7. FACILITIES AND EQUIPMENT

7.1 COMPLAINTS RELATING TO EQUIPMENT

The quality of health care depends as much on the availability of quality equipment as on the skills and commitment of health workers.

A huge number and variety of equipment critical to good care is required in all hospitals. Two hospitals have been bold enough to report that deaths have occurred as a result of equipment not being available or being broken after passing its useful lifespan a long time ago.

Particular aspects of the problem are:

- Faulty and old equipment giving wrong readings
- Difficulty in finding replacement parts for old equipment
- Breakdowns of X-ray equipment
- Inability of the medical personnel to perform important procedures due to the unavailability of specialised equipment.

Being hamstrung by a lack of equipment or by poor equipment puts strain on doctors and nursing staff. Patients, too, endure distress due to the delays caused before they receive the health care they require.

The root causes of shortcomings in relation to medical equipment are the cost of the equipment on the one hand, and limited financial resources on the other. Hospitals know what they require and could very easily implement an equipment updating/replacement programme. However, the Public Service's budgetary process poses an obstacle. Certain types of equipment are just too expensive to be purchased in one financial year, but payment may not be split up over two or more financial years by the rolling over of funds.

Recommendations

The Commission recommends that -

- the Gauteng Provincial Government approach the Department of State Expenditure to allow hospitals to lease equipment or, where this is not feasible, to spread the purchase of expensive equipment over more than one financial year;
- every hospital appoint dedicated staff to manage small item equipment;
- The Department make a special short-term effort to obtain funds for the replacement of much needed equipment, according to replacement programmes. It has been stated that a once-off capital injection would improve services and result in a much needed morale boost;
- equipment be standardised as far as possible;

- the Department should establish a central data base of equipment and use this as a monitoring tool to prevent the under-utilisation of equipment;
- hospital managements do regular audits of the serviceability and utilisation of equipment;
- equipment which has exceeded its lifespan be replaced as far as practically possible;
- personnel be constantly trained on the use and handling of equipment, especially those items that are sensitive and expensive; and
- hospitals consider the pooling of equipment by area.

7.2 USE OF PRIVATE SECTOR EQUIPMENT

The lack of equipment has led to the use of private sector equipment at great cost. Chris Hani Baragwanath, for instance, sends patients to Sunninghill Hospital at a cost of roughly R1 600 per patient for procedures like angiograms. Approximately 10 patients per week are sent to this private hospital, leading to an expenditure of R16 000 per week.

Recommendations

The Commission recommends that -

- in order to reduce expenditure, hospitals be allowed to tender for provision of services by the private sector where certain equipment is not available to public hospitals; and
- hospitals explore public/private sector sharing of equipment.

7.3 INADEQUATE FACILITIES AND STRUCTURAL PROBLEMS

Various facilities in hospitals are not conducive to patient care. Casualty departments and storerooms in some dispensaries are among the least functional. There is also a shortage of psychiatric wards in most hospitals.

Individual hospitals do not budget for maintenance managed by the Department of Public Works. Hospitals do provide budgetary inputs to the Provincial Department of Public Works, but despite this there is a chronic shortage of funds for maintenance and other works-related activities.

Almost all hospitals complained that Public Works staffs are not really pro-actively committed to the upkeep of hospital facilities and only respond to official work orders. Although there may be two sides to this story, it would nevertheless seem to be advantageous to define Public Works' role as a pro-active advisory relationship whereby Public Works staff could monitor conditions and advise hospital management.

In this way hospitals would also be more aware of what budgetary inputs and concomitant motivation to provide to the Provincial Department of Public Works which, for its part, would be in a better position to do strategic planning and budgeting.

Recommendations

The Commission recommends that -

- the allocation of maintenance personnel be extended to all hospitals;
- hospitals be permitted to secure private services if the PWD does not respond to maintenance requests within a given time; and
- the Public Works Department is made responsible for the monitoring and repairs in a pro-active manner to avoid property becoming dilapidated.

8 PATIENT WAITING TIMES

Patients spend long times waiting to be attended to. However, times differ from hospital to hospital and are dependent on a number of factors. Waiting takes place mostly at out-patient and casualty departments and sometimes in relation to theatres.

The following are the average waiting times affecting outpatients and casualty patients.

- - 2 months when booking appointments (OPD)
- - 3 hours before being served by clerks (OPD and casualty)
- - 3 hours before being screened medically by nursing staff
- 45 minutes to be examined by a doctor
- - 3 hours before being served at hospitals' dispensaries (OPD)
- 46 minutes and more before being transferred to hospital by ambulance
- 46 minutes and more to be examined by a doctor (OPD and casualty)
- 46 minutes and more to be X-rayed (OPD and casualty)
- - 3 hours to undergo diagnostic tests (OPD and casualty).

The Commission noted with concern that some hospitals have incidences of patients waiting up to 4 months for tests such as angiograms. In one hospital patients are turned away after a certain quota of prescriptions had been issued. Waiting times in this instance can be as high as 24 hours.

A major delaying factor in the administration section is the manually administered patient record system, which exists at four out of the five hospitals. Slowness is due to -

- the large numbers of patients;
- the labour-intensive nature of the work ;
- a fairly high incidence of misplaced files; and
- removal of patients' MVA files, allegedly for lawyers' purposes.

Other delaying factors include -

- overall staff shortages relative to patient numbers;
- insufficient ambulance services;
- a lack of serviceable equipment, relative to patient numbers; and
- unavailability of high-care beds.

Patients also complain that it takes a long time before they are attended to by medical and nursing staff.

Waiting is also experienced by in-patients, especially due to cancellation of theatre procedures. Numerous reasons are given for such delays -

- shortages of linen for surgical use;
- staff shortages;
- unavailability of theatre time due to emergencies; and
- shortages of equipment.

It is difficult to make a value judgement on the various waiting times reported. On the one hand it can be argued that these waiting times are, by any standard, not acceptable. However, an absolutely open and accessible health-care service, coupled with the socio-economic and crime-related problems that this country is faced with and with limited resources (which all countries face), is bound to place the available infrastructure under strain.

Nevertheless, there would seem to be room for updating administrative technology and procedures to speed up patient administration. Current manually operated patient record systems are not acceptable in this day and age, given the patient numbers that hospitals have to cope with.

Although financial constraints will not allow all hospitals' systems to be upgraded simultaneously, it is nonetheless proposed that the process be commenced with, even if only in a piecemeal fashion. Delaying the addressing of the issue will only tend to exacerbate problems.

Recommendations

The Commission recommends that the Department and hospitals urgently address the following:

- The installation of appropriate IT systems or, where this is not possible, an efficient filing system
- Safekeeping of motor vehicle accident files
- Aligning high-care beds with patient demand and a liaison system/common database for high-care beds
- The display of Patients Charters in visible areas at all times and a process to inform patients of their rights
- Display by hospitals of contact telephone numbers and addresses where complaints can be lodged

9 SHORTAGE OF LINEN AND THE ROLE OF LAUNDRIES

9.1 GENERAL

Two laundry systems are in operation. The first is where laundry services are available on site or within the hospital premises. In this case the linen belongs to the hospital. The second is where laundry services are provided by a central laundry servicing several hospitals. In this case the linen is the property of the laundry.

The shortage of linen manifests itself in –

- unavailability of clean linen to patients;
- cancellation of theatre proceedings;
- patients being exposed to soiled linen with the risk of cross-infections; and
- patients being asked to bring their own linen.

The two central laundries - Masakhane in Pretoria and Dunswart on the East Rand - as well as the in-house Chris Hani Baragwanath laundry were investigated. Issues like the inadequacy of the budget, services provided to other provinces, constant breakdown of machines, non-replacement of condemned linen and inventory control problems were identified as major problems.

9.2 NON-REPLACEMENT OF CONDEMNED LINEN

Linen replacement has not kept pace with demand due to insufficient funds. At Masakhane Laundry, for instance, due to limited funds (R400 000 was allocated for the 1999/2000 financial year) it has been next to impossible to replace condemned linen. The effect has been a 33% decrease in inventory/stock levels between 1994 and 1999.

There is a sewing room where torn linen is mended at Masakhane Laundry. Our unconfirmed assessment of this operation is that it could be more costly to run than the savings brought about by repairing linen.

9.3 CANCELLATION OF OPERATIONS DUE TO LINEN SHORTAGES

Theatre procedures are from time to time cancelled due to non-availability of linen. Linen supplies exist but they are not washed and sterilised for use. Sudden cancellation of surgery has a psychological effect on patients and it leaves theatre staff unproductive. In some instances theatre staff have resorted to using sterile gowns as towels to deal with emergency operations.

9.4 LACK OF LINEN INVENTORY CONTROL AT HOSPITALS

The Commission found that most hospitals do not count outgoing linen and as a result the number of used items sent back by hospitals does not always tally with that issued. The effect of this is the continuous accusation by laundries that hospitals do not return the alleged number sent.

Unlike hospital staffs, who fear infections from handling dirty linen, laundry personnel fulfil the task of counting linen. The conditions under which they do so leave much to be desired. Gloves and nose/mouth covers are provided but counting personnel (including managers) do not use them as required. This could constitute an occupational health hazard.

9.5 FREQUENT MACHINE BREAKDOWNS

Hospitals with in-house laundries seem to have more breakdown related problems than, for instance, Masakhane. At Chris Hani Baragwanath, we were informed that the backlog in clean linen supply is caused by continual breakdowns.

Chris Hani Baragwanath has four state-of-the-art, fully computerised machines. We were informed that at no stage are all the machines in operation. On discussing breakages with senior management, suspicion of deliberate breaking of the machines by laundry personnel in order to create a need for overtime came to the fore. It is difficult to validate this allegation.

9.6 LINEN THEFT

Hospitals alleged that theft of linen takes place at the laundries while the laundries alleged that theft happens at the hospitals.

In the case of Masakhane, linen losses between September 1998 and February 1999 amounted to R 2 225 140.84, an amount not provided for in the budget.

An example of the magnitude and the financial implications of theft at Chris Hani Baragwanath is as follows:

TABLE 7: DETAILS OF LINEN LOSSES AT CHRIS HANI BARAGWANATH HOSPITAL

LINEN LOSSES 96/97	Units	Unit price R	Total cost
Gowns green	4824	57.00	274968.00
Cloth lotion green	9084	19.20	174412.80
Blanket Wool large	1502	104.06	156298.12
Towel Turkish	5474	24.00	131376.00
Trouser pyjama large	3842	34.00	130628.00
Wrapovers	2141	57.00	122037.00
Nightdress XXX large	3112	38.00	118256.00
Cloth lotion white	4510	19.20	86592.00
Sheet large	1747	41.00	71627.00
Nightdress infant	4828	13.80	66626.40
Sheets draw	2255	27.00	60885.00
Gowns dressing large	458	127.00	58166.00
Gowns nurses	974	56.00	54544.00
Drs shoes	7206	14.00	50442.00
Jackets waiters	1127	44.00	49588.00
Drs shirts	1426	26.00	37076.00
Blankets cotton large	742	44.00	32648.00
Jackets pyjama large	764	41.00	31324.00
Nightdress 7-12 years	1118	23.00	25714.00
Drs trousers	947	26.00	24622.00
Cloth kitchen	1164	12.88	14992.32
Aprons white	675	21.00	14175.00
Nightdress 3-6 years	759	18.60	14117.40
Trouser pyjama small	463	26.00	12038.00
Blankets bunny	415	28.59	11864.85
Trousers waiters	277	26.00	7202.00
Trunks orthopaedic	24	24.00	576.00
Cover bed pan	58	7.50	435.00
TOTAL	**61916**		**1 833 230.89**

LINEN LOSSES 97/98	Units	Unit price R	Total cost
Gown wrapover white XXX large	7045	52.01	366410.45
Bath towel	9653	31.02	299436.06
Woolen blanket large	1511	194.41	293753.51
Gown theatre green XXX large	3308	60.21	199174.68
Towel theatre green	8560	17.94	153566.40
Gown dressing XXX large	962	153.2	147378.40
Pants operating doctor X large	3154	45.96	144957.84
Nightdress XXX large	3695	38.69	142959.55
Bed sheet	2769	49.5	137065.50
Jacket pyjama XXX large	1431	58.28	83398.68
Bedspreads large	1320	58.68	77457.60
Draw sheet	3513	20.32	71384.16
Nightdress infant	4107	17.27	70927.89
Pants pyjama XXX large	1030	58.13	59873.90
Woolen blanket small	1186	45.5	53963.00
Blanket bunny	1767	29.64	52373.88
Towel dressing white	3411	15.06	51369.66
Tablecloth damask	504	65.57	33047.28
Pillow slips	2328	13.96	32498.88
Shirts operating doctor X large	1107	27.17	30077.19
Nightdress medium	570	34.23	19511.10
Cradle sheet	810	16.53	13389.30
Cloth kitchen	721	7.56	5450.76
Apron bleached calico	196	15.12	2963.52
Maternity skirt large	43	30.36	1305.48
TOTAL	**64701**		**2 543 694.67**

9.7 AD HOC SOLUTIONS TO THE LINEN SHORTAGE

As a result of linen shortages some wards have resorted to advising patients to bring their own linen. At Chris Hani Baragwanath, for instance, ward 20 has colourful beds covered with a variety of linen brought in by patients who otherwise would have been without linen.

9.8 LAUNDRY SERVICES TO HOSPITALS OUTSIDE GAUTENG

Some of the laundries, especially Masakhane, also serve hospitals outside Gauteng. Though this is done at a fee, the charge of 80c an item does not cover all the overhead costs. For instance, the distance between the laundry and the Northwest hospitals makes for high transport costs, which impact, negatively on the laundry's budget.

While the concept of charging for services to outside hospitals is generally a good idea for continued sustainability, charges should reflect the actual costs.

Recommendations

The Commission recommends that an Organisational and Work-Study investigation be done urgently in respect of the methodology of laundry management.

In the interim it is proposed that:

- Hospitals employ laundry inventory control at ward level
- The Department investigates outsourcing linen and laundry services
- Theatre linen is given priority over other linen to avoid cancellation of operations
- Technicians be made available, if possible, on site to expedite repairs and that reasons for such breakages are recorded and trends analysed to detect negligence or deliberate sabotage
- Security be strengthened by clearly marking linen
- Communication between laundries and hospitals be improved.

10 DISPENSARY-RELATED PROBLEMS

10.1 GENERAL

The Commission was made aware of various systems in operation at the different dispensaries. Time did not allow for an in-depth study of these systems but it was suspected that they have a bearing on the different abilities of hospitals to deal with dispensary demands. The systems are:

- “Drop bin” : Sebokeng
- Queuing system : Tembisa, Chris Hani Baragwanath and Natalspruit
- “Drop bin”/Card/ Number system: Pretoria Academic.

Some hospitals are unable to cope with the load and between 300 and 500 patients are requested to return the following day for medication after spending the greater part of the day waiting for medication. This happens when a specified target is reached.

At other hospitals pharmacists continue working until all patients have been attended to. However, this involves remunerated overtime, which impacts negatively on the budget.

Generally, hospitals experience high turnover rates of pharmacists. Stressful conditions under which they perform their duties, remuneration which is not market-related, an inability to do ward rounds and be intellectually stimulated and a lack of career prospects were cited as major reasons for the hospitals' inability to retain this category of employees. As a result, hospitals are forced to make do with skeleton pharmacy personnel, an element that contributes to long waiting times.

The Commission noted the dilapidated state of the pharmacies and their furniture.

10.2 THEFT OF MEDICATION

Theft of medication is a major problem. Expensive medicines are specifically targeted. Due to a lack of control measures, medicines are lost between dispensaries and wards.

Most hospitals rely on alarm systems, steel doors and a few have CCTV to curb theft. This does not seem to be adequate since most of the thefts involve insiders who understand the systems.

10.3 STORES STOCKS AND MEDICATION INVENTORY CONTROL

Most dispensaries have no formal system of inventory control. Stock control is normally allocated to one individual who is required to know what is available and what needs to be ordered.

As a result of lack of control, in four out of the five hospitals expired medications were found, especially in wards. According to the pharmacists, checking ward stocks used to be the function of pharmacists but in the light of shortages of pharmacists this function was allocated to ward sisters.

Recommendations

The Commission recommends that the Department and hospitals urgently address the Following:

- Recruitment of pharmacists and pharmacist assistants
- Training of pharmacist assistants
- Initiating a review of the salaries of pharmacists
- The installation of appropriate IT systems
- Installation of effective security systems in areas where medicines are kept
- Research on the different systems (drop bin, queuing and card number) to identify and institute a system which will ensure that no patients are sent home without medication
- Monitoring of overtime worked by dispensary personnel to prevent abuse
- Implementation of formal systems of inventory control at all pharmacies
- Designation of individuals (pharmacists or ward sisters) responsible for ensuring that no expired medication is retained by wards and for ensuring stock rotation
- Destroyal of expired stock
- Regular audits of the medicine kept in the wards
- Locking of ward boxes and introduction of boxes where they do not exist. Any discrepancy in the medicine ordered and the medicines delivered to the wards should be reported
- Organisation of structured meetings between pharmacists of the various hospitals at which information is exchanged
- The review of structural arrangements around pharmacies.

11 CATERING AND FOOD SERVICES

Complaints about the quality and quantity of food do not affect all hospitals. Where food is an issue the following aspects were mentioned:

- Staff in the wards eat meals and/or snacks intended for patients
- Patients sent for tests to other hospitals do not get food either at the referring hospital or the hospital performing the tests
- Patients admitted after a certain time do not get food on that day
- Sometimes patients are alleged to be "starved". The counter-charge is that some patients refuse to eat
- Nurses do not feed patients who cannot eat without assistance
- All hospitals reported high levels of pilfering or theft in their kitchens – in some cases it had reached alarming proportions
- Pilfering also occurs when food is transported to patients. This creates problems, particularly in the case of patients on special diets.

Financial constraints limit the diversity of menus. Hospitals do in some cases admit that the food portions are perhaps smaller than they would like them to be.

Recommendations

The Commission recommends that the Department and hospitals:

- monitor dieticians' adherence to dietary guidelines;
- institute better control over food ordered and food dispatched to patients; and
- Take strict disciplinary action against staff stealing supplies and food intended for patients.

12. COMMUNICATION

Communication within the health system can be improved. Communication problems exist -

- between the Department and hospitals;
- between hospitals;
- within hospitals;
- between hospitals and the primary care facilities;
- between hospitals and communities; and
- Between health workers and patients.

13. PATIENT ADMINSTRATION AND INFORMATION

Record-keeping systems are central to any administrative environment and hospitals are definitely no exception. Four out of the five hospitals do not as yet have a computerised health-care management system, making the admission and billing of patients a cumbersome process. This also hampers the recovery of bad debt.

As already mentioned, this poses a major obstacle to attending swiftly to patients, be it

in the outpatient section, the casualty section or at the dispensary.

Recommendations

The Commission recommends as follows :

Although information technology is never cheap, the effectiveness and efficiency benefits make it a financially viable route to consider as a matter of urgency. A province-wide computerised patient record system would detect cases where patients use multiple institutions for the same condition at State cost.

14. MANAGEMENT

14.1 INTRODUCTION

The health-care environment is human resource intensive and therefore human resources play an extremely important role in health care. No inquiry into the status of health care and possible causes of poor care would be complete without focussing on this issue.

The inquiry therefore deemed it appropriate to monitor a number of basic operational areas that could adversely affect the management of the hospitals' human resources - and therefore service delivery. This was done by means of a set of questionnaires, which were filled in at hospital level. The results of this survey are discussed below. They were made available to management prior to the public hearings for their comment.

Hospital managements are generally faced with the following behavioural problems in the workplace:

- Absenteeism without prior warning/arrangement
- Poor adherence to official hours of attendance
- Limited numbers of staff available after hours
- Difficulty in planning shifts when staff -

  Want to go on leave; and/or
  Are absent on sick leave

- Poor supervision after hours because of workloads
- Insubordination
- Intimidation
- Lack of commitment
- Low morale
- Poor work ethic
- Substance abuse
- Safety issues

- Security issues.

Running an institution successfully with any combination of the above problems is no mean feat. Each of these problems normally requires the skills of industrial psychologists if it is to be successfully solved. Yet it is expected of fairly low-level managers with limited delegated authority and practical training, to deal with such serious/issues.

14.2 SUPERVISORY/MANAGERIAL RESPONSIBILITIES

Supervisory/managerial responsibilities stretch across all of the matters that follow, but it is perhaps necessary to provide a general survey in this respect.

Hospital management, although following specific organisational structures, is generally poorly organised:

- Hospitals are not divided into manageable units with realistic spans of control
- Any hospital is a multi-disciplinary institution where the day-to-day managerial complexities surpass those of many Departments. Yet hospitals are headed by people at director level or even deputy director level
- Considering the cascading of responsibility to subsequent managerial levels, it is clear that far too much is expected in management terms from people at rather junior ranks
- There is no training or inadequate training for management
- Hospital managers also lack executive decision-making powers.

This combination of factors is a sure recipe for administrative disaster.

It is symptomatic of the foregoing that internal co-ordination and liaison between various sections in hospitals are often problematic, despite a general initiative at all hospitals for sections to have regular discussions and exchange ideas on problem-solving.

The solution to this cluster of problems is not at all clear, considering national implications and financial constraints. It requires a careful Organisational and Work-Study investigation.

One thing is certain: A hospital's organisational structure and delegated powers of authority cannot realistically be approached in accordance with conventional Public Service blueprints. A fresh approach is required.

Some more specific problems which emerged were:

- Job descriptions, duty sheets and procedure manuals do not truly reflect current job content, are not aligned to the hospital's objectives for service delivery and lack ethical guidelines. This gives rise to situations where staff can legitimately refuse to obey requests or instructions. Out of date job descriptions and duty sheets have little value in terms of guidance or training.

- Supervisors and managers have not been trained for supervisory/managerial duties. This may contribute to a situation where they do not always pay adequate attention to this aspect of their role.

Recommendations

The Commission recommends that the Provincial Department of Health accord high priority and pay careful attention to the revision of hospital structures and the delegation of executive powers to hospital managers.

This factor is by no means a cure-all for health care problems, but it will no doubt go a long way towards improved decision-making and raising the general level of efficiency in hospitals.

The Commission further recommends that -

- hospitals attend to the regular updating of duty sheets and the drafting of appropriate job descriptions; and
- Supervision over junior supervisory and non-supervisory staff, especially in nursing, be stepped up.

14.2.1 ACCESS TO AND KNOWLEDGE OF REGULATORY PRESCRIPTIONS

To enable supervisors/managers to perform their duties within the ambit of existing regulatory prescriptions, access to and a thorough understanding of all prescriptions relevant to their jobs are essential prerequisites.

All hospitals indicated that their supervisors/managers were either provided with or had access to most of the regulatory prescriptions applicable to their responsibilities. In cases where they were provided with their own sets of prescriptions, it was their responsibility to update these. However, there was no control mechanism in place to ensure that everybody who should receive these documents and their amendments did indeed receive them. This could lead to supervisors/managers not necessarily having access to updated regulatory prescriptions.

Considering that supervisors/managers are also responsible for disseminating policy information to their subordinates (who, in the majority of cases, indicated that they do not have access to regulatory prescriptions), this could be detrimental to effective and efficient hospital management.

Four hospitals reported that training was provided to empower supervisors/managers in respect of their supervisory/managerial responsibilities, whilst all hospitals also provided procedure manuals. However, the survey revealed that the quality of both training and procedure manuals was inferior.

The bulkiness of the documents concerned hampers the process of making regulatory prescriptions available to supervisors/managers and their subordinates.

Although the Department provides quite a range of training, unfortunately hospital managements attend these poorly, apparently as a result of their workloads.

Recommendations

The Commission recommends that -

- hospitals identify all role-players who should receive particular policy documents

(and amendments), develop a distribution list and (in order to maintain control) ensure recipients sign for receipt;

- the Department should conduct a training needs survey to determine supervisors' and managers' training needs in respect of their supervisory/managerial duties.The Department should also ensure the development of relevant training material; and
- the Department should review or redevelop procedure manuals to which supervisors/managers can refer for guidance.

14.2.2 ASSESSMENT OF STAFF PERFORMANCE

The timeous and accurate assessment of staff's work performance is of critical importance for the following reasons:

- Effecting rank/leg/post promotions
- Identifying and addressing training needs
- Attending to the suitable placement of staff
- Confirming probationary reports and effecting permanent appointments
- Allocating 2nd or 3rd notches in accordance with the Salary Grading System
- Rewarding sustained above-average work performance.

All hospitals reported that their supervisors/managers were familiar with hospital policy on the management of staff assessments and did not require additional training. They did, however, point out that widespread uncertainty existed about the Personnel Performance Management System (PPMS).

However, all hospitals reported that delays occurred in respect of -

- the timeous assessment of staff ;
- the timeous effecting of rank/leg promotions;
- the timeous assessment of probationers' performance;
- the timeous allocation of 2nd or 3rd notches;
- the timeous assessment of promotability for promotion purposes;
- the timeous rewarding of sustained above-average work performance; and
- The timeous identification and addressing of training needs.

According to the hospitals, the above delays were brought about by -

- heavy workloads, both on the part of the employees being assessed who had to provide incidents for assessment and supervisors/managers, who had to actually deal with cases;
- large spans of control for supervisors/managers; and
- Budgetary constraints - for example where merit awards and notch increases had to be effected.

Considering the reasons given, it is appreciated that these delays cannot be addressed with any speed and are symptomatic of the less than ideal management at hospitals,

arising from inappropriate organisational design.

It is nevertheless important to note that this state of affairs will hamper all attempts to raise the morale of staff. Having to wait for official acknowledgement and feedback on performance as well as financial rewards for sustained above-average performance can hardly be expected to promote staff morale.

Delays in identifying training needs can also not be afforded in an environment where excellence in service delivery is the aim.

Discussions with unions and staff on the dilemmas that supervisors/managers and hospitals at large face could bring about some understanding, but will not eliminate the serious problems in hand.

Recommendations

The Commission recommends that, in the interim -

- all hospital role-players schedule backlogs in order of priority, plan work days in accordance therewith and see to it that a number of cases are dealt with each day on a continuous basis. The Provincial Department of Health may want to consider monitoring the situation to encourage hospitals to make progress; and
- that the Department consider addressing the organisational design at hospitals, including the spans of control of supervisors and managers.

14.2.3 PROCESS IN THE FILLING OF POSTS

The timeous filling of posts is critical to effective service delivery. All role-players involved in this process ought therefore to be optimally empowered and the regulatory framework should promote efficiency in its procedural steps.

All hospitals indicated that they did have a policy on the filling of posts and that their supervisors were adequately trained in this respect
The majority of hospitals reported the following constraints in respect of the staffing of their hospitals:

- Number of “frozen” posts
- Number of vacancies
- The turnover of staff
- The time it takes to fill posts
- Insufficient occupational types allocated to hospitals.

The majority of hospitals reported that the following constraints hampered the timeous filling of vacant posts:

- Cumbersome recruitment procedures
- Lack of delegated authority
- Drawn-out process of advertising posts
- Lack of applicants meeting requirements.

The new Public Service Regulations will go a long way towards assisting hospitals in addressing the matter of cumbersome post-filling procedures**.**

Recommendations

The Commission recommends that the Department provide hospitals with a policy and procedural framework for the filling of posts and also provide training in its application.

14.2.4 STAFF SHORTAGES

The well-oiled and interactive support provided by the various constituent parts of an institution are crucial to effective and efficient service delivery. It is unfortunately so that if one organisational unit is disfunctional, all others dependent on it for their smooth functioning are immediately negatively affected.

Whereas each hospital would have its own unique profile of staff shortages, all hospitals complained that -

- a shortage of anaesthetists was adversely affecting the functioning of general, orthopaedic and neuro-surgery; and
- Staff shortages at pharmacies, nursing departments, portering and cleaning services were adversely affecting all clinical departments.

Several hospitals reported critical staff shortages in -

- administrative staff;
- rehabilitative staff (occupational therapists, speech therapists; and physiotherapists)
- specialists.

There is great appreciation for the responsible manner in which the Department currently handles the Province's health-care budget. However, it has to be acknowledged that this is having an *extremely* negative effect on the filling of sometimes-crucial vacant posts.

The current policy in this regard is that hospitals may only fill posts if they are operating within their individual budgets. Against the backdrop of budget provision below previous spending patterns, post-filling is in practice not possible, with the result that –

- hospitals are often unable to fill critical posts; and
- Hospitals are currently not in a position to offer careers too much needed registrars.

The Department has, however, developed its Service Plan. When implemented this will provide clarity on the number of posts and the level of services at hospitals. It will also enable hospitals to plan and to fill key posts when needed.

While the constraints on immediate post-filling are understood, the problem is that hospitals arrive at such a situation in a non-strategic manner and the resultant vacancies in vitally important posts adversely affect services.