. In this regard, the researcher was able to conclude that CG has seven pillars that require consideration when CG implementation is investigated. The second benefit of the in-depth literature review of theories and theoretical frameworks that exist in relation to CG were considered. From all these theories, the researcher developed what he considered the proper theoretical framework for the study. Thirdly, the researcher considered relevant legislation that affects CG implementation. In this regard, he considered the constitution of the country, the national health act, various health professions acts and national health policies as crucial when failures and successes of CG implementation are evaluated.

Chapter 3 Literature Review

3.1 Introduction

This chapter presents the review of the literature regarding the views of senior health managers, clinical managers, and clinical specialists about barriers and challenges of the implementation of CG. The literature review focuses on the seven pillars of CG, namely clinical audits, clinical performance and effectiveness, patient and public involvement, information management, clinical risk management, training and education, and EBP and research; the assumption is that the successful implementation of all these seven pillars will imply overall successful implementation of CG.

3.2 Search strategy

This literature research study section employed Google, Google Scholar, and Mendeley as the search engines and extensions. A literature search for research articles on the barriers, challenges, and facilitators in the implementation of CG was done using the search strategy "CG, implementation, barriers, challenges." A search was conducted for each CG pillar. In this way, the researcher hoped that the search strategy could cover all the seven pillars or elements (education and training, clinical audit, clinical effectiveness, research and development, openness, risk management, and information management). The search period selected for the search was 2010-2019. All journal articles on barriers and challenges in the implementation of CG were selected and analyzed for study site (country), purpose, background, participants, methods, results, and conclusion. The literature search revealed that there has been extremely limited research done to assess the barriers and challenges in the implementation of CG. Notably, only one evaluation of CG has been undertaken in Africa.

3.3 Literature search results

In this section, the researcher discussed search results in respect of each CG pillar. In each case, the search phrase used was the name of the pillar. For example, for clinical audit, the phrase “clinical audit” was used to search for literature in that regard. In this way, all relevant articles on the subject were accessed and perused for barriers and challenges in its implementation.

3.3.1 Clinical Audit

A clinical audit is a method that healthcare professionals use to measure the quality of the care they offer. It allows them to compare their performance against set norms and standards to see how they are doing and identify opportunities for improvement. Burgess and Moorhead (2011: xi) define Clinical Audit as a quality improvement process that involves measurement of the effectiveness of health care against agreed and proven standards for high quality and taking action to bring practice in line with these standards to improve the quality of care and health outcomes. Properly carried out, a clinical audit should involve three main categories of stakeholders: service providers (clinical and non-clinical), service users (patients, community members), and people who are required to implement change (such as operational managers, HR) (Connell, 2014:22). The benefits of a clinical audit include improved communication among HCPs and other professional groups, improved health care and service delivery, enhanced professional satisfaction, knowledge, performance, and teamwork, and better administration in health establishments (Johnston et al. 2000:23).

In an audit review of barriers and facilitating factors for an effective clinical audit conducted in Belfast, UK, Johnston et al (2000:25) found the key reason for the floundering clinical audits had been that doctors were not convinced that clinical audits improved quality. Their perception was that clinical audit diminished their clinical ownership, their fear of litigation, that it

encouraged hierarchical and territorial suspicions, and that it resulted in professional isolation. The study also found that clinicians felt that clinical audits detracted them from their clinical work at the expense of patient care. Regarding barriers to clinical audit, Johnston et al (2000:26) found a lack of resources, lack of appropriate expertise or advice in the design of projects and analysis, relationship problems between HCP groups and individual HCPs, non-availability of overall audit plans, and departmental impediments such as lack of supportive relationships between programme managers and clinicians, to be serious barriers to the implementation of clinical audit in the UK.

In a comprehensive review of the literature about a routine clinical audit (outcome measurement) in the allied health professions, Duncan and Murray (2012:4-6) found a range of barriers and facilitators to routine clinical audit by allied health professionals in practice. These barriers and facilitators ranged from knowledge, education and perceived value in clinical audit at an individual level, support and priority for clinical audit within health establishments and practical considerations such as availability of time, workload and lack of funding, to be the most mentioned by interviewees. Kediegile and Madzimbamuto (2014:127) consider a clinical audit is a method used to address the clinical environment to bring about change and improvement in healthcare delivery. According to them, a clinical audit model should involve a six-stage cycle consisting of (i) identification of the applicable standard, (ii) measurement of the practice against the standard, (iii) comparison of the practice with the standard, (iv) identifying areas for change and making recommendations, (v) implementation of the changes or interventions as recommended, and (vi) re-auditing (Kediegile and Madzimbamuto, 2014:128). According to Kediegile and Madzimbamuto (2014:128), the barriers faced when conducting clinical audits in Botswana included (i) difficulties in retrieving medical records both in the clinical unit and in the hospital records department, (ii) poor and unsatisfactory documentation, (iii) non-availability of standard operating procedures (SOPs) for

admission and referrals, and (iv) reluctance to participate in clinical audits by the clinical departments for fear of consequence management. To a large extent, Kediegile and Madzimbamuto confirmed what Johnston et al (2000:27) who had, more than a decade earlier, classified the main barriers to clinical audit under five main headings being a lack of (i) resources, (ii) expertise or advice in project design and analysis, (iii) healthy relationships between healthcare provider groups and group members, (iv) an overall plan for clinical audit and (v) some organizational impediments.

In South Africa, a clinical audit is described as an essential tool that helps HCPs to assess the quality of health care they offer, objectively, in terms of best practice and desired patient outcomes (Connell, 2014:19). No study was found on the barriers and challenges in conducting clinical audits in health establishments of Mpumalanga province, South Africa. From the literature review of barriers and challenges in clinical audit, no article was found for the South African perspective, thus revealing a knowledge gap in this regard.

3.3.2 Clinical Performance and Effectiveness

Quality health care for patients should be based on superior quality evidence from clinical research (Connell, 2014:11). Connell (2014) describes clinical effectiveness as a measure of the extent to which a clinical intervention works and argues that in these modern times, clinical practice needs to be refined in the light of emerging demand and evidence for effectiveness, efficiency, and safety for both patients and HCP. Clinical effectiveness seeks to ensure health care based on the 6 Rs: right care, right patient, right time, right clinician, right skills, and right way (Connell, 2014:11). The requirements for effective health care include regular review of clinical records, availability of skilled HCWs at the point of service delivery, accessibility of higher levels of care, and the use of early warning systems to help relevant and prompt patient referral.

Daly et al (2014:81) posit that while effective clinical leadership plays a vital role in clinical effectiveness and best hospital performance, there are considerable barriers to participation in clinical leadership. Daly et al (2014) categorize these barriers as (i) individual (lack of confidence, clinician cynicism), (ii) organizational (lack of incentives, poor communication, poor teamwork, poor leadership), and (iii) system barriers (poor preparation for leadership roles, curriculum deficiencies at undergraduate level in medicine and health professional courses, inadequate resourcing of development programs, lack of vision and commitment at the higher levels, poor interdisciplinary relationships, role conflict, resistance to change).

Reminding us of the adage “you can’t improve what you can’t measure” Atkins (2016: S3) warns that measuring clinical performance has become an integral part of current efforts to drive improvement in CG globally. Atkins (2016) however, observes that measuring clinical performance is a health system intervention that needs careful examination. Atkins (2016: S3) concludes that patient experience and perception of care are useful for the assessment of healthcare quality and safety.

3.3.3 Clinical Risk Management

Heyman et al. (2010:19) define risk as the projection of uncertain expectation, viewed in terms of randomness, about the occurrence of a negatively valued outcome category within a selected period. Heyman et al. (2010:19) aver that risk management is a good safety culture where staff has a constant and vigilant awareness of the potential for things to go wrong, can identify and acknowledge mistakes, learn from them and take action to put things right to make patient care safer. According to Connell (2014:37), providing health care is a risky business, and no matter how well a health system functions and how dedicated and competent the HCP staff in a health facility might be, things can still go wrong.

Risk management is categorized into three components: (1) Risks to patients which can be minimized by ensuring that systems are regularly reviewed; (2) Risks to practitioners which require ensuring that HCPs are protected against infectious diseases, work in a safe environment, and are kept up-to-date on important parts of quality assurance; and (3) Risks to the organization which requires that in addition to reducing risks to patients and practitioners, organizational own risks are reduced (Department of Health, Western Australia. 2019:35).

In Iran, (Farokhzadian, Nayeri and Borhani, 2015:1), there was recognition of healthcare risks and clinical risks as major challenges in healthcare provision, resulting in the introduction of clinical risk management (CRM) system in the country's health system to improve the quality of services. However, implementation of the CRM system was found to have impediments ranging from (1) organizational culture and leadership challenges, (2) limited financial, human, and physical and equipment resources, and (3) working related conditions such as emotional, psychological, and social atmosphere and the heavy workload (Farokhzadian, Nayeri and Borhani, 2015:8). Exploring the barriers to effective risk management at the Georgia State University, Cho (2016:66) found that (i) accountability-related issues, (ii) poor risk management skills, (iii) inadequate supervision, (iv) lack of risk management strategies, (v) disparities in organizational risk management processes, (vi) lack of clearly documented risk issues at the local level, (vii) exclusion of lower-level managerial involvement in risk assessments, (viii) conflicts between risk management issues within organizations and socio-political pressures, and (ix) risk management systems, were important barriers to effective risk management. Cho's findings were like those of Farokhzadian, Nayeri and Borhani (2013).

In their review of the barriers and challenges to the implementation of risk management guidelines in low- and middle-income countries, Stokes et al (2016:7) found that in South Africa, (i) poor recording and extraction of clinical information, (ii) division of data collection between numerous workers, (iii) non-motivated data collectors, (iv) audit meetings that are

characterized by victim-blaming, (v) lack of local clinical leadership, (vi) unprofessional audit meetings and (vii) poor communication of audit findings and feedback, were the main barriers to the implementation of risk management guidelines. In this regard, Dizon et al (2017:11) note the eagerness of South Africa to produce locally applicable clinical practice guidelines (CPGs) that seek to assist in standardizing and improving care but realise the enormous workload pressures on too few HCPs on the ground to meet the demand. The HCPs' poor understanding of the clinical complexities associated with treating patients presenting with complex conditions were major barriers to the production of appropriate guidelines. By interviewing the participants on risk management, the researcher hoped to establish whether these barriers and challenges had been experienced in Mpumalanga province and what could be done to improve the situation.

3.3.4 Evidence-Based Practice and Research

The WHO requires that healthcare provision be based on the best available evidence to the HCP, (Mathieson, Grande and Luker, 2018:1). For many years now, Evidence-Based Practice (EBP) has become an aspiration for many HCPs (Mathieson, Grande and Luker, 2018:1). Across the globe, professional regulatory bodies expect HCPs to deliver EBP in all situations during the delivery of health care.

Brooke and Mallion (2016:340) state that the provision of good health care requires that change be brought about through evidence-led research. Such change must be implemented timeously. Research and development encourage healthcare practitioners to use techniques such as a critical appraisal of the literature, project management, and the development of policy guidelines, protocols, and implementation strategies as tools for promoting the implementation of research practice.

In a study that was conducted in the Cape Metropole, South Africa, Pather (2015:8) found that time constraints, practitioner workload, lack of financial resources, lack of ownership, the lack of timeous organizational support, and practitioner resistance to change, were notable barriers to EBP. In a similar study done in the Eastern Cape province, South Africa, Jordan, Bowers and Morton (2016:50) stressed that EBP was increasingly being recognized in health establishments as a pivotal component of patient care delivery and that EBP in health care aims to provide quality patient care using the best available and valid scientific evidence. In the study, Jordan, Bowers and Morton (2016:50) largely concurred with Pather (2015:8) regarding the common barriers to EBP but categorized them into individual barriers that included familiarity with EBP, perceptions of EBP, frequency of accessing required information, frequency of accessing best-practice guidelines, information sources of evidence, other sources of evidence, inability to synthesize the amount of literature available and resistance of HCPs to change from traditional and ritualistic practices to EBP and organizational barriers that included lack of organizational support, organizational change, and operations.

In a study undertaken in Cape Town, South Africa, to explore the experiences and understanding of family physicians (FP) in primary care regarding EBP and the implementation of evidence-based guidelines, Pather and Mash (2019:2) conclude that little was known about the attitudes and behaviour of primary care practitioners towards EBP and the implementation of clinical practice guidelines. Pather and Mash establish that evidence quality and relevance, guideline development, contextualization of the guideline, guideline dissemination, guideline implementation, monitoring, and evaluation were important considerations in the development of a framework to improve EBP among HCPs. With this study, the researcher wanted to establish if there were similar barriers and challenges among clinicians in the Mpumalanga province, and if so, what had been done to resolve them.

3.3.5 Patient and Public Involvement

Patient and Public Involvement (PPI) is the inclusion of patients, family members, carers and the public in various aspects of clinical work to help develop and improve patient care in a meaningful and informed manner (Lemma, 2018). It is about empowering patients and the public to have a say. According to Ridley and Jones (2002:4-7), there are four main types of involvement: (i) the direct involvement of individuals and carers in their health care; (ii) user and public involvement in service quality; (iii) in policy and planning; and (iv) involvement through community development approaches. This suggests that healthcare processes should ideally be open to public scrutiny, while individual patient and healthcare practitioner confidentiality is still observed and respected. Open proceedings and discussion about CG issues should be a feature of the framework. It is the responsibility of all organizations providing high-quality health care to ensure that they meet the needs of the population they serve. This requires cooperation between healthcare organizations at all levels. By interviewing research participants on this pillar of CG, the researcher sought to establish to what extent patients and their communities were involved during the implementation of CG and whether the necessary governance structures such as hospital advisory boards and clinical committees do a feature on issues of CG.

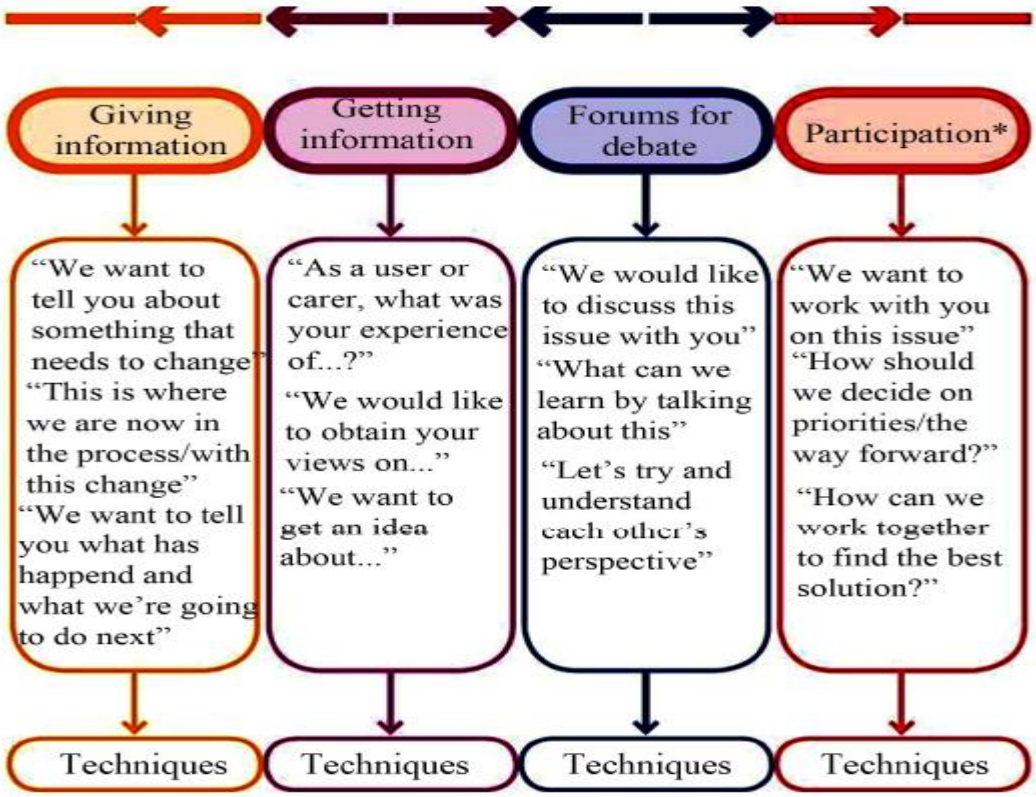
Ridley and Jones (2002:4-7) aver that the involvement of individual health users in their care has been found to result in better health and treatment outcomes and increased user satisfaction. Involving health users and carers in the development of healthcare standards is important in ensuring quality health care. User involvement in health service planning is essential in ensuring that such plans are informed by real needs, aspirations, personal experience, and direct evaluation (Ridley and Jones, 2002:4-7).

Ridley and Jones (2002:3) further warned about the helpfulness of distinguishing between involving people as individual users or carers and involving them as groups (users' groups or citizens). The researchers listed barriers and challenges to the user and public involvement as negative perceptions of involvement of staff members, general lack of understanding of the nature of PPI, skill and knowledge gaps, resource issues, and failure to work together.

Maccarthy et al (2019:1) agree with Ridley and Jones that implementing meaningful PPI can indeed be a challenge and note that patients and the public are increasingly sought as participants in study design and governance in health care. This results from an increasing requirement by national, international, and charitable funders to include PPI as a condition of funding. According to Maccarthy et al (2019:5), the major identified barriers to PPI implementation were ethical challenges, engagement of patients and the interested public, funding to carry out PPI as well as a perceived lack of relevant guiding documents among healthcare providers.

PPI as a concept is now recognized and linked with quality health service delivery globally and especially in Europe. Countries such as the Netherlands, Greece, Austria, Finland, Hungary, Norway, and England have implemented a wide range of user empowerment measures, including patients' rights legislation, the introduction of ombudsperson services, and increasing patients' involvement and participation in healthcare planning, implementation and monitoring, and evaluation. Boudioni and McLaren (2013:472) aver that England's NHS policies have increasingly quoted patient-centred health care and called for high-quality care for everyone based on an NHS that gives patients and the public more information and choice, working in partnership and has the quality of care at its heart. According to Boudioni and McLaren (2013:473), the English NHS adopted the concept of Involvement Continuum as an enabler for policy implementation (Figure 3.1). According to the involvement continuum, giving to and getting information from health users and the public and establishing forums for debate and

participation, are crucial for PPI implementation. However, Boudioni and McLaren (2013:473) identified deficiencies in financial and human resources, organizational capacity, lack of relevant data, difficulties in supporting the public, and accessing seldom heard groups were identified as barriers to facilitating PPI implementation in the NHS. Like the European countries referred to above, South Africa realized the importance of PPI shortly after the birth of its new democracy in the nineties and recognized and linked it with quality health service delivery. In addition to the wide range of user empowerment measures that it implemented, including patients' rights legislation, the introduction of health ombudsperson services, and increasing patients' involvement and participation in healthcare planning, implementation, and monitoring and



evaluation, it introduced the Batho Pele Principles through the White Paper on Transforming Public Service Delivery (Department of Public Service and Administration, 1997).

Figure 3.1: The Involvement Continuum
Source: Boudioni and McLaren (2013)

The purpose of this White Paper was to provide a policy framework and a practical implementation strategy for the transformation of Public Service Delivery to ensure that users of public services are consulted about their needs and priorities during service delivery. Khoza and Du Toit (2011:11) found that inefficient hospital management, inefficient nursing unit management, and patients' lack of knowledge about their rights in the healthcare system were significant barriers to the implementation of the Batho Pele Principles.

In respect to each of the eight Batho Pele Principles, Ngidi and Dorasamy (2013) found that staff shortage, lack of appropriate monitoring, incapacity and budgetary constraints were barriers to the Batho Pele principle of consultation; corruption was a barrier to service access; giving some users preferential treatment over others was found to be a barrier to courtesy; failure to interpret sign language and non-availability of braille forms was found to be a barrier to provision of information; the gap between senior management and frontline staff in understanding the strategic plans of the department and lack of funds to implement it (Public Service Commission, 2008:15) presented as a barrier to openness and transparency; failure by higher offices to address problems that confront frontline staff on a day-to-day basis and

poor service delivery systems presented as barriers to the implementation of the principle of redress; and inadequate budgets and failure by service delivery establishments to use resources efficiently presented as barriers to the value for money principle. The Public Service Commission (2008:20) states that the major barrier reported by most government departments in the implementation of all Batho Pele principles was the lack of funds to implement them. Jardien-Baboo et al (2016:397) relate the quality of health care concept of patient-centred care to the enactment of the Batho Pele Principles and the Patients' Rights Charter. Jardien-Baboo et al (2016:403) further aver that lack of resources (staff and equipment), excessive administrative work and unprofessional behaviour (bad attitude towards patients) are serious barriers to patient-centred care among healthcare professionals (especially nurses).

3.3.6 Training and Development

Training and development or continuing professional development (CPD) ensures that HCWs who have completed their academic programmes, can practice safely, effectively, and competently to meet the ever-changing healthcare demands of society, advances in health care, revised scopes of practice (task sharing), and emerging health conditions (Feldacker et al. 2017:2). According to Feldacker et al. 2017), CPD seeks to meet the goal of improving quality health care. It is, therefore, important that personnel caring for health users have the knowledge and skills needed to provide quality health care and should, therefore, be given opportunities to update their skills to keep up with the latest developments and new skills in health care.

Feldacker et al. (2017:3) note that in Malawi, the authorities responsible for CPD are the Nurses and Midwives Council of Malawi (NMCM), the Medical Council of Malawi (MCM) and the MOH Nursing Directorate. CPD guidelines already exist for nurses, midwives, and doctors. Feldacker et al. (2017 further observe that like in South Africa, CPD is mandatory for license renewal for

doctors, nurses, and midwives in Malawi. CPD compliance monitoring for nurses is done through an audit of 5% of registered nurses and midwives using trained CPD facilitators deployed to districts/ facilities. CPD accreditation is done for doctors by the MCM, which is the main accreditor of CPD providers. There is no formal CPD accreditation system yet for nurses/ midwives in Malawi (Feldacker et al. 2017:3).

In Tanzania, the Tanzania Nursing and Midwifery Council (TNMC), the Medical Council of Tanganyika and the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), are responsible for CPD. It was only in 2016 that draft guidelines were developed for nurses, midwives, and doctors. These guidelines make CPD mandatory for all HCPs in Tanzania. No audit system for monitoring compliance had been implemented by 2016, neither was a formal CPD accreditation system for HCW-related CPD programs (Feldacker et al. 2017:3).

One of the important things that should happen when CG is introduced, is to ensure that CPD happens on an ongoing basis. In this regard, a close working relationship between professional bodies and tertiary institutions should be forged. Connell (2014:11) argues that reading to keep up to date with the latest evidence and guidelines, taking an active part in journal clubs and multi-disciplinary training activities, and seeking feedback on performance from clinical colleagues, are crucial for CG. In a study conducted in Canada about barriers and challenges affecting CPD, Jeong et al (2018:1249) found that time constraints, limited access to tools/programs, competing demands/interests, cost, technological problems, and lack of faculty with expertise and experience in team training constituted the most common barriers to CPD participation among physicians.

In another study conducted in Tanzania on challenges in the implementation of CPD, Feldacker et al (2017:5-11) concur with Hemmington, (2000:11) that challenges are found at three levels:

system, implementation, and individual levels. CPD funding, gaps in CPD coordination, shortage of HCPs, and lack of resources at the health establishment level, are challenges that impede CPD at the system level. The Rurality of the area where health establishments are located, top-down versus HCP-driven selection of CPD topics and pieces of training, were the two most important impediments to CPD at the implementation level. At the individual level, Feldacker et al (2017:5-11) found a lack of self- motivation and money for attendance of CPD activities to be the most familiar challenges in the implementation of CPD.

An assessment of barriers to pharmacy practitioners' participation in CPD activities in Kenya (World Health Organisation, 2013:18), revealed that inadequate support from employers for participation in CPD activities and lack of funding were serious challenges. The reason for these was given as the distance to the venues of CPD workshops, meetings, courses and other competing commitments, and the lack of information on what CPD activities are available.

In South Africa, the Health Professions Council of South Africa (HPCSA) through the HPCSA Medical and Dental Board, the South African Nursing Council (SANC), and the National DOH are the regulating bodies that ensure that CPD happens. In this regard, CPD guidelines exist for nurses, midwives, doctors, and various other health professionals including pharmacists, therapists, and so forth. CPD is mandatory for license renewal for doctors, nurses, and midwives. To ensure that healthcare professionals (HCPs) undergo regular CPD, the health professional bodies have created an Audit system in which a certain percentage of HCPs in the registry are sampled and audited at regular intervals. While SANC is in the process of developing formal guidelines for the accreditation of nurses in this regard, the HPCSA has delegated the accreditation of CPD activities to providers to the professional councils (Feldacker et al. 2017:3). In South Africa and among social workers, finances and costs, workload, time, availability, accessibility, and the affordability of CPD activities were found to be serious barriers and challenges in the successful implementation of CPD (Lombard,

2010:139). Naidoo and Naidoo (2018:213) found that among radiographers in KwaZulu-Natal province, South Africa, the two main barriers to CPD participation were a lack of time and shift work. Lack of support from employers in terms of funding and their failure to provide funding, time, and motivation were added limiting factors to CPD participation by radiographers. Regarding CPD participation by nurses and midwives in South Africa, Mnguni (2019:103-106) found that staff shortage, time constraints, and lack of internet connection were major challenges. This confirmed earlier findings by Mosol et al (2017:) that staff shortages, lack of time due to heavy workload, lack of finances, night shift, and lack of information on the availability of CPD were barriers to CPD participation by nurses in Western Kenya.

No formal study has yet been conducted in Mpumalanga province, South Africa to explore barriers and challenges of CPD participation among medical doctors. By interviewing the three DCSTs and selected clinical managers of hospitals in the province, the researcher hoped to establish what barriers and challenges were encountered by medical practitioners in CPD participation.

3.3.7 Information Management

As part of CG and healthcare quality improvement, health organizations are expected to develop and implement health information systems (HIS) that seek to improve data management inclusive of data collection, data analysis, data storage, and transfer of information to networks utilized to produce timely and high-quality data for decision making (Afrizal et al. 2019:1). This ability to capture, exchange and use accurate information about patients and services is vital for building strong health systems, provision of comprehensive and integrated health care, management of public health risks, and informing policies for public health and health financing (Akhlaq, Sheikh and Pagliari, 2015:284). Information management in health includes user records that contain demographic, socio-economic, and clinical

information about the user, proper collection, management, and use of the information within health systems. These elements of information management determine the system's effectiveness in detecting health problems, defining priorities, identifying innovative solutions, and allocating resources to improve health outcomes.

Afrizal et al (2019:5) aver that people play important roles in healthcare information management as driving forces in the development of a health organization. The continuity in the daily use of health information systems in health establishments depends on the availability of appropriate technology infrastructure and the existence of a dedicated IT unit that has responsibility for all health data in the health organization. For health information to be managed properly, Afrizal et. al. believe that there is a need for a specific policy that regulates health information management, ensuring coverage of the healthcare service from the health establishment level, through the provincial, to national level. Both public and private sectors should be covered in health information management policies.

The researcher concurs with Keshvari et al (2018:1) regarding the identification of barriers in the use of health information systems as an important first step in improving information management and better implementation of quality improvement and CG plans. Keshvari et al (2018:4) consider knowledge, hardware, and organizational factors as critical areas to be investigated when barriers and challenges to implementing health information systems.

In a study conducted in Indonesia, Banten Province, to establish barriers and challenges to the Primary Health Care Information System (PHCIS) adoption from a health management perspective, Afrizal et al (2019) conclude that the four major problems encountered in the implementation of health information system were: human resource, infrastructure, organizational support, and health information process barriers. According to Akhlaq et al (2016:1310), the lack of importance given to data in decision making, corruption and insecurity,

lack of training and poor IT infrastructure were major challenges to the implementation of health information systems in low- and middle-income countries. Eygelaar and Stellenberg (2012:6), after exploring factors conducive to quality patient care in selected hospitals in the Western Cape, South Africa, found that inadequacies relating to human resources, professional development, consumables, and equipment influence information management relating to patient care. No study was found that investigates barriers and challenges to health information management in Mpumalanga.

3.4 Chapter Summary

This chapter presented a review of the literature regarding the barriers and challenges in the implementation of CG by several researchers in various countries. The review focused on the seven pillars of CG, namely clinical audits, clinical performance and effectiveness, patient and public involvement, information management, clinical risk management, training and education, and EBP and research. The researcher found different country experiences about each CG pillar. No study of the barriers and challenges in the implementation of CG was found in the literature for Mpumalanga Province. This highlighted an important knowledge gap that requires this inquiry.

Chapter 4 Research Methodology

4.1 Introduction

This study aimed to explore barriers and challenges in the implementation of CG, with a view toward the development of a framework for good governance in Mpumalanga, South Africa. The researcher uses the exploration of barriers and challenges in respect of each CG pillar (clinical audit, clinical performance and effectiveness, clinical risk management, staff training and development, EBP and research, patient and public involvement, and information management) as the study objectives.

This chapter presents the research methodology followed in establishing the views of senior health programme managers, clinical managers, and clinical specialists about the barriers and challenges in the implementation of CG. This chapter covers the research approach, research design, study site, sampling, data collection, data analysis, trustworthiness, credibility, ethical considerations, and delimitation and scope of the study. A chapter summary concludes the chapter.

4.2 Research Approach

A research approach is a plan and a procedure for research that stretches from broad assumptions that a researcher makes to data collection, analysis, and interpretation (Creswell and Creswell, 2017:34). The approach is used to explore and understand the meaning that individuals or groups ascribe to a given situation (Creswell and Creswell, 2017:34) and is considered a method that assists researchers in their understanding of context, exploration of new phenomena, identification of new research questions, and for uncovering new models of change (Kegler et al., 2019:1). Furthermore, a qualitative research approach is an essential data evaluation process for identifying facilitators and barriers to policy implementation (Kegler

et al., 2019:1). Quality research methods elucidate models of change through logic model pathways, thus providing evidence of policy and program impact through case studies and causal qualitative analysis (Kegler et al. 2019:1). To achieve the aim and objectives of this study and based on the relevance of the qualitative approach to this study, the researcher chose a qualitative research approach as the most appropriate one for the study.

4.3 Research Paradigm

Creswell and Creswell (2017:36) highlight four philosophical worldviews or paradigms that the researcher may choose from to guide research methodology: constructivism, postpositivism, transformative, and pragmatism as it relates to the preferred research approach. Of these, the researcher chose constructivism. This was because constructivism as explained by Creswell and Creswell (2017:39-41), entails an understanding, meaning, socialization and experiences of participants' views of the situation being studied, using semi-structured questions. This allows the participants to assign meanings to the situations being investigated and typically takes the format of discussions or interactions with other persons (Creswell and Creswell, 2017:39-41). In this regard, Vasilachis (2009:20) had already proposed that epistemology of the known subject, be used as the most appropriate ontological and epistemological foundation for qualitative studies. For the above reasons and the researcher's belief that the goal of this study could best be achieved if the constructivist qualitative research worldview were applied, the researcher chose constructivism as the philosophical paradigm that best suited this study. While there were no clear and specific ethnographic procedures or approaches in place for qualitative research inquiries before the 20th century, a few have since been identified over the past few years and are now available. These include narrative, phenomenological, grounded theory, and case study (Creswell and Creswell, 2017:45). Of these, the researcher chose a case study design. Case study designs are mostly used in policy or programme evaluation, where the researcher seeks to undertake an in-depth analysis of the policy or programme

implementation, and the impact it has had on the target population or group (Creswell and Creswell, 2017:47). Cases are bounded by time and activity. Baxter and Jack (2008:544) consider case study research as valuable for health science research in that it helps in developing theory, evaluating policies and programmes, and crafting relevant interventions. Through a qualitative case study, therefore, the researcher can explore a variety of phenomena using different data sources. In this study, participants who had been part of the CG policy implementation in Mpumalanga province were interviewed to establish their experiences, individually and collectively, regarding barriers and challenges. The interviews focussed on the pillars of CG to ensure that an in-depth exploration of the barriers and challenges is established.

4.4 Qualitative Research Methods

4.4.1 Study Setting

The study was undertaken in the Mpumalanga province of South Africa. Mpumalanga province is situated in the north-eastern part of South Africa, bordered by Mozambique in the east and eSwatini in the southeast. The province has common boundaries with Limpopo province in the north, Gauteng province in the west, Free State province in the south-west, and KwaZulu-Natal province in the south-east. Mpumalanga makes up 6.5% of South Africa's land area and is home to a population of 4 523 900 (Mpumalanga Department of Cooperative Governance and Traditional Affairs, 2018:11). There is a high in-migration of people from the neighbouring countries (Swaziland, Mozambique and Zimbabwe) to Mpumalanga. This poses a challenge in the rendering of healthcare services resulting in healthcare demands that cannot be projected accurately in terms of planning and resource allocation. According to StatsSA (2018:18), the Mpumalanga DOH provides health services to a total population of 4 523 874 citizens of the Mpumalanga province and surrounding countries and provinces of which 88% (3,9 million) are

uninsured. These healthcare services range from district health services; to regional, specialized, and tertiary hospital services; as well as healthcare support services (Mpumalanga Department of Health, 2017). Mpumalanga province was chosen for this study because it is one of the nine provinces that are policy implementation arms of the National DOH in South Africa. The introduction of CG through District Clinical Specialist Teams in 2011, was done in each of these provinces.

4.4.2 Study Sample

Major researchers on social research methods have defined sampling in diverse ways. Adwok (2015:95) defines sampling as “the process of selecting a smaller group of participants to tell us essentially what a larger population might tell us if we asked every member of the larger population the same questions”. A more direct definition by Mertens (2014:4) is that sampling is the method used for selecting a given number of people (or things) from a population. Robinson (2014) on the other hand, describes a sample as a small group of individuals, items, or things that are taken from a larger population such, as from whom a set of observations are drawn. The sample should ideally be representative of the larger population to ensure that findings from the sample can be generalized to the entire population. Inferential statistics are used to conclude about populations from samples, thus enabling investigators to determine that population’s characteristics. Adwok (2015:95) argues that the desire to draw inferences about a large population from a subset of that population is the main concern for an investigator. He concurs with Leedy and Ormrod (2005) that the researcher must ensure that the selected sample truly represents the population, using strategies that ensure the selection of an appropriate sample that minimizes bias and distortion of data.

Because of the risk of inappropriate procedures seriously affecting the findings and outcomes of a study, an effective sample selection process is considered very crucial in qualitative

research (Lopez and Whitehead, 2013:124). Several types of sampling procedures have been adopted for qualitative research guided by the chosen qualitative research design. Unlike in quantitative research where *probability* sampling is used by recruiting the population with characteristics that represent a wider community, *non-probability* sampling is used in qualitative research where the researchers recruit only specific populations to investigate a specific topic or when the total population is unknown or unavailable (Lopez and Whitehead, 2013:124). Lopez and Whitehead (2013:124) describe four main types of non-probability sampling for qualitative research: 1) snowball sampling, 2) theoretical sampling, 3) convenience sampling and 4) purposive sampling. Purposeful sampling was chosen for this study. Purposeful sampling is also known as purposive and selective sampling. Palinkas et al (2015) described purposeful sampling as a technique whereby the researcher identifies and selects individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest. This commonly used sampling strategy entails the recruitment of research participants according to pre-selected criteria relevant to the research phenomenon under investigation. It is for this reason that some researchers refer to it as 'judgment sampling' in that it provides information-rich cases for the in-depth study where the participants have the required status or experience or are known to possess special knowledge to provide the information the researchers seek (Lopez and Whitehead, 2013:124). As already stated by Lopez and Whitehead (2013:124), selection criteria include (i) current active participation in the phenomenon (programme) under consideration and (ii) current employment at the study site, and (iii) experience (number of years) in the programme or post-basic qualifications in the profession. This is to ensure that participants have a similar foundation and background.

Lopez and Whitehead (2013:125) aver that quota sampling and maximum variation sampling are two other types of sampling that come under the umbrella of purposive sampling. (i) In

quota sampling, the investigator decides the number of participants and which characteristics they need to possess, with consideration of the selection criteria including age, gender, profession, diagnosis, ethnicity, and so forth. In this regard, purposive sampling differs from quota sampling in that the latter is more specific to the sizes and proportions of the sub-samples for each prescribed quota. (ii) Maximum phenomena variation sampling, on the other hand, is sometimes used to ensure that the full range and extent of the phenomena are represented. In this sampling technique, the focus could be either on people, periods, or context.

The non-probability (purposive) sampling technique helped the researcher in selecting the most appropriate participants which made the researcher better understand the barriers and challenges in the implementation of CG in Mpumalanga (Creswell and Creswell, 2017:239; Dehnavieh et al. 2013:2). Four chief directors (hospital services, primary care, human resources management, and HAST) at the provincial level, three district managers, clinical managers of regional and tertiary hospitals, three DCSTs, and CEOs of five selected hospitals were invited to take part in the study. Each invited person was provided with a participant information sheet and a consent form. Two chief directors, three district managers and four clinical managers participated in the study. All nine participants were interviewed individually using semi-structured questions. The interviews took the form of virtual zoom meetings that still provided confidentiality, quietness, and privacy and lasted for about sixty minutes each.

The implementation of the DCST programme was very poor in Mpumalanga. This resulted in only one DCST in Ehlanzeni district being available as a focus group for interview. To make up for the other focus groups, the researcher grouped CEOs of five selected hospitals to form a focus group. The one DCST for Ehlanzeni district and the group of CEOs participated as focus groups in the study and were interviewed through a virtual zoom meeting using a semi-structured questionnaire. Once again confidentiality, quietness, and privacy were ensured

during the interviews. All interviews were conducted after-hours ensuring that service delivery was not interrupted. Each group interview lasted sixty minutes.

4.4.3 Inclusion and Exclusion Criteria

In research, specific individuals or groups with homogeneous characteristics are selected using inclusion and exclusion criteria to decide who can be included or excluded from the study sample (Garg, 2016:8). The inclusion criteria are used to identify the study population in a consistent, reliable, uniform, and objective manner. The exclusion criteria, on the other hand, include factors or characteristics that make the recruited population ineligible for the study. It is especially important to establish specific inclusion criteria in qualitative research because it helps the researcher in ensuring that the individuals who participate can provide the information necessary to address the research questions. Lopez and Whitehead (2013:126) state that for a participant to take part in a study, there are specific characteristics called inclusion criteria that he/she must possess. The qualitative methodology that the investigator chooses automatically determines these inclusion criteria.

In this study, five provincial programme managers, three district managers, seven hospital clinical managers, and five CEOs of selected hospitals, were recruited for this study, resulting in a sample size of twelve individuals. Healthcare professionals who do not deal with day-to-day clinical management were not considered for participation in the study and were, as a result, excluded.

4.4.4 Data Collection

The most common methods of data collection used in qualitative healthcare research are interviews, focus groups, and observation (Gill et al. 2008:291). Interviews are used to explore the views, experiences, beliefs, and motivations of individual study participants, while focus

groups are used to generate qualitative data from a group of participants (Gill et al. 2008:291). Dilshad and Latif (2013:191) describe qualitative research interviews as a way of appreciating the world from the participant's perspective and exploring the significance of people's experiences. In this study, the researcher used interviews, focus groups and document reviews to collect data. These are described below.

4.4.4.1 Individual interviews

Gill et al (2008:291) describe three types of qualitative research interviews: structured, semi-structured, and unstructured [also referred to by Stuckey (2013:56) as narrative]. According to Stuckey (2013:56), the primary difference between these interview types is the extent of control that the interviewer has over the encounter and the aim of the interview. Structured interviews are verbally administered questionnaires, in which predetermined questions are asked, with little or no variation and with no scope for follow-up questions to responses that warrant further elaboration (Gill et al. 2008:291). For this reason, structured interviews do not allow for in-depth participant responses.

In an unstructured interview, there is little or no prior preparation, and the interview takes the form of a regular conversation between two people beginning with an opening question and then asking further questions based on the initial response. According to Stuckey (2013:58), unstructured interviews (narratives) are stories that are based on the unfolding of events or actions from the perspective of a participant's life experience.

Semi-structured interviews, on the other hand, combine both structured and unstructured interviews. In semi-structured interviews the researcher prepares a list of questions to be asked in the interview and asks follow-up questions, where necessary, to get depth from the respondent's response. In this way, the researcher sets the outline for the topics covered, but

the interviewee's responses determine the way, in which the interview is directed (Stuckey, 2013:57).

For this study, the researcher chose to use semi-structured interviews to obtain detailed responses from the selected programme managers, senior clinicians, and clinical managers who were involved in the implementation of CG in Mpumalanga, using an interview protocol. This enabled the researcher to interrogate participant responses further by asking follow-up questions, where necessary, to get depth from the respondent's response (Table 4.1).

At the start of each interview, the researcher introduced himself and gave the reasons for the interview. As part of the informed consent process, he took the participant through the participants' information sheet allowing him/her enough time to read the document and ask any questions that the participant might have. While collecting the signed consent forms the researcher reminded the participant of his/her right to withdraw from the interview at any stage, should he/she choose to do so, and that there would be no negative consequence because of such a decision. He further explained that the names of individual participants would not be divulged to anyone to ensure confidentiality. The individual interviews were conducted using semi-structured questions as shown in the protocol and probing where necessary. An audio recording was done during each interview. This ensured that the researcher did not lose any information provided by participants and that the record of responses be reliable (Creswell & Creswell, 2017:245-246). Each interview was concluded with closing remarks and acknowledgment of the interviewee.

Table 4.1: Interview Protocol

No	Question	Response	Comment
1	What is your understanding of Clinical Governance and what are its pillars?		
2	What are the barriers and challenges in conducting clinical audits in the department?		
3	What are the barriers and challenges in clinical performance and effectiveness in the clinical governance?		
4	What are the barriers and challenges in clinical risk management in the department?		
5	What are the barriers and challenges in evidence-based practice and research within the Department?		
6	What are the barriers and challenges in patient and public involvement in clinical governance?		
7	What are the barriers and challenges in the training and development of healthcare workers on clinical governance?		
8	What are the barriers and challenges in information management in the Department?		
9	What are your views and suggestions that might help improve clinical governance in Mpumalanga?		

4.4.4.2 Focus Groups

Citing Cornwall and Jewkes, Nyumba et al (2018:21) describe focus group discussion as a qualitative research information gathering technique where a researcher assembles a group of individuals to discuss a specific topic, to draw from the complex individual experiences, beliefs, perceptions, and attitudes of the participants, through a facilitated interaction. Focus groups are regarded as the best way for participants to exchange viewpoints and discuss disagreements between among them – dynamics that are not captured in individual interviews. Focus Group discussion is a data collection technique consisting of three steps: pre-session preparation, discussion, and closure. The first step requires the facilitator to familiarise the

group with the script, understand group dynamics, allow for the seating preferences of group members, have the right equipment to record the discussion, and record the duration of the discussion. This is then followed by self-introduction, obtaining consent, ensuring confidentiality and privacy, and observing non-verbal cues. Each posed question needs to be followed up with probes where necessary. The discussion should be ended with concluding remarks and acknowledgment of the participants.

The researcher interviewed each focus group using the three steps: pre-session preparation, discussion, and closure. In this regard, the facilitator prepared a participant information sheet that he would use to familiarise the group with the study. According to Toseland, Jones and Gellis (2004:21), two group dynamics may be observed in focus groups: the here-and-now interactions of individual group members and what each member brings to the group from their respective clinical disciplines. As Gençer (2019:223) says, groups reflect both individual perspectives and those of the whole society. Another group dynamic that needs to be observed and allowed for is the seating preferences of individual group members.

For this study and at the start of the group meeting, the researcher introduced himself and gave the reasons for the meeting. As part of the informed consent process, he took the participant through the participant's information sheet and gave the group members time to read the consent section of the document and ask any questions they might have. He collected the signed consent forms and reminded the participants of their right to withdraw from the meeting at any stage they choose to. He further explained that the names of individual participants would not be divulged to anyone to ensure confidentiality.

The researcher facilitated the discussion by using open-ended semi-structured questions that had been prepared before the group meeting and probed where necessary. Body language,

non-verbal cues, and other group dynamics were observed and noted. The discussion was concluded with closing remarks and acknowledgment of the participants.

4.4.4.3 Document Analysis

Document analysis was used as part of data collection in this study. This analysis method contributed to the trustworthiness of the findings. Reviewed documents in this regard included the National Health Act 61 of 2003, the Ministerial Team report on the appointment of DCSTs in South Africa, the handbook for DCSTs in South Africa, Mpumalanga DOH staff structure, and the Mpumalanga DOH Annual Performance Reports. In this regard, the Ministerial Task Team Report, presented to the then Minister of Health, made specific recommendations to help guide the National and Provincial Departments of Health in their implementation of the Primary Health Care Re-engineering process and the DCSTs in South Africa (Ministerial Task Team, 2012). The recommendations included, inter alia the composition, roles, reporting lines, and location of DCSTs in each province. Regarding the role of DCSTs, a handbook was written to guide them. In the handbook, CG is defined as the clinical leadership and accountability, as well as the organization's culture, systems, and working practices, which ensure that quality assurance, quality improvement, and patient safety are central components of all activities of the healthcare organization (National Department of Health, 2014:11). DCSTs were assigned the task of coordinating CG in districts and health establishments. It is for this reason that DCSTs were interviewed as a focus group.

4.4.5 Data Analysis and Interpretation

Vosloo (2014:355) describes data analysis as the process of bringing order, structure, and meaning to the collected data. It requires the application of deductive and inductive logic to analyze and interpret research data. As stated by Schurink *et al* (2011:397); Sesay (2012:95); Atkins and Wallace (2012:245) and Tuckman and Harper (2012:387), in qualitative research

there is an inseparable relationship between data collection and data analysis resulting in a coherent interpretation of the data. Vosloo (2014:356) goes on to posit that data analysis involves four aspects: (i) Inference which uses reasoning to reach a conclusion based on evidence; (ii) Public method or process which reveals the study design in some way; (iii) Comparison as a central process that identifies patterns or aspects that are similar or different; and (iv) Striving to avoid errors, false conclusions, and misleading inferences.

Kreuger and Neuman (2006:434-435) assert that qualitative data analysis: (i) is less standardized with the wide variety of approaches in qualitative research, (ii) its results guide subsequent data collection, resulting in a less-distinct final stage of the research process, (iii) by using qualitative data analysis qualitative researchers can create new concepts and theory by blending empirical and abstract concepts; and (iv) it is in the form of words, which are relatively imprecise, diffuse and context-based. In analyzing the data, the researcher adopted a case study approach to understanding the knowledge, experiences, and practice of the participants in respect of CG over a period of two years. In keeping with qualitative research methods, data analysis of earlier interviews was done simultaneously with new data collection and the write-up of findings (Creswell & Creswell, 2017:246). Each audio-recorded interview was transcribed verbatim by the researcher, numbering each line of text and ensuring anonymity in the transcript so that the participants would not be identifiable from anything they had shared with the researcher (Creswell & Creswell, 2017:249-450). The content analysis technique (Elo et al. 2014) was used to analyze the transcripts to get underneath what each participant had said, which enabled the researcher to understand the CG from the participants' perspective. In this regard, manual coding was used for identifying topics, issues, similarities, and differences that were revealed through the participants' views. These were then interpreted by the researcher (Creswell & Creswell, 2017:249-250). The information from the transcripts was grouped into seven predetermined themes or codes comprised of the seven CG pillars

and sub-themes (Table 4.2) which guided the writing of this study report (Creswell & Creswell, 2017:251).

Table 4.2: Analysis Protocol for interviews

CG Pillar	Barriers	Challenges	Proposed Intervention
Clinical Audit			
Clinical Performance and Effectiveness			
Clinical Risk Management			
Patient & Public Involvement			
Evidence-Based Practice & Research			
Training & Development			
Information Management			

For the analysis of document reviews that were conducted on selected policy documents, performance plans, and legislation, a protocol was used that highlighted implementation barriers and challenges (Table 4.3).

Table 4.3: Analysis protocol for document review

CG Pillar	Barriers	Challenges	Proposed Intervention
Clinical Audit			
Clinical Performance and Effectiveness			
Clinical Risk Management			
Patient & Public Involvement			
Evidence-Based Practice & Research			
Training & Development			
Information Management			

4.4.6 Trustworthiness

Elo et al (2014:1) posit that qualitative researchers must show the trustworthiness of their findings using four aspects: credibility, dependability, transferability, and confirmability. Gunawan (2015:4) concurs with these researchers and stresses that a study can only be trustworthy if and only if the reader of the research report judges it to be so. Gunawan (2015:11) concludes by emphasizing that to ensure rigor and trustworthiness, the qualitative researchers must consider doing member checking, triangulation, detailed transcription, systematic plan, and coding.

Credibility is considered the most important aspect in the establishment of trustworthiness, as it requires the researcher to show the linkage between the study's findings with reality on the ground to demonstrate the truth of his/her findings. Credibility is, therefore, concerned with the right correspondence between the participant's view and the researcher's interpretation of those views. Triangulation and member checking are commonly used in qualitative research (Elo et al. 2014:1). In triangulation, multiple methods including data sources, observers, and theories are used to gain a more comprehensive understanding of the phenomenon being studied (in this case CG). There are four types of triangulations: methods, sources, analysts and theoretical (Abdalla et al., 2018: 66-98). In member checking, also referred to as informant feedback or respondent validation, a technique used by researchers to help improve the accuracy, credibility, validity, and transferability. These techniques include narrative accuracy checks, interpretive validity, descriptive validity, theoretical validity and evaluative validity. When conducting member checks, the researcher gives the interpretation and report to the participants to check the authenticity of the data. The participant comments serve as a check on the viability of the interpretation (Yanow & Schwartz-Shea, 2015).

In this study, the researcher used interviews, focus groups, and document analysis as methods of triangulation to ensure that the study findings were robust, rich, comprehensive, and well-developed. Member checking was not used. The researcher ensured credibility through prolonged engagement with each participant during interviews and focus group discussions and sources triangulation inclusive of individual interviews, focus group discussions, and document analysis to obtain information (Creswell and Creswell, 2017:234).

4.4.7 Ethical Considerations

Arifin (2018:30) states that the protection of research participants through the application of appropriate ethical principles is important in any research study and that in qualitative research ethical considerations are particularly important due to the in-depth nature of the study process. In this regard, Sanjari et al (2014:6) suggest that anonymity, confidentiality, and informed consent be considered important ethical considerations in qualitative research. Roth and von Unger (2018) reflected on informed consent, analytic opportunities, privacy, transparency, and minimizing harm to participants. In compliance with these ethical issues, the researcher undertook the following:

4.4.7.1 Ethical Clearance

Permission was obtained from the UFH Research Ethics Committee for ethical clearance of the study (Annexure 8.2).

4.4.7.2 Authorisation by DOH

Permission was obtained from the Mpumalanga DOH to conduct the study in the province (Annexure 8.3).

4.4.7.3 Coding

Code names for participants were used to ensure confidentiality, anonymity, respect, and privacy.

4.4.7.4 Informed Consent

Denzin and Lincoln (2011) posit that the cornerstone of ethical research is informed consent – a term that consists of two essential elements: informed and consent, each one requiring careful consideration. Informed consent requires that study participants be fully informed of what will be asked of them, how the data will be used, and what (if any) consequences there could be if they either refuse to participate or withdraw from participation. In line with informed consent, the study participants must provide explicit, active, signed consent to express their willingness to take part in the research, including understanding their rights to access their information and the right to withdraw at any point. The informed consent process may therefore be regarded as the contract between the researcher and the participants.

The information aspect of giving consent is often undertaken using a short, carefully worded information sheet that states who the researcher(s) are, what the intent of the research is, what data will be collected from participants, how the data will be collected from participants, the level of commitment that is required from participants, how this data will be used and reported, and what the potential risks of taking part in the research are (Denzin and Lincoln, 2011)

The consent process offers the participant information on the right to withdraw at any time without reason, including withdrawing data already provided), assurances that participant identity will be kept confidential, clarity of ownership of the data (participants own their raw data, researchers own the analysis data), their right to access to their data, the right to ask for more information as well as information of the complaint process (contact details of the

researcher along with a line manager, or the chair of the ethics committee) (Denzin and Lincoln, 2011)

Miles and Huberman (1994) stressed the fundamental importance of the information sheet and consent form being robust, clear, and professionally written. If the information sheet and consent form are unclear, it will result in a weak consent agreement, which may compromise the quality of data collected due to mistrust and not provide good protection for the participant or the researcher.

In this study, the researcher developed a patient information sheet about participation in the research and attached a consent form which the participant had to sign. The document was sent to each participant for perusal and a decision to take part. Each participant was requested to sign the consent form before the virtual interview. All interviews were recorded and saved electronically by the researcher. To ensure confidentiality and data security, the researcher did not share the audio-recordings of interviews with anybody and kept the recorded data in a secure folder in his computer. Additionally, the names of the participants were coded in the transcripts.

4.5 Chapter Summary

This chapter focused on research methodology, covering research approaches, philosophical research paradigms, qualitative research styles, research methods, and study delimitation and scope. The qualitative research approach was chosen for the study. The constructivist philosophical worldview was selected, using a case study qualitative inquiry. The research methods included choosing Mpumalanga province as the study site, purposively selecting senior managers and clinicians at provincial, district, and facility levels, and using interviews, focus groups, observation and document review for data collection.

Chapter 5 Study Findings

5.1 Introduction

This chapter focuses on data presentation, data analysis and discussion. The data was obtained from the study titled clinical governance implementation challenges in the Department of Health, Mpumalanga, South Africa and were based on the seven specific objectives which were (i) to check if clinical audits are conducted in the health establishments, (ii) to find out about clinical performance and effectiveness, (iii) to establish how clinical risks are managed by the health teams, (iv) to ascertain the extent of the patient and public involvement in patient care, (v) to find out about evidence-based practice and research, (vi) to check if training and development of healthcare workers is done, and (vii) to establish how health information is managed in the department. In this chapter, the transcripts of the interviews conducted (Annexure 8.1) are presented. All the transcripts are presented verbatim. A brief explanation of each table is presented in this chapter with participant responses summarised in tables 5.1 and 5.2. The findings of document reviews concerning the CG pillars are briefly discussed and summarised in tables 5.3 to 5.8. The documents include relevant legislative, policy, planning, and performance documents that guided CG implementation between 2015 and 2019 in Mpumalanga province.

5.2 Individual interview responses

Two provincial programme managers, three district managers, four hospital clinical managers totalling nine individuals, were interviewed for this study. Healthcare professionals who do not deal with day-to-day clinical management were not considered for participation in the study and were, as a result, excluded. Each individual interview was recorded and transcribed verbatim by the researcher. Participant responses were themed or grouped according to the study objectives as presented below.

5.2.1 Clinical audit

Reluctance to conducting clinical audits and poor clinical leadership were said to be the strongest barriers to the clinical audits in health establishments. A lack of health background, a highly unionised health environment and inadequate protocols for common conditions in health establishments were rated as added barriers as well. Poor communication among key health service stakeholders was presented as a significant challenge within the Mpumalanga DOH. To help resolve this problem and prioritise clinical audits, participants felt that the staff structure of the department should be revised to support CG at the provincial level, and it should be located within the office of the HOD (Table 5.1).

5.2.2 Clinical risk management

Poor staff and patient security within health establishments, lack of prioritisation of risk management in the department's APP, the appointment of non-health risk managers, and inactive risk committees in health establishments were mentioned as barriers to effective and efficient clinical risk management in the department. These barriers resulted in clinical errors that were committed by clinical personnel, poor risk management, non-functional PSI committees, a high litigation rate against the department and negative staff attitudes. To overcome these challenges participants suggested that regular clinical risk management meetings be held in health establishments, CEOs be trained on risk management and that CEO qualification, experience and knowledge be taken into consideration when they are appointed. Additionally, dispensing practices should be improved to reduce the high number of dispensing errors (Table 5.1).

5.2.3 Clinical performance and effectiveness

As may be seen in Figure 5.1, poor accountability by heads of clinical units, inadequate training of health care workers (HCW) and non-availability of resources at the health establishment level were mentioned as the most significant barriers to clinical performance and effectiveness. Non-availability of strategies to mitigate against inferior performance and staff attitude towards performance and effectiveness were also regarded as barriers. The result of these barriers were poor clinical performance and effectiveness in the department, poor supervision and high litigation rates. Staff exhaustion, a low skills base and medical negligence are rife in the department. To address these barriers and challenges, participants suggest that the department's recruitment strategy be improved to ensure that personnel with right qualifications, skills and experience are appointed. It is also suggested that out-reach specialist services and telemedicine, and the training of clinicians on CG be improved to improve clinical performance and effectiveness.

5.2.4 Evidence based practice and research

Staff shortages and conducting research that is not related to the advancement of health service delivery were mentioned as the biggest barriers to evidence-based practice and research development (Table 5.1). A lack of a departmental research policy and inadequate sharing of research findings by researchers with the department were also mentioned as barriers. The challenges that confront the department because of these barriers include a poor research output by the department, poor leadership for research in the department and poor motivation to undertake studies for various aspects of health service delivery. The participants suggest that tertiary hospitals play a leading role in research development and that qualified managers be appointed to the departmental research unit.

5.2.5 Patient and public involvement

The biggest barriers to patient public involvement (PPI) include failure by health establishment governing bodies to report back to the communities they are representing and the non-availability of clinic services in certain areas (Table 5.1). Of significance also is the lack of awareness by patients of services that are available closest to where they live, staff attitudes in health establishments, and failure by HCWs to explain clinical procedures that are performed on patients. The effect of these barriers includes inefficient governing bodies, violation of patient rights and bypass of local health establishments by patients. Participants suggest that workshops on proper patient interviews be conducted for HCWs and community members who have relevant knowledge of their areas to be appointed to governing bodies (clinic committees and hospital boards).

5.2.6 Education and Training

The lack of a departmental skills development and management strategy was presented as a major barrier to CG (Table 5.1). Managers who fear their subordinates, negative attitudes of staff towards training and development, a PMDS system that is non-functional and staff ignorance about PMDS are also presented as barriers to the implementation of CG. Haphazard departmental attempts at staff induction and a poor skills base among staff members were presented as serious challenges in the delivery of health services. Poor patient records management was added as another challenge confronting the department. Participants suggested that (i) management teams be informed and trained on CG, (ii) staff be motivated about self-development, (iii) supervision of junior staff by their seniors be improved, (iv) education and training be done in partnership with academic institutions, and (v) that seminars and workshops on CG be conducted regularly.

5.2.7 Information management

The main barrier that was mentioned was an inadequate information management system in the department (Table 5.1). Poor documentation of patient files, non-availability of IT equipment such as computers, ipads and cell phones, inadequate archiving of patient records as well as poor communication among key information management stakeholders were reported as serious challenges for the department. Improvement of the information management system by introducing electronic information management, online application, encouraging managers to use electronic information for decision making and appointing data capturers in health establishments, were suggested as required interventions to improve information management in the department.

Table 5.1: Individual barriers, challenges and interventions by CG pillar

CG Pillar	Barriers	Challenges	Proposed Intervention
Clinical Audit	1. Clinicians' attitude towards clinical audits 2. Clinical leadership at the operational level is not standard practice 3. There are hospital CEOs who are administrators who do not necessarily have a clinical background. 4. Mpumalanga is highly unionized with no distinction between clinical governance and corporate governance 5. There are no protocols for common conditions in health establishments	1. Lack of proper communication among key stakeholders 2. The attitude of the CEO together with the clinical manager 3. Clinical managers' lack of experience in clinical management 4. Clinical audits in our health establishments are not being done correctly 5. Missing patient records	1. At the provincial level, CG should be provided for in the HOD's office and should be provided for in the departmental staff establishment 2. Newly appointed clinical managers should be brought on board in terms of CG 3. Revive those clinical meetings, the morbidity, and mortality meetings at the facility level and keeping of good clinical records 4. Develop a proper clinical audit policy 5. Develop treatment protocols for common conditions
Clinical Risk Management	1. Poor staff and patient security service provision within facilities 2. Departmental risk management plan not linked to APP 3. The department has underestimated risk management by appointing a junior official to head the unit 4. Being a manager who is a non-healthcare professional is a limiting factor 5. No risk management committees in hospitals	1. Numerous clinical errors by clinicians 2. Poor risk management 3. PSI Committees are not functional 4. High litigation rate 5. Staff attitudes	1. The virtual meetings are necessary for clinical managers 2. Hospital CEOs must be trained in risk management 3. Appointment of CEOs must be based on qualification, experience and knowledge Conduct regular clinical to correct medical errors 4. Improve dispensing checks and balances to reduce dispensing errors 5. Instil a sense of responsibility to manage risk in the managers
Clinical Performance & Effectiveness	1. Poor accountability by the heads of units/supervisors 2. Inadequate training of health care workers 3. non-availability of resources at the facility level	1. Poor clinical performance 2. Supervision has deteriorated at all levels 3. High litigation rate 4. Medical negligence 5. Inadequate skills for the job	1. The recruitment strategy to be worked out 2. Ensure outreach specialist services to district hospitals including telemedicine 3. Training of clinicians on CG needs to improve

	4. No strategies to mitigate against these challenges 5. The attitude of some health professionals	6. Staff are exhausted	4. We need to have oversight meetings, perinatal meetings, and M&M meetings 5. A clinician, preferably a doctor, should be appointed to be DDG: Clinical Health Services
Evidence-Based Practice & Research	1. Staff shortages 2. Undertaking research that is not related to service needs 3. Little research is being undertaken in the department 4. There is no research policy in the department 5. There is no sharing of research outcomes with Department	1. Low research output 2. Research is being done by private individuals for their academic degrees 3. Poor leadership for research 4. Inadequate job skills 5. Inferior quality of service	1. The tertiary hospitals should take a lead in getting research started and improving EBP. 2. Appointment of a properly qualified lead for the research unit
Patient & Public Involvement	1. Governing bodies do not report back to the communities they represent 2. Non-availability of clinic services in some areas 3. Lack of awareness by patients of services that are provided in the nearest health facility 4. Staff attitudes 5. Procedures are not explained to the patient	1. Governing bodies' inefficiencies 2. Community members by-pass lower levels of care 3. Patient Rights are violated	1. Provide workshops on the importance of proper patient interviews. 2. Appoint to hospital boards those community representatives who know health issues
Education & Training	1. There is no skills management and development strategy or plan 2. Managers fear their subordinates 3. Management attitude towards Training and Development of staff is negative 4. The PMDS system is not functional 5. Managers themselves have no clue about PMDS	1. The induction programme is done haphazardly and is not programmatic 2. Poor job skills among staff members 3. The patients' records get lost 4. Patient information in files is not complete 5. The consent form is not completed fully	1. Hospital management teams need to be fully trained and made to understand what clinical governance is. 2. Staff motivation and sensitizing the about the importance of self-development. 3. Ensure that junior staff members are properly supervised. 4. Organize training seminars and workshops. 5. Work closely with tertiary academic institutions

Information Management	1. Inadequate information management system 2. Poor documentation of clinical information in patient files 3. Non-availability of IT equipment: laptops, desktops, ipads, and mobile phones 4. Inadequate archiving of patient records 5. Poor communication among key information management stakeholders	1. Poor patient information management 2. High litigation rate against the department 3. Inadequate HR recruitment and retention systems 4. Long waiting times for patients 5. Persistent negative findings by the Auditor General	1. Improve management of available information systems 2. Introduce electronic information management systems 3. Introduce an online application system 4. There is a need to encourage managers to use information collected for decision making 5. Appoint data capturers in health facilities

5.3 Focus group responses

Two focus groups comprising a DCST for Ehlanzeni and CEOs of five selected hospitals, were interviewed for this study. While the initial plan was to interview three DCSTs from Ehlanzeni, Gert Sibande and Nkangala, the latter two districts did not have complete teams. Each focus group interview was recorded and transcribed verbatim by the researcher using the same questionnaire that was used for individual interviews. The researcher facilitated group discussions in respect of each study objective. Participant responses were themed or grouped accordingly as presented below:

5.3.1 Clinical audit

Non-availability of audit policies, norms and standards, un-informed clinicians and clinicians who engage in private work at the expense of their appointments in public health establishments were presented as major barriers to service delivery and CG implementation. Failure to conduct routine clinical audits and lack of implementation of clinical audit recommendations where these are conducted were mentioned as the challenges in the department (Table 5.2). Participants from the focus groups suggested that the department develops a clinical audit policy and relevant SOPs.

5.3.2 Clinical risk management

The participants from focus groups presented a shortage of clinical staff, inadequate infrastructure including CCTV cameras in high-risk areas, and a lack of appointed risk managers as major barriers to service delivery and CG (Table 5.2). Challenges to CG were given as combining all risks and failure to conduct morbidity and mortality meetings at all levels within the department.

5.3.3 Clinical performance and effectiveness

One barrier to CG is the department's focus on curative rather than primary care. There is still a tendency to refer level 1 cases to the regional and tertiary hospitals where there is a big shortage of specialists and senior doctors in the specialist and general hospitals, respectively. There is poor leadership and supervision of junior clinicians by their supervisors in the province (Table 5.2). Mpumalanga DOH is said to be not supportive of the family physician programme resulting in its total collapse. The lack of family physicians and experienced medical practitioners in districts has resulted in poor clinical skills among young inexperienced doctors and nurses in these areas. The focus groups suggest that family physicians should be appointed in districts to supply and oversee clinicians in the health establishments at this level. It Is further recommended that more specialists be recruited and appointed in the regional and tertiary hospitals within the province.

5.3.4 Evidence based practice and research

Both focus groups highlighted low morale as a barrier to EBP and research. In this regard, staff shortage and the resultant high workload were highlighted as factors that made it difficult for clinicians to find time to improve themselves. The only clinical department that attempted to develop a personal development programme was Family Medicine at Themba Hospital. However, this programme was not supported.

5.3.5 Information management

A poor provincial filing system, inadequate electronic systems and poor archiving of information were presented as the main barriers to CG implementation (Table 5.2). What is described as the absence or poverty of information in patient files has become the

order of the day in the department. This results from an inadequate recording of information and improper signing of these records by clinicians and support staff. A paper-based information management system has resulted in a high rate of missing patient files. Long waiting times for patients continues to be a challenge.

Table 5.2: Focus group barriers, challenges and interventions by CG pillar

CG Pillar	Barriers	Challenges	Proposed Intervention
Clinical Audit	1. There are no audit norms and standards in place. 2. Clinicians are not empowered. 3. There are no policies in place. 4. Doctors are distracted by rushing hospital work to do private work outside.	1. Recommendations from the few audits that are done are not implemented. 2. Clinical audits are not done routinely.	1. Develop clinical audit policy and SOPs.
Clinical Risk Management	1. Clinical staff shortage. 2. Inadequate infrastructure. 3. No appointed risk managers for most hospitals. 4. No CCTV cameras in high-risk areas.	1. Mixing clinical risk together with the other risks. 2. Morbidity and mortality meetings are not held as required.	1. Appoint additional staff to allow for risk mitigation. 2. Enforce morbidity and mortality meetings at health establishment level.
Clinical Performance & Effectiveness	1. Patient care is largely curative. 2. Level 1 clinical conditions get referred to specialists in regional and tertiary hospitals. 3. Poor supervision of junior doctors by senior ones. 4. There are vacant posts for heads of clinical departments. 5. Shortage of senior doctors in district hospitals.	1. Poor clinical leadership. 2. Mpumalanga DOH is not supportive of the Family Physician programme in districts and district hospitals. 3. Community service doctors only rotate through one or two clinical disciplines only and end up being unable to cover all disciplines in the rural hospitals where they are deployed. 4. Inadequate clinical skills of medical officers because of referral of level 1 conditions to specialists in Levels 2 & 3.	1. Family physicians should be appointed in districts and health facilities to supervise community service doctors. 2. Recruit more specialists to provide clinical leadership.
Evidence-Based Practice & Research	1. Staff shortages. 2. Lack of appropriate clinical protocols 3. No research events in the department	1. There is no motivation to do research. 2. High rate of medico-legal events.	1. Appointment of adequate staff to allow for time to conduct research and undergo personal development.

Patient & Public Involvement	1. Staff shortage. 2. High workload. 3. Language barrier. 4. Dysfunctional governance structures for both clinics and hospitals	1. Long waiting times. 2. Appointment of inappropriate members of hospital boards. 3. Some doctors do not engage the patient in decision making.	1. Improve staffing situation in health establishments. 2. Appoint relevant clinic committee and hospital board members.
Education & Training	1. No incentives for successfully completing any course be it a diploma of degree. 2. No budget for journal clubs. 3. Health professional training grant (HPTD) is no longer used to incentivise staff members to improve themselves.	1. Lack of personal development among staff members 2. No journal club sessions are held by clinical staff members.	1. Ensure regular staff induction. 2. Incentivise personal development through the HPTD grant
Information Management	1. Poor filing system resulting in lost files and lack of continuity of care. 2. Inadequate electronic systems. 3. Inadequate file archiving space.	1. Absence or poverty of information in patient files. 2. Inadequate recording of information and signing on patient records by some doctors. 3. Information management still largely paper based. 4. Missing patient files. 5. Long waiting times for patients.	1. Introduce electronic filing system for both patient records and staff files. 2. Train personnel on electronic systems. 3. Train staff on information management legislation such as PAIA and PAJA.

5.4 Document Reviews

As part of triangulation in this study, the researcher analysed documents which have a bearing on the implementation of CG in Mpumalanga and how the Department planned for, implemented, monitored and reported on CG. Reviewed documents in this regard included the National Health Act 61 of 2003, the Ministerial Team report on the appointment of DCSTs in South Africa, the handbook for DCSTs in South Africa, Mpumalanga DOH staff structure, and the Mpumalanga DOH Annual Performance Reports.

5.4.1 National Health Act 61 of 2003

In compliance with section 41(1)(a) the Mpumalanga MEC: Health has determined the range of health services that should be provided in the Mpumalanga public health establishments. There is a display of the service package at the entrance of each health facility for public knowledge. There has not been full compliance with Section 41(1)(b) of the NHA in that not all clinical standard operating procedures (SOPs), admission criteria and a patient referral policy are available in all health establishments in Mpumalanga. No clear, care and support guidelines have been developed for the Mpumalanga DOH.

5.4.2 District Clinical Specialist Teams in South Africa

Despite recommendations by the Ministerial Task Team (MTT) for the implementation of CG in all provinces in the country, including Mpumalanga, no uniform CG policies were developed in Mpumalanga. In this regard, the recommended CG framework that required district clinical specialist teams to drive it was not implemented. The DCST programme for the department had collapsed with no active DCST in each district and

in Ehlanzeni where a team was still active, the membership was not complete. A review of the DCST policy in South Africa revealed that certain imperatives were developed for the establishment of DCSTs and what role they would play in the implementation of CG. Table 5.3 below shows the CG policy imperatives. Mpumalanga did not follow these imperatives.

Table 5.3: DCST policy imperatives for South Africa

Policy Focus Area	CG Policy Imperatives
CG	1. DCSTs are appointed to improve both the quality of health care and health outcomes. 2. DCSTs are the core component for strengthening the DHS. 3. DCST to be comprised of a family physician, a PHCN, an O&G specialist, an advanced midwife, a paediatrician, a paediatric nurse, and an anaesthetist. 4. The family physician within the DCST to be appointed at a higher head-of-unit level with more responsibilities including CG and capacity building. 5. Specialist family physicians to be appointed at all CHCs and District Hospitals as the most senior clinician. 6. The primary role of DCSTs is supportive supervision and CG (NOT direct delivery of clinical services) 7. DCSTs should work together with hospital-based specialists to ensure the following: quality of clinical services; clinical training; monitoring, evaluation, and improving clinical services; supporting organizational activities; supporting health systems and logistics, collaboration, communication and reporting; and teaching and research

5.4.3 Handbook for DCSTs in South Africa

Although this CG policy implementation document had been developed through collaboration between the NDoH and the RMCH programme, guided by a report from the MTT, its implementation had not taken place at the time of this study. This handbook covers the principles and practice of CG in the context of the DCSTs and their role in its implementation. Furthermore, the handbook described four pillars of CG, their components, sub-components, and recommended activities. The review of the handbook for DCSTs further revealed that the envisaged activities/ actions as summarised in Table 5.4 were not undertaken in Mpumalanga.

Table 5.4: Summary of handbook for DCSTs review by CG pillar

CG Pillar	Components	Sub-Components	Activities/ Actions
Clinical Risk Management	1. Risk to patient 2. Risk to HCP 3. Risk to organization	1. Incident and adverse event reporting, monitoring, and trend analysis. 2. Event reporting, monitoring. and clinical investigation 3. Risk profile analysis 4. Morbidity and Mortality (M&M) review meetings	1. Identify risks. 2. Assess the credentials of staff qualifications and quality training. 3. Analyze incidents (critical events, complaints, reviews) 4. Develop PDSA cycle from the M&M review meetings. 5. Recommend improvement plans to prevent a recurrence
Clinical Performance & Effectiveness	1. Clinical norms and standards 2. Clinical audits 3. Clinical Indicators	1. National Core Standards 2. Treatment guidelines 3. Treatment protocols 4. Standard operating procedures 5. Set performance targets	1. Review of clinical records 2. Deployment of skilled HCWs at point of service delivery 3. Provide effective patient transport systems. 4. Establish an early-warning system for patient referrals
Professional development and management	1. CPD 2. Competency standards	1. regular skills audits 2. Human resource policies and guidelines 3. Evidence-based practice	1. In-service training 2. On-site staff mentoring 3. Coordinate and monitor mandatory pieces of training. 4. Motivate and coordinate operational research
Integration of demand-side perspective to assess supply-side interventions and patient behaviour.	1. Satisfaction surveys 2. Service user participation	1. Contributory factors to service over or underutilization	1. Liaise with WBOTs on health promotion and disease prevention. 2. Liaise with health promoters and communication officers on the development of health messages for communities

5.4.4 Mpumalanga DOH staff structure

The structure of the Mpumalanga DOH that had been approved on 22 October 2008, which is more than ten years ago had not been updated at the time of this study. The policy requires that a department's staff structure be reviewed every five years to accommodate the change in policy and new service demands. The stated purpose of the organizational structure is to ensure the provision of health services in Mpumalanga. The stated functions include management of the provision of primary healthcare services, secondary, tertiary, and specialized hospital services, sound fiscal management, and accounting services, provision of strategic human resource services, coordination of planning, research, development of macro-policy, monitoring, and evaluation, as well as ensuring good governance in the department.

A review of the old structure revealed a lack of a dedicated manager who would ensure good clinical governance at provincial, district, or health levels. While the national policy has put DCSTs as drivers of the CG policy at the district level, the organogram does not allow for dedicated posts for the coordination thereof at the provincial, district and health establishment levels. No posts exist for DCSTs in the district structures either. As shown in Figure 5.1, the provincial organizational structure does not provide for a dedicated CG branch, chief directorate, or directorate, rendering it very deficient in that regard. The Health Care Support Branch, which would be appropriate for CG, has not been filled over the years, leaving the Clinical Health Support Branch to carry both responsibilities. This has rendered the department very weak to deliver on its core mandate. The terminologies and roles of both the CD: Corporate Services and CD: Clinical Support are not clear (Figure 5.1). Once again, it is not understandable why these posts were created and yet not filled over the years.

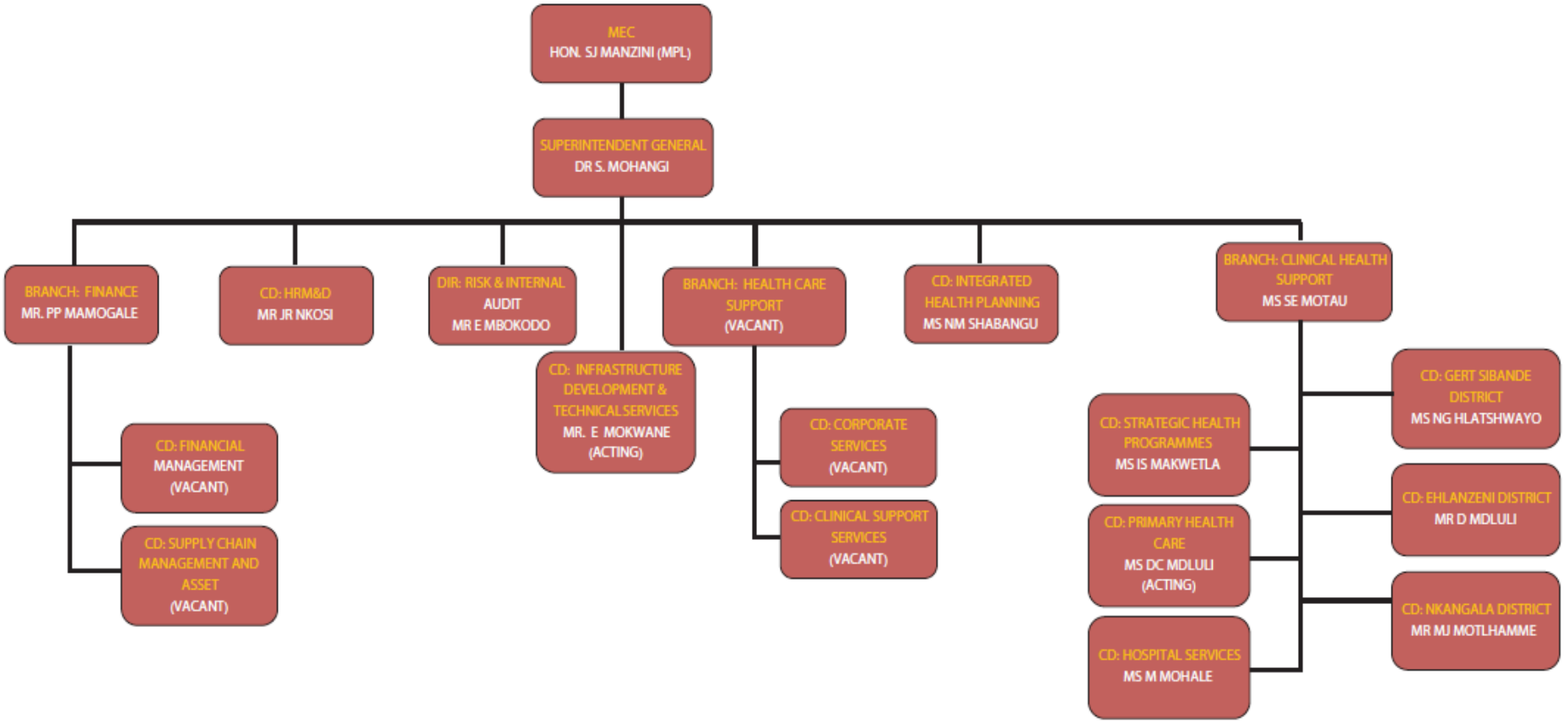


Figure 5.1: Organizational Structure Provincial Office
Source: Annual Report Department of Health 2018/2019

5.4.5 Mpumalanga DOH Annual Performance Reports

Three subsequent Mpumalanga DOH Annual Reports for the fiscal years 2016/17, 2017/18, and 2018/19 were reviewed to establish the overall performance of the Department and identify those areas that persisted as challenges to its performance. For each report, inferior performance in respect of each budget programme was explored and such areas were listed programmatically, as shown in Table 5.5.

Budget programmes that performed well include programmes 6, 7, and 8. The rest of the programmes showed persistent inferior performance in respect of finance management, human resource management, health systems, and CG. High litigation rates resulting from poor clinical outcomes, continue to make the department fail to achieve unqualified audits on its contingency liabilities. Hospital management teams continue to be inadequate due to budgetary constraints. Key senior clinical staff, including DCSTs, continue to impact negatively on the quality of care. There seems to be no hope for improvement in the emergency medical services with the persistently long response time due to ambulance shortages. EMS is not successful in integrating PPTS into the mainstream EMS due to chronic shortages of both staff and vehicles. The poor achievement on the national core norms and standards by one-third of the regional hospitals and the resultant high expenditure per PDE from costly laboratory tests, medicines, and implants, is indicative of almost non-existent CG.

Table 5.5: Mpumalanga service delivery challenges by budget programme

	Service delivery challenges		
Budget Programme	APR 2016/17	APR 2017/18	APR 2018/2019
Programme 1 Administration	1. Poor performance of Internal Control Unit 2. Poor performance of Contract Management 3. Executive managers for 15 hospitals not appointed. 4. Planned appointment of 18 information officers not done. 5. Record management system not developed	1. The DOH received a qualified opinion on contingency liabilities	1. Hospital management has not improved due to budgetary constraints. 2. Department received a qualified opinion on contingency liabilities. 3. The target of having PHC facilities with access to broadband connectivity not achieved
Programme 2 DHS	1. Shortage of essential equipment and cleaning materials for PHC facilities 2. Shortage of staff for PHC facilities 3. Failure to appoint functional DCSTs in districts. 4. Poor complaints resolution 5. Inadequate infrastructure for PHC 6. Poor safety and security systems in district hospitals 7. Long ALOS for orthopaedic patients 8. Long ALOS for mental healthcare users in district hospitals 9. High loss to follow up and mortality of MDR TB patients	1. A shortage of team leaders to support CHWs and ensure that they perform as expected. 2. Poor data management due to teams not registered in the DHIS and the backlog on data capturing. 3. Vehicles procured for CBS teams are also used for other activities due to a shortage of vehicles. 4. Patients by-passing PHC facilities to hospitals. 5. Limited budget for infrastructure and Staff resulting in poor complaints management.	1. Inadequate implementation on policy on complaints management 2. Expenditure per PDE high for district hospitals mainly due to costly laboratory tests and medicines 3. Low hospital bed utilization rates 4. Shortage of ISHTs due to shortage of PNs 5. Inadequate Measles dose coverage in ECD centers 6. High neonatal death in facility ratio due to inadequate

	12. Poor recording and reporting 13. Inadequate number of ophthalmologists and cataract surgeons 14. Difficulty in recruiting and retaining medical specialists.	patients and low birthweight childcare 7. Under-utilisation of district hospitals 8. High expenditure per PDE in District Hospitals 9. Low TB cure rate because of high defaulter rate and loss to follow up. 10. Inadequate data capturers / Admin clerks at facilities 11. Inadequate data capturing due to poor connectivity. 12. Poor compliance to management guidelines resulting in poor antenatal and intrapartum care. 13. Low cataract surgery rate because of staff shortages	7. Low cataract surgery rate due to shortage of ophthalmologists
Programme 3 EMS	1. Poor response time due to the absence of a monitoring system to track ambulances. 2. Shortage of personnel 3. Shortage of operational ambulances	1. Poor response time because of shortage of ambulances	1. Long response time due to ambulance shortages 2. PPTS not integrated into EMS due to shortage of staff
Programme 4 Provincial Hospital Services	1. Emergency trolleys are not standardized. 2. Non-availability of tracer drugs as per essential drug list 3. Lack of isolation wards 4. Poor security in high-risk areas because of non-availability of CCTV Camera system and shortage of staff 5. Poor clinical complaints management 6. Overspending on key cost drivers (Laboratory investigations and Blood products and medicines)	1. Non-compliance with National Core Norms and Standards 2. Emergency trolleys are not standardized. 3. No isolation wards in some regional hospitals 4. Shortage of medical equipment 5. Policies and protocols not updated. 6. Clinical audits are not done. 7. Medical records are not secured.	1. Poor achievement on national core norms and standards by one-third of regional hospitals 2. High expenditure per PDE due to costly laboratory tests, medicines, and implants

	7. Overspending on overtime payment	8. Lack of security in high-risk areas within hospitals 9. Shortage of specialist clinicians in core clinical disciplines 10. Clinical management complaints take a long time to resolve	
Programme 5 Tertiary Hospital Services	1. Lack of isolation wards 2. Security challenges such as lack of CCTV camera systems in high-risk areas and inadequate number of security officers 3. Inadequate in-house laundry services 4. Long ALOS for mental health users 5. Long ALOS for orthopaedic patients 6. Difficulty in the recruitment of medical specialists 7. Poor management of clinical complaints 8. Inadequate provision of tertiary services	1. Long ALOS for orthopaedic patients 2. Tertiary Hospitals not providing a full package of tertiary services	1. ALOS long because of mental healthcare users staying long in hospital. 2. High BUR because of the influx of level 1 and 2 patients who bypass the lower levels of care facilities. 3. High expenditure per PDE due to costly laboratory tests, medicine, and implants
Programme 6 Health Science and Training	1. None	1. None	1. None
Programme 7 HCSS	1. Inadequate availability of medicines and surgical sundries at Medical depot 2. Poor laundry services 3. Failure to establish functional Hospital Transfusion Committees in two identified hospitals	1. Poor compliance with Radiation Control prescripts	1. None
Programme 8 HFM	1. None	1. The DOH received a qualified opinion on contingency liabilities	1. None

5.4.6 Mpumalanga DOH Annual Performance Plans

To explore if the Mpumalanga DOH aligns its Annual Performance Plans (APPs) with the outcome of the Annual Reports for previous years, the researcher reviewed the APPs for the fiscal years 2016/17, 2017/18, and 2018/19.

5.4.6.1 Mpumalanga DOH APP for 2016/17

Table 5.6 presents the review findings of the review of the Mpumalanga DOH APP for 2016/17. It lists twenty-six risk areas like those of the previous fiscal year. The review findings that relate to CG include the inability to recruit and retain scarce skilled staff; inadequate skilled personnel for healthcare service provision; insufficient basic equipment; absence of a psychiatric facility in the province; inadequate information management; inadequate implementation of clinical guidelines; inadequate management of medical waste; EMS failure to take control of PPTS; inadequate compliance with infection control guidelines; non-compliance with professional clinical standards and protocols; inadequate compliance with medical and condemned pharmaceutical waste management; clinical adverse events; poor patient care and long patient waiting times; ineffective management of performance, high attrition of HCPs; inadequate management of the bursary system; shortage of pharmacy personnel; shortage of pharmaceuticals and surgical sundries; inadequate maintenance of medical equipment; and a critical shortage of clinical engineering technicians and radiographers. From this review, it is obvious that minimal improvement has been made in improving CG in the Department.

Table 5.6: Mpumalanga Risks and planned mitigation as per APP 2016/17

Item No.	Identified Risk	Planned Risk Mitigation
1	Inadequate security measures	1. Review draft policy. 2. Involve all stakeholders. 3. Conduct security awareness campaigns. 4. Establish sustainable leadership. 5. Establish security committees. 6. Review security structure
2	Inadequate records management systems	1. Approve and implement departmental records management policy and strategy. 2. Approve the main series of departmental staff structures.
3	The high number of litigations	1. Finalization and approval of litigation strategy. 2. Recruitment of legal officers specializing in medical cases. 3. Prioritize training for legal officers. 4. Appointment of personnel following the legal services organogram. 5. Review of the recruitment and retention strategy. 6. Establishment of the provincial adverse event committee. 7. Submission of monthly reports on the journalized expenditure on cases against their institution for monitoring. 8. Improvement of the Department's record-keeping system.
4	Poor asset management	1. Strengthen the asset verification process through monthly reporting. 2. Enhance the security system (electronic devices). 3. Regular update of the asset register. 4. Enforce compliance with the asset management policy. 5. Intensive training of Asset Managers. 6. Appointment of loss control officers.
5	Fruitless, wasteful, irregular, unauthorized, and delayed expenditure	1. Monthly creditors reconciliations. 2. Enforce compliance with policies. 3. Train staff regarding fruitless, wasteful, irregular, and unauthorized expenditure 4. Train staff on the overall Supply Chain Management (SCM) process 5. Implement a Zero-to-Nine Filing system and Invoice Register. 6. Hold monthly meetings on commitments and accruals. 7. Implement payment procedure manual.

6	Inadequate alignment of Departmental targets to MTEF budget	1. Conduct training on planning and budgeting. 2. Standardize outputs linked to targets. 3. Facilitate arrangement of Budget Advisory Committee (BAC). 4. Promote accountability on non-submission of budget inputs. 5. Conduct quarterly meetings with Integrated Strategic Planning (ISP).
7	Inadequate monitoring and evaluation of departmental performance	1. Enforce managers' accountability for performance monitoring and evaluation. 2. Apply punitive action for non-adherence to performance M&E processes. 3. Approval and implementation of Monitoring and Evaluation plan. 4. Implementation and monitoring of policies.
8	Lack of ICT business continuity plan	1. Finalization of the disaster recovery plan and ICT business continuity plan. 2. Conduct disaster recovery awareness workshops.
9	Ineffective implementation of PHC re-engineering	1. Roll out WBOTs to other districts. 2. Review the referral policy. 3. Appoint outstanding DCSTs. 4. Accelerate the appointment of Built Environment Health Professionals. 5. Accelerate maintenance programmes for facilities.
10	Poor quality of healthcare services	1. Improve contract management for bursary holders. 2. Review and implement recruitment and retention strategy. 3. Accelerate the appointment of Built Environment Health Professionals. 4. Accelerate maintenance programmes for facilities. 5. Ensure quality reporting on head-hunting of scarce skills. 6. Refresher training on Batho Pele principles
11	Ineffective management of obstetric complications	1. Employment of more healthcare providers (HCP) 2. Train staff. 3. Procure additional resources. 4. Conduct community awareness workshops on early Ante-Natal Care (ANC) bookings and appropriate health-seeking behaviour.
12	Non-compliance with certain PHC norms and standards	1. Appoint monitoring and evaluation coordinators. 2. Strengthen referral between hospitals and PHC facilities. 3. Fast track implementation of RPHC. 4. Implement and monitor quality improvement plans.
13	Nosocomial infections	1. Appoint dedicated infection prevention and control practitioners. 2. Intensify training of HCWs.

14	EMS failure to take control of Planned Patient Transport Services (PPTS)	1. Fast track taking over the process of PPTS by EMS. 2. Develop and implement transformation strategy. 3. Develop, approve and implement PPTS policy.
15	Inadequate / Inappropriate emergency vehicles	1. Procure additional ambulances, PPTS buses, and all-terrain response vehicles. 2. Provide fleet management training to station managers. 3. Provide debriefing services for ECPs. 4. Train staff on defensive driving.
16	Poor response time	1. Procure additional ambulances. 2. Develop, approve and implement appropriate organogram for EMS.
17	Shortage of higher categories of Emergency Care Practitioners (ECP)	1. Fast track accreditation of EMS college for ECT and ECA courses. 2. Head hunt ALS, ECT, and ILS practitioners.
18	Lack of counseling and debriefing sessions for EMS staff	1. Provide EMS psychology and/ or chaplain services.
19	Inadequate infection control measures	1. Erect additional isolation wards in provincial hospitals. 2. Appoint additional infection control staff. 3. Improve compliance with policies and procedures. 4. Ensure the addition of medical practitioners in Infection Control Committees. 5. Ensure availability of adequate Personal Protective Equipment (PPE) for staff.
20	Incomplete package of Level 2 services	1. Effective HCP contract management. 2. Improve recruitment and retention of HCPs. 3. Improve supervision of sessional HCPs.
21	Poor management of medical waste	1. Decentralize waste management budget to health establishments.
22	Incomplete package of Level 3 services	1. Strengthen relationship with academic institutions. 2. Decentralize HR delegations.
23	Clinical adverse events	1. Increase outreach programmes. 2. Strengthen clinical supervision. 3. Conduct clinical audits and peer reviews, 4. Enforcement of compliance with clinical protocols. 5. Appointment of critical clinical staff. 6. Strengthen security measures in high-risk areas.

		7. Improve capacitation of HCPs on clinical skills.
24	Insufficient and poorly maintained medical equipment	1. Improve implementation and adherence to maintenance plans. 2. Improve contract management. 3. Ensure inclusion of maintenance plans as part of specifications in all medical equipment requisitions. 4. Provide in-service training on the use of medical equipment.
25	Ineffective patient record system	1. Provide training on information management. 2. Appoint adequate information officers. 3. Introduce the use of registers to control patient file movement. 4. Strengthen security management at all patient and staff exit points.
26	Inadequate management of bursary system	1. Strengthen relationship with universities. 2. Tighten bursary contracts with the desired area of specialty and the duration and clause binding defaulting bursars.
27	Ineffective learner-recruitment strategy	1. Develop exit plan for placement of learners who complete their studies.
28	Inadequate facilities for nursing training	1. Revitalize the Nursing College. 2. Motivate for the establishment of a psychiatric institution. 3. Alignment of student intake with available resources.
29	Non-alignment of student intake with departmental academic capacity	1. Extend Nursing College by establishing satellite campuses. 2. Enforce compliance with SANC regulations.
30	Ineffective implementation of PMDS	1. Senior Managers to take responsibility for enforcement of the PMDS. 2. Staff to undergo continuous training on PMDS. 3. Appointment of a designated officer for PMDS.
31	Inadequate Forensic Pathology Services	1. Recruitment and appointment in line with organogram. 2. Implementation of recruitment and retention strategy.
32	Shortage of pharmacy personnel	1. Implementation of learnership programme. 2. Employment of Pharmacists in all health establishments. 3. Provide bursaries for pharmacy students.
33	Unavailability of pharmaceuticals and surgical consumables in health establishments	1. Appoint Pharmaceutical and Therapeutic Committees (PTC) in all health establishments. 2. Regular monitoring of adherence to delivery schedules. 3. Drug supply management workshops. 4. Development of provincial medicine formulary.

34	Poor maintenance of infrastructure	1. Include maintenance requirements in infrastructure planning. 2. Facility maintenance skills development.

5.4.6.2 Review of Mpumalanga DOH APP 2017/18

Table 5.7 presents the review findings of the review of the Mpumalanga DOH APP for 2016/17. It lists twenty-six risk areas like those of the previous fiscal year. The review findings that relate to CG include the inability to recruit and retain scarce skilled staff; inadequate skilled personnel for healthcare service provision; insufficient basic equipment; absence of a psychiatric facility in the province; inadequate information management; inadequate implementation of clinical guidelines; inadequate management of medical waste; EMS failure to take control of PPTS; inadequate compliance with infection control guidelines; non-compliance with professional clinical standards and protocols; inadequate compliance with medical and condemned pharmaceutical waste management; clinical adverse events; poor patient care and long patient waiting times; ineffective management of performance, high attrition of HCPs; inadequate management of the bursary system; shortage of pharmacy personnel; shortage of pharmaceuticals and surgical sundries; inadequate maintenance of medical equipment; and a critical shortage of clinical engineering technicians and radiographers. From this review, it is obvious that minimal improvement has been made in improving CG in the Department.

Table 5.7: Mpumalanga Risks and planned mitigation as per APP 2017/18

Item No.	Identified Risk	Planned Risk Mitigation
1	Inability to recruit and retain scarce skilled staff	1. Apply targeted recruitment and retention. 2. Review staff structure using WISN in PHC facilities. 3. Decentralize HR delegations. 4. Compliance with public service prescripts when advertising and filling vacant posts. 5. Develop, implement and monitor an appropriate HR plan.
2	Poor asset management	1. Ensure monthly asset verification process. 2. Enhance security system. 3. Enforce compliance with the asset management policy. 4. Appointment of appropriate staff;
3	Inadequate skilled personnel for healthcare service provision	1. Develop HR strategy to cover recruitment and retention, HR delegations, and baseline of vacancies.
4	Insufficient basic equipment	1. Develop and implement an SCM strategy. 2. Appoint dedicated SCM staff. 3. Ensure maintenance plan for all procured equipment.
5	Absence of a psychiatric facility in the province	4. Develop a comprehensive tertiary health services plan.
6	Inadequate information management	1. Procure information management equipment. 2. Appoint data management personnel. 3. Conduct information management skills gap analysis and provide training. 4. Secure adequate record storage facilities. 5. Develop and implement a Record Management Policy.
7	Inadequate implementation of clinical guidelines	1. Appoint skilled HCWs to provide clinical services. 2. Conduct continuous training and orientation. 3. Conduct Mentoring and on-site in-service training. 4. Conduct monitoring and evaluation of healthcare services.
8	Inadequate management of medical waste	1. Appoint / delegate responsible managers in health establishments. 2. Ensure compliance with contract management by service providers. 3. Provide staff training on waste management.

9	EMS failure to take control of PPTS	4. Hold awareness campaigns and information-sharing sessions with communities on the take-over process. 5. Determine numbers and types of staff required for the take-over. 6. Create and fill identified posts. 7. Determine equipment and vehicle needs and develop a demand plan. 8. Secure resources required.
10	Inadequate / inappropriate emergency vehicles	1. Engagement with COGTA and DPWRT. 2. Monitor SLA for management of the fleet. 3. Train EMS staff on emergency driving. 4. Implement consequence management.
11	Poor response time of EMS	1. Procurement of additional ambulances. 2. Appointment of additional EMS staff. 3. Procure communication system. 4. Implement shift system.
12	Inadequate compliance with infection control guidelines	1. Motivate for infrastructure project for the construction of isolation wards. 2. Create and fill an adequate number of posts for infection control. 3. Improve compliance with infection control policies and procedures.
13	Incomplete access to Level 2 services	1. Develop an equipment procurement plan. 2. Enforce compliance with attendance registers by sessional doctors. 3. Implement recruitment and retention strategy for scarce skills.
14	Non-compliance with professional clinical standards and protocols	1. Strengthen quarterly clinical audits. 2. Enforce compliance with policies and procedures. 3. Motivate for appointment of senior professional staff for supervision and mentoring purposes. 4. Train clinical audit committees.
15	Inadequate compliance with medical and condemned pharmaceutical waste management	1. Appointment of dedicated waste manager.
16	Incomplete package of Level 3 services	1. Increase the number of registrars. 2. Strengthen relationships with universities/ academic institutions. 3. Implement HR delegations to Tertiary hospital CEOs.
17	Clinical adverse events	1. Fill vacant posts. 2. Develop, implement and monitor clinical policies and procedures.

		3. Procure needed medical equipment. 4. Strengthen record-keeping security measures in clinical units. 5. Strengthen supervision/conduct clinical audits and peer reviews.
18	Poor patient care and long patient waiting times	1. Train staff on customer care. 2. Re-launch Bato Pele Principles. 3. Reinforce referral policy. 4. Strengthen PHC services and outreach programmes by sharing information.
19	Ineffective management of performance	1. Develop PMDS implementation guidelines. 2. Establish quarterly assessment committees. 3. Identify gaps and implement continuous training on the management of performance.
20	High attrition of HCPs	1. Implement recruitment and retention strategy. 2. Provide training opportunities with academic institutions as well as in-house. 3. Finalize retention strategy.
21	Inadequate management of the Bursary System	1. Implement recruitment and retention strategy. 2. Provide training opportunities with academic institutions as well as in-house. 3. Finalize retention strategy.
22	Inadequate Forensic Pathology Services	1. Implementation of recruitment and retention strategy. 2. Implementation of an internal training programme. 3. Monitor compliance by service providers to the SLA.
23	Shortage of pharmacy personnel	1. Implement approved revised organizational structure. 2. Employ additional CSPs and pharmacists in facilities. 3. Ensure compliance with recruitment and selection policy.
24	Shortage of pharmaceuticals and surgical sundries	1. Install stock management systems in facilities. 2. Improve pharmaceutical warehouse management.
25	Inadequate maintenance of medical equipment	1. Fast track filling of critical vacant posts. 2. Review SLAs for medical equipment to provide for equipment maintenance plans. 3. Develop SOP for medical equipment maintenance.
26	A critical shortage of clinical engineering technicians and radiographers	1. Streamline recruitment processes. 2. Rectify and Implement OSD policy for Engineering personnel.

5.4.6.3 Review of Mpumalanga DOH APP 2018/19

A look at Table 5.8 below which shows the Mpumalanga DOH annual performance plan, reveals that the Mpumalanga DOH has not significantly reduced health service delivery risks over the three years under review. 29 risks were identified in the 2018/19 APP, inclusive of inability to recruit and retain staff with scarce skills, inadequate skilled HR resources to deliver healthcare services, increasing rate of maternal and child mortality, increasing malaria incidence and mortality rate, inadequate healthcare waste management, inadequate information management, EMS failure to take control of PPTS, inadequate or inappropriately qualified personnel, inadequate compliance with infection control guidelines, non-compliance with professional clinical standards and protocols, inadequate medical and condemned pharmaceutical waste management, clinical adverse events, poor patient care and long patient waiting times, inadequate management of the bursary system, ineffective management of performance, inadequate forensic pathology services, shortage of pharmacy personnel, shortage of pharmaceuticals and Surgical sundries and inadequate maintenance of medical equipment.

From the above, the department continues to perform poorly from a CG point of view, which is why the risks continue to repeat every year.

Table 5.8: Mpumalanga Risks and planned mitigation as per APP 2018/19

Item No.	Identified Risk	Planned Risk Mitigation
1	Inability to recruit and retain staff in scarce skills	1. Implement targeted recruitment and improve retention strategy. 2. Review the organizational structure and implement WISN in PHC facilities 3. Implement HR delegations 4. Ensure compliance with advertisement and post-filling prescripts. 5. Develop appropriate HR plan and monitor its implementation
2	Poor asset management	1. Strengthen asset verification through monthly reporting. 2. Enhance security systems. 3. Ensure regular update of the asset register. 4. Appoint appropriate staff for asset management and loss control
3	Inadequate skilled HR resources to deliver healthcare services	1. Develop and implement a DPSA compliant HR strategy to address recruitment and retention, HR delegation framework, acceptable baseline vacancy rate, and WISN prescripts
4	Inadequate mental healthcare services in the province	1. Appoint 3 mental healthcare review boards. 2. Appoint additional (9) sub-district mental healthcare coordinators. 3. Upgrade and build Infrastructure Unit Support System (IUSS) compliant infrastructure for psychiatric patient care
5	An increasing rate of maternal and child mortality	1. Appoint skilled HCWs to provide MCWH services. 2. Conduct continuous training and orientation. 3. Conduct on-site mentoring and in-service training
6	Increasing malaria incidence and mortality rate	1. Appoint additional staff. 2. Strengthen community awareness campaigns, Malaria surveillance, and indoor residual spraying. 3. Train HCWs on accurate diagnosis and treatment of Malaria
7	Inadequate healthcare waste management	1. Appoint/ delegate responsible managers in facilities. 2. Enforce SLA compliance by service providers. 3. Embark on annual training for HCWs
8	Inadequate information management	1. Procure appropriate equipment. 2. Appoint additional information management personnel. 3. Undertake ongoing training for HCWs. 4. Enforce compliance with the National Archives Act regarding the storage of records.

9	EMS failure to take control of PPTS	1. Integration of PPTS into EMS 2. Implement Operational PPTS Plan
10	Ineffective Emergency Communication Center (ECC)	1. Train ECC staff 2. Ensure multilingual ECC. 3. Appoint shift leaders for ECC. 4. Upgrade ECC system
11	Inadequate/ inappropriate emergency vehicles	1. Procure additional EMS vehicles with the right specification. 2. Appropriate skilled ALS practitioners 3. Appointment of ECTs and ALS practitioners
12	Inadequate/ inappropriately qualified personnel	1. Recruit appropriately skilled personnel
13	Inadequate compliance with infection control guidelines	1. Motivate for infrastructure project for the construction of isolation wards. 2. Create and fill posts for infection control officers. 3. Improve monitoring of compliance with policies and procedures. 4. Allocation of adequate resources and consumables
14	Incomplete package of Level 2 services	1. Develop an equipment procurement plan. 2. Regional hospitals to hold referral meetings with feeder facilities. 3. Monitor compliance to attendance registers by sessional doctors. 4. Implement recruitment and retention strategy for scarce skills
15	Non-compliance with professional clinical standards and protocols	1. Strengthen quarterly clinical audits. 2. Enforce compliance with policies and procedures. 3. Motivate for appointment of senior professional staff for supervision and mentoring purposes. 4. Staff debriefing, motivation, and team building
16	Inadequate medical and condemned pharmaceutical waste management	1. Appointment of dedicated Waste Manager 2. Secure budget and approval for waste storage facilities
17	Incomplete package of Level 3 services	1. Increase the number of registrars. 2. Provincial tender for medical equipment and consumables 3. Strengthen relationship with academic institutions. 4. Implement the Delegation Framework of HR authority to CEOs. 5. Increase the number of clinical specialist domains in specialist hospitals
18	Clinical adverse events	1. Fill all critical vacant positions.

		2. Develop, implement and monitor clinical policies and procedures. 3. Procure the needed medical equipment and consumables. 4. Strengthen security measures in clinical units concerning record keeping. 5. Strengthen supervision. 6. Conduct clinical audits and peer reviews
19	Poor patient care and long patient waiting times	1. Train staff in customer care 2. Re-launch Batho Pele Principles 3. Reinforce referral policy. 4. Tertiary hospitals to conduct referral meetings with feeder facilities. 5. Strengthen PHC services and outreach programme
20	Inadequate management of the bursary system	1. Monitor compliance through the Personnel and Salary System (PERSAL)
21	Inadequate implementation of the training cycle	1. Conduct needs analysis and training evaluation
22	Ineffective management of performance	1. Conduct training on PMDS
23	Inadequate Forensic Pathology services	1. Submission of infrastructural needs to the Infrastructure Section 2. Submission of prioritized needs to Budget Section 3. Submission of prioritized posts for advertisement 4. Provision of wellness programme to employees 5. Monitor compliance be the service providers to the SLAs
24	Shortage of pharmacy personnel	1. Approved new organizational structure. 2. Employment of Community Service pharmacists (CSP) and pharmacists at facilities 3. Ensure proper planning to increase budget allocation. 4. Adhere to recruitment and selection policy
25	Shortage of pharmaceuticals and Surgical sundries	1. Install stock management system in all facilities. 2. Secure budget for warehouse facilities 3. Improve pharmaceutical warehouse management
26	Inadequate maintenance of medical equipment	1. Fast track the filling of critical posts 2. Review and implementation of medical equipment SLAs with service providers to incorporate maintenance plans. 3. Emphasize motivation for more maintenance of medical equipment budget. 4. Develop an SOP in medical equipment maintenance. 5. Replacement of old vehicles for the CE workshops

		6. Engage SCM section to expedite the processing of requisitions for maintenance
27	Poor maintenance of infrastructure and equipment	1. Include maintenance requirements in infrastructure planning. 2. Conclude SLAs with the MRTT for the placement of artisans. 3. Secure adequate budget via Construction Procurement Standard (CPS) for a multi-year programme
28	Cost over-runs on projects	1. Coordinate development of a business case and clinical briefs before the design 2. Planning according to the allocated budget 3. Continuous professional skills development 4. Establishment of individual project budget estimates
29	Inadequate budget for health facilities management	1. Develop costed Provincial Maintenance Master Plan 2. Motivate for a needs-driven budget.

5.5 Chapter summary

This chapter presented, analyzed, and discussed the findings of the study. The presentation included interviews (individual and group) and document reviews covering policies, plans, and annual reports of the Mpumalanga DOH. Tables were used to summarise responses and review findings. These were analyzed for relevance to the seven pillars of CG and challenges in their implementation in the province. The discussion compared findings of other similar studies conducted elsewhere.

Chapter 6 Discussion, Conclusions and Recommendations

6.1 Introduction

South Africa became a democracy in 1994. Among other early initiatives, the new democratic government embarked on a health reform process, which sought to provide South Africans with a universal health system based on a District Health System (DHS), using a PHC approach. In 2010, the government identified a need to strengthen the health system through RPHC with a specific emphasis on CG. However, these efforts have not yielded the required results in respect of public health programme performance and have resulted in poor health quality outcomes. As a result, the quadruple disease burden continues to worsen.

This resulted in the researcher identifying the need to explore barriers and challenges to the implementation of CG in Mpumalanga, South Africa. The approach resulted in seven fundamental questions being prepared for purposively selected senior health officials, to establish their views about barriers and challenges in the implementation of CG, as well as obtain their views as to how the situation may be improved.

Based on the responses from the interviews and document reviews, a summary of the findings, conclusions, and recommendations are made below.

6.2 Discussion

In this section, the researcher discusses the study findings in relation to the seven research objectives. A comparison is made with the findings of other similar studies and commonalities are identified.

6.2.1 Clinical Governance (CG)

As mentioned above, in South Africa, CG is defined as “a framework that helps managers and clinicians (such as nurses, doctors, physiotherapists) to improve the quality of their services and safeguard standards of care, continuously, thoughtfully and in a coordinated fashion, by creating and environment in which excellence in clinical care will flourish” (Connell, 2014:10). This study sought to establish to what extent this ambitious goal of patient care has been achieved in Mpumalanga province. This was done through the interview of individuals and focus groups,

In this study, interviews were initiated by asking each interviewee to share his/her understanding of CG to explore to what extent managers and clinicians are aware of it. The study found that participants varied in their understanding of the subject and the pillars thereof (Table 5.1). Some had a good understanding of CG and included in their definition the key concepts of CG such as quality of health care, compliance with clinical norms and standards, continuity, service coordination, and service excellence.

In Table 5.1, for example, CG is described as involving all activities that relate to the good outcome of treating a patient. All activities relating to services rendered to a patient: from the time the patient enters the facilities premises, the registration because the clerk needs to take proper information of the patient so that at a later stage we know where the patient is coming from, just like now tracing of (Covid-19) contacts is used to record the relevant information of the patient accordingly. Several other participants also did not have a comprehensive understanding of the concept. In Table 5.2, CG is described as that approach that, as a health system, we need to maintain so that we improve the quality of health care. One participant explains describes CG as that which

> *“Is to make sure that we manage that part to make sure that clinicians render quality services which are free of medical risks.”*

As can be seen from Table 5.1, the extent of lack of knowledge about the pillars of CG is further exposed where another respondent says:

> "*But for me in CG there are four pillars. As you speak, I was thinking, you know one of those 4 pillars that I have in mind and I think I will have to give you those later because as I see it you caught me slightly off guard, I do not know what you are going to say and what we are going to do. But for me, there are four outstanding pillars and those are the ones we must look at, you know, looking at a hospital of that size and how you would go about those. So, I do not know if you will ask questions about those.*"

This variability in the understanding of CG may be attributed to a lack of emphasis and prioritization of, CG by the Mpumalanga DOH for effective health service delivery and provision of quality health care. The provincial (Figure 5.1), district, and health facility organizational structures reflect this lack of focus by the Mpumalanga DOH on CG. A review of samples of clinical posts advertisements also confirmed this lack. The appointment of individuals who do not have a health qualification, experience, and background to key health service delivery management positions is another example of failure by the department to prioritize CG. Further analysis of a sample of PMDS agreements, entered between programme managers, clinical managers, medical specialists, and their supervisors, which are signed annually, do not prioritize and emphasize CG. This statement by one of the participants explains the root cause of the problem:

> "…*there are negative clinicians' attitudes towards clinical audits…*"

This finding confirms what Gauld and Horsburgh (2015) found in a study to explore healthcare professionals' perceptions of CG in New Zealand where only 47,7 percent

of respondents were found to be familiar with the concept of CG. This study agrees with Gauld and Horsburgh (2016:366) who posit that there is an association between CG knowledge and the position that an individual holds in the organization (management or professional).

6.2.1.1 Clinical Audit

Brain et al (2011:1) define Clinical Audit as a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality and taking action to bring practice in line with these standards to improve the quality of care and health outcomes. Limb et al (2017:1) on the other hand, describe a clinical audit as an assessment of certain aspects of health care in attaining a recognized standard and informing healthcare providers and patients whether the service provided is meeting the set standards or not and whether there is a need for improvement.

From both individual and focus group responses (Tables 5.1 and 5.2), lack of clinical audit policy, lack of clinical audit SOPs, and staff attitude are the largest barriers to the implementation and practice of clinical audits.

The Audit Committee that has been appointed at the provincial level is not helping much clinically as its primary purpose is to provide oversight of the financial reporting process, the audit process, the department's system of internal controls and compliance with applicable laws and regulations, thus largely ignoring clinical issues.

The internal control unit, which works closely with the Audit Committee, is headed by a manager who has no health background and is also largely skewed in favour of oversight of financial reporting and corporate governance in line with the King IV

Report (Institute of Directors of South Africa, 2016:55), but not specifically for CG. A health department, like other departments, requires an internal control unit that should benchmark its performance against leading best practices and global trends (Ferreira, 2008:91). However, this does not appear to be the approach in Mpumalanga. To ensure that the recommended mix of knowledge, skills, and experience exists in the Department, audit structures should be headed by officials with a public health background.

As participant DC07 states:

> "*There is no oversight structure, so I could say may be either at the national level, which cascades to provincial level to standardize clinical audits. So, people are left on their own, you know, to decide how they manage clients in their sector."*

The direness of the situation is confirmed by participant DC05 who says:

> "*The clinical audits, I think this where we lack much as a department*. *I think most institutions do not do this.*"

A positive finding by the review of the departmental staff establishment is, however, that clinical manager posts exist in the staff structure of each health establishment. Most posts are filled, and each clinical manager is charged with the responsibility to conduct clinical audits regularly and ensure that clinical care is provided in line with approved clinical norms and standards.

> "*In terms of clinical audits what I have observed is that it is an activity that is seldom conducted and when it is conducted very often there is a lack of proper communication in that when it is initiated it is not broadly communicated to the relevant key stakeholders within the facility in case it is being done at the facility*

level, or a hospital-level or even at a district level. It is being done in silos and then the communication part of it is not proper because you will find that only a select few of the people involved are taking part in the clinical audit." (Participant DC01).

Challenges in the conduct of clinical audits range from the fact that clinical managers, who should lead the process, are often too busy with other pressing commitments and do not have time to conduct clinical audits. Participant DC05 had the following to say about this:

"*…as a clinical manager myself, I find it incredibly challenging, imagine how many committees are there in which I must sit in as a chairperson, but at the end of the day, also the fact that there is a shortage of staff, you must juggle between doing the audits and the many meetings that are there. The issue of staff shortage is a serious impediment in terms of auditing the patient files*."

In addition to clinical managers being overstretched as indicated above, clinical audits are not happening because of the refusal or reluctance of the clinical unit leads to do them. In this regard, participant DC09 had the following to say:

"*…those have given me a lot of headaches because I also must have those things done. But here I have a lot of resistance from my specialists. There is a lot of resistance. I do not know if they understand. I have at various times tried clinical audits. It will just not happen. I do not have a lot of buy-ins and the resistance is the main issue, from the specialists*."

The above findings confirm the findings of Ravaghi et al (2014a) in a study that explored facilitators and barriers to implementing CG in which senior managers in Iran were interviewed. The study concluded that insufficient resources, legal challenges,

workload, and parallel quality programmes were the most common barriers to the implementation of CG. In this study, the failure of key clinicians to cooperate is another barrier to clinical audits.

6.2.1.2 Clinical performance and effectiveness

Clinical performance and effectiveness are dependent on the provision of the right care to the right patient at the right time by the right clinician who has the right clinical skills that are applied the right way. Clinical care requires that appropriate clinical norms and standards be in place, clinical audits routinely done and that a set of agreed clinical indicators are available to use when determining performance and effectiveness. Required for the above are approved national core clinical standards with aligned guidelines and policies, clinical protocols at the facility level, specific clinical targets at all levels, clinical SOPs, and early warning systems (National Department of Health, 2014:12).

According to the Australian Commission on Safety and Quality in Health Care (ACSQHC) (2012:10), for effective clinical care and good clinical performance, the clinical workforce must have the right qualifications, skills, and supervision. With regards to safety and quality of care, the ACSQHC prescribes that health departments provide an orientation of governing bodies, clinicians, and other HCWs on the roles and responsibilities for safety and quality that the department expects of them.

In the UK, the National Institute for Health and Care Excellence (NICE) has put together numerous clinical guidelines focusing on improving the present quality of care within the National Health Service (NHS) of the UK (Drummond, 2016:525)

In Mpumalanga, the study findings suggest a lack of compliance with national and international practices referred to above. Both individual and focus group responses

highlight poor supervision of junior personnel by their seniors. This is attributed to a shortage of senior staff (Tables 5.1 and 5.2). This defeats the whole notion of providing the right care to the right patient at the right time by the right clinician who has the right clinical skills that are applied the right way that South Africa advocates should happen in health establishments.

> "*In terms of clinical performance looking at the issues you mentioned regarding litigations, the number of litigations show that the clinical performance is not up to scratch. And my thinking, the reasons or the causes for this might be that our staff does not find time to improve this because they have overworked themselves, they are doing extra-overtime and they do not rest due to a shortage of the staff, of course. Then they do not rest and when they come, they are exhausted, and they would not perform appropriately which would lead to medical errors.*" (Participant DC03).

This study confirms similar findings by Gauld and Horsburgh (2015), Ravaghi et al (2014), and Dehnavieh et al (2013) who also found the shortage of staff and resultant overwork as important barriers to clinical performance and effectiveness.

6.2.1.3 Clinical risk management

Clinical risk management focus in the South African perspective should focus on risk to the patient, HCP, and the organization. In this regard, incident and adverse event reporting, clinical investigation and risk profile and trend analysis are important considerations (National Department of Health, 2014:13). The National Guideline for Patient Safety Incident Reporting and Learning in the Public Sector of South Africa (National Department of Health, 2017) stresses the need for preventative measures and continuous improvement of the quality of care for patients. The Mpumalanga DOH

(2018) has adopted and adapted the same guidelines for implementation. Patient Safety Incident (PSI) reporting and learning committees have been established at all levels. However, these committees remain dysfunctional from poor support and leadership at provincial, district, and health establishment levels.

The findings of this study about clinical risk management were that clinical staff shortage, inadequate infrastructure, lack of dedicated risk managers in health establishments, poor security systems in high-risk areas within health establishments, staff attitudes towards clinical audits, and lack of standardized clinical leadership at health establishment level, are the main barriers to efficient and effective clinical risk management. On the other hand, failure to distinguish between clinical risk from non-clinical risks as well as failure to hold routine and regular morbidity and mortality meetings are notable challenges (Tables 5.1 and 5.2).

Participant DC03 summarises the risk management barriers and challenges as follows:

> "…*There is something that we still need to be instilled in the managers because even what especially us in programme one, you find that managers they do not have an insight on the issue and even when you go for the first session where you will identify risks the attendance would not be good. People do not show any interest. It starts there before we can be able to deal with the risks*."

The lack of interest in clinical risk management issues is like what Khayatzadeh-Mahani et al (2013) found when they explored how the CG policy and patient satisfaction had progressed on the ground within Iran's health system. This hopeless situation was confirmed by Participant DC04 who had this to say:

> *"I think, there is, if we want to go into risk and what are the risks around, if I could look at Witbank Hospital where I have been for 20 years now, there are so many*

risks. Unfortunately, there is not a person trained, in looking into that who can guide and help so that one can plan. So, we do not have anyone trained to investigate risk management. So, what we trying to do is just to get ideas here being to try and put that together and to produce a risk file, does not produce something proper that one can use and can work on."

Gauld and Horsburgh (2015), in their exploration of healthcare professionals' perceptions of local implementation of a National CG Policy in NZ by probing the extent to which key components of CG policy had been implemented, came to a similar conclusion of reluctance by clinicians to step up and lead on CG.

6.2.1.4 Patient and Public Involvement

As discussed above under the PPI pillar of CG, Maccarthy et al (2019:5) identified the major barriers to the patient and public involvement (PPI) implementation to be inclusive of ethical challenges, engagement of patients and the interested public, funding to carry out PPI as well as a perceived lack of relevant guiding documents among healthcare providers.

In this study, inefficiencies of appointed governing bodies such as the appointment of inappropriate members of hospital boards and failure by governance bodies to report back to the communities they represent were found to be barriers to effective PPI. On the other hand, the non-availability of health services for some communities, again because of governing bodies failing to report back to their respective communities, has resulted in community members bypassing lower levels of care in their plight to access health services (Table 5.1). When asked about PPI, participant DC06 had this to say:

"We are not doing well, because we do have clinic committees and hospital boards that need to serve, you know, as an extension of DOH. But given the fact that even the hospital boards, will only be effective when we have meetings, but how do they share the information outside? There is no evidence that you can see. Another way as a department maybe if we can have a hub where the committee can throw or put in their suggestion. It worked much easier. We can suggest the view of the community. Or else, we appoint to hospital boards those who know, not political. Once we start criticizing clinical work it becomes a horror. So, if we can appoint hospital boards as per regulation, as per what it is, because it says you need to have someone who is an advocate. We need not have someone who has the knowledge or an advocate, we must just state it clearly, we appoint people who are knowledgeable, who are going to assist the board. But not the board that we appoint and the clinic committees that we are appointing now. For me, it is not assisting."

Service-related issues such as staff shortage, high workload, and language barriers among HCPs and patients were cited as impediments to patient involvement in clinical decision making. This resulted in long waiting times, with some doctors chasing queues instead of engaging their patients in decision-making (Table 5.2). As expressed by participant CEO4:

"*The other issue is the language barrier. This is another hassle because if you are short of nurses, and the doctor and the patient are not able to communicate in a language that the patient can understand, obviously regardless of how many doctors you may have, and they can be many, but the language barrier will always be a problem of engagement.*"

When the above barriers and challenges are contrasted against the PPI Involvement Continuum referred to under Patient and Public Involvement in Chapter 3, it became obvious that there are challenges in giving and getting information from health users and the public in Mpumalanga. The established governance structure, which provides forums for debate and participation, is inefficient. This supports Boudioni and McLaren's (2013:473) assertion that deficiencies in financial and human resources, organizational capacity, lack of relevant data, difficulties in supporting the public, and accessing seldom-heard communities, are barriers to facilitating PPI implementation in health systems.

6.2.1.5 Information Management

To reiterate what Afrizal et al (2019:1) and Akhlaq, Sheikh and Pagliari (2015:284) emphasized, to improve health quality, it is expected of health organizations to develop and implement Health Information Systems (HIS) that improve data management to produce timely decision making. This is vital for building strong health systems, provision of comprehensive and integrated health care, management of public health risks, and informing policies for public health and health financing. Information management in health includes user records that contain demographic, socio-economic, and clinical information about the user, proper collection, management, and use of the information within health systems.

The outcomes of studies conducted by Afrizal et al (2019) and Akhlaq et al (2016:1310) in Indonesia and many other low- and middle-income countries (LMIC) respectively, were suggestive of human resource; infrastructure; organizational support; health information process barriers such as lack of importance given to data in decision making; corruption and insecurity; lack of training; and poor IT infrastructure being important barriers in health information management.

In South Africa, Eygelaar and Stellenberg (2012:6) confirm that inadequacies relating to human resources, professional development, consumables and equipment, influence information management relating to patient care.

In this study (Tables 5.1 and 5.2), inadequate information management system, poor documentation of clinical information in patient files, non-availability of IT equipment, inadequate archiving of patient records, and poor communication among key information management stakeholders are barriers to effective and efficient information management. This results in information management challenges including the absence or poverty of information in patient files, the persistence of remaining paper-based, missing patient files, and long waiting times for patients. Participant FP02 sums it up as follows:

> *"My view is that it is poorly done, poorly managed. We have got lots of patients who have been your patient for the past 5 years and have a thick file. The patient comes and they tell him they cannot find his file. So, they give him a duplicate file. But that duplicate file will tell you nothing because the information about this patient is in the file that has gone missing. It is an everyday occurrence. Then you see the patient and you put him on the same treatment. The next time they come, the duplicate file shall have gone missing, and a second duplicate file is opened. Now if were to do an audit or sometimes just to answer queries, you have no information. So, it is a big, big problem. I tried to sort it out at some stage, with our admission clerks, but failed. The issue continues, the problem continues, there is no continuity of care (Participant FP02)."*

Participant FP02 gives more reasons for the weaknesses of the system:

"We are not there in this regard, and here I am not going to blame the people. They are frustrated, because, you know, we are supposed to provide resources for keeping records, cabinets, our infrastructure is prioritizing other things. The prioritization for infrastructure maintenance management is done without clinicians. It is important to involve clinicians because they are the business (core business of the department). Bring any component for any budgeting for infrastructure maintenance, there must be consensus to say, we have limited resources, let us prioritize this part and the other will follow. But decisions are made separately, unilaterally, you know, to give somebody a tender."

6.2.1.6 Education and Training

As has been alluded to in Chapter 2, health organizations have the added responsibility of skills development through Training and Development programmes to ensure that HCWs are continuously developed and skilled to provide quality care to respond accordingly to the ever-changing healthcare demands of society, advances in health care, revised scopes of practice (task sharing) and emerging health conditions (Feldacker et al. 2017:2). On the part of the HCWs themselves, it is expected of HCWs that they take the initiative to read and keep up with the latest evidence and guidelines, taking an active part in journal clubs and multi-disciplinary training activities (Connell, 2014:11).

This study has found that (i) absence of a skills management and development strategy or plan to guide and ensure proper HCW education and training, (ii) negative attitude of senior management towards Training and Development of staff, (iii) non-functional PMDS, (iv) lack of incentives for successful completion of academic studies (diploma or degree), (v) lack of budget for journal clubs, are key barriers to staff education and training. A haphazard staff induction programme poses a further

challenge to the training and development of staff. The resultant effect of these barriers and challenges is a poor job skills base within the Mpumalanga Health Department (Tables 5.1 and 5.2).

> *"For now as the department most of the time, we just employ and from there, just because a person has come in with a piece of paper that says I am a doctor, we expect people to be knowing what has been done and we just allow them, and even very short courses that we used to have to try and upskill your cadre of health workers that you have in the hospital, I think now it's a thing of the past, you hardly can get any training on whether it's ATLS, ACLS, PALS, and all those things. You expect people now to be doing it on their own, and if you find people do not care if they do not know, it is fine with them. You would not get people who say I will spend my money to try and improve myself in the way how I manage casualty, how I manage paediatrics, how I manage all the patients. So, at the end of the day, it becomes a problem"* (Participant DC02).

These findings are in support of findings by Naidoo and Naidoo (2018:213) that lack of support from employers to provide funding for further studies, their reluctance to afford employees time to improve themselves, and poor motivation from employees themselves, were limiting factors to CPD participation. This study concurs with Mnguni (2019:103-106) and Mosol et al (2017) findings that staff shortages, time constraints, lack of internet connectivity, and lack of finances, are the main barriers to CPD participation by HCWs.

6.2.1.7 Evidence-Based Practice (EBP) and Research

As discussed in Chapter 2, Brooke and Mallion (2016:340) state that the provision of good health care requires that change be brought about through evidence-led

research. Such change should be implemented timeously. The researchers agree that research and development encourage HCPs to use techniques such as the critical appraisal of the literature, project management, and the development of policy guidelines, protocols, and implementation strategies as tools for promoting the implementation of research practice.

CG is no exception to these notions, as confirmed; first, a study undertaken by Pather (2015:8) in the Cape metropole, South Africa, concluded that time constraints, practitioner workload, lack of financial resources, lack of ownership, the lack of timeous organizational support and practitioner resistance to change, were notable barriers to EBP.

Secondly, in another study on EBP undertaken in the Eastern Cape province, South Africa, Jordan, Bowers and Morton (2016:50) observed that EBP was increasingly being recognized in health establishments as a pivotal component of patient care delivery and that EBP in health care aims to provide quality patient care using the best available and valid scientific evidence. These researchers agree with Pather (2015:8) regarding common barriers to EBP. They classified them into those that had to do with (i) familiarity with EBP, (ii) perceptions of EBP, (iii) frequency of accessing required information, (iv) frequency of accessing best-practice guidelines, (v) information sources of evidence, other sources of evidence, (vi) inability to synthesize the amount of literature available, (vii) resistance of HCPs to change from traditional and ritualistic practices to EBP and (viii) organizational barriers that include lack of organizational support, organizational change, and operations.

Thirdly, in a recent Cape Town study that explored the experiences and understanding of family physicians (FP) in primary care about EBP and the implementation of evidence-based guidelines, Pather and Mash (2019:2) observe that little was known

about the attitudes and behaviour of primary care practitioners towards EBP and the implementation of clinical practice guidelines. Furthermore, they established that (i) evidence quality and relevance, (ii) guideline development, (iii) contextualization of the guideline, (iv) guideline dissemination, and (v) guideline implementation, monitoring and evaluation, were important considerations in the development of a framework to improve EBP among HCPs.

From the individual interviews (Table 5.1), this study found that (i) staff shortages, (ii) undertaking research that is not related to service needs, (iii) little research that is being undertaken in the department, and (vi) lack of a research policy in the department, are the main barriers to EBP, while (i) the low research output, (ii) research done for their private academic degrees, and (iii) poor leadership for research in the department, are the biggest challenges that impact the conduct of applied research negatively. The focus group interviews (Table 5.2), on the other hand, revealed a general lack of interest in research by HCWs in the department as the main barrier. These findings agree with Pather (2015:8) and Jordan, Bowers and Morton (2016:50).

While CG national policy (Tables 5.3 and 5.4) requires of HCPs to support the provision of quality health care through clinical research, the staff structure of the Mpumalanga DOH (Figure 5.1) is not supportive of such. There are, for example, no dedicated posts for DCSTs at all levels of care, and specialist family physicians are appointed as medical officers.

Failure to appoint functional DCSTs in districts, difficulty in recruiting and retaining medical specialists, and shortage of specialist clinicians in core clinical disciplines, are some of the numerous challenges that are highlighted in the annual performance review (APR) reports, as shown in Table 5.5. The review of the APPs of the

Mpumalanga DOH (Tables 5.6, 5.7 and 5.8) revealed recurring ineffectiveness of the implementation of PHC re-engineering, inferior quality of healthcare services, and non-compliance with certain PHC norms and standards, across the three fiscal years.

6.3 Limitation and scope of the study

While the study was conducted in the whole province of Mpumalanga, only selected managers and healthcare professionals at head office, district offices, and selected health establishments were purposively sampled and interviewed, thus limiting the study to reflect CG implementation barriers and challenges to the Mpumalanga province at head office, district and selected health establishments only.

CG has a wide range of stakeholders, inclusive of programme managers, healthcare professionals, corporate support managers, governing bodies (e.g., hospital boards and clinic committees), communities, and health service users. This study targeted a few middle and senior programme managers and healthcare professionals only, thus limiting its findings.

6.4 Study Conclusion

The implementation of the four pillars of the RPHC programme, namely DCSTs, WBOTs, ISHTs, and contracted general practitioners in Mpumalanga province and the rest of South Africa, has not been successful. Support for the DCST programme at provincial, district and health establishment levels has been inadequate. The researcher ascribed this poor performance to failures in the implementation and practice of CG in the department. This situation has, in turn, resulted in poor outcomes in relation to clinical audits, clinical performance and effectiveness, clinical risk management, training and development, EBP and research, patient and public involvement, and information management.

This study was undertaken to explore the barriers and challenges in the implementation of the CG in Mpumalanga, South Africa, with the view of making recommendations for the development of a framework for effective and efficient CG in the province. To achieve this, the researcher investigated barriers and challenges for each CG pillar comprised of clinical audits, clinical performance and effectiveness, clinical risk management, training and development, EBP and research, patient and public involvement, and information management. Additionally, each study participant was asked to share his/her views in terms of improving CG in the department.

The study was qualitative with participants drawn from provincial, district and health facility levels of the Mpumalanga Department of Health (DOH) using the non-probability (purposive) sampling technique. Twenty-two individuals participated in the study. A semi-structured interview, focus groups and document review were used for data collection. The interviews were transcribed verbatim by the researcher ensuring confidentiality by coding of interviewee names. The CG pillars which acted as the study objectives were used as themes for purposes of data analysis. For document reviews, selected policy documents, APPs, as well as annual reports for selected fiscal years were reviewed to establish recurring risks and overall performance of the Mpumalanga DOH.

The study found a general lack of understanding of the concept of CG, as well as inadequate leadership and support for CG at provincial, district and health establishment levels. There are barriers and challenges with each pillar of CG. The lack of policy and guidelines, staff shortages, poor planning and inadequate budget are common among the CG pillars.

CG is the heart of ensuring a health system, which is characterized by service delivery that is effective, safe, accessible and available to those who need it, with minimum

wastage of resources; a productive health workforce that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible; a well-functioning health information system that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status; equitable access to essential medical products, vaccines and technologies of good quality, safety, efficacy and cost-effectiveness and their scientifically sound and cost-effective use; a health financing system is able to raise adequate funds for health, in ways that ensure people can use needed services without having to pay for them and leadership and governance that involves ensuring that strategic policy frameworks exist and are combined with effective oversight and accountability. The study found that this concept was poorly understood by the participants. Findings regarding specific CG pillars are given below.

There was a lack of a clinical audit policy, standard operating procedures, and negative staff attitudes were the biggest barriers to the implementation and practice of clinical audits. On the other hand, challenges in the conduct of clinical audits result from the fact that clinical managers, who should lead the process, are often too busy with other pressing commitments and do not have time to conduct clinical audits. Also, clinical audits are not happening because of refusal or reluctance by the clinical unit leads to undertake them.

The Mpumalanga DOH lacks compliance with national and international practices when it comes to clinical performance and effectiveness. This is due to poor supervision of junior personnel by their seniors, which interviewees attribute to a shortage of senior staff.

Clinical risk management is not taken seriously within the Mpumalanga Department of Health. This is evidenced by risk committees remaining dysfunctional with poor

support and leadership at provincial, district, and health establishment levels. Clinical staff shortage, inadequate infrastructure, lack of dedicated risk managers in health establishments, poor security systems in high-risk areas within health establishments, staff attitudes towards clinical audits, and lack of standardized clinical leadership at the health establishment level, have featured as the main barriers to efficient and effective clinical risk management. Inability to distinguish between clinical risk from non-clinical risks as well as failure to hold routine and regular morbidity and mortality meetings are notable challenges.

PPI is poor in the department. The DOH is confronted with long patient queues, which force doctors to chase queues rather than engage patients in clinical decision-making. This is exacerbated by the non-availability of health services within some communities, resulting in community members bypassing lower levels of care in their plight to access health services. Service-related issues such as staff shortages, high workloads, and language barriers, are serious impediments to patient involvement during clinical care. Inefficiencies within the appointment of members of hospital boards and failure by governance bodies to report back to the communities they represent are common barriers to effective public involvement in Mpumalanga.

Inadequate information management systems at all levels, poor documentation of clinical information in patient files, non-availability of IT equipment, inadequate archiving of patient records and poor communication among key information management stakeholders are barriers to effective and efficient information management. This results in information management challenges, including the absence or poverty of information in patient files, the persistence of remaining paper-based, missing patient files and long waiting times for patients.

When it comes to staff training and development, the absence of a skills management and development strategy or plan to guide and ensure proper HCW training and development, the negative attitude of senior management towards training and development of staff, the non-functional performance management development system (PMDS), the lack of incentives for successful completion of academic studies (diploma or degree) and the lack of budget for journal clubs, constitute the main barriers to staff training and development. The DOH is confronted with a haphazard staff induction programme, which poses a big challenge to the general training and development of both new and old staff.

Staff shortages, undertaking research that is not related to service needs, little research that is being undertaken in the department and lack of a research policy in the department, are the main barriers to EBP, resulting in low research output, staff members mostly researching their private academic degrees and poor leadership for research in the department, as the biggest challenges confronting the DOH. In addition, there is a failure by the DOH to appoint functional DCSTs in districts, recruit and retain medical specialists and appoint specialist clinicians in core clinical disciplines.

6.5 Study recommendations

This study highlights the importance and need for Mpumalanga DOH policymakers to develop a provincial policy specifically for CG which emphasizes its implementation at provincial, district, and health establishment levels, emphasizing a deliberate shift from a corporate management system to one where clinical care, support, and governance are prioritized. The departmental staff establishments at the provincial, district, and health establishment levels, should be inclusive of healthcare professional personnel in positions such as DDG: Clinical Care and Support (CG), Public Health Medicine,

Epidemiology and Research, and Heath Economist, to name but a few. At the provincial level, CG should be provided for in the departmental staff establishment, to report directly to the Head of the Department.

6.5.1 General recommendations

South Africa has already adopted the WHO Health Systems Framework with its six building blocks. This framework is the blueprint for good health service delivery that would result in effective, safe, and quality personal and non-personal health interventions for those who need them, when and where needed, using existing resources. The Mpumalanga DOH should improve the implementation of this policy framework to ensure that there is a (i) well-performing health workforce with enough numbers, appropriate mix, fair distribution, competent, responsive, and productive under given circumstances and environments, (ii) well-functioning health information system that will ensure the production, analysis, dissemination, and use of reliable and timely information on health determinants, health systems performance, and health status, (iii) well-functioning health system that will ensure equitable access to essential medical products, vaccines, and technologies of assured quality, safety, efficacy, and cost-effectiveness and their scientifically sound and cost-effective use, (iv) good health financing system that will raise adequate funds for health service delivery, ensuring strict compliance with the Public Finance Management Act (PFMA) and leadership and governance that will ensure the existence of strategic policy frameworks combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system design, and accountability.

To implement the WHO six building blocks for health systems strengthening in Mpumalanga, the following suggested systems thinking steps are suggested to ensure that the province benefits maximally from the wisdom of diverse stakeholders in designing solutions to the identified barriers and challenges that this study has identified. The systems thinking approach links intervention design and evaluation more clearly, both to each other and the overall health system framework, and places

people at the centre of any intervention. The first four Intervention design steps include (i) the convening of stakeholders, (ii) collective brainstorming, (iii) conceptualization of effects, (iv) adaptation and redesigning. These first four steps are followed by six evaluation design steps that include (i) determination of indicators, (ii) choice of methods, (iii) selection of appropriate design, (iv) development of plans, (v) setting budget, and (vi) sourcing of funding. This study established that these steps were not followed during the introduction of CG in Mpumalanga. It is recommended that the Mpumalanga DOH takes these steps to improve implementation and practice of CG in the province.

To ensure a fundamental shift in the way health services are funded, managed, and delivered, it is recommended that Mpumalanga DOH applies the WHO Health Integrated strategy which emphasises integrated people-centred health service delivery UHC. The following five interwoven strategies are recommended for implementation in this regard:

a) Engaging and empowering people and communities: Through this strategy, community and individual resources are unlocked for action at all levels. This enables communities to become actively involved in co-producing healthy environments, empowers individuals to make good decisions about their health, provides carers with the necessary Training and Development to optimize their participation in the health of their dependents. In this way, the underserved and marginalized communities are accessed to benefit from quality services that are co-produced according to their specific needs.

b) Strengthening governance and accountability: This strategy requires a participatory approach to policy formulation, decision making, and performance evaluation at all levels of the health system, from policymaking to the clinical intervention level. For this strategy, good governance, that is transparent, inclusive, reduces vulnerability to corruption, and makes the best use of available resources and information to ensure the best possible results, is required. Good governance must be reinforced by mutual accountability among policymakers, managers, providers, and users and by incentives aligned with a people-centred approach.

c) Reorienting the model of care: This seeks to ensure the design, purchase, and provision of efficient and effective healthcare services using innovative models of care that prioritize primary and community care services. It suggests a shift from inpatient to outpatient and ambulatory care and from curative to preventive care. Using this strategy, health organizations are investing in holistic and comprehensive care, including health promotion and ill-health prevention strategies that support people's health and well-being.

d) Coordinating services within and across sectors: This strategy requires that services be coordinated around the needs and demands of people. This is achieved by integrating healthcare providers within and across healthcare settings, developing referral systems and networks at all levels of care, and creating linkages between health and other sectors. It encompasses intersectoral action at the community level to address the social determinants of health and optimize the use of scarce resources, including, at times, through partnerships with the private sector. Coordination does not necessarily require the merging of the different structures, services, or workflows, but rather

focuses on improving the delivery of care through the alignment and harmonizing of the processes and information among the different services.

e) Creating an enabling environment: This strategy requires the creation of an enabling environment that brings together all stakeholders to undertake transformational change. This involves a diverse set of processes that will change leadership and management, information systems, methods to improve quality, reorientation of the workforce, legislative frameworks, financial arrangements, and incentives.

A strong CG framework should embrace these five strategies of this framework. In this study, the author has established that these strategies were not considered when CG was introduced in Mpumalanga in 2012.

6.5.2 CG pillar specific recommendations

6.5.2.1 Clinical audits

The department must develop a proper clinical audit policy, clearly indicating governance structures at provincial, district and health establishment levels and applicable performance indicators. Role clarification of role players must be indicated and included in their performance agreements. Implementation guidelines and protocols must be developed. Routine morbidity and mortality clinical meetings at the health establishment level must be routinely done, supported by meticulous patient record-keeping.

6.5.2.2 Clinical Performance and Effectiveness

The department's staff structure must be reviewed and updated as a matter of urgency. It must, in addition, be aligned to the mandate of each level of health service

delivery as outlined in the Health Act, as amended and as a public service delivery entity, with the Public Service Act. The recruitment strategy of the Department must also be reviewed and updated to ensure successful recruitment and retention of personnel, especially the scarce skills professionals. HCPs, especially medical practitioners, nurses, pharmacists and allied HCPs should be prioritized. The shortage of medical specialists requires urgent implementation of supportive systems such as telemedicine, teleradiology and telehealth. Virtual clinical meetings should become a routine. Local training of healthcare professionals in collaboration with the University of Mpumalanga through the establishment of a Health Sciences Faculty needs to be fast-tracked.

6.5.2.3 Clinical Risk Management

The Departmental Risk Committee must include more clinicians to emphasize health as the core business of the department. In this regard, provincial specialists from tertiary health facilities should become *ex-officio* members of the risk committee. Internal control should preferably be headed by an official with a health management background. The risk management strategy must include an intense training component that will ensure that clinicians, clinical managers, hospital CEOs and programme managers are continuously trained on risk management. To prevent facilities from the risk of underperformance, the department must ensure that the appointment of CEOs and other key managers is always based on qualification, experience and knowledge and not favouritism. Mitigation of clinical risks should be achieved through regular clinical meetings in line with the patient safety incidence policy prescripts.

6.5.2.4 Training and Development

The department must develop a strong working relationship with academic institutions. The establishment of a Health Sciences Faculty at the Mpumalanga University will go a long way in this regard. Existing Memoranda of Agreements (MOAs) with other universities should be reviewed and strengthened to include training, personal development, research and CG. Within this context, hospital management teams need to be fully trained and made to understand what CG is about. It is envisaged that this initiative will also motivate staff and sensitize them about the importance of self-development.

The Departmental Regional Training Center (RTC) needs to be strengthened. Urgent consideration should be given to each health district to have an RTC to improve accessibility. Consideration should further be given to establishing a skills laboratory within each RTC to ensure ongoing clinical skills development for clinicians. The RTC should be coordinated by a team of appropriately qualified, experienced and seasoned HCPs. Continuing Professional Development (CPD) accredited training seminars and workshops should be coordinated through these RTCs.

The Bursary Policy of the department should be urgently reviewed and upgraded. An initial health skills assessment should be undertaken to establish which key health skills the department is in dire need of. All urgently required skills should be prioritized and invitations are made for communities to send names of potential candidates. Bursaries should be allocated according to those identified needs and potential candidates who would then be contracted and supported to obtain those skills.

6.5.2.5 Evidence-Based Practice and Research

The study found that currently, the department does not have a research and development (R&D) unit that innovates and introduces new health service delivery practices internally. It is well-known that this should traditionally be the first stage in the human skills development process. The study further found that while recognized as being extremely important for the delivery of benefits to the individual, their profession and the public, continuing professional development (CPD) is not receiving any measurable support at all levels within the department. This situation hampers the capabilities of HCPs to keep pace with the current standards of others in the same field.

It is recommended that a strong coordinating R&D unit be established at the provincial level with extensions in the tertiary hospitals where leadership in getting research started should be prioritized and this will go a long way in improving EBP. The appointment of properly qualified leads for such research activities will be crucial.

6.5.2.6 Patient and Public Involvement

To enhance patient and public involvement in clinical care, workshops on the importance of proper patient care should be organized for the staff and community representatives. The appointment of community representatives who are knowledgeable about health-related issues should be prioritized. To ensure that communities are represented at all levels of care, clinic, community health centre committees and hospital advisory boards must be appointed for each health establishment, ensuring that they understand their role and all health-related issues affecting the communities they represent.

6.5.2.7 Information management within the department

The study found serious gaps in information management, especially patient records, where the records, which should contain demographic, socio-economic and clinical information about the user, proper collection, management and use of the information within health systems, are incomplete. This renders the information management system both ineffective and inefficient. In this regard, it is recommended that the department improves the management of available information systems by introducing an electronic information management system and an online application system. To ensure that collected information is used for decision-making, it is recommended that managers are trained on the available systems. Often, the problem is capturing data at the facility level. For this, it is recommended that trained data capturers are appointed in health facilities and provided with functional equipment with reliable internet connectivity.

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8 Annexures

8.1 Interview Transcripts

8.1.1 Individual Interviews

Participant DC01

What is your understanding of CG and what are its pillars?

CG involves all activities that relate to the good outcome of treating a patient. All activities relating to services rendered to a patient: from the time the patient enters the facilities premises, the registration because the clerk needs to take proper information of the patient so that at a later stage we know where the patient is coming from, just like now we are busy with tracing of (Covid-19) contacts so the relevant information of the patient must be recorded accordingly. It moves on in the diagnosis of the patient that it needs to be diagnosed correctly and given the necessary treatment and in doing so following all the policy guidelines and protocols, of which it is strictly followed and then the expected outcomes that the patient would receive and better outcome to the what the patient expects – which better quality of care. That is how I understand CG.

What are the barriers and challenges in conducting clinical audits in the Department of Health?

In terms of clinical audits what I have observed is that it is an activity that is seldom conducted and when it is conducted very often there is a lack of proper communication in that when it is initiated it is not broadly communicated to the relevant key stakeholders within the facility in case it is being done at the facility level, or a hospital-level or even at a district level. It is being done in silos and then the communication part of it is not proper because you will find that only a select few of the people involved

are taking part in the clinical audit. The other issue is that clinical audit needs to be done in the urban areas, peri-urban areas, and in the deep rural areas. Very often it is done within the convenience of the person or the team that is conducting the audit, in that the facilities at the remote areas in deep rural areas, are not touched and not visited. So, what are the findings within the urban and peri-urban areas is taken for granted that it is applicable at the far rural areas of which most of the time you find that rural areas have their unique situations or circumstances that need special attention.

What are the barriers and challenges in clinical performance and effectiveness in the Department?

In terms of clinical performance and effectiveness, challenges around that issue I am not much involved in and is based on my discussions with clinical colleagues and not on information that I have acquired in my work participation, but it is information that I share with colleagues when we discuss common challenges. So, what normally would compromise quality health care of patients or clients, would be issues of non-availability of instruments at a facility level, because these devices need to assist the clinicians in taking rational decisions, in his clinical examination who needs devices to enhance and contribute towards rational decision making. So, the lack of those facilities at the clinic or even at the hospital level compromises the decision making and it impacts negatively on the patient that is being assisted.

Also, the availability of medicine contributes to compromising the quality of health care. Patients are they have been examined and specimens were taken and information that this patient needs a drug when the drug is not available, it compromises the quality of health care. Just today we were discussing the adverse events of the drug TLB which is available but in some areas is not available. That itself compromises the quality of care to the patient. The other issue that I can think of is the availability of

human capital itself, in that when you do not have the necessary workforce or the workforce does not have the necessary expertise, necessary skills, that also contributes to compromising the quality of health care.

The equipment also is a big issue, the availability of basic equipment hence the government intervention of producing ideal clinics in the context of primary health care in that there must be specific standardized equipment available at clinic level, so you still find some facilities without essential equipment in a particular facility. For them not to be available, it compromises the quality of care of the patient. There are quite a few factors that contribute to that.

What are the barriers and challenges in patient and public involvement from a clinical perspective?

The barriers between us as the healthcare providers and the patients, I would say the accessibility of health care in that it is not every village and township which has got a clinic because the norm that government is supporting is that health facilities, particularly clinics must be within reasonable walking distance within a 5 km radius, so in several areas where there is no clinic that I view as a barrier which also causes constraints ill-feelings of various nature of communities towards the officials, towards the administration and government. So, I would regard that as a barrier as it stands where clinics are not readily available and not accessible.

There are areas where clinics are available. Those clinics are there but in terms of accessibility, they are not readily accessible because the communities expect that the clinic should be accessed throughout the day, 24 hours, seven days a week. You find that as it is now the clinic is open to seven, many of our clinics are closed apart from the community health workers which operate for 24 hours. So, for me that is also a

barrier that puts a constraint on all persons involved from the community even to the healthcare workers it is causing stress to them.

Even a challenge within the community leaders because you find a community challenging the integrity and capability of some of the community representatives in that they are failing to meet their needs and their expectations because they cannot hold the health care providers to render a service that is accessible, affordable to them. So, these are some of the issues which I regard as causing a barrier to the administration. There are other points that one can touch because you find that there is a clinic, is accessible and a clinic that is available 24 hours but there are certain services that are not readily available, there are hospitals that are part of primary health care.

The community expects a hospital to provide a full range of services that can be provided in a hospital but because we categorize hospitals that when you go to Tonga, or you go to Shongwe or Matikwana you do not expect to provide the services that are provided in a tertiary hospital. Therefore, for you to access services you must commute from the rural areas to those hospitals and the transportation is also a big issue lately which is causing a lot of strain in a relationship particularly in areas of Nkomazi and is a long waiting queue for patients to tertiary hospitals, wither within our province or in Gauteng. So, there are several barriers. One can think of the budget in all these facilities but there are budgetary constraints to it and the community expect that as a CEO who is there representing government, we should be able to do a lot of things: when a hospital is dirty and you need to have cleaners, to have a budget, to have posted to be able to take a decision as a CEO and appoint a cleaner, but you wait for 3, 4, 5 months until some posts are frozen and then you will be told that the post is frozen and now you have started a new financial year, your posts seized to exist on

the 31st if March you cannot fill in the posts now. That itself causes a lot of stress, constraints within all the stakeholders including the clinic committee, hospital board, the management because they are viewed as a bunch of people who are not able to deliver. So, briefly, this is what I would regard as a barrier to both the service provider. The patient is a recipient of the service.

What are the barriers and challenges in information management in the Department?

Information management is important as a tool that must be used in the management of health care and the introduction of health information systems like the district health care information system and the HPRS and the many other information management systems is very, very, critical and for these information systems to be effectively implemented utilized, it depends on various platforms. Those platforms are lacking in administration.

The first thing information can only be delivered through technology gargets: laptop, desktop, and iPad, capable smart mobile phones. So, these things are not readily available, where they are available, they are outdated, they are not compatible with the advancement of technology. And also, the network itself, yes, there have been quite concerted efforts to get platform available but there are still challenges in that in some rural areas in some remote areas the use of technology district health information is still a challenge because we don't have current time usage of information, so we have to capture and upload and then the information can be processed at a later stage and decision making needs to be done on the spot when a doctor sees a patient and information about demographics of the area should be readily available so that decisions are taken here and there.

So, also issues relating to the platform itself like HPRS which is also an information system that can be introduced to prevent patients from shopping, they do shop in our facilities moving from one facility to the other collecting prescriptions, collecting medication. The most common one is ARVs so if we do have a good system that can prevent that because we will be able to pick up a patient to say no you have already shown up in another facility and you are here for the second time.

What are the barriers and challenges in clinical risk management in the Department?

This is not my area of focus. I depend on clinical managers to deal with this.

What are the barriers and challenges in the training and education of healthcare workers on CG?

I would say there is a system in place. However, all systems are not perfect so the same applies to the system that the department is using. There is a bursary scheme that seeks to capacitate personnel to redress skills deficiencies that the department has identified and there is an induction programme of newly appointed people. I must mention that the induction is not programmatic, sometimes it happens, sometimes it does not happen. As it is now, there are people in the employment of the department, they have been there for the past 6 months, past 8 months and they have not been inducted and the induction will be done as a matter of compliance and not as a need to enhance and capacitate the staff as such.

I have seen several people like those who have served the department for quite some time and they left because they were not accommodated when they say I have been here in the department for years I am working in this paediatric department and I think I have a calling in this particular department I want to be trained to be specialized in this field and every often that I request that I be given the necessary attention,

something that would prompt the official to resign after having served so many years and after qualifying the official normally they do not come back to the department, they go to other entities, if they still want to remain within the same area of Ehlanzeni, you see them in the private sector opening their private practices because we did not accommodate them while they are still in the employment of the department.

So, I would say there are still many things to be done and have them structured so that the training, the education, the in-service training is available to everyone who has the desire and the need and the determination to pursue studies and training.

What are the barriers and challenges in evidence-based practice and research within the Department?

On evidence-based practice or research, the first thing is that we do not have much research being undertaken in the department. That is why when I started the interview I commented and welcomed this type of research because we will be addressing problems, we will be approaching challenges from a scientific point of view, not based on aspirations or desires of what needs to be done. So, also what I will say is a barrier is a policy itself. Okay, it is acceptable that one cannot just undergo research or a study or evidence-based acquiring of information, you need to follow certain processes and protocol, but ours is too bureaucratic and there is red tape. You cannot easily just do it, you must go through several committees: we have an ethics and research committee which is not that much efficient, but it still exists to approve this, and very often the research or studies are not done for the benefit of the department per se but most if not all of the studies that I am aware of or researches they are done for personal gain of individuals because they want to get their masters or want to get their doctorates.

Personally, at a district level, all the research that is done within the space of Ehlanzeni must go through the District Manager to approve. It is a common remark that I normally put to say the study is supported on the condition that the researcher would share the results with the management of Ehlanzeni or the Department. Out of many research proposals that we approve, I think it's only Wits University, the people who have got a rural clinic in Tintswalo that from time to time they will come back and say: You allowed us to conduct a study, this is the outcome of the study, this is the result, and this is what we recommend that you implement to enhance and improve the performance of the facility. But others once they get their masters and their doctorate degrees, off they go and disappear. So that is the biggest barrier, it is the biggest challenge that we are experiencing.

What are your views and suggestions that will improve CG implementation in Mpumalanga?

What I would recommend is that CG should be viewed and be regarded as the most essential element of the administration, because a person who propagates and put CG in the spotlight is since you came here. We often hear about it compared to the past.

That prompts me to say, in our organizational structure, it should be provided for, it should be elevated and be playing a staff function. Not a broken line function. Staff function which advises the HOD just to be in line with other important components of the administration like your risk manager is not accountable to any person, he is accountable to the HOD, your auditor. So, it should be up there so that each person should view it: This CG person is the HOD, HOD is not here but when we see this person is like we are seeing the HOD. He is the ears, the eyes, and the mouth of the HOD. So, I will strongly propagate that in the organizational structure he should

prominently feature, contrary to the situation now. He does not feature anywhere, he features as a small unit somewhere under the DDG and it is suppressed, is not visible enough, it is not playing a critical role. And if it must perform, there is a lot of red tape and bureaucracy that it must go through. It operates at the mercy of whoever is in charge, and I would strongly recommend that it should be autonomous, be cross-cutting, and be able to talk to whoever is in the organization, whether is in Mbuzini clinic or whether is in a tertiary hospital Rob Ferreira or Witbank – just be cross-cutting. So, I think that if that office is elevated, it would enhance CG which is particularly important in the organization.

Participant DC02

What is your understanding of CG and what are its pillars?

My understanding about CG as a concept would be that approach that as a health system, we need to maintain so that we improve the quality of health care. The issue then is what is the quality of health care and what is expected when you are talking health quality wherein, we say it is the degree to which the health services for individuals and the population increases the likelihood of the desired outcomes.

When the patient comes to us, they expect a particular outcome. If our CG is at that level that produces quality, it will mean that at least patients are served at their expectations. Today we talk of patient's experience of care would be when we run those it will tell us as to whether we are producing the quality that we think we are producing. At the end of the day, it is an approach that needs a lot of things to ensure that at the end of the day, our patients are part of what we serve them so that at the end of the day we produce that quality that is expected.

What are the barriers and challenges in conducting clinical audits in the Department of Health?

I think, okay, it is happening, although not at what we expect because we think of clinical audits as the area to start with is to make sure that how we produce the records are that are standardized. We start with documentation audits. A proper file should have 1, 2, 3, 4, 5 to make sure that all the hospitals, all the facilities at least meet them. Before you can even look at how we can manage a particular disease, let us say diabetes, we need to say this is what is expected from protocols or this is what is expected to manage mild hypertension, hypertension emergencies, and all those.

So, if we start and make sure that at least our documents that we produce are at a standard that is good so that even if we have litigation at some stage with the patient or persons long gone, we will still be able to follow the systems. So, I think the very first thing is to try and make sure that that happens. Yes, in the few areas that I have been, I tried to produce all documents to say for a file to meet a standard we need each file to have this, and if we do that then I think we should be able to say at least what the first hurdle we have overcome and from there we look at the protocols and see whether we manage according to the protocols.

What are the barriers and challenges in clinical performance and effectiveness in the Department?

I would not say it is happening because at most we still as health professionals think that we know best in terms of what patients are expecting of us and the fact that we don't first ask ourselves in terms of what is it that patients expect of us and make sure that we reach their expectation because clinical effectiveness on its own would be how we render the best practice according to what is expected of our patients, obviously

our patients when they come to us, they expect the care that will be safe, to be timely, that would be effective, equitable and efficient and also patient-centred. Most of the time it is about me as a health professional more than making sure that I meet these six/ seven aspects of what the patient expects. It then health care came to all of us saying when we start the process, we need to know how effective our system in terms of meeting this kind of aspect that the patient expects of us. If then we do it that way then we would be able to say, yes, our systems are effective to meet the patient's expectations.

I would not say there are barriers to this. It is a mindset that we always thought we know better. In private, it might be a bit different compared to government because in government we think all the people that come to us do not know anything about their health, it is us who can tell them what is it that needs to be done. So, if we change mindset to say even patients who might not be educated and not paying any cent, they still know what they expect and we try to deal with it from the beginning, whether you from internship training when we welcome our new interns or new com servers, we make sure that that ingrained in them to say these are the things that we expect as we grow people are going to know that this is what is expected, and we will be able to grow. The old people might be difficult to change because they are used to say I am the boss in this, the patient does not know anything about how I treat him or her in terms of the things they require.

What are the barriers and challenges in patient and public involvement from a clinical perspective?

I think what I have seen as of now we think we are at the centre of the whole health system, we know it all and we hardly, if any, listen to what patients expect because we think I am the expert that is why you came to me. So, this is how we going to do it.

That is why even the outcomes at times that we expect, are not always coming out as expected because patients are not part of the decision-making in terms of their treatment and health care.

So, we have a long way to go in terms of how we make sure that we involve our patients or our clients. My thinking in terms of changing this practice is open. To start the whole consultation process, you would start by checking with your patient, although people might say that you will not be able to do all these things. But you need to know what expectations the patient, who is sitting in front of you to say if you say you have done everything well, what is it that you have done. Once we know this is the expectation of the patient or those that can be able to lay out their expectations, then everything that you are going to do, you try to do to meet the expectation. So, if that can be taught and be drilled like one other group call when you start a consultation they use this acronym of AGIE (Acknowledge, Greet, Introduce, Explain) where you Acknowledge the patient if you know the name you start by ***G****reeting and saying good morning Mr so and so, and you* ***I****ntroduce yourself, you tell the patient a bit about who you are and* ***e****xplain what it is that you are going to do, and then in the course of explaining, then you try and find out what is the expectation and after everything that you have done, you, at the end of the day you tell the patient, thank you for coming and you go through all those things go a long way in terms of making that patient trust and once we have done that patients can go home satisfied. This I think our consultation did either meet our expectation and how best we could do.*

So, at the end of the day, it might not come in as a one-off kind of a thing, it will take some time, there will be some resistance because we are used to saying we are in charge and this is what we are going to do quickly in this consultation, and I am out. But if we try to inculcate it, like I say, mostly, if it can come in our teaching that come

early when we start training our interns this CG become part of what we wish to train them to say this is what we expect as this organization of this quality of our health system and from there, I think, we should be going somewhere to make sure that at least all these steps get into their training so that at the end of the day we call this a high-reliability organization.

What are the barriers and challenges in information management in the Department?

For me, yes, I think as I said, the first issue is that of record-making first. I am unhappy about how we do because I see it even when I sit and chair some of our adverse events committee meetings. You sit and look at a file you hardly understand what this person was trying to document and immediately for some, even when a script is already written and the patient has collected the medication, if you think there was a medication error or anything, it is difficult to get to know the understanding to say what is it that this person was given in terms of this.

And other than that, if our record-making is poor, even the way other files are kept, because sometimes the patient will come today, two days down the line you look for the file and you cannot find it anywhere. So again it says to us our information system in the department as a whole is also a problem wherein I think everybody is talking going towards electronic information keeping which involves lots of money, but it will help you in going a long way in terms of making sure that whatever information you have if it is kept electronically irrespective of whether 10, 15 years down the line if something happens you can simply go back and retrieve it. This is how we can be able to get around that information, because now if a file gets lost after a week or a month, there is litigation immediately when you can't produce that document you can't even argue what you have done, you have already lost the case and you must now start

looking at the quantum, how you pay what amount we are looking at the investigation and without necessarily opening yourself from whatever you have written.

So, the issue here, as I said, the record-making on its own and thereafter how do you keep then and make sure that you go electronically, which I think will help the Department to cope. For now, we are extremely far because we always looking for files and duplicating information where you find that after few months, now you have 2 or 3 files, you cannot even follow up how you managed the patient with the kind of records you have.

What are the barriers and challenges in clinical risk management in the Department?

My issue is eh...okay because if you look at it may be worldwide when they talk of clinical risk mostly, making clinical errors is something that is supposed to. it looks very basic, it's one of the highest in terms of what can go wrong in an institution, wherein maybe from my handwriting, I said I have written ampicillin or cloxacillin or whatever and somebody from that row says he saw something else and at the end of the day something is dispensed or even when you look at your TTO's that we write for patients to go to the pharmacy to collect. When I was in KwaMhlanga every day I am trying to introduce to build some redundancy into what is happening in pharmacy, how we dispense. So that once a script can be dispensed by a minimum of four people. Yes, with the numbers that we have, because if we have one person who will get the file and go pick, one records, and when he comes from picking somebody checks what is picked against what is written and confirm that, and the fourth person will be the one who is calling in the patient and then explain how it is given. So, it is a system that, where you are building some redundancy so that even if there is a mistake, the first person has picked a wrong item, the second one who is checking and recording will

say but no this was amoxicillin, but why did you pick this kind of a drug instead of what is written.

So, if you build in some redundancy to reduce medication error, which for me is what, I think, is working because if you look at where I have been, in the USA or whatever, there is even a document that says to err is human and they were looking at the amount of medication that caused patients to die because they were given a wrong thing. Like even here at Mapulaneng I was discussing a case of a patient who was given a suspension that was supposed to be applied on the head but the patient was taking it, ingested it, and 2 days down the line the young patient I think he was 5 or 6 years, either died and now we were saying that this looks like a circus, and the doctor says I wrote this that and that because at the end of the day there was not that certainty in terms of checking. Everything was done and immediately was given the wrong medication and the outcome was bad. Well, the patient would have died or any other thing you cannot tell but now you have this item that was not legibly written, and it only took one person to give and, in that way, then you miss the boat. Whether your equipment problem or your clinical processes… just the whole thing about after you have done a ward round, the notes that you have made for anybody to follow on what you have written, you need one or two people to say yes, in the clinical round this is what has happened. We had all the necessary and all the other sections to say this is the decision that was taken, but how do we follow up on it to make sure that all that we do is exactly what was expected from the discussion and that would in this way reduce issues of bad outcomes in terms of how we manage our patients.

What are the barriers and challenges in the training and education of healthcare workers on CG?

For now as the department most of the time, we just employ and from there, just because a person has come in with a piece of paper that says I am a doctor, we expect people to be knowing what has been done and we just allow them, and even very short courses that we used to have to try and upskill your cadre of health workers that you have in the hospital, I think now it's a thing of the past, you hardly can get any training on whether it's ATLS, ACLS, PALS, and all those things. You expect people now to be doing it on their own, and if you find people do not care if they do not know, it is fine with them. You would not get people who say I will spend my money to try and improve myself in the way how I manage casualty, how I manage paediatrics, how I manage all the patients. So, at the end of the day, it becomes a problem.

The issue came in when we started centralizing everything as HIV training. We have all the budget in one unit, and you say in the department, the whole department, for ATLS I will train thirty people for the entire year or and not train the whole thirty imagine the number of hospitals that you have, and you say you going to train thirty. How are you going to select those thirty in the thirty-two hospitals? Are you going to train one person at per time or ACLS I am going to train another thirty? So, at the end of the day, if you were to try and try your staff other than the core training that they received in their medical schools, all these short courses are necessary for them. I saw the guys who were doing ATLS last week or 2 weeks ago. In their training now for ACLS, there is also the management of Covid-19 which was not there a year ago or 6 months ago because it was not there. So, it means these things are evolving and we need a training budget that will ensure that your staff is relevant to what they are doing every day if not then it will just be taking whatever they can offer if the outcomes are bad, you can look at them and blame but why this? We used to have doctors who were better qualified or better trained doing 1, 2, 3. No, things are changing, and as they change

it needs us to make sure that we jerk up all the information that they have every day of our running of the department.

So, for me, I think either this decentralizing gets backed with the training grants to make sure that hospitals can look at what they think and be able to do that, would go a long way in terms of improving services to our clients.

What are the barriers and challenges in evidence-based practice and research within the Department?

This one will be a bit difficult. I do not have much, though maybe because if I look at us in the department, I will be reliant on what is happening in the other bigger provinces and bigger institutions. There is not much that is happening in terms of, even in our protocols most of them leaves much to be desired, because we have a protocol because you trying to get something from either your Pretoria circuit, your Steve Biko, and everything, but you cannot talk much about what we are doing as a department. So, it becomes difficult to comment on that.

It is all about working, because where I trained this is how we were managing this condition, and somebody says I trained in this circuit and this how we were managing this condition and you find that sometimes protocols may not be aligned but at the end of the day we all think we are managing the one kind of disease.

So, we also need us as a province, maybe we may not be re-inventing the wheel but it's something that has been done and has been working and we adapt it and make sure that at least a unit may be from our 2 tertiary hospitals coordinate to say this is how we will manage this condition so that we get something from consultants in those levels then at least it will filter down to regional and district hospitals or at primary health care, and we know that we are doing it the same way everywhere. But for now,

it is about where did I train, this is how I am going to do things and that is a lack a bit in that instance.

What are your views and suggestions that will improve CG implementation in Mpumalanga?

OK for me, yes, as I said, maybe when we welcome our new cadres it is one of the things that we need to do to make sure that other than that we welcome have done provincially and everything if we have documentation or any presentation that we can have to say this is what is expected of them but other than just the juniors.

The people who oversee CG in the institutions know that we have what we call the PMDS and everything, to say, yes, I am going to put some of this as part of my performance expectations. But it is not only enough to be on the PMDS and say you are assessed according to that because if the person in charge of CG in the hospital does not see a value in that it does not matter. That teaching that happens when you welcome your interns or community service doctors will just be bad and nobody will follow it up.

So, the first will be to make sure that all the clinical managers have the same understanding about what CG is, have some workshop with them or even with the nursing service manager because it is not only about doctors. The nursing service managers should also be involved in terms of how nursing is done in terms of improving that quality. If these two areas out of the clinical training or provision of service have the same understanding, then they will be able to make sure that interns and doctors are followed up to make sure that they improve in terms of what services will be rendered.

So, for me, it either be not only new doctors or clinical managers that are appointed, even all the old ones in their meetings that they have there is this kind of training to say this is what we expect of you and it should be monitored that it happens in every hospital that at least we follow the…we not only received it once at the end of the year when you are assessed and for money or whatever to say, yes, I have done so many clinical audits, I have done this. That does not help as such, we need to make sure that what is inculcated despite the…. If we, do it that way, I think for me we might see an improvement in terms of what we do. I will send you something. There is this course that we attended that was run by Prof Pillay wherein they are looking at hospitals. He introduced this when we started to say why hospitals should fly.

So, everything that we were looking at health sector comparing with the aviation industry to say that why if there is one air disaster accident or airplane accident, they stop everything and restart to look at what is it that has happened, why did this happen and everything to make sure that at the end of the day such things should not repeat itself. But with us as healthcare professionals – today you have a maternal death because of PPH, hardly may be in the same hospital in the next 2 months or 3 months you might have the same thing on, even the next week without having gone back to say but what has happened, why did we get back to where we are. So, they talk of what we call a high-reliability organization such that if we make our hospital a high-reliability hospital to make sure that we assist our operations to make sure that everything that will happen, you quickly identify an anomaly. If a patient presents with a post-partum haemorrhage (PPH), why did you have post-partum PPH? The skills were not good enough, without looking at a lot of things, you say let us help the doctor in terms of improving the skills without looking at a lot of things. You look at ... you are reluctant to simplify, you are preoccupied with failure. You look at what is it that can

go wrong in me rendering this service, in me taking this patient to theatre for this small procedure. And if you look at all those things you try your best to make sure that all those things are part of the … If there is a problem, we do not call senior managers to say let us discuss so many PPH. We must start with people who do the work because the problem is you get the answers from the people who are doing the work on a day today. Then senior managers can come and say, ok, this is our strategy to make sure that whatever we are talking about should not happen but in our case, most of the time senior managers will discuss the number of maternal deaths and everything and come with strategies without necessarily involving …. So, if we would come out and say our organization or health system or our hospitals are reliable, high reliable organizations where you are sure that the patient that goes in has a better chance of coming out alive than what is happening now as we run the health system.

Participant DC03

What is your understanding of CG and what are its pillars?

My understanding of the CG issue that under CG, is not it that we are rendering support to the clinical people, the core. So, the core needs to make sure that they render quality services that are free of medical errors that can happen so that we cannot be sued for adverse events that can happen in our clinical setup. So, that is my understanding of CG, to say, it is to make sure that we manage that part to make sure that clinicians render quality services that are free of medical risks. Yes, to make sure that if we have all the available staff to render the service. Let me take the example of if a patient is to undergo surgery, then we need to have an anaesthetist as well as a surgeon. So, the surgeon has skills for anaesthetics but cannot be the same person that is doing both roles. So, to avoid such errors because sometimes you find that a person can do it and save a life, but if there is an error or an adverse event, it

turns around and you are no longer a hero, but you can even be expelled from the Health Professions Council.

What are the barriers and challenges in conducting clinical audits in the Department of Health?

I think the first thing before we even have the clinical audit, we need to have the protocols in place so that we can conduct the clinical audits. So, I think eh although I have never been exposed directly, we need to have the tools to conduct those audits and make sure that there is compliance in terms of the implementation of the protocols that are put for people to carry out their functions.

What are the barriers and challenges in clinical performance and effectiveness in the Department?

In terms of clinical performance looking at the issues of the – as you mentioned that there are several litigations, the number of litigations show that the clinical performance is not up to scratch. And my thinking, the reasons or the causes that might be that our staff might not be pre-skilled, or they need to be re-skilled on certain procedures. For some errors you find that they would happen because people have overworked themselves, they are doing extra overtime and they do not rest due to a shortage of the staff, of course. Then they do not rest and when they come, they are exhausted, and they would not perform appropriately which would lead to medical errors.

So, that is my assumption to say that might be the cause and others might not even be working overtime in the government, they might be doing their locums elsewhere then they are exhausted when they come then they make those errors. And I think in most cases they are not keen to sign performance agreements and be assessed in

terms of the performance management system, so you find that they would not have anything like to commit or operational plan to say this is what I must do. So, you find that a person would just do any harm because they do not have anything that is binding. Because they are very reluctant to sign any performance agreement. From my experience, I do not know now if they do but normally, they will not want to sign and be assessed.

What are the barriers and challenges in patient and public involvement from a clinical perspective?

In terms of patient involvement, I would not say we are involving them as individuals, but what I know is that we plug those Patient Rights Charter, they read them but involving them to explain what is happening to them, I do not think we are meeting that one, but in terms of community involvement I would say the hospitals have got governance structures called hospital boards. I would say the hospital boards are the advocates for the community that we are serving. So, where there are hospital boards functional, I would say there is community involvement because they know exactly, they play an oversight role on what is happening in the hospital, so they know what is happening in the hospital. If they have their regular meetings and they are fully functional. This is how I would say we involve them. From experience, sometimes you find that they are not fully involved, and some of the facilities do not have those hospital boards, but where they are, the expectation is that they would be told, they would know exactly the strategic plan of the facility, and all the - and have the APP or the operational plan, they would know exactly would get addressed if those objectives or those activities are being carried out.

So, I will say if they have regular meetings, they would be privy to that information and be able to go to the hospital to visit them as and when they feel. They need not wait

for the meeting to know what is happening in the hospital. So, that is what will be happening but, on the ground, I would not be sure what is happening. But sometimes you find that the community would be protesting outside the hospital and then you ask yourself where the hospital board is if the people are then complaining about what is happening in the hospital. So, I do not know from the hospital board if then they do take the message back to the community to say this is what we discussed in the hospital, and this is what is happening. In most cases you find that the community thinks that is where we have the gap, we are having a gap. Even feedback and giving feedback to the management to say no we attended a meeting with the community, and this is what they are saying about our services and all that. So, from my experience, because I have been a CEO before, I have never experienced that, to say they go back to the community to feedback to them and then the community comes back.

What are the barriers and challenges in information management in the Department?

The hardware, let me say that, but the relevant software is what might not be having, the relevant software that we need to be having. Because you could find that, let me make an example of HR, to say we were still receiving applications like manual applications, and just recently we have explored that issue of having online applications which we will be starting to do this month. But if you look at … without the using the information management appropriately it causes a lot of delays which impact on the delay of the filling of posts because now if you look at the volumes of applications that are received and the time it takes to process one post, it is a lot of time and we do not meet the turnaround time. If it is electronic, it is extremely easy to use the system because it will just do the shortlisting and you do not need people to work overtime to do shortlisting, to profile the forms because they must start sorting

them properly, and then there will be shortlisting process before the interviews. It takes more than 3 months to conduct interviews for one post. So, also, in terms of the DHIS, it is not accurate information that is out there. I do not know if it is a lack of checking what is captured on the system because you find that some of the information is not so accurate. But I am not sure now because there are other systems that they are using like the HPRS or whatever, how those work, but once the information is not correctly captured, then it becomes a problem, and you find that some of the indicators are not even appearing in the DHIS as those indicators that might be assisting us as the Department. For instance, the information on Allied HCPs is not on the DHIS. So, then you can see that once you do not have the information then you must go to the manual registers and dig the information if you want to see the workload for the Allied HCPs, it is not there.

What are the barriers and challenges in clinical risk management in the Department?

The issue here is that it is more, the managers will take it as more of a compliance matter. For instance, last week we had a risk management meeting, and then you know you find that we as managers we do not submit reports as and when required, like your quarterly reports then you find that when the quarterly report, because of the workload that people are having they would only remember when they are reminded. It is not like; I do not think it is advantageous to say hey the issue of risk management is critical because the risks are a barrier to you to achieve your objective. But there is something that we still need to be instilled in the managers because even what especially us in programme one, you find that managers do not have an insight on the issue and even when you go for the first session where you will identify risks the attendance would not be good. People do not show any interest. It starts there before we can be able to deal with the risks. But I am not sure what needs to be done to make

sure that we as managers take risk management seriously. So that is what I have observed to say we do not respond timeously to the ..., We do the risk management plan, improvement plan but then to monitor the implementation it becomes a problem. We are having a challenge in terms of monitoring and evaluation of whatever we do. We are lacking there.

What are the barriers and challenges in the training and education of healthcare workers on CG?

In terms of HRD or HR Development, what I have seen is that before we can be able, like in-service training, we must sit with the person and train the person on the job so that he is competent enough as a manager, then I will not be able to impart the skills to the other person. It starts with us to say are we as managers capacitated for the job that we are employed for before we can do in-service training. Other people you will find that a person knows the job but does not have the skills or the patience to take a person through the job, because what I have seen is... eh... let me make an example with HR. We employ the people and we expect them to know everything but without taking the people through and showing them the road to go, then they won't perform and we blame it on the people to say this person is not competent and also the issue of… because we do have a workplace skills plan; each section must have the skills that are required for the workplace skills plan but what I have noticed is that the gap that we are having is that we do not conduct a skills audit because that is where we need to start. That is the first gap, conducting a skills audit is not happening. We rely on the people to say I need to do this course then we would tell the person because the person says, and I would recommend. But to say these are the skills that are required, and these are the skills that the people possess, and these are the gaps, and let us address these gaps is not practically happening as it is supposed to be.

Let us say we identify the needs without conducting that skills audit, when you come now with the workplace skills plan and submit it for implementation or approval, you do not get the money that is supposed to be allocated. We are supposed to be allocated 1% of the wage bill, then you find that you are not given that money because of the constraints and people end up not attending the course or we end up not implementing the workplace skills plan that we planned for that fiscal year. And then people get discouraged to say every fiscal year we tell you that we want to attend this course and then I am not sent to that course because there are financial constraints then people get demotivated in that regard. But also, you find that other people are not... they do not have insight, they do not want to even go to any training. They enjoy just sitting and doing the work from where they are and do not even want to be rotated to learn how the other sections working … you do have those people but then they also need to be motivated and be told the importance of developing yourself.

What are the barriers and challenges in evidence-based practice and research within the Department?

I think there, we are not yet there. I know we do have a research unit. They have established it and we do have… last year they launched it … after that, we will see the results, but we did have the research committee but very few people would show interest, but I do not know how we can market it so that people would know that we must do the research. But I do not think it is that effective because I would say the first thing we need to as the department to say let us identify the challenges as the department. We sit together as the management and identify these challenges and make sure that we are practical in terms of that research to say let us focus on these areas of research and make sure that people do research but what I have seen is that you will find or you will see those topics, but you would not find people being interested

in doing those topics. Maybe if we had involved the relevant stakeholders in producing the challenges, to do that, but then if maybe a few people would see it and then identify the topics and then people would not be interested in those topics. That is why we are not assisted on that one.

And, we do not have a senior manager responsible for research in the department. So, that is another reason currently we have a deputy director that is responsible, and you would know that once a person is not at a higher level, then your voice cannot be heard as much maybe as if it was a directorate. But I do not think it has been given much attention. There is a post of research and epidemiology that is vacant although it is not funded the HOD said we need to advertise the post. Maybe once we have an appropriate person that is placed there, we might, it might yield good results I would suppose, because that person might also have epidemiology and would be able to look into... because obviously if the person or the senior manager was placed in that post, just placed there because he was displaced from somewhere and then they said no, let's look for an available post, and then the person was placed there and the person was about to go on pension. So, I do not think it was fair for her to be put there because she did not have the necessary expertise to be in that position.

What are your views and suggestions that will improve CG implementation in Mpumalanga?

I would say to involve the people on the ground on the issue. Because they are the ones who know exactly where the challenges are. Because if we focus on... we as head office people we do not know the issues right there on the ground. But if you go to the districts and talk to the programme managers directly or to the clinicians or even the medical managers or the senior medical personnel or even the junior, they are the ones that know exactly, they will exactly tell you what is. where the challenges are

because those people have a lot of information that we do not have where we are sitting. That would be my suggestion. Although we do conduct the staff satisfaction surveys, we also need to look... are we including the key on those staff satisfaction surveys?

Let us look at them so that because they are conducted every year, to say are they addressing what we want to address. Ms. PM is dealing with staff satisfaction surveys, so I would advise that we, we just look at her questionnaires to see if they are really, effective or are they giving what we need to. I think let us make use of those staff satisfaction surveys. The same would also apply to the client satisfaction survey because also quality assurance they do the client satisfaction surveys, so, you touched on the patient involvement, which is where, but I do not know what is covered in those client satisfaction surveys whether they fully address what we need to know. So, you need to look at both the client satisfaction survey and the patient satisfaction and see if we cannot get the information.

Participant DC04

What is your understanding of CG and what are its pillars?

I was just trying to produce a proper PMDS for a clinical manager on that level, and I was still busy with that but there are so many things coming up. The moment I am done then I think about something else then I start afresh. But for me in CG there are four pillars. As you speak, I was thinking, you know one of those 4 pillars that I have in mind and I think I will have to give you those later because as I see it you caught me slightly off guard, I do not know what you are going to say and what we are going to do. But for me, there are four outstanding pillars and those are the ones we must

look at, you know, looking at a hospital of that size and how you would go about those. So, I do not know if you will ask questions about those.

What are the barriers and challenges in conducting clinical audits in the Department of Health?

When we had, a couple of years ago, the COHSASA idea of doing certain things in the hospitals in setting standards, I was a little bit unhappy with the way they handled that in the sense that they did not tell us what they wanted, they wanted to see what we have. Now clinical audits, what I have been trying to do is to produce a universal tool that would work for all sixteen clinical departments in Witbank Hospital. Now it does not apply to everyone, but everyone must do what they think would be appropriate. So, clinical audits are extremely important. But what happens now, it is a little bit biased, in the sense that they are trying to work around that to get a proper score, and that is not what it is supposed to be. There is a tool, a form, that you need to fill in with this file that you have. But I think, more than on hand sort of thing, if I go there, take the file, and do my audit, I would like to, on the spot, rectify the problems.

So, auditing for me is there, it is not having thirty files audited for the month or for the quarter that I have a form filled in and presented to the clinical manager and CEO or further on. So, auditing for me is extremely important but for me, it is a sort of, I always say, a teaching platform on site now. I can give you a good example: What you see in the ESMOE files in maternal death assessment. If I do a maternal death assessment where the mother suffered an anaesthetic death, and those files are confidential. If I go through that file, I would like to write there. Now because it is confidential, I do not want to call another official and say look, I am sorry to see but things went wrong here. Let us talk about it, let us see if we can rectify it in such a way that I do not want to

offend you, but I want to help you. For me, that is where we sit with clinical audits and the answer thereof in preventing such things.

What are the barriers and challenges in clinical performance and effectiveness in the Department?

I once attended a session between universities and provincial management and there was a break where we did not have anything to say, and I had to come in and I said everything for me comes down to attitude. If you have the attitude, the right attitude, you would be able to perform better and you would be much more effective in what you do. Do not wait for me to give you the guidelines and the urge to go on and do something. It should come from the inside.

One of the previous deans at the University of Pretoria, Prof Tanyani Mariba, said one day: working in Witbank Hospital is a calling, and if you do not have the calling and the attitude, you will not have the performance, the activity, and the output that one would expect from you. So, that comes from the inside. Within the guidelines and what is expected from you, the way that you perform is from the inside. There are so many operational plans, guidelines that we put up everywhere on the walls but if it is your inside it will go nowhere.

What are the barriers and challenges in patient and public involvement from a clinical perspective?

We are there in providing the facilities with more than enough resources. The big gap is between the public using the facility and understanding what the facility can provide in them have the correct care that they think they would get. An example would be, for example, that a patient would by-pass a clinic, go to the hospital directly because of the expectation, whereas I have a family physician, a specialist in that sense, being

2km away from you and that would be able to help you and guide you and decide whether it is necessary for you to go to the higher level.

So, we have a facility, I do not think we have enough workforce, but I think we could try to provide but it is also the same that, you know, that the public knows can provide at a higher level. To be frank the hospital boards was a clever idea and unfortunately some of the board members, do not produce that expectation. We had boards where it looks more like a court case: coming in and saying the hospital must present, and then the board will go out and come back and ask questions. How I see it from the hospital side, is that you are our voice, and I would like to please for example now please go out and go and be public about the constraints that we have as the hospital, and by you just going there you are creating a problem instead of solving the problem or being part of the solution. So, my personal view is that I understand we now have a new board, luckily one of the board members who was a member of the previous board was a fantastic person, and I am so happy to see her there because you can call on her, she will be there and will take the necessary message across. But some boards are not at all functional and I do not think give the correct message across.

I think clinical committees no, but I think clinical committees if we would like to have clinical committees for example. I try to call now a meeting with clinical managers in our district to discuss what we have, the constraints we have and how we can help, is there anything that you need us to help you with. That is useful. Unfortunately, everyone is under a lot of strain with the demand of workload in those hospitals in that we would call a meeting and would get two instead of six. So, does it work? And my suggestion to Mr. Letlalo was that cannot we just have a zoom meeting with everyone and have a discussion around certain things that we would like to put forward. So, yes,

it is we are at that level where this type of conversation media would be appropriate for improving the format that we are supposed to have.

What are the barriers and challenges in information management in the Department?

I agree with you 100%. I think the support one would get and to be able to use that format effectively in distributing information that is useful in what you want to do, is most crucial. If you were there, and I was there, I was forced to go there and you would be called into a meeting, a management meeting. You know all the information, this is what you plan, this is what you are going to do and tomorrow you will give a report back. And I think that does not happen now and at the crucial time that we are having now, it is key that we have that sort of information coming through to us and we need to provide that information for the better for everyone. You cannot sit in an office and run your farm on the outside if you are not there to negotiate with the people on the ground: where are the problems, what can we do and how can we do this effectively. So, I was keen, I was instructively keen to get information across from all sectors. I always said you know if I get a message now on a Sunday afternoon saying how many medical officers do you need to cover this? I need to think, and I need to consult and plan. And there is a thumb sucked information and it comes up at the end and that is what you say, type of thing. There is a huge gap there in our planning and our consultation regarding what one can do. About patient records, it is appalling. There are so many patients coming in. They make records for them in files and then if they cannot find the files and the patient is in front of them, they make another one. The keeping of those records, during this Covid thing where we walked around and looked at space and what one can do, and we made many such rounds around the hospital, we discovered that there are heaps of patient files. Now if the lawyers ask me to get a

file, this specific file, may be above in ward one, it could be in Paeds OPD, it could be in archives, or it could be in just in the patient admin.

So, that system does not work. It is terrible, and I get letters from lawyers and even from our legal department to say can you please find the record for this one. So, our record-keeping, there are two things about record-keeping: it is what we write in the file, but it is also helping if the file if we can find the file to get the information, which is terrible, that is not good enough.

What are the barriers and challenges in clinical risk management in the Department?

I think, there is, if we want to go into risk and what are the risks around, if I could look at Witbank Hospital where I have been for 20 years now, there are so many risks. Unfortunately, there is not a person trained, looking into that that can guide and help so that one can plan.

So, we do not have anyone trained to investigate risk management. So, what we trying to do is just to get ideas here being to try and put that together and to produce a risk file, which does not produce something proper that one can use and can work on. So, there is a big gap in risk management and in all spheres of managing the hospital in total. I think if you look at clinical for sure, but I think also in the health support services. There is a lot of risk in health support services and if one looks at the pharmacy, at the NHLS, at financials, for me there is a huge gap that we can be able to reduce. So, we not doing well there.

What are the barriers and challenges in the training and education of healthcare workers on CG?

They always try to do training and put training forward because, Witbank used to be, when we started it was a steppingstone for people to improve and to go further. That would be on a clinical basis, it would be medical, it would be nursing, but also the other fields of support system: Technical, Public Works and all those would come in and work and learn and be trained, etc. So, I think we did always well in that. One thing that Tanyani Mariba taught me, was that there is a big problem, not only in Witbank but also in the province where we need to produce a system where we get people back on to the flow of teaching, training, and performing and improving yourself and building skills that is needed. So, that entire system almost fell apart. You know it is about 10% where it was a ninety-five.

But what we do is, and if I do the PMDS as I am now looking at the PMDS as in my acting process as a clinical manager, the PMDS that come in, I make sure that there is proper training for each person coming on board. And what we do now with the Covid thing, is we identify the person who has been involved in such previously and say this is your job, this is part of your job. You are going to make sure that everyone is trained properly on what is expected as far as this is concerned. This morning in our exco meeting I said we should allow him to go around with a valid history, visit the hospital and make sure that people are trained. We keep a record of those who trained and do not make an excuse and say I cannot do this because I have not been trained. So, this is one of the major aspects of us and the way we go along with our employees, who say the training was not done. There was a time we looked at the placement of interns and com serves. I complete my form on the maternal death assessments, one of the test questions turned down to that one. What is the experience of the person and what time of the day was it. We have seen that most of the patients would appear

at night around midnight. In other words, the junior would be left alone, there was not on sight supervision and that's where things go wrong. So, that is true.

The second thing is that the idea that the community service doctors must go out and work in the district hospitals, is fine but the district hospitals are not always good in training and guidance in improving the skills and I can make an example: if you take Bethal Hospital for example. The community service doctors who go there and the junior medical officers got put into a position that they supervise community service doctors and we used to have that in Barberton Hospital. I think the two best district hospitals we have in my time that I was there, was Barberton and Bethal Hospitals where we, almost nursed those community service doctors into getting into a better position than they would handle certain things which to us were crucial and very important. But there is a gap, and I have always wondered about this when there was a time when if interns come to my department, I could always tell you where they come from, but one can clearly see that and is not always about the academic training of them, but it is also about, you know there are 2 things: there is a difference from graduation and education. You graduated but you are not educated, you do not have that attitude that is conscious of, I need to do things properly and you are here with a person that you do not like but a person who will teach me and train me to do a better doctor. That is what is happening here. So, yes, we miss on that one. Our motto in Witbank is that any person who wants a bit of training in a specific department, comes in stay with us, we train you and we send you back. We just had a couple from, specifically from Bethal, in Obstetrics and Gynaecology for training so that we can see if we can reduce the numbers of maternal deaths.

The other epicentre is from Tshwane. We need to focus on KwaMhlanga, and I do not know if these are community service doctors. I do not know the doctors there. But it is

important that we do, that we fill that gap, not specifically with community service doctors, but medical officers, junior medical officers, and all those in that sequence who have been there for quite a while and have forgotten all the basic things. Yes, there is a gap there, a huge gap. I want to confirm those because we, but we do not have any concrete evidence that that is the case, but I presume it is, and I think if I look at the clinical notes that one would get, it looks like someone is trying to, I almost want to say gather, and it could be from that perspective. We try to incorporate them in, when we had, I used to do a lot of outpatients and we do teach, and training and they would invariably say that they are busy. I was once invited by, I do not know if it was a pharmaceutical company, to Hazyview talk to them. I was shocked to see how many of them were there. It looked like the whole of Ehlanzeni came, on a Saturday. We did a proper, nice session and it went very well. So, it is timewise they are busy in their practices, they think they are good because they are experienced, but they are not experienced in terms of doing newer technologies, and I think, we said the other day we must re-look the appointment of the sessional doctors.

What about CPD points as an enticement?

That could be but it needs to be properly audited and done correctly. Because just doing the session, I recall one or two names, and, in fact, the one I want to fire because really, he is not doing what is expected from the person, not supporting, but they are getting paid for it. So, we need to take care of our sessional doctors, I do not know how many they are, but what do they do and to what extent do they teach and help. I mean there is a lot of value in that way they work in private. And now they work in the public sector. they need to bring that wisdom and share it with your doctors but, I do not know if you know Dr. Zimu. Dr. Zimu is, I do not know if he is still working. He wanted to work in Tintswalo, I think he still working for free. But he is the type of person

who would teach and train the youth, he would ask the juniors to assist him … I mean there is so much they can learn from that person. Then there is Dr. X, if you phone him, he says he is busy, he cannot come now. How can you be a sessional on call and you are busy in your private practice and cannot help a junior who needs you now.

What are the barriers and challenges in evidence-based practice and research within the Department?

I think as far as research is concerned, it had always been key for the University of Pretoria to say to so many registrars and consultants that research is so important and must be done. Unfortunately, with staff available, it never got to a point where we would do proper research. The only research that took off, was when a certain Professor investigated malaria and that was a little bit of research that we could, that we managed to do. But now, with basically no one there, we have two registrars in Obstetrics and Gynaecology, and because of this Lockdown and us not having theatres are not operating and therefore they are not functional.

So, research at this stage is zero, which is a pity. We could have done a lot more with so much more material and that we could do a lot more. I think the guidance and the, you need to put a little bit of fire into someone to get them to research certain things. And if you look at the registrars and half of the registrars, the main impediment is research. They do not need time, pass exams, and research not done. So that is that. At some time, I used to walk around and attend the clinical meetings in the morning just to see how they do and what they are up to.

I must say that all the clinical departments have their morning meetings, have departmental meetings, and where they also do presentations on certain topics, and they need to report to me quarterly. I want to check on the departmental meetings, I

want to see the academic meetings, how many of them have been done, I check on the clinical audits if they have been done. And there one can see that they do have these academic meetings and if someone has a topic, they do a little research, reading, produce a proper thing. You cannot just thumb suck and make a PowerPoint presentation to the rest of the staff. The consultants sitting there, of course, are going to ask you questions. That is still going on. Not necessarily in all the departments but some of the major departments still do that. And that is not at the level that one would expect it to be for such a level of hospital, but that is something that is still going on, but if I can say 35% instead of ninety.

What are your views and suggestions that will improve CG implementation in Mpumalanga?

If we look overall, not talking about Covid, Covid now side-tracked us completely from what we do, because we have other patients as well. I think the idea of having specialist teams in the three districts, was a clever idea. Unfortunately, that did not happen I think apart from Ehlanzeni where there was some of it, but in the others not really. And if you want to have a proper clinical service with teaching and training, we will advance the quality of service from clinic level to the district level, to tertiary service level we need to improve the skills of everyone. And that is not only the doctors but also the nursing staff, it is the support staff as well and all of that. And that was a great idea, but unfortunately, that did not come through, that is one thing. We need to start from the bottom. and if things go wrong.

Would it be a thing that we need to revisit if it were a clever idea?

I think so, and I think need to start there. We cleared this with Prof Jack Moodley in the sense that because for example maternal death assessment is a confidential

inquiry into deaths. But it leads to litigation and that has caused us so much more and when I spoke to Advocate Charles Ndhlovu of the departmental legal unit recently and he showed me what is on the table. Now if we could have corrected what is on the bottom, we could have decreased the beginning. So, my take would be to help people if we have enough to go down to the district hospitals and… So, if we improve the service there, we will improve the service at the top and not have so much of a burden on the top where must identify the problems. So, I think that would be one thing that we do.

Secondly, teaching and training is an important thing that is ongoing, and they must not see that as a witch hunt, they must see that as support that we are here to help you and guide you. And the third aspect is I think it should come from top to bottom. I know the top is busy, I do not want the job at the top. It is important and it is crucial, and I can see why. If I were the chief director, I would avoid going to the hospitals because if I lend there, they are going to come forward with millions of questions and I must sort that out now. And that is almost impossible, it must not be, look, I know we need more nurses, I know we need more cleaners, but what can we do with what we have. We are here to support and help but and I think that support from the top is key in supporting the staff at the bottom.

You touched on a crucial point where you said the budget is limited and the way we operate now is no longer guided by the required services, but it is guided by the availability of money specifically. Now it then raises the point or the question of activity-based planning and budgeting. Do you think that would not improve health service delivery?

It is difficult to, for example, when we must compile a budget for a centre such as Witbank Hospital. I will say it is easy, there are 382 beds, National says it costs you

R3200 per day per patient, which is your budget. Now I would say we make sure that we do not have 382 patients in the hospital, we going to have 230 patients in the hospital. That will give us the saving. So, while we have 5 patients in the orthopaedic ward, going out with a wheelchair, sitting outside in the sun, that we could have done or sent out to a district hospital, say, if you want to go home let us call you next week and you come for your operation, 2 days later you can go home. So, I think that case management, better planning, and how we get patients in to get done so that you get a good turnover in the surgical division of the hospital, would make a huge saving on what we do.

We have a lot of sick patients in the medical wards and there is not much we can do on that side, and the third thing that I want to say is that maintenance is a big problem, and it is costing us a lot of money. Now, if we have a leaking tap, we need the contractor in. I can fix the tap for R2.50 because that is the cost of the washer, but now it is R1 000. We need to fix three geysers. The cost is R4000 per geyser, but it is only the element. I mean the whole geyser with the element cost you R2 000. So, how come you now ask me for R4 000 per geyser just to replace an element? That is something that has been there but not addressed. Another thing is that our maintenance budget is going very quickly, and many things are not working in many hospitals because we do not have tight control over those and with enough money available, we can do a lot more for our patients, than this fruitless expenditure.

Participant DC05

What is your understanding of CG and what are its pillars?

My understanding will be that it is more of a system that ensures that patients receive superior quality care and that it monitors from the service that is being provided, to

training of the personnel. Putting all the resources that are needed to make sure that the service that is given to people is of decent quality.

What are the barriers and challenges in conducting clinical audits in the Department of Health?

The clinical audits, I think this where we lack much as a department. I think most institutions do not do this. But, I think, the challenge, and I will talk from the district because of the experience that I have from the district level and where I am now. There is a huge gap there, remember when you do clinical audits, you need to bring the files, run through them, and evaluate in terms of what services did people receive. But as a clinical manager myself, I find it challenging, imagine how many committees that are there, that I must sit in as a chairperson, but at the end of the day, also the fact that there are staff shortages, you must juggle between doing the audits and the many meetings that are there. The issue of staff shortage is a serious impediment in terms of auditing the files.

For me, I would say audits are not on board, because if look at the district level, we used to have the CG committee there. Most of the doctors would complain that they do not have time to do these audits. So, the staff shortage becomes a problem to do the audits. But we were not given enough in terms of the hands. I think that would have been better there. The little files that you audit, you do formulate a position and say this is the position, although it is not representative of all the cases that are in the institution, then the issue of having to say may be based on what I have found, this is maybe the midway to go and say let us implement. It is difficult to implement some of the recommendations that you have picked up because number one, you have protocols that are there that need to be followed and they sometimes feel that you are

interfering with their autonomy as a clinician. Now you are guiding them to say this how you must do it, sometimes they feel that you are interfering in their clinical issues.

What are the barriers and challenges in clinical performance and effectiveness in the Department?

In terms of evidence-based practice and clinical effectiveness, we are also well challenged there, but I think even the training, remember, from medical school, I think the training thereof, is different from what you find in the practice. I will say, the barrier is the way we have been trained. The training is the challenge there, because the training is not, let me say this thing of business compartment makes it difficult to say this is evidence-based or anything. It is more like it is a one-way but without evidence that supports your training. At times, I can use a small example of someone with flu. I mean we have all been that it is antibiotics until evidence realized that these things are not supposed to be done. As I am saying I am blaming it on the training that you received as clinicians.

But, of course, that training has since changed over the years. We used to focus on one training platform: the medical school and the hospital, and then they changed to say let us also experience community health out there by going into primary healthcare facilities. Do you reckon that that has not assisted to bring us closer to where things are happening?

Probably it would have helped, but the problem is, I am thinking, based on what I am seeing happening to junior doctors now, because we take them and send them let us say to a clinic or PHC level, but there is no one there to even supervise them, nobody even does checks and balances and say but what you are doing is like this. So, you are running on your own, and because of the established opinion that what you are

doing is correct. So, supervision, I think, is still a problem. There I would say it might assist but you need to have someone you need to have peers who will guide you to say but this is not how it is supposed to be. I know at that level, but you also need the guidelines that are there, the booklets that are there to guide people in terms of how to manage patients and the like. Those are the things which will assist there: a peer or a more senior person, to guide you.

What are the barriers and challenges in patient and public involvement from a clinical perspective?

There is progress on that side. I remember, as a child when you see a doctor there, you will see a sort of a god person there, and they just do what they, at times as if they know it all, you go in, they do not check you and they give you medication without any explanation. Now things are getting a little bit better, that people are involving both the patients and the families and other stakeholders in terms of patient care. But I also think the fact that people are getting more educated becomes a little bit ... because, in a way when the patient comes in front of you, he is the one who starts to pose questions to say you also check on this one, do you think I might have this and that. So, the education of the patient, I think over time, is also assisting. There is progress on that side in terms of involving the patient. But when it comes to seriously a full informed consent, we are still paternalistic, that when I say this and this what it is. Exactly what is happening in Western Medicine, we only know that option and no other option. So, it is difficult for me to advise on any other, even today you can come across a patient to say Doc is this working? It is difficult to make comments because of that. But I think, as I was saying earlier on, there is progress.

What is your comment on hospital boards and clinic committees? Isn't it that they are supposed to form a bridge between us and communities? What is your observation in that regard?

To be honest with you, I not so sure how they appoint them, but the appointment of the boards, I will start from there, sometimes it becomes too much of a political field, when one party is popular at one point, the next day you are not popular, and they want to take you out. When it comes to medicine or hospital or the functioning thereof, you find that they still do not know what was happening and then they get trained. By the time they come to understand their role and what is it that they are supposed to be doing, then the popular vote takes them out and now you must get another person. But for me most of them, but I think it would have been nicer if ever a person is there for a longer period and stay and be the lead but most of them to be honest with you are non-functional and just come in to get their stipend and not interactive. I know at some point when I was in Northwest those were even better because you would see them walking along the corridor, interacting with the staff, interacting with the patients. But the ones that we have here in Ermelo, to be honest with you, if I can say they pitch up for a meeting, I would be lying. It is because of how they get paid or something because remember what they are saying, some of them are employed somewhere else, they used to come in after hours, something that has a bearing of some sort. But I have to say that when it comes to hospital functioning and so on, even clinics, some of them do not even understand what is supposed to happen. It is a different ball altogether. By the time, their term is up. That is my problem.

What are the barriers and challenges in information management in the Department?

It is embarrassing, to say the least. I will talk to you about a simple issue – the filing of patients' records. I mean now we are even talking about the performance of our

institution, we are talking about waiting times. Patients can wait almost 4 hours for retrieval of a file. That becomes a problem. Just to get a file, a person has already wasted 4 hours, it is unacceptable. Let alone even after that the patient has been seen by the doctor, the file just disappears. There are many cases that, we are getting sued on and you look for a file in the institution and there is no file. It is only when you interact with the lawyers and the laypeople that you get the information on what was happening. So, the issue of the information, I have to say that no, we are far, far, behind. I think that something must be done in terms of information management. I think of those challenges on that side.

You have spoken about keeping the patient records or archiving being a problem, but the making of the record itself? Are you happy that your clinicians are capturing information in such a way that you are happy or are there challenges in that space?

I was saying that the issue of record-keeping remains a challenge. The doctors in terms of writing the full notes, is a problem. People do things to patients without recording. I can take you now actually to most of our theatre cases that are there. You do find that the anaesthetist has not recorded anything, but when an adverse event comes in then you start asking how the patient's condition was inter-operatively, he indicates to you: no, it was difficult anaesthesia, or it was a difficult operation (that is the surgeon now), but on the notes, there is nothing that talks that … But if you did not record it, how, what are you saying? The record-keeping is a disaster and even the safety thereof just bad. But the Department is reportable now because people are not recording notes and not record keeping is a bit of a problem.

What are the barriers and challenges in clinical risk management in the Department?

Ideally, we are even supposed to have a committee that looks at the risks on daily basis and compiling reports. But also, with this one, it is because of the shortages that you have. So now we are more reactive than proactive. The PSI committees are trying to do a decent job. But even then, as I am saying, most of the time it because we are reacting to something that has already gone bad. We don't even look, I mean the issue of near misses you never even had one meeting where that has been reported to say here we were lucky because we are just short-staffed and overwhelmed with these other work issues, then something goes wrong and people start jumping into it and say but you don't go out pro-actively and say let's look for those risky areas put measures to make sure that this does not become harmful at the end.

What are the barriers and challenges in the training and education of healthcare workers on CG?

I do not think we are doing well on that front. I have to say that when it comes to training for doctors, dentists and physiotherapists, the hospital HRD has those topics that they normally organize that people must come in for training. But as it is, we find that most of them are not relevant for doctors. I use an example let us say now we want to train him for ATLS or ACLS mostly these institutions want upfront payment. I am not so sure why they have created a problem between the department and institutions for the payment. Now they do not even want to hear when you say NO, it is the department that is going to pay. Now it becomes a bit of a challenge. Now you see the official must pay upfront himself. But even there to get a refund becomes a little bit of a problem. Even now, the HPTD grant is supposed to be there for the development and training of the healthcare professional but the topics that are there, I do not they are relevant for doctors. The many short courses that the doctors are doing, the Department is not funding them for some reason or the other. They have

used the reason of saying no this doctor is choosing this topic because once he completes, he is going to leave the department. But I am not sure but in terms of the training, we are not doing well on that one. I have seen that via Director Ncumisa Ndlovu, there is something that is coming up there, the issue of the registrar posts and getting specialists are ongoing. But as I am saying there is something on that side, there is a light on that side, we might be winning. I know that the department on that side is already sending some of the medical officers for training to learn and after that, they come in to serve the department. But there is still a long way to go.

What are the barriers and challenges in evidence-based practice and research within the Department?

I am aware that the province is trying to push much on that front, but I do not see anything happening. It is because we do not have a university as such as a province and must depend on other ones. That may have a bearing. But in terms of the latest research and readiness, as we develop SOPs and policies based on research, I have not seen that happening, but I do not think that whatever information that comes from research, we are using it as a department. Still those practices that are there are not looking at the evidence that is there and what the evidence shows. But what I am seeing, there are small pockets of areas that if people are looking at that, trying to put into our daily practices. Maybe when we get a university in our province there will be light on that side, but most people get involved in research because, yes, I am under training and I am supposed to do research but once that part is done on the issue of research, that chapter gets closed forever.

Would you agree that because of staff shortage you get busy only seeing patients and end up having little time to focus on research?

I think it does. After all, you remember that when you conduct research you need to collect the data and sit down to analyze and make conclusions on that, so if ever then it is a busy day like that, you might have data in front of you that is telling you that there is a problem there. But just because you did not have enough time to sit and analyze and you start to implement what the data is showing you because of your business and the issue of the short staff. Because what you do even though you have the data, you must check what is happening and you put on measures to say okay, this will mitigate this one. But again, you need to go back again, the same cycle, and check if whatever I implemented did assist. Because researchers need time, they need more hours. So, shortage of staff does have an impact on research.

What are your views and suggestions that will improve CG implementation in Mpumalanga?

I know that you already have a CG structure in the province. What I think should happen, even at a district level, we used to have one in our district here in Gert Sibande but for some reason… The issue of getting these structures at the district and even at the provincial level will assist. Then where we even bring those cases like the PSI cases where we sit together with clinicians and even the legal division. We discuss cases and then actually go through those institutions as you guide us in terms of how to improve in terms of patient care. That is one. But of course, the one that is for me that is a thorn is we allow the district hospitals to be run by junior doctors who are inexperienced without supervision. So now that entry point, because that should be where we should be offering top quality service so that people do not complicate. So, if we going to take an experienced doctor like me, you put him at a tertiary hospital, you are not stopping the complications, to come in early. By the time the patient lends at, say Witbank Hospital, the damage has already been done. Though I am not so

sure if ever you might have words to say why do not you, even, because it should not be those district hospitals should not have specialists, it should nave even the senior personnel there that can manage cases. I am not so sure what impact it would have to say if we put the senior people at the district hospitals to prevent these complications from happening.

Let us put the senior doctors at district hospitals who will manage these cases because, by the time they come in, it is already late and creates a problem. Of course, the staff shortages that, because I only have four doctors, it is difficult for me to let go of one doctor to go for training because I am afraid that the numbers and staff shortages become very crucial.

It is even embarrassing, as is most of the institutions that we have, do not even have staffing norms, and the organogram that is there is one of long ago. We need to look at what is happening. Let us look at the staffing norms as a department and see what is happening in the department and try and improve it if we cannot improve quality health service.

Because as is now, you know that we depend on the sessional doctors. If the sessional doctors can pull out actual the entire system can collapse. Because what we need to happen, let us fill up the institutions with numbers. If we got numbers inside of the personnel here, then we can choose and say but doctor so-and-so is not giving superior quality service and we can be able to let go. But as it is right now, we cannot let one person go because we do not have the numbers. Once you say let go then the service will collapse. So, we need skilled staff. And then from there, we start speaking of superior quality.

Participant DC06

What is your understanding of CG and what are its pillars?

I will just indicate in a very simplified way. My understanding when it comes to CG, it all speaks to governing all the clinical practices that will lead to preventing the adverse events, or the occurrence of any adverse event, as well as proper guidance and functioning of a health establishment. This is how I would explain it. And when I am referring to CG, I expect that I will be able to see a health establishment with guidelines, protocols, standard operating procedures, policies, and plans to be available that have been approved. Further than that, in a health establishment, my expectation will be those meetings that will observe your perinatal mortality meeting, you are speaking about adverse events or patient safety committees that need to be there, you are speaking about all the committees that will ensure that the health establishment operates properly and correctly, without any, yes we cannot prevent the adverse events and some can be explained, but some cannot be explained, and some are purely errors as a result of not realizing the guidelines, the protocols, the SOPs and the policies that are there.

What are the barriers and challenges in conducting clinical audits in the Department of Health?

Clinical audits are part of CG. This is one thing that needs to take place in all our health establishments. But to be honest, the clinical audits in our health establishments are not being done correctly. I expect that, let me say, in each mortality, there must be an audit to check if one was diagnosed correctly, treatment was given correctly, you know, the cause of death and everything so that we can improve based on our mistakes. Clinical audits, my understanding is that they, must be led by clinical

managers, and of which in our clinical establishments, the clinical audits are not active enough. You can see if we are attending, if there is any adverse or any patient incident that happens, when you go to those facilities, you want records for the conical audits, they are not there. You want to find out what happened, they are not there.

The clinical managers are not hands-on. As well as it is not an issue about the clinical manager only, it is an issue about the healthcare workers, because we are auditing what we have done to identify whether we did it well or there have been some gaps so that we will be able to close the gaps. This is how I am understanding the clinical audits.

What are the barriers and challenges in clinical performance and effectiveness in the Department?

I do not know whether it is the training that changed, that needs to be improved, or it is an individual change. Some are, few are performing better, but most of our clinicians, not only doctors, clinicians, including the multidisciplinary team, let me say, even the nurses and the doctors, whose performance leaves much to be desired. In few cases the performance is unsatisfactory. If their clinical performance was effective enough, I do not think the department was supposed to be in what we are regarding the issues of litigation which is coming because of negligence, and negligence is coming because of poor clinical performance, it is coming because of being ineffective.

We need to look at the training as well of our doctors. Previously when I started nursing, while a doctor was doing an intern, he was able to do the evacuation, was able to do even Caesarean Section (C/S), but nowadays, they come in post ComServe, they cannot do Caesarean Section, they cannot perform evacuation, they cannot even perform ectopic pregnancy, they cannot give general anaesthesia (GA).

That on its own gives me a challenge. And what if that doctor, who cannot even give general anaesthesia, has a patient where spinal has failed? Who is going to give the GA then? And that is the biggest challenge, Dr. Maduna, in all our district hospitals. The reason we have got so many referrals and so many inferior performance areas is that most of our doctors cannot give GA.

What are the barriers and challenges in patient and public involvement from a clinical perspective?

We are not doing well, because we do have clinic committees and hospital boards that need to serve, you know, as an extension of DOH. But given the fact that even the hospital boards, will only be effective when we have meetings, but how do they share the information outside? There is no evidence that you can see. Another way as a department maybe if we can have a hub where the committee can throw or put in their suggestion. It worked much easier. We can suggest the view of the community. Or else, we appoint to hospital boards those who know, not political. Once we start criticizing clinical work it becomes a horror. So, if we can appoint hospital boards as per regulation, as per what it is, because it says you need to have someone who is an advocate. We need not have someone who has the knowledge or an advocate, we must just state it clearly, we appoint people who are knowledgeable, who are going to assist the board. But not the board that we appoint and the clinic committees that we are appointing now. For me, it is not assisting.

Also, just to say that they are supposed to be a bridge between the department and the communities they represent. But do they hold community meetings, so that they come and present what they have brought from the communities? To me, it appears

as a one-way process. They come, sit, and you must account to them. I do not know what your experience and comment would be on that one.

Yes, you do not get feedback. Anyway, they do not go. There is no portfolio of evidence that they are going to show and say they had a meeting on this, they communicated the information. Maybe if we move away, we appoint them like, we take the road like the way they have appointed the mental health review boards. They are being compensated correctly, and we appoint the correct people. Because another issue is are, we appointing correct people?

What are the barriers and challenges in information management in the Department?

In terms of information management, it is true that our information management is extremely poor and is coming because of poor record-keeping. We do not have space, we do not have archives, and file that is missing, because we do not have proper control. But at the same time, we have got a particularly good system: the HPRS. We are not using it in full. If we were using the patient registration system – the system that is being used, I am sure our filing system would improve. Because it has patient records, it has got everything. You can store everything, we are supposed to be looking on the backup system, but now we are still using bits and pieces, not using the complete system and it takes time. So, our information becomes distorted and that is why we are not winning in terms of A-G. Our record system is in chaos in all our health establishments. The filing system is extremely poor.

In terms of capturing the information, I am looking at doctors, nurses writing on the records, there appear to be some big challenges there. Would you share with me whether you think this is the case?

I noted that one specifically when we have got our patient adverse events committee. They do not write information, the information that is there is a summary. A one-sentence summary. It does not tell anything it does not rescue the department and one who is coming from outside cannot even understand. Not only the doctors, even the nurses themselves. They do not write all the detailed information. So, it is a problem. If they do not write, we assume they did not do. It does not have anything and does not tell you anything about what transpired.

What are the barriers and challenges in clinical risk management in the Department?

We are not doing well. These things are interlinked. If we were doing the clinical risk management, proper implementation of CG, we were not supposed to be having billons of litigation. So, to show that, to prove and to display that we are not doing that, is the different case that is there, all the adverse events that are taking place in our health facilities on daily basis.

What are the barriers and challenges in the training and education of healthcare workers on CG?

We are not doing well as a department. I will just cite one example like now in Gert Sibande we are implementing the HPRS. We have appointed a professional nurse who does not even know how to use a computer. And I expect that professional nurse, because with the HPRS you expect to collect information, then you record on word DHIS. You need to have those skills to work with a laptop. Another thing: if we were appointing professionals, and making sure that we train them, we were not supposed to be in the situation where we are now – where we are still saying we do not have an orthopaedic surgeon, we do not have a psychiatrist, we do not have this and that because should we have taken them for further training, we were supposed to have

enough of ourselves. So, we were not supposed to be crying now. During the Covid-19 we need to do a short course on high care management because we have few nurses that are trained in ICU. You know, we were not supposed to find ourselves in those situations. We should have done it a long time ago. But just because we were not considering and not being serious with the training, that is where we are finding ourselves today.

What are the barriers and challenges in evidence-based practice and research within the Department?

I think what we are not doing well there may be, we are not (including myself) encouraging all our colleagues, you know, to undertake research. Besides that, there are those research studies that you can do just to diagnose a problem, to treat and we are not doing it. Another contributory factor might be an issue that we lack knowledge and insight in doing those, or interest, or lack of understanding at all. That might be the challenge.

What are your views and suggestions that will improve CG implementation in Mpumalanga?

I think the Exco for the hospitals needs to be fully trained and to understand what CG is. The provincial office as well needs to understand. Let us say I like patient safety incidents. We started implementing it at the facility level. It took time for the provincial office to start sitting. I, at the facility level, they come to me intervene. We draft reports, we expect the intervention from the provincial office. It took time for the committee at the provincial level to be established. Therefore, it is a problem.

Secondly, I suggest that all the clinical managers, because when you, clinical managers and NSMs, when you check CG, it is that clinical group of clinical managers and the nursing service manager. And some of our clinical managers are not strong enough, some of our nursing service managers are not strong enough. They need to be fully trained. So that they can continue with this. And the CEO's as leading or ... as well as keep information because you cannot have direction when you do not know. There are those CEOs who are blank at all. They do not understand. So, it becomes a problem. I will say let us, unfortunately, it is not going to be discussed anywhere, let us not appoint based on political interest when it comes to any clinical position. We must base that on qualification, experience, and knowledge.

Participant DC07

What is your understanding of CG and what are its pillars?

To me, CG refers to the standards that we have set ourselves as a DOH to manage the department in as far as clinical care is concerned.

What are the barriers and challenges in conducting clinical audits in the Department of Health?

You know, in my view, on the ground we have clinicians, and here I am talking of all categories of clinicians that do not see a clinical audit as one of their responsibilities, as they execute their functions. Maybe because of leadership at the operational level, as that must be made the culture, you know, standard practice in that facility. So, if the leadership, talking about leadership, I am taking it back to the old school of thought where previously, you would have the leadership of a facility comprising of people with clinical expertise, starting with your superintendent who was then CEO, who

understood issues of CG. Now, we have CEOs who are administrators who do not necessarily have clinical backgrounds. But they do have clinical managers. But to me, the clinical managers themselves, are either newly qualified, who have never had any experience, you know, in operations, as to how things are done in public hospitals, or sometimes, you find that it is somebody who has been a private GP, for example. Who comes in as a clinical manager who is not familiar with how things must be done? And the issue of having the proper public-private sector disparities where the public sector will do things like this, the private sector will do things their way. So, there is no oversight structure, so I could say maybe either at the national level, which cascades to the provincial level to standardize practice (clinical practice). So, people are left on their own, you know, to decide how they manage clients in their sector.

I think I would agree because if you look at the clinical managers we appoint, I know a person who was doing ComServe last year. If they apply, we give them that responsibility and it does not help.

Yes. Fresh from the pot. I must indicate that although it may be controversial, that very same thing, that no, no, no, let's go for South Africans, you know, for these management positions, you find that they don't even have that expertise, they have never led any programme in the clinical area, and you also have a cadre of foreign health professionals who qualify, but unfortunately, they are foreign, and they can't be utilized for that. And the fact that the health system in Mpumalanga (and throughout the country), but Mpumalanga is highly unionized. It is highly unionized where decisions cannot be made without consulting with the unions, where we are unable to distinguish between CG and corporate governance. So, we have given unions too much power. It is because when I say 'us,' I am starting from the top which cascades to the facility level, where the clinical manager (the CEOs themselves), cannot make

any decisions. Or if the clinical manager feels or they know something, be it what they googled or they have been to a course, they want to implement something which thing must be referred to the CEO. The CEO knows nothing. So, they are afraid to decide. A decision that will benefit the client.

What are the barriers and challenges in clinical performance and effectiveness in the Department*?*

Well, I think, linked to the previous question, is that we have abandoned those old practices of monitoring clinical performance. I am not convinced that in hospitals or our facilities, including PHC facilities, as management, there is the monitoring of performance through, you know, performance management of individual clinicians, so that their performance is linked to the strategic objectives. But they know what the APP is all about and how they contribute to the APP or the achievement on the APP. Secondly, I am not convinced that there are those clinical meetings or whenever there are meetings (talking from my experience as a facility manager), to say every Monday as a nursing service manager, we would sit with the superintendent (CEO), the clinical manager, the CFO, and the administrator. every Monday, to reflect on each of our respective areas of responsibility - the key issue being clinical care, adverse events so that the management of the hospital is aware that, okay, this is what happened, but besides that, each manager has to account whether they had their clinical meetings, there they did their clinical audits, where there has been mortality, you know, those that we used to call mortality meetings (maternal, paediatric, whatever). So that each manager can account for each death or adverse event that happens in the hospital. So that the rest of management should be aware that, okay, we experienced this death. As a matron, I did not do this, I did not allocate the correct nurses in that section, let us say, in the maternity section. As a CFO of the hospital, I refused that they procure

certain equipment. Because if there is any death, you cannot point at one person. There must be an account for any death that occurs. I mean that is how it used to happen, which is no longer happening. To me, it used to be an exceptionally good practice where everybody, every part of management, knows what is happening. It is no longer happening. You know I can still remember when we had the previous provincial health minister. Although I did not agree with everything that he used to say. But he used to ask CEOs: Do you take rounds? Do you have meetings? Except when unions are outraged and you are forced to meet, do you have regular meetings with them? He wanted them to assure him that they had those meetings. Most of them did not have those regular clinical meetings. Because the business of this sector is clinical.

What are the barriers and challenges in patient and public involvement from a clinical perspective?

Well, I think, our constitution has done very well in terms of recognizing the Bill of Rights, the Patient Rights Charter, and all those. As clinicians, we are quite aware of those, but now I am thinking that at the facility level clinicians are overwhelmed by the numbers of clients with which they are contracted. Secondly, I will talk on the side of clinical nursing science, where it was necessary when you engage a patient, wherewith everything, explain the procedure to the patient. Hear their views. That is no longer happening, mainly because we are pushing targets, we are pushing numbers and we forget that this patient has a right to say something, you know, to be a participant in the management of their condition to air their views. It is not happening from the time the patient comes in, gets managed, even at the dispensary. There's no longer that explanation to say, okay, this is the medication. It is no longer like what you were getting. Secondly, the issue of the record management system, we have a challenge there, where, you know, each time, where you get a patient, it is like a new

patient. There is no progressive data that tells you that – you have medication why has the doctor decided to change. Even our clinicians, are now lazy to document, and if they do you cannot read. But they opt for not writing a proper record that will enable you to read. I am talking about all clinicians because, I mean I served in the Nursing Council, and most of the cases that we brought in for inquiry due to professional misconduct, people no longer write progress reports. Then you do not know what happened. If you have not written it, you have not done it. So, it becomes very, very, difficult, you see.

The other thing is that supervision has deteriorated at all levels. Because previously you would know that your supervisor will come anytime. You would know that if I have not checked the drugs, I will have to account for why I have not done so. If I have not checked the emergency trolley, it is routine to check the emergency trolley, the emergency equipment in the ward, to see that all equipment is in good working order, every day. Even with the handover, if I knock off, the person who takes over must know that when I took over, this is the report that I got. In the ward, 4 BP machines were there, and I signed off, even the drugs. So, we have abandoned a lot of all those good practices.

What are the barriers and challenges in information management in the Department?

We are not there in this regard, and here I am not going to blame the people. They are frustrated, because, you know, we are supposed to provide resources for keeping records, cabinets, our infrastructure is prioritizing other things. The prioritization for infrastructure maintenance management is done without clinicians. It is important to involve clinicians because they are the business (core business of the department). Bring any component for any budgeting for infrastructure maintenance, there must be

consensus to say, we have limited resources, let us prioritize this part and the other will follow. But decisions are made separately, unilaterally, you know, to give somebody a tender.

What are the barriers and challenges in clinical risk management in the Department?

On risk management, it is a new terrain for most managers who cannot connect the importance of risk as one of the essential CG areas. So, I do not think we are all on the same page in terms of risk and even when we draw our risk management plan, I do not think we are on the same page about why we are doing this, how we are supposed to draw it. We do it for compliance, or most of the time it is for compliance rather than for risk mitigation. So, unfortunately, in our department, we have underestimated risk so much that even the grading of the post of the risk executive is very junior, and yet you are dealing with a vital component. Because if Vusi Khathwane tells me I will say: no man, Vusi, do not come and tell me that. I am his senior, he might not be able to put his foot down to say, no, this is that. Our mid-risk plan also is not linked to our APP, because our risk plan must be based on our APP, and even how we are going to mitigate those risks so that on that quarterly basis when we assess, we should say we anticipated this risk, it happened, so our plan changed like this as a result. So, we are not clued up, we would rather pay thinking that having paid, we have gotten rid of the problem.

What are the barriers and challenges in the training and education of healthcare workers on CG?

To me, HRD has not started doing what they are supposed to be doing. But what I appreciate is that now HRD directorate is now linked to the PMDS. Because HRD must be starting from when the person gets appointed. They go for competency assessment

to determine gaps in terms of their competencies, their skills, and all those things. We are not using that to draw up a skills management strategy or plan. So, people remain with their incompetencies. Nothing happens. Secondly, we still do not implement the principles of PMDS, in the sense that the Department we link PMDS thinking that it is an incentive. Because why? Managers fear their subordinates. Managers fear the unions. Managers themselves have no clue of PMDS, so they cannot, because if I do not know something, how will I tell you if you are my subordinate, to say, hang on, you are not doing well here. If I know that I was put there as a manager, for you to work for me, how will I discipline you? So, you know, it is a very, very, complex situation, where people were appointed, was deployed in those positions in the DOH so, unfortunately, this is a system, it is supposed to be a system. If one part of the system is out of hand, it affects the entire system. Starting from the top! Where, I mean, the accounting officer is unable to command, to be the commander in chief, because she fears what the unions are going to say because so and so is linked to the MEC. Or this and that. Especially for the department of health, where when a person is seen to be a threat in a certain position to certain corrupt activities, they get moved. When people are being competent, they are moved, especially to HR. And HR is a vital component. It is the backbone of the Department – Human Capital. So, if you do not have that backbone, how are you going to operate? All components: you call it Labour Relations, Organizational Development, HR Planning, and so on, there is no one there! There is just no one there! Because there are warm bodies, warm bodies that are occupying those key positions without any performance. Most areas! The other issue is that if you do not want to put in somebody that is recommended, they will tell you that the post should remain vacant. You will suffer!

What are the barriers and challenges in evidence-based practice and research within the Department?

We used to try as a department to have the key positions that were filled by people, for example, we used to have the post of an epidemiologist, which was abolished. Because you abolish out of ignorance. You do not know. In terms of research, the research committee deteriorated to thinking that we can have a deputy director that is there, to coordinate health research. But health research is guided by the national health act. You need a researcher. You need academics that will help you in the absence of an academic institution, but we have MOUs with academic institutions. And now we have a university here that we could be making use of, you know, within that research unit get a person that will draw all these things, these components to say this will assist us in the absence of an epidemiologist. Where can I get this? But with Covid, I am happy we were forced to draw in the wisdom of people who know. We cannot just work based on assumptions and do the guesswork for compliance.

Our research agenda is not informed by the epidemiological profile within Mpumalanga. That is why whatever we are implementing, we are just complying with the strategic objectives and priorities of National. I am not saying we should not take cognizance of that, but we are in Mpumalanga. We have certain things that bother us as a province. What are we doing about that? Do we have any concrete data that guides that? The approval or the recommendation of research proposals, we just do it and if you say I just want to do my research, I go to the research unit, they support, without saying, hey, how is it going to benefit us as a province. It must be informed by the research agenda, which research agenda must be known by the top management at all levels, so that if anyone wants to carry out, because we do have people that research facility level, maybe they are doing their masters, their doctoral theses, and

all those things. They must know that this is the research agenda for Mpumalanga, and I think I can benefit the Department by researching this area. I cannot address somebody's research agenda who is a professor somewhere and take advantage that in Mpumalanga you do as you please. It is because, even now, I cannot tell you what the research agenda is, and yet I am in this department.

What are your views and suggestions that will improve CG implementation in Mpumalanga?

I think some systems have been set up already, which is a good thing. The PSI committees and the Quality Assurance are in place. To me, it was a good thing that a person like yourself was brought in. Because it was terrible. It was terrible because you are a clinician to start with. You are a clinician that worked in the CG terrain. Because in the absence of a clinical person, because previously, in our structure we used to prefer to have a clinician, preferably a doctor, to be DDG: Clinical Health Services because that person is like the superintendent responsible for all clinical services, who will crack the whip when EMS is not functioning well, who will crack the whip when these specialists are not working. So, it is either, for DDG clinical services, let us have a clinician, preferably a medical doctor. Because a medical doctor will have insight, I am not saying a nurse will not have insight. But we need a person who will say, no, no, no, in terms of these standards, we shall do it this way and so on. Or, if we want innovation, for me it is better to have an advisor like you are, you are the advisor on clinical issues. So, retain that on clinical issues, and then you will be able to join all the dots.

Let us go to the district level. I do not mind the current structure of District Management. To me I am comfortable with the current structure because it has a

directorate: PHC and the directorate PHC is led by a clinician. Directorate: Hospital services, still must be led by a clinician. District Manager is like the accounting officer, all these people will advise.

At the facility level, because we already have people that have been appointed, we cannot get rid of them. So, the training programme must be developed and make use of clinicians that are about to exit, or who have exited that you bring in on a contract basis, to bring in all those best practices. I am not saying let us revert.

Let us look at the current linkage between the office of health standards compliance. We have that governance structure so that each facility has a person that coordinates if it is the quality assurance person, they need to be clued up with, not only on ideal clinic realization but they must also be clued up about issues of risk, issues of audits (clinical audits) and the other audit systems. So, this manager must be overly broad. So, they must be there at the facility level to advise the CEO (who must be the know-all). But they cannot function that efficiently. Well, some of them you will find that are clued up. So, if we could revive those clinical meetings, the morbidity, mortality meetings at the facility level and keeping of clinical records.

Participant DC08

What is your understanding of CG and what are its pillars?

I think the key around CG is the question of quality care that must be provided by the institution. In this regard, it is your clinics, your CHCs, as well as your hospitals, wherein the healthcare professionals play a role in ensuring that we can attain that and preventing adverse incidents that normally put our department in disrepute. And the key to that is the question of that which our healthcare professionals have got to

possess, and leadership that has got to be provided at the clinical level, and in this regard, our, in the hospital setup: your clinical manager and your nursing service manager, will play a pivotal role in ensuring that we can attain a sound provision of health services to our clients. So that at the end of the day you can prevent adverse events like maternal deaths, neonatal deaths, and any other incident that may expose the Department towards litigation.

What are the barriers and challenges in conducting clinical audits in the Department of Health?

Well, the key issue here is that there must be monitoring that needs to be done to ensure that we can prevent all incidences. We need to be honest to have such oversight meetings, your perinatal meetings, your M&M meetings like we used to have in the past. A substitution to that but you find that some inadvertently and you find that that goes with the attitude of the CEO together with the clinical manager. In areas that we have the clinical managers who have been with us for a lengthy period, can be able to assist and we still need to do a lot in ensuring that newly appointed clinical managers are also brought on board. We, for example, have Witbank Hospital, which must lead us in terms of several clinical meetings. But we have been battling to get them to lead us. Heads of departments that we requested that they should assist us, but if it is not entrenched, at the level of the CEO at that hospital. So, there is a need for us to create awareness and empower our clinical managers to take a lead in this regard. So that we can ensure that all CG structures can operate.

What are the barriers and challenges in clinical performance and effectiveness in the Department?

I think the number of complaints that will come our way, will be an indicator of whether we are performing well or not. Let us just look at clinical performance. Those will be a pointer to us to say are we doing well or not. When it comes to areas like maternal deaths, there was a time when our maternal deaths were exceedingly high. When we zoomed in to a hospital-like KwaMhlanga, it was a problematic hospital for us in terms of maternal deaths. But with the introduction of the DCSTs, we were able to put our focus and clinical effort into supporting them and we reduced the maternal deaths. And further, with the deployment of Prof M in that hospital, the number of maternal deaths has reduced. But then you investigate a hospital such as Witbank Hospital, we still have maternal deaths. The fact that it is a referral or tertiary hospital for both Nkangala and part of Gert, you will realize that we still have several maternal deaths in that hospital. The strategy would have to mitigate against these challenges, but we also have complaints that come to our desk in terms of our clients, some expressing dissatisfaction about the performance of some of our facilities. In the main, we would say it is that of clinical, but complaints that have to do with the attitude of our health professionals. Here and there you do have cases that are referred for litigation, but not to as many cases as you will find in some other areas, except that a number of those cases have got huge and astronomical claims against the department which run into hundreds of millions which is costly. So, there are cases where performance requires us to try of fixing them.

What are the barriers and challenges in patient and public involvement from a clinical perspective?

We do attempt to involve our communities to some extent, though it is not sufficient. We encourage that each hospital should conduct open days at least once a year where they interface with our community structures. But I do not think those interactions are

sending a clear message that is coming from our communities in terms of what their needs are. We also do attend the IDP meetings. There are IDP meetings that are conducted by municipalities and there is one that is conducted by the district municipality. So, with us, in Nkangala there are six municipalities, and then we make sure that our sub-district managers and CEOs do participate at that level. But the issues that are of interest to politicians at that level, it is all about infrastructure rather than awareness. The awareness does link with the open days where we invite all forms of structures including our political leadership at the sub-district level. That interface does happen.

The other element that we have is the clinic committees. For the clinic committees, we ensure that each clinic should have its open day. We have ninety-six clinics in Nkangala. So, we ensure that those clinics organize their open days where they interact with our community structures. The clinic committees are also required to have monthly meetings with the OPMs. In those meetings, we monitor and check their minutes. We also have hospital boards that are meeting every quarter and they do oversight in our facility and can communicate with our managers. There are your complaints and suggestion boxes wherein we expect that the governing structures once a month, look at the content and we can respond to each issue that is given. The MEC's office also receives complaints or compliments that are shared with the respective institutions.

In your view, are hospital boards functional or are there gaps in their functionality? Please also touch on the clinical committees. It is one thing having them, but the question of whether they are serving the purpose they were established for, is another.

Their term of office is 3 years, just to commence with that aspect. When they start, they start with, they start being effective, they try and do their work. But because the tendency is that at the expiration of their term, some of them withdraw and we end up with few people being active. We just have received the appointment letters right now, and they are busy launching those. There have been institutions in which the hospital boards have been helpful, there are areas where they will be dormant, and not assisting, not understanding what their role is. Though you try to capacitate them as the department after their appointment, they arrange training for them to try to capacitate them so that they understand their role, though there are instances where they can interact with the department to raise issues that are critical at the local level. I can give an example where the Mmametlhake Hospital extension was because of interaction by the Board. That hospital was originally a 55-bedded hospital, and it was meant for the former Bophuthatswana which served about 60 000 population, and with the new dispensation, the population increased to over 260 000 people, which has taken a portion of former KwaNdebele and was upgraded. The hospital was inadequate to serve the increased population to the extent that it admitted patients on mattresses. The Board was able to when the Premier visited the municipality on interaction with citizens, they were able to seek for a hearing with the MEC and the MEC arranged a meeting with the Premier and today we see Mmametlhake Hospital being upgraded with infrastructure and is going to have at the ultimate end over 182 beds. So, in this regard, the Board was able to assist. So, in some instances, the Board was interfering with the administration, not understanding their role. It is dependent on the level of their understanding and conceptualization of the concept of governance structures comes from.

When I spoke to other colleagues, the issue of how hospital boards are constituted, and that they are not necessarily coming from that community or if they do, they are working far away, has been raised as a challenge. What is your view in this regard?

It is a fact. Even now, we have a person that is not from the municipality or the catchment area of the hospital for which these members are. We sensitized the MEC about that. But the allocations were for people around for example Thembisile who are employed in Gauteng, and they reside in town and have no contact with their constituency. At their appointments sometimes we look at the guidelines in terms of the establishment of hospital boards. There is a provision that is attached to the university and, as you know that the only university that we have in Mpumalanga, which is in the Lowveld, we end up looking for people that are residents or that are originally from that village or town, who are prepared to assist us, because they are linked to the university, to meet that requirement in terms of attachment to the university.

Some are appointed because they have a clinical background. They are not attached to any structure where they report or bring any issues from the community, and it becomes like an academic appointment rather than representing their constituencies. The Key is that you should have people you are representing and even when there are challenges, you should advocate for them. The same way when, particularly when we are facing challenges of unhappiness by communities that lead to marches. These are people that correctly should have raised issues with communities so that we can prevent such and be able to call their constituencies to update them about the developments in our facilities so that our communities are appraised about such developments. Sometimes amid challenges, there are employment opportunities

when there are infrastructure developments people want to get opportunities like sub-contracting to the main contractor.

Committees should be able to represent us. When you introduce your services, they are supposed to be the mouthpiece between us and our communities. But at times they communicate through social media, but interfacing is very key so that if there are further inquiries on the subject matter, they can advocate for us. Also, when you have cases where people or communities want to raise their grievances, you do not want to have interruption of services and raise alarm and fears between your patients and your staff. Then you used them to assist us, but to be honest, they are not effective in those areas. We had only an incident around the Emalahleni municipality in Delmas where we had our staff being harassed by these young, upcoming members of youth when they socialize in the evenings. They will come and intimidate our nurses. We had an exceptionally good chairperson of the board who then summoned them in their different structures and intervened.

What are the barriers and challenges in information management in the Department?

Information management is key for our planning. The data that we collect, should be used to inform our decision-making. We come from an era where we had challenges especially around human resources, human capital, in terms of information management. The department has done a great deal in that regard. We are glad that in each sub-district we have an information management officer, in the district office we have an information manager as well. Data is being collected regularly. There is also a bit of improvement in terms of equipment. Where we still need to strengthen in terms of our rural sub-districts and some of our hospitals and clinics. It is a connection which sometimes is not so strong and leads to a situation where sometimes data

collected is not transmitted at that level, only to be processed. So, we still need to encourage managers to use information collected for decision-making. Managers at the facility level should understand that the data that is collected by their information managers, is not only meant for transmission to a higher level. They must also use that bit to be able to plan correctly, as well as take proper decisions. So, there are many areas that we can use the data, particularly as indicators for our performance, at the hospital level, at the clinic level, as well as the district and provincial level.

When it comes to the patient's record, are we capturing the information, correctly, legibly, or are there gaps in that space? The concept of garbage-in-garbage-out, remember?

Sometimes we indeed have challenges it is still a challenge how our records are, firstly, how we record information, particularly patient-related information. Sometimes you have pieces of information, and you write, and the capturing is not assisting, particularly when it comes to defending the department. I am not sure why we still are lagging in using IT. I have been liaising with my IT and the previous managers at Top Management to say we are not moving enough in terms of using IT solutions to assist us. Some years back, there was a course that we were exposed to on infrastructure planning and health planning. We attended this course in Durban and we were privileged to go to Chief Albert Hospital where we noted that clinicians were using an IT solution for capturing information. It appears Kimberly Hospital and Joburg General were also leading in this field. But we, as a province, late to the extent that it is only now that we are starting to move towards that.

Would the idea of providing doctors with desktop computers in their consulting rooms so that they capture patient information directly onto the system be a good one? What are your thoughts in that regard?

We have got to attempt because now we are moving towards the IT era, we have moved already it is a question of the implementation. It would assist even on records that get lost when required for litigation. But not only for litigation, but for continuity in terms of patient care so that the health practitioner should be able to access information out of the chart. But if such a system could be introduced, it would also reduce the patient waiting time because even the pharmacy will be linked and other clinical support areas. From the moment the patient is given an appointment to when they arrive at the patient administration and when they are seen or taken over by chance, up until the patient exits the facility. I think our ... has that capacity. The private hospitals can, and I do not understand why we should note.

What do you think of the HPRS – hospital patient record system? Does it help in information management?

The system was introduced in Gert due to it being a pilot site and was also rolled to our district as well. The understanding was that it would assist in record-keeping for patients when they arrive at the front desk. But it does not go as far as the clinic level, because you want an integrated system. There is, in this regard, Doc, at the level of the province, your voice could be stronger than ours if you could engage with the IT director. Because we have capacity.

What are the barriers and challenges in clinical risk management in the Department?

Again, as a department, we should try and put policies for implementation. Now again it is capacity at the coalface where we interface with our patients and communities.

From the moment they enter the premises when they pass security and at different wards and even at casualty. Firstly, you will know that our security is not the best security we could have. That is why we ended up having a case in Witbank Hospital. So, it is one area that is still a bit of a challenge. The other aspects based on the skills that our clinicians have an attempt is being made to improve such skills.

What are the barriers and challenges in the training and education of healthcare workers on CG?

An attempt is made to upskill our employees within the department. Annually we develop skills development plans that are accompanied by a budget. The training on that is happening at the RTC in Gert Sibande. We also have skills development committees that investigate the various needs of our different facilities. You have one in the district and the sub-district. We also do provide opportunities for our personnel to go and further their studies. Some nurses are training via the university for specialties. But the numbers are not sizable, they still need to go a bit far. We do provide training to our general workers including clinical support. The unfortunate part is that we no longer have an opportunity for managers.

Coming in with a qualification will not suffice because the environment changes. I do not know, Doc, whether you remember in the past we used to have opportunities like the Oliver Tambo Programme and the Albertina Sisulu was a programme of interest, but only once, a cohort of managers, but we have not done anything. The DOH can link up with universities. We have universities like Limpopo, Pretoria, and UJ that are within the proximity of the province, with whom we could collaborate and put some of our managers in the programme. But we need to increase the cohort of areas where we do not have skills and ensure that we can build the necessary capacity. We do not

have enough specialists as you know. We either have foreign doctors or people that are already about to exit the system.

I think we should consider sending, particularly those doctors that we trained in Cuba, for specialties. We have got one that is has resigned and left the department, Dr. Masango. These understand the element of patriotism. Immediately they are trained they should come and serve. That will increase the cohort of specialists that we require.

Now, what would you say if I say you have staff shortages on one side, and we are running the Department on what could be regarded as a skeleton staff. How possible is it that you still create opportunities for some of them to go away and leave the Department in a crisis?

I take it that if we do not provide that opportunity, they end up leaving to other provinces when opportunities are created. The question of having a job done, in a way it depends on where our priorities are. If the head is too big, we have a lot of directors in the province, and in the post of a director, you can appoint 3-4 professional nurses. Now, some of the directors should have been re-deployed to other areas. I saw yesterday a presentation was given by the CFO even mentioned the number of senior managers that still need to be appointed. When you look at the total cost of that planned appointment, you know you can appoint more than fifty professional nurses, in my view. So, it goes with, at a strategic level, how are we approaching some of these issues. Because I do think that somehow, we can affect the shortages that we are having.

What are the barriers and challenges in evidence-based practice and research within the Department?

In the main, I think, we have a unit that is supposed to coordinate research within the Department. But I have not seen us as senior managers having a presentation that talks to any research that the Department conducted, to say we would like to focus on this area. Here and there, there have been tasks that we assigned to say let us look at, for example, we had a by-pass of patients leaving PHC facilities, going to the hospital. But it was a task more than research and we see a lot of research being made by private individuals that are studying for their academic degrees, requesting that we support their research, and we normally do as districts, and then approval is then granted. Normally we say please share with us the outcome of your research. But because coordination is done centrally, we hardly see a lot of them coming back to share with us what the impact of their research is.

As a department, we are a department that has different experts in different teams. The focus is on patient care, but research will assist us in exploring new avenues that will assist better in the clinical care of our patients. These are things that we are saying as a department. And we have a lot of colleagues that have done Masters' degrees or Doctorates, but their research has never been shared with colleagues within the department.

Is there no problem right there because as a department if we say to somebody go ahead and do the research, but you should share the research outcome with us, and we are not explaining exactly how.

Yes. It takes me to the period the MEC launched the committee. You can remember the committee, but its impact is another matter. Ideally, at top management, we should be reflecting on some of the research conducted by colleagues. If it works like you are indicating, Doc, that it should come from the interaction that we have with our

communities. In this regard, each district should be required to, requested, or directed to ensure that each hospital provides a written report about their interaction with the community during open days. We should not need to do that. It becomes a compliance issue. We could also explore that those colleagues that are working within the department that acquired whatever qualification, that with their permission it will also assist to publish the outcome of their research and put that on the Departmental website. So that it can be accessed by a larger portion of our population, and not only our staff.

Regarding the point which you raised earlier about creating a closer working relationship with universities, is this happening in Mpumalanga?

It is quite eye-opening, Doc. It depends then on, but at the district level, we can try and do that at the micro-level. At the strategic level, it is key that we reflect on such so that the positive effects can be felt throughout the department. So, it is something that should be shared with the HOD. We are operating under duress, and some of these creative ideas are not coming out to flourish. Something that can be done.

What are your views and suggestions that will improve CG implementation in Mpumalanga?

I think the area that, in my view, is key, foremost, Doc is placed to guide the department at large, but at a strategic level to both the DDG and the HOD. The direction that you must go is, you have already picked up pointers of whatever you need to do. At the service delivery level, the interaction between clinical managers is very, very, important. Fortunately, we are operating in the modern era we no longer must have physical interactions. Virtual meetings are necessary for clinical managers. The close to twenty-seven clinical managers it would assist in sharing of information, because

we come from diverse backgrounds, and we have our different strengths, and we shall share on the strength of people, and we can learn from each other to make sure that we provide direction to our different institutions. I come from and the era of former homelands. I was in Bophuthatswana. Just as I was when I arrived, I was exposed to such quarterly meetings where the meeting of minds would converge. We would discuss different issues with people like Mr. Aphane. People like David also came from the era, and Shabangu at Themba. So, some of the issues as they are discussed there, they assist us. And the focus should be on clinical issues because we are not providing that guidance to our doctors, our allied health staff, which are the key. They are in the frontline, including our nurses. At that level, though you introduced a lot of training it does not assist. Sometimes it is coaching and mentoring that is very key. So, it is strongly emphasized at that level, it will assist in improving CG.

At the management level, we should also try to guide our CEOs. Although sometimes it is the attitude of a person. Attitude also determines our attitude. So, we have got that given as an area that you should explore, Doc. I would say let that forum be introduced and monitored. We know there's a clinical managers' forum. But as district managers, I do not know what issues are discussed in that forum. Somebody at the provincial level should coordinate.

Similarly, there has been a CEO Forum. But when I look at the issues that are being discussed in the CEO Forum; it should not be about leadership only that we guide our facilities. It is all about our privileges and benefits in terms of our own offices. Rather than us saying let us look at the performance indicators of the province, as hospitals collectively and say how can we improve the performance of our different hospitals.

The other matter is issued that is discussed at senior management meetings. I think with Mpho being appointed as the director for hospital services, slightly there is a bit of direction towards looking at performance. But in the past, we were talking about general issues in management. But there was no focus on issues related to nursing care, be it CG issues. So, at the level of management, we should give ourselves time to discuss so that meetings are not about issues of general management. We are a Department of Health, and our focus should be around health-related issues.

Another critical issue and Doc you will know this is our outreach services. If we could ensure that our specialists do outreach to our district hospital. Now, none is happening, and if you remember well, Doc, when the classification of hospitals when tertiary hospitals were introduced in 1995/1996 when joint appointments were made, the intention for them was for them to also do teaching in the district hospitals.

An orthopaedic surgeon would go to a hospital, do orthopaedic cases, and simultaneously teach the doctors within the respective wards to make sure that they are capacitated. And we would see an improvement in terms of management of cases. The same would also go for our nurses. When the specialist is on-site, the doctor and the nurse would be together, and they are asking questions. We also need to exploit, which we are not doing, your telemedicine. We are very weak in telemedicine. We had a facility in Tonga Hospital at the facility. But it remained a white elephant. We are in an era where we should exploit that. Doctors in remote areas do not have to refer always. There are cases in which a specialist can guide a medical practitioner. We can save on cost, simply because of telemedicine. Really and earnestly in this regard, we are not exploiting the opportunity.

Participant DC09

What is your understanding of CG and what are its pillars?

My understanding of CG is that it is got to do with all the rules and regulations and guidelines of hospital functioning, which involves even HR matters, it involves also clinical work. For example, when it involves clinical work, it is what is expected from me with my subordinates, like having monthly M&Ms where you get to find out what are the problems, how to solve them. Another example is to have committees like Patient Safety Incidents whereby you must produce ways to avoid near misses. Whereby there is mismanagement and there is a clear indication that things went wrong and that must be referred to relevant structures like Labour Relations, the Health Professions Council, bodies like that. Legislative framework. In CG are the running and the management of clinical affairs in the hospital and accountability. You must take into consideration efficiency and effective management of all components of CG.

What are the barriers and challenges in conducting clinical audits in the Department of Health?

Those it has given me a lot of headaches because I also must have those things done. But here I have a lot of resistance from my specialists. There is a lot of resistance. I do not know if they understand. Dr. Maduna, if I may call a spade a spade, I do not know, they do not understand administrative CG issues and to them, it is like these things. To them it is nothing. All they will tell you is that they are busy with is patients. But there has got to be outcomes and there are, as I said, guidelines to say: what is happening in whatever clinical thing that you do, you are seeing patients, but there are things – positive or negative. There are so many factors. They do not seem to

understand. I have at various times tried clinical audits. It will just not happen. I do not have a lot the buy-in and the resistance is the main issue, from the specialists.

In terms of dealing with that, what do you suggest? How do we solve that problem?

I would have wanted buy-in from you. We have written letters to all the heads of units and so on, and we have mentioned, specifically CG. It has come from me; it has come from the CEO. It just cannot take off! This bird will not fly! So, I would have wanted to have your buy-in, whereby we can call these people. Maybe if they hear from someone externally, it will make sense. Because the whole issue here is about the attack. Even where things have gone wrong, for example in a patient safety incident, I think the situation, in my recent ad-hoc meeting, because I keep on calling ad-hoc meetings, whereby you have a maternal death. You look at it, you go back and get as objective as possible, and what you get is defence whereby there is no supervision, and when you mention that you get attacking responses. Hence sometimes I ask, I send to yourself some of the matters to say let us hear it from someone else.

What are the barriers and challenges in clinical performance and effectiveness in the Department?

There is no accountability on the heads of units/supervisors. Poor accountability. When I bring someone to book (let me put it that way), all I get is defence. Even if I ask for a report, even if it is basic things on some adverse event or a patient safety incident happens, a report that I will get is in defence although I am not attacking, I just want facts.

What are the barriers and challenges in patient and public involvement from a clinical perspective?

As far as the hospital board is concerned, it is only now that we have new appointments. We had challenges when this old thing was there. But now as we heard from the CEO, we have a new hospital board who are the people who will investigate patient involvement that we will work together with them. It started OK, there were years that we did not have a hospital board. Eventually, when they were appointed, we had a good 2 years, and their contract expired and then we could not get people who could be appointed, but then now we appointed them. I think we will get back on track, because to my understanding, a hospital board is very core as one of our stakeholders as they are linked with the MEC. Through them, the hospital board, have their meeting and do presentations on finance, clinical, HR matters. We involve them according to what they are supposed to do.

In your view as far as the very same hospital boards, are they the bridge that they are supposed to be between us and communities? A bridge, remember, is a two-way thing, it is not only you who need to report, but they must also report.

At a higher level, the MEC level they do, that is my understanding. From where I come from hospital boards played a key role. But here, it is like they are not up to optimum.

This new one, just out of interest, is it nine people? Did you manage to get all?

No, it is 4 or 5. If I can give a little background, the previous one that we had, there was someone from finance, someone from HR, there was someone who was an environmental officer, we are also a legal person. That legal person did not prove effective. You see when you talk about legal issues like litigation and so on, the person was more interested in knowing because she was working for her pocket. She is not neutral, because she would have legal cases against us. You cannot be both! At some stage, she wanted to know about certain file numbers. I tipped the CEO and said this

is a disaster coming. But the ones with HR and Finance backgrounds, those people used to give a lot of advice, even when we are doing presentations. There was one hospital board member who was highly active honestly. He used to come in, and sometimes you would find him doing his rounds in the hospital. I found it remarkably interesting, and I would sit down with him and explain how things are functioning at that level.

Now at the patient level: doctor-patient, nurse-patient, do we involve patients in decision making? Do we talk to them? Or are our chaps just telling them what to do?

We have not reached, although I hop around to see what is happening. We are still very much stuck with what the doctor says to the patient. The patient just listens to the doctor. Some of the patients who are enlightened about this, express this as a complaint and it comes back to quality assurance whereby, I get involved personally and try to explain how things are supposed to be. Patient Rights are violated. The rapport between the doctor and the patient, to me, is not even at 50%, it is less. Because for you to get optimum clinical issues done well, you need to have good patient rapport. The patient's input is particularly important to me because I have done Family Medicine.

What are the barriers and challenges in information management in the Department?

The patients' records, like if I can look at patient files as an example, files get lost. Patient information is not up to scratch. In my training, when you get the patient's demographics, they should be telling you something (she pulls out a file as an example). Here you have the patient's name, surname, and everything, there is no cell number of the patient, this is a duplicate file. If you get this patient, for example, the next of kin section has no content. Now if you discover that this patient has a notifiable

disease, how do you go according to Epidemiology?! From the outside of the file, what is it telling us? Who recorded this? Because the section on the clerk is blank? Files are lost. Getting into the file and looking at all the relevant documents: the consent form is not completed fully, there is no discharge form, there is a death verification form, indicating that the patient died. But because there is no contact information on the front of the file, nobody could be contacted and informed about the death of the patient. The doctors' notes were made by a medical intern and reflect no countersignature or confirmation by the senior doctor. There are no continuation notes by a senior medical doctor until the patient died in the hospital. Plotting of vital signs by nurses is not properly done.

What are the barriers and challenges in clinical risk management in the Department?

I never concentrated much on clinical risk management. Clinical risk management I used to do where I was working before. To be honest, I have not looked much into that. We have a lot of problems that are there. When it comes to clinical risk even the very case about which I am talking.

But when the hospital goes for strategic planning, is that not linked to risk management?

We have done strategic planning, but on my side, whatever input I try to do on our side, it is never taken, until things turn the other way round. Then: "Koete, please sort this thing out." I cannot work with crisis management! You give input because you have a reason to because you have fog expertise. But if you are looked down upon (but that is my feeling), it means you are not effective, you are useless, you are just there. It is just like when anything goes wrong on the clinical side, even if it was not on my clinical side, even if it is nursing and whatnot, I take the blame. It is always be said

that it is clinical. It brings one's morale down… There is a lot of political interference in the appointment of personnel that has affected my hospital negatively. This presents a serious risk in the clinical management of the hospital. As an example, a certain person was given a post at Themba hospital, for interviews that were done at Rob Ferreira Hospital. This is political interference in clinical work that is a serious risk. Incidentally, that person did not last at Themba. I just do not understand. I got someone I was forced to take. Political interference is a nightmare in this province. Here is now in the radiology department, it is 4 years now. He came here as a recruittee. There was someone who was a director for hospital services by name of Mndebele. He, because he knew this recruittee, said take this as a radiologist although he has not passed his final exams. He set for the final examination three times without passing. When I asked him for his qualification documents, he ignored me. He is still employed and is getting his salary. I am expected not to say anything because I have been told that he was recruited for me. This is a serious clinical risk because we are paying money for good nothing. The next thing is that the same person reports me to his union saying that his employment agreement was that he is going to go to the level of a clinical manager because he was an advisor to the then Health HOD and that he was recruited to be a strategic planning manager, so he still holds high esteem. Mr. Mnde then recruited him to be a radiologist. When the interview came my CEO calls me and says please arrange for a telephonic interview for this person. I said over my dead body! I wanted a face-to-face interview with this person because if it is a telephonic interview, how will I know if the person we are interviewing is the right person? Will not it be someone who will be given good answers and so on. Sometimes body language is important. You need to see the person because the deal was that we will not take you as a specialist, you do not have the papers. We are taking you as a medical officer that will be according to your experience. I continue to be forced to appoint people

who do not qualify for the posts they have been interviewed for. Just now I have a big problem on my hands: I was forced to take someone who had score 35 percent in the interviews in this very hospital. But I told the panel of which I was the chairperson that this person you want to recommend is not mentally sound, he is fighting with the world, he is paranoid, and says he is going to shoot people here. He is now appointed but cannot do his work and I must take accountability while he is being paid. This is an impaired physician. I tried to get people who know him, including his parents in KZN so that they could come and help me get him admitted. Our efforts to have him admitted to Witbank Hospital failed. I have resorted to reporting him at the Health Professions Council.

What are the barriers and challenges in the training and education of healthcare workers on CG?

I have tried, where I could, and I have even involved outside stakeholders and there are people that I work with closely. I always take advantage of, let us say the Operation Smile Project when I picked up that you cannot work in casualty if you do not have the expertise, and casualty is the point where you should know what you are doing. I have asked for free training because we do not have funds. We could have funds here and there, but I have tried that they do BLS, TLS, you know, all those things. Yes, the time that Operation Smile helped us, yes, I got many doctors trained in casualty as the entry point. I have involved even other companies that I know and asked for training. There are those that I am working with even now to empower doctors and so forth.

But in terms of budget, isn't it that there is that 1 percent of your budget that is reserved for training according to the policy?

Yes, that one we are doing like our operational plan, I always have something for them, but it is not enough. Because remember here, the specialists also commit to go for that, even like CPD points and so forth, so even to improve, I always prefer that I plan, per department sometimes that they can go and train for this and so forth. I have been working on that. There are CPD points that are arranged. There is one that is done here privately, where we get professors from Cape Town for Anaesthesia to get them to come here. Individual doctors pay for that. And then we have got a 3- or 4-days training session which usually starts like on a Thursday, Friday, Saturday. And then I do not only involve my doctors because I always think if you involve the outside stakeholders so that, where there is need for money, everything is paid for both in the private hospitals and so forth. This is formalized but it is too little, and I wish I could do more.

What are the barriers and challenges in evidence-based practice and research within the Department?

There are doing research, although we take their information or the research reports from the universities and link it with the Department. But not much is going on with research. I was happy, it was last year or last of last year, where I was part of the people having been invited by Drs Dudu Mdluli who thought of me. I had to go to this place that we went to, and it was dealing with research. I came back with so many, you know, whatever I learn I always try to put it into practice. But you get hindrances here and there. The follow-up of that one I could not attend because, I do not know, for me not to be here in the hospital unless it is conducting interviews, it has taken as if I have gone on a holiday. NO! What I learn I come back, and I want us to get it done, let us do this. But it also boils down, Dr. Maduna, not to offend, Mpumalanga is going down. I request that you try to enlighten those in leadership, including my direct

supervisor. I have nothing against her. But people should be prepared to listen to what clinicians are saying. That has a lot of potential because if we are on par, we can go far. If we want to be, what we can call, an ideal tertiary hospital, we can do that. I have tried recruiting doctors; I have done my best when it comes to recruiting but where do I sit? Any slight negativity is attacked. And that brings my morale down and makes me miserable. I am not a person who likes comfort zone, I get bored, I must do something. If it is like this (pointing at her desk), it is because I am frustrated, it is depressing. You sit in a meeting you produce issues. Things that you know that you are going to follow up but that is it! When things crash, you are called, and you cannot go back and say, do you remember in such a meeting?

What are your views and suggestions that will improve CG implementation in Mpumalanga?

I want the recruitment strategy to be worked out. Recruitment and retention strategies for specialists and doctors of course are needed. In the recruitment and retention strategies, I think, Rob Ferreira Hospital has the potential for people to come in and end up getting diplomas, going even to specialize. If that can be sustained, we can go somewhere. It is not there. Themba Hospital, you would think, if you would recruit, let us say a specialist, though it is a regional hospital, how do they retain that specialist? Themba gives them accommodation to their specialists both on-site and in town. They get their rural allowance. We do not get a rural allowance; we do not give accommodation. When you stay in the doctors' quarters, you are easily available and accessible.

If you do not have a recruitment and retention strategy, and you do not have accommodation, how will you retain these doctors? I have recruited Drs Khumalo and

Molomo for ENT, where there has not been a specialist for many years. At their age, these doctors have their families. They were appointed as heads of units. As part of the retention strategy, why don't we offer them subsidized accommodation?

Secondly, discouragement of clinical issues where we have a lot of political interference that is a nightmare. Because now doctors are made to admit because someone is saying this patient must be admitted. I cannot even protect my doctors who must go against what they were trained to do, just because someone up there says this patient must be operated on.

We have a problem of racism at Rob Ferreira, Dr. Maduna, if you are trying to groom young doctors it is difficult. An example is the Anaesthesia Unit where whites are favoured.

RWOPS is another problem. When doctors are supposed to be here, they would rather be at Kiaat Private hospital. Doctors sign attendance registers in the morning and then leave to work in the private hospitals.

8.1.2 Focus Group Interviews

8.1.2.1 Focus Group One

What is your general understanding of CG and what are its pillars?

Participant CEO-01

It is putting measures in place to ensure quality patient care. Currently, it is not adequate. CG is a leadership function, especially from the clinical managers.

With regards to clinical audits, protocols are not developed because many people are acting in the clinical positions they currently occupy. Doctors also tend to rush things in the public hospital so that they can do private work in the private sector.

As far as clinical performance and effectiveness are concerned, where we are winning on our part, (to start positively) is that we are winning on infection prevention (IPC). The reason we are winning there is that we have some years back sent some of Health Care Professionals: doctors and nurses to go and train on the IPC. They now have qualifications in IPC. We sent them to Durban in UKZN (KwaZulu Natal) to do IPC at the University of KZN at the Medical School. As a result, we are now reaping the fruits, and have sent some of the nurses and some of the doctors to go and train full-time there. With that knowledge, we are using it now almost 100 percent because, you know, doctors are a difficult group. They are few in terms of the numbers of employees in the hospital, but if there is no one among them leading, you will have a problem, because some of them have been trained and it is easy for them to take part in the prevention and control. We are not 100 percent, but we do have people who are trained.

The other issue is that in the clinical leadership, we do have most of the HODs (Heads of Department), few gaps in vacant posts, but we do have doctors who are in charge (HODs). As a result, we do have some protocols.

The area where one has some concern is the issue of clinical audits. In the past, we did send some of our doctors and nurses to go and attend courses on clinical audits, but there was a challenge of transferring that training into implementation. There was no movement in that regard. But there we are lacking very much.

The other area where we lack is that in most of the issues of nursing management some people are still acting. As a result, it contributes to what I have said earlier that if you do not have people who are appointed permanently in positions it becomes a problem. So, I think there we are lacking.

The other area is your clinical risk assessment. We are lacking there. But for the adverse events, we do have a committee that deals with the adverse events, it is functional and is working. So, we have a mixture of failures, successes, and shortcomings.

Participant CEO-02

With Tintswalo Hospital, we have won in terms of having a PTC (Pharmaceutical Therapeutic Committee), a functional committee following the appointment of a full-time pharmacist last year (2019) July. PTC meetings are held every quarter. There are minutes, implemented resolutions resulting in the many problems that we have had, being addressed in a brief time, because of the energy that our pharmacy manager is having, so things are going well, despite the infrastructural challenges. The admin and support staff are supporting our pharmacy. The service there is particularly good.

Well, with the IPC (Infection Prevention and Control) and quality assurance programmes, I do have appointed staff. The IPC is doing very, very well and now during the Covid-19 Pandemic, she is at the forefront of everything we appreciate the spirit that she is having. But I am not so happy with the quality assurance manager. He just managed to speak at the interview but is not as active as the IPC manager is. We are still in engagement to see if we cannot shift him to another position so that we can get an active quality assurance coordinator. Also, in that area, it is not so good.

When it comes to records management and in terms of the doctors the issue of name stamps used for signing, most of them have bought them. It is only a few of them that need to be followed, but I believe that with the clinical manager on-site, we will have the stamps that are required for records signature. Because we have given them the clinical guidelines that you provided us with last year. So that has been shared with them.

With mortality meetings, now due to the Covid-19 lockdown, we are no longer coming together. We are now focusing on the screening which is a lot of work based on a monthly schedule. We have been attending to the PHC (primary health care) facilities within the catchment area. Another problem that we are having is that we do not have enough senior doctors now, but we are busy recruiting, and the approval of doctors and nurses is helpful. We have recruited two doctors and the documents are towards approval now and one of the doctors is a Grade 3 medical officer and this will assist us. We are also recruiting one other Grade 3 doctor who is good in surgery and paediatrics. So, we believe that things will come together clinically within a brief period. Otherwise, we are now operating with more and particularly good Community Service doctors who need to be supervised, which is what we are addressing now by getting senior doctors to supervise the Community Service doctors.

What are the barriers, challenges, and successes in patient and public involvement in the Department?

Participant CEO-03

I think with the patient and public involvement, this we are doing through the involvement of hospital boards that are appointed. So, we take it that the hospital boards are serving as a link between the hospital and the community because from us having meetings with the hospital boards, we can provide information about the functioning of the hospital, and they can disseminate because they belong to other structures within the communities. So, they can do what we expect them to do. Otherwise, apart from the hospital boards, we are also involving communities by having events like Imbizo's although we do this once in a year. That is where we can get what the communities would like us to do, what type of services and we can share with them. Otherwise, the other way of involving the community or the patients at large is through the very patient satisfaction surveys because they can express their opinion. So far, I can say on our side like in Mapulaneng Hospital, among the various points which I spoke about, what is strong is the engagement with the hospital boards, but with the Imbizos you find that due to financial constraints, we are unable to have them every year. Otherwise, the rest of seeing how to involve the community is just through the hospital boards.

Participant CEO-02

I also want to come in on patient and community involvement. We also have radio slots. At times we present health topics according to the health calendar. We do go to the local radio stations to talk to the community members about a health topic, whether it is substance abuse, depending on the identified issue. Some of the community

members do invite us as well to their events and we send our staff members to go and represent us in those events. And they come back with attendance registers, as a portfolio of evidence that they did meet with the community members. We also through suggestion boxes can get complaints or suggestions in terms of what we should improve to make our clients happy. The challenge with all these is that there is no budget. We must see to finish how to get the community to attend our event we give them something to eat. So, it becomes a challenge sometimes to get those donations for the events.

Do these hospital boards function? What do you think of the process of appointing them?

Participant CEO-02

From my experience, especially with the recently appointed hospital board, without attempting to offend our principals, the board was not appointed according to the guidelines for the appointment of hospital boards. In our case we have teachers, most of them are teachers. We do not have anyone with legal expertise, there is no one with financial expertise and even a representative from the university. Now, they are all politically appointed, politics being the main criterion for their appointment. So, we are just hoping that they will be helpful now, but at times if the combination is not that good, productivity might take longer than we expect.

As far as individual patients are concerned, do doctors dictate to patients and tell them what to do, or is there an engagement in terms of the management of the patients?

Participant CEO-01

Well, it is a difficult one. But to respond to it, some of the doctors do engage the patient and do take the views of the patient in terms of the presenting issue. But in most cases, because the public health service sees more patients. There is no time to fully engage patients for more than 30 minutes or more, so that you may exchange ideas. Doctors are working under pressure to push the lines or the queues to minimize the average waiting time. In most cases, you find (this is my observation) that they are under pressure to push more patients. So, the issue of staying with one patient for a lengthy period, under an influx of patients is exceedingly difficult. To process, in most cases up to 300 or 400 patients per day, becomes a demanding thing. So, I believe in most cases it is just one-sided because of the time pressure.

Participant CEO-04

The other issue is the language barrier. This is another hassle because if you are short of nurses, and the doctor and the patient are not able to communicate in a language that the patient can understand, obviously regardless of how many doctors you may have, and they can be many, but the language barrier will always be a problem of engagement.

What are the barriers, challenges, and successes in information management in your facilities?

Participant CEO-01

Records management is a problem. I want to talk about it in terms of the quality, as a problem also in terms of records management. We are paper based, because of which many happen. You find that you cannot provide the best quality that you want to

provide because a file of a patient has been misplaced, or is missing, or is stolen because patients also take it for safekeeping. Other stakeholders are interested in these files. If it is a road accident matter or is an issue of suspicion of negligence, that file we know that in most cases it will disappear. So, the continuation of rendering quality service to a patient, means the doctor must start afresh with the record that is no longer there. So, there is no proper continuation, because we are paper based as a result files disappear for several reasons. So, there is a challenge there if I can speak specifically for patient records.

Is the health patient record system that has been introduced in some hospitals not helpful in this regard?

Participant CEO-01

In our case at Themba Hospital, this system has been introduced as a pilot project. The Department has created a partnership with Vodacom where Vodacom is starting to implement an electronic patient filing system. We have just started, and we are hopeful that once it is up and running, we shall have our files not disappearing. It is expected that we are going to move away from being paper based, as a pilot site.

Participant CEO-04

The other issue that I can add to patient record management is that we are having problems in terms of archives. As much as we are opening files for patients every day, there is no proper storage where files are kept locked safely from fire, water, and theft. Files are put in different buildings and thus retrieval when patients come at any time, whether at night or any other day, you find that for a clerk to move from the front desk to go to a building behind the hospital to get the file, is a very daunting task. You find that this contributes to duplication, duplication, and duplication resulting in continuity

of care. So, the introduction of an electronic patient records system will do away with this problem. The other thing is that because we must dispose of certain files according to the policy on records management where some files must be destroyed after 3 years and some 5 years, while accident and maternity files must be kept for 21 years. You then ask yourself where you are going to keep those files for 25 years because storage space is our pain so that the electronic system will help.

What are the barriers, challenges, and successes in clinical risk management in the Department?

Participant CEO-02

In terms of risk management, I am one of the blessed hospitals with a risk manager, and a senior admin officer post in the office of the risk manager is filled. Risk management, risk assessments, risk audits are being conducted and the reports are there. So, the risk manager is taking full responsibility and assisting other facilities that do not have risk staff appointed yet. Just to add that there is no budget to address the identified hospital risks. For example, we do not even have a closed-circuit television in the hospital and all these risks need to be budgeted for. With us, even if we have an appointed risk manager, the budget is not enough. You look at the hospital, like today, there are leakages all over, it is an old hospital, and we look at this risk today and address it, but tomorrow there is a breakdown elsewhere.

Participant CEO-01

In our case, it is not happening. The challenge that we have is that risk management is a tool and can be used as a risk assessment tool that should be used for good management because there are various risks in other areas: it could be clinical, it could be related to safety and security, it could be related to electricity or whatever. In our

situation, the major, major shortcoming or gap, is the failure to fill the post of a security or risk manager. That contributes a lot not to manage risk. As a result, we are having a situation where we just fighting fires which, if there was a risk manager, those fires could have been foreseen and would have been prevented before they occur. In other words, in terms of risks, we are more reactive rather than being proactive because of this gap that this hospital has no risk manager at all.

8.1.2.2 Focus Group Two

For the same reason cited above, where DCSTs have collapsed in the province, the investigator resorted to choosing selected Family Physicians who are currently in the employ of the department, to constitute the second focus group. A total of seven (N=7) family physicians who are employed in various hospitals in the province, were invited to participate. Only two of them attended the meeting, resulting in a response rate of 29 percent. The discussion of the group is presented below with each participant's inputs transcribed from the audio-recording verbatim:

What is your understanding of CG and what are its pillars?

Participant FP01

I understand it to be the coordination, implementation, and assessment of the way the clinical aspect of the healthcare delivery system is being run either electively or on an improved basis.

Participant FP02

To govern means ensuring leadership as far as clinical matters are concerned, there is also auditing, there is peer review. Discipline and training are also important aspects of CG.

What are the barriers and challenges in conducting clinical audits in the department?

Participant FP02

This is one of the areas that are neglected in most of our hospitals. But we need to look back, we need to look back and see how things have been done, are they being done according to standards or not. That is missing. An audit can be done during admission to the institution, it can be done within departments or in the wards and decide to audit ten files every week on Friday. You can randomly take ten files and look at them and see if things are being done properly, and if you pick up all these shortfalls, you address them with the people that are involved. This aspect, I do not think is being done in our hospitals, or if it is done it will be just to hoodwink head office).

Is there an SOP that guides file auditing?

Participant FP02

There are lots of templates for auditing. I have seen three types.

Participant FP01

Auditing should not be based in the hospital alone. It must be disseminated or integrated with the clinics because that is where we have the bulk of the problems, and that is where while the hospital is overpopulated. People need to be empowered. There are tools, as you have rightly said. You will remember when we were active and we were conducting a chronic disease forum, the first step to do is to go to the clinic to audit some of the files. That was a day or two before we come to the presentation. All those audited files from the clinics, we went around the province to different districts to do auditing of the clinic files. The advice was given, but implementation was lacking.

Participant FP02

I do remember that the audits that were done, we did in the clinics. But of course, there was no follow-up and, as you have said, there was no implementation of the recommendations. For the implementation, we need to have an audit team. This does not have to be at the provincial level but should be at the district, even at the sub-district level, to ensure that the audit findings are acted upon.

Participant FP01

To add to that, most of the information that we find was submitted to head office, about the audited clinics in a different part of the province that was done over a period of 4 to 5 years. It took us some time until it was done. Dr. Nkombua will be of major help to that. The person that did the coordination at that time was Sara Gumede.

What are the barriers and challenges in clinical performance and effectiveness in the Department?

Participant FP01

If I may chip in there, we cannot say that the generic training that we received from medical school is ideal. When you look at it the old generation of doctors was trained to look at the complications of diseases. Every patient that we see in the framework of the medical school is less than 5% of the patients that we are treating. And that is the basic issue. Decentralization was attempted when medical students were sent to rural areas. That was an attempt to say that medical students should spend at least one year in the rural areas because 95% of the patients that we on a day-to-day basis are ambulatory. Attempts were also made to say community service doctors should not be in teaching hospitals or level 2 or 3 hospitals. They should be in the rural

community. But when they get to rural communities, Family Medicine should be the champion that leads in terms of clinical knowledge, which have not been given this position. Where we wanted to try to do it in Mpumalanga, that has been the core problem for most of us.

Participant FP02

As far as clinical performance is concerned, the issue starts with the way as Dr. Thiyamiyu has just mentioned. The way we deploy our Community Service doctors and the things that usually happen in hospitals – what usually happens if that the Community Service doctor will come to the hospital and will spend the entire year in one department. If it is anaesthesia, he will be doing anaesthesia that entire year. He does not become diverse. This person is taken to a district hospital to go and reduce fractures, do simple laparotomies, and all that. He will not be able to manage there or even diagnose some of these diseases that he was not exposed to when he did community service. So, we need to start with the community service doctors to ensure that they rotate through these main disciplines and leave out the small clinical disciplines such as ophthalmology so that at the end of training this person can function in a district setting or primary healthcare setting.

Participant FP02

Just to add that the problem we have, and I do not know where it started from, is this notion of a surgeon must be the one who will perform an appendectomy, I do not know where it came from. Because the surgeon must correct complications or do stabilization. Now for every little thing, you must call a referral hospital, and if they reject it believe me most of the medical officers of the last 10 years are never skilled to work in district hospitals. Every little thing they see, they will phone the surgeon,

which makes them deficient. Even management of simple fractures is exceedingly difficult for them to do.

Participant FP02

The clinical performance also requires supervision. A patient seen in Casualty and admitted to the ward is not seen by any doctor. By the time the patient is seen after a day or two, there are complications. The other thing is that ward rounds are not done every day the excuse being that during theatre days or outpatient clinic days there is no time for ward rounds. This results in in-patients that came in not being seen. So, you find that there is a gap there which causes a lot of trouble most of the time. So, we need to have a system where if you need to admit a patient, we must have a holding ward, so that the following morning when we come, somebody can assess all the patients before they go to the ward. But we do not have these holding wards).

What are the barriers and challenges in information management in the Department?

Participant FP02

My view is that it is poorly done, poorly managed. We have got lots of patients who have been your patient for the past 5 years and have a thick file. The patient comes and they tell him they cannot find his file. So, they give him a duplicate file. But that duplicate file will tell you nothing because the information about this patient is in the file that has gone missing. It is an everyday occurrence. Then you see the patient and you put him on the same treatment. The next time they come, the duplicate file shall have gone missing, and a second duplicate file is opened. Now if we are to do an audit or sometimes just to answer queries, you have no information. So, it is a big, big problem. I tried to sort it out at some stage, with our admission clerks, but failed. The issue continues, the problem continues, there is no continuity of care.

Participant FP01

The core of the information management problem lies with documentation by clinicians. If you look at the files of all the litigations that come to your table, you will see that there is an absence or poverty of information. Even if you can retrieve, you cannot make out what is the clinical assessment or clinical reasoning, and you will find out that people just do not treat patients, they just feel for the contractions, and put their finger in the vagina of a woman who is delivering and write 5cm dilated and that is all. Nothing is said about the patient, the baby, and the relative. Therefore, litigation is so high. Even if you go to the emergency unit, the same is happening. No information is recorded.

What are the barriers and challenges in clinical risk management in the Department?

Participant FP01

Managing risk is a very dicey situation. We need people to be coordinated and focused and know what they are doing and what the risk is all about.

Participant FP02

As far as clinical risk management is concerned, the hospitals are not doing the correct thing because they are putting clinical risk together with the other risks where, for example, a patient jumps from a roof. When you attend those meetings, you feel as if it is not addressing the issues of clinical risk. The clinic must take into consideration whether the organization is providing the right environment for work in, are enough tools for clinicians to provide care with, are there enough numbers of clinicians to work. These are the risks that we must look at. When you look at our organograms, they do not address these things. If anything, our organograms have been contracting over

the years: if a doctor leaves, then they freeze that post because they want to save money. Until unions start toy-toying for more money, and the money that was saved from the non-appointment of a doctor is used to pay the toy-toying people. We need an organogram which will tell us the number of people that are needed for each department: how many doctors should be there, how many specialists should be there, so that if there is a shortage, we should know for example that you were supposed to be 6 here, but you are only 4 and are short of 2 doctors. But then we do not have such a structure. If it is there, it is being hidden from many of us.

What are the barriers and challenges in evidence-based practice and research in the Department?

Participant FP01

Quality improvement is what we must investigate and must be practical. The research itself in the PHC is not happening because there is no motivation, at least on my side. When you look across the province, there is a lot that needs to be done, which we do not do, but research in PHC is very crucial.

What are the barriers and challenges in the training and education of healthcare workers on CG?

Participant FP01

I remember when I was first employed by the then KaNgwane Government many years ago. You would be given incentives if you have completed any course be it a

diploma or degree. A percentage of your salary would be given to you as an incentive. There used to be something called journal clubs those days where the hospital itself would have a budget that would be allocated to different sections where journals would be organized on monthly basis. Everything that would encourage people to further their studies has since fizzled away.

Participant FP02

The Department had a health professional training grant (HPTD) that was used to incentivize staff members to improve themselves. It is no longer been used for this reason.

8.2 Ethical clearance certificate

FACULTY OF HEALTH SCIENCES
Research Ethics Committee
P.O Box 1054
East London 5200
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University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE
REC-100118-054

Certificate Reference Number:	**Ref # 2019=10=007=MadunaP**
Project title:	**Challenges in the implementation of clinical governance in Mpumalanga: towards the development of a framework for good governance**
Nature of Project	Doctor of Philosophy in Nursing Science
Principal Researcher:	Maduna P
Student Number:	201928136
Supervisor: Co-supervisor	Prof DR Thakhathi Prof E Seekoe

On behalf of the Health Sciences Research Ethics Committee (HREC), I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instruments(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the HREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the HREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

FACULTY OF HEALTH SCIENCES
Research Ethics Committee

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The HREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
  - Any unethical principles or practices are revealed or suspected
  - relevant information has been withheld or misrepresented
  - regulatory changes of whatsoever nature so require
  - the conditions contained in the Certificate have not been adhered to

- Request access to any information or data at any time during the course or after completion of the project
- In addition to the need to comply with the highest level of ethical conduct principal investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to HREC monitoring@ufh.ac.za.

The Ethics Committee wishes you well in your research endeavours.

Yours sincerely

Professor DT Goon
Chairperson: HREC
28 January 2020

8.3 Provincial research approval letter

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

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Ref: MP_202002_007

Provincial Research Approval Letter

Dr PH Maduna
P O BOX 12838, STEILTES. 1213
Mbombela, 1213

TITLE: **APPLICATION FOR RESEARCH AND ETHICS APPROVAL: CHALLENGES IN THE IMPLEMENTATION OF CLINICAL GOVERNANCE IN MPUMALANGA: TOWARDS THE DEVELOPMENT OF A FRAMEWORK FOR GOOD GOVERNANCE**

Dear Dr Maduna

The Provincial Department of Health Research Committee has approved your research proposal in the latest format you sent.

- Approval Reference Number: MP_202002_007.
- Data Collection Period: 15/03/2020 to 30/09/2020.
- Approved Study Sites for Data Collection:

  i. Mpumalanga Provincial Offices
  ii. Ehlanzeni District Municipal Offices
  iii. Mapulaneng and Rob-Ferreira Hospitals
  iv. Gert Sibande District Municipal Offices
  v. Ermelo Hospital
  vi. Nkangala District Municipal Offices
  vii. Witbank Hospital

Kindly ensure that the study is conducted with minimal disruption and impact on our staff. You are expected to notify facilities in time before you start with your data collection process. You are also required to provide us with a soft or hard copy of the report once your research project has been completed.

Kind regards

DR C NELSON
MPHRC CHAIRPERSON
DATE: 12/03/2020

MPUMALANGA PROVINCE
DEPARTMENT OF HEALTH
12 -03- 2020
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MPUMALANGA
THE PLACE OF THE RISING SUN

8.4 Thesis language editing certificate

Linda Scott
Editing Services

Masters (Linguistics: Intercultural Communication); BA (Hons) Lang Prac; ACE; NPDE
Reg. Member of SATI and SACE

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6 April 2021

To whom it may concern

This is to confirm that I, the undersigned, have language edited the thesis of

Patrick Hawkins Maduna

for the degree
Doctor of Philosophy: Nursing

entitled:

Challenges in the implementation of clinical governance in the Department of Health, Mpumalanga, South Africa: Towards the development of a framework for good governance

The responsibility of implementing the recommended language changes rests with the author of the document.

Yours truly,

Linda Scott