



Batho Pele Skills Development Programme

PROJECT KHAEDU

Coal face deployment report

Rob Ferreira Hospital

Nelspruit

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1 EXECUTIVE SUMMARY

Situation

- Weak organisation structure and management structures at both hospital and provincial level delay decision-making, but most critically resolving the major human resources and industrial relations issues
- Some important processes such as Outpatients need to be overhauled at both a macro (I.e. Province must engage) and a hospital level to solve excessive wait times (3-10 hrs)
- While the unions appear obstructive, this is often due to lack of engagement and management attention to key issues

Complications preventing resolution

- Actual authority levels at the hospital level are very low, despite this being a R175 million (2005/06 budget including conditional grants), 700-person operating unit
- Significant confusion and duplication of effort and authority between Province, District and hospital
- Absolute shortage of key professional and support staff, with very long lead times to fill

Some suggestions

- Urgently review the decision-making processes between the 3 spheres of authority
 - Consider delegating authority in critical areas like budget and HR down to the Hospital level
- Reinforce the hospital management team
 - Restructure roles and responsibilities
 - Hire (even on a short-term contract) key IR, HR and technical skills
- Engage with organised labour
 - Remove key contentious issues such as career progression and training
 - Consider a one-off testing of staff seeking promotion
 - Fill roles through promotion where possible
 - Aggressive recruitment campaign headed by a dedicated hospital HR project manager
- In outpatients, develop an overall strategy to move patients back to primary healthcare and/or spread the load of patients across the day by:
- Review budget priorities in the province (e.g. more wards being built while we are chronically short of staff to run existing)

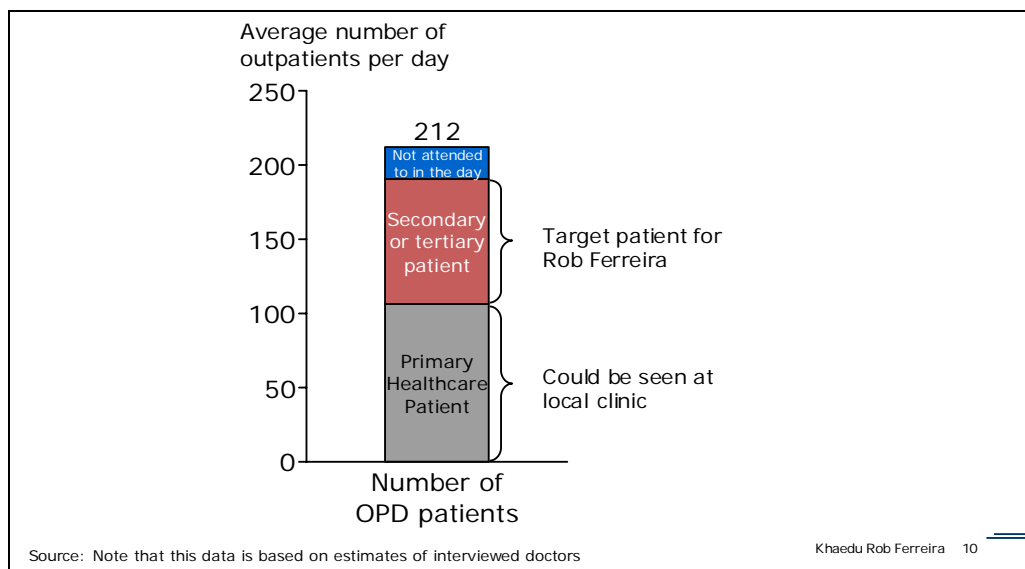
2 CURRENT SITUATION

Despite the problems that are identified here below, the Rob Ferreira staff are trying their best to make things work given the limited resources and the difficult situation in which they find themselves. We would therefore like to thank the Staff for their cooperation and, in particular, the CEO for allowing the Khaedu project members to learn about the coalface challenges in his institution.

The report therefore must not be seen as a criticism but as a learning instrument that could be used to address those problems that are of a micro nature and those of a macro nature could be discussed at a provincial level for consideration.

2.1 PATIENT ADMINISTRATION

Patients at Rob Ferreira hospital are generally unhappy about the waiting time at the registration desk. There is a high volume of patients, many of whom are primary healthcare patients, and come from other areas which, if clinics were well resourced, they would not need to come to the hospital. The graph below shows an estimate of the split between patient types.



The waiting time for new comers varies between 3 and 10 hours, despite the fact that it only takes about 15 minutes for a new patient to be registered. The same can be said about the repeat patients who have to wait for 4 hours or longer for file retrieval (many files get lost).

There is a high bed occupancy rate (average of 86% last year) and long waiting lists for non-emergency functions (e.g 18 months for prostheses).

2.1.1 Outpatients department

Currently the OPD at Rob Ferreira Hospital (RF) is characterised by congestion and long waiting times for both first time and repeat patients. Waiting times of 8 – 10 hours are a common occurrence. Some patients end up having to go back home without being attended to.



The OPD receives an average of 212 patients per day (excluding Casualty). These patients are classified as either first-time patients or repeat patients. The first-time patients have their own queue with separate officials who register them. The process of registering a first time patient takes about 10 – 15 minutes to complete. This period could be shortened by improving the computer skill levels of the officials. Repeat patients also have to wait for long periods while officials search for their files, which frequently get lost.

The filing system itself seems to be complicated because it is attached to the patient's date of birth. There is no easy way of tracking missing files. This results in the OPD officials opening new files for repeat patients. This has significant problems because the medical history of the patient get lost and a patient may end up with more than one file, resulting in other complications.

Photograph of the records room – many files are in unmarked bundles

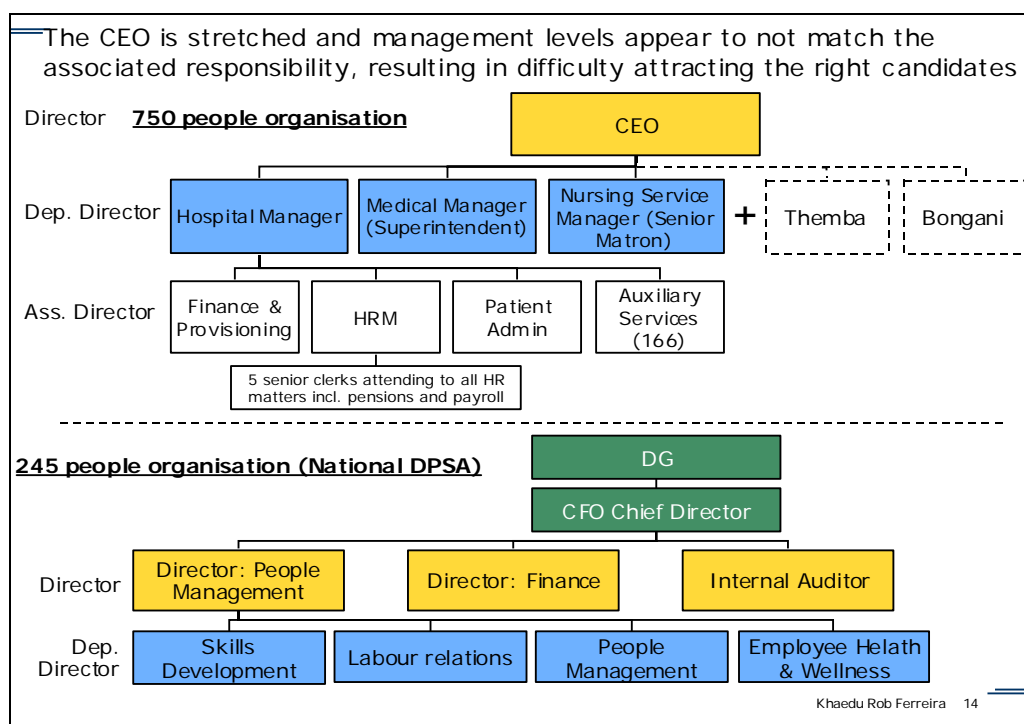


2.2 HOSPITAL ORGANISATIONAL STRUCTURE AND MANAGEMENT

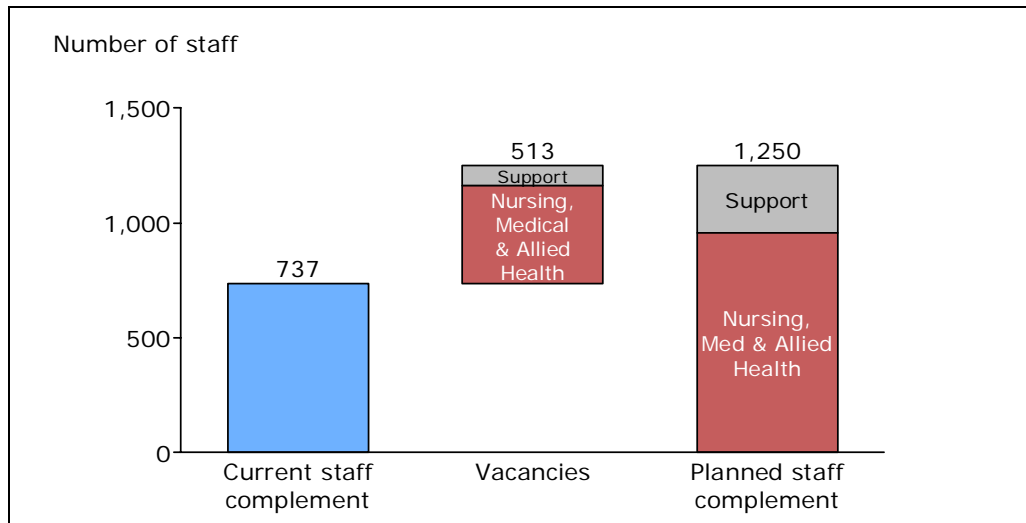
There is a high level of centralisation at the provincial head office with limited branch delegation resulting in cumbersome delays. The hospital as a tertiary health institution and a referral hospital is being used for primary health care. There are severe shortages of professional and support staff and this has been going on for a long time (years) without any recourse.

The executive management and professional staff levels and remuneration do not appear to match levels of responsibility. For example, the CEO's job is overstretched with 3 hospitals over large geographical areas. As a result, the CEO is unable to give undivided attention to any one hospital.

The CEO has limited autonomy and delegations. For example, every purchasing or maintenance decision over R100,000 needs to go through the Provincial Head Office procurement process, although the provincial procurement function appears to add little value and is cumbersome and slow contributing to long delays in procurement of equipment and maintenance of facilities. There is no Finance Director to drive alignment of budget with strategic objectives. The most senior finance person is appointed at an assistant director level. Other South African government benchmarks show that much smaller organisations (with fewer people and smaller budgets) have finance directors appointed at chief director or director level. It also appears that professional staff remuneration is not commensurate with the degree of responsibility allocated.



In addition to this, there appears to be a severe shortage of professional as well as support staff. According to the latest data, there are only 737 people, while the planned staff complement is about 1250. Many of these positions have been vacant for a number of years. The staff situation is shown in the graph below:



2.3 PEOPLE MANAGEMENT AND DEVELOPMENT

The situation at Rob Ferreira Hospital (RFH) in term of the people management is that the morale of staff at all levels is low. The staff is generally frustrated by the high vacancy rate and the fact that the staff who resign or die are not replaced. They often feel that they are doing jobs that should be done by more than one persons and yet are not paid for this extra effort or are not recognised for it

Management lacks credibility with the staff, and unions appear to be dominant and sometimes obstructive, deterring management from executing their role. For example, there is an ongoing resistance to the PMDS and yet unions themselves do not seem to understand the causes of resistance to the system. They are more loyal to their union provincial office than to their jobs as they say they are still waiting for an instruction from their provincial office for them to implement the PMDS. This seems to be a delaying tactic.

Management also does not seem to understand that performance management is their prerogative, that the PMDS is a national requirement and that they are in effect punishing good behaviour when those who have signed their performance agreements are rewarded in the same way as those who refuse to sign. Other staff members who have signed and have been evaluated are discouraged because they have not received any feedback; they got the same evaluation mark (3) and the same percentage bonus (1%) and are therefore demoralised and discouraged to sign Performance Agreements (PAs).

Employees want to be trained and to receive performance incentives yet they do not want to sign PAs, which are the basis of training and development, salary progression and other performance incentives. It can therefore be concluded that there is a general lack of understanding of practical implementation of the PMDS system.

There appears to be no clear HR plan and there was uncertainty with regard to the link of the strategic plan to all the other activities of the hospital.

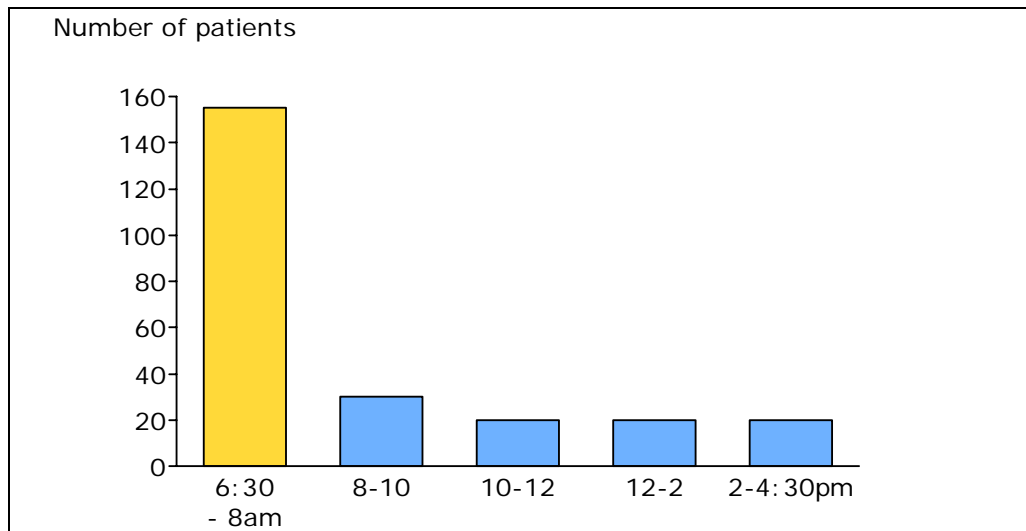
There is a serious lack of basic supervisory and management skills, such as people management, problem solving, communication, conflict resolution and disciplinary skills. For example when asked about their responsibilities the subordinates response is: "*This is not your farm*".

Training and development seem to be done for management and professional staff only and the support staff is left out. However it would seem as if training and development is also centralized too much at the provincial level.

3 COMPLICATING MATTERS PREVENTING RESOLUTION

3.1 OUTPATIENTS DEPARTMENT

1. No information / help you desk at reception to inform patients what to do and where to go on arrival results in some patients spending a long time in the wrong queue.
2. People seem to have no confidence in the primary health care facilities (clinics) in their districts resulting in people who do not really need to be attended to by doctors, swelling the numbers at the OPD of RF when they could have been helped at their local clinics. The approximate split of the different types of patients is shown in the graph below. It can be seen from this graph that if all the primary healthcare patients could be seen to at the clinic level, it would nearly halve the volume of patients at RF OPD. However, a major complicating factor in resolving this issue is the fact that local clinics do not appear to have the required facilities, skills and medicines to cope even at a primary healthcare level.
3. The public transport system (buses and taxis) delivers patients up to the Hospital gates in the mornings (until 9h00). Thereafter patients are dropped off at the terminus in town. They then have to walk the distance of more than 3km on foot or pay extra for delivery to the hospital. This forces many patients to use the early buses, resulting in the OPD being flooded in the first two hours of business.



4. The loss of files results in some repeat patients having to wait for hours while their files are being traced.
5. There appears to be no clear decision about the status of RF hospital as a tertiary institution. As a result of this, it has to do the work that should be done by Primary Health Care Facilities as well as the work of a Tertiary Hospital (Hospitals like Grootte Schuur in the Western Cape only deal with referrals).
6. There is no arrangement for patients to phone in and book for specific times to see a doctor.

3.2 PEOPLE MANAGEMENT

Many of the people management issues are complicated by the fact that decisions are referred up to the provincial head office, while the provincial office appears to lack capacity to carry out this role effectively (it has not been determined whether this failure at the provincial level is due to the volume of skills or the quality).

3.2.1 Recruitment and selection

- The recruitment and selection process is formally handled and authorised by the provincial head office (all the way down to porters and cleaners), although much of the "footwork on the ground" is actually done by the hospital staff. **With the current lack of capacity at the level of hospital HRM, as well as at Province, it is clear that recruitment of 513 people in a short time frame is simply not possible.** There are only 6 people in the Hospital HRM department and they are responsible for all HRM functions for all 700+ staff, including payroll, pensions, training and development, recruitment, labour relations etc. Adverts for most of the outstanding positions were developed in October 2004 and advertised in November. The process is currently (mid-Feb 05) only at the stage of profiling with the unions what competencies are necessary for each post.
- An additional complicating factor with respect to recruiting is that it is unlikely that there are enough medical and allied professional skills available for recruiting, even if there was an efficient recruitment process. The public sector is critically short of doctors, nurses, pharmacists, physiotherapists, radiographers etc all over the country. It is estimated that the average vacancy rate for healthcare posts in South Africa is over 30% (although Mpumalanga seems to be the worst affected at about 67%).

3.2.2 PMDS

- Some unions are not cooperating with regards to the implementation of the PMDS and the unions seem to be dominating management.
- Performance evaluation forms (if they are completed) are sent to the provincial office, which has little to do with the performance of employees. There seems to be too much referral to the provincial office on the day to day running of the hospital and the CEO is therefore left with little authority over the employees.
- There is no clear retention and career development strategy
- There is no clear HR strategy, and training and development of staff is sanctioned from the provincial Head office.

3.3 ORGANISATION STRUCTURE

- Managers responsible for people management seem to be employed at low levels and therefore do not, or are not capable of, taking their management responsibilities seriously.
- The level of remuneration of professional posts and others makes it difficult to attract medical specialists and well qualified support staff.
- Without a national decision on the levels and remuneration of hospital management and professional staff, the situation is unlikely to be rectified. The scarce skills allowance does not appear to be doing enough to compensate.

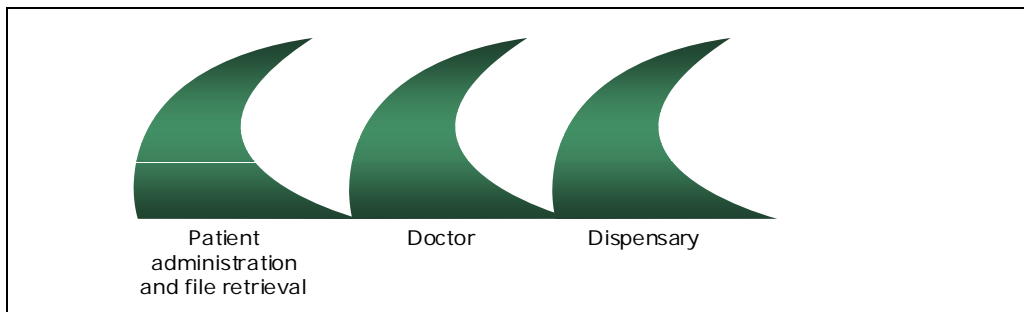
3.4 STRATEGIC OBJECTIVES

- The strategic plan does not appear to be aligned with activities of the hospital.

4 POSSIBLE INTERVENTIONS

4.1 OUTPATIENTS DEPARTMENT

A careful process and capacity analysis showed that to balance the patient administration process in order to avoid bottlenecks, 6 administration staff are required at any point during the day (including new patient registration and repeat patient file retrieval). This is currently very close to the actual number of staff in this section (4 upstairs and 2 in the records room downstairs). Please see the detailed analysis in the appendix. However, evidence clearly shows that the staff are not coping with the volumes. This is due to the fact that patients do not arrive evenly throughout the day, but instead descend on outpatients in the first 2 hours of the morning. It will not solve the problem to throw more staff at outpatients administration. Even if patients get dealt with quicker at administration, they will only move on to the next bottleneck, that of waiting for the doctor and then the dispensary.



Therefore, there are 2 main problems that must be solved in the OPD:

1. Reduce the overall number of primary health care patients flooding the facility.
2. Spread the volume of patients more evenly throughout the day to avoid bottlenecks.

These 2 problems should be attacked from all angles and the resolution should combine short-term with long-term initiatives.

Reduce Volume

1. Short term
 - a) Introduce Help-desk at reception point to inform patients of procedures, and facilities available at primary healthcare clinics.
2. Medium-long term
 - a) Continue with provincial communication campaign to encourage patients to visit the primary healthcare clinic first before coming to the hospital.
 - b) Introduce a gate clinic at the hospital where patients are seen first and only referred to the doctor at the hospital if primary healthcare cannot solve the problem.
 - c) Improve facilities at clinics and outlying district hospitals

- o Shortage / absence of drugs at primary healthcare facilities appears to be one of the main reasons for patients flocking to Rob Ferreira.
- o Consider using the model of ARV distribution for all other chronic medication. I.e. Many patients clogging up the system at Rob Ferreira are repeat patients that have only come for repeat medication. It would be more efficient to package these repeat prescriptions, label them and send them to the Primary Healthcare Clinic for distribution (as is happening with ARV's). The patient would then only need to come to the hospital for periodic checkups (6-monthly instead of monthly, for example)

Spread Volume

1. Short term
 - a) Improve management of file archives. Despite a number of limitations with the filing system per se, filing discipline appears to be very lax. Many files are mis-filed, left lying around, not filed immediately etc. This lack of discipline results in lost files.
 - b) Improve queue management e.g. copy the system at Witbank hospital where each patient is given a number when they arrive. The patient is then able to gauge when he/she will be called by tracking the movement of numbers on the screen. In this way, patients can relax elsewhere while they are waiting.
2. Medium – Long term
 - a) Consider introducing an appointment system to avoid the majority of patients arriving between 6.30am and 8am, and to enable file retrieval the night before. This could be done in 2 ways:
 - i. Set up an appointment desk at reception (for repeat patients and for those who have arrived without an appointment).
 - ii. Get an 0800 toll-free number to enable patients to phone ahead of time and book an appointment with a Doctor. Switchboard would have to be upgraded to handle calls and an additional switchboard operator/s would have to be appointed.

Patients who do not make an appointment will have to make one at the reception desk when they arrive or, if the appointment book is full, will have to wait for a "gap" (a cancellation or a quick appointment which may leave time to see an extra patient).

Suggested appointment system for Rob Ferreira Hospital

Time	Doctor 1	Doctor 2	Doctor 3	Doctor 4	Doctor 5	Doctor 6
07:30						
07:45						
08:00						
08:15						
08:30						
08:45						
09:00						
09:15						
09:30						
09:45						
10:00						
10:15						
10:30						
10:45						
11:00						
11:15	Lunch					
11:30						
11:45		Lunch				
12:00						
12:15			Lunch			
12:30						
12:45				Lunch		
13:00						
13:15					Lunch	
13:30						
13:45						Lunch
14:00						
14:15						
14:30						
14:45						
15:00						
15:15						
15:30						
15:45						
16:00						
16:15						
16:30						
Total patients	33	33	33	33	33	33

The average number of outpatients per day is 176 (excluding an additional average of 36 at specialist clinics, which are seen by different doctors).

This system would have to be planned in much more detail than piloted for a few months before being fully implemented. The detailed implementation is out of the scope of this report.

- b) Investigate the use of a WIP (work in progress) system to track location of files. In this system, each file is bar-coded with a sticker as soon as it is removed from the records room. It is scanned each time it moves e.g. from records to outpatients, from outpatients to dispensary etc. The system will only work, however, if there is continued discipline by all staff to scan the file when they receive or pass a file on to another department.

4.2 ORGANISATION STRUCTURE AND DECISION MAKING

Short-medium term solutions

The staff shortage needs to be viewed as a crisis and managed as such. Despite the overwhelming consensus that staff shortages are critical, there is unfortunately little evidence of a well-managed mass recruitment process (e.g. there does not even seem to be a readily available database of number and type of vacant positions, number and type advertised, number and type which have been profiled, those which have been short-listed, interviewed, filled etc.). We therefore would recommend the following:

- Outsourcing of a project manager to coordinate, monitor, develop and implement recruitment plan and processes.
- Recruitment and selection of staff from Assistant Director level must be done at the hospital/CEO level, once the capacity is improved as described above
- Appoint temporary staff in areas where there are the most severe bottlenecks parallel to the recruitment processes since funds are available for those posts.
- Put clear and reasonable time frames for wiping out the backlog. Head hunt scarce skills, but be practical about the number of professional staff that can be recruited e.g. we do not think that it is a reasonable target to be recruiting 425 professional staff (nurses, doctors etc) – they do not exist.
- Consider moonlighting of medical and support staff from neighbouring institutions (although we do understand that neighbouring institutions are also critically short).

The levels of delegation and authority should be urgently reviewed:

- Provisioning of equipment must be done at CEO level, which means that the delegations must be increased from R100 000, to at least a million rand.

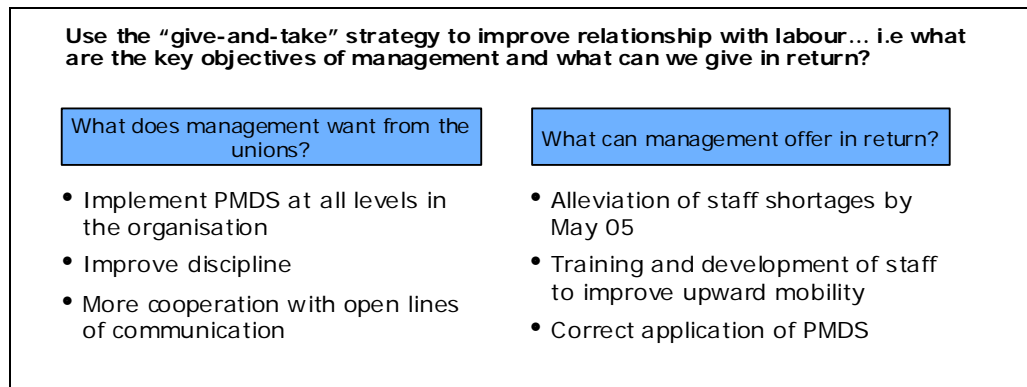
Long term solutions

- One CEO has to be appointed per hospital, with CEO level determined by the size of the hospital.
- Employ more senior managers with the ability to deal with labour relations, skills development and people management.
- Clearly outline a revised recruitment process, with service level agreements e.g. time frames.
- For a long term benefit consider training more medical personnel (offering contractual bursaries).
- Contract medical specialists with attractive packages.
- Ongoing recruitment strategy aligned to HR plan, rather than reactive recruiting.
- Develop a retention strategy.

4.3 PEOPLE MANAGEMENT

It is a priority for management to regain control of the hospital. This will necessitate a clear strategy for negotiating with the unions, who currently dominate the management environment. We recommend that management clearly define their top 3-5 objectives with the unions i.e. what does management most want from the unions? They should then offer something in return – there

are many legitimate complaints from the unions that management could address. The schematic below illustrates this point:



- A labour relations/ disciplinary committee must be set up at the hospital level to deal immediately with disciplinary hearings (currently disciplinary hearings get referred to head office, where a very protracted process ensues).
- Batho Pele revitalisation strategy roll-out.
- A good communication strategy with all staff must be developed and adhered to. (Monthly management and staff meetings)
- All staff must be re-trained on the use of PMDS. PAs and Work plans to be signed by all staff by 30 April of each year. This will then form the basis of evaluation, training and development and performance incentives. Reward good and punish poor performance.

Medium to long-term solutions

- Khaedu and Change Engagement Programmes to be undertaken by Executive Management.
- Maintain a good rapport with labour.
- HR plan must be developed and linked to the strategic plan of the hospital
- Training and development must be linked to the PMDS and be done at a hospital level.
- An annual consultative strategic plan must be developed and communicated to all staff members so that it could be linked to the PAs (performance agreements) and all the daily activities.
- A costed strategic plan and the annual action plan must be developed.

4.4 FINANCIAL MANAGEMENT

- Budget priorities should be reviewed in the province (e.g. more wards being built while we are chronically short of staff to run existing).
- Budgets should be carefully aligned with service delivery strategic objectives to ensure that the needs of the people are addressed according to identified priorities. (There is currently a great degree of frustration amongst the professional staff who claim that available funds are not channeled into the priorities at the hospital i.e. decisions get made at head office that "don't make sense").

5 APPENDIX

Outpatients Department Process Analysis - Rob Ferreira

Assumptions

Number Outpatients per day (excl Casualty)	212
Percentage existing patients	50%
Percentage new patients	45%
Percentage lost files	5%
Minutes per day per employee (70% efficiency)	336
Percentage paying patients	25%
%age patients requiring medication	90%

	Take details of existing patient on dummy	Send dummy to filing room	Retrieve file and replace with dummy	Register new patient & create file	Patient pays	Doctor consults patient and prescribes medication	Dispensary prepares prescription	Dispensary calls patient and hands over medication	Total	Total cycle time
Minutes to complete step	2	1	5	10	3	12	5	1	39	120-600
Number of patients	116	116	116	106	53	212	191	191		
Total time to process all patients	233	116	582	1,059	159	2,541	953	191	5,834	
Number of staff required	0.69	0.35	1.73	3.15	0.47	7.56	2.84	0.57	17.36	

Total = 5.9 staff required