Recommendations

The Commission recommends that the Gauteng Provincial Government should, as a matter of urgency, initiate the freezing of non-critical administrative posts in the Department or in the Province at large to make funds available to fill a number of predetermined key posts in hospitals.

14.2.5 HOURS OF ATTENDANCE

Faithful adherence to official hours of attendance is a pillar on which effective and efficient service delivery stands. It also represents a basic principle of discipline in the workplace.

Three hospitals reported that all of their staff were familiar with hospital policy on hours of attendance. All hospitals also reported that they utilised attendance registers, two hospitals had duty rosters for shift workers and three hospitals had call lists to ensure that hospital staff rendered the minimum prescribed hours of service per day in order to sustain service delivery.

Despite this, hospitals reported that all categories of staff did not faithfully adhere to prescribed hours of attendance. This was also borne out by patients' perceptions and the superintendents' testimony at the public hearings the Commission held.

It is clear that there is room for improvement.

More effective enforcement of adherence to work hours will have the spin-off effect, together with the more speedy assessment of work performance, renewing awareness that work environments need to be run with discipline in order to be effective and efficient.

The recently abolished system of doctors doing limited private practice (LPP) during working hours led to considerable abuse. The fact that a number of senior doctors and specialists were routinely absent during working hours had a negative impact on other categories of staff.

The system has recently been replaced with the generally applicable procedure for Remunerative Work outside the Public Service (RWOPS). Compliance with the RWOPS provisions will require close monitoring by hospital managers.

Recommendations

The Commission recommends the following:

- Tightening up on control and discipline is looked into without delay.
- In order to avoid creating despondency and resistance, unions and staff alike should be informed on this matter in a non-autocratic and positive manner, pointing out that by tightening up on hours of attendance, service delivery can be enhanced in a very fair and effective manner without spending more money.
- The RWOPS procedures, which replace limited private practice, be carefully monitored and equitably applied.

14.2.6 LEAVE

Discretion regarding the granting and taking of leave is essential to ensure optimal human resource capacity for effective service delivery.

All hospitals indicated that all of their staff were familiar with hospital policy on leave and that annual vacation leave was discussed, planned and scheduled well in advance.

However, hospitals also reported -

- a significant degree of absenteeism as a result of sick leave amongst nursing staff and auxiliary staff;
- a significant degree of abuse of sick and study leave by nursing and auxiliary staff; and
- that the frequency of leave taken hampers the capacity to deliver services among nursing, medical, pharmaceutical and auxiliary staff.

One of the first areas in which unhappiness in the work sphere manifests itself is in absenteeism, notably excessive use of sick leave. To some extent sick leave presents an easy way for people to escape their unhappiness – stemming perhaps from a wide-spread perception that large numbers of posts are vacant and each worker is handling the work of more than one person (although this may not actually represent an excessive workload).

Against this backdrop, staff in basically all hospitals feels hamstrung by staff shortages, budgetary constraints and/or lack of equipment. It is therefore no surprise to find high incidences of sick leave. It has also been reported to the Commission that some staff members view sick leave as an entitlement.

Be that as it may, absenteeism further compounds the already disruptive effect of staff shortages on hospitals' ability to function optimally.

Addressing this problem in a positive manner requires that the causal factors be removed. However, this is for obvious reasons. Easier said than done. The adoption of the Service Restructuring Plan of the Department may assist by bringing certainty in this regard and even in dispelling a couple of myths.

Recommendations

The Commission recommends that -

- team-building initiatives, positive reinforcement for work done and opportunities for venting concerns and frustrations be used in the interim to improve staff morale;
- the Department and hospital managers communicate the budgetary problems of the Department and its plans for restructuring service (including the rationale for this) to all levels of staff in order to establish much-needed understanding; and.
- the use of sick leave by individual staff members be monitored and followed up.

14.2.7 OVERTIME

In order to ensure effective service delivery; overtime can be employed to effectively address abnormal workloads and emergency situations. Whereas overtime norms have been established for doctors, this is not the case in respect of other staff members. Hospitals' ability to utilise remunerated overtime effectively in respect of other staff categories is limited by budgetary constraints.

Four hospitals reported that their supervisors and managers were familiar with hospital policy on overtime and did not require additional training in this regard.
In order to curb unnecessary expenditure in respect of remunerated overtime, hospitals take the following sequence of steps prior to the granting of such overtime:

- Redistribution of duties
- Simplification of duties
- Reallocation of staff
- Temporary utilisation of staff from other components.

However, the following factors necessitate the working of overtime at the majority of hospitals:

- A high incidence of emergency situations
- A sustained heavy workload
- The limited number of posts
- Large numbers of vacant posts.

Recommendations

The Commission recommends that staff working unremunerated overtime are to be rewarded for their efforts by giving them time off, when and if possible, and by recognising this additional work in the assessment of their work performance***.***

14.2.8 LABOUR RELATIONS

The inculcation of key labour relations principles and procedures is necessary to ensure the pro-active promotion of labour peace, which represents another pillar on which effective and efficient service delivery rest.

Four hospitals have their own labour relations units to oversee the management of labour relations. However, all hospitals experience a shortage of officials to deal with -

- labour relations issues;
- providing or arranging for training on labour relations;
- the investigation of collective disputes; and
- Advising on grievances and disputes.

Labour relation's officers are, according to hospitals, generally not adequately trained

for advising on grievances and dispute settlement.

The survey also revealed that hospitals' labour relations officers are largely dependent on the initiatives of the Department to guide their activities - for example, in respect of facilitating training, holding consultative talks between hospital management and unions, developing policy, etc.

Three hospitals reported that they have labour relations policies and that their supervisors and managers are familiar with these. These three hospitals also reported that staffs were conversant with these policies and the basic principles of the Labour Relations Act, as a result of information sessions and circulars.

Only two hospitals have a strike management team, whereas three hospitals have a contingency plan to deal with industrial action. According to these hospitals, their supervisors and managers were familiar with the contingency plans. However, this can be questioned in view of the foregoing limitations.

Although all hospitals recognise various trade unions, only three have entered into recognition agreements with such unions. The lack of agreements in all instances may contribute to the sometimes-troubled relationships between hospital management's and union representatives at the hospitals.

It would help to resolve this problem if recognition agreements were entered into for all institutions that contained, amongst other things, a code of conduct for shop stewards.

Another reason for an unsatisfactory relationship could be poor communications between hospitals and unions, despite regular meetings. There appears to be a lack of co-management of problems, a practice which should not only be used during crises and in a piecemeal fashion.

Because union officials are not being properly informed by management on numerous issues, they have no alternative but to draw their own conclusions, which are tainted with misunderstanding, mistrust, suspicion and antagonism.

It is quite clear that hospital management's and unions are in opposing camps. Where and when they do interact, the interaction is more often than not strained and seldom constructive.

The above negative relationships inevitably spill over into practically all-human resource management areas, notably the enforcing of discipline. Although supervisors and managers may be conversant with hospital labour relations policy, they are in many cases out of their depth as far as labour rights and basic procedural steps are concerned.

Union representatives on the other hand are well informed about these matters and quite easily intimidate managers with their knowledge, causing managers to become reluctant to deal with disciplinary problems. Although the Department has expended a lot of time on training hospital management's in this regard, it is quite apparent that they have met with poor results.

Unions actually have an important role to play in the workplace and have made a constructive contribution in respect of -

- enhancing ethical behaviour by being involved in educating their

members in this regard; and
- Enhancing service delivery by participating in the formulation, monitoring and facilitation of hospitals' service delivery programmes, general trouble-shooting and problem solving.

This is the type of involvement that should be encouraged at hospitals. Unions should be viewed as part of the problem-solving team and not as part of the problem. Unions should adopt a similar approach of concentrating on problem solving. It may not always be appreciated, but unions actually hold the key to enhancing service delivery. An institution can have any number of good managers and managerial systems in place, but if their relations with organised labour are strained, hospital management will have difficulties in managing and mobilizing its workforce.

Recommendations

The Commission recommends as follows:

- Hospital management's should share their knowledge, insights, concerns and constraints with unions on a regular basis to bring about a thorough understanding of the day-to-day problems they have to deal with

- Hospital management's should pay greater heed to unions' requests for meetings and should take special care to treat all unions equally

- The Department should obtain the assistance of labour relations specialists, if need be, to enter into recognition agreements for all hospitals which also deal with the conduct of shop stewards

- The Department should evaluate its labour relations training for managers, revise it if necessary and repeat it, making attendance obligatory for supervisors and managers

- The Department should facilitate training of shop stewards by outside training companies and should take this up with unions in the context of rebuilding labour relations at hospitals

- Hospital managements should also receive training, which enables them to understand and come to terms with the role of shop stewards.

14.2.9 GRIEVANCES AND DISPUTES

The timeous addressing of grievances and disputes plays an important part in effective and efficient service delivery. It stands to reason that a discontented workforce's attention will not be on their work but will be taken up by their concerns and frustrations.

According to three hospitals, their supervisors and managers were fully acquainted with the policy regulating the management of grievances and disputes and did not require any training in this respect. All hospitals indicated that they had a person assigned to oversee the handling of grievances/disputes.

As far as the incidence of grievances and disputes in the five hospitals over the last 12 months goes, the following can be said:

- A small number of grievances/disputes were formally lodged
- A small number of conciliation board meetings were requested
- A small number of disputes were referred to the Labour Court
- A small number of grievances were referred to the Public Service Commission.

The following represent the types of grievances that were lodged over the last 12 months:

- Rank and salary disputes
- Conflict with supervisors
- Sexual harassment
- Job content of porters (unwillingness at lower levels to transport corpses)
- Protracted unremunerated overtime.

It is evident from the above that the incidence of grievances/disputes in hospitals is comparatively low against the backdrop of the apparently poor morale of hospital staff and the many variables that could militate against job satisfaction.

Recommendations

The Commission recommends that hospitals should enhance the effectiveness of their internal communications and emphasise to supervisors/managers that they should always endeavour to lend an empathetic ear to their subordinates and to resolve issues at an early stage, before these evolve into grievances or disputes.

14.2.10 MISCONDUCT

As in the case of grievances and disputes, timeous prevention and/or addressing of misconduct by staff is important in maintaining effective and efficient service delivery.

Four hospitals reported that their supervisors and managers were familiar with the hospital policy on misconduct and that they did not require any additional training in this respect. Further to this, four hospitals also reported that they had a person assigned to oversee the management of misconduct cases.

As far as the incidence of misconduct in the five hospitals over the last 12 months is concerned, the following is worth mentioning:

- A small number of staff were formally charged with misconduct
- A small number of staff were actually found guilty
- A significant number of staff transgressed but were not officially charged
- A small number of staff committed misconduct unknowingly
- A small number of staff were discharged as a result of misconduct

- A small number of staff were criminally prosecuted as a result of misconduct
- A small number of appeals were referred to the Public Service Commission.

The types of transgressions of which hospital staff were found guilty of over the last 12 months were as follows:

- Negligence
- Theft
- Assault
- Unprofessional conduct
- Sleeping on duty
- Using hospital medication
- Absenteeism
- Substance abuse
- Insubordination
- Intimidation.

Hospitals further reported that the management of misconduct cases was hampered by the following:

- A lack of disciplinary powers. Hospital management's can currently at the most only serve a written warning to staff displaying undesirable conduct
- The delayed processing of misconduct cases by the Gauteng Department of Health
- Cumbersome procedures
- A lack of expertise on the part of managers and supervisors
- General lack of knowledge on the part of staff as to what constituted misconduct
- Victimisation and intimidation of witnesses and also managers.

Although line managers were provided with training on the handling of misconduct, it would nevertheless appear that they are either not fully familiar with the application of progressive discipline, or that they neglect this responsibility. Either way, this results in discipline not being enforced or in delaying the processing of misconduct cases. It also seems that the Department is being inundated with cases of misconduct, which inevitably delays the processing of such cases. The Department reports that hospitals unnecessarily refer 40 - 60% of cases to the Department.

The general perception in hospitals is that perpetrators of even very serious misconduct are untouchable and getting off scot-free. Such perceptions do nothing to discourage misconduct, indolence, defiant behaviour and corruption.

The disciplinary process must be seen to be working - albeit fairly, congruently and equitably - and all role-players responsible for the process should be familiar with the do's and don'ts and the procedures that have to be followed. This will also give supervisors and managers the necessary self-confidence to act.

Recommendations

The Commission recommends that the Department should urgently look into the causes for institutions' failing to institute disciplinary action and for delays in taking action and address them in conjunction with hospitals.

14.2.11 ORIENTATION AND IN-SERVICE TRAINING

The timeous training and skilling of staff is crucial to the effective performance of their duties and to good service delivery.

All hospitals provide in-service (functional) training for their staff. However, such training is mainly focussed on nursing staff. Training needs are generally determined by means of person-to-person interviews, questionnaires and performance appraisal.

The Department currently provides a wide spectrum of training as is evident from the submission comprising Annexure G.
However, hospitals do not provide bursaries or study assistance to enable their staff to improve their tertiary qualifications or to recruit scarce staff categories. This is dealt with by the Department, with seemingly no input from hospitals.

Although training is generally conducted by -

- supervisors and managers;
- training officers;
- personnel officers; and
- private companies -

heavy workloads, budgetary constraints, a lack of training material and a lack of facilities hamper the provision of training. Nevertheless, four hospitals reported that their supervisors and managers had received training on ethical work behaviour and service delivery.

Further to the above, it was also reported that supervisors and managers urgently required training in respect of -

- financial management;
- human resource management;
- conflict management;
- diversity management;
- change management;
- facility planning;
- project management;
- information technology;
- the health regulatory framework;
- post-basic nursing skills (in the case of nursing managers specifically); and
- Lobbying and marketing skills.

As regards other categories of staff, the following training needs exist per broad staff grouping:

- Medical staff

  Outcome-based patient management
  Cost centre management
  Human resource management
  Asset management
  Customer care and quality management
  Role of medical ethics
  Management skills
  Information technology

- Nursing staff

  Labour relations and conflict management
  Human resource management
  Contractual agreements
  Financial management
  Information technology
  Ethos and professional practice
  Medical regulatory framework

- Health therapists

  Labour relations and conflict management
  Financial management
  Diversity management
  Change management
  Public health
  Information technology
  New equipment
  Management skills

- Pharmaceutical staff

  Asset and stock management
  Public relations
  Lobbying and marketing
  Financial management
  Information technology
  Medical regulatory framework

- Medical technical staff

  Asset management
  Financial management
  Orientation to new technology
  Information technology

- Auxiliary staff

  Labour Relations Act, 1995
  Conditions of service
  Basic human resource management principles
  Work scheduling

Asset management
Code of Conduct
Literacy skills
Job contents
Grievance procedures.

In considering the above training needs, it is evident (as pointed out by one hospital) that the training provided by the so-called traditional sources of training in the Public Service is no longer in keeping with current realities.

Many hospitals only have one training officer to oversee training. This is totally inadequate. Given the relative size of hospitals and the diversity of training that has to be provided within a hospital, hospitals require training components to attend to matters such as -

- the orientation of new appointees;
- the co-ordination of training needs surveys;
- the establishment and functioning of training committees;
- the formulating of hospital training policy, procedures and strategies;
- facilitating the provision of training at hospitals;
- processing the nomination of staff that need to undergo training outside of hospitals; and
- The provision/attendance of Adult Basic Education and Training programmes.

Building capacity for training should take place in accordance with the White Paper on Public Service Training and Education and other relevant guidelines. These responsibilities cannot be left to one or two officials and are most definitely not an over-and-above function.

Recommendations

The Commission recommends as follows:

- The Department should look into the above training needs, starting with those areas that can be dealt with readily. An incremental approach could be adopted whereby general orientation training is first provided, and this is later supplemented with in-depth, specific training tailor-made to specific training needs.

- Despite financial constraints, the Department should look into improving the capacity for training at hospital level as a matter of priority. On-site training (for example, on various issues relevant to hospital functioning, raising the ethical values in the workplace and guiding supervisors and managers to better cope with their responsibilities) will obviously go a long way towards raising the quality of hospitals' service delivery.

14.2.12 ASSESSMENT OF STAFF MORALE

Monitoring and timeous addressing of matters that threaten staff morale are extremely important to good service.

According to their management's, three hospitals formally monitor staff morale on a regular basis (quarterly and annually) by means of person-to-person discussions, questionnaires and group interviews. Four hospitals also reported that they had purpose-designed programmes in place to address staff morale. However, non-supervisory staff from only one hospital confirmed this.

In general, hospitals rated the morale of their staff to be low for the following reasons:

- Working conditions
- Budgetary constraints resulting in staff shortages
- Poor supervision
- No acknowledgement or rewards for sustained above-average work performance
- Poor communication between hospitals and the Provincial Department
- Insubordination after the 1992 strikes
- Introduction of rapid policy changes
- State of facilities
- Negative media reports
- Incongruency in managing staff
- Workloads due to staff shortages.

Hospitals reported that low morale was found amongst all categories of staff.

Since low staff morale in hospitals is symptomatic of a combination of many causal factors which have been alluded to already, it will be appreciated that the process of normalising matters, let alone building morale, will be long and complicated. However, since quality health care is dependent on a contented workforce, it is of vital importance that deliberate and carefully thought-out practical plans/programmes be devised and followed by hospitals to raise staff morale, prioritising those issues that can receive immediate attention.

Recommendations

The Commission recommends that the Department, in conjunction with human resource management consultants (if financial resources allow), oversees the launching of a province-wide initiative in this regard.

14.3 FOREIGN TRAINED DOCTORS

Although foreign trained doctors only represent 10% of the Province's doctors, it is important to note that they are in the majority at some hospitals. These are mostly hospitals which, due to their location, often experience difficulty in attracting doctors.

These doctors play an important role and are often also the mentors of registrars and junior doctors. Despite this, their limited registration results in them are being career medical officers with no prospects of career progression.

Apart from this, they experience endless difficulty in renewing work and residential permits. This not only prevents them from paying undivided attention to their work, but also causes them unnecessary emotional trauma.

Recommendations

The Commission recommends that the Department should interact with the national Department of Health and the Department of Home Affairs in order to address the frustrations and uncertainties of foreign-trained doctors in relation to permits and registration.

14.4 ETHICAL CONDUCT

The pro-active instilling of ethical behaviour in hospital staff is crucial for purposes of stamping out corruption, good patient care and effective and efficient service delivery in general. The Government's commitment in this respect is well known and has been widely publicised.

Hospitals reported that their staff were in general fairly well-acquainted with the Code of Conduct for Public Servants and that this had been brought about by briefing sessions, circulars and discussions.

However, despite the above, hospitals reported that the incidence of corruption, negligence and indolence had remained high. According to the hospitals, the following were playing a significant role in the incidence of corruption:

- Inside syndicates of corrupt officials
- A lack of career progression opportunities
- A prevailing lack of ethical values.

Hospitals furthermore attribute the incidence of negligence mainly to fatigue, whereas indolence is attributed to a lack of commitment by staff.

Hospitals reported that fraudulent behaviour was more common in -

- pharmacies;
- mortuaries;
- admissions departments, specifically at cashiers;
- security services;
- stores; and
- Nursing sections.

Both negligence and indolence were reportedly more frequent amongst -

- security staff;
- porters;
- cleaners;
- drivers;
- catering staff; and
- Nursing staff.

The following measures have thus far been taken by hospitals to promote ethical work behaviour:

- The establishment of a Code of Conduct for managers in one hospital
- Regular meetings
- Workshops.

Despite these measures, it is quite apparent that amongst large numbers of hospital staff ethical behaviour leaves much to be desired. Although the perpetrators may be able to advance many reasons forward for their behaviour, the bottom line here is that many hospital staff unfortunately lacks moral fibre. Addressing this problem will obviously have to start at the individual level.

Recommendations

The Commission recommends that –

- training and education regarding practical and relevant examples of unacceptable behaviour, as well as the impact these have on service delivery and the Government's resources need to be embarked upon;

- hospitals should in future take greater care in the selection of staff, doing reference checks on candidates prior to their appointment; and

- the Department should take the overall initiative in driving a renewed ethics awareness programme. The Department may wish to consult with the Chief Directorate of Ethics in the Office of the Public Service Commission.

14.5 HUMAN RESOURCE STAFF SUPPORT FUNCTION

A smoothly functioning personnel component is crucial to effective human resource management. Although line managers have an inalienable responsibility to manage hospitals' human resources, they are nevertheless, in view of their line function training and responsibilities, extremely dependent on an efficient and expert human resource management function. In a nutshell, personnel components are required to -

- deal with the many areas of administration linked with human resource management on behalf of line managers who cannot, together with their line function responsibilities, attend to these matters themselves;
- provide line managers with expert advice on human resource management problems; and
- Provide a variety of informations to line management, either on request or pro-actively, so that line management can take informed decisions.

With this in mind, the inquiry evaluated the five hospitals' personnel offices on a number of basic operational requirements, viz. -

- disseminating policy information and documents to line management;

- updating centrally kept policy documents;
- establishment of hospital policies where required;
- maintaining statistics in respect of -

  - staffing levels;
  - staff turnover;
  - resignations;
  - staff assessments;
  - overtime;
  - leave;
  - grievances/disputes; and
  - misconduct cases;

- scheduling staff assessments;
- establishing an annual HRM plan to programme the personnel offices' work;
- maintaining an updated Personnel and Salary (PERSAL) Record System comprising -

  - an establishment record;
  - a personnel biographical record;
  - a record of staff's career incidents;
  - a leave record;
  - a merit record; and
  - a housing record.

- cross-checking PERSAL-generated ID numbers against personal ID numbers;
- maintaining personal files containing documented mandates for purposes of auditing;
- monitoring merit files;
- monitoring leave files;
- monitoring grievance files; and
- monitoring housing files.

It can be reported that all hospitals' personnel components are, in terms of their core administrative responsibilities, operationally geared to render a comprehensive support function. Hospital management teams at these hospitals are seemingly also satisfied with the service they get from their personnel offices.

However, despite this vote of confidence, the inquiry revealed that hospitals' personnel components neglected important research into many human resource management activities. For example, although a fairly comprehensive set of statistics is maintained on some human resource management issues (leave, absenteeism, overtime and grievances) these are not interpreted and reported on to hospital management's to enable them to strategically position hospitals in respect of staff-related problems.

It was specifically also discovered in this regard that all these hospitals did not conduct exit interviews which could assist, if reported to hospital management's, in addressing high staff turnover and low morale.

Recommendations

The Commission recommends that -

- hospital management's better utilise their personnel components to support strategic decisions on staff-related problems; and
- the Department of Health monitors the training needs of staff in personnel units, especially in as far as they have to be equipped to assist line managers with advice on crucial matters, such as the management of grievances and misconduct.

14.6 NATIONAL DECISIONS

All hospitals reported that the Termination of Pregnancy (TOP) legislation has had a significant impact on their ability to cope with obstetrics and gynaecology-related health-care needs. The inquiry also revealed marked increases in TOP cases. In some hospitals patients even undergo multiple TOP procedures within a given year.

It is important to realise that the introduction of this policy did not coincide with an increase in health-care budgets or staff. This tends to have a compromising effect on other obstetric and gynaecological services.

Free medical care to children under the age of six was also instituted with no additional funding, and all hospitals have reported that this too has had a highly significant impact on their ability to cope with health-care needs.

It is extremely important to bear the above findings in mind when contemplating new national and/or provincial health policy formulation.

In addition to the foregoing, unfounded agreements in the Public Service Bargaining Council also had a marked impact on hospitals' budgets, for example in the case of nurses' rank promotions.

Recommendations

The Commission recommends as follows :

It would in future be advisable to thoroughly research the impact of new policies or policy amendments on hospitals' budgets and infrastructures in order to assist Cabinet at national level and the Executive Council at provincial level in taking informed decisions.

The matter of unfounded mandates should be taken up with the Department of Public Service and Administration as well as the Mandating Committee at national level.

SECTION IV: CONCLUSION

As is self-evident from Section II of the report, there are indeed a number of issues that patients did not find to be to their satisfaction at hospitals. These are obviously in need of redress. However, what is quite apparent is that all is not necessarily bad with health care in the relevant hospitals.

Although a number of patients and/or their relatives reported appalling examples of health care to the Commission at its public hearings, these were the exception.

Not too much comfort must however be taken in this. Where lives are at stake one would ideally not want these exceptional cases to occur at all.

The Commission will have failed its duty if it does not say that, although there are a multitude of matters over a wide and multi-disciplinary spectrum that requires the attention of the Department, generally speaking health care at the hospitals investigated is not what the media has made it out to be. A lot of good is done at these hospitals.

The Commission of Inquiry into Hospital Care Practices trusts that its work will contribute to putting health care in the Gauteng Province on a sound footing.

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