THE PERFORMANCE MANAGEMENT AND DEVELOPMENT SYSTEM AND ITS UNINTENDED INFLUENCE ON QUALITY OF CARE IN RE-ENGINEERED PRIMARY HEALTH CARE HEALTH FACILITIES

By

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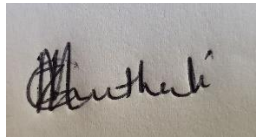**University of KwaZulu-Natal (Howard College)**

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DECLARATION

I, Cynthia Zandile Madlabana, certify that the work in the thesis titled, **"The Performance Management and Development System and its unintended influence on quality of care in re-engineered primary health care health facilities"** has not been previously submitted for a degree nor has it been submitted as part of the requirements for a degree to any other university or institution other than the University of KwaZulu-Natal.

I herewith declare this work to be my own; I have acknowledged all references, citations and borrowed ideas. Therefore, any help and assistance that I have received in my research work and the preparation of the thesis itself have been appropriately acknowledged.

In addition, I certify that all information sources and literature used are indicated in the thesis.

Cynthia Zandile Madlabana

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April 2019

DEDICATION

To my father, Mnuz Sipho Aubrey Madlabane, you left this world before we could celebrate.

You always encouraged me reach my full potential. You always believed in me.

I will cherish my memories of you forever.

Lala Kahle Wawawa!

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"Ask and it will be given to you; seek and you will find; knock and the door will be opened to you."
Matthew 7:7

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ABSTRACT

Introduction

The concept of performance management (PM) is fairly new within the South African healthcare system. It was introduced into the public sector in 2001 as a tool to assist, measure, develop and monitor the performance of public service employees in an effort to drive service delivery. In the healthcare system, PM provides the opportunity for managing the performance of healthcare workers (HCWs) in order to determine strategies for identifying training needs, and improving professional development and the competencies of healthcare professionals. The effective use of PM systems has many benefits and contributes greatly to successfully managing HCWs. Thus, it is likely to result in improved quality of care and accountability in the provision of health services, thereby ensuring better human resources and health outcomes. This is as desired by national objectives and as stipulated by the national development plan and other national government goals towards improving public services.

Presently, the public healthcare sector is engraved with challenges that threaten the provision of quality health services; these challenges include lack of resources, poor staffing and managerial capacity, as well as large health system reforms. Thus, these mentioned challenges have increased the need to further train and develop HCWs to adapt to the evolving health system.

This thesis investigated: 1) the implementation of the Performance Management and Development System (PMDS) by professional nurses at primary healthcare (PHC) facilities; 2) the perceptions and experiences on PMDS by professional nurses and nurse managers within the context of re-engineered PHC, national health insurance (NHI) and Integrated Chronic Services Management (ICSM); 3) nurses' and nurse managers' attitudes to how performance is evaluated; and 4) nurses' and nurse managers' perceptions and experiences of what hinders optimal use of PMDS and what actions could be taken to enhance job performance and quality of care within the context of re-engineered PHC, NHI and ICSM.

Research design and method

To determine current existing evidence on methods and practices on PM systems in PHC, a systematic scoping review was utilised. For the primary study, a sequential cross-sectional mixed-methods research design was employed, which was divided into two phases. The first

phase consisted of a quantitative study, which was a cross-sectional descriptive survey. A self-administered questionnaire was used to collect data from 201 professional nurses and facility managers at the study site. These data were analysed using the Statistical Package for Social Sciences (version 25.0) for descriptive statistics. The second phase was a qualitative study; through purposive sampling, semi-structured interviews were conducted with 18 professional nurses and 14 frontline nurse managers. Data were analysed thematically. Both phases were conducted at four sub-districts of Dr Kenneth Kaunda District Municipality, North West province, South Africa.

Results

Findings from the scoping review revealed that PM systems methods may differ across various countries; however, the practices that are deemed effective for PM systems are shared, and so similarities between countries were noted. For the primary study, both the quantitative and qualitative findings of this study confirm that the PMDS has been implemented to a certain extent. However, there exist major gaps and flaws in its implementation that threaten its usefulness within the health system in PHC settings. It was evident that the perception exists that it is unfairly and poorly implemented. This, consequently, has a negative impact on staff motivation, team collaboration, nurse-supervisor relationships and performance.

Practical/managerial implications

The PMDS should not be implemented in isolation; instead, it should be utilised as part of a systems approach to drive effective staff performance to promote quality care within the healthcare reforms for NHI in PHC settings. Evidently, the PMDS is flawed in its current state. Thus, the PM system is arguably unintentionally impacting negatively on staff morale, job satisfaction and the provision of quality care. Instead, its methods and practices should be improved to include the appraisal of attributes that are key to health outcomes, such as the provision of patient-centered care and promoting quality of care.

Key terms: *Performance management; performance appraisal; quality of care; professional nurses; frontline nurse managers; re-engineered primary health care; national health insurance; integrated chronic services management; patient-centred care; human resources for health.*

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GLOSSARY OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BARS	Behaviorally Anchored Rating Scales
BREC	Biomedical Research Ethics Committee
CD	Compact Disk
CHC	Community Health Centres
CINAHL	Cumulative Index of Nursing and Allied Health Literature
COPC	Community-oriented Primary Care
CQI	Continuous Quality Improvement
CZM	Cynthia Zandile Madlabana
DALYs	Disability-Adjusted Life Years
DCST	District Clinical Specialist Team
DHS	District Health System
DMT	District Management Team
DoH	Department of Health
GDP	Gross Domestic Product
GNI	Gross National Income
HCPs	Healthcare Professionals
HCWs	Healthcare Workers
HIV	Human Immunodeficiency Virus
HR	Human Resources
HRH	Human Resources for Health
HRM	Human Resource Management
ICDM	Integrated Chronic Disease Management
ICSM	Integrated Clinical Services Management
KK	Dr Kenneth Kaunda District Municipality

KPI	Key Performance Indicator
LMIC	Low- and middle-income country
MDG	Millennium Development Goals
MHPN	Maquassi Hills Professional Nurse
MMAT	Mixed Methods Appraisal Tool
MPN	Matlosana Professional Nurse
MPSA	Ministry of Public Service and Administration
NBD	National Burden of Disease
NCD	Non-Communicable Diseases
NDoH	National Department of Health
NDP	National Development Plan Vision 2030
NGO	Non-Governmental Organisation
NHI	National Health Insurance
NWDoH	North West Department of Health
OCLC	Online Computer Library Center
PA	Performance Appraisal
PCC	Patient Centred Care / Person Centred Care
PHC	Primary Health Care
PHF	Public Health Foundation
PM	Performance Management
PMDS	Performance Management Development System
PN	Professional Nurse
PPN	Potchefstroom (Tlokwe) Professional Nurse
PPP	Purchasing Power Parity
PR	Performance Review
PSR	Public Service Regulations

RDP	Reconstruction and Development Programme
SA	South Africa
SANC	South African Nursing Council
SDG	Sustainable Development Goals
SPSS	Statistical Package for the Social Sciences
STATS SA	Statistics South Africa
TB	Tuberculosis
TS	Thandeka Smith
UCTD	Union Catalogue of Theses and Dissertations
UHC	Universal Health Care
UK	United Kingdom
UKZN	University of KwaZulu-Natal
USA/US	United States of America
VPN	Ventersdorp Professional Nurse
WBOT	Ward-based Outreach Teams
WHO	World Health Organisation

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction

This chapter commences with the background of the South African health system. It highlights the current restructuring within the system, providing a brief overview of key health reforms. A summary of the need for quality of care is thereafter discussed. The chapter also provides the objectives, problem statement and motivation for the study. The chapter concludes with the structure of the thesis.

According to the *National Development Plan (NDP): Vision 2030* (Republic of South Africa, 2012, p. 329), "[h]uman capacity is key. Managers, doctors, nurses and community health workers need to be appropriately trained and managed, produced in adequate numbers, and deployed where they are most needed". This statement refers to one of the focal points in promoting health stipulated in the *NDP: Vision 2030*. It highlights the prioritising of human capacity in the health sector. Accordingly, there exist numerous studies on the health workforce in recent years, both globally (Ranson, Chopra, Atkins, Dal Poz, & Bennett, 2010; Roome, Raven, & Martineau, 2014) and locally (Chopra et al., 2009; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Mayosi et al., 2012). The emphasis of research on healthcare workers is motivated by the proven and inextricable link between weak human resource management, poor healthcare outcomes and failing health systems throughout the world (Bangdiwala, Fonn, Okoye, & Tollman, 2010). Therefore, current health systems restructuring and reforms require effective management of health workers (Lutwama, 2011).

In order for this to be achieved, strengthening health systems across developing and developed countries requires appropriate training and development of staff (Naylor & Kurtzman, 2010). Furthermore, it necessitates motivating, rewarding and retaining the workforce (Frenk et al., 2010). The National Department of Health (NDoH) also emphasises the value of health workers in improving the health status of the population and has explicitly re-asserted their role in implementing effective health systems interventions (2016). It has been noted that ad hoc and reactive interventions will invariably fail to correct workforce imbalances, as it often takes years to educate, train and socialise health professionals (Chen et al., 2004; Nair et al., 2015). Clearly, refraining from quick fix solutions to human resource

problems in healthcare is necessary, since decisions often have long-lasting effects and are often difficult to reverse (Chopra, Munro, Lavis, Vist, & Bennett, 2008).

At present, sustaining any health initiative is hindered by poor working environments, shortage of qualified staff and the inequitable distribution of health workers, with few staff in public health facilities in remote rural areas (Mkoka et al., 2015). This is further exacerbated by the use of inappropriate policy tools that often fail to provide significant incentives or optimise performance of the health workforce (Tshabalala, 2002), and this situation continues to persist many years later (Delobelle et al., 2011; Blaauw et al., 2013). The challenge appears to rest on identifying the appropriate steps to move towards sustainable and effective development of the health workforce. In addressing this situation, there has been an increase in human resources for health (HRH) initiatives for developing and implementing effective human resource policies that promote the shift towards primary healthcare and patient-centred care (Republic of South Africa, 2012). Furthermore, beyond the implementation of structural policy changes is the necessity to develop healthcare workers to facilitate change (Rispel & Barron, 2012). It is vital therefore to increase the workforce's flexibility to achieve these objectives, to improve the working life of the existing workforce, to further improve productivity and retention, and to revitalise aspects of education, training and research (Blaauw et al., 2013).

Consequently, the NDoH called for an end to reactive interventions, or worse, not responding at all. The development of an innovative and strategic approach will therefore be conducive to an evolving health system (NDoH, 2016). This approach should be grounded in the national vision and goals for the healthcare system, which embrace re-engineered primary health care (PHC), patient-centred care (PCC), and community health promotion and prevention (Republic of South Africa, 2012). Considering the current changes in the health environment, policy responses and any form of strategic action should be designed to be flexible, to facilitate learning and to encourage innovation and self-sustaining processes at all levels (Rispel, Moorman, & Munyewende, 2014). Even 14 years ago, Chen et al. (2004) also acknowledged health workers as the ultimate resource of health systems. These authors conducted a global study of HRH and its impact on overcoming the healthcare crisis, and they established that strengthening human resources for health is neglected yet crucial and central to combating health crises and building sustainable health systems. Further, they advanced that evidence on workforce strategies suggests effective interventions which enhance the

performance of health systems, even in adverse circumstances. Unfortunately, no progress has been made in improving HRM outcomes since then (Nair et al., 2015).

Hence, research on human systems strengthening and human resources for health is investigating best practices focused on patient-centred care, change management, leadership and improving quality of care (Chopra et al., 2008; Republic of South Africa, 2012). This study is cognisant of this and contributes to the existing gap in literature by generating knowledge on performance management methods and practices. More so, those methods and practices are necessary to promote quality of care and patient-centredness. This study further sheds light on the challenges and opportunities for managing health workers within systems that promote PHC and PCC. In addition, it contributes to evidence on the challenges of implementing reforms in the approach to healthcare while neglecting a review of policies on how performance is measured, developed and rewarded. Lately, this study will provide a guideline for improving the performance management system in primary health care and develop a training programme for the district on PMDS and its effective use.

1.2   South Africa and the healthcare system

1.2.1 Country profile

According to Statistics South Africa, in the year 2016, the total South African population was estimated at 56 million people. There are nine provinces, which are divided into 52 districts, with eight metropolitans and 44 district municipalities. The district municipalities are subdivided into 226 local municipalities (Statistics South Africa, 2016). Furthermore, the life expectancy at birth for 2017 was estimated at 61 years for males and 67 years for females. The total population by province is given in Table 1.1.

Table 1.1**.**

Population Estimates by Province (2017)

	Province	Total population	Percentage (%)
1	Gauteng	14,278,669	25.3
2	KwaZulu-Natal	11,074,784	19.6
3	Western Cape	6,510,312	11.5

4	Eastern Cape	6,498,683	11.5
5	Limpopo	5,778,442	10.2
6	Mpumalanga	4,444,212	7.9
7	North West	3,856,200	6.8
8	Free State	2,866,678	5.1
9	Northern Cape	1,213,996	2.1
	South Africa	56,521,948	100.0

Adapted from Statistics South Africa: Population estimates by province 2017

North West province, the site of this study, is the third smallest province in terms of population size. It has a population of approximately 3.9 million people who constitute 6.8% of the South African population (Statistics South Africa, 2017). The focus of this study was limited to only certain members of the population, namely, professional nurses, facility managers and sub-district managers of the four local municipality districts in the district municipality named Dr Kenneth Kaunda. The local municipality districts are: City of Matlosana, Maquassi Hills, Ventersdorp and Potchefstroom (renamed as Tlokwe municipality).

1.2.2 Socio-economic profile

The South African economy is the third largest in Africa; it was recently overtaken by Nigeria and Egypt, respectively, losing its spot and title as Africa's leading economy (World Bank Group, 2018). It is a mixed economy, of private and state-owned enterprises. South Africa is classified as a middle-income country with a per capita gross national income (GNI) of US$ 12,860 (Purchasing Power Parity (PPP), as of 2016). However, although the South African economy is performing better when compared to most African countries, it is burdened by high inequality and is acknowledged as one of the most unequal countries in the world (Keeton, 2014). In particular, the majority of South Africans continue to experience high rates of poverty and unemployment; unemployment was estimated at 26.6% by the World Bank Group (2018).

Such disparity in the distribution of resources is attributed to the apartheid era; the segregation of people according to race meant that those considered non-white were denied basic access to services such as education and health (Southall, 2016; TerreBlanche, 2002). These resources were provided primarily to white citizens of South Africa. In the new democracy, government aimed to address these challenges to ensure all citizens have access to basic public services. Specifically, the post-apartheid government focused on restructuring state resources and improving service delivery. Such a commitment also created the expectancy for speedy service delivery. However, presently, many municipalities are not providing effective service delivery which results in the public protesting for better services (Kuatzky & Tollman, 2008; Mayosi et al., 2012). Post 1994, the health system continues to face countless challenges, some of which prevail presently. These challenges are discussed below. Table 1.2 illustrates the racial demographics of SA.

Table 1.2.

The South African Population Racial Demographics

	2014 (%)	2015 (%)	2016 (%)	2017 (%)
Black African	80.2	80.5	80.7	80.8
Coloured	8.8	8.8	8.8	8.8
Indian/Asian	2.5	2.5	2.5	2.5
White	8.4	8.3	8.1	8.0

Source: Statistics South Africa racial demographics of South Africa (2017)

The largest population is Black African, followed by Coloured, White, then Indian/Asian South Africans. The racial demographics of North West are not substantially different from those of the country (see Table 1.3). The table further presents each local municipality within the Dr Kenneth Kaunda District.

Table 1.3.

Dr KK District Population: Racial Demographics

Local municipality	Black African (%)	Coloured (%)	Indian/Asian (%)	White (%)	Other (%)
Ventersdorp	90.1	2.7	0.3	5.9	1.0
Potchefstroom (Tlokwe)	71.3	6.8	0.9	20.6	0.4
City of Matlosana	81.0	3.5	0.8	14.5	0.3
Maquassi Hills	88.7	2.3	0.4	8.2	0.3

Source: Statistics South Africa racial demographics per district (2011)

As mentioned before, resources historically were largely distributed for the white minority. When considering a comparison of access to health, South Africa has a dual health care system (i.e. a private and public sector). The NDoH (2015, p. 1) described this thus: "The South African health system has been described as a two-tiered system divided along socio-economic lines". According to various sources (Naidoo, 2012; Pillay 2009; Republic of South Africa, 2012), the private health sector comprises for-profit organisations and individuals who serve those who can afford medical health care on an out-of-pocket basis, while the public sector comprises government institutes which care for most of the population. According to Stats SA (2017), the national average of people belonging to medical aid schemes is 17.4% of the total population of South Africa. From this average, the percentage membership per population group is shown in Figure 1.1.
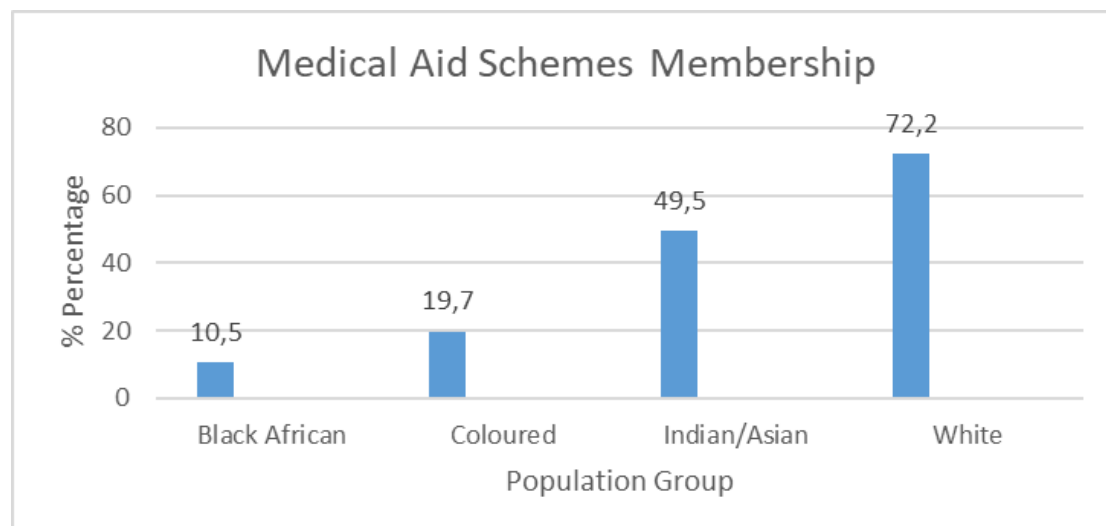
Figure 1.1. Medical aid schemes membership according to racial demographics

Evidently, from the table above, more than 72.2% of White individuals are members of a medical aid scheme compared to 49.5% of Indian/Asian individuals, 19.7% Coloureds, and only 10.5% of Black Africans, despite the Black population constituting 80.8% of the population. Thus, this inequality in distribution of resources has a negative impact on the performance of the health system.

The National Development Plan further confirms this in the Vision 2030 report (Republic of South Africa, 2012), which highlighted that the performance of South Africa's health system post-apartheid has been poor, despite good policy and high spending as a proportion of the GDP (compared to other countries). Additionally, this report states that services are fragmented between the public and private sectors, while "the public sector serves 83 percent (41.7 million) of the population and the private sector 17 percent (8.3 million)" (Republic of South Africa, 2012, p. 331). These findings are not different from those of Pillay (2009), who reported that the public sector is responsible for the well-being of 82% of the overall population but accounts for just 40% of the total health expenditure of South Africa.

Conversely, even in 2009, the private sector accounted for 60% of the health expenditure and catered to less than 20% of the overall population (Pillay, 2009). Accordingly, these imbalances in financing between these sectors have skewed the distribution of resources and services. Consequently, this has been detrimental to both sectors and has led to increased healthcare costs (Republic of South Africa, 2012). These factors contribute to the current challenges in the public health sector's inability to provide quality healthcare in PHC settings. Noticeably, the NDoH has progressively attempted to narrow the existing gap in healthcare services through policies such as the NHI; this will be discussed in detail later in this chapter.

Another concomitant factor is the standard of living in North West province. The available documentation (Stats SA, 2011) suggests that, during this period, average annual household income increased from approximately R25,000 p.a. to R68,000 p.a. This is the third lowest, according to these provincial statistics, with the highest being Western Cape (R143,000 p.a.) and Gauteng (R156,000 p.a.). Thus, beyond the great differences in wealth distribution in SA, North West is considered in the bottom three provinces, in terms of income. The above

factors suggest that health reform initiatives logically should be tailored to reach the communities that constitute the largest population group and those who are most vulnerable.

1.2.3 Epidemiological profile

According to Pillay-van Wyk et al. (2016), the South African health system is facing a quadruple disease burden. This is described in a report on the first National Burden of Disease (NBD) study in 2000 (Bradshaw et al., 2003) as a concoction of four colliding epidemics: the HIV/AIDS epidemic (along with a high burden of TB); high maternal and child mortality; high mortality caused by levels of violence and injuries; and a growing burden of non-communicable diseases (NCDs).

The 2010 SA NBD list comprised 140 specific causes of death in 24 disease categories and by four broad cause groups, as discussed below. Pillay-van Wyk et al. (2016) created a sub-division in Type 1.

- **Type 1:** Pre-transitional causes

   a) Communicable diseases, maternal causes, perinatal conditions and nutritional deficiencies

   b) HIV/AIDS & TB (HIV and AIDS, as well as all forms of tuberculosis, are combined as a category due to the need to integrate care for these conditions).

- **Type 2:** Non-communicable diseases

   Malignant neoplasms, cardiovascular diseases, chronic respiratory diseases, digestive diseases, musculoskeletal and genitourinary conditions, as well as mental disorders and neurological conditions.

- **Type 3:** Intentional and unintentional injuries.

   Unintentional injuries are harmful acts that occur without any intention of causing damage to oneself or others, while intentional injuries are injuries resulting from purposeful harmful actions upon oneself or others.

Previously, the first report of the National Burden of Disease estimates for South Africa (2000) by Bradshaw et al. (2003, 2005) reported that NCDs accounted for 37% of the deaths, followed by HIV/AIDS which was accountable for 30% of deaths. Interestingly, females had a greater proportion of HIV/AIDS and NCDs while males had a higher proportion of deaths attributed to injury. Twelve years later, the top ten causes of death had not greatly changed. In

2012, NCDs accounted for the highest proportion of deaths at 43.4%, followed by HIV/AIDS and TB with 33.6%, and other pre-transitional causes (communicable diseases, maternal causes, perinatal conditions and nutritional deficiencies) at 13.5%, with injuries causing 9.6% of all deaths (Bradshaw, 2003). In addition, the leading causes of death amongst men were HIV/AIDS (32.3%), interpersonal violence (7.3%) and road injuries (5.8%). Although HIV/AIDS was also the highest cause of female deaths (39.5%), violence and injury was not a major cause of death for females. Table 1.4 provides a breakdown of the top ten causes of death in South Africa, according to the latest National Burden of Disease estimates for South Africa report.

Table 1.4.

Top Ten Causes of Deaths (2012)

	Type of disease	Percentage of deaths (%)*
1	HIV/AIDS	29.1
2	Cerebrovascular disease	7.5
3	Lower respiratory infections	4.9
4	Ischaemic heart disease	4.7
5	Tuberculosis (TB)	4.5
6	Diabetes mellitus	3.6
7	Hyperactive heart disease	3.5
8	Interpersonal violence	3.5
9	Road injuries	3.3
10	Diarrhoeal diseases	3.1

Source: National Burden of Disease estimates for South Africa report (2000)

*Percentage calculated from a total number of deaths: n = 528, 947

The leading causes of death contribute to how healthcare priorities need to be planned and monitored (WHO, 2017). Further, this data allows healthcare stakeholders to respond to the health needs of the population (Statistics South Africa, 2016). Of concern is the growing rate

of deaths that are as a result of non-communicable diseases internationally (WHO, 2017) and locally (Mayosi et al., 2009; Statistics South Africa, 2016). According to the WHO (2017), NCDs are responsible for 70% of all deaths globally (estimated at 40 million people each year). Moreover, 80% of NCD deaths occur in low- and middle-income countries. Cardiovascular diseases accounts for most NCD deaths globally, followed by cancers, respiratory diseases, and diabetes (WHO, 2017). Significantly, these diseases are also on the top ten list of causes of death in South Africa (Pillay-van Wyk et al., 2016; Statistics South Africa, 2016).

In terms of the DALYs per 100 000 population, the WHO (2016a) estimated that the burden of NCDs in South Africa is two to three times higher than that in developed countries, and is similar to that in some other sub-Saharan countries and central European countries that fall into the highest burden quintile (Mayosi et al., 2009; Pillay-van Wyk et al., 2016). For the purpose of this study and its focus on PHC and district health systems, the leading causes of death per province have implications (see Table 1.5).

Evidently, North West province's top natural causes of death are TB, hypertensive diseases, heart diseases, viral diseases, and influenza and pneumonia. This inevitably means an increasing demand for chronic care for communicable and non-communicable diseases in order to ameliorate the situation. In response, ultimately an integrated model of care at all levels of the health system is needed, which should be supported by a robust control measure system that will facilitate accountability for poor performance is required (Mayosi et al., 2009). These authors contended that the public health system has not successfully transformed into an integrated and comprehensive national service. They add that the public health systems have failed to improve leadership and management competencies of health workers. The above has led to a substantial human resource crisis facing the health system. Thus, most policies are good on paper, but do not adequately translate into implementable practice. The benefits of investing in human capacity, and the rewards this may yield if done appropriately, are paramount to a good healthcare system (Coovadia et al., 2009).

Table 1.5.

Provincial Top Five Leading Natural Causes of Deaths.

Provinces	1	2	3	4	5
Eastern Cape	TB	HIV	Diabetes mellitus	Other forms of heart disease	Cerebrovascular disease
Free State	TB	Influenza and pneumonia	Hypertensive diseases	Cerebrovascular diseases	Diabetes mellitus
Gauteng	Other forms of heart diseases	TB	Influenza and pneumonia	Diabetes mellitus	Cerebrovascular diseases
KwaZulu-Natal	TB	Other forms of heart diseases	Diabetes mellitus	HIV	Cerebrovascular diseases
Limpopo	Influenza and pneumonia	Diabetes mellitus	Cerebrovascular diseases	TB	Hypertensive diseases
Mpumalanga	TB	Cerebrovascular diseases	Diabetes mellitus	Other viral diseases	Influenza and pneumonia
North West	TB	Hypertensive diseases	Other forms of heart diseases	Other viral diseases	Influenza and pneumonia
Northern Cape	TB	HIV	Other forms of heart diseases	Hypertensive diseases	Cerebrovascular diseases
Western Cape	Diabetes mellitus	HIV	Ischaemic heart disease	Cerebrovascular disease	TB

Source: Adapted from Statistics South Africa (2016).

1.3 Investing in a good healthcare system

According to Nair et al. (2015) and Ashton (2015), there is often debate on what makes a good healthcare system and measures that may be put in place to determine if a healthcare system is performing to its full potential. It is established that some countries' health systems perform well, while others perform poorly (Naidoo, 2012; Pillay, 2009). Furthermore, variation in healthcare system performance is generally not due to factors such as differences in income

and expenditure. Such performance may vary remarkably, even in countries with extremely similar levels of health spending. For instance, the South African health system performs poorly when comparing the health status of the nation with other countries that have a similar or weaker per capita gross domestic product (GDP).

Most recently, during the February 2018 National Budget Speech, the then minister of Finance, Mr. Malusi Gigaba announced continued investment towards improving the healthcare system. He confirmed government plans to spend R205 billion on health in 2018/19, growing to R240 billion by 2020/21. Previously, the South Africa government has spent more than 8.7% of its GDP on health; from this, approximately 4% is spent in the public sector which services the majority of the population. The proportion of GDP spent by the South African government is more than any other African country, and it is slightly less than some developed countries such as Sweden (8.9%) (Engelbrecht & Crisp, 2010). Despite this fact, South Africa is one of only 12 countries in which maternal mortality and mortality of children younger than five years has increased since 1990 (Moodley, Fawcus, & Pattinson, 2018; Republic of South Africa, 2012). Various factors contribute to this finding, such as the HIV/AIDS epidemic and the rise in NCDs. However, it is also clear that investing in healthcare has not yielded results that are visible in health outcomes. Therefore, a change in the management and implementation of health services is needed (Harrison, 2009; Republic of South Africa, 2012).

It therefore becomes imperative not only to understand current healthcare challenges, such as shortage of healthcare workers and migration of skilled health labour, but also the burden of disease that engulfs the health profile of the South African population. In light of these challenges, it has been advanced that a prerequisite for a well-functioning health system is a well-motivated healthcare workforce (Coster, Watkins, & Norman, 2018). In most national healthcare systems, professional nurses constitute more than 60% of the healthcare workforce (Coster et al., 2018). Thus, maximising nurses' contribution to health is essential to achieve positive health outcomes (WHO, 2013). Generally, professional nurses are the only contact patients have when accessing primary healthcare (Awases, 2006; Awases, Bezuidenhout, & Roos, 2013; Coster et al., 2018). Therefore, as the first-line carers, nurses play an essential part in improving patient satisfaction and providing quality care for those who are often from vulnerable communities (Baker & Fatoye, 2017; WHO, 2016b). Thus, the present status of the South African healthcare system requires nurses to contribute, influence and inform better healthcare practices (Republic of South Africa, 2012).

Accordingly, much attention is required on the management of professional nurses in healthcare, more particularly, the role of human resources initiatives in enhancing the work environment of a professional nurse (Coster et al., 2018). This is achievable through providing training and development opportunities, creating a conducive work environment and providing a framework for developing and improving job performance (Baker & Fatoye, 2017). As the face of healthcare in South Africa, nurses are often blamed for poor health outcomes, which results in healthcare workers being overstrained and overstressed (Petrus, 2017).

Furthermore, Koen, Van Eeden and Wissing (2011) and Petrus (2017) argue that the high levels of stress within the nursing profession are evidently related to high rates of staff turnover, absenteeism and burnout. They affirm that stress is a result of inadequate staffing which consequently leads to high workloads, poor managerial support and lack of appropriate human resource practices. These stressors have a negative impact on job satisfaction, morale and positive organisational behaviour, globally (Choi, Kim, & Kim, 2014; Ida et al., 2009), and within the South African context (Koen et al., 2011; Petrus, 2017; Pillay, 2009; Rothmann, van der Colff, & Rothmann, 2006). These various studies support the premise that, in order to reach health objectives, the provision of quality healthcare is essential. It is within such a commitment that the role of the nurse becomes focal to the quality of care provided. The investment therefore in healthcare workers, if prioritised, will build a high-performance workforce over a protracted period of time. There are no quick fixes or shortcuts (Koen et al., 2011; Petrus, 2017; Pillay, 2009; Rothmann et al., 2006).

1.4   Current restructuring within the South African healthcare system

In an effort to strengthen the public health system, the NDoH has introduced various health reforms, pro-equity policies and regulations throughout the public health sector. Many of these policies are designed to deal with the significant challenges faced by the national health system (NDoH, 2015). Some of these challenges include: a quadruple burden of diseases, structural inequality in communities, barriers to the access of healthcare services, inequality in the distribution of healthcare resources, and human resource capacity needs, in the form of professional healthcare providers and health facilities leadership (NDoH, 2015; Schaay, Sanders, Kruger, & Olver, 2011; Republic of South Africa, 2012). Ultimately, there has been a shift from a curative, hospital-based service to primary health care community-based

services. It is imperative to be cognisant of the impact of healthcare reform and the goals these reforms aim to achieve. These are discussed below.

According to Schaay et al. (2011), the chief change in the healthcare system is the re-engineering primary health care reform initiative. Re-engineering PHC aims to strengthen the district health system with greater emphasis on service delivery and highlighting social determinants of health. According to Kuatzky and Tollman (2008), for the vast duration of the twentieth century, South Africa has been considered a global leader in the conceptualisation and development of the PHC approach. These authors further provide an overview of PHC and demonstrate how South Africa has contributed to the PHC approach internationally. This is presented in Table 1.6.

However, these achievements have had limited impact, particularly because of the consequences of the apartheid era. It has been conceded that despite over a decade of structural reform and genuine commitment to achieving 'Health for All', there are a series of obstacles that continue to limit the full implementation of PHC today (Kuatzky & Tollman, 2008; NDoH, 2017; Republic of South Africa, 2012). These persisting challenges include: health worker shortages, inequities in resource distribution; and shortcomings of political, public sector and medical/health leadership. Importantly, beyond addressing these persisting challenges, a renewed commitment to the values set by primary health care requires effort towards innovative solutions to health system designs and human resource management for health, in order to reorient the over-bureaucratised and seemingly rigid primary care system (Kuatzky & Tollman, 2008; NDoH, 2017; Republic of South Africa, 2012).

Table 1.6.

Timeline of Health Reform in SA from 1940-2018

Timeline	Key Outcome	Contribution to PHC Approach
1940-1970	The Pholela Health Centre Model	- This model is considered a forerunner to community-orientated primary care (COPC). - It is regarded as one of the earliest demonstrations to inform and conceptualise the practice of PHC and its benefits. - Pholela used population-based enquiries to inform how healthcare is provided and how to incorporate health education and health promotion as an essential element to health services delivery. - The focus was on community engagement and participation in the delivery of healthcare.
1970-1994	Progressive PHC: An apartheid legacy	- During a period of racial segregation of health services and deregulation of the health sector, key HCWs were resigning and transferring from township areas as a result of violent protests. - Many primary care clinics closed and hospitals became overcrowded. - Better utilisation of nurses became key. - Nurses were trained and the PHC nurse was established, enabling a nurse-based primary care that is prevalent today. - A further development of PHC principles.
1994 onwards	Re-engineered PHC	- Pro-equity policies and programme under the Reconstruction and Development Programme (RDP). - Free PHC for all using public health. - District-based PHC system. - Re-engineered PHC. - National Health Insurance (NHI). - Integrated Chronic Disease Management (ICDM) model. - Patient-centred care - Quality of care.

In order to address these, the most recent restructuring effort is the introduction of the National Health Insurance (NHI), which commits to better quality health service. NDoH (2015) reported that the purpose of the NHI is to achieve universal health coverage (UHC) and establish a unified health system. Naidoo (2012) and Petrus (2017) also reported that the NHI intends to ensure that everyone has access to appropriate, efficient and quality healthcare, thereby achieving universal healthcare. These authors maintain that, in order to address challenges, the NHI proposes four key interventions: 1) transformation in healthcare provision and delivery; 2) total overhaul of the healthcare system; 3) radical change in administration and management; and 4) provision of a comprehensive package of care underpinned by the re-engineered primary health care. NHI will be phased in over a 14-year period, with the initial phase being piloted in re-engineered PHC systems in ten districts across the country. The NDoH, however, proposes the need to reinforce and strengthen PHC before the benefits of NHI can be fully utilised. As a consequence, the piloting of NHI has not yielded fruitful results as envisaged, due to the existing challenges that continue to prevail within the healthcare system. Some of the challenges mentioned as paralysing to pilot sites, above all, include a lack of medical equipment, staff and medicine shortages (Mkhwanazi & Nkozi, 2014).

A noteworthy effort was the development of the Integrated Chronic Disease Management (ICDM) manual which was in response to the renewed attention of the NDoH on strengthening the prevention and management of chronic conditions at the PHC level. This model consists of facility reform, clinical supportive management, assisted self-supportive management and strengthening of support systems and structures outside the facility. It was piloted in 42 PHC facilities within three health districts (Mahomed & Asmall, 2017).

According to Bodenheimer, Wagner, and Grumbach (2002) and Bodenheimer and Bauer (2016), the ICDM highlights managed care that provides for an integrated method for prevention, treatment and care of chronic patients at primary healthcare level. It also aims to ensure a seamless transition to achieve 'assisted' self-management within the community. It is further envisaged that this will be achieved through the adoption of a patient-centric approach to healthcare that encompasses the full value chain of continuum of care and support. As such, according to Ameh et al. (2017), and as previously indicated, South Africa faces a complex burden of chronic communicable and non-communicable diseases.

In response, the ICDM model was initiated in PHC facilities in 2011 to scale up services for NCDs, achieve optimal patient health outcomes and improve the quality of medical care. Moreover, the shift to integrated chronic care was in response to the shifting burden of disease to multi-morbid chronic diseases and the need for the healthcare system to respond accordingly. This challenge is highlighted by Smith, Wallace, O'Dowd, and Fortin (2016), who mention that many people with chronic disease have more than one chronic condition, which is referred to as multi-morbidity. The impact of multi-morbidity on healthcare resources and costs was investigated by McPhail (2016), who revealed that effective and resource-efficient long-term management of multi-morbidity is one of the greatest health-related challenges facing patients, health professionals and healthcare systems.

One of the core structural changes to respond to the current health challenges is the need for workforce preparedness for a shift from task-centred to patient-centred care. These reforms suggest a shift towards chronic collaborative patient-centered care. Furthermore, it has been acknowledged in the NDP report (Republic of South Africa, 2012) that the inability to get primary healthcare and the district health system to function effectively has contributed significantly to the failure of the health system. In response, a shift to a people-centred approach to healthcare is appropriate.

Bergeson and Dean (2006) described patient-centered care as providing care centered on patients' needs and expectations, which captures concisely the role of PCC in healthcare systems. These authors maintained that an integral part of patient-centred care is empowering patients to be knowledgeable about their illness and to practice self-management. This is supported by Ogden, Barr and Greenfield (2017), who argued that a patient-centred approach to care requires a system redesign, which will allow for an improved patient-clinician relationship, patient access and continuity of care. In addition to system redesign, there exists the need to equip service providers with non-technical skills for patient-centred care (Hansen, Walters, & Howes, 2016). These authors extend their definition of patient-centred care, seeing this as an approach to healthcare that emphasises communication with patients, partnership between health practitioners and patients, and being cognisant of issues that go beyond any single disease/condition. Thus, patient-centred care interventions are recognised to positively impact on self-management, patient benefits, health system quality, budget efficiencies and clinical safety (Ogden et al., 2017).

Interestingly, Ogden et al. (2017) conducted a study on determining requirements for patient-centred care. They observed that, although the recognition of a need for patient-centred care remains, making PCC a reality remains a challenge for various organisations. Another factor mentioned by Bodenheimer, Chen and Bennett (2009) was that prevention and management of chronic disease are best performed by multidisciplinary teams in primary care and public health. Such a modality will prepare for the growing chronic disease burden, as a larger interdisciplinary primary care workforce is required. Also, Bodenheimer et al. (2009) noted that managing performance initiatives must incorporate rewarding multidisciplinary teams.

Moreover, there is an ongoing debate on the importance for training and practice for PCC, and how this can be better achieved. To address this, Sharma, Bamford and Dodman (2015) conducted an investigation on PCC to explore nursing and healthcare provider behaviours that are patient centred, as well as systems level supports required to enable PCC. Sharma et al. (2015) confirmed that, across literature, the common required component of PCC is establishing a therapeutic relationship. Other components include shared power, accountability and responsibility (Republic of South Africa, 2012); getting to know the person; empowering the person; trust and respect (Ogden, et al., 2017); and communication (Petrus, 2017). These invariably require nurses to be equipped with clinical communication skills, emotional coping skills and a shift towards relational leadership (Petrus, 2017).

Fix et al. (2018) too contribute by suggesting that PCC is now ubiquitous in health services research, and healthcare systems are currently going ahead with patient-centred care implementation. However, little is established about how healthcare practitioners, who are at the forefront of implementing PCC, conceptualise what they are implementing. In the above study on how health workers conceptualised PCC, it was found that fundamental to achieving progress is a cultural shift (Fix et al., 2018). Evidently, for PCC not to be a minor movement, it must essentially become a way of doing things. Leadership is particularly a central feature in creating a cultural shift that promotes PCC.

In addition, Scholl, Zill, Härter and Dirmaier (2014), in their review on patient-centeredness, found that policy-level conceptualisations of this term were absent in the literature. They also established that key stakeholders such as policymakers and frontline providers exhibited engagement in understanding systems-level implications of PCC. Similar to Fix et al. (2018), Scholl et al. (2014) also described PCC as a cultural shift, to be imbued into care practices and

organisational initiatives. Implementing discrete PCC programmes may not be effective at culture change, without a system-level multipronged approach. Part of creating a system-level change is creating structures to measure and monitor PCC performance. This involves redesigning and developing a framework for measurement, monitoring and evaluation. Such restructuring will drive innovative programmes to collect patients' and healthcare workers' experiences about care received and providing timely feedback to improve the quality of healthcare, thereby providing positive or negative lessons to improve performance. Therefore, managing performance is key to providing accountability and improving the quality of healthcare. An evaluation of how the PMDS is implemented is imperative to identify the bottlenecks to improving the quality of care and strategies that could be used to improve job performance.

1.5 Quality of care

Quality of care is defined as a process of improving services in health systems. This is achieved through applying safe, effective, patient-centred, efficient and equitable services to achieve desired health outcomes (WHO, 2006). Quality of care prioritises patient safety, that is, the prevention of harm to patients, and it employs clinical governance processes to ensure quality.

1. Improving staff attitudes and the values underpinning them.	2. Reducing the long waiting times or delays in receiving care.	3. Ensuring all facilities are spotlessly clean and tidy.
4. Protecting the clinical as well as the physical safety of the patients and staff.	5. Ensuring that the required measures to avoid transmission of infections and cross-infection are in place.	6. Ensuring that basic medicines and supplies are available when patients are seen.

Figure 1.2. Fast track to quality: The six most critical areas for patient-centred care

Such health reforms require a focus on quality of care which synergises with patient-centred care. A revised set of core national standards and the identification of six critical areas for fast-tracking the attainment of quality standards across the health care system have been developed, along with the establishment of an Office of Health Standards Compliance (Schaay et al.,

2011). This is aligned with priority three of the ten-point plan, relating to the need and significance of improving the quality of care in public health institutions. The NDoH logically initiated a number of mechanisms to facilitate such improvement of quality of care. The six critical areas identified as necessary to improving quality in healthcare are presented in Figure 1.2. They were launched at the National Consultative Conference on Quality of Health Services (6 October 2010) (NDoH, 2011, p. 24).

Noticeably, apart from the first most crucial area for patient-centred care, the majority of these areas emphasise organisational/structural factors that need to be addressed. Conspicuous is the absence of the need to orientate and equip staff with essential skills to practice patient-centred care. In the WHO report (2006) on quality of care, key roles and responsibilities in improving quality of care were identified. These relationships were captured as pivotal by the 1997 NDoH White Paper on the transformation of the health system.
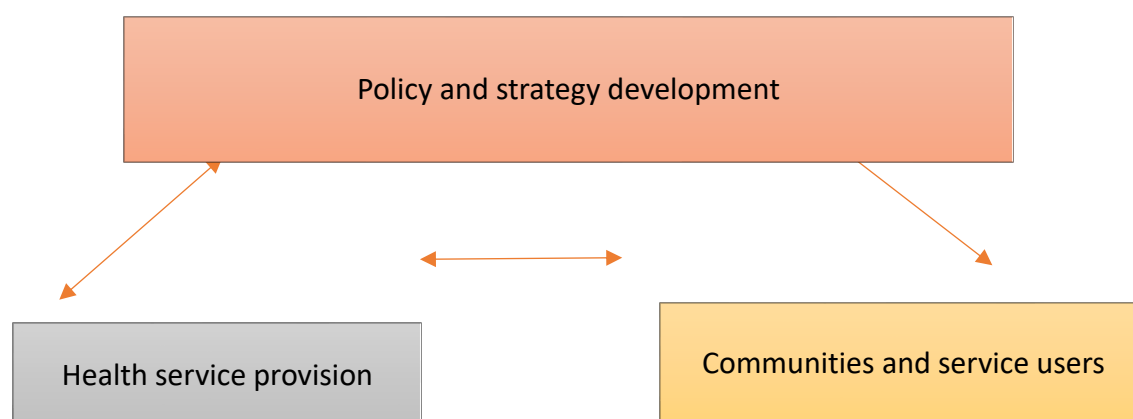
Figure 1.3. Roles and responsibilities in improving quality of care (adaped from WHO, 2006)

Figure 1.3 emphasises the first aspect of joint partnership between governmental policies, health service provision and communities to unify the fragmented health services at all levels, thus promoting a comprehensive and integrated national health system. Other aspects are to decrease disparities and inequalities in service delivery and to improve access to quality healthcare services based on PHC principles. Furthermore, it is important to prioritise key NDP goals and ensure joint ventures between all partners (including the private sector, NGOs and communities), in support of an integrated national health system. Another concomitant aspect

of quality in health systems is to differentiate among roles and responsibilities of various stakeholders within the health system.

The WHO framework further acknowledges the importance of health policies and strategic plans that facilitate engagement of key parties throughout the health system. Likewise, the NDoH (1997) recognises the collaborative role of national, provincial and local governance in the provision of health. In addition, the WHO framework advocates strategies to improve quality must be applied uniformly across the entire system.

The second essential component in *Figure* 1.3 refers to the core responsibilities of health-service providers that ensure the provision of quality care. It establishes that a provider is evaluated at three levels: individual, group and system. Thus, to ensure that standards of services they provide should be of the highest possible quality, meeting the needs of individuals, their families, and communities, this collaborative teamwork ethos is encouraged in PHC settings.

Also evident is that the framework demonstrates that, in order to be effective, patients and communities must be equally engaged in management of their own health. Moreover, it is imperative that patients have a critical role and responsibility in identifying their own needs and preferences, with appropriate support from HCWs.

Fundamental to change are organisational interventions to build the capacity of professional staff and the institutions (Schaay et al., 2011). It is evident that, with the emphasis on the need to improve human capacity and performance, it is the logical necessity to measure that performance. According to Schaay et al. (2011), to ensure a paradigm shift towards effective change, it is necessary to know how to improve attitudes and values towards change and how to motivate staff to go beyond the call of duty. It therefore becomes imperative to highlight the current challenges in human resources within the health sector.

Human resources for health (HRH) research is specifically concerned with the management of the health workforce. This discipline focuses on issues such as recruitment and selection, training and development, performance management, retention, personnel management and information, and research on human resources for the healthcare sector. Stressing the significance of such are Diallo, Zurn, Gupta and Dal Poz (2003) who noted that raising

awareness of the critical role of HRH in strengthening health system performance and improving population health outcomes has placed the health workforce high on the global health agenda (Chen, Chiang, & Storey, 2012).

Therefore, one of the aims of this study was to examine the current PMDS as it is a focal aspect within the aforementioned healthcare reforms. The researcher evaluated the implementation of the PMDS at PHC facilities and investigated health professionals' (nurses and facility managers) perceptions on leadership, change reforms and quality of care. Ultimately, this study intended to emphasise the need to use the PMDS to appraise patient-centred care and other key competencies, such as relational leadership, in order to achieve quality of care.

1.6   Problem statement

South Africa performs poorly on international healthcare indicators (Swaartbooi, 2016), although South Africa spends more of its GDP than other countries on improving the healthcare system (Pillay, 2009; Stats SA, 2016). This suggests a dire need for better quality health services. Also, more than 80% of the South African population depends on the public health service, which is characterised by a shortage of staff, lack of resources and poor working conditions (Naidoo, 2012; NDoH, 2015; Republic of South Africa, 2012; Swaartbooi, 2016). Nurses, who are an integral cohort within the medical team, are noted to be experiencing high levels of occupational stress and burnout (Petrus, 2017; Van der Colff & Rothmann, 2009). With nurses constituting the largest workforce of the health system and being the drivers of reforms in health systems, poor morale and well-being impacts on the provision of services and therefore impacts on quality of care. Moreover, any changes within the healthcare environment also have an effect on nurses (Mokoka, Oosthuizen, & Ehlers, 2010).

If implemented correctly, performance management initiatives drive employees' attitudes and behaviours towards their work. Currently, the researcher is not aware of any existing study that investigates performance management and improving quality of care in PHC settings that are in alignment with the health systems reforms towards integrated patient-centred care in South Africa. Although a few studies have evaluated the public service PMDS and its impact on service delivery in SA, no known published research studies have evaluated the system within the healthcare sector, considering the associated changes occurring within the health system. At present, the public healthcare sector is characterised by lack of resources, poor staffing and large health system reforms that require further training and development of staff (Awases et

al., 2013; Swaartbooi, 2016). Clearly, the efficiency and effectiveness of public health services in SA depend on the capacity and willingness of health workers to implement any interventions. Therefore, identifying the current challenges and opportunities with performance management and quality of care will assist in developing strategies to minimise the negative effect of poor performance. It will also assist in creating better performance and improving quality-of-care initiatives. Ultimately, it is worth investigating performance management and appraisal methods and practices that are preferable in PHC settings with their unique characteristics.

1.7 Research aim and objectives

The main aim of this present study was to explore nurses' perceptions and experiences on the Performance Management and Development System (PMDS). In doing so, the aim was to understand how performance management influences quality of care in the context of the re-engineered PHC, NHI and ICDM.

In order to address the main aim, the specific objectives of this study were to:

Objective 1: To map existing evidence on the influence of performance management methods and practices on quality of care amongst nurses in PHC Settings.

Objective 2: To evaluate the implementation of the PMDS in Dr KK District.

Objective 3: To explore nurses' and nurse managers' perceptions and experiences with the PMDS within the context of re-engineered PHC, NHI and ICSM.

Objective 4: To explore nurses' and nurse managers' attitudes to how performance is evaluated within the context of re-engineered PHC, NHI and ICSM.

Objective 5: To explore nurses' and nurse managers' views on what hinders performance and quality of care within the context of re-engineered PHC, NHI and ICSM.

Objective 6: To explore nurses' and nurse managers' suggestions on improving the quality of services and job performance within the context of re-engineered PHC, NHI and ICSM.

1.8 Research questions

The research questions of this study are separated into two main sections which are identified below.

1.8.1 Scoping review research questions

To meet the objectives of the scoping review, these questions needed to be answered:

i. What is the existing evidence of the influence of performance management methods and practices on quality of care amongst nurses in PHC settings?

ii. What are common challenges and opportunities reported on various performance management methods and practices?

iii. What are the key gaps in literature on the contribution of effective performance management on quality of care amongst nurses in PHC settings?

1.8.2 Mixed-methods research questions

Phase 1: Quantitative study

i. What are the psychometric properties of the performance management instrument used?

ii. How has the PDMS been implemented?

Phase 2: Qualitative study

i. What are nurses' and nurse managers' perceptions and experiences with the current PMDS within the context of re-engineered PHC, NHI and ICSM?

ii. What is the influence of the PMDS on nurses' and nurse managers' attitudes to how performance is evaluated within the context of re-engineered PHC, NHI and ICSM?

iii. What are nurses' and nurse managers' views on what hinders performance and quality of care within the context of re-engineered PHC, NHI and ICSM?

iv. What do nurses suggest can assist them in improving the quality of services and job performance within the context of re-engineered PHC, NHI and ICSM?

1.9 Outline of chapters

The structure of the thesis is as follows:

Chapter 1: The first chapter comprises the introduction and the background to the research problem. The statement of the problem, aim and objectives and the research questions are included. This chapter also features a background of the South African healthcare system. It concludes with an outline of chapters providing a structure of the thesis.

Chapter 2: The second chapter provides a review of performance management systems, how these systems are different from performance appraisal, the function of performance management systems as well as characteristics of an effective system. The chapter further

provides an outline of the PMDS and a review of literature on the PM systems in SA. It ends with the theoretical framework underpinning the study.

Chapter 3: In this chapter, a scoping review is presented instead of the traditional literature review. The review of relevant literature of performance management methods and practices amongst nurses in PHC settings globally is included, together with a detailed methodology followed for the review.

Chapter 4: This chapter consists of the methodology employed in conducting the mixed-methods study and motivates for the type of design used, sampling, data collected and data analysis methods used.

Chapter 5: This chapter focuses on the quantitative phase findings in the evaluation of the implementation of the PMDS by facility managers and professional nurses in North West (Dr KK District).

Chapter 6: For this chapter, the qualitative findings on the experiences and perceptions of the PMDS amongst nurses in PHC settings in Dr KK District is discussed.

Chapter 7: This chapter focuses on findings on the exploration of frontline nurse managers' experiences of the PMDS and its influence on human resources outcomes in PHC settings in Dr KK District.

Chapter 8: This chapter provides a synthesis and integrative discussion of all the findings. It includes the associated recommendations for interventions and future research. The chapter concludes with the limitations of the study.

CHAPTER 2
A REVIEW ON PERFORMANCE MANAGEMENT SYSTEMS

2.1   Introduction

This chapter offers a definition of performance management and key concepts that relate to managing performance. Thereafter, it distinguishes between the two related and yet often confused concepts of performance management and performance appraisal. It also provides an overview of PM systems and the key characteristics that determine their effectiveness. Thereafter, the PMDS within the South African context is outlined, and the purpose of the PMDS in the public sector is explored by reviewing previous literature on the implementation of this system. The section that follows is devoted to the use of the PMDS in the healthcare system, and HRH initiatives that require effective management control systems. The chapter concludes with a critique of the PMDS process and the conceptual foundation underpinning this study.

2.2   Performance management

Aguinis (2013) described performance management as a continuous process of identifying, measuring and developing the performance of individuals, teams and organisations; it involves aligning performance with the strategic goals of the organisation. Similarly, DeNisi and Pritchard (2006) confirmed that PM comprises a broad set of activities aimed at improving individual employee performance for the purpose of improving performance at an individual, group and ultimately at an organisational level. Furthermore, as Fletcher (2001) pointed out, performance management goes beyond performance appraisal (PA). PM is a wider approach to integrating human resources management (HRM) strategies. In 1999, David Otley (1999) described PM systems as part of management control systems that provide valuable information that is intended to be useful to managers in performing their job and to assist organisations in developing and maintaining patterns of behaviour that are deemed to be valuableto the operations of the organisation. Indeed, Williams (1998) suggested there are at least three different models of PM:

- A system for managing organisational performance;
- A system for managing employee performance;
- A system for integrating the management of organisational and employee performance.

Due to the interconnectedness of the nature of managing performance processes, these different models often interlink. In layperson terms, the performance of employees impacts on the performance of an organisation and vice versa. Therefore, regardless of the various models that exist of different types of PM systems, ultimately, individual performance and organisational performance are linked. Aguinis (2013) further confirmed performance management is defined by two main components:

- Firstly, **performance management is a continuous process**. It involves an endless process of setting goals and objectives, monitoring and observing performance and ongoing exchange of feedback between the involved parties.

- Secondly, **performance management requires that employees' activities and outputs are aligned with the organisation's goals**. In corporate firms, this culture of alignment assists in the organisation gaining a competitive advantage. Thus, performance management creates a clear link between employee performance and organisational goals and therefore makes explicit the employees' contribution to the organisation.

It is not uncommon for organisations to label a performance appraisal system as a 'performance management' system. Therefore, it is vital to distinguish between performance appraisal and performance management. This distinction is outlined below.

2.3   Distinguishing between performance appraisal and performance management

DeNisi and Pritchard (2006) note that a performance management system is often confused as a system that involves employee evaluation at a given period without any effort towards providing performance feedback and coaching so that performance can be improved. Instead, such system is a performance appraisal system. It is assumed that the term performance appraisal, as described by Aguinis (2009), is a systematic description of an employee's strengths and weaknesses. Similarly, DeNisi and Murphy (2017) argued performance appraisals refer to a formal process of assessing people's performance at work. This process may occur infrequently, and it involves an evaluation of the employee's performance by a judge (the rater is commonly a supervisor) who assesses based on predetermined dimensions. Once a score is assigned, the employee is generally informed of his or her formal rating.

DeNisi and Pritchard (2006) previously stipulated that the ultimate goal of performance appraisal should be to provide information that will best enable managers to improve employee

performance. Therefore, organisations typically base a variety of decisions concerning the employee partially on this rating. In his later work, Aguinis (2013) explained that performance appraisal has been popular with scholars and practitioners for decades; however, there are various pitfalls of pure performance appraisal systems that created a need for a system that goes beyond measuring performance. This need led to the concept of performance management (DeNisi & Murphy, 2017).

According to DeNisi and Murphy (2017), these concepts are related but are not identical. These authors noted:

> *Performance management* refers to the wide variety of activities, policies, procedures, and interventions designed to help employees to improve their performance. These programs begin with performance appraisals but also include feedback, goal setting, and training, as well as reward systems. (DeNisi & Murphy, 2017, p. 1)

Therefore, performance management systems rely on performance appraisals as a basis for identifying performance gaps, then focus on improving individual performance in a way that is consistent with strategic goals and with the ultimate goal of improving the organisation's performance. Thus, in the context of performance management, rating accuracy is important as it might affect employee motivation and perceived fairness, which have been proven to affect change in behaviour and performance improvement. Aguinis (2013) therefore explained that performance appraisal is an important component of performance management; however, it is just a component of a larger concept because performance management involves much more than just performance measurement. He further stated, generally, that the management of performance is neglected, and the consequences of this neglect to the individual, team and the organisation are catastrophic to improving performance and efficiency of an organisation.

2.4   The purpose of performance management systems

There are six main functions of a PM system as specified below:

2.4.1 Strategic function

The first purpose of performance management systems is considered to be strategic. PM systems aim to achieve the strategic objectives of the organisation; this is achievable by linking the organisation's goals with individual goals (as previously discussed) (Du-Plessis, 2015; Lutwama, 2011; Lutwama, Roos, & Dolamo, 2013; Nxumalo, Goudge, Gilson, & Eyles, 2018). The PM system serves the role of reinforcing behaviours consistent with the attainment of

organisational goals. In doing so, to indicate such a link serves as means of communicating what are the most crucial strategic initiatives of the organisation. Furthermore, PM systems are considered to play a vital role during 'onboarding' (the process of inducting new employees into the organisation). Here, PM allows new employees to understand the types of behaviours and results that are valued and rewarded, which, in turn, leads to an understanding of the organisation's culture and its values (Lee & Steers, 2017).

2.4.2 Administrative function

Many scholars have recognised that PM systems serve an administrative purpose (Aguinis, 2013; Du-Plessis, 2015; Lutwama et al., 2013; Nxumalo et al., 2018). Administratively, performance management provides essential information to help managers make important decisions such as salary increments, promotions, recognitions and rewards. Therefore, the implementation of reward systems based on information provided by the PM system falls within the administrative purpose. This function is considered valuable to prevent favouritism, corruption, and bribery, and, if implemented correctly, it emphasises the importance of impartiality and merit in administrative decisions.

2.4.3 Informational function

PM systems serve as an important communication mechanism that may inform employees about their strengths and provide them with information on specific areas of improvement. However, related to the strategic purpose, they also provide information on the job expectation and individual contribution to the organisation (Aguinis, 2013).

2.4.4 Developmental function

The developmental function is facilitated through the provision of feedback. It is thus maintained that feedback is a central component of a well-implemented PM system. Feedback may be used to inform remedial action and steps to improve performance; it is an opportunity for managers to coach employees and aid improvement in performance on an ongoing basis (Aguinis, 2013; Lee & Steers, 2017; Lutwama et al., 2013; Du-Plessis, 2015; Nxumalo et al., 2018). In identifying individual strengths and weaknesses, during feedback, discussions on the causes for performance deficiencies (which could be due to individual, group, or contextual factors) are discussed, and actions are taken to minimise barriers to performance. Importantly, various scholars indicate feedback is useful only when employees are willing to receive it (Awases et al., 2013; Lutwama et al., 2013). Aguinis (2013) contended that organisations

should create a 'feedback culture' that reflects support for feedback, including feedback that is non-threatening and is focused on behaviours, and coaching to help interpret the feedback provided. Another aspect of the developmental purpose is that employees receive information about themselves that can help them individualise their career paths. Thus, the developmental purpose refers to both short-term and long-term aspects of development (Nxumalo et al., 2018).

2.4.5 Organisational maintenance function

A fifth function of PM systems is to provide information to be used in workforce planning. Workforce planning comprises a set of systems that allows organisations to anticipate and respond to needs emerging within and outside the organisation, to determine priorities, and to allocate human resources where they can do the most good (Aguinis, 2013; Nxumalo et al., 2018). An essential component of any workforce planning effort is the talent inventory, which is information on current resources (e.g. skills, abilities, promotional potential and assignment histories of current employees) (Saravanja, 2010). PM systems are the primary means through which accurate talent inventories can be collected. Other organisational maintenance purposes served by PM systems include assessing future training needs, evaluating performance achievements at the organisational level, and evaluating the effectiveness of HR interventions (e.g. whether employees perform at higher levels after participating in a training program). These activities cannot be conducted effectively in the absence of a good PM system (Aguinis, 2013, Lutwama et al., 2013; Nxumalo et al., 2018; Saravanja, 2010).

2.4.6 Documentational function

Finally, PM systems allow organisations to collect useful information that can be used for several documentation purposes. This information can be especially useful in the case of litigation against decisions made administratively. For instance, if an employee disputes the outcome of a promotion decision, such documents serve as evidence of effective management (Aguinis, 2013; Lutwama et al., 2013; Nxumalo et al., 2018).

The above functions of PM systems were adapted from the work of Aguinis (2013) and supported by various scholars over the years who have confirmed the value of using PM systems across different work sectors globally (Awases et al., 2013; Du-Plessis, 2015; Lee & Steers, 2017; Lutwama, 2011; Lutwama et.al., 2013; Nxumalo et al., 2018; Saravanja, 2010), amongst many others. Apart from the value of having a PM system, the key characteristics of an effective PM system are discussed below.

2.5 Key characteristics of an effective performance management system

The following characteristics are considered vital to the successful implementation of a PM system in any context; although how each characteristic is applied may differ, the main principles of each characteristic are applicable.

2.5.1 Strategic and context congruence

As mentioned above, one of the main functions of PM systems is to align with the strategic objectives of their organisational context. An effective system thus demonstrates a clear congruence of individual performance with the unit's and organisation's strategy (Aguinis, 2013; Ahmad & Bujang, 2013; DeNisi & Murphy, 2017; Saravanja, 2010). Context congruence refers to the need for the system to be congruent with the organisation's culture, as well as the broader cultural context of the region or country within which it operates (Aguinis, 2013; Lee & Steers, 2017). A PM system that operates obliviously to the context and cultural underpinning of the organisation runs the risk of subordinates, peers, and superiors being resistant towards it. For instance, if a certain country values results over behaviour and a system is implemented that drives behaviour, such a system is likely to be ineffective (Aguinis, 2013; Lee & Steers, 2017). Therefore, successful PM systems are those that approach performance management from an integrated perspective (Aguinis, 2013; Nxumalo et al., 2018; Saravanja, 2010). In this instance, synergy must be created between the PM system and the strategic objectives of the organisation in areas such as strategic planning, HRM processes, organisational culture and structure, as well as with all other major organisational systems and processes (Lee & Steers; Saravanja, 2010).

2.5.2 Accuracy and thoroughness

The system should be thorough in its evaluation of performance. This entails all employees being evaluated (including managers) (Nxumalo et al., 2018). Secondly, all major job responsibilities should be evaluated; this may be in form of behaviours and results (Lutwama et al., 2013). Thirdly, the evaluation should include performance spanning the entire review period, not just the few weeks or months before the review (Aguinis, 2013). Lastly, feedback must be given on positive performance as well as areas that need improvement (Cardy & Korodi, 1991; Du-Plessis, 2015; Public Service Commission (PSC), 2007; Saravanja, 2010; Skinner, Van Dijk, Stothard, & Fein, 2017; Swaartbooi, 2016).

2.5.3 Practicality

An effective PM system must be user-friendly for both the rater and ratee. Systems must not be too expensive, time-consuming, or convoluted (Republic of South Africa, 2007). Good easy-to-use systems will not be an administrative burden for their users. Aguinis (2009) reiterates that the benefits of using the system (e.g. increased motivation, job satisfaction and improved performance) must be seen as outweighing the costs (e.g. effort, time and expense).

2.5.4 Meaningfulness

The system should be meaningful to the user, which may be achieved in many ways. Chandra and Frank (2004) maintained that the standards and evaluations conducted must be considered important and relevant. Also, it must emphasise performance assessment of functions that are under the control of the employee. Often, PM system standards are set without consideration for barriers beyond the control of the user that might affect performance (DeNisi & Murphy, 2017). In addition, according to Aguinis (2013), evaluations are only meaningful if they take place at regular intervals and at appropriate moments. He argued that one formal evaluation per year is generally not sufficient, and so informal reviews on a quarterly basis are recommended. Furthermore, the results from the system should be used for important administrative decisions (Lutwama et al., 2013; Nxumalo et al., 2018; Semakula-Katende, Pelser, & Schmikl, 2013; Swaartbooi, 2016). Aguinis (2009, 2013) adds that consequences (in terms of outcomes) must be viewed as valuable to users.

2.5.5 Specificity

A good PM system is specific and provides detailed and clear guidance to employees about what is expected of them and how they can meet these expectations. Cardy and Korodi (1991) suggest that employees must be aware of the system, and written guidelines and other forms of reference must be readily available for employees. Aguinis (2013) suggests PM systems should provide information to allow for distinguishing between effective and ineffective performance. That is, the system should allow for identification of what constitutes effective and ineffective behaviours and results (Boachie-Mensah & Seidu, 2012). Therefore, specificity informs participants about the system, helps ensure uniformity of treatment, and it provides employees with formal means of appeal. It also increases users' perceptions of fairness and legal defensibility against poor labour practices (Aguinis, 2013; Skinner et al., 2017).

2.5.6 Reliable and valid

In terms of reliability, a good system must include measures of performance that are consistent and free of error. This suggests that, if two raters are assessing the same ratee and using the same performance dimensions, the results of the rating should be similar (Awases et al., 2013; Du-Plessis, 2015; Lutwama et al., 2013; Skinner et al., 2017; Swaartbooi, 2016). Validity refers to the question of whether the measurement is assessing what it should. To be valid, a measure must include all relevant constructs and all performance facets; it should not exclude any important aspects or be contaminable with factors that are unrelated to performance (DeNisi & Murphy, 2017). Therefore, Aguinis (2013) confirms PM systems must be standardised; that is, performance should be evaluated consistently across people and time.

2.5.7 Acceptability and fairness

According to Aguinis (2013), an effective system is acceptable when it is perceived as fair by all participants. As perceptions of fairness are subjective, the only means available to know if a system is perceived by its users as fair or not, is to question the participants themselves. Aguinis (2013) mentioned four different types of justice that impact on acceptability and fairness of a system.

First is *distributive justice*, which refers to the perceptions on the rating received in relation to the work performed, and or the reward received, relative to the results of the performance appraisal. When a discrepancy is perceived between work and appraisal or between appraisal and rewards, then the system is likely to be seen as unfair. For instance, if employees complain, "We work just as hard but only the favourites receive bonuses", this indicates employees perceived their work to be bonus-worthy but, due to practices of unfairness, the same employees receive bonuses each year. Second is *procedural justice*, which is concerned with participants' perceptions of the procedures used to determine the ratings, as well as the procedures used to link ratings with rewards. Third, perceptions regarding *interpersonal justice* refer to the quality of the design and implementation of the PM system. Lastly, *informational justice* refers to fairness perceptions about performance expectations and goals, feedback received, and the information provided to justify administrative decisions.

A constant concern evident in literature is how to develop systems that are regarded as fair from the distributive, procedural, interpersonal, and informational perspectives, to minimise poor HR outcomes that result from PM systems that are perceived as unfair. This is confirmed

by various scholars who have written on challenges regarding fairness and acceptability of PM systems (AbuAlRub & Al-Zaru, 2008; Adejoka & Bayat, 2014; Arnaboldi, Lapsley, & Steccolini, 2015; Ahmad & Bujang, 2013; Saravanja, 2010; Skinner et al., 2017; Swaartbooi, 2016).

2.5.8 Inclusiveness

Good PM systems are participatory in nature (Steers & Lee, 1982). When a system demonstrates inclusiveness, it values input from multiple sources on an ongoing basis. Participation is vital for the evaluation process because it allows for all users to be able to share their concerns and see to these concerns being addressed (Saravanja, 2010). Also, employees must participate in the process of creating the system by providing input regarding what behaviours or results should be measured and how (Lutwama et al., 2013). Scholars such as Lee and Steers (2017) found that when participants are included in the process of designing and implementing the system, such inclusive systems are likely to lead to more successful management systems. These are also less prone to employee resistance, deterioration in performance, and legal challenges (Skinner et al., 2017).

2.5.9 Openness and correctability

An effective PM system is open and transparent regarding performance reviews and their outcomes. Therefore, frequent performance appraisals are accompanied by performance feedback being provided on an ongoing basis. As early as 1980, authors like O'Reilly and Anderson (1980) maintained that the PM process consists of a two-way communication in which information is exchanged, and not delivered from the supervisor to the employee without any input from the receiver. Skinner et al. (2017) added that performance communications must be factual, open and honest. Often, managers do not want to provide unfavourable feedback; however, any type of feedback is perceived as being better than not receiving feedback at all (Du-Plessis, 2015; Lutwama et al., 2013; Swaartbooi, 2016).

Openness also requires honesty; therefore, it is safe to add that the process of managing performance cannot completely eliminate subjectivity because there is an element of human judgement, which is a crucial component of the appraisal process. Thus, when employees perceive an error has been made, there should be a mechanism through which this error can be corrected. Some authors have suggested an appeals process must therefore be established,

whereby employees can challenge unjust decisions; this is an important aspect of a good PM system (Aguinis, 2013; DeNisi & Gonzalez, 2017; DeNisi & Murphy, 2017).

2.5.10 Ethicality

A good PM system must comply with ethical standards (Skinner et al., 2017). This means that managers should be trained to suppress personal self-interest in providing appraisals and making decisions based on the results of these appraisals (Lutwama et al., 2013; Nxumalo et al., 2018; Swaartbooi, 2016). If the above-mentioned characteristics are present, it becomes easier to point out mismanagement in practice, and so users became accountable for their actions. Below, the implications of having a poorly implemented PM systems are mentioned.

2.6   Implications of poorly implemented PM systems

As mentioned previously, a poorly implemented PM system may be flawed in any one of the key characteristics of a good system mentioned in the previous section. The implications of having such a system are important to discuss, as often researchers warn it is better to not have a PM system at all than to have one that is of poor quality. Authors such as Aguinis (2013) and DeNisi and Gonzalez (2017) say that one of the key arguments for the need for PM systems to be implemented as intended are the negative consequences of low-quality or poorly implemented systems that affect individual, group and organisational effectiveness.

2.6.1 Wasted resources, risk of litigation and turnover

PM systems require effort, time and money. These resources are thus wasted in a system that fails to serve its intended purpose (Saravanja, 2010). Furthermore, a poorly implemented PM system is susceptible to litigation from employees who perceive them as unfair labour practices (Skinner et al., 2017). Furthermore, if the PM process is perceived as unfair, employees may become upset and choose to leave an organisation. They may choose to leave physically or became psychologically withdrawn (i.e. minimise their efforts towards their job tasks until they are able to find better employment opportunities). Singh and Twalo (2015) also confirmed that poorly implemented PM systems have a negative impact on job behaviour which then in turn affects the performance of employees. Further, AbuAlRub and Al-Zaru (2008) also reported that the implications of turnover are extremely high amongst nurses. The need to constantly recruit and train new staff because of high turnover must be minimised.

2.6.2. Use of distorted information

As previously mentioned, PM is a tool for information regarding employees' performance and development. Therefore, a system that lacks standardisation creates the opportunity for fictitious information regarding an employee's performance and this contributes to poor working relationships, unfair labour practices and lack of accountability for true performance. Chandra and Frank (2004) also mentioned that PM systems must be fully utilised by healthcare organisations, and this is only possible if the information used is factual and accurate.

2.6.3. Damaged working relationships

Due to a PM system that is defective, many working relationships may be impacted negatively, damaging relationships (often permanently) amongst staff. There may be growing notions of 'Us' versus 'Them' amongst those who are perceived to be benefitting from an irregular system. Such damaged relationships are also common amongst ratee and rater relationships, if the ratee perceives unfair and unjust treatment (Aguinis, 2013; DeNisi & Gonzalez, 2017).

2.6.4 Decreased self-esteem, motivation to perform and job satisfaction

Decreased self-esteem is experienced especially if constructive feedback is not provided or remedial actions taken to improve employee performance following a negative appraisal. Poorly implemented PM systems also affect the employee's motivation to perform (DeNisi & Pritchard, 2006; Kuvaas, 2006; Saravanja, 2010). Motivation may be lowered for various reasons, including the feeling that superior performance is not translated into meaningful tangible (e.g. pay increase) or intangible (e.g. personal recognition) rewards. Furthermore, a low-quality PM system also impacts on employees' levels of well-being and job satisfaction. When the performance assessment instrument is not viewed as valid and the system is not perceived as fair, employees are likely to feel increased levels of job burnout and dissatisfaction. As a consequence, employees are likely to become increasingly irritated and wish to revolt against such system (Boswell & Boudreau, 2000; Kampkötter, 2017; Kuvaas, 2006; Mone & London, 2018; Poon, 2004). Therefore, a carelessly and haphazardly implemented PM system should be avoided.

2.7   Performance management in South Africa

In South Africa, the PM system used by public servants is referred to as the Performance Management and Development System (PMDS). Therefore, in this thesis PM system and PMDS are used interchangeably as the study is focused on nurses within the public sector.

Noticeably, in the South African PM system, there is overemphasis on using the system as a tool for development. In later chapters, it is argued that although the PMDS is an effective tool, at present, it is not fully utilised as a developmental staff tool, and so the name of the system is misleading.

2.7.1 The origins of the PMDS

Performance management was introduced in April 2002 by the Department of Public Services. The PMDS was included in the previously known Ministry of Public Service and Administration (MPSA) and was introduced as a way of creating checks and balances with regard to the provision of public services (Brauns & Stanton, 2016). The key principle underpinning the implementation of the PMDS is for all departments to function more effectively. Since 1994, the SA national government has successfully expanded access to basic services; however, the quality of these services has often been questionable. Hence, the five priority areas identified for the allocation of resources to improve services were education, health, creating employment, rural development, and safety (Republic of South Africa, 2012; Saravanja, 2010).

Despite such allocation, the national government has acknowledged that several factors impact on why many objectives have not been met in delivering quality services (). These factors include: 1) lack of political will; 2) inadequate leadership; 3) management weaknesses; 4) inappropriate institutional design; and 5) misaligned decision rights.

Amongst these core issues also lies the absence of a strong performance culture that effectively provides rewards and sanctions in the various government departments. More specifically in healthcare, poor quality health outcomes have shown a drastic gap between vision and reality in relation to realising the NDP and the ten-point plan goals highlighted as part of the NDoH strategic objectives.

The current PMDS calls for departments to manage performance in a more effective manner that fosters an environment with a strong performance culture (Republic of South Africa, 2007). All departments are urged to manage performance in a consultative, supportive and non-discriminatory manner, so to enhance organisational efficiency and effectiveness (PSC, 2007). The proper implementation of the PMDS will create transparency and accountability for the use of resources (Public Service Act, 1994 amended 2007). It will also lead to improved performance which would result in the achievement of departmental goals and objectives. The

Public Service Regulation calls for performance management processes to link with broader plans for staff development and to align with the various departments' strategic goals (Kalashe, 2016; Maepa, 2015).

Furthermore, the regulation stipulates that performance management's primary orientation shall be developmental, to allow for effective responses to consistently inadequate performance and recognising outstanding performance (Republic of South Africa, 2007). It further advises performance management procedures should minimise the administrative burden on those who have supervisory roles while maintaining transparency and administrative justice (PSC, 2007; Public Service Regulation, 2016; Republic of South Africa, 2007). The focus of the present study was on the PMDS implementation and application in the public healthcare system, more specifically, in the South African primary healthcare system.

2.7.2 The state of human resources for health in SA

In the NDoH *White Paper for the transformation of the health system in South Africa* (1997, p. 6), one of its fundamental goals is to develop human resources available to the health sector. This involves:

1. Promoting the optimal use of skills, experience and expertise by all healthcare workers (HCWs);
2. Developing appropriate education and training programmes;
3. Recruiting and retaining HCWs who are competent to respond to the health needs of the communities they serve;
4. Ensuring the HCWs in the health sector reflect the demographic patterns of the general population;
5. Promoting a new culture of democratic management, accountability and transparency;
6. Ensuring a caring and compassionate workforce.

The above points emphasise the commitment to improving HCWs' skills and expertise to meet the demands of the changing system. This is further reiterated in the NDP report, which demonstrates that human capacity is also recognised as fundamental in strengthening the national health system and ensuring the provision of quality healthcare (Republic of South Africa, 2012). In addition, the NDPstipulates the need to effectively manage human resource throughout the country. Interestingly, the NDoH's *Human resources for health South Africa: HRH strategy for the health sector 2010/13-2016/17* (Republic of South Africa, 2011)

highlights specific objectives to improve human capacity and the challenges encountered by NDoH in training and retaining HCWs who are skilled, committed and competent. Evidently, any workforce planning is a huge challenge and it is complex in any environment; the health system is also not immune to such. To demonstrate the current trends and challenges in HRH for South Africa, there exist three areas of concern as highlighted by the *Human resources for health SA 2030* document published in the year 2012 (NDoH, 2012). These are:

1. The supply of health professionals and equity of access;
2. Education, training and research;
3. The working environment of the health workforce.

In terms of **the supply of health professionals and equity of access**, the primary task is to ensure equity of access to well-trained healthcare workers for the South African population. According to the NDP report, the supply of health professionals in South Africa is not managed appropriately. As a result of the shortage of HCWs, the provision of services has been compromised (Republic of South Africa, 2011). Seemingly, this highlights negative growth in public sector clinical posts over some years and has led to the NDoH prioritising the filling of vacant posts by means of increasing the capacity to train health professionals in line with PHC needs and managing performance. Previously, it has not been possible to achieve the above due to insufficient planning and budgeting for clinical posts. There exists less attraction to work within the public health sector versus private health, with poor retention of critical healthcare workers such as community health workers and high attrition of key health professions such as nurses (Republic of South Africa, 2011).

Mokoka et al. (2010) further commented on the concern of the distribution of professional categories in public and private sector. Interestingly, the HRH report indicated approximately 44.4% of professional nurses' work in the private health sector (NDoH, 2012). Mokoka et al. (2010) reported on factors affecting the retention of professional nurses; as mentioned by the HRH SA and NDP reports, HCWs are less attracted to the public healthcare sector due to the lack of posts in the public sector, poor working conditions, heavy workloads, lack of workplace security, poor relationships with management, and poor staff morale (Republic of South Africa, 2011, 2012). Therefore, workplace interventions are imperative to address these challenges and the need to develop and effectively manage HCWs in order to strengthen HRM and, consequently, improve health outcomes.

The second theme is **education, training and research**; this is essential for work planning and filling vacant positions in the public health sector. However, one of the greatest challenges for the public health sector is retention of health professional graduates. There are more graduates being produced than are absorbed into the public sector healthcare system (Armstrong & Rispel, 2015). Unfortunately, the education and training system for the health sector in South Africa has not grown sufficiently enough to meet health needs and health system requirements as highlighted in the HRH report (NDoH, 2012). Evidently, prioritising the redesign of medical and public health schools' and colleges' curricula to effectively educate and train the new intake of HCWs is necessary. Further, it requires strengthening the development of PHC personnel and providing training opportunities for HCWs to develop their skills (Rispel, 2015).

The third identified theme addresses the **working environment of the health workforce**; this highlights the need for competent leadership and management. It is imperative for leadership of the health sector in the various levels to ensure a healthcare environment where the health workforce is developed, valued and supported while providing high quality healthcare. Importantly, there are various inter-related issues within the work environment that promote or hinder motivation and the ability of healthcare professionals. According to this report (Republic of South Africa, 2011), performance management, the culture of the health organisation, and other poor human resource practices play a vital role in experiences of job satisfaction at work. This report reiterates the future for HRH; the quality of the healthcare system will be determined by how well the healthcare system is led and managed at the different levels, especially within the community health centres (CHC) that are the drivers of the principles of PHC and the district health system (DHS). Emphasised in the HRH SA strategy (Republic of South Africa, 2011) is performance management and its link with the provision of healthcare; this will be discussed below.

2.7.3 The PMDS in public health

People play a vital role in the economic success, growth and development of any organisation (Avey, Luthans, & Jensen, 2009). The acknowledgement of the pivotal role played by human capital in the success of an organisation has led to an increase in research on human capital and how it may be utilised to achieve organisations' strategic goals and objectives (Luthans, Norman, Avolio, & Avey, 2008; Wright & Cropanzano, 2004). Hence, even in the national healthcare system, the quality of healthcare lies with the healthcare workforce's performance and ability to get the job done (Swaartbooi, 2016). Others have also acknowledged that human

resource management within healthcare contributes to employee well-being and job satisfaction. Furthermore, managing employees well leads to improved organisational outcomes such as better job performance and lessens negative outcomes such as turnover (Kalashe, 2016). However, a concomitant factor of PM systems and talent management initiatives in the health setting is that they fail to encourage performance and development of staff, which has detrimental effects on overall functioning (Swaartbooi, 2016). The PM cycle is discussed below in more detail.

2.7.4 The performance management and development cycle

The South African Public Service and Administration PMDS framework (Republic of South Africa, 2007) provides guidelines to all departments that wish to implement the PMDS. The guidelines suggest a 12-month period during which performance must be planned, executed and assessed. They identify four phases that are necessary in a full performance cycle, as indicated in *Figure* 2.1.
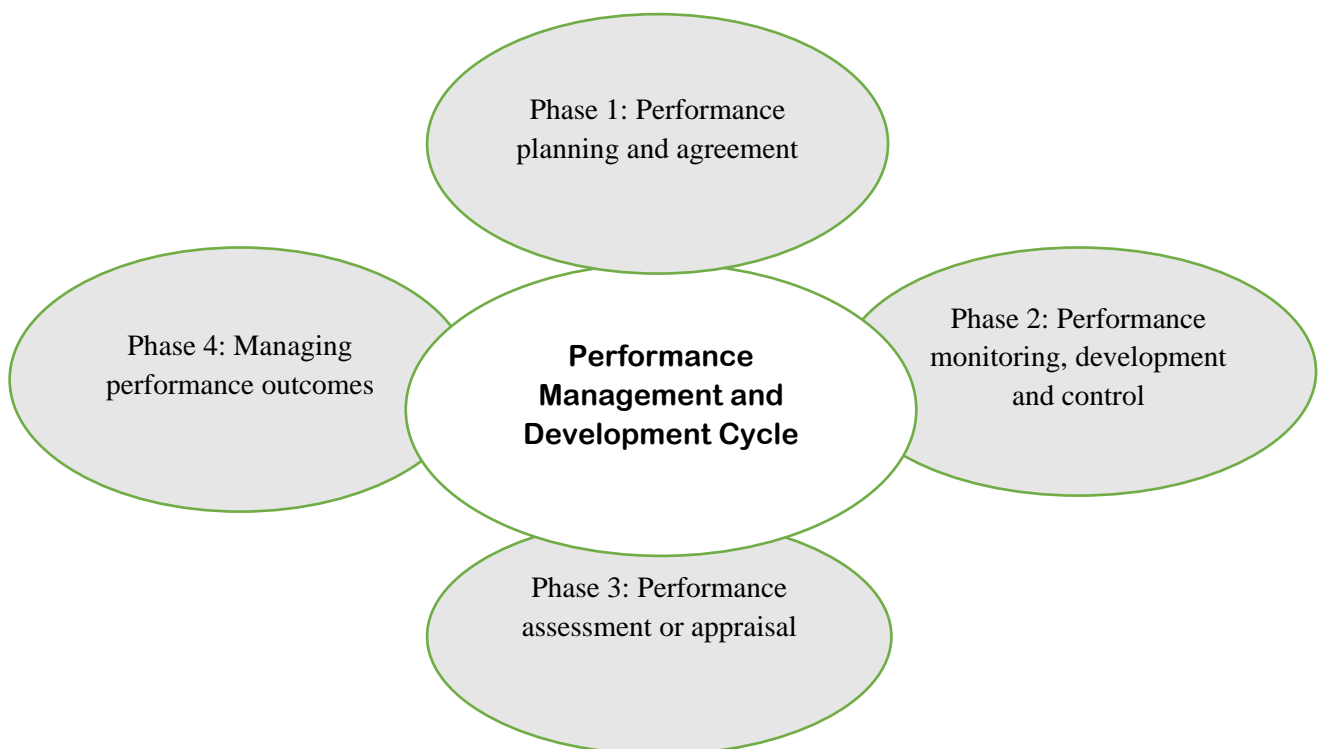
Figure 2.1. The employee performance management and development cycle

Adapted from: Department of Public Service and Administration: Employee Performance Management and Development System (Republic of South Africa, 2007).

2.7.4.1 Performance planning and agreement

The first phase in the cycle requires employees and their direct supervisors to engage in discussions on planned performance in which employees set a personal development plan and individual performance targets. This agreement is considered the cornerstone of individual performance, as it requires content on performance expectation, how performance will be measured and how individual performance links to departmental objectives. At the end of this phase, each employee signs a performance agreement which consists of employee data (job description, generic assessment factors, etc.), workplans (key performance areas, activities and outputs) and personal development plans (individual training and development needs as required). This forms the basis for how performance is monitored and evaluated during the 12-month cycle (Du-Plessis, 2015). It is during this phase that supervisors gain employee commitment to achieving set expectations. Therefore, without a completed performance agreement, the entire PMDS process is considered invalid and of little benefit in managing performance (Republic of South Africa, 2007).

2.7.4.2 Performance monitoring, development and control

The Public Service Commission toolkit for managing poor performance in public services (2007) addressed the need for supervisors to continuously monitor staff's individual performance in order to identify performance barriers and changes so that these are proactively dealt with. This means development and any performance improvement needs are dealt with as they arise. Thus, in this phase, employees and supervisors should determine progress and/or identify if there are any obstacles to achieving set objectives and targets, and identify support when required. Du-Plessis (2015) and Swaartbooi (2016) both reaffirmed the need for continuous monitoring and providing constructive feedback to employees to improve performance and reinforce key results and behaviour.

2.7.4.3 Performance assessment or appraisal

According to Choudhary and Puranik (2014), performance appraisal for healthcare professionals has become popular, with increased need to use it to improve accountability to patient and the community. The review process generally involves a one-on-one formal discussion between the supervisor and the employee in which the contents and outcomes of the mid-year and/or end-of-the year performance appraisal are discussed. Both parties provide an assessment of the employee's performance. An impactful appraisal process is one where both parties engage in the process, and regardless of a high/low rating, the employee is provided the

opportunity to get feedback on their score. Furthermore, a meaningful discussion on performance improvement and key development areas post the appraisal is essential. Swaartbooi (2016) argued that, presently, the process is contested due to lack of training on the PMDS; this leaves it vulnerable to misuse and negative experiences and perceptions regarding its usefulness for nurses.

2.7.4.4 Managing the outcomes of the appraisal

During this phase, the supervisor has to manage performance assessment outcomes. Various interventions are suggested that include personal counselling, on-the-job mentoring and coaching, formal training and retraining, as well as environment audits to determine if other factors may be affecting performance (Republic of South Africa, 2007). If the appraisal process is not managed with transparency, openness and objectivity, the outcomes are generally negative, hindering the employee-supervisor relationship. Poon (2004) indicates that performance ratings that are perceived as manipulated for political purposes can negatively influence job satisfaction and intention to quit.

Chandra and Frank (2004) suggested the need for training on performance management processes and creating a conducive environment for employee involvement in the process, as this is connected to employee acceptance of and commitment to the process. These findings are confirmed in studies that investigated the use of PMDS in low- and middle-income countries (Boachie-Mensah & Seidu, 2012; Du-Plessis, 2015; Lutwama et al., 2013; Semakula-Katende et al., 2013; Swaartbooi, 2016). There continues to exist growing interest in the use of HRM processes and practices by health systems and the positive outcomes on health and healthcare professionals. Accordingly, it is vital to evaluate the implementation of PMDS in primary healthcare in order to identify gaps in implementation that may threaten the system's ability to measure and manage the healthcare worker's performance.

2.8   Previous research on performance management

The purpose of this study was to investigate the extent to which the PMDS has been implemented effectively in PHC facilities in North West province, as well as nurses' experiences and perceptions on how performance is evaluated. Early in 2007, Letsoalo conducted an evaluation of the PMDS in public service in the health setting and found health professional reported that the PMDS lacked consistency and monitoring of progress. This led to many employees losing confidence is how the PMDS was implemented. More recently, in

2015, Du-Plessis conducted a study on the implementation of the PMDS in selected PHC clinics in Gauteng and found that despite having an established system to evaluate and monitor performance, healthcare professional staff found the PMDS as not beneficial, extremely complex and not encouraging performance (Du-Plessis, 2015). In addition, also recent, Kalashe (2016) and Swaartbooi (2016) conducted research on the public service PMDS and both studies revealed poor implementation of the PMDS and its negative impact.

These studies on the PMDS are concerning and may have detrimental results on service delivery. Others have also found the lack of a good PM system has a direct link to poor performance, high turnover rate, poor staff attitude and counter-productive work behaviour (Luthans et al., 2008; Kalashe 2016; Swaartbooi, 2016). Similarly, as early as 2003, researchers like De Waal found behavioural factors play a role in the successful implementation and use of PM systems. In the same light, Markos and Sridevi (2010) highlights that performance measurement and control systems cannot be designed without considering human behaviour. She further stipulates that successful implementation of a PM system is dependent on understanding and accommodating human elements.

Upon a closer inspection of literature globally and within the SA context, it is evident that research on behaviour and performance has focused largely on the relationship between behaviour and rewards. The most common factors affecting performance in organisational settings are thus constructs such as motivation, role ambiguity/role conflict, and rewards (Letsoalo, 2007; Onyemah, 2008 Saravanja, 2010). Role ambiguity and role conflict are commonly experienced in settings where change is experienced. The current changes within the healthcare system are thus likely to lead to confusion and uncertainty in the roles of the various healthcare workers such as nurses (Petrus, 2017; Swaartbooi, 2016).

As previously stated by Pillay (2009), nursing is a highly stressful profession. The current changes in the healthcare system are thus likely to lead to more stress for nurses, as this change will require increased demands from an already strained nursing staff cohort. A study conducted by Onyemah (2008) illustrates the importance of considering the role stressors play in relation to changes. In her study on role ambiguity, role conflict and performance, Onyemah (2008) mentioned role ambiguity and role conflict as negatively related to motivation and job performance. Similarly, a previous study by Fried et al. (1998) also found that the simultaneous

increase in both role conflict and role ambiguity are associated with lower levels of job performance.

Other factors as noted by Swaartbooi (2016) that affect performance of nurses include healthcare systems that have deficiencies in human resource management aspects; these include recognition of good performance, poor working conditions and poor implementation of performance appraisal systems, as well as lack of feedback on performance outcomes and poor management skills. Further, a study by Awases (2006) was conducted in Namibia and also had similar results; however, these findings are not unique to Namibia, and have implications for South Africa as well. In 2010, Saravanja investigated the PMDS in the South African public sector and its influence on motivation, and found a lack of leadership and management in the implementation and monitoring of performance in all departments in the public sector. More so, he established a lack of feedback and poor evaluation of the performance process resulted in negative attitudes towards the PMDS and its potential benefit to employees.

Saravanja's study advocated the redesigning of the current PM system to a system that fosters talent management and career development instead of the current system that was viewed as punitive. In the year 2016, Swaartbooi also confirmed the need to re-evaluate the current PMDS to promote rather than hinder good performance. At present, negative views of the PMDS by employees are not conducive towards creating a culture of openness and accountability. Unless there is a systemic change in how performance is measured and evaluated, there is no motivation for employees to change towards outcomes-based performance (Kalashe 2016; Luthuli 2005; Maepa, 2015).

Until recently, managing performance in healthcare systems has often been neglected in literature. Research conducted by Bartram and Dowling (2013) on performance management in the health sector attested to the importance of human resource management in this sector. These researchers confirmed that poor management of employees has a potentially adverse impact on employee well-being and improving healthcare outcomes. Bartram and Dowling (2013) further argued that the nature of a healthcare system may differ depending on the national context. However, what remains constant across different national settings is measuring and evaluating performance, in terms of both the healthcare system's ability to impact on patient outcomes and health facilities' operational costs. Additionally, impacting on

the effectiveness of any healthcare system are challenges such as shortage of staff, poor working conditions and lack of service delivery (Swaartbooi, 2016). Bartram and Dowling (2013) suggested a census of international health systems research where well-implemented performance systems make positive contributions towards achieving better clinical outcomes in health systems. However, these authors remarked that there is a paucity of research on the impact of PM systems on patient outcomes and often this aspect is viewed with reservation by health workers, management and government. Consequently, there is limited understanding of how various components of human resource management (such as the PMDS initiatives) impact on health workers, how these initiatives can be used to impact on care delivery, and ultimately influence patient outcomes.

In support of the above statement, Luthans and Stajkovic (1999) highlighted the need of PM systems to go beyond pay and reward. They posit that, initially, pay-for-performance has been human resources' response to making employees more productive. However, presently, employees demand more than an improved salary; this is a factor for consideration when seeking employment. Luthans and Stajkovic (1999) also maintained that workers want growth opportunities, training and empowerment. Therefore, a good PM system is one that uses performance data not just for rewards or disciplinary purposes but to identify training needs and other development initiatives. Bartram and Dowling (2013) identified this area as lacking in research both internationally and within the South African context, and they advised extending the research agenda. They suggested researchers conduct both quantitative and qualitative studies to assess the influence of the PMDS and attitudes towards the PMDS; it is important to investigate how these attitudes might influence HCWs' behaviour and job performance and, thus impact on quality of care. These studies highlight the necessity of a study that investigates these concepts within the South African context in times of health systems strengthening and reform.

Much research on performance management and appraisal systems generally focusses on methods and practices that are effective for PM. Coens and Jenkins (2002) argued that the knowledge generated on the use of PM systems is generally concerned with problems with using these systems, rather than yielding any serious, in-depth discussion of the bigger question: Are such systems needed at all? Instead, much research is focused on advice and suggestions on how to improve these systems rather than considering the possibility of a work

environment without any kind of PM or PA system. Below is a detailed critique of PM systems and the possible that the underlying assumptions of an effective system are flawed.

2.9   An attainable dream: A critique on PM and PA systems

A few authors critique the relevance of using PM systems. For instance, Coens and Jenkins (2002) have argued that such systems should be abolished. They explained that the underlying assumptions on PM systems are not logical or realistic. To elaborate, these authors mentioned that it has been established that, for a PM system to be a reliable and useful tool, certain premises must hold true. Such premises may be, first, all employees want relatively the same thing, for example, to be developed or coached in the same or similar manner. Second, such a system can be unbiased and objective. However, previous research suggests these two conditions are impossible to meet. These authors have thus argued that the key underlying assumptions of PM are not achievable. They argued the problem is not with top managers, raters or ratees, but the challenge is PM systems themselves. Although the motives for such systems are noble and worthy, such systems have constantly failed to produce desired outcomes; therefore, new alternatives that may prove more effective must be considered. Some authors do not take such a strong stand and also point to issues with PM systems that are embedded in their implementation and use.

Brudan (2010) argued that the challenges experienced with PM systems are fundamentally due to three areas that require great attention regarding PM research and its practical application in the work context. These are: firstly, there is lack of standards regarding definition, classification and the usage of specific tools; this is caused mainly by a fragmented body of knowledge of performance management as a discipline. Secondly, there seems to be tension regarding the style of thinking that should be associated with PM systems. Some practices are focused on the command-and-control style of thinking (culture that emphasises on a top-down approach to leadership and management), while others are concerned with systems thinking in organisational managerial practice. A third area of tension in PM practice is overemphasis on a measurement and rewards ethos, as opposed to learning and development for the purpose of performance improvement. As a consequence, the focus on target achievement and rewards means that such PM systems yield a negative halo effect, arguably to the detriment of the PM system's knowledge and improvement role (Brudan, 2010; Keong Choong, 2014).

DeNisi and Pritchard (2006) had also previously reported that, although there has been a great interest in the field of performance appraisal and management, little is known about specific recommendations for designing and implementing appraisal and PM systems whose goal is performance improvement. These authors believe this is due to research in the field being focused on measurement issues and not interested enough in ways to improve performance (DeNisi & Murphy, 2017).

Similarly, as early as 1987, Longenecker, Sims and Gioia argued that the political nature of PM systems will never be entirely resolved, there is too much focus on the problem and not enough on the solution which gives no direction to improving the system. These authors candidly expressed there is some place for politics in a PM system and this is necessary to a certain extent. The goal should not be to haphazardly try to eliminate politics from this process, instead, to effectively manage the role politics plays in employee appraisals and PM. Rousseau (2012) disagreed, arguing that, currently, the important influence of power and politics in organisational life is downplayed as a minor by-product of radical improvement to organisational processes and management practices. Murphy (2008) has argued that, although the flaws of appraisal and PM systems are noted, the continuing survival of these systems is due to a lack of better alternatives. However, this author did note that efforts to improve PA and PM systems have not yielded successful results. A weak link continues to exist between ratings of job performance and true performance; therefore, performance ratings continue to be poor measures of job performance (De Waal & Counet, 2009; Heathfield, 2007).

Ultimately, the above authors debated the traditional focus on building better scales or better training programmes as solutions to PM systems shortcomings. Instead, more focus should be on building a better organisational climate for performance management. Thus, it is argued interventions most likely to improve the quality of performance appraisals and management in organisations are those that are more concerned with organisational development than scale development. Thus, organisational factors that may hinder efforts to improve performance must be considered as equally important as the type of measurement used.

The following section details the framework used to understand the value of PM systems within the public healthcare system. The section concludes with a brief explanation of the relevance of this framework to this study, thus showing the applicability of the framework within the study context.

2.10 A framework for PM systems in public health

PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM
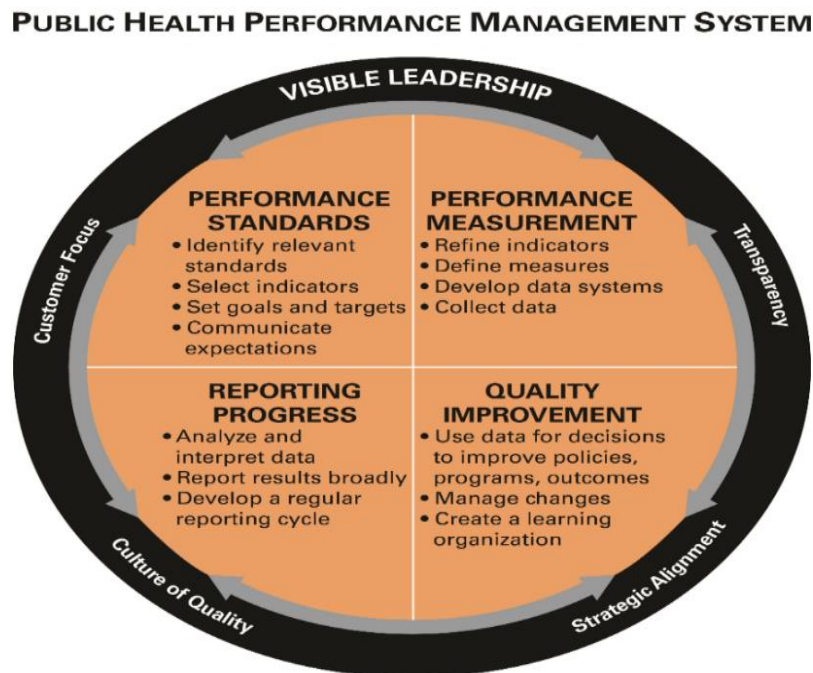
Figure 2.2. The Turning Point Model adapted from: Public Health Foundation (2014).

According to the Public Health Foundation (2014), there exist five components of the Performance Management System Framework. These include: visible leadership, performance standards, performance measures, reporting progress, and quality improvement (see *Figure* 2.2).

Visible leadership competency refers to the extent to which senior management is committed to a culture of quality that aligns PM practices with the organisational mission of healthcare facilities. This includes regularly considering feedback provided by patients, and enables transparency about performance between leadership and staff. This also means the successful implementation of a PM system relies largely on strong leadership to drive the process of change. Furthermore, a good PM system has clearly set **performance standards**, along with targets and goals to improve health practices; this is crucial to the successful implementation of a PM system. Moreover, the standards of performance set by the healthcare system should be based on benchmarks using similar organisations or national standards.

Also significant is the **type of performance measurement** used to assess achievement of performance standards. These authors recommended that the measurements used to assess performance must be fair and standardised across the health sector. Therefore, when performance standards and the type of performance measurement used are negatively viewed by employees as unattainable or a tool of organisational injustice, this may impact on how motivated they are to achieve set goals (Du-Plessis, 2015; Nxumalo et al.; 2018; Swaartbooi, 2016).

The PHF also suggested that it is vital for the PM system to have a solid mechanism for reporting progress. This requires performance to be well documented, which ensures the responsibility of **transparency**. Equally, important, healthcare workers must be provided with appropriate feedback through well-established feedback channels. The PM system should be viewed as a form of regulating development and facilitating personal growth, rather than just a strategic means of punishing under-performance. In this model, the PM system is viewed in relation to improving quality. To achieve this, the PM system must possess an element of rewarding great performance. The PHF further contended that this will lead to greater efforts from HCWs to achieve measurable improvement in the provision of quality healthcare.

In light of the current health reform, this framework is suitable as it recognises that the public health sector priorities are evolving. The framework was developed specifically to assist public health systems manage performance while considering the changing priorities of health systems. Therefore, the Turning Point Performance Management Framework was updated in 2012. It provides a good conceptual model describing critical elements of a PM system. However, according to Moran, Epstein and Bietsch (2013), it is not without any shortcomings. These authors argued that, although the model provides important elements of a PM system within the public health sector, it also leaves a few questions unanswered; these include the following:

- How should standards be established?
- How should those standards be measured?
- How should data be reported?
- What process should be established to prioritise areas that need improvement?
- How do we ensure an efficient 'system' that is not an administrative burden? (Moran et al., 2013, p. 4).

Arguably these questions require the consideration of contextual factors from the setting in which this model is applied. Such factors may include: the health needs of that particular health facility; national health objectives; factors enabling or hindering performance; and human resources capacity to implement a PM system.

2.11 Chapter summary

This chapter provided an overview of performance management systems. It detailed the key characteristics of an effective PM system, and the impact of poorly implemented systems. It also provided a review of the South African PMDS and appropriate research conducted on PM specifically in healthcare. It further provided a critique on PM systems by various researchers and the chapter concluded with the conceptual framework underpinning the study.

CHAPTER 3

MAPPING EVIDENCE ON PERFORMANCE MANAGEMENT METHODS AND PRACTICES AMONGST NURSES IN PRIMARY HEALTH CARE SETTINGS: A SCOPING REVIEW

3.1   Introduction

In this chapter, a literature review is presented in the form of a scoping review. The review details existing evidence of the influence of performance management (PM) methods and practices on quality of care amongst nurses in primary health care. This chapter commences with the study background, and then it provides an overview of the study aims and objectives, as well as the research questions to be addressed by the review. Thereafter, the methodology used for the scoping review is provided, detailing the steps followed to retrieve articles that were reviewed and the inclusion and exclusion criteria that determined each study's suitability. This section is followed by a presentation of the results of the scoping review through data synthesis. This chapter ends with a discussion of the results and a critique of literature pertaining to methods and practices that contribute to performance management within the global environment.

3.2   Background

3.2.1 The global quest for quality health care

> *Globally, more than 400 million people lack access to essential health care. Where it is accessible, care is too often fragmented or of poor quality, and consequently the responsiveness of the health system and satisfaction with health services remain low in many countries.* (World Health Organisation, 2016a, p. 1)

Central to the WHO vision towards achieving universal, quality and sustainable provision of essential health services are improvements in health systems strengthening. More so, the philosophy of primary health care (PHC) in particular requires a radical strategic shift in the manner in which health and healthcare are considered across the globe. A critical element to the successful implementation of these strategies of change has been inter-sectoral collaboration, policy reforms, reassessment and reallocation of human resources, and the application of cost-effective interventions that would facilitate the PHC vision (WHO, 2016a).

According to the WHO *Global strategy on human resources for health: Workforce 2030* (2016b), one of the fundamental reasons declared for unsuccessful implementation of PHC is the lack of, or misuse of, human resources and material resources. Various researchers have highlighted inappropriate human resource management (HRM) policies (Diallo et al., 2003; Dussault & Dubois, 2003) and poor workforce planning as the main cause of imbalances between healthcare providers with adequate skills and training and those without (Chen et al., 2004; Cometto & Campbell, 2016). Moreover, other authors cite health workers' dissatisfaction with working conditions, career development and salary structures that further exacerbate the situation (Lehmann, Van Damme, Barten, & Sanders, 2009). Furthermore, the HRM methods and practices also face the challenge of mismanagement in the form of weak managerial capabilities at all levels of care; this has been seen as a cause of ineffective and inefficient implementation of health interventions. Thus, due to mismanagement, there is poor organisation and delivery of health services at all levels. Such problems are not unique to low- and middle-income countries (LMICs), although in countries with low resources these challenges are aggravated by contextual challenges faced by LMICs (Cometto & Campbell, 2016; WHO, 2016b).

Noticeably, part of the strategic planning for the healthcare workforce is developing and capacitating the PHC workforce, which includes ensuring the management of healthcare professionals' (HCPs) development and performance (Bertone & Witter, 2015; WHO, 2016b). Thus, literature affirms that the greatest challenge has been providing appropriate incentives for health workers to work optimally and be accountable for their performance. Research on PM in healthcare settings globally has predominantly concentrated on healthcare facilities' performance rather than improving methods and practices of managing and developing healthcare providers' performance for the purpose of training and development, career advancements and rewarding top performing employers (Cometto & Campbell, 2016; WHO, 2016b).

PM is generally acknowledged as performance review (PR) through performance appraisal (PA) activities. Such focus on PAs warrants a focus on individual performance outcomes more than the process of managing and development employees' performance. It is thus not surprising that PAs are generally accused of over-emphasing quantitative health outcomes over quality of care. Authors who advocate for better management of HCPs have argued that, despite research that prescribes human resource principles on effective management practices, that the

focus on set health objectives, most of the time, neglects practices to effectively manage performance of HCPs, and so fails to address under-performance or reward good performance (Campbell et al., 2013; Dawson, Stasa, Roche, Homer, & Duffield, 2014).

Therefore, there exists the need for performance management and appraisal methods and practices to support the re-configured healthcare system towards integrated health services, improving quality of care and patient-centred care (PCC) (Bartman & Dowling, 2013, WHO, 2016a). Therefore, this review aimed to identify how managing performance methods and practices is applied within the healthcare sector and its benefit to nursing staff well-being, job satisfaction and motivation. Globally, there is generally limited understanding of how PM methods and practices impact on HCPs and how they may be used to influence care delivery and, ultimately, patient outcomes. However, there is no doubt that HCPs are increasingly becoming accountable to the communities they serve and are under immense pressure to improve services provided to patients and the community. Thus, in an era of constant monitoring and evaluating health systems performance, the contribution of HCPs towards improving key performance indicators (KPIs) at individual, group and organisational level is under the spotlight (Brady Germain, & Cummings, 2010; Dieleman, Gerretsen, & van der Wilt, 2009).

In light of the above, the purpose of performance management systems (PMs) is to monitor, evaluate and develop employees' performance. In doing so, PMs act as a managerial tool to identify training and development needs, motivate staff through providing performance-based incentives and ultimately improve staff morale, while effectively meeting the key performance objectives of the organisation. Furthermore, in health settings, PMs are considered one of the most vital components of human resource management (HRM). They provide justifications for decisions on recruitment and selection, training and development, needs of exiting employees, and how to optimise the quality of work and efficiency within individual healthcare centres and the health system (Choudhary & Puranik, 2014). Therefore, if not managed appropriately, a poorly implemented PM system is detrimental to staff morale, turnover rates and overall job satisfaction. The literature suggests a variety of approaches to performance management and development, and notes the value added by the PMDS to the health system's HRM outcomes and quality of care. In order to gain a comprehensive understanding of the PMDS in healthcare, identify knowledge gaps and provide recommendations for future research, a scoping review was undertaken.

Scoping reviews have gained popularity as a method for synthesizing research evidence and mapping evidence for broad topics. By mapping existing literature in terms of volume, nature and charateristics of the topic, scoping reviews may serve as a preliminary step to a systematic review. However, it may also be a standalone project. As standalone projects, scoping reviews are credited for scientific rigour in summarising and disseminating research findings as well as identifying research gaps in existing literature.

3.3 Scoping review aims and objectives

This scoping review aimed to map evidence on the use of performance management methods and practices amongst nurses in PHC setting. It was driven by the following objectives:

- To explore existing evidence of the influence of performance management methods and practices on quality of care amongst nurses in PHC settings;
- To identify common challenges and opportunities reported on various performance management methods and practices;
- To examines key gaps in literature on the contribution of effective performance management on quality of care amongst nurses in PHC settings.

3.4 Research questions

- What is the existing evidence of the influence of performance management methods and practices on quality of care amongst nurses in primary healthcare settings?
- What are common challenges and opportunities reported on various performance management methods and practices?
- What are the key gaps in literature on the contribution of effective performance management on quality of care amongst nurses in primary health care settings?

3.5 Methodology of the scoping review

The methodology adopted for this scoping review was guided by Arksey and O'Malley's framework (Arksey & O'Malley, 2005), which specified the procedural systematic steps. These guidelines were considered in conjunction with a quality assessment process of reviewing literature that was later proposed by Levac, Colquhoun and O'Brien (2010).

This review offers a broad overview of the performance management of nurses working at various PHC settings. In addition, it provides an analysis of international methods and practices

used to manage nurses and, from these, identifies best practices for effective performance management and development. The review of primary research has gained popularity as evidence-based practice gains recognition as the benchmark for care, and the number of, and access to, primary research sources continues to grow (Peters et al., 2015). A scoping review is considered a relatively new method for reviewing literature, with the first framework published in 2005. This method of literature review is considered advantageous for synthesising research evidence and mapping existing literature in a given field in terms of its prevalence and key features. Thus, it is also referred to as a 'mapping' review' (Peters et al., 2015).

3.5.1 Search strategy utilised

Relevant studies were identified through conducting a comprehensive search on the following electronic databases: Academic Search Complete, PsycARTICLES, PsycINFO, Cumulative Index to Nursing and Applied Health Literature (CINAHL), Medline and PubMed. Primary studies with a transparent empirical base utilising qualitative, qualitative and mixed-methods research designs, published in peer-reviewed journals and grey literature, and addressing the research question, were included. To achieve a comprehensive search, websites such as the World Health Organization and governmental websites were also considered, especially for policies and guidelines for performance management in the healthcare sector. In addition, Google Scholar, Union Catalogue of Theses and Dissertations (UCTD) via SABINET Online and World Cat Dissertations and Theses via OCLC were also accessed. These databases were recommended as the most relevant for human resources, health systems strengthening and nursing management.

A hand search through the main published texts used in PM and its outcomes was conducted. Articles were also searched for through the 'Cited by' search, as well as citations contained within the reference lists of included articles. The search terms included Nurse OR Nurse Practitioners OR Registered Nurse AND, Performance Management OR Performance Appraisals OR Performance Review. The primary investigator conducted a database search and screened titles. The results of the keyword search and title screening are presented in Table 3.1. Following keyword searching by CZM, eligible titles were selected; thereafter, these were exported to the Endnote library and duplicates were removed (see *Figure* 3.1). Two reviewers (CZM and TS) thereafter began abstract screening independently, guided by the eligibility criteria. Once abstract screening was completed, the reviewers discussed eligible and ineligible

studies to identify any discrepancies. When the reviewers were unable to resolve disagreement through discussion, a third reviewer (TMT) was consulted. To fully optimise the full article search procedure, a senior librarian at the University of KwaZulu-Natal (UKZN) library services (FB) assisted in retrieving and finding articles that were included in the full article screening. In instances where we were unable to retrieve the articles from databases, attempts were made to contact relevant authors to request the articles; most of these attempts were not successful. Full article screening was conducted against the inclusion and exclusion criteria which are presented next.

3.5.2 Selection criteria

Articles were deemed eligible if they met all of the following **inclusion** criteria:

- Articles available in full-text;
- Studies with evidence on performance management, appraisals, evaluation or review;
- Studies must have been based on professional nurses (registered nurse, nurse practitioner, nurse clinician – a nurse category recognised/registered by a governing body of any particular country);
- Studies published between 1978 and 2018, since 1978 was the year the Alma Alta Declaration on PHC was made;
- Studies within the PHC setting and all study designs were considered eligible.

Studies that were **excluded** which did not meet the inclusion criteria were:

- Those studies that had no evidence on performance management, appraisal or evaluation or review;
- Studies that were published before 1978;
- Studies that were not within the PHC setting;
- Studies not based on nurses or nurse practitioners or registered nurses (or any form of nurses not governed by a nursing body of a particular country);
- No studies were excluded on the basis of language.

The title screening results are presented in Table 3.1.

Table 3.1.

Title Screening Results

Date of search	Keywords search	No. of publications retrieved	Search engine utilised	Number of eligible studies
19 Feb 2018	Nurse OR nurse practitioner OR registered nurse AND performance management OR performance appraisal OR performance evaluation	4,777	EBSCOhost (Academic Search Complete; PsycArticles, PsycInfo, CINAHL, Medline)	548
23 Feb 2018	Nurse OR nurse practitioner OR registered nurse AND performance management OR performance appraisal OR performance review	6,098	PubMed	217
15 Mar 2018	Nurse OR nurse practitioner OR registered nurse AND performance management OR performance appraisal OR performance review	860,000	Google Scholar	92
15 Mar 2018	Nurse OR nurse practitioner OR registered nurse AND performance management OR performance appraisal OR performance evaluation OR performance review	1,950	Grey literature – WHO and relevant government websites	12
15 Mar 2018	Nurse OR nurse practitioner OR registered nurse AND performance management OR performance appraisal OR performance evaluation OR performance review	7	UCTD via Sabinet Online	0

3.5.3 Abstract and full article screening results

The scoping review yielded 872,832 articles that were considered eligible after the database search. During 856 title screening and 12 from manual search (see Table 3.1), a total of 866 articles were exported to Endnote. Once duplicates were removed, 586 articles remained. Upon

completion of abstract screening, 278 articles were removed; 308 articles were screened at full article screening. From 308 articles screened, 20 were considered eligible for data extraction and quality appraisal.
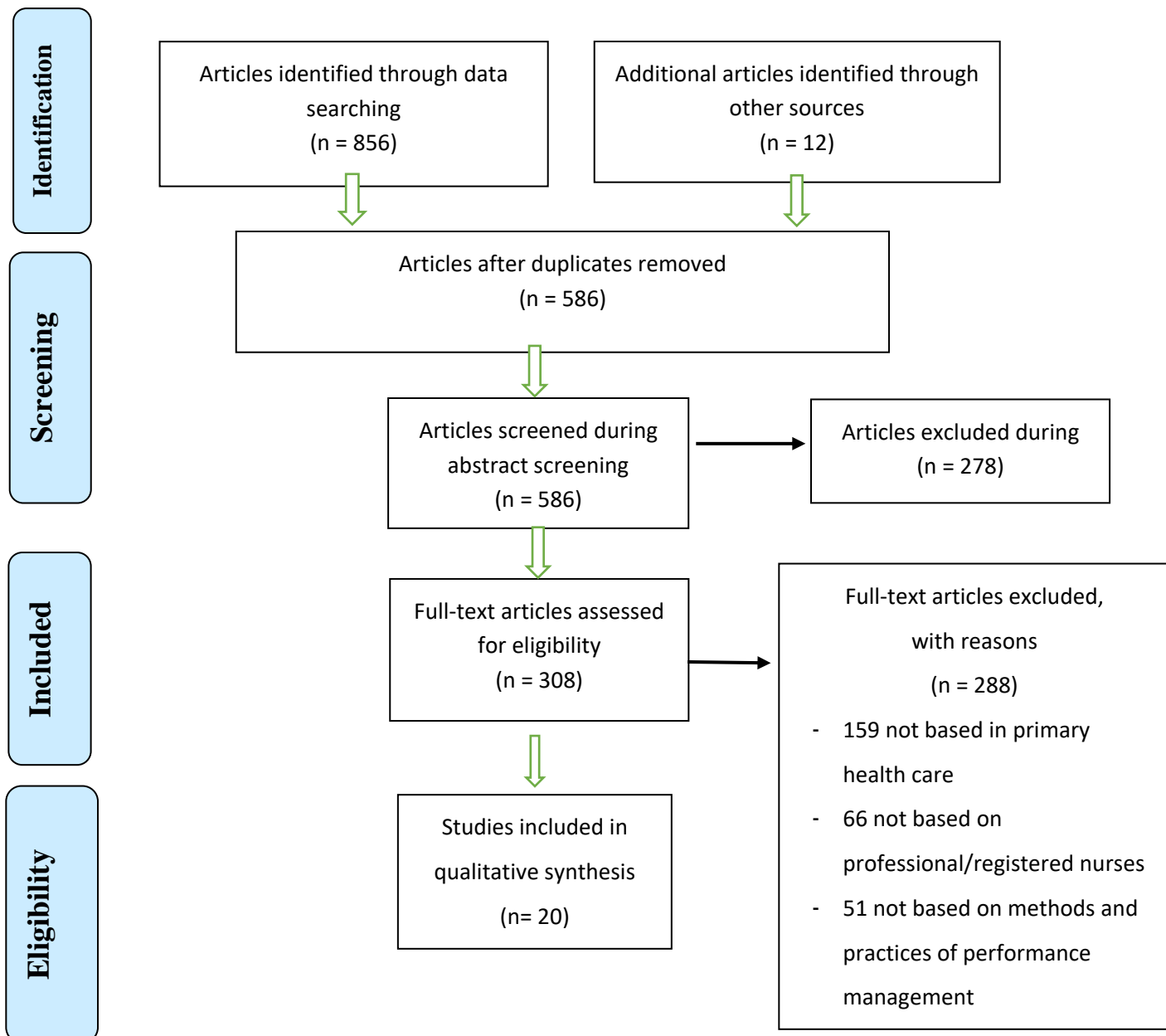
Figure 3.1. The PRISMA flowchart depicting the screening result

From the 308 articles that were eligible for full title screening, 288 were excluded from this study because 159 articles were not based in primary health care settings, and 66 articles were not based on the population sample, that is, professional/registered nurses. Fifty-one articles were not based on methods and practices used in performance management and 12 were not accessible after the researcher had exhausted all avenues to gain access to the full articles.

3.5.4 Data synthesis

Data was analysed through qualitative synthesis (thematic synthesis) of qualitative and quantitative data (Barnett-Page & Thomas, 2009; Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005; Tong, Flemming, McInnes, Oliver, & Craig, 2012). The method is a three-step process that involves: i) coding text of included studies; ii) developing descriptive themes; and iii) generating analytical themes (Thomas & Harden, 2008). Data was extracted around the following themes: i) performance management and development initiatives, ii) managing performance of nurses in PHC settings, and iii) the use of performance management to influence quality improvement. Thus, a cross-country analysis using the extracted information was considered, and thereafter the information was organised to indicate key findings and the significance of the results to evidence on performance management methods and practices. Each final article included is presented in table form below (see Table 3.3). This table includes a summary list of the final articles included, organised alphabetically by author. Articles from a single country were given the same importance as multiple-country articles.

3.6 Results

3.6.1 Characteristics of included studies

Twenty articles from eighteen different studied were included in the review. The main characteristics and quality assessment for these studies are presented in Table 3.2.

Table 3.2**.**

Summary Characteristics of Included Studies

Variables	Number of studies	%
Primary health care setting		
• PHC health centre/clinic	5	25%
• Community-based health service	6	30%
• General practices	6	30%
• Home-based health service	3	15%

Region

• North America	3	15%
• South America	0	0%
• Africa	1	5%
• Europe	12	60%
• Asia	3	15%
• Australia	1	5%

Study design

• Qualitative	6	30%
• Quantitative	7	35%
• Mixed methods	4	20%
• Other (review/discussion article)	3	15%

Quality appraisal

Qualitative

• Adequate	3	50%
• Weak/Unknown	3	50%

Quantitative

• Adequate	6	85%
• Weak/Unknown	1	15%

Mixed methods

• Adequate	2	50%
• Weak/Unknown	2	50%

The Mixed Method Appraisal Tool (MMAT) version 2018 was used to review the quality of the studies. This tool is recommended for appraisal of primary research articles. From the included articles, 17 were appraised for quality (Pace et al., 2012). From the reviewed articles, 11 were found to have adequate quality, while six articles were considered to have a weak method (a detailed outline of how quality appraisal was performed is available in Appendix 5). Three articles were not primary research articles and so were included for quality appraisal.

Table 3.3.

Description of Included Studies

Author (s) and publication year	Country	Title	Study design	Sample, population and setting	Measurement/ instruments/ tools	Key findings
Aird, R., Kennedy, S., & Mcintosh, P. (2016).	UK	Benefits of peer appraisal for general practice nurses	Literature review	Registered nurses - general practice	Review of survey studies	Prepared appraisers that enhance learning and constructive reflection.
Barriball, K. L., & While, A. E. (1995).	UK	The different appraisal profiles of a group of nurses and nursing aides: Implications for policy initiatives.	Quan research	Registered nurses; clinical units - hospitals and community practices - district health	Semi-structured interview	Appraisal systems need to be available to all nurses in the clinical domain, not on ad hoc basis to a selected few.
Cheyne, H., Niven, C., & McGinley, M. (2003).	UK	The PEER project: A model of peer review.	Intervention - mixed-methods study	Midwives - three medical centres – community- and hospital-based centres	1. Semi-structured interviews 2. Questionnaire 3. Group interviews	Findings demonstrate clear benefits in midwives' changed attitudes and awareness, and in increased confidence.
Crumbie, A., & Kyle, L. (2006).	UK	Nurse partnership: The challenge of appraisal.	Reflection discussion paper	Registered nurses - general practice		A properly conducted and fully documented appraisal process is necessary for nurses'

						competence and professional development.
Durcho, J. J., Speroni, K. G., Jones, R. A., Daniels, M. E., Beemer, C. P., & Daniel, M. G. (2016).	USA	A subjective view: Nurse satisfaction and the review process.	Quan + qual (mixed methods)	Registered nurses - a rural community hospital.	Survey + open-ended interview	PMs generate anxiety for managers and staff because of their ties to performance. Fairness and objectivity influence performance behaviour.
Fereday, J., & Muir-Cochrane, E. (2004).	Australia	Evaluating performance feedback: A research study into issues of credibility and utility for nursing clinicians.	Qual	Registered nurses and/or midwives - private/public hospital	Focus groups - semi-structured interviews	Performance utility and credibility influences whether feedback is accepted or dismissed. The findings indicate the social relationship between the source and the recipient of feedback.
Fort, A. L., & Voltero, L. (2004).	Armenia	Factors affecting the performance of maternal healthcare providers in Armenia.	Quan	Nurses and midwives working at three types of service delivery points: polyclinics, health centres and primary posts or FAPs, in the regions of Lori and Shirak.	Survey	Performance factors and health provider's performance were found to be strongly associated. Barriers and facilitators to effective PM are discussed.

Horman, L., Hellens, J., & Baker, M. (2014).	UK	A proposal for practice nurse appraisal: Report of a pilot project.	Pilot study - mixed methods	Practice nurses - Somerset County Practice Managers Group (SCPMG)	Survey (quan) and interviews	External peer appraisals as opposed to in-house performance appraisal were received positively. The benefits of peer-led appraisals were discussed.
Keegal , T. (2013).	UK	Poor performance: Managing the first informal stages.	Case studies	Nurse managers - primary health care	Disciplinary action cases data	There is a need for improved managerial training focused on managing poor performance.
Knox, L. J., & MacKay, R. C. (1982).	Canada	Performance appraisal for community health nurses through self-appraisal and goal setting.	Quan	Community health nurses - Alberta	Self-administered survey	Self-appraisal and goal-setting found as valuable methods of assessing performance under certain conditions.
Li, I. C., Huang, H.-C., Kuo, H.-T., & Hung, C.-M. (2015).	Taiwan	Development of a performance scale for nurses in community-based long-term care facilities in Taiwan.	Mixed-methods - action research	Nurses working in community health long-term care facilities -Taiwan	19 experts evaluated the results from the focus groups; field testing of the instrument was carried out among 190 nurses working in long-term care facilities.	Findings indicate the use of valid assessment tools for assessing clinical performance are required and should be developed to facilitate personal and professional development.

Maisey, S., Steel, N., Marsh, R., Gillam, S., Fleetcroft, R., & Howe, A. (2008).	UK	Effects of payment for performance in primary care: Qualitative interview study.	Qual semi-structured interview study	Nursing clinicians - 12 general practice in Eastern London	Semi-structured interview schedule	Payment for performance is driving major changes in the roles and organisation of English primary healthcare teams.
Murie, J., Wilson, A., & Cerinus, M. (2009).	UK	Practice nurse appraisal: Evaluation report.	Qual	General practice nurse and GP appraisers - Lanarkshire	Interviews	All counties in the UK emphasise that practice priorities and development plans should be reflected in their employed nurses.
Pelle, D., & Greenhalgh, L. (1987).	Israel	Developing the performance appraisal system.	Qual	Nurses - Beth Israel Hospital		PA best tailored to exact needs of its users.
Sheahan, S. L., Simpson, C., & Rayens, M. K. (2001).	US	Nurse practitioner peer review: Process and evaluation.	Quan - descriptive, correlational study	Nurse practitioners practicing in primary care and specialty clinics within a Veterans' Administration Medical Center (VAMC)	Using a standardised review form, 15 NPs performed a peer review on a total of 163 medical records; each review was re-reviewed by two researchers who were also NPs.	Motivation and professional commitment are essential components of a successful peer review process.

Styles, J. A., Burgham-Malin, M., & Bayliss, S. (2004).	UK	Practice nurse appraisal: A systematic approach.	Review/ discussion paper			Findings indicated there is a need to offer a systematic approach to appraisal for practice nurses. A collaborative approach is required so that the appraisal system is structured and coordinated.
Swaartbooi, O. N. (2016).	South Africa	Performance appraisal: The experiences of nurses working in primary health care clinics.	Qual	Professional nurses Western Cape - PHC clinics	Semi-structured interview guide	The findings of the study suggest that the rating tool used allows subjectivity, as favouritism was perceived by most of the participants.
Vasset, F., Marnburg, E., & Furunes, T. (2010).	Norway	Employees' perceptions of justice in performance appraisals.	Quan	371 home nurses	Measurement/ instruments/tool	PA system perceived by some respondents as unfair.
Vasset, F., Marnburg, E., & Furunes, T. (2011).	Norway	The effects of performance appraisal in the Norwegian municipal health services: A case study.	Quan	Health professionals - 90% nurses - distributed to 25 municipalities at municipal health services	Questionnaire	Feedback from qualified peers leads to increasing performance and motivation in the job.
Vasset, F., Marnburg, E., & Furunes, T. (2012).	Norway	Exploring different effects of PA in groups and individual conversations.	Quan	60 nurses	Measurement/ instruments/tool	Group PA experienced higher professional learning than individual PA.

3.6.2 Results of data synthesis

3.6.2.1 Theme 1: Benefit of performance management and appraisal systems in healthcare

This theme consists of evidence mapping the benefits of PM systems in healthcare. Across all included literature, the value of good PM systems was noticed and encouraged. Each of the indicated benefits of PM systems will be discussed further. The sub-themes included: 1) professional development; 2) identifying key gaps in skills and knowledge; 3) motivation; 4) recognition and reward in performance management; and 5) improving quality of care.

Professional development

From the reviewed research articles, two-thirds reported the value of performance management and appraisal in healthcare. The benefit of assessing, developing and managing performance for nurses employed in PHC settings was viewed as directly impacting on the process of improving and increasing staff capabilities through skills-based training and other development opportunities (Aird, Kennedy, & Mcintosh, 2016; Barriball & While, 1995; Crumbie & Kyle, 2006; Durcho et al., 2016; Fereday & Muir-Cochrane, 2004; Fort & Voltero, 2004; Horman, Hellens, & Baker, 2014; Knox & MacKay, 1982; Li, Huang, Kuo, & Hung, 2015; Swaartbooi, 2016; Vasset et al., 2010; Vasset et al., 2011; Vasset et al., 2012). These studies indicated that continuous development of nurses was not only necessary but imperative to improve performance in light of evolving health systems and the changing needs of patients in the 21st century.

Identify key gaps in skills and knowledge

The role of PM systems as a tool to identify key gaps in skills and knowledge was reported in eleven articles. According to Aird et al. (2016), in nursing literature in the UK, the process of identifying key gaps in skills and knowledge of nurses is aligned with national health services imperatives towards the development of health professionals (Li et al., 2015; Maisey et al., 2008; Styles et al., 2004). There was evidence that personal development needs were rarely tailored for specific healthcare settings (Horman et al., 2014). Two articles further mentioned that there is a greater need to identify gaps in skills and knowledge, particularly in community-based nursing care. In this context, practitioners generally work without any supervision, and it is thus difficult to identify clinical incompetence (Keegal, 2013; Knox & MacKay, 1982). Murie, Wilson, and Cerinus (2009) also established that during PA interviews, the rater

(commonly the supervisor or front-line manager) is usually unable to identify learning needs, compared to nurse peers.

Ultimately, the majority of the articles reported that PA methods were valuable for revealing skills and knowledge deficiencies for informing continuous education (Sheahan, Simpson, & Rayens, 2001). Accordingly, the identification of knowledge gaps during PA can contribute towards training nurses. Styles et al. (2004) confirmed that appraisals provide an opportunity to articulate skills and knowledge that are required to meet the evolving health agenda and provide effective patient care. Although Fort and Voltero (2004) identified skills and knowledge gaps as important, they cautioned against the common assumption that the gap in healthcare providers' performance is always attributable to inadequate knowledge and skills. They contend that, occasionally, the lack of performance improvement is due to other factors such as lack of motivation, commitment and incentive to change behaviour.

Motivation

Ten articles credited well-planned and well-executed performance appraisals with having an impact on increasing employee motivation to stay in a job and improving individual performance (Barriball & While, 1995; Sheahan et al., 2001; Vasset et al., 2011; Vasset et al., 2012). Murie et al. (2009) reported that internal motivation influenced an improvement in a high-quality general practice in Glasgow, Scotland. In a study by Fereday and Muir-Cochrane (2004), it was confirmed that credible communication and engagement with staff on their performance has great potential to motivate behaviour change. These authors offered further that there is a need for nurse managers to understand what motivates behaviour within particular contexts. Fort and Voltero (2004) also added that motivation is commonly linked with monetary rewards. In their study of factors impacting on the performance of healthcare providers, non-financial incentives such as recognition from peers and the community proved as strong a motivator for enhancing performance as financial incentives. These authors advocated for more research to inform the value of non-financial incentives for HCPs.

In a review of the determinants of the performance model, Knox and Mackay (1982) specified that, when an employee is satisfied with their performance, they become motivated to maintain that same level performance. Therefore, discouraging factors such as dissatisfaction with how performance is managed have the opposite effect. These findings were considered in a study by Durcho et al. (2016), who maintained that perceived fairness and trustworthiness are crucial

elements of a functional performance appraisal system. These authors conveyed that, when employees perceive the PM process to be unfair, they are likely to disregard information they receive during the process and become demotivated to change their behaviour. Swaartbooi (2016) supported this view, finding that the results of a poorly planned and executed system to review performance can have a negative impact on staff morale, result in staff perceiving the system to be unfair and demonstrating hostility towards the system.

Recognition and reward in performance management

As an administrative task, PM provides information to assist managers to make informed decisions such as pay progression, promotion and other rewards. Recently, the link between performance and monetary incentives has been focused upon. Various countries have introduced pay-for-performance as a means of incentivising performance of health professionals, as is evident in UK and US literature. Six articles mentioned recognition and reward initiatives within PM systems and how these impact on motivation, quality of care and perceived fairness in various countries (Barriball & While, 1995; Durcho et al., 2016; Maisey et al., 2008; Fort & Voltero; 2004; Knox & Mackay, 1982; Swaartbooi, 2016).

Maisey et al. (2008) investigated the effects of payment for performance in PHC teams in the UK. The study concluded that non-incentivised activities and patient concerns received less clinical attention. These authors encouraged further assessment of the impact of pay-for-performance in PHC on quality of care and the patient-centred care health agenda. Indeed, in the 1980s, a study conducted in Canada by Knox and Mackay (1982) found that financial rewards and promotion were influential in individual performance, serving as incentives to perform better.

While Fort and Voltero (2004) and Swaartbooi (2016) mentioned the impact of monetary rewards on motivation, team spirit and team recognition, the value of non-monetary incentives to improve performance was also highlighted (Barriball & While, 1995; Fort & Voltero, 2004; Swaartbooi, 2016). Durcho et al. (2016) conducted a study in the USA that indicated that when PAs are related to compensation and salary adjustment, if perceived as being unfair, they are likely to result in negative outcomes such as a decrease in motivation and commitment to change undesirable behaviour. This was previously mentioned by Fort and Voltero (2004), who confirmed the motivation link to monetary rewards. They found non-financial incentives, such as recognition from peers and the community, were as strong a motivator for enhancing

performance as financial incentives. These authors reiterated that more research is needed to inform the value of non-financial incentives for HCPs.

Some authors argued against monetary rewards and claimed these types of rewards caused friction among colleagues and team members. Those who did not receive any rewards often felt devalued and so retaliated by punishing those who have received the rewards (Swaartbooi, 2016). Ultimately, many have argued that monetary incentives promote individualism; this is particularly a concern in PHC, where team-based care is pivotal to integrated health services and the provision of person-centred care (Durcho et al., 2016; Swaartbooi, 2016).

Improving quality of care

There was strong evidence globally that links the use of PM systems to assess, monitor and develop performance to improved clinical outcomes and quality of care. This was evident from fourteen out of the twenty articles that met the inclusion criteria of this review. Eight articles were based on the UK's current national health services initiatives that are focused on continuous quality improvement (CQI) through the Quality and Outcomes Framework (QOF), personal and professional development of health professionals, as well as monitoring and evaluating competency in nursing practices (Aird et al., 2016, Barriball & While, 1995; Cheyne, Niven, & McGinley, 2003; Crumbie & Kyle, 2006; Horman et al., 2014; Maisey et al., 2008; Murie et al., 2009; Styles et al., 2004).

Key findings revealed that a good performance appraisal system must be linked to improvement in patient care and safety (Crumbie & Kyle, 2006). Appraisals are thus informed by core dimensions of the knowledge and skills framework, as cited by Aird et al. (2016). More recently, the Nursing and Midwifery Council in the UK drafted a new revalidation process to be conducted through their annual appraisal system. The revalidation is used to determine nurses' fitness to continue practice nursing, and can be considered a competency test. Therefore, appraisal systems will continue to play an essential role in the UK, in ensuring compliance with policy on issues of revalidation, nursing competence and nurses' accountability.

The impact of PM initiatives on quality of care is further indicated in the study conducted by Maisey et al. (2008). These authors argued that the payment-for-performance initiative had a negative impact on quality of care as health staff focused on incentivised health outcomes and

admitted not paying attention to patient concerns. Therefore, these authors suggested a re-evaluation of the QOF to include new performance indicators that are aligned with reforms in healthcare services and the shift to promote patient-centred care (Styles et al., 2004). Similarly, Sheahan et al. (2001) and Fort and Voltero (2004) also reported on prioritising clear evaluations of clinical competence, professional development and promoting productivity as key to achieving improvement in quality of care. These findings were concluded from USA and Armenian studies, respectively. Furthermore, four articles from three countries (Norway, Israel and Taiwan) did not have an appraisal system that was linked as obviously to national health systems policies/initiatives as the above-mentioned studies (Li et al., 2015; Pelle & Greenhalgh, 1987; Vasset et al., 2011; Vasset et al., 2012). These authors reported PA systems to have a positive effect on work environment and the quality of service rendered (Vasset et al., 2011).

In a study on PA use in Norway, Vasset et al. (2012) recommended the use of team-based PA to promote quality care in PHC teams that are commonly multidisciplinary in their constitution. On the other hand, Li et al. (2015) suggested the need to develop performance scales that are relevant to nursing practices, where there is a distinct link between essential performance and quality measures to determine improvement in care.

From the reviewed literature, there is no doubt that one of the greatest driving forces to having effective and efficient PM systems is to be able to improve the provision of care and utilise HCPs' knowledge and skills. Being able to identify training needs and manage under-performance as and when needed is proactive, ensuring HCPs' potential is fully optimised.

3.6.2.2 Theme 2: Methods used in performance appraisals

From the twenty studies included in the review, nine referred to specific forms or methods used during performance appraisal for the purpose of managing nurses' performance (Aird et. al., 2016; Cheyne et al, 2003; Crumbie & Kyle, 2006; Durcho et al., 2016; Horman et al., 2014; Keegal, 2013; Knox & MacKay, 1982; Murie et al., 2009; Sheahan et al., 2001; Swaartbooi, 2016). These included: 1) peer review; 2) self-assessment; and 3) various other methods for performance appraisal.

Peer review

Six articles discussed the use of peer reviews as a method that enhances professional development and facilitates the improvement of health services. Articles that focused on the peer review method predominantly reported that the use of peer appraisal was of significant value in nursing practice. This approach was more apparent in UK studies, where peer appraisals were used in revalidation and continuous quality improvement initiatives (Aird et al., 2016; Crumbie & Kyle, 2006; Sheahan et al., 2001). Horman et al. (2014) investigated the use of external peer appraisals and reported them to be an acceptable and positive experience. However, not all studies identified peer appraisals as being viewed positively. Cheyne et al. (2003) found midwives in Scotland who participated in the PEER (Peer, Education, Evaluation, Review) evaluation to be ambivalent towards peer review. Similarly, Durcho et al. (2016) found that, although peer input was desired, registered nurses shared concerns about peers evaluating them and the implications for pay progression and rewards.

As a method, peer appraisals are considered beneficial for determining competency and improving professional development to ensure nursing behaviour is at an expected level, based on an integration of ability, knowledge, skills and attitudes (Becker et al., 2018). However, as indicated above, no method is without any flaws.

Self-assessment

Three articles discussed the use of self-assessment as a method in performance appraisals (Knox & MacKay, 1982; Murie et al., 2009; Vasset et al., 2011). Knox and MacKay (1982) found that nurses created highly specific goals and perceived these as more achievable than goals that were pre-set. They found goals set focused on improving nurses' nursing skills. Murie et al. (2009) and Vasset et al. (2011) found that the use of self-assessments in appraisals was useful for the purpose of nurses being able to reflect on their professional development, strengths and training needs.

Other methods for performance appraisal

Swaartbooi (2016) provided an overview of methods of performance appraisal ratings that included the critical incident method, graphic rating scale, narrative essays, ranking method, checklist method, management by objectives (MBO), 360-degree appraisal (e.g. ratings are received from self, peer, management and patients), and behaviorally anchored rating scales (BARS). From the methods mentioned, appraisal methods such as narrative essays, the ranking

method and 360-degree appraisal were subjective in nature, and therefore the appraisals were often perceived as having a potential for bias. Methods such as BARS and MBO were perceived as more objective and therefore more acceptable to users when implemented and applied correctly.

All articles alluded to the importance of ensuring methods used to measure performance are fair and without bias. It is evident that, regardless of the method used, the process of managing performance effectively is threatened by the users' perceptions and experiences of the evaluation process, as this consequently impacts on the usefulness of the system. Durcho et al. (2016) claimed that subjective performance appraisal processes must be eliminated, and focus should be on developing more objective criteria-based methods.

3.6.2.3 Theme 3: Characteristics of effective PM systems

Across the reviewed articles, there are several PM system characteristics identified as being facilitative of effective performance management. These include: 1) PM systems that have a participatory aspect; 2) PM systems that are implemented soundly; 3) PM systems that engender positive user experiences, perceptions and attitudes; 4) training of raters and ratees; and 5) provision of performance feedback.

Participatory systems

Six articles indicated the importance of participatory methods in planning, monitoring and evaluating performance (Aird et al., 2016; Crumbie & Kyle, 2006; Durcho et al., 2016; Pelle & Greenhalgh, 1987; Vasset et al., 2011; Vasset et al., 2012). Aird et al. (2016) reported the need for nurses to be involved in decisions regarding appraisal, more so during the inception of these systems. Durcho et al. (2016) noted, in particular, the importance of employees having the opportunity to contribute to the content of the appraisal. As early as 1987, Pelle and Greenhalgh (1987) advocated for participative PA systems. Further supporting the need for participatory PM systems, Crumbie and Kyle (2006) reported that participation allows for those who are part of such PM systems to take ownership of the process, to be listened to and for their concerns to be taken seriously in advocating for fairness and a non-biased system.

More importantly, early participation of staff in establishing the PM system can prove valuable to decisions that are imperative to its formation, such as establishing the purpose of the system. To elaborate, some researchers have found PM systems that are used for administrative

purposes tend to be more lenient than those for research purposes. Thus, as early as 1986, authors such as Anderson and Barnett (1986) argued the need for communicating the objectives of a PM/PA system and ensuring that activities agreed on during the process take place, as this is vital for the effectiveness and efficiency of the system. Therefore, the type of method used and the purpose of the appraisal require further investigation.

Implementation

Seven articles mentioned factors that may present as a challenge or opportunity in the implementation of PA systems. According to Barriball and While (1995), for performance to be managed effectively, it has to be managed across all nurses in the clinical domain, and in a manner that is comprehensive and organised, not on an ad hoc basis for a selected few. This is particularly important as nurses generally work within a team with diverse qualifications. Fort and Voltero (2004) reported that an essential element for managing staff performance is organisational support from the implementation stage. This support may be defined as creating a work environment conducive to performance. In this Armenian study, Fort and Voltero (2004) concluded that performance outcomes were influenced by sixkey factors namely: job expectations; performance feedback; availability of resources and tools required for the job; motivation; incentives; and knowledge and skills.

Keegal (2013) expressed that performance management is time-consuming and advocated for it to be implemented in a structured manner, while Crumbie and Kyle (2006) mentioned that PM systems must operate within clear rules of engagement. Written guidelines on PM systems inform participants and assist to ensure uniformity. Furthermore, Pelle and Greenhalgh, as early as 1987, reported the need for PA systems to be redesigned periodically to adapt to changing needs and circumstances. How well a PA system is implemented plays a huge role on how it is received by users, and therefore it is important to ensure the PM system's principles are adhered to (Vasset, Marnburg, & Furunes, 2010; Vasset el., 2011).

User attitude towards the system

Eleven articles indicated the need for PM systems to be accepted with positive attitudes and perceptions (Aird et al., 2016; Cheyne et al., 2003; Crumbie & Kyle, 2006; Durcho et al., 2016; Fereday & Muir-Cochrane, 2004; Knox & MacKay, 1982; Pelle & Greenhalgh, 1987; Swaartbooi, 2016; Vasset et al., 2010; Vasset et al., 2011; Vasset et al., 2012). For instance, Durcho et al. (2016) reported a fundamentally flawed PM system is one that is considered to

be unfair and biased by its users. Crumbie and Kyle (2006) had previously advocated for appraisals to be conducted by health professionals who are trusted and respected by their peers. Aird et al. (2016) suggested appraisers be external instead of internal, to avoid conflict of interest or negative staff perceptions towards the fairness of the review process. Vasset et al. (2012) reported the need for managing perceptions of justice and fairness from inception.

Training for raters and ratees

Five articles mentioned the need for training of the users to minimise and/or avoid misuse and malpractice. According to Aird et al. (2016), the appraiser or rater must be trained and well prepared for conducting an appraisal. This will ensure the process is structured, safe and supportive, allowing time for the rater and ratee to have a reflective discussion on individual practices. These sentiments are shared by Swaartbooi (2016), who also expressed the need to train nurses and nurse managers in the use of the PMDS, as well as their rights and responsibilities. Similarly, Horman et al. (2014) also advocated for a careful selection and training process for raters, to mitigate any challenges caused by untrained appraisers. Murie et al. (2009) recommended the use of external appraisers, suggesting that they are more likely to have fewer conflicts of interests or potential for collusion. Keegal (2013) added that there is a great need for improved training and support for raters, to manage poor performance.

Facilitating effective performance feedback

Seven articles pointed to the need to establish a performance feedback mechanism (Barriball & While, 1995; Crumbie & Kyle, 2006; Durcho et al., 2016; Fereday & Muir-Cochrane, 2004; Pelle & Greenhalgh, 1987; Vasset et al., 2010; Vasset et al., 2011). Durcho et al., (2016) recommended that, to be trusted and considered fair, feedback should be supported by objective data. Fereday and Muir-Cochrane (2004) reported that, during feedback, it is worthwhile to consider techniques that could stimulate open discussions on performance, self-reflection and self-competence by nurses. This is because the recipient determines the meaning and usefulness of the feedback and makes the choice to change behaviour, both on a personal and professional level. It is therefore imperative to understand how feedback is communicated, received and interpreted by the recipient (Vasset et al., 2011). Furthermore, in their study, Fort and Voltero (2004) found that nurses were more satisfied with feedback when they believed it was constructive, immediate and credible. Pelle and Greenhalgh (1987) reported that managers generally prefer to give positive rather than negative feedback, so as to avoid the unpleasant duty of confronting subordinates who are under-performing.

3.7   Discussion

The findings of this chapter reported on evidence of the methods and practices in performance management amongst nurses in PHC settings globally. Thirteen papers reported that performance appraisals need to be developmental in nature, with eleven indicating the important role of PM systems in identifying key gaps in skills and knowledge, and fostering a culture of constant learning and development of clinical competency. Eight studies identified the strategic purpose of PM systems, especially in relation to being linked to national health outcomes goals. Studies such as that by Gillam, Siriwardena and Steel (2012) elaborated on the need to consider the impact of national policies on promoting structured and team-based care for the purpose of achieving evidence-based quality targets. Lastly, some studies (six) mentioned the role of PM systems as mainly administrative, as means to recognise, reward and incentivise good performance.

The increase in the practice of pay-for-performance, particularly in the UK and USA, has reintroduced this concept (Bodrock, Mion, & FAAN, 2008; Buchan & Ball, 2011; Petersen, Woodard, Urech, Daw, & Sookanan, 2006). However, the impact of rewards and recognition is linked to motivational factors that drive performance, which are not always financial. Kurtzman et al. (2011) have criticised performance-based payment incentives. According to these authors, performance-based payment incentives do not have a positive link to improvement in quality care.

Mackey, Rooney, and Skinner (2009) reported conflicting evidence as to whether financial incentives produce positive outcomes. According to Maisey et al. (2008), when comparing healthcare providers who receive financial incentives to those who do not, it appears there are significant improvements in patient outcomes for those who are incentivised. However, other researchers have argued that financial incentives in the healthcare field may not always produce improved quality and outcomes. Maffei, Turner, and Dunn (2008) and Maisey et al. (2008) argued that reimbursement rewards quantity, with less focus on the quality of care and resulting health outcomes. Not much is known about non-financial incentives and motivation of healthcare staff. From the reviewed literature, only three articles referred to the use of non-monetary incentives to improve performance. Further investigation is needed into what attributes are necessary for non-financial incentives to influence motivation.

The findings of the current study also identified that peer appraisal/peer review was a common method for assessing performance. More precisely, six articles mentioned the use of peer review as an effective PA tool. There was an emphasis on the promotion of self-assessment to encourage nurses to reflect on their developmental needs, strengths and professional development. These results are similar to the results previously indicated by Lévesque-Barbès (1987) and Liaw, Scherpbier, Rethans and Klainin-Yobas (2012).

Even though some studies did not mention any specific set of PM/PA methods, across all studies various authors mentioned that, regardless of the type of method used, it is important to ensure performance appraisal and management tools are objective, in an effort to minimise the possibility of subjectivity. Methods used to assess performance that are perceived as unfair, biased or lacking transparence, are likely to be less effective for motivating employees to improve performance. Indeed, Aguinis (2013) and Cardy and Korodi (1991) confirmed that the PM literature indicates that the effectiveness of any appraisal and management system is highly related to the type of appraisal method that is used. The characteristics of an effective PM system are discussed in detail in Chapter 2.

Practices that assist to optimise the effectiveness and usefulness of PM that emerged from the literature included a participatory approach to the PM system from inception. This has been found to aid in promoting healthcare workers' buy-in to the value of the PM system. Six articles highlighted the importance and benefit of involving PM system users in the decisions that inform the planning, monitoring, evaluating and managing of performance, with participation considered a vital competence for employees to accept and use the PM system as intended.

Kleingeld, Van Tuijl, and Algera (2004) conducted a study regarding the participation of employees in the design of PM systems. These authors argued that most literature on the relationship between participation in decision-making and performance consider what they coined a 'tell-and-sell strategy' as a viable alternative to facilitating employee participation. A tell-and-sell strategy is a quick fix solution to a larger problem. However, such a strategy is meaningless. To achieve meaningful participation, the engagement between the employees and employer must be formal, long-term, direct and with a higher degree of influence. Kleingeld et al. (2004) argued this is particularly important when a sensitive and important issue is at stake. Performance management is certainly considered to be a sensitive issue, especially if it is tied to financial incentives as well as development and training opportunities (Kleingeld et al.,

2004). There is not enough evidence on the role and benefit of participation in PM systems, especially in PHC settings.

Other characteristics related to performance management and appraisal that emerged from the reviewed literature as influencing PM development system practices included the importance of managing trust in the system; training of raters and ratees; strong accountability (written guidelines); ratee awareness of the system; opportunities for appealing ratings by ratees; and the extent of feedback to the ratee. For a PM system to be effective, employees must have trust in the system, with the reviewed literature referring to this directly or indirectly (Aird et al., 2016; Cheyne et al., 2003; Crumbie & Kyle, 2006; Durcho et al., 2016; Fereday & Muir-Cochrane, 2004; Knox & MacKay, 1982; Pelle & Greenhalgh, 1987; Swaartbooi, 2016; Vasset et al., 2010; Vasset et al., 2011; Vasset et al., 2012). These findings are confirmed by literature on trust and performance in organisations.

As early as 1964, authors such as Argyris proposed that trust in management was fundamental to organisational performance and accountability. Indeed, Cardy and Korodi (1991) confirmed that trust in the PA system influences how appraisees viewed the review results, and whether they viewed the results as fair. Similarly, findings from research by Lashinger, Finegan, Shamian and Wilk (2001) also found that trust has increasingly become an important factor in building work relationships. In Chapter 2, one of the key characteristics of an effective PM system was noted to be acceptability and fairness; a PM system that lacks specific guidelines, reliability and validity, and methods of appealing the results of the PA process is unlikely to be trusted by its employees. The findings of this study confirm the importance of trust, transparency and fairness in PM processes.

Some of the studies reviewed have also highlighted the need for training for raters and ratees (Aird et al., 2016; Horman et al., 2014; Keegal, 2013; Murie et al., 2009; Swaartbooi, 2016; Woehr & Huffcutt, 1994). There has been a substantial amount of research in the performance appraisal literature that has focused on rater training as a means of improving performance ratings. These studies advocated for the use of a general framework for the evaluation of rater training. Training should be presented in terms of four rating training strategies, namely: rater error training, performance dimension training, frame-of-reference training, and behavioural observation training. Training should be based on four dependent measures, namely halo, leniency, rating accuracy and observational accuracy.

As much as the reviewed literature did not specify what duration of training is required for raters, most literature did highlight that training must focus on and find means of alleviating inaccuracy in rating, regardless of the reasons for the inaccuracy (Aird et al., 2016; Horman et al., 2014; Swaartbooi, 2016). In support of the above findings, Bernadine, Thomason, Buckley and Kane (2016) conducted a study on rater-level bias and accuracy in performance appraisals, especially on the impact of rater personality, performance management competence, and rater accountability. The results of the study confirmed that the tendency for managers and supervisors to be lenient in their performance appraisals is still one of the most significant problems related to performance appraisal systems.

DeNisi and Murphy (2017) found that, essentially, when it comes to training raters, there are two dominant themes that emerge: firstly, how to train raters, and secondly, how to determine if the training was successful. There is consensus that training raters on 'What not to do' (i.e. training raters to avoid rater error) is ineffective. Therefore, further investigation on training that is suitable for raters in healthcare is needed. At present, there seems to be consensus that training raters to adopt consistent conceptions of what constitutes good performance or poor performance – and aligning this with behaviour and competencies – proves more beneficial.

From the ratees' perspective, training on performance management requires creating awareness about the PM system, its principles and processes, how it will benefit the individual, the team and the organisation, appeal opportunities and new developments (DeNisi & Murphy, 2017). Ratees' awareness of the system, beyond trust and participation, involves understanding the process. DeNisi and Gonzalez (2017) confirmed that ratees' perceptions of appraisal accuracy also have important implications for the effectiveness of appraisal systems, as previous findings have indicated. This point was previously mentioned in Chapter 2; a good PM system is one that is consistent and free of error. It is important for such systems to be standardised across people and time (Aguinis, 2013).

Lastly, an important characteristic of an effective PM system was that it provides communication on performance, in the form of feedback, after the performance appraisal phase of PM. Reviewed literature discussed the value of providing feedback that is constructive and adequate to help improve performance; managers' ability and willingness to provide feedback and the credibility and utility of the feedback provided are also important. DeNisi and Kluger

(2000) confirmed that performance feedback is often viewed as necessary for an employee to know how well he or she is performing at work. These authors argued that feedback is also seen as an important source of motivation; thus, when employees receive feedback, this has been proven to improve job satisfaction and work motivation. Recently, DeNisi and Murphy (2017) advocated that research on performance management and appraisals must also be contextually based. This implies paying attention to when and why performance appraisals are carried out, and the contextual variables that are likely to be important and so may influence how the system is received and ultimately used. Future research is required to determine how cultural norms may influence PM practices.

Interestingly, although aware of the change in nursing practice (Aird et al., 2016), no papers on actual methods used to conduct PAs or manage performance were found. According to Kasangara et al. (2014), performance metrics commonly do not reflect current performance goals. These authors mentioned that performance metrics are not accurately measuring patient-centered care quality; rather, they are focused on quantitative outcomes that may not necessarily indicate improvement in care. This aspect should be further investigated. Most papers discussed emanated from the UK, thus primary care was skewed around general practice, quality improvement, revalidation and competency (Aird et al., 2016; Barriball & While, 1995; Crumbie & Kyle, 2006; Fereday & Muir-Cochrane, 2004; Horman et al., 2014; Knox & MacKay, 1982). Further investigation into the impact of payment-for-performance should focus on patient-centred care and quality improvement in low- and middle-income countries; this may prove valuable. Literature on practices in PM is centred on factors that influence or may impact on effective PM systems; therefore, based on each country's contextual needs, PM systems require constant re-evaluation, validation and revision to remain responsive to changing practices in healthcare. Thus, the quest for evidence-based practice is continuous and without an expiry date.

3.8   Chapter summary

This scoping review discussed evidence on PM methods and practices, discussed common challenges and opportunities of effective PM methods and practices, as well as key gaps in the literature on how performance management and appraisal systems contribute to quality of care amongst nurses in PHC settings. Some of the key issues raised were the need to ensure ratees' input, in terms of self-evaluations and in terms of participation in the design and other factors. Further, it was apparent that performance methods and instruments need to be as clear and

simple to use as possible for all those who use these systems. More so, literature reviewed indicated the need for standards for performance to be clear and to be communicated to all parties; adequate training should also be provided to users of the system. Some studies indicated that managerial control systems like PM systems require constant re-evaluation and revalidation to ensure these systems are not obsolete, especially following change or reform.

CHAPTER 4
RESEARCH METHODOLOGY

4.1 Introduction

The aim of the study was to assess the implementation of the Performance Management and Development System (PMDS) and to understand professional nurses' perceptions of how performance is managed in the context of the re-engineered primary healthcare (PHC), Integrated Chronic Services Management (ICSM) and the National Health Insurance (NHI) scheme. In order to achieve this aim, a sequential cross-sectional mixed-methods research design, divided into two phases, was employed. The objective of the first phase was to evaluate the implementation of the PMDS in an NHI pilot site (Dr Kenneth Kaunda District, North West province) and to assess if there existed any differences in the evaluation of the PMDS from the four sub-districts.

The second phase was qualitative in nature; it was conducted across the sub-districts. The objective of this phase was to develop an understanding of the experiences and perceptions of nurses concerning their performance, factors that impact on their performance, and how performance is managed in light of health reforms. This was done through the use of semi-structured interview schedules. Each phase had corresponding research questions to assist in achieving the objectives of this study.

4.2 Recapitulation of research questions

Phase 1: Quantitative study

- What are the psychometric properties of the performance management instrument used?
- How has the Performance Management and Development System (PMDS) been implemented?

Phase 2: Qualitative study

- What are nurses' and nurse managers' perceptions and experiences on the current PMDS within the context of re-engineered PHC, NHI and ICSM?

- What is the influence of the PMDS on nurses' and nurse managers' attitudes to how performance is evaluated within the context of re-engineered PHC, NHI and ICSM?

- What are nurses' and nurse managers' views on what hinders performance and quality of care within the context of re-engineered PHC, NHI and ICSM?

- What do nurses suggest can assist them in improving the quality of services and job performance within the context of re-engineered PHC, NHI and ICSM?

This chapter provides a detailed description of the research design and methods that were employed to conduct this study. It details the rationale of the research, a description of the phases of data collection, sampling methods utilised and the instruments for data collection. It provides a detailed account of the data collection processes and procedures. To ensure distinct understanding of the research processes employed, each phase will be presented in distinct sections, each with relevant subsections. The chapter also includes the appropriate analytical procedure employed and the measures taken to ensure validity and reliability of the results. The chapter concludes with a discussion of the ethical considerations of the study.
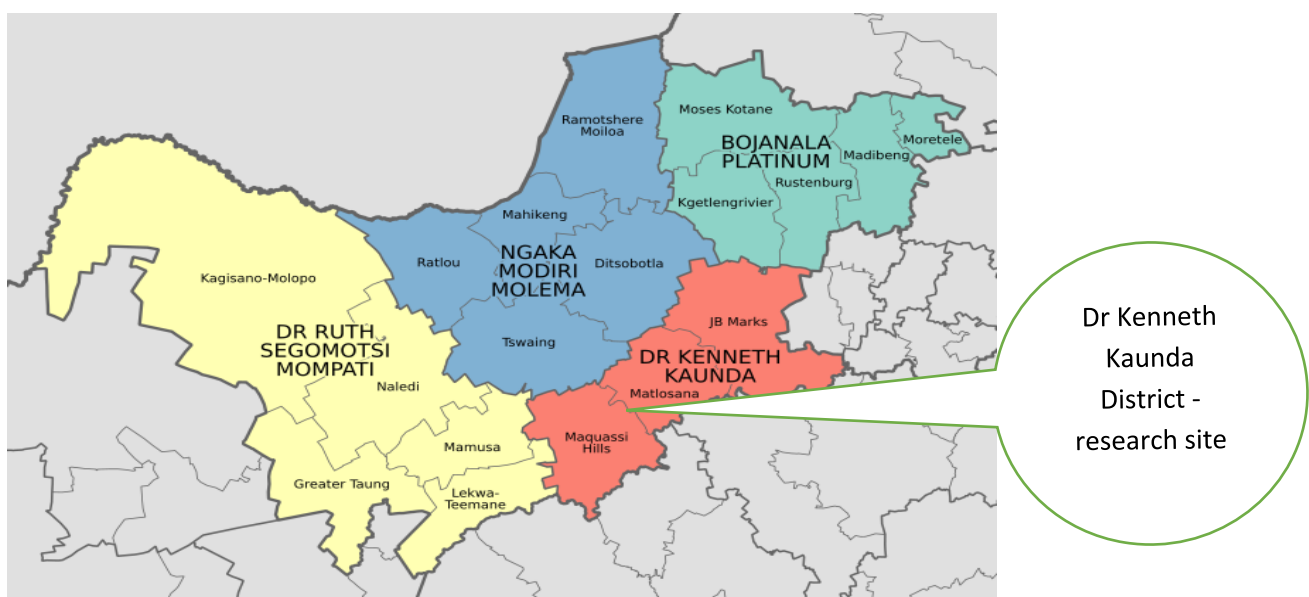
Figure 4.1. Map of North West province (North West municipalities, 2017)

4.3   The research setting

4.3.1 North West province (South Africa)

This study was conducted in South Africa in the North West province, which is one of nine South African provinces. According to Statistics South Africa (2017) population estimates by province for 2017, the North West province is the third-smallest province with an estimated population of 3.9 million (6.8% of the total SA population). The province has four district

municipalities namely; Dr Ruth Segomotsi Mompati, Ngaka Modiri Molema, Bojanala Platinum and Dr Kenneth Kaunda Districts. This study was conducted in the Dr Kenneth Kaunda District municipal area; the sample population consisted of 30 PHC health facilities comprising clinics and community health centres.

4.3.2 Dr Kenneth Kaunda District Municipality

According to the North West Dr Kenneth Kaunda District profile (2013), the district comprises. These are Matlosana and Tlokwe (previously Potchefstroom), which are peri-urban areas and have the largest population, respectively, while Ventersdorp and Maquassi Hills are considered rural sub-districts. Stats SA reported that the Dr Kenneth Kaunda District (KK) has a total population of 796,823 (Stats SA, 2014), and it covers a geographical area of 14,767 square kilometers.
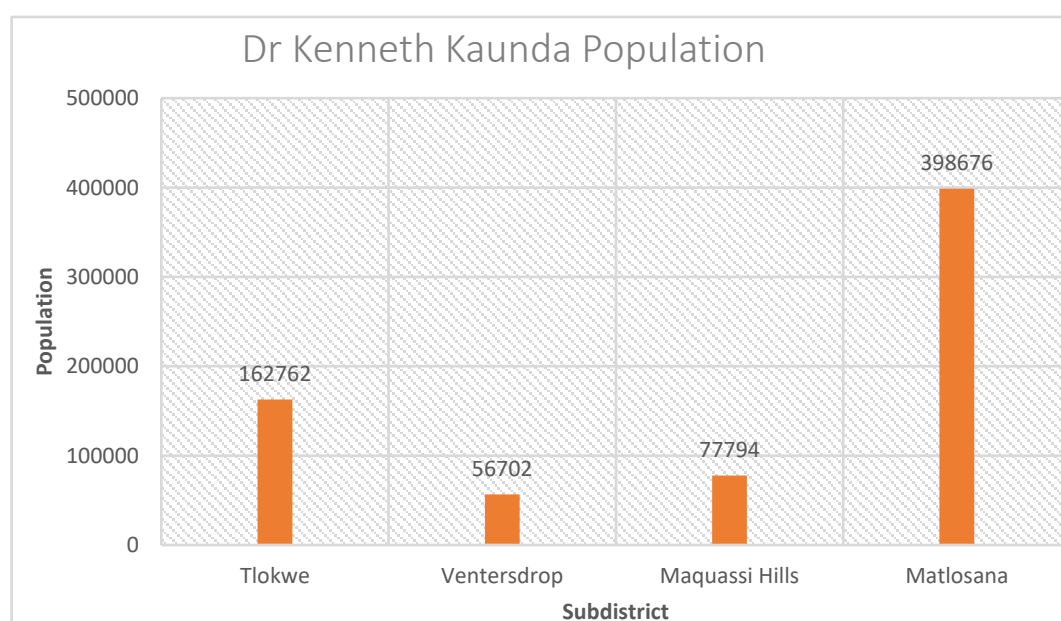
Figure 4.2. Population distribution in Dr Kenneth Kaunda sub-districts (North West Kenneth Kaunda District profile (2013)

Within the health spectrum, the Dr Kenneth Kaunda District Municipality is one of 11 district municipalities chosen as pilot sites for the National Health Insurance (NHI) and various other projects related to ICSM. Health services are delivered by one regional hospital, two district hospitals, nine community health centres, 27 clinics, 15 mobile health services units and six satellite clinics (North West Kenneth Kaunda District profile, 2013). The health facilities in Dr KK District are depicted in Table 4.1.

Table 4.1.
Health Facilities at Dr Kenneth Kaunda District

Sub-district	Clinic	Community health centre	District hospital	Health post	Mobile services	Regional hospital	Satellite clinic	Specialised psychiatric hospital	Total
Maquassi Hills	6	2			4				12
Matlosana	13	4			5	1			23
Potchefstroom (Tlokwe)	6	2	1	1	2			1	13
Ventersdorp	2	1	1		3		6		13
Total	27	9	2	1	15	1	6	1	62

Source: North West Kenneth Kaunda District profile (2013)

4.4 Research design

The research methodology approach undertaken by the researcher was based on the unique investigation of each study and so was determined by the aim and focus of the study. In principle, the method adopted influences the kind of data that is obtained, the analyses that will be used and the interpretation of those results. Thus, it is important to provide a detailed plan on how the study will be conducted with full advantage of control over factors that may interfere with the desired outcome (Creswell & Clark, 2011). According to Bordens and Abbott (2002) and Wahyuni (2012), it is fundamental to consider at the outset the important decisions when designing and conducting research, and how early decisions affect the manner in which data is collected, analysed and interpreted at the end of the process. Creswell and Clark (2017) stipulate that a research design is important because it facilitates smooth running of the various research operations, thereby making the study more efficient. In deciding which research design to use, the researcher has to consider a number of factors. These include the focus or orientation of the research, the units of analysis and the time dimension (Wahyuni, 2012). Therefore, in order to obtain a full picture regarding the PDMS and its influence on quality of care, the research design utilised in each of the phases is described below. In the first instance, the study used a mixed-methods approach as indicated below.

4.5   Mixed-methods research approach

A mixed-methods approach refers to a "plan for collecting, analysing and combining both quantitative and qualitative research methods or data in a single study or a series of studies in order to understand the research problem" (Creswell, Clark, & Garrett, 2008, p. 66). According to Creswell (2013), with the development and established legitimacy of both qualitative and quantitative research in the social and behavioural sciences, a mixed-methods research design, using a combination of quantitative and qualitative approaches, has gained popularity over the years. It is particularly favoured as it is believed to utilise the strengths of both quantitative and qualitative research. This approach brings together the quantitative and qualitative data either simultaneously or sequentially (Creswell & Creswell, 2017).

The use of the mixed-methods research approach, although evidently valuable, has not gone without any backlash against it. One of the main debates in literature relate to the definition and best practices when utilising this approach. However, the main reason for using a mixed-methods design is that neither quantitative nor qualitative methods are sufficient by themselves to fully capture details of the implementation of the PMDS. This needed to be investigated in two forms: 1) evaluating its implementation, which was done quantitatively; and 2) evaluating current practices and how these practices are perceived and experienced by professional nurses, which could only be captured through qualitative means.

Gray (2013) argued that, when used in combination, qualitative and quantitative approaches can complement each other and allow for more robust analysis, by leveraging the strengths of each method and limiting the weaknesses. Previously, Hanson, Creswell, Clark, Petska, and Creswell (2005) had encouraged the use of a mixed-methods approach in health services investigations, stating that multi-method research holds potential for rigorous, methodologically sound studies for health systems so as to understand this complex research context. For the purposes of this study, a sequential explanatory mixed-methods design was used. This approach was ideal to, firstly, assess the implementation of the PMDS and, secondly, understand nurses' perceptions and experiences of the PMDS and its influence on health outcomes. Ivankova, Creswell, and Stick (2006) reported that this approach is particularly favoured for its straightforwardness, and that it provides opportunities to explore the quantitative results in more detail.

4.6   The Research Process

Phase	Procedure	Product
Quantitative data collection	• Administered questionnaire (n=201)	• Numeric data
Quantitative data analysis	• Data screening • Frequencies • SPSS QUAN software version 25	• Descriptive statistics
Connecting quantitative and qualitative phases	• Purposefully selecting participants (professional nurses and frontline managers) • Developing interview schedule	• Sample size: 32 Professional nurses: 18 Frontline managers: 14 • Developed semi-structured interview schedule
Qualitative data collection	• In-depth interviews	• Recorded data • Transcribing
Qualitative data analysis	• Coding • Thematic analysis • Cross-thematic analysis	• Categorisation of themes • Interpretation of qualitative findings • Matrix of findings
Integration of the quantitative and qualitative results	• Integration and explanation of the quantitative and qualitative results	• Synthesis • Discussion • Implications • Future research

Figure 4.2. Visual model for mixed-methods sequential explanatory design procedures
Adapted from Invankova, Creswell, & Stick (2006, p. 16).

4.7 Phase 1: Quantitative research study

4.7.1 Research design

According to Yilmaz (2013), quantitative research can be defined as "research that explains phenomena according to numerical data which are analysed by means of mathematically based methods, especially statistics" (p. 311). Neumann (2013) adds that quantitative studies rely on positivist principles, and the emphasis is on measuring variables and testing hypotheses. This study administered an evaluative survey that assessed the implementation of the PMDS in PHC; thus, a descriptive cross-sectional survey design proved to be appropriate. To conduct the present evaluation of the PMDS, this study design is appropriate as it is a design used to investigate a phenomenon over a short period of time and for investigating the prevalence of a problem at a particular time (Busk, 2014).

4.7.2 Sampling technique and procedure

4.7.2.1 Sample and sampling technique

The study was conducted in 30 health facilities, namely the clinics and community health centres from the four sub-districts of the Dr KK District Municipality. For the purposes of this study, the researcher used the purposive sampling method, as the research focus was specific. This was guided by Silverman (2000), who asserted that "purposive sampling demands that we think critically about the parameters of the population we are interested in and choose our sample carefully on this basis" (p. 104).

4.7.2.2 Criteria for selection

To be eligible to participate in the study, nurses needed to be registered as professional nurses. The sample consisted of professional nurses, operational managers, facility managers and other specialist professional nurses such as those involved in the PHC ward-based outreach teams (WBOT). The data collection period was over two months (June 2016 – July 2016). A sample size of 250 professional nurses was informed of this study and from the 250 professional nurses who received the questionnaire, 201 professional nurses chose to participate by completing the research booklet and returning it to the researcher. Thus, the total sample size obtained for the quantitative phase was 201.

4.7.2.3 Sample size calculation

The research team visited thirty health facilities at Dr Kenneth Kuada district from four subdistricts. According to the information management sector at the district, they had

approximately 250 registred nurses working are primary healthcare facilities at Dr KK district at the time of the study. To calculate the appropriate sample size for the quantitative survey study, the guides provided by Marlow (2010) were followed. Thus, the recommended sample size for a population of 250 is 152 participants. An online sample-size calculator also confirms this (Qualtrics, 2018). Therefore, with a sample size of 201 participants, this study is therefore representative of the sampled population.

4.7.3   Research instrument

4.7.3.1 Questionnaire booklet

During the quantitative phase, the researcher created a questionnaire booklet that was used to collect data. The questionnaire booklet comprised an information sheet, an informed consent letter, a biographical data sheet and an evaluative PMDS questionnaire. A copy of the questionnaire booklet containing all the instruments is provided in Appendix 3.

The processes and practices used to measure and manage performance of professional nurses were evaluated using seven subscales. Subscales, based on a three-point Likert scale, required the participants to indicate their level of agreement with the statements. The seven subscales that elicited information regarding performance management under these constructs were: setting performance standards (8 items), performance measurement (9 items), performance reporting (6 items), performance improvement (10 items), rewarding system (5 items), staff training and development (9 items), and the final subscale is performance data (6 items).

4.7.3.2 Reliability and validity of the evaluative PMDS

The evaluative performance management scale was developedby Dr George Lutwama in the year 2011 for his doctoral studies (Lutwama, 2011). The scale was used to assess the implementation of PM for healthcare workers in Uganda. The internal consistency of the questionnaire was established by means of Cronbach alpha. The overall alpha was 0.86, which is adequate. No study has used this instrument in South Africa and therefore one of the researcher's objectives was to determine the psychometric property of the instrument. The internal consistency for this study was established as Cronbach alpha 0.95. Further analysis was conducted and the results for these tests are provided in chapter 5 under the subheading: reliability of the data collection scale.

4.7.4 Data collection

Provisional ethical clearance was obtained from the Biomedical Research Ethics Committee (BREC) at the University of KwaZulu-Natal (UKZN) – reference number: BE084/16. Once the provisional approval was granted, gatekeeper approval was obtained from the North West Department of Health (NWDoH): Policy, Planning, Research, Monitoring and Evaluation. Upon obtaining approval from NWDoH, full ethical clearance was granted by t he BREC. Both ethical approvals are available in appendices (see Appendices 1 and 2).

The quantitative data was collected using a self-administered survey. Once the principal investigator had received full ethical clearance, facility managers for each facility were contacted and informed that the research team would be visiting the facility. The purpose of the visit was also mentioned.

On the day of the scheduled meeting, during the morning staff meeting, the facility managers of each facility provided the research team (consisting of the principal investigator and a research assistant) an opportunity to present the study to potential participants. During the presentation, the research team explained the purpose of the study and the rationale for conducting the research. Further, the participants' rights, such as the right not to participate and right to confidentiality and anonymity, were also highlighted. Participants were thereafter furnished with the questionnaire booklet and full instructions were given on how to complete the contents in the booklet, including the PMDS questionnaire. Participants completed the questionnaire booklet in 45-60 minutes. From the 250 distributed booklets, a total of 201 questionnaire booklets were completed and returned; thus, there was a response rate of 80.4%.

4.7.5 Data analysis

The data analysis was conducted with the use of the Statistical Package for Social Sciences® (SPSS®) version 25.0. The data entry was conducted by a research assistant who captured the data from the questionnaires after the initial coding. The coding of variables was undertaken by the researcher. The data was entered into the SPSS® system by using numerical codes for all variables. Descriptive analysis was conducted to organise and summarise the data. Sidel, Bleibaum, and Tao (2018) noted that descriptive analysis relies on measurement and quantification. This also allowed the identification of any data entry mistakes and their correction before continuing with further analysis of the data. The data was screened for errors

by running frequencies for all variables to ensure that all values fell within the possible values for each variable. Any errors found were noted and corrected accordingly.

4.8 Phase 2: Qualitative research study

4.8.1 Research design

Qualitative research is difficult to define clearly. It has no theory or paradigm that is distinctively its own ... Nor does qualitative research have a distinct set of methods or practices that are entirely its own. (Denzin & Lincoln, 2011, p. 6)

The second phase of the research study followed a qualitative research design. Denzin and Lincoln (2000) described the meaning of the term 'qualitative' as implying emphasis on the qualities of entities, and on processes and meanings that cannot be experimentally examined or measured. Thus, qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry (Clark & Creswell, 2008). Thus, this design was best suited to meet the objectives of the study. The benefits of using a qualitative research design highlight that this design offers more descriptive and rich data about people's lived experiences (Patton, 1990; Ritchie, Lewis, Nicholls, & Ormston, 2013). Therefore, a qualitative design was suitable for this study, since the focus was on exploring the perceptions and experiences associated with the implementation of the PMDS and how this influences quality of care and other human resources management outcomes.

4.8.2 Framework analysis

The Framework Method is an excellent tool for supporting thematic (qualitative content) analysis because it provides a systematic model for managing and mapping the data.
(Gale Heath, Cameron, Rashid, & Redwood, 2013, p. 7)

Framework analysis was used for the purpose of meeting the qualitative objectives of this study. According to Ritchie and Spencer (2002), framework analysis has gained popularity as a methodological approach in qualitative research within the health and public policy fields of interest. As an investigative method, the primary goal of using framework analysis is to understand complex behaviours, needs, systems and cultures (Gale et al., 2013; Srivastava & Thomson, 2009).

Smith and Firth (2011) also reported that framework analysis is used as a method of managing and analysing qualitative data in health and applied policy research. The framework approach is relatively similar to thematic analysis, especially in the initial stages when re-occurring themes are identified; it is used in conjunction with thematic analysis. In addition, analytical frameworks such as the framework approach emphasise transparency in data analysis and the links between the stages of the analysis. In the framework approach, a central element of the analytical process is found in the interconnected stages that allow for the researcher to move back and forth across the data until an intelligible account emerges (Smith & Firth, 2011).

The questions that need to be addressed can be divided into four categories namely: contextual, diagnostic, evaluative and strategic. *Contextual* questions focus on identifying the form and nature of what currently exists, while *diagnostic* questions focus on examining the reasons for, or causes of, what exists. *Evaluative* questions focus on appraising the effectiveness of what exists, and *strategic* questions are derived from identifying new theories, policies, plans or actions from what exists. This approach was particularly suitable for this research study because it allowed the researcher to interpret participants' experiences transparently. The framework approach also allowed for a systematic analysis of data collected during the scoping review and semi-structured interviews.

4.8.3   Sample technique and procedure

Participants were selected for the second phase of the research using the same principles of sampling that were used during phase one. Therefore, the study was conducted in 30 health facilities, from the four sub-districts of the Dr KK District Municipality. To be part of this study you had to be a registered professional nurse. Further, facility/operational managers are professional nurses that are currently employed at a facility/distict management level. A total of 18 professional nurses and 14 facility/operational managers were purposively sampled in the second phase of the study.

4.8.4   Research instrument

The data collection process was conducted through the use of semi-structured interview schedules, one for nurses and one for managers. The interview schedules were developed using open-ended questions that were informed by the aims of the research, as well as by the constructs the researcher was hoping to measure during the quantitative phase of this study. The use of open-ended questions is encouraged by an open inductive approach to data

collection and analysis; this helps to provide rich and detailed descriptions of the phenomenon being studied (Breakwell, 2012). The interview schedules included open-ended questions on performance management, quality of care, factors impacting on performance and suggestions on effective performance interventions. The questions were also sanctioned by the research supervisor prior to them being utilised. A copy of the interview schedules can be found in Appendix 4.

4.8.5 Data collection

Ethical approval was obtained for the mixed-methods study as indicated in Section 4.9 (reference number: BE084/16). Operational managers of all facilities in each sub-district were contacted to schedule a suitable time for the research team to visit. On the day of the interviews, the researcher explained the purpose of the research to the potential participants. All participants were informed of their rights, such as the right to confidentiality and anonymity. Thus, participants were informed that participation in the study was voluntary, and that their anonymity would be protected at all times. Each participant was given an information sheet and a consent form to complete. Each facility provided the researcher with an office to provide interviews. In most facilities, the interviewers were permitted by the facility managers to use the manager's office. The participants were also informed that the sessions were to be audio-recorded. The interviews were conducted in English, and each interview was conducted for approximately 45-60 minutes.

4.8.6 Data analysis

To maintain anonymity and confidentiality, all interviews were coded only by the researcher. Audio-tapes were transcribed verbatim, and every effort was made to minimise the effects of bias and distortion. The researcher transcribed the data and further made meaning from the data by coding and writing down significant points of convergence and divergence, as outlined by the framework analysis methodology.

Thematic analysis was used to analyse the data (Nowell, Norris, White, & Moules, 2017). This approach is favoured in qualitative research for its accessibility and theoretically flexible approach to analysing qualitative data through identifying and interpreting patterns of meaning across data content (Braun & Clark, 2006; 2014). It has further been credited as a method that provides a rich and detailed, at times even complex, account of data. The steps that were followed are described below.

For the purpose of analysis, it was important to create a descriptive presentation of the qualitative data. By doing so, common themes were identified to enable analysis. These themes were created from the actual words of participants and, based on such themes, a name was given to each theme in a manner that directly reflected the texts as a whole (Anderson, 2003). The above process was conducted by first reading through the interview transcripts and writing down possible themes that would answer the research questions as laid out in previous chapters. The researcher then read all the transcripts and noted down the common themes that emerged from each participant's responses to each question (Braun & Clarke, 2014). The themes were then further separated and grouped into two categories, namely, main themes and sub-themes. The themes serve as an abstract entity that provides meaning and identity to frequently mentioned experiences and how these experiences manifest (Braun & Clarke, 2014).

This was followed by highlighting parts of the transcribed interviews from each participant that substantiated the theme in terms of direct quotes and thus represented the phenomenon of interest. The process of refining themes and determining coherent patterns was adhered to, in order to ensure all of the attributions under each main theme and determine if themes accurately reflected the meaning orientated in the data set. At this stage, some themes were merged and those that did not possess enough evidence were collapsed. The process of analysis ended by identifying attributes and conclusions drawn from the themes based on what the literature and research had to say about each theme (Hayes, 1997). This process required a concise, logical and non-repetitive account of the data, and literature was used to confirm and or challenge the research findings. An illustration of the process followed is provided in *Figure* 4.4.

THEMATIC ANALYSIS
Phase 1: Familiarising yourself with the data
↓
Phase 2: Generating initial codes
↓
Phase 3: Searching for themes
↓
Phase 4: Reviewing themes
↓
Phase 5: Defining and naming themes
↓
Phase 6: Drawing conclusions on patterns developed across data
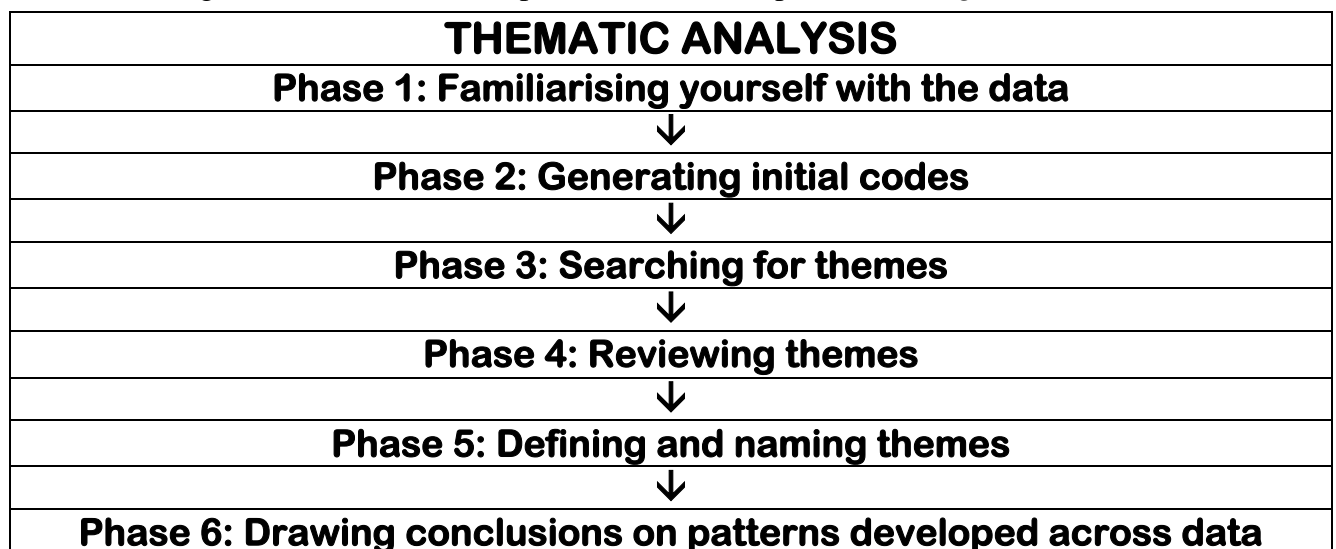
Figure 4.3. Qualitative data analysis process (Clarke & Braun, 2013)

4.8.7 Determining validity and reliability in qualitative research

The traditional criteria for validity and reliability are not used in qualitative research. Alternative means to judge qualitative research are through the concept of trustworthiness. For the research to be accepted as trustworthy, the researcher must demonstrate that the research process has been conducted in a precise, consistent and credible manner (Nowell et al., 2017). The concept of trustworthiness is measurable through four main criteria, namely: credibility, transferability, dependability and confirmability.

4.8.7.1 Credibility

Tobin and Begley (2004) ascertained that credibility is addressed by the researcher's ability to show a 'fit' between the views or experiences of the participants and how the researchers have captured those experiences. Lincoln and Guba (1985, cited in Nowell et al., 2017) provided various suggestions to researchers on techniques to use that address credibility of the results; these include activities such as member checks, peer-briefing and data collection triangulation, as well as researcher triangulation, to name a few. To provide credibility, the researcher engaged with participants until the point of data saturation. Once the transcriptions were completed, participants were also provided the opportunity to check for accuracy of the transcriptions through telephonic discussions.

4.8.7.2 Transferability

Transferability refers to the degree to which the results of qualitative research are generalisable or may be transferred to a different case or setting. Nowell et al. (2017) stated that, although the researcher may not proactively be aware of the sites that may wish to transfer the findings, he or she is responsible for providing thick descriptions for those who seek to transfer the results to their own cases, so that they may judge transferability. Transferability was ensured by means of ensuring good representation of PHC nurses across the sub-districts through purposive sampling, as well as ensuring thick descriptions of the results (presented in Chapters 5 and 6), and through providing health management personnel from similar settings with these descriptions, so as to enable them to judge if the results may be transferred.

4.8.7.3 Dependability

According to Tobin and Begley (2004), dependability may be likened to reliability in quantitative research. Thus, the researcher must show evidence that the research process is logical, traceable and clearly documented. In essence, reliability is the assumption of

replicability or repeatability (Farrelly, 2013). Dependability was achieved through documentation of all steps of the research process and through external controls, with the study supervised throughout the process. All interview materials (such as audiotapes, transcripts, field notes, findings, interpretations and recommendations) are available and accessible for the purpose of a clear audit trail (Lincoln & Guba 1985, cited in Nowell et al., 2017).

4.8.7.4 Confirmability

Tobin and Begley (2004) claimed that confirmability refers to establishing if the researcher's interpretations and finding are derived from the data. Thus, the onus is on the researcher to demonstrate how conclusions and interpretations have been reached. As cited in Nowell et al. (2017), confirmability is established when credibility, transferability and dependability are all achieved. Importantly, White, Oelke and Friesen (2012) asserted the need for establishing confirmability in complex studies such as health services research. These authors encouraged researchers to provide a detailed and comprehensive account of all data collection and data analysis activities that were completed, as well as the purpose and rationale for methods employed. Apart from creating a clear audit trail, the researcher compared data with previous research findings, and so confirmability was maintained.

4.9 Data management and storage

All data collected for the purpose of this study is safely kept. The qualitative data (audio-tapes and transcribed interview materials) have been stored on a compact disk (CD) for safe keeping. The quantitative data (completed questionnaires, hard copies) are kept safely in a locked compartment provided by the researcher's supervisor in the Discipline of Psychology, School of Applied Human Sciences, Howard College Campus, University of KwaZulu-Natal, Durban, South Africa. Electronic copies of both the qualitative and qualitative data are safely kept in the researcher's computer that is encrypted with a password known by the researcher only. The researcher has ensured that all data is kept safely to ensure confidentiality and to avoid possible access by any third party to the data.

4.10 Adhering to ethical protocols

Ethical protocols were adhered to at all times; the research procedure and principles guiding the research study are discussed in this section.

Facility managers from all healthcare centres and clinics were contacted telephonically by the principal investigator and research assistant who requested a date, place and time suitable to administer the questionnaire (occurred in June – July 2016), as well as conduct semi-structured interviews (occurred in December 2016 – January 2017). Once a date was set with the facility managers, the research team travelled to North West province to conduct data collection during the periods specified above.

On the day of each meeting, the research team presented to staff, informing the participants of the purpose of the study and ethical principles/outlines guiding the study. Each member of staff was given an information sheet and consent form. Both these documents provided detailed information on the participant's rights, such as the right to voluntary participation and confidentiality of information. The information sheet also indicated how participant information would be maintained in any published output of this study; the use of coding ensured that no participant was vulnerable to breach of privacy. It also mentioned how data would be managed and stored (see Section 4.9).

4.11 Chapter summary

In this chapter, the research objectives were revisited, and the research method and methodology employed were detailed. For each research activity, the researcher provided a rationale for the activities chosen to derive the interpretations and findings that will be presented in the following chapters. For each phase of the study, the researcher detailed the study processes and its outcomes.

The data analysis for each phase was discussed in line with the validity and reliability determinates for each research design. The chapter ended with an outline of how data was stored and the ethical considerations that informed the study.

The results and discussions of the quantitative study are presented in the next chapter (Chapter 5), followed by the results and discussion of the qualitative study. The qualitative findings are separated into two chapters; Chapter 6 provides the findings from interviewing professional nurses. Chapter 7 provides the findings from interviewing frontline nurse managers (i.e. facility managers). All the chapters pertaining to the research findings consist of a short introduction and methodology section, followed by a presentation of the results and discussion sections.

CHAPTER 5

NURSES' EVALUATION OF THE IMPLEMENTATION OF THE PERFORMANCE MANAGEMENT AND DEVELOPMENT SYSTEM

5.1 Introduction

A properly implemented performance management and development system establishes a strong foundation for effective service delivery (Mello, 2015). The detrimental impact of poorly designed and poorly implemented PM systems is documented by Du-Plessis (2015) and Lutwama, Roos and Dolamo (2013), who reported that when performance is poorly managed, it negatively affects staff motivation, acceptance of performance results, and the performance of individuals, teams and the organisation as a whole. Thus, well-designed and well implemented PM processes in health settings have the potential to positively impact on improving health services and strengthening health systems (Adejoka & Bayat, 2014). Therefore, practices aimed at managing performance should not be implemented in isolation from other organisational and management policies, strategies and processes (Saravanja, 2010).

With the introduction of National Health Insurance (NHI) and the re-engineering of primary health care (PHC) to promote integrated clinical services management (ICSM) of acute and multi-morbid chronic conditions, the South African health system is presently undergoing reforms. Such reforms have emphasised the need for person-centred care as a means to improve quality and outcomes of health care (Jardien-Baboo, van Rooyen, Ricks, & Jordan, 2016). These authors defined person-centred care as healthcare that is designed and practised with the patient/person at the centre, thereby being sensitive to patients'/persons' preferences for information and shared decision-making, and responding appropriately to these.

The aim of this study was to investigate the extent to which the performance cycle is applied amongst professional nurses at PHC facilities, in line with the key principles underpinning effective performance management outlined in the Public Service Regulation (PSR) 2001 Chapter 1 Part VIII. These principles state that performance must be managed in a consultative, supportive and non-discriminatory way for the purpose of: i) enhancing efficiency and effectiveness of the organisation; ii) improving accountability for the use of resources and the achievement of results; iii) staff development; and iv) aligning performance with the departmental strategic goals.

Therefore, this quantitative study was conducted to provide answers to the following question: How has the Performance Management and Development System been implemented in PHC settings? To help answer this question, an evaluative cross-sectional descriptive PMDS survey was distributed to 250 professional nurses in 30 health facilities across four Dr Kenneth Kaunda sub-districts; 201 of these nurses responded and thus participated in the study. The quantitative data was analysed using the Statistical Package for Social Sciences (version 25.0), using descriptive statistics as outlined in Chapter 4.

5.2   Results

5.2.1 Socio-demographic characteristic of the sample

The demographic characteristics of the professional nurses who participated in the study are provided in Table 5.1.

Table 5.1.

Description of the Participants Involved in the Quantitative Study

Demographic characteristics	Frequency (n)	Percentage
Gender		
Male	37	18.4%
Female	164	81.6%
Age		
20-30	37	18.4%
31-40	58	28.9%
41-50	59	29.4%
51-60	33	16.4%
61+	12	6.0%
Other	2	0.9%
Level of qualification		
Higher certificate and below	11	5.5%
National diploma	151	75.1%
Bachelor's degree	34	16.9%
Postgraduate qualification	1	0.5%
Other	4	2.0%

Profession		
Professional nurse	147	73.3%
Community service nurse	12	6.0%
Clinical nurse practitioner	23	11.0%
Operational/facility manager	10	5.0%
Acting operational/facility manager	6	3.0%
Advanced midwife	3	1.5%
Years of experience		
0-5	61	30.2%
6-10	56	27.7%
11-15	45	22.3%
16-20	14	6.9%
20+	23	11.4%
Other	2	0.9%
Name of sub-district		
Matlosana	98	48.5%
Potchefstroom (Tlokwe)	68	33.7%
Ventersdorp	25	12.4%
Maquassi Hills	10	5.0%

As depicted in Table 5.1, the majority of the participants were female (81.6%), aged between 41 and 50 years (29.4%). Further, most participants indicated either possessing a diploma in nursing (76.6%), followed by a bachelor's degree in nursing (17.3%). More than 30% of participants had less than five years' work experience, with 27.7% having six-ten years and 22.3% having 11-15 years' work experience.

5.2.2 Reliability of the data collection scale

Reliability is described as the extent to which the data collection and analysis techniques yield consistent findings. It measures the degree of consistency a research instructment measures any given attribute. Therefore, a reliability test measures how consistent participants were in responding to a group of related questions. Thus, it is important to ascertain weather the responses were reliable before calculating the findings. Inter-item reliability was tested by means of Cronbach"s coefficient Alpha (α), which is an index for testing internal consistence

of the test items using SPSS. The Cronbach alpha ranges from .00 to 1.00. A measure of 1.00 indicates a perfect reliability. As a rule, Alpha (α) should be at least 0.70 or higher. Rule of thumb for intrepreting the Cronbach alpha: ">.90 – Excellent; >.80 – Good; >.70 – Acceptable; >.60 – Questionable; >.50 – Poor; and <.50 – Unaccepatble." (George & Mallery, 2003: p.231). Therefore, ideally an alpha of .70 and above is considered a reasonable goal.

5.2.2.1 Performance Standards

Table 5.2

Performance Standards Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.816	.814	8

The Cronbach alpha for performance standard .81.6 which shows this subscale is reliable. The inter-item correation for performace standards is shown below. The correlation matrix dislays how each item correlates with other items. If items are measuring the same construct, we expect them all to correlate well together. Any items that have consistently low correlations across the board may need to removed/ admended from the questionnaire in future to make it more reliable. Any r=.3 is considered as relatively weak.

Table 5.3

Performance Standards Inter-Item Correlation Matrix

		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
1.	All health care workers are familiar with the organization's mission towards clients.	1.000	.300	.309	.221	.160	.253	.166	.204
2.	I have a clear job description.	.300	1.000	.498	.340	.416	.358	.327	.310
3.	The performance standards are clear.	.309	.498	1.000	.580	.404	.473	.273	.327
4.	There are appropiate performance indicators to assess the health care worker's performance.	.221	.340	.580	1.000	.413	.393	.296	.301
5.	Targets are set for activities to be achieved in a given period.	.160	.416	.404	.413	1.000	.437	.408	.317
6.	The performance standards, indicators, and targets are communicated to all departments to ensure that health workers understand them.	.253	.358	.473	.393	.437	1.000	.452	.461
7.	This organization regularly reports the performance of standards, indicators and targets to the external stakeholders.	.166	.327	.273	.296	.408	.452	1.000	.519

8. All the stakeholders in this organization particpate in setting performance standards.	.204	.310	.327	.301	.317	.461	.519	1.000

5.2.2.2 Performance Measures

Table 5.4

Performance Measures Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.859	.859	9

The Cronbach alpha for performance measures α = .85 which shows this subscale is reliable.
The inter-item correation for performace standards is shown below.

Table 5.5

Performance Measures Inter-Item Correlation Matrix

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
Objectives to be achieved are known by individuals to be assessed	1.000	.586	.483	.519	.445	.308	.510	.356	.281
The performance standards expected from the staff are clear and understood by all	.586	1.000	.498	.291	.408	.275	.368	.235	.307
The district clearly defines how to measure individual activity performance	.483	.498	1.000	.498	.461	.399	.488	.300	.444
This organization has a system for collecting and tracking staff performance data	.519	.291	.498	1.000	.561	.445	.442	.246	.238
The organization measures most of the established individual performance standards and targets	.445	.408	.461	.561	1.000	.446	.390	.310	.326
Individual health care worker's performance is measured regularly	.308	.275	.399	.445	.446	1.000	.504	.344	.412
I am fully aware of the process used to measure my performance	.510	.368	.488	.442	.390	.504	1.000	.488	.457
My performance is evaluated based on my job description	.356	.235	.300	.246	.310	.344	.488	1.000	.456
My performance is fairly measured	.281	.307	.444	.238	.326	.412	.457	.456	1.000

5.2.2.3 Performance Reporting

Table 5.6

Performance Reporting Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.828	.828	6

The Cronbach alpha for performance reporting α = .82 which shows this subscale is reliable. The inter-item correation for performace reporting is shown below.

Table 5.7

Performance Reporting Inter-Item Correlation Matrix

	Q1	Q2	Q3	Q4	Q5	Q6
This organization documents the progress related to performance standards and targets	1.000	.604	.353	.363	.474	.268
This organization has a specific system that regularly reports the performance of health care workers	.604	1.000	.463	.424	.514	.434
Constructive feeedback on performance appraisal is provided on a regular basis	.353	.463	1.000	.530	.480	.475
This organization always reports the health care workers' performance information to the external stakeholders	.363	.424	.530	1.000	.541	.372
The health care workers' performance data are analyzed and reviewed according to the set performance standards, indicators and targets	.474	.514	.480	.541	1.000	.396
The health care workers are given opportunity to make commments on the results of their performance	.268	.434	.475	.372	.396	1.000

5.2.2.4 Performance Improvement

Table 5.8

Performance Improvement Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.879	.879	10

The Cronbach alpha for performance improvement α = .87 which shows this subscale is reliable. The inter-item correation for performace improvement is shown below.

Table 5.9

Performance Improvement Inter-Item Correlation Matrix

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Timely action is taken when performance falls below the acceptable levels	1.000	.656	.448	.543	.298	.498	.336	.355	.406	.438
The performance reports are effectively used for decision making	.656	1.000	.596	.545	.388	.443	.421	.444	.452	.450
The health care workers' performance information is used to set priorities for personal development	.448	.596	1.000	.519	.384	.449	.518	.535	.441	.370
The staff is involved in decisions about performance improvement	.543	.545	.519	1.000	.407	.451	.490	.388	.452	.373
The organization has specific processes to manage changes in policies, programs or infrastructure	.298	.388	.384	.407	1.000	.292	.315	.376	.285	.220
My supervisors encourage me to use different ways to improve my performance	.498	.443	.449	.451	.292	1.000	.361	.415	.383	.434
Rewards and sanctions are based on performance results	.336	.421	.518	.490	.315	.361	1.000	.506	.411	.428
The analysis of employees' training needs is based on the performance appraisal reports	.355	.444	.535	.388	.376	.415	.506	1.000	.429	.282
There are procedures to collect suggestions for performance improvement from employees	.406	.452	.441	.452	.285	.383	.411	.429	1.000	.340
I always have access to my supervisors when i neeed support	.438	.450	.370	.373	.220	.434	.428	.282	.340	1.000

5.2.2.5 Performance Reward

Table 5.10

Performance Reward Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.808	.812	5

The Cronbach alpha for performance reward α = .80 which shows this subscale is reliable. The inter-item correation for performace reward is shown below.

Table 5.11

Performance Reward Inter-Item Correlation Matrix

	Q1	Q2	Q3	Q4	Q5
I am paid according to my experience	1.000	.616	.411	.331	.404
My salary is according to my job responsibilities	.616	1.000	.490	.305	.346
Hard work is acknowledged and rewarded accordingly	.411	.490	1.000	.495	.595
All health care workers know their fringe benefits	.331	.305	.495	1.000	.647
I am satisfied with the fringe benefits i get from my organization	.404	.346	.595	.647	1.000

5.2.2.6 Staff Training and Development

Table 5.12

Staff Training and Development Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.826	.825	9

The Cronbach alpha for staff training and development α = .82 which shows this subscale is reliable. The inter-item correation for staff training and development is shown below.

Table 5.13

Staff Training and Development Inter-Item Correlation Matrix

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
This organization has a staff training and development policy	1.000	.407	.307	.229	.183	.300	.314	.158	.264
Opportunities exist for career advancement in this organization	.407	1.000	.289	.179	.190	.314	.320	.232	.373
Appropriate training is conducted to ensure that health care workers carry out their duties well	.307	.289	1.000	.532	.544	.463	.280	.276	.357
Job specific refresher courses are provided on a regular basis	.229	.179	.532	1.000	.634	.549	.229	.309	.349
The in-service training provided is adequate to deal with the existing skills gap	.183	.190	.544	.634	1.000	.604	.330	.394	.294
Health care workers who are less competent are provided with the necessary support to improve their knowledge and skills	.300	.314	.463	.549	.604	1.000	.449	.323	.327
Health care workers participate in identifying thier career development needs	.314	.320	.280	.229	.330	.449	1.000	.364	.335
In the last 6 months my supervisors discussed my career development prospects with me	.158	.232	.276	.309	.394	.323	.364	1.000	.391
I have recieved the training required to succeed in my position	.264	.373	.357	.349	.294	.327	.335	.391	1.000

5.2.2.7 Performance data

Table 5.14

Performance Data Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.558	.561	6

The Cronbach alpha for performance data α = .55 which shows this subscale is relatively poor.

The inter-item correation for performance data is shown below.

Table 5.15

Performance Data Inter-Item Correlation Matrix

	Q1	Q2	Q3	Q4	Q5	Q5
Training of staff	1.000	.478	.137	.318	.253	-.139
Promotion in service	.478	1.000	.266	.315	.365	-.153
Demotions of staff	.137	.266	1.000	.375	.150	.163
Rotation of staff	.318	.315	.375	1.000	.131	.072
Rewards	.253	.365	.150	.131	1.000	-.096
Not used at all	-.139	-.153	.163	.072	-.096	1.000

It appears this subscale has a few problematic items, namely Question 3, Question 5 and Question 6. For these questions most correlations are are relatively weak… they are all under r = 0.3.

- **Overall interpretation of Inter-item reliability**

A reliability analysis was carried out on the seven subscales of the PMDS evaluative scale. Each subscale consists of various items. Cronbach's alpha showed the questionnaire to reach acceptable reliability, with all subscales indicating α = 0.80 and above. Except for the last subscale, which had the α = 55. Therefore, overall most items appeared to be worthy of retention, resulting in a decrease in the alpha if deleted. The one exception to this was the 7th subscale, which would increase the alpha if the problematic items are removed. As such, removal of this item should be considered in future research.

The results relating to the dimensions of performance management evaluated are depicted below.

5.2.3 Establishing performance standards

The majority of professional nurses (64.2%) indicated they were familiar with the National Department of Health (NDoH) mission towards health care. A total of 63.7% reported to have a clear job description. However, only 45.5% reported that the performance standards are clear. From the results, only 46.2% of the nurses agreed that appropriate performance indicators were used to assess their performance. Over two-thirds (68.8%) affirmed targets that should be achieved were set in a given time period. About a third (32.8%) of nurses disagreed that the performance standards, indicators, and targets were adequately communicated to ensure that

all health workers understand them, while 40% were undecided. Furthermore, just over a quarter (27.5%) confirmed that all stakeholders participated in setting performance standards (see *figure* 5.1).
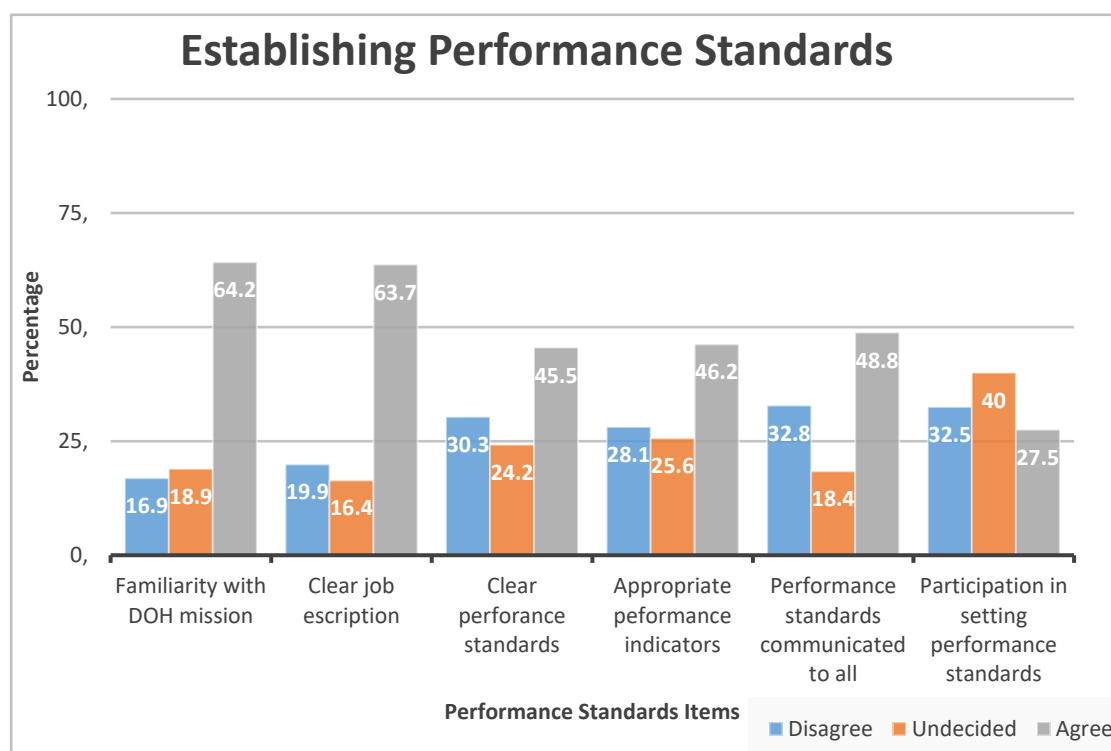
Figure 5.1. Items concerning performance standards (n=201)

5.2.4 Performance measures

Half (50.0%) of the participants agreed that objectives to be achieved were known by staff, while over a third (38.3 %) did not agree that performance standards expected from staff were clear and understood by all nurses. More than forty per cent (45.8%) of nurses stated the district did not have clearly defined processes on how to measure individual performance. With regard to the frequency and process of performance review, just over one-third (35.3%) of nurses affirmed performance was measured regularly as well as reporting they were fully aware of the process used to measure performance (37.3%). Over half (56.2%) confirmed their performance was evaluated according to their job description. Importantly, only about one in five (17.9%) nurses felt that performance was measured fairly, with over half (56.2%) indicating that they felt performance was not fairly measured (see *Figure* 5.2).
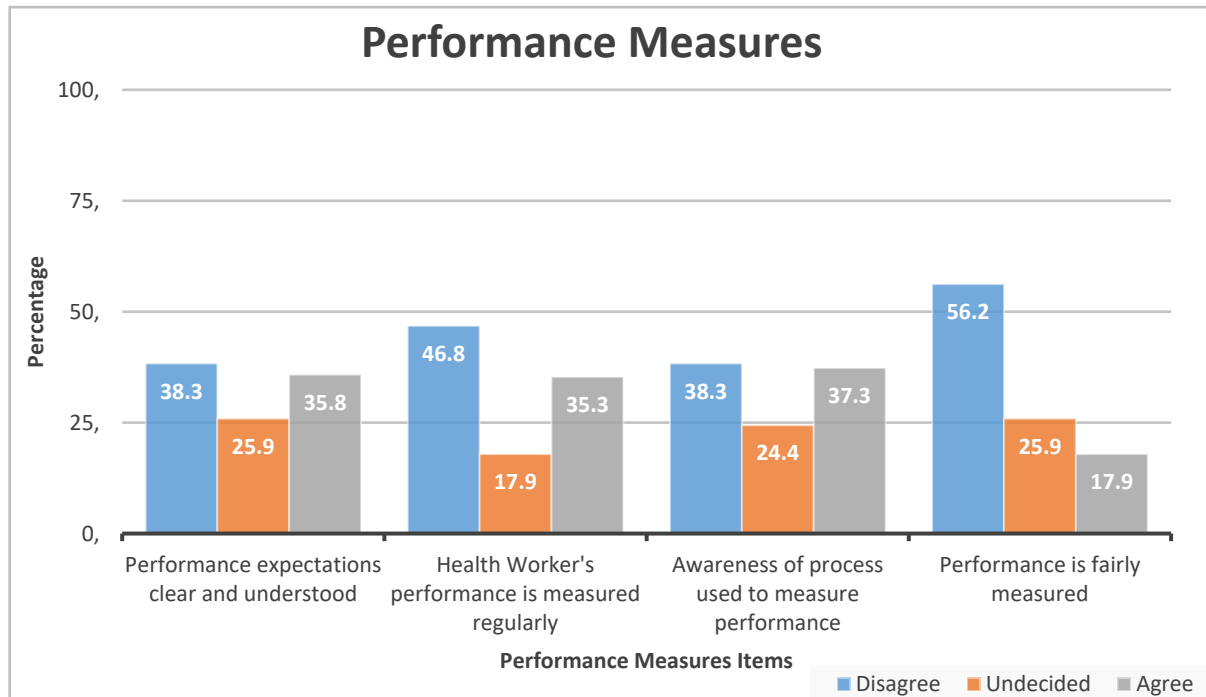
Figure 5.2. Items concerning performance measures (n=201)
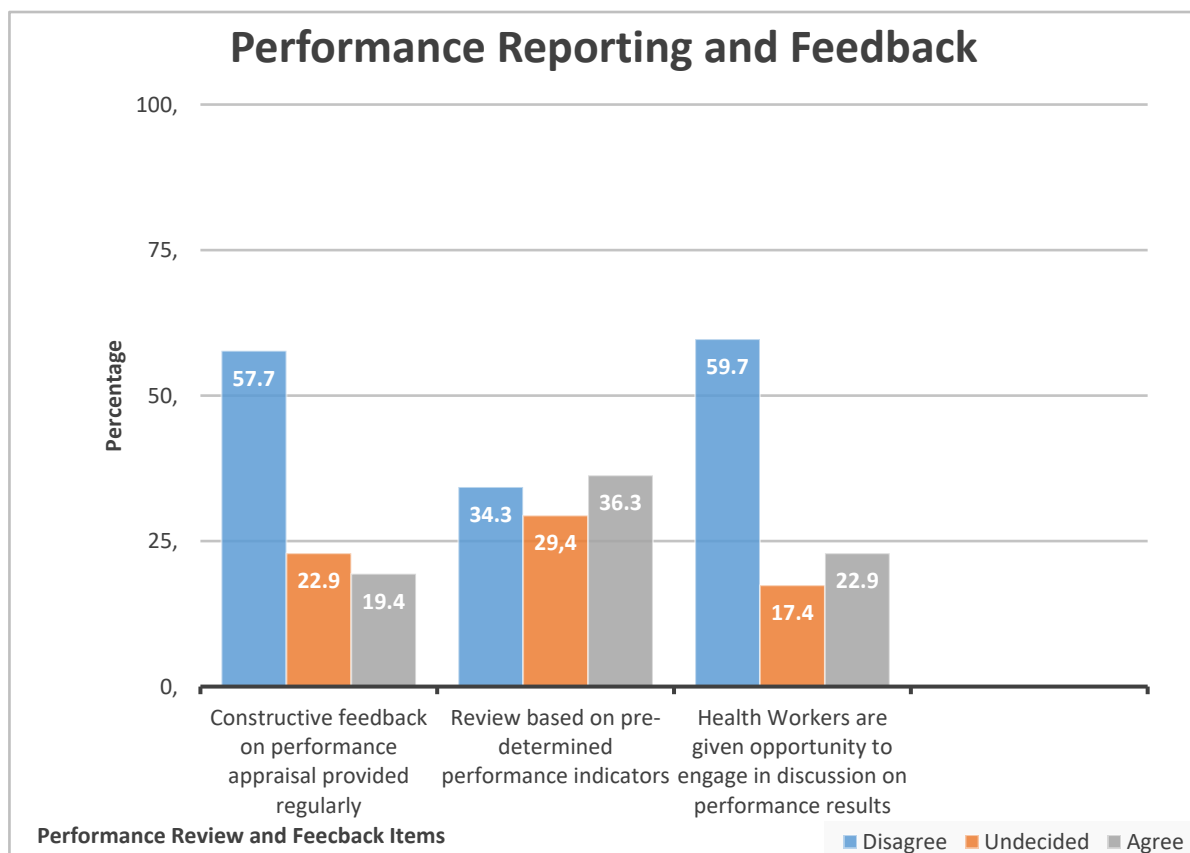
5.2.5 Performance reporting and feedback

Figure 5.3. Items concerning performance reporting and feedback (n=201)

Only one in five (19.4%) nurses reported receiving constructive feedback on their performance, with the majority (57.7%) indicating that they did not receive feedback on a regular basis. Just over a third (36.3%) stated performance data was analysed and reviewed according to predetermined performance standards, indicators and targets. In addition, almost sixty per cent (59.7%) indicated being deprived of the opportunity to engage in discussions on their performance results (see above *Figure* 5.3).

5.2.6 Performance improvement

Half the participants (50.5%) reported having good access to their supervisor when they needed support, with 44.5% of nursing staff reporting supervisors encouraged them to use different methods to improve on their performance. On addition, close to one-third (29.9%) indicated timely action was taken to deal with under-performance. However, roughly only one in five (21.4%) reported being involved in decisions that aided performance improvement or agreed there were procedures in place to collect suggestions from staff for performance improvement (22.4%). Importantly, close to one-third (31.3%) of participants stated rewards and sanctions were based on performance, with 48.4% disagreeing that this was the case (see *Figure* 5.4).
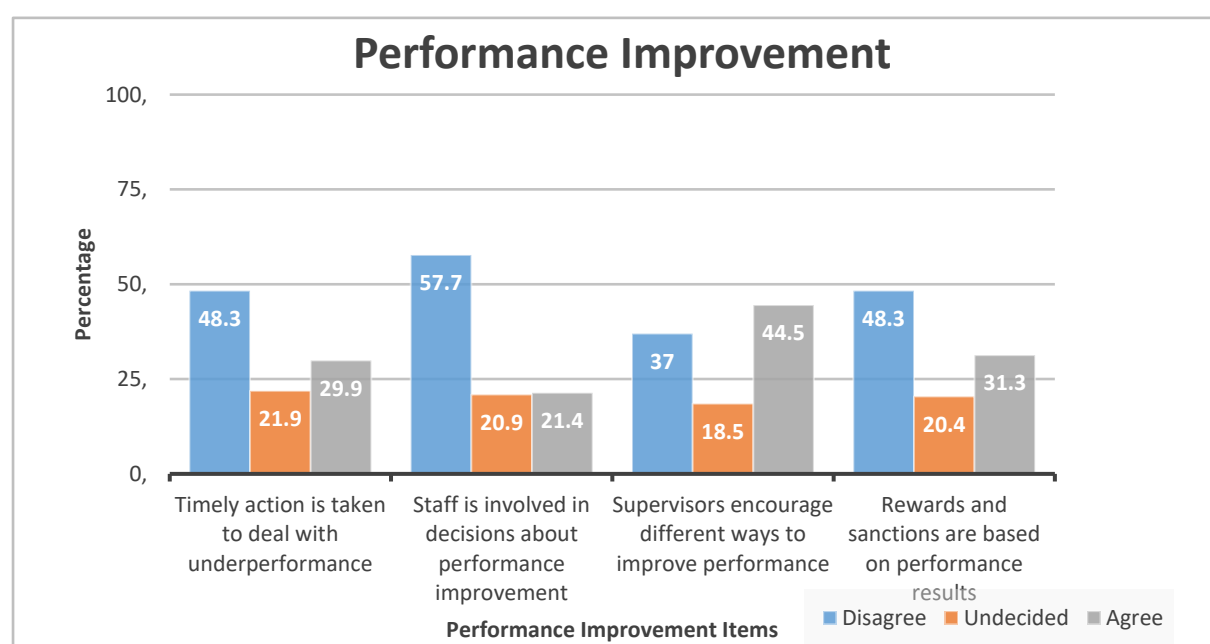
Figure 5.4. Items concerning performance improvement (n=201)

5.2.7 Performance benefits and reward

Only 15.5% were satisfied with their fringe benefits, while more than half (57.5%) were dissatisfied. Similarly, only 15.5% reported that hard work was acknowledged and rewarded accordingly, with the vast majority indicating otherwise (see *Figure* 5.5).

110
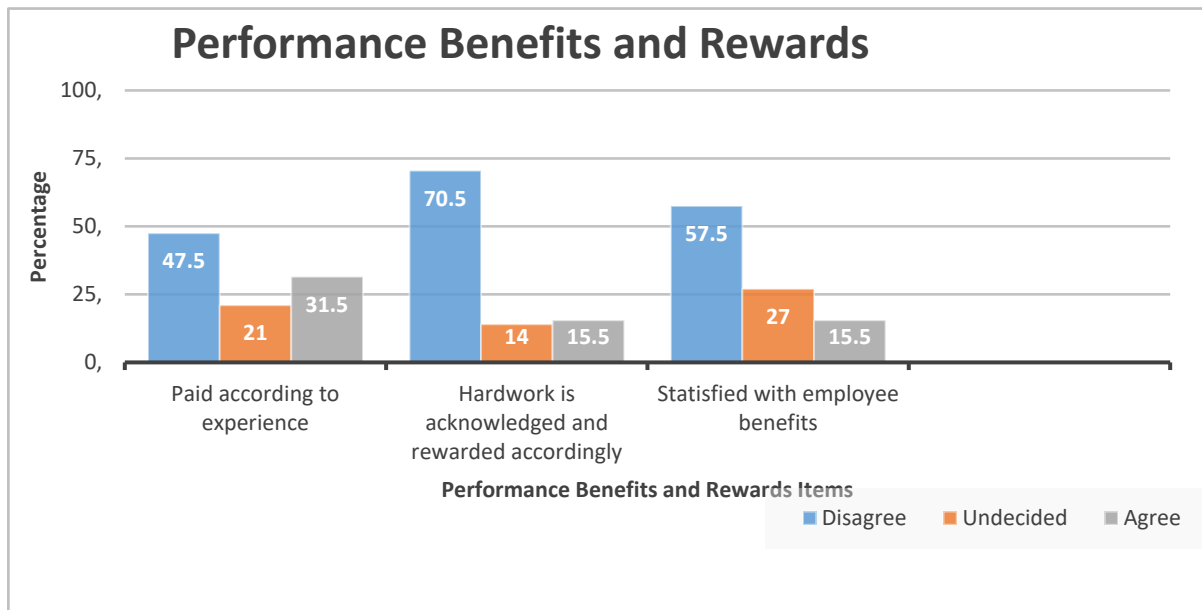
Figure 5.5. Items concerning performance reward (n=201)

5.2.8 Staff training and development

Roughly half (53.0%) of the participants felt that opportunities existed for career advancement, with close to a two-thirds (61.0%) indicating appropriate training was conducted to ensure healthcare workers carried out their duties. However, about a third (35.5%) of the participants felt that less 'competent' staff were provided with necessary support (see *Figure* 5.6).

Figure 5.6. Items concerning staff training and development

5.3 Discussion

The results from this study indicate that, with respect to performance standards, the majority of participants were aware of the NDoH mission towards service delivery and quality of care. For an effective PMDS for nurses, all workers should have knowledge of the NDoH mission and goals, and how these are related to their job performance. Most nurses also reported to have a clear job description.
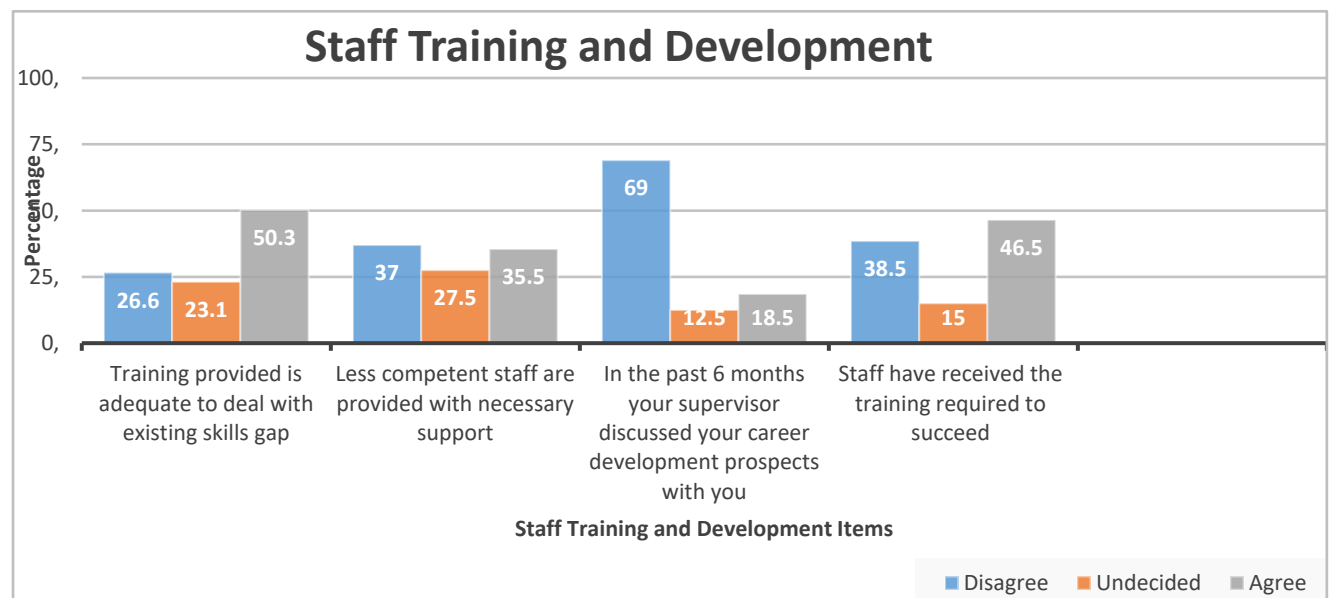
However, only a minority indicated that they clearly understood performance standards and the indicators set to achieve these targets. This suggests that performance standards and indicators are not clearly communicated to professional nurses. Furthermore, the majority of nurses also indicated that they did not believe the performance indicators were appropriate, with only a quarter of the nurses believing that all stakeholders participated in setting performance standards and indicators. This is particularly concerning, given the evidence that PM systems need to be participatory to be effective (Du-Plessis, 2015; Lutwama et al., 2013; Roberts, 2003; Swaartbooi, 2016), with more successful PM systems putting greater emphasis on processes and quality standards than on indicators (Kruk et al., 2018). Indicators have in fact been found to be unhelpful, given problems with accurate measurement, potential to promote employee conflict and negative competition (Awases et al., 2013; Lutwama et al., 2013). Authors such as Martinez and Martineau (2001) further argued indicators assign the responsibility for under-performance to individual staff members rather than understanding the impact of work processes, and other work related-challenges that may hinder employee performance such as lack of adequate staff and resources (Martinez & Martineau, 2001; Kamati, Cassim, & Karodia 2014; Rowe et al., 2005).

During the performance planning and agreement phase, it is important for supervisors to ensure adequate discussions take place concerning performance objectives, standards and improvement strategies (Lutwama et al., 2013). This is an important element of setting performance standards, as it establishes performance expectations between the employee and his/her supervisor (Republic of South Africa, 2007). Steers and Lee (1982) previously reported that the greater the information flow between supervisors and subordinates, the greater the likelihood that the desired outcome will be achieved (Lee & Steers, 2017).

In addition, the majority of nurses indicated that they did not believe their performance was fairly measured. This is understandable in light of the finding that a majority of nurses felt they

were not fully informed of the process used to measure their performance. A number of studies indicated that one of the main reasons performance appraisals are poorly received by healthcare workers is due to poor communication of performance expectations, how these expectations will be achieved and how their performance will be evaluated. This has been confirmed by similar studies (Adejoka & Bayat, 2014; Du-Plessis, 2015; Paile, 2012; Semakula-Katende et al., 2013; Swaartbooi, 2016).

Another area of concern indicated by nurses was the seeming lack of performance feedback and remedial action taken for under-performing staff. This was seen as a key barrier to improving the performance of practitioners and directly linked to improvement in quality of care. The findings of the study indicated less than a quarter of nurses believed constructive feedback on performance was given on a regular basis. Equally alarming was that a majority of nurses did not believe performance data was reviewed according to set performance indicators. Saravanja (2010) found similar results previously in South Africa and attributed PM systems' failure to a lack of synergy with other HRM systems and practices, such as management processes, organisational culture and structures. Ahmad and Bujang (2013) found employee dissatisfaction with how performance is managed had a direct impact on other HRM outcomes such as employee well-being, job satisfaction and intention to quit. Similar findings emerged from Skinner et al.'s (2017) study on nurses' experiences of injustice in the workplace and its impact on well-being.

This study provides valuable insights into how nurses perceive and experience injustice at work. Furthermore, the findings of the study confirmed previous research (McVicar, 2003 on a link between injustice and nurses' decreased well-being and effectiveness. These findings paint a compelling picture of poor implementation of the PMDS across the district. This is further exacerbated by communication loopholes and the lack of a proactive communication strategy and processes that can create a safe environment for timeous and continuous engagement between supervisors and nurses on how to improve performance. The findings indicate that participants were not given the opportunity to reflect on the results of their performance appraisal with their supervisors, and the paucity of timely remedial actions found by this study runs counter to the guidelines provided by the Public Service Commission on the PMDS (2007). This has serious implications for quality of care, as without remedial strategies to improve the performance of health staff, quality of care is unattainable, as it requires consistent development of clinicians to meet evolving patient needs, expectations and

preferences (Jardien- Baboo et al., 2016). Thus, key to quality of care are the monitoring and evaluation of nurse competencies to meet new healthcare demands.

In addition, lack of feedback and timely remedial actions can be related to poor motivation, uncertainty, scepticism and negative perceptions of the consistency and fairness of PM across the district. Skinner et al. (2017) confirms that experiences of injustice and unfairness negatively influence performance and well-being, as previously mentioned. Further, in line with previous studies (Delobelle et al., 2011; Munyewende, Rispel, & Chirwa, 2014; Pillay, 2009), this study also revealed that the majority of nurses were not satisfied with the reward system, which they believed was unfair and did not reward hard work. Previous studies have also suggested an imbalance towards monetary rewards over other drivers such as performance development and sustainability in South Africa (Semakula-Katende et al., 2013), which was confirmed by nurses in this study. The need to review the reward system is thus paramount for improving quality of care, given the role it plays in the behaviour and performance of employees (Awases et al., 2013; Decramer et al., 2015; De Spiegelaere, Van Gyes, & Van Hootegem, 2016).

In relation to staff development and training to equip staff with the necessary competencies to provide the expected services, the majority of staff indicated that they were aware of existing policies on training and development, with a large number of staff believing opportunities existed for career advancement and training to ensure HCWs carry out their duties well. Implementation, however, appeared to be a challenge, with many nurses not having discussed career development prospects with their supervisors or being provided with the training opportunities that were available to improve their competencies. Previous studies have indicated training to be inadequate for equipping staff to handle the changes that are due to the current health reforms of re-engineered PHC (Munyewende et al., 2014). This study thus highlights the need for attention to implementation of training and career development opportunities to equip nurses with the necessary competencies to provide quality services within the current healthcare reforms, notably related to person-centred care. Numerous studies have demonstrated the role of personal development in influencing employees' motivation and performance (Awases et al., 2013; Bartam & Dowling, 2013; de Waal, 2003).

5.4   Chapter summary

In the quest to improve quality of services provided within the roll-out of NHI in South Africa, this study has identified several barriers to the implementation and application of the PMDS that should be addressed. In particular, there is a need to improve healthcare worker involvement in setting performance standards, which should assist to improve understanding and buy-in to performance standards. There is also a need to improve on implementation of the PMDS to ensure that it is implemented regularly, fairly and in a non-threatening way that promotes personal development, and where constructive feedback is provided and remedial action taken to improve on poor performance.

CHAPTER 6

NURSES' PERCEPTIONS AND EXPERIENCES WITH THE PERFORMANCE MANAGEMENT AND DEVELOPMENT SYSTEM IN PRIMARY HEALTH CARE

6.1 Introduction

Currently, health system reforms are under way in South Africa, notably the introduction of National Health Insurance (NHI) and the re-engineering of PHC to promote integrated clinical services management (ICSM) of acute and multi-morbid conditions that demand person-centred care (Jardien-Baboo et al., 2016). Accordingly, these reforms require that organisational systems and processes such as performance management, organisational culture and organisational strategic objectives must be harmonised to align with these reforms. Poor human resource management (HRM) methods and practices in the healthcare system have been found to threaten the successful implementation of quality healthcare in South Africa (NDoH, 2012). Furthermore, these processes must be managed appropriately to encourage a shared vision, inspire health workers (HWs) and build a culture of performance that drives the entire health system towards a common purpose. Given that nurses are at the frontline of healthcare, constituting 80% of HWs of public healthcare providers nationally (Rispel, Blaaw, Chirwa, & de Wet, 2014; Stats SA, 2017), the need to ensure that nurse-related HRM practices are aligned with the current reforms is not only important but indeed essential.

According to Rispel (2015), South Africa faces a nursing crisis that is characterised by shortages, a declining interest in the profession, staff disengagement and lack of resources. In addition, the nursing profession has come under attack for poor service delivery (Republic of South Africa, 2012). In an attempt to attract and retain nurses within the South African healthcare system, as well as improve quality of service provision, there has recently been increased attention on how HRM processes and outcomes influence nurses' experiences, attitudes, behaviour in the workplace, and ultimately the quality of care they provide (Mayosi & Benatar, 2014; Rispel, 2015; Rispel & Barron, 2012).

In light of the paucity of evidence on nurses' perceptions and experiences of the PMDS in PHC, understanding nurses' perceptions and experiences of the PMDS is a vital first step in understanding how it can be improved to promote quality of care in the context of the health systems reforms at PHC level. This study thus aimed to explore nurses' perceptions and

experiences of the current PMDS in relation to the changes in their roles and functions as a consequence of the current health systems reforms in South Africa. More specifically, the objectives were to: i) explore nurses' perceptions and experiences of what hinders performance and quality of care within the context of re-engineered PH C, NHI and ICSM; and ii) describe actions that PHC facilities could consider towards improving the use of the PM system to cultivate a culture that fosters quality of care within the context of re-engineered PHC, NHI and ICSM.

An exploratory, descriptive and qualitative design was utilised. Through purposive sampling, a semi-structured interview tool was used to collect data from eighteen nurses in four sub-districts of Dr Kenneth Kaunda District in the North West province. Data was analysed through thematic analysis (as outline in Chapter 4).

6.2   Results

6.2.1 Characteristics of the sample

Participants were selected from all four sub-districts in Dr KK District (see Table 6.1).

Table 6.1.

Participation Distribution per Sub-District

Name of sub-district	Number of professional nurses interviewed	Percentage %
Matlosana (M)	8	44%
Potchefstroom (Tlokwe) (P)	4	22%
Ventersdorp (V)	3	17%
Maquassi Hills (MH)	3	17%
Total number of participants	18	100

Table 6.1 depicts the distribution of participants per district. The majority of participants worked at Matlosana (n=8), followed by Potchefstroom (Tlokwe) (n=4). The other two sub-districts, namely Ventersdorp and Maquassi Hills, each had the same number of participants (n=3).

The demographic characteristics of professional nurses who participated in the study are provided in Table 6.2.

Table 6.2.

Demographic Characteristics of Professional Nurses

Demographics	Professional nurses (n=18)	Percentage
Race		
African	16	89%
White	2	11%
Indian	0	0%
Mixed race	0	0%
Gender		
Male	3	17%
Female	15	83%
Age		
20-30	3	17%
31-40	3	17%
41-50	10	55%
51-60 +	2	11%
Marital Status		
Single	10	55%
Married	5	28%
Divorced	1	6%
Widowed	2	11%
Highest qualification		
Certificate	0	0%
Diploma	13	72%
Degree	5	28%
Postgraduate studies	0	0%

0-5	9	50%
6-10	8	44%
11-15	1	6%
16-20	0	0%
20+	0	0%

As depicted in Table 6.2, the majority of the participants were Black and female, aged between forty-one and fifty years (n=10). Further, most participants indicated either possessing a diploma in nursing, followed by a bachelor's degree in nursing, with approximately half having less than five years' work experience, and the other half having between six and fifteen years.

6.2.3 Themes emerging from the study

A number of themes emerged from the data (see Table 6.3).

Table 6.3.

Themes and Sub-themes

Themes	Sub-themes
1. The importance of the PMDS in healthcare	• The PMDS as strategic, administrative and developmental managerial tool.
2. The system is flawed	• Experiences of poor implementation of the PMDS
	• Inconsistencies in application of the PMDS across sub-districts
	• Weak accountability
3. Rewarding performance	• Rewarding system
	• Favouritism
4. Overcoming barriers to effective performance management	• Re-evaluate the administration of the system
	• Provide adequate training on the PMDS as a valuable managerial tool
	• Facility managers' competency and capacity to evaluate nurses' performance
	• Team dynamics and their consequences
5. Improving quality of care	• Quality of care requires staff, resources and time

The main themes and sub-themes reflected the nurses' perceptions of the current PMDS within PHC healthcare settings. Although many nurses mentioned the PMDS as a vital HR component, many argued that it may become more relevant if it accurately measures performance and is used for development purposes (Hyde, Harris, & Boaden, 2013; McDermott & Keating, 2011); this suggests that, currently in practice, the PMDS is not used effectively. Each theme and sub-theme is discussed comprehensively below. Data was coded according to sub-district and occupation, as indicated below:

MPN = Matlosana professional nurse

PPN = Potchefstroom (Tlokwe) professional nurse

VPN = Ventersdorp professional nurse

MHPN = Maquassi Hills professional nurse

6.2.4 Theme 1: The importance of the PMDS in healthcare

This theme covered the importance of the PMDS according to the narratives; it includes the purpose of the PMDS and its current use in PHC health facilities.

6.2.4.1 The PMDS as strategic, administrative and developmental managerial tool

The majority of participants perceived one of the goals of the PMDS as being to evaluate performance for the purpose of identifying areas for development in nursing practice and thus assisting nurses in improving the quality of care rendered to patients. This is captured by the participants below:

> **PPN14:** *It is developing because, where you are able to see gaps, they are able to come back to you and say, you lack knowledge on this and that, and then take you for training.*

It was also observed that, if applied correctly, the PMDS has the potential to help improve quality of service delivery through monitoring and evaluating performance. These aspects were mentioned by the participants below:

> **MHPN16:** *It is like auditing the staff, like how far did you go, are you in line with the working environment and the guidelines, etc.*
>
> **PPN11:** *It is a good thing to also control performance and to reward people that need … rewarding.*

The participants above demonstrated that the PMDS has a quality assurance aspect, while also providing incentives for good performance. The remunerative incentive emerged as a key positive factor of the PMDS for a number of participants:

> **PPN14:** *For remuneration, for payment purposes and rewards, that is the only important part about it. Somehow it encourages us: "If you work hard you will be rewarded". You become more interested in doing your job and wanting to do more.*

6.2.5 Theme 2: The system is flawed

This theme covers nurses' perceptions and experiences concerning how the PMDS is implemented at district level. It highlights the inconsistencies in its application across sub-districts, as well as its weak accountability control measures.

6.2.5.1 Experiences of poor implementation of the PMDS

The majority of participants complained about poor implementation of the PMDS. For example, participants articulated that, while the appraisal process was meant to acknowledge and reward diligence as reflected in the previous theme, this was not always the case:

> **MPN1:** *It is failing us because even though we work ... you end up being at the same salary level for so many years.*

The participant below also mentioned that, as a result, staff have become reluctant to participate in the process. Further, this participant reported there were no serious repercussions if staff chose not to complete the appraisal at all, thus demonstrating how the PMDS was compromised.

> **MPN5:** *Everybody is just reluctant ... I don't see any progress in this system ... even if we don't write it ... nothing is done.*

Interestingly, another participant (MHPN16) also passionately advocated against the use of performance management, citing its idealistic aims that create animosity given the unrealistic demands associated with it and with it having the potential to create an unconducive working environment that is contradictory to the vision of the system.

> **MHPN16:** *The PMDS is out of order, it is unrealistic ... it is not working, the targets, its numbers, it is just imaginative numbers ... The PMDS is creating some form of hatred to some people who are working and are not getting it.'*

Another related issue was the unrealistic targets set by the North West Department of Health (NWDoH), which results in nurses feeling undermined when they do not reach their targets.

> **MHPN16:** *This year you must treat a hundred patients, critical patients who are involved in an accident. Then you find you only have ten patients who are involved in an accident. How are you supposed to do that? Are you now supposed to spread the message to those people to please get into accidents? That is the problem with PMDS. They are not applicable and realistic. The problem with the PMDS is the targets.*

6.2.5.2 Inconsistencies in application of the PMDS across sub-districts

Another complaint to emerge related to inconsistencies in the scoring and rewarding of the PMDS system across sub-districts, with more than half of the participants mentioning this was an issue.

> **PPN14:** *They are not measured in the same way ... with remuneration ... same - if I compare myself with a professional nurse with the same experience as mine, maybe* [in] *Klerksdorp, we are doing the same thing like on a daily basis. She will be recognised and I won't be.*

6.2.5.3 Weak accountability

Half of the participants mentioned that weaknesses in implementation of the PMDS compromised the legitimacy of the system. For example, nurses were being allowed to refuse to participate without repercussions, others were just writing anything so as to avoid being penalised, and some nurses were recycling submissions.

> **MPN3**: *Last year I refused to write.*
>
> **MPN4:** *You just write to get finished, just to get it done because when you don't write, they will always be on your neck, putting pressure on you saying: "We need your PMDS; we're going to penalise you if you don't write".*
>
> **MPN3:** *We are only told to write it, then we copy from others. Then we ask others how you write it, so we only get information from other staff.*

6.2.6 Theme 3: Rewarding performance

The majority of participants repeatedly expressed perceptions and experiences of great dissatisfaction with the rewarding system and further highlighted that the PMDS was engraved with favouritism at facility level.

6.2.6.1 Rewarding system

While participants acknowledged the potential of the PMDS as a system for motivating them to perform better, a majority of the participants mentioned that there was a strong sense across the board that the way rewards were distributed was unjust.

> **MPN3:** *I want them to treat us equally … we are all going the extra miles … they should also give us some bonus for our hard work … we are working very hard compared to other clinics.*

The participant below also argued that, in instances where staff members did not receive a bonus, feedback should be provided on why they did not qualify:

> **MHPN15:** *They* [facility managers] *should explain why you didn't qualify for a performance bonus …* [and others do]. *We're coming to work every day, doing what you are supposed to do.*

A majority of participants identified the need for the PMDS to measure performance accurately, consistently and without any ambiguity. In doing so, these participants expressed great dissatisfaction with how performance decisions are made. Comments that attested to this were:

> **MPN3:** *The people that get it* [performance rewards] *are the ones who are not working.*
>
> **MHPN16:** *It is not benefiting the people on the ground who are actually doing the job.*

Like the participants above, the two participants below also confirmed the lack of uniformity and discrepancies, and questioned the fairness of the system:

> **VPN9:** *Sometimes those that are absent and dodging at the end of the year they are getting* [performance rewards].
>
> **PPN11:** *People that are writing PMDS are getting all these good remarks but they are not doing anything in the clinic.*

Apart from the value of monetary rewards previously described, some participants also mentioned the need for non-monetary means of recognition and appreciation of hard work that can boost self-esteem and commitment:

> **MPN7:** *To be appreciated in a way, I don't say they should give money or whatever just to say, "Hey you have done well today". People's self-esteem is being built up. At least I am being appreciated; it doesn't mean it is all about money.*

6.2.6.2 Favouritism

Almost all the participants suggested that the PMDS was riddledwith favouritism at facility level. Participants noted the following as they interacted within their own work environment:

> **PPN11:** *The manager does play a role … they do also have their favourites; it is not fair.*

> **MHPN15:** *It is favouring other people … it is the same people that always get PMDS* [rewards].

Other participants indicated the impact favouritism has on performance and how it created conflict between employees. This is also evident with some participants reporting:

> **VPN9:** *It causes friction. It breaks the spirits because if someone gets a reward and I don't get it when we are in the team. What's the difference?*

> **MHPN17:** *I don't think PMDS is working … people will tell you that if your manager favours you, it will benefit, but if your manager doesn't favour you then you don't benefit.*

MHPN16 cited managers as the instigators and the beneficiaries of favouritism in the workplace:

> **MHPN16:** *It has some sort of favouritism … the managers are getting the PMDS* [rewards], *but the ones who are working, who are hands-on, are not getting the PMDS* [rewards].

Overall, participants felt that favouritism ultimately has devastatingly negative consequences for positive work outcomes such as motivation, job performance and team collaboration.

6.2.7 Theme 4: Overcoming barriers to effective performance management

This theme highlights nurses' opinions on key considerations for effective performance management. These considerations include: i. re-evaluating the administration of the system; ii. provide adequate training on PMDS for all staff; iii. facility managers' competency and capacity to evaluate nurses' performance; and iv. team dynamics and their consequences.

6.2.7.1 Re-evaluate the administration of the system

Many participants suggested the need for a change in the current PMDS, wanting it to be aligned with the PMDS within the district hospital setting. This was because the latter PMDS was perceived to be more user-friendly, with nurses merely having to rate themselves on certain criteria using tick boxes as opposed to writing, which was used by the PHC PMDS:

> **MPN5:** *I came here from the hospital, and usually the hospital, they had already, written it* [the appraisals]. *It was just for you to maybe tick* [rate] *yourself and then immediately when I came here, I heard that everyone has to write the PMDS. No one showed me how to do it.*

> **PPN14:** *If you can check Potch hospital, they are not writing; they are scoring themselves. They get everything written with a column on the right to score. So you tick.*

6.2.7.2 Provide adequate training on the PMDS for all staff

The majority of participants advocated for compulsory training on the PMDS for all staff involved. They expressed that they did not feel confident about their capabilities to use the system, and that left them vulnerable to making errors. The training of staff should focus on the process that raters and ratees should follow during the performance management cycle. In doing so, the focus of the training must be centred on setting performance objectives, performance appraisal and communicating performance feedback. These sentiments were shared by a majority of participants and are further expressed by the participant below:

> **MPN4:** *We don't even know how we should write PMDS because always when we write the PMDS, they will always tell you that this is the wrong way; this is not the correct way. But they have never conducted a workshop or training, so that we can all be on board as to what they expect from us.*

Participants also indicated lack of feedback and communication as factors that impacted negatively on them.

> **MPN4:** *Sometimes they don't even tell you; you will be scoring yourself, take the PMDS to your supervisor and sometimes she will be scoring you and then attach the signature then send the forms to HR, without knowing the percentage you got.*

The lack of feedback on performance has prompted participants to suggest:

> **PPN14:** *If it was useful* [the feedback]*, you would know what to write in the next PMDS and be sure that this is the correct way of writing it. They should call us individually*

and sit you down, discuss everything that you wrote so you know what it is that you did good [well] *and what is it that you didn't do well. Because after presentations, no one is coming back with the feedback.*

6.2.7.3 Facility managers' competency and capacity to evaluate nurses' performance

Many participants questioned whether facility managers had the time or competency to carry out the PMDS effectively. They suggested that nurse managers were involved in a lot of administrative tasks that consumed a substantial amount of their time, compromising contact time with nurses. The following statement illustrates these participants' views:

> **MPN2:** *The managers. They don't have time. Even when you have a problem or you sitting down with her, she will just tell you this and this and then you must go … So we are not satisfied about this PMDS, the evaluation, the improvement and management.*

Some participants suggested that nurse managers did not adequately represent the performance of professional nurses during panel evaluation committee meetings when individual and facility performance rating are evaluated and the manager must provide a motivation for the rating they have assigned each ratee.

> **MH15:** *I don't think she is doing enough when she presents us at the panel … Maybe she is not doing enough to prove that, "No, this person is really a hard worker".*

Other participants stated that managers were not supportive in assisting them to improve performance and were only concerned with meeting targets. Thus, managers were often not proactive in addressing under-performance.

> **VPN10:** *They are not supportive, they are concerned about the numbers. They address the problem as it comes. It is only when something happens afterwards, they will come in and say, "Why did this happen?". I have seen that at the top, that if the sub-district is not doing well, they come down and they put the pressure on us.*

6.2.7.4 Team dynamics and their consequences

The majority of participants also perceived the PMDS as largely individualistic in nature and consequently not encouraging teamwork, which was regarded as essential to achieve facility performance and improve the quality of collaborative team care which underpins the chronic care model. The existing PMDS system was viewed as working against collaborative team

care, and the need for the PMDS to be aligned with organisational changes promoting teamwork was thus highlighted.

> **MHPN15:** *It* [is] *dividing the staff. Currently, we are trying to work as a team, but if we are working as a team and then I alone get the PMDS or something but we are doing the same thing together, I think that is separating the teamwork, so someone will start only concentrating on the things she is supposed to achieve to get the performance bonus.*

6.2.8 Theme 5: Improving quality of care

This theme detailed the need for improving the quality of care and factors that need to be considered in this regard.

6.2.8.1 Quality of care requires staff, resources and time

The majority of participants complained of staff shortages, with pressure to see many patients, and that this compromised the quality of care they were able to provide.

> **PPN13:** *With quality … we try our best, but the numbers increase and what happens is that we open 08:15 up until 16:30. The clinic can be full up until 16:00, so we hurry up because we want to go home in time. You won't render quality services to your patients; you just want them out of here.*

> **PPN14:** *Work overload … so many patients to see, you end up not seeing one patient in totality. We run to push the line, making the hall empty, helping people sitting outside so that we can go. So that affects the quality of care we are rendering the patients.*

One nurse, however, had a different view, highlighting that quality should not be compromised, regardless of the long queues. This participant noted the need for nurses to pay attention to individual cases. Further, this nurse noted the importance of nurses providing health-promoting messages; however, she was not optimistic about patients' willingness to receive such care:

> **VPN9:** *We cannot just hurry up because the queue is long. If you see that this patient needs attention, you just do what we have to do. We have to give quality … We encourage patients to keep healthy and also the information we are giving our clients, it must at least help them to change their lifestyle … In our clinic, patients are discouraged to come because of long queuing. Sometimes, even if you can give them information, they are not listening to you; they just want to go. I think our community lost hope in* [the] *health system.*

Some participants indicated the need for greater support for the challenges faced by nurses, indicating the need for greater awareness on the part of management in this regard, with the current PMDS only interested in numbers and not quality of care.

> **MHPN17:** *I think support and communication would be the best, if management can come down and maybe look at the work that we do, so to understand how many patients we administer.*

> **MHPN16:** *The PMDS is more about the numbers, not the quality of work you are doing. It has nothing to do the people but the numbers!*

6.3 Discussion

The vast majority of participants identified the positive benefits of the PMDS. They understood its main purpose was to meet evaluative and developmental objectives, and that the value of the PMDS lay in its potential to provide feedback that was helpful to improve their job performance and the provision of quality care. This developmental ethos in managing performance is supported by Lutwama et al. (2013), who identified it as one of the three main functions for a performance management system (the others being strategic and administrative).

Both monetary and non-monetary rewards emerged as important aspects of performance appraisal in this study. The majority of the participants expressed that the profession was extremely stressful, and lack of recognition and reward was one of the major reasons for their job dissatisfaction. While monetary rewards were reported to be important to improve job satisfaction and retention, the importance of other forms of recognition and acknowledgement also emerged as important. Other forms of appreciation, such as recognition for daily progress, were reported to enhance positive attributes such as dedication, hard work and self-esteem. AbuAlRub and Al-Zaru (2008), who conducted a study on job stress, recognition, job performance and intention to stay at work among Jordanian hospital nurses, also found a direct and buffering effect of recognition of nurses' performance on job stress and the level of intention to stay at work. This reiterated the importance of recognition for outstanding performance as well as other achievements. This is also supported by Mokoka et al. (2010), who found that, from a nurse manager perspective, both monetary and non-monetary rewards were important for improving retention of professional nurses in South Africa.

Evidently, the nurses highlighted that the system was poorly implemented. Nurses complained that the way in which the PMDS was implemented failed to truly capture performance, did not provide feedback on remedial steps to improve poor performance, and did not promote accountability or set realistic performance targets. Mone and London (2018) suggested that, if true performance is not accurately or consistently captured, it will decrease the natural motivation climate to enhance performance. On the other hand, if the system is implemented correctly, it should facilitate identification of non-performance and implementation of remedial measures to improve performance.

Further, in addition to being poorly implemented, participants in this study perceived the system to be unfairly implemented and lacking impartiality, with the participants questioning whether those receiving rewards truly deserved them. Monetary gain as an incentive was reported to fuel favouritism and distrust. Such beliefs are in line with previous literature that investigated the perception of performance management in the public sector in South Africa (Makamu & Mello, 2014; Mello, 2015; Swaartbooi, 2016). Daskin (2013) found similar experiences in the hospitality industry, with favouritism having the potential to create distrust, causing diligent performers to disengage from the process. Favouritism has been found to be disruptive to productivity and staff morale, create conflict between employees, and impact negatively on motivation, job satisfaction, job performance and team collaboration (Alotaibi, 2016; Isaed, 2016; Platis, Reklitis, & Zimeras 2015). The need for nurse managers to be trained in the negative implications of favouritism in the PMDS process is thus highlighted.

Because of the perceived unfairness of the system, not feeling competent in how to complete their side of the PMDS, as well as lack of feedback on their performance and how it could be improved, nurses purportedly did not take the system seriously and participated in the process only to avoid being disciplined if they did not comply. While the tools and processes of performance management are based on sound principles, how they are implemented and utilised is contentious. One of the greatest challenges in literature on PM systems and PA involves employees contesting its usefulness in fostering self-development and promotion (Adler et al., 2016; Mone & London 2018). The need for management training in the purpose and use of the PMDS to ensure that it is implemented as intended is again highlighted.

Nurses in this study also mentioned that the over-emphasis on outcomes-based measures of performance compromised attention to quality of care. For instance, it is known that, in order to improve health service delivery, the patient and the HW must work collaboratively.

However, there were no incentives for professional nurses to practice patient-centered care. Behaviour-based measures of performance were neglected. Examples of such evaluation include measuring the relationship between patient and nurse, patients' and nurses' agreement on patient problems, and efforts towards evaluation of medical and other interventions to resolve or improve patient care. Instead, the PMDS encouraged nurses to spend less time on each patient in order to reach their targets and ensure all patients who visit the healthcare facility are served (Hanefeld, Powell-Jackson, & Balabanova, 2017; Petersen et al., 2006).

In the context of the current reforms under way in PHC, the PMDS presents as a valuable tool that could assist in ensuring implementation of these reforms. This is especially the case in relation to re-orienting staff to providing the person-centred team-based collaborative care necessary for treating the multi-morbid chronic conditions that commonly present at PHC as a result of the clashing HIV and NCD epidemics (Kengne & Mayosi, 2014). Awases et al. (2013) warned that the performance of health workers is linked to productivity, while quality of care provision within healthcare facilities is neglected. The results of this study call for a review of i) the current PMDS, in light of its goals to improve quality of care and promote patient-centered care, as well as ii) the way it is implemented, so as to ensure that the system fully meets its strategic, administrative and development goals without any compromise on its validity and accuracy.

6.4   Chapter summary

The current PMDS needs to be overhauled so as to promote healthy working relationships between nurses and nurse managers to facilitate a collaborative work environment that does not promote individual gains over team capacity. Nurses and nurse managers need to be equipped with the necessary understanding of the value and usefulness of the PMDS, as well as the skills to implement it appropriately to ensure that nurses' contributions are recognised and rewarded accordingly, without any favouritism or unfair practices impeding this process. This will allow for it to be fully utilised as a managerial tool that is valuable for improving health outcomes, identifying training and development needs, as well as acknowledging hard work and dedication.

CHAPTER 7

THE PERCEPTIONS AND EXPERIENCES OF FRONTLINE NURSE MANAGERS ON PERFORMANCE MANAGEMENT IN PRIMARY HEALTH CARE

7.1 Introduction

Research on the quality of the relationship a nurse has with his/her frontline manager (this term will be used interchangeably with the term 'nurse manager') and its influences on the nurse's work attitude is well documented (Rodwell, McWilliams, & Gulyas, 2017). In addition, there is global recognition of the importance of the health workforce to strengthening health systems and the achievement of positive health outcomes (including universal coverage and improved quality of care). Therefore, there is increasing awareness of the need to identify best practices for managing health professionals, with an associated increase in research outputs related to human resource management (HRM) practices and methods, and their influence on staff motivation, satisfaction and individual performance (Bartram & Dowling, 2013). This is especially the case as the South African health system is currently undergoing healthcare reform; this includes the implementation of the National Health Insurance (NHI) and re-engineered primary health care (PHC) (Naidoo, 2012) to encourage integrated chronic service management (ICSM) of acute and multi-morbid conditions that require patient-centred care (Barnett et al., 2012; Little et al., 2001. In this environment, the role of a nurse manager expands to include managing or leading interdisciplinary teams to optimise person-centred care. This requires ensuring that nurses' performance is continuously evaluated and managed, to provide quality care to patients (Jardien-Baboo et al., 2016; Republic of South Africa, 2011).

The benefits of performance management in organisations have been greatly debated. Equally deliberated has been the role of frontline managers in implementing HRM practices and the influence of this on organisational/individual performance. Noticeably, frontline managers are increasingly charged with the implementation of many HR practices such as performance management and appraisals (Purcell & Hutchinson, 2007; Van De Voorde & Beijer, 2015). The manner in which managers undertake their HR performance management duties, such as appraising, communicating and involving employees is, however, dependent on a wider set of leadership behaviours. This potentially influences employee attitudes and behaviour, resulting in positive or negative work outcomes that impact on productivity, job satisfaction and commitment.

In the first instance, frontline managers must be committed to the implementation of PM systems. They should also be equipped with the necessary leadership capacities to create a shared mission, vision and the necessary performance to achieve this vision and mission at the individual, team and organisation level. This includes the capacity to inspire staff and promote a culture of accountability and openness in performance management (Lutwama et al., 2013).

The South African Minister of Health identified leadership and management as priority number one for human resources for health (Republic of South Africa, 2011). The health ministry attributed the current challenges in the health sector to weaknesses of management and leadership at all levels of the health system. Some of these weaknesses included demotivated healthcare professionals, the lack of retention of healthcare professionals and inability to fill vacant posts; these are attributable to a poor organisational culture and work environment. Engelbrecht and Crisp (2010) argued that improving the organisational culture, and ultimately the performance of the health system, will require paying greater attention to promoting good leadership and management within and across all levels of the health system (i.e. national, provincial and local/district). In particular, these authors stressed the importance of improving management in health facilities, as well as HR practices and communication. Furthermore, the PMDS can play an important role in strengthening accountability and quality of care provided (Van Deventer & Mash, 2014).

This study aimed to understand nurse managers' perceptions of the current PMDS in relation to changes in their roles and functions as a result of the current health systems reforms in South Africa. More specifically, the objectives were to understand nurse managers' perceptions of what hinders optimal use of the PMDS, and what actions could be taken to enhance job performance and quality of care within the context of re-engineered PHC, NHI and ICSM.

A qualitative descriptive design was utilised. Through purposive sampling, a semi-structured interview tool was used to collect data from fourteen frontline nurse managers in four sub-districts of Dr Kenneth Kaunda District Municipality, North West province, South Africa. Data was analysed through thematic analysis.

7.2 Results

7.2.1 Characteristics of the sample of the study

Frontline nurse managers were chosen from 13 visited facilities. The distribution of participants according to each sub-district is noted in Table 7.1.

Table 7.1.

Participant Distribution per Sub-district

Name of sub-district	Current number of facilities (clinics/ CHCs)	Facilities visited (n=13)	Number of facility managers (FM) interviewed (n=14)	Percentage
Matlosana	17	6	4	28.5%
Potchefstroom (Tlokwe)	8	3	4	28.5%
Ventersdorp	3	3	2	14.5%
Maquassi Hills	8	2	4	28.5%
Total	36	13	14	100%

The socio-demographic characteristics of nurse managers who participated in the study are provided in Table 7.2.

Table 7.2.

Demographic Characteristics of Nurse Managers

Demographics	Nurse manager (n=14)	Percentage
Race		
African	12	86%
White	0	0%
Indian	0	0%
Coloured	2	14%
Gender		
Male	1	7%
Female	13	93%

Age		
20-30	1	7%
31-40	5	36%
41-50	7	50%
51-60 +	1	7%
Marital status		
Single	4	29%
Married	8	57%
Divorced	0	0%
Widowed	2	14%
Highest qualification		
Matric	1	7%
Certificate	1	7%
Diploma	8	57%
Advanced diploma	1	7%
Degree	2	14%
Postgraduate studies	1	7%
Years of experience		
0-5	4	28.6%
6-10	4	28.6%
11-15	6	42.8%
16-20	0	0%
20+	0	0%

As depicted in Table 7.2, the majority of the participants (n=12) were Black and female (n=13). Half of the participants were between 41 and 50 years old (n=7). Furthermore, most participants indicated either possessing a diploma in nursing (n=8) or a bachelor's degree in nursing (n=2). Just under half of the participants had 11-15 years' work experience (n=6).

7.2.2 Themes emerging from the study

Table 7.3 summarises the themes that emerged from the study. The main themes and sub-themes reflect the frontline nurse managers' perceptions of the current PMDS within PHC healthcare settings.

Table 7.3.

Themes and Sub-themes

Themes	Sub-themes
1. Understanding the need for performance management in healthcare	• PMDS: A managerial tool
2. Perceptions on the implementation of the PMDS	• A system issue • Inconsistency in application of the PMDS across sub-districts • Subjective measuring tool
3. Weak appraisal process	• Participation or obligation? • Setting performance standards • Providing performance feedback • Taking remedial action to improve performance
4. Outcomes: Organisational injustice and politics	• Fairness • Lack of funds • The exercise of copy-and-paste from previous reports
5. Improving performance and quality of care	• Managing human resources • Managing resources • Managing health reforms as facility manager • Providing management training on performance management • District management support • Enhancing quality of care

Each theme and sub-theme is discussed comprehensively below, with excerpts from participants. Excerpts are labeled according to participants' sub-districts and occupation, as indicated:

MFM = Matlosana facility manager

PFM = Potchefstroom (Tlokwe) facility manager

VFM = Ventersdorp facility manager

MHFM = Maquassi Hills facility manager

7.2.3 Theme 1: Understanding the need for performance management in healthcare

7.2.3.1 PMDS: A managerial tool

The importance of PMDS in a healthcare setting was understood by most managers as a positive tool that could assist them in identifying training and development needs; meeting strategic goals; and rewarding performance amongst nurses. This was communicated by thirteen nurse managers, as seen in some of the excerpts below:

> MFM2: *The main aim is to acknowledge people for their hard work ... Also to identify if there is any gaps, should there be any challenges or should anyone need training or assistance ... those certain things.*

The above participant recognises the role of the PMDS as an instrument to acknowledge hard work, and as a means of identifying specific development and training needs of staff.

The participant below focused mainly on the PMDS as a mechanism to distinguish nurses who are working from those who do not work regularly to meet performance standards:

> MFM3: *It helps us measure the performance of the personnel. Some of the personnels* [sic]*, will be hiding behind other people. So if we don't measure performance individually, we won't be knowing if they were doing what was expected of them or not.*

Some participants demonstrated understanding of how the PMDS may influence positive work attitudes such as job satisfaction, retention and 'organisational citizenship':

> MFM5: *It is important because it assists you to identify skills gap for yourself and subordinates. Plus, it improves job satisfaction, staff satisfaction. It assists with retaining of personnel and to do introspection at all levels of management within the department to see if you are doing things right.*

Several nurse managers mentioned the PMDS's main purpose was to reward outstanding performance:

> VFM14: *It is a tool that we can use as managers to manage the performance of our personnel as well as to award those who deserve to be awarded correctly.*

From the above narratives, most participants identified the role of the PMDS in administrative or development terms. Administratively, they mentioned the rewards incentive for outstanding performance and its influence on nurses' attitudes and work behaviour. Developmentally, they mentioned the role of the system as a tool for identifying gaps in training and development. None of the managers mentioned the strategic importance of the system outside of personal performance or its link to the provision of quality healthcare.

7.2.4 Theme 2: Perceptions on the implementation of PMDS

Three pertinent aspects emerged in terms of the perceptions of how the PMDS is implemented. These were i) issues with the PDMS system; ii) inconsistency in the application of the PMDS across sub-districts; and iii) the subjective nature of the measuring tool.

7.2.4.1 A system issue

Most of the nurse managers (12) shared great reservations about the current system, mentioning it was greatly flawed in its implementation:

> MFM1: *We are just given things and expected to do them as they are. We feel that if maybe they can come up with a certain strategy or system, a better one, because this one really, it is not being implemented in the correct way.*

Another manager expressed dissatisfaction with what was seemingly a lack of consultation when systems are implemented, and she further added that it was not implemented properly:

> MFM5: *There is still a lot of confusion on how to implement it … the PMDS is not well implemented.*

Another participant shared a negative viewpoint on the PMDS's usefulness and relevance:

> PFM7: *It is not relevant and it is not in any way assisting* [us].

With regard to the actual cause of dissatisfaction with the PMDS, a manager was explicit:

PFM9: *It's time-consuming, it's time wasting, it's tiring, it is so much work; we are writing so many pages.*

Furthermore, some managers argued that most professional nurses were unaware of the performance appraisal procedure, and the associated criteria, due to lack of training on the system when it was introduced. These views are articulated below:

PFM7: *I don't think they know ... the person will score themselves and then the manager will score and then that's it, but deeper* [more in-depth] *how it is done, we don't know.*

One manager felt that the reason for lack of knowledge was the absence of training on the system:

PFM9: *We never got training about the PMDS and what is expected.*

As reflected in the above quotations, managers highlighted that the PMDS was not properly implemented. Some managers failed to acknowledge the system's relevance and utility. Furthermore, other managers found the system to be time-consuming, and requiring extensive content, which was burdensome. Managers also mentioned professional nurses were generally unaware of the assessment procedure and criteria used during appraisal. The above concerns were exacerbated by the fact that most managers emphasised the lack of training on the system, which impacted on their knowledge of what is required from them.

7.2.4.2 Inconsistency in PMDS application across sub-districts

Five frontline managers expressed concerns related to the different PMDS tools used across different levels, as well as across different districts. This created confusion as illustrated by the inconsistent application across the sub-districts of Dr Kenneth Kaunda District:

MFM3: *One of my professional nurses, she was a transfer in from Potch district. She came in with a different type of PMDS that I don't know, one that* [requires] *just ticks, whilst we are expected to write a very long story ... So it is confusing me because I don't know if we are doing the right thing ... we are just in the dark.*

Similarly, different PMDS tools used at district hospitals, community health centres and clinics also created confusion. One manager commented as follows:

VFM14: *The hospital has been degraded to a CHC* [community health centre]. *I was in the moderating committee. If you compare their work plans and us, their scoring is*

much simpler compared to us. For us, because we at PHC and our people are doing more work, so our work plans and job descriptions are more intense.

7.2.4.3 Subjective measuring tool

Most of the nurse managers generally perceived the current performance management tool as susceptible to subjectivity:

> PFM8: *It depends on how you write and how your writing convinces. So, you can be a hard worker but if your writing does not convince, then it means nothing. You won't get anything.*

The above managers reported that those who get recognition or rewards are those who are able to express themselves well in writing on the performance review form. Therefore, those who are rewarded are not necessarily those who perform well but rather those who are able to articulate and justify themselves in writing. This salient aspect is further confirmed by the manager below:

> PFM9: *She is writing the opposite* [of what she does]*, so that is why she is forever receiving bonuses. But the people who are working very hard are not getting anything and it is because, although those people can read and write, but they are not expressing* [themselves] *or they do not have proof, because when you do the PMDS, you have to have proof.*

Another manager mentioned further that the tool is dependent largely on the interactions between the frontline manager and nurse:

> VFM4: *If I am the buddy of someone in management, then I get a better score than the other personnel.*

Subjectivity is also evident in the relationship between the moderating committees and the frontline manager; it appears there is frequently no solid basis for assessment results:

> MHFM11: *PMDS favours some people, and others it doesn't favour. It favours those at top management; they are the ones that get the money.*

Ultimately, the above narratives collectively suggest an inconsistent and inaccurate system; thus, it is vulnerable to grievances for lack of standardisation across the district, and lack of fairness and impartiality.

7.2.5 Theme 3: Weak appraisal process

This theme addressed views on how performance is appraised and under-performance is managed within the health district. One of the central aims of managing performance is ascertaining performance areas and identifying remedial steps to be implemented to eliminate factors which hamper the employee's performance. Managers communicated their views on this process in the following sub-themes: i) unwilling participation in the PMDS; ii) setting performance standards; iii) providing performance feedback; and iv) taking remedial action to improve performance.

7.2.5.1 Participation or obligation?

Six nurse managers were of the view that the PMDS was seen as a work demand rather than a process that could be beneficial for improving services, as well as for their own development. Due to this, some managers and nurses see no value in participating in the PMDS and so refuse to do so. A manager cites verbatim a response from a nurse:

> MHFM10: *"No, I'm telling you that I am no more going to write the PMDS report. I am working so hard and I am just wasting my time by writing the report when I don't benefit anything."*

Managers across all the sub-districts indicated that nurses did not want to participate as they could see no tangible benefit for themselves. They reported that some nurses even refused to submit reviews and had to be issued with threats of disciplinary action against them should they not submit immediately:

> PMF7: *They don't like it but they are just writing for the sake of not getting a warning as a discipline.*

Some frontline nurse managers were also hesitant to participate in the PMDS themselves:

> MHFM11: *I once wrote a letter stating I don't want to write the PMDS anymore and I was told by the district manager herself that, "No, you have to write it".*

Seemingly, in cases where nurses/nurse managers resisted participation in the PMDS, they were reminded of the consequences.

7.2.5.2 Setting performance standards

An integral part of managing performance is setting performance standards that are clear and understood by all subordinates. A good PMDS involves staff in this process in the form of personal development goals and goal-setting. When nurse managers were questioned if they believed performance standards were understood by all professional nurses, one nurse manager revealed that:

> FM3: *They are understood, the ones we develop, because immediately when we develop the performance standards for each category, we sit with them so they do understand their performance. Because it's linked to APP* [annual performance plan] *target, the sub-district APP targets.*

However, another manager disagreed with this view:

> FM11: *No, we not, we are just given…*

Importantly, the nurse manager below reported awareness of performance standards to a certain extent and felt that standards are set at a facility level:

> FM13: *I have seen from the previous one* [appraisal] *is that most of them were assessed in terms of the facility; so if the facility is not performing, then the high performing individuals will be downgraded.*

Clearly, there are mixed views on setting performance standards, and how these related to sub-districts' annual performance plans.

7.2.5.3 Providing performance feedback

To facilitate monitoring and evaluation of performance, nurse managers must be equipped with the skills of providing effective performance feedback. The credibility and utility of performance feedback determines if those provided with feedback use it to improve performance and change behaviour. A majority of nurse managers declared performance feedback is not provided, and, in cases that it is, it is not provided properly:

> PFM6: *Feedback on performance is given; because of our workload, there isn't always a time that you can give maybe proper feedback.*

The feedback specifically provided by HR is cited:

PFM9: *They will be receiving letters from HR saying they will be getting a performance* [bonus] *on their PMDS and if you did not receive a letter, then you must know that you are not going to receive anything.*

When explored further if nurses are provided with the opportunity to query results, the manager below asserted:

FM13: *They are not given an opportunity.*

Many nurse managers shared their difficulty with providing feedback because they themselves do not receive feedback from the moderating committee after the review process has been moderated:

MFM1: *There is no feedback because normally they have to after presentations, but we are told that we have to sit with our manager* [area manager] *and give her feedback, but it is not happening.*

One manager highlighted how the lack of feedback from the area manager and the district affects progress:

VMF4: *There is not really a review; they don't call you in and talk to you and say that, "Ok, this is the gap I found and let me assist you to improve".*

The above narratives indicated that the majority of the managers mentioned that feedback is not adequately provided, and nurses are not provided with any opportunity to engage with managers concerning their results. They reported that HR provides a letter as a form that indicates whether or not one has received a bonus.

7.2.5.4 Taking remedial action to improve performance

Following the appraisal process, and after identifying under-performance, the participants were questioned on how they managed this process. The majority indicated that there were few opportunities for training to close identified skills gaps, and, although there is career development to some extent, the PMDS was not used as tool for identifying those who required training. This was evident in the following statements:

MFM1: *When people have to be sent for training, they don't prioritise those people who need it; they just take* [those who require training]. *They are the ones who are supposed to be prioritised whenever there are trainings.*

The manager below shared her perceptions on a contributing factor to poor performance:

> PFM9: *Some people are not performing because they feel that they are not being developed. And they are not given valid reasons as to why they are not being developed, because they have been here for a long time.*

The above narratives confirmed that the majority of managers maintained that insufficient remedial action exists to improve performance. In cases where nurses are trained, it is generally not linked to the PMDS and their training needs.

7.2.6 Theme 4: Organisational injustice and politics

This theme addresses perceptions and experiences of perceived organisational injustices and other forms of organisational politics in performance management processes and practices that are viewed as outcomes of the mismanagement of performance. The identified sub-themes included: i) fairness; ii) lack of funds; and iii) the exercise of copy-and-paste from previous reports.

7.2.6.1 Fairness

When questioned on whether evaluating and measuring staff is fair, eleven nurse managers reported the PMDS as an unfair system:

> MFM1: *There is no fairness in PMDS.*
> MFM2: *… just look at the facilities situation … the service area has increased over the past five years and has like tripled in size of the patient population, without* [numbers of] *staff being relooked, so how can it be fair?*

These managers cite how an unfair PMDS process and system compromise the situation. The manager below viewed lack of fairness as the result of lack of standardisation of the measure:

> VFM14: *The tools we are measured in are not standardised, they are not the same. So we don't have a way of verifying that* [it is fair].

7.2.6.2 Lack of funds

Some nurse managers referred to the role of the NWDoH financial budget in the administration of pay progression and performance bonuses. They suggested that, at times due to lack of funds,

nurses will not receive bonuses regardless of their performance. The participants articulated the lack of finances as a great barrier to incentivising outstanding performance:

> MFM1: *I think this is unfair because sometimes you will be told before being presented that there is no money. They are already telling themselves that we are not going to be giving the bonuses, even if you have worked very hard. But, because of financial concerns they are having, you won't get anything.*

Some nurse managers referred to the process as an unnecessary and futile exercise if funds are unavailable. This participant then questioned the legitimacy of the PMDS as a tool to reward outstanding performance. As a result of lack of funds, few people are awarded bonuses, as established below:

> MFM1: *Few people get bonus ... the ones at the offices, the facility managers and other managers will be the ones that will be getting the bonuses.*

Another manager also confirmed inconsistences:

> MFM5: *It demotivates the colleagues; you have been working, all of us come on duty to work here and then only one person amongst them will get the bonus.*

Evidently, from the narratives above, the financial constraints experienced at district level influence the distribution of rewards.

7.2.6.3 The exercise of copy-and-paste from previous reports

The narratives below on the practice of recycling previous reports suggest it is prevalent; this ultimately demonstrates a malpractice that has become a norm and that is against the objectives of the PMDS. This practice is exacerbated by lack of frontline management control over this practice. More than half of the participants mentioned this problem. A manager mentioned herself experiencing extremely different results although submitting the same content, and she questioned the lack of consistency in what is expected each year:

> MFM3: *Because this year you will write this way, the panel will tell you that, it's ok. The following year you will copy from the previous year and they will tell you that, you will be writing the very same way, the very same thing that you wrote the previous year, and then they will be telling you that it's the wrong way.*

Such procedural inconsistency and contradiction was noted as being rewarded:

MHFM11: *That year they decided to give me* [a performance reward]*; it is* [the] *very same report.*

The habitual pattern of submitting the same reports each year without any effort is also declared below:

MHFM13: *Now since people are not motivated, they just cut and paste because they don't know the importance of PMDS.*

Another related aspect of this practice is demoralisation since managers are aware of this practice, but still accept submissions from the previous year.

VFM14: *And also with being demoralised, a lot of nurses are now saying even facility managers, that they know that a lot of the nurses are copying and pasting from the previous year, and it just goes through.*

7.2.7 Theme 5: Improving performance management and quality of care

In order to improve performance management and the provision of quality healthcare, numerous factors act as facilitators or barriers to these objectives. According to nurse managers, the organisational factors that have influenced how performance is managed and quality of care include: i) managing human resources; ii) lack of resources; iii) managing health reforms; iv) providing management training on performance management; v) facility managers' relationship with district management; and vi) enhancing quality of care.

7.2.7.1 Managing human resources

More than half of the participants reported how the shortage of staff in facilities impacted on staff morale and quality of care. The following statements support these perspectives:

PFM7: *How do you improve quality when there is shortage of staff? The biggest challenge is the number of patients that you see versus the staff.*

This problem was further aggravated by staff turnover and poor retention of professional nurses at the district:

MHFM13: *The shortage of staff is because their morale is very low … most of them, they go outside for greener pastures.*

Similarly, other contributory factors were cited:

MHFM12: *Job satisfaction and money ... people go for money; they go for greener pastures. They are going to the private because our work is too much.*

Lack of staff influenced a realistic articulation of district plans for healthcare, which had a direct impact on facilities.

7.2.7.2 Managing resources

Managers mentioned the need to strengthen the provision of health resources in order to improve the provision of quality care and overall facility performance.

PFM9: *Managing a 24-hour facility is the biggest problem, and you have a shortage of professional nurses and there is no equipment.*

This was also confirmed by other managers:

PFM7: *Shortage of equipment; they are not doing anything about your resources.*

Managers thus reported shortage of resources as a persisting factor that impacted on managing the facility to ensure quality of care.

7.2.7.3 Managing health reforms as facility manager

Most nurse managers accepted the need for health reforms such as re-engineered PHC, NHI and ICSM and admitted that the value of these reforms in improving quality of care is indisputable. However, some expressed reservations on the training staff receive for reforms, as seen by the words of the manager below:

MFM1: *In this area, for PHC, only one professional nurse from this clinic should go; after each year it will be another. They are not sending people from individual clinics; it's one per area, of which it delays* [implementation].

The manager above shared concerns about the rate at which training is received per facility. Due to shortage of staff generally, a single professional nurse is taken for training and that nurse becomes the champion on the training they received. However, this does not always work as intended.

Other managers expressed satisfaction with training received for career development and enhancing nursing practices in response to health reforms. However, some cautioned against the lack of monitoring and evaluation of the impact of training:

> MFM5: *We need to do auditing in our facility, and to be very serious with auditing because we cannot go train, every time in-service training and not checking the impacts of the very same trainings, the in-services and workshops we have attended. When the auditing is done, we can check if we are on the right track.*

These managers both indicated the need to manage staff and the process of staff development during the period of reform.

7.2.7.4 Providing management training on performance management

Across all sub-districts, nurse managers reiterated the need for training on the performance management system. Although some managers had attended training, it was brief and thus did not comprehensively explain the PMDS. Comments that attested to this included:

> MHFM11: *We have never been trained on it; we just told to write and present.*

Managers who had attended training were not satisfied, for reasons stipulated below:

> MFM1: *When it was introduced, I think it was 2001 or 2002; after that I haven't gone under any training on PMDS. Even the newly employed people, during the induction and orientation, they have to explain thoroughly. They don't give an in-depth training on PMDS.*

However, one participant acknowledged training, although the nurse manager below commented on the existing gaps:

> PFM6: *We all go for the trainings, including all the categories, but it is like they still cannot link what was expected from them and the PMDS process. There is still a gaps* [sic].

The above narratives emphasised the need for consistent training on the PMDS, so that the system is understood across the district by all categories.

7.2.7.5 District management support

More than half of the nurse managers mentioned lack of district management support in matters relating to the facility. These opinions are illustrated as follows:

MHFM10: *Within the management, there is no support, and if there is no support, how am I going to support the staff in the facility?*

Another manager confirmed the lack of support, and also reported that when she required assistance from her management team, there was no assistance, and this was more pronounced with PMDS-related issues.

PMF9: *Some of the challenges, they will leave it to you to manage and then you will feel like but here, "I need the support of my local area manager or the sub-district manager". But they won't be there to support you, especially when it comes to the PMDS.*

The role of district management in supporting the PMDS processes seems unclear. With that said, the lack of support from district management is apparently clear.

7.2.7.6 Enhancing quality of care

Nurse managers offered recommendations in order to enhance quality of care, as illustrated below:

MHFM12: *They should maybe have a new clinic; they should build clinics and then hire more nurses.*

The above narrative mentioned improving on infrastructural and human capacity. Another manager discussed the nurse-patient ratio and its impact on the provision of quality health services, as well as the acceptance of such a situation by the professional body:

MFM2: *The biggest challenge here that affects quality is staff shortage. People are overburdened. If I have to see 80 patients instead of the 40 that the South African Nursing Council is approving of, what is happening to quality?*

Another manager mentioned the need to recognise good performance, identify training needs and ensure appropriate training. This manager added issues of staff attitudes and teamwork:

VMF4: *Do something good that improves the quality, give praise and say, "Thank you, I see and I acknowledge what you are doing". We must first see where the lack of knowledge is. People that need training must be sent for training. Teamwork and staff attitude, that's a big problem.*

The nurse manager below also specified the need for career development, training and increasing the staff complement as enablers of quality care.

> PFM8: *That quality improvement comes with trainings. You cannot just say people must improve, but you are not training them. And there must be opportunity for growth. Yes, because if there is more staff, the waiting time will be reduced. Then you will have time to sit with your patient.*

There is general consensus across managers on improving quality of care. Participants expressed the need for an effective PMDS that manages under-performance, provides regular training and provides the necessary human and equipment resources.

7.3 Discussion

The findings of the study on frontline managers' experiences and perceptions on performance management indicated that a majority of participants were dissatisfied with the current PMDS. Frontline managers viewed the PMDS as a potentially useful managerial tool if used correctly, as it could assist in identifying poor performance, employee training and development needs, and rewarding good performance. Further, managers saw the potential for the PMDS to promote positive work outcomes such as job satisfaction, improved employee retention and job commitment. However, participants consistently emphasised dissatisfaction with the implementation of the PMDS. This is consistent with the findings by Lutwama et al. (2013), who reported the negative impact that is caused by inconsistent and inaccurate performance management systems.

In identifying the PMDS as a managerial tool, most participants noted its usefulness in an administrative and development capacity, rather than in terms of setting strategic objectives and a shared vision towards improving quality of care. Imperative to setting performance objectives is a shared understanding of how individual, team and facility performance is linked to district and national health performance indicators, as well as to overall improved health outcomes (Du-Plessis, 2015; Mone & London, 2018). This is not the current case at Dr Kenneth Kaunda District.

In relation to how the current PMDS is poorly implemented, the findings highlighted several aspects. Some managers expressed there was no consultation with frontline managers and, due to this, nurse managers are not happy with the system, labelling it as useless and irrelevant.

The value of employee participation in the design and implementation of a PM system is confirmed by Steers and Lee (1982), Saravanja (2010) as well as Choudhary and Puranik (2014). These authors argued that increasing employee participation in the design and implementation of PM initiatives is essiential to the success of the system as it increases employee acceptance and support of the system (Lee & Steers, 2017; Saravanja, 2010).

Similarly, one of the greatest challenges faced by nurse managers is lack of interest by nurses in participating in performance review and feeling like they have to force nurses to complete the appraisal by threatening to take punitive action against them. Chandra and Frank (2004) reported there is a need to create a conducive environment for employee involvement, that is, an environment where employees feel free to rate themselves honestly, based on their performance. Boachie-Mensah and Seidu (2012) also stipulated that lack of involvement of employees in the implementation phase of a PM system contributes to negative perceptions on the system and thus, yields negative attitudes and behaviour. Therefore, for effective evaluation and management of performance, participatory performance appraisal is essential and indeed more effective. Nurse managers should facilitate employee involvement. Factors that prevent effective participation include lack of training, accountability and frontline managers' resistance.

In addition, nurse managers expressed that the main source of dissatisfaction with the PMDS was that it is administratively burdensome, and they found it time-consuming and requiring extensive content. This is in contradiction with the guidelines provided by the Department of Public Service and Administration on the EPMDS (Republic of South Africa, 2007), which indicates that the principles of EPMDS include that "performance management procedures should minimise the administrative burden on supervisors while maintaining transparency and administrative justice" (p. 10).

Moreover, most nurse managers indicated that they were not aware of the performance appraisal procedures and the associated criteria of evaluating performance; this was largely due to lack of training on the system when it was introduced. Again, this is in contradiction with the EPMDS guidelines that stipulate the need for training key role-players in order for the PMDS to be successful (Republic of South Africa, 2007). Indeed, training on the PMDS is imperative to its success as a legitimate system. Frontline nurse managers, in particular, need training on how to implement the system, how to ensure that training and development needs

are adequately identified, and they need to be provided with information that allows full participation in the processes. The above must be done with the support and cooperation of the Human Resources Department (HRD) unit in the department (Republic of South Africa, 2011). Lack of training on the PMDS has contributed to inconsistency in its application across sub-districts and subjectivity in applying the measuring tools. Training of frontline managers should cover the mechanics of the system and other influential contributors such as communication, problem-solving and conflict management.

A majority of nurse managers reported that performance feedback is not provided to nurses; most nurses indicated feedback is provided in the form of a letter apprising nurses whether or not they have received any form of reward. The reasons for low scores are generally not discussed and, furthermore, nurse managers reported that nurses are not given an opportunity to query their performance. This was not unique to the relationship between nurses and nurse managers, but was also apparent in the relationship between the nurse managers and district managers. Roberts (2003) highlighted that performance appraisals require employee feedback to be effective. Therefore, in order for appraisals to be effective, there must be ongoing formal and informal feedback. Earlier, Steers and Lee (1982) identified that key to this is an increase in the flow of information throughout the process. Appraisals are only effective to the extent that they provide useful and valid information concerning employee performance. Feedback must be constructive in order to facilitate positive outcomes for evaluation, guidance and motivation (Saravanja, 2010). This is driven by the nurse manager who, as mentioned before, must be trained in facilitating this process. Ongoing feedback is one of the ways in which a nurse manager is able to take remedial action to improve performance (Public Service Commission, 2007).

As is often inherent in PM systems that are highly contested, nurse managers indicated that the PMDS outcomes were generally negative. A majority of those who participated in the process did not believe it was fair, transparent or impartial. Some nurse managers implicated lack of funding as a crucial element to performance evaluation, and this was a legitimate barrier to incentivising outstanding performance. The above has resulted in many nurses losing interest in the PMDS and its benefits. Retaliation against the system is visible, as many nurses do not complete their review on time; nurse managers are also aware that some nurses (and managers) recycle previously submitted appraisals and do not put effort into honestly participating in the rating of their performance.

Such inconsistencies and their impact on accountability, good performance and efforts towards improved quality of care are identified by authors such as Skinner et al., (2017), who investigated the impact of perceptions of injustices in nursing. These authors found experiences of injustice and unfairness negatively impacted on the performance and personal health of nurses. Mone and London (2018) mentioned nurse managers are the key drivers of the organisational climate, through their potential for openness, and for creating an environment that is supportive and friendly, and where professional ethics are supported.

A culture of accountability and openness is driven by nurse managers being supported by district management; without this, PM systems often fail (Lowe, Plummer, & Boyd, 2018; Lutwama et al., 2013). This study found that more than half of the nurse managers mentioned lack of district management support in matters relating to the facility. Saravanja (2010) argued that lack of support from top management on practices such the PMDS impedes any efforts towards improving performance. Swaartbooi (2016) also confirmed the need for improved managerial support at all levels to create positive health outcomes, including improved quality of care.

The findings of the study indicated numerous factors that may be facilitators or barriers to improved performance and quality of care. Nurse managers mentioned that shortages in human resources impacted greatly on staff morale and quality of care. The shortage of healthcare workers is not a surprise in SA's public health system (Naidoo, 2012; Pillay, 2009). This is further aggravated by high turnover and poor retention of professional nurses in South Africa (Mokoka et al., 2010). Nurse managers also mentioned the need to strengthen the provision of health resources in order to improve the provision of quality care and overall facility performance. Martinez and Martineau (2001) found resources influenced the extent to which staff are able to perform; therefore, health systems must consider challenges unique to each system's context, and the impact on performance of having limited resources. Performance standards must be set, based on realistic reflection of obstacles that may hinder progress, be they lack of human or material resources (Martinez & Martineau, 2001).

Thus, enhancing quality of care requires improving infrastructural and human capacity, motivating staff and enhancing teamwork. The nurse managers mentioned a need for greater emphasis on career development, and on training and increasing the staff complement, as

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enablers of quality care. There was general consensus across participants on improving quality of care, where participants expressed the need for an effective PMDS that manages under-performance, provides regular training and provides the necessary human and equipment resources.

7.4 Implications for nursing management

The role of the frontline nurse manager in PHC settings is incontestable. As managers are at the bottom of the three-tier health system, they are generally accountable to the community. With that said, district-level nurse managers face different challenges and require unique strategies to manage performance and improve quality of care.

It is without doubt that an effective performance management and development system requires a synergy between the PMDS and other managerial processes, as well as with the national strategic health objectives. It is also important that the PMDS is re-evaluated to identify system challenges in its implementation. Tools used for the PMDS must be designed to address a particular need. The review must include key role-players, especially future users. The review must be consultative and interactional in nature. Those who participate in the design must be experts in both performance management and using PM systems in the healthcare setting. Those involved must consider current health reforms and should question the validity of the current system, in line with the reforms and their objectives.

As the core implementer of the PMDS at facility level, nurse managers must be trained efficiently to understand the context of performance management in the health sector, setting performance expectations, effective performance appraisal, and providing ongoing feedback. This is to ensure that performance decisions are accurately identified, under-performance is managed appropriately, and outstanding performance is recognised and rewarded fairly.

7.5 Chapter summary

Although there is a Performance Management and Development System developed by the Department of Public Service and Administration, its implementation is questionable as it is characterised by complaints of unfairness, bias and mismanagement. The role of the nurse manager is to effectively manage performance and this role is seemingly compromised. Nurse managers communicated a good understanding of the need for the PMDS as an effective managerial tool. However, issues with the system's implementation and application impede its benefit.

CHAPTER 8

INTEGRATIVE DISCUSSION AND CONCLUSION

8.1 Introduction

The value of managing performance of healthcare workers through a performance management system has been vastly investigated globally, more so, the use of performance appraisals. Perceived purely as a managerial tool, PM systems, when developed and implemented correctly, are often praised for contributing to job satisfaction, motivation and engendering positive staff attitudes towards the organisation. In healthcare, PM systems are linked to improving service delivery through promoting accountability on the part of healthcare providers and improving the provision of quality healthcare services. In this doctoral thesis, a scoping review of global literature on performance management methods and practices was first conducted. Following this, a mixed-methods research study was conducted for the purpose of assessing the implementation of the Performance Management and Development System (PMDS) amongst professional nurses in primary healthcare settings in one of the NHI pilot district in South Africa. The goal of the study was to understand nurses' perceptions and experiences of the implementation of the PMDS and how it influences job performance and quality of care within the context of the current health systems reforms in South Africa.

Each phase of this doctoral thesis has been undertaken as a discrete study that has been written up as a series of journal articles that are under submission and are reported in separate chapters of this thesis:

- A systematic scoping review mapping evidence on performance management methods and practices amongst nurses in PHC settings – Chapter 3.
- A quantitative research study on the evaluation of the implementation of the PMDS by professional nurses in PHC settings in Dr Kenneth Kaunda District – Chapter 5.
- A qualitative study on nurses' perceptions and experiences of PMDS amongst nurses in PHC settings in Dr KK District – Chapter 6.
- A qualitative exploration of facility managers' experiences of the PMDS and its influence on human resources outcomes in PHC settings in Dr KK District – Chapter 7.
- Discussion to highlight strategies to address key challenges of the PMDS and improve HR outcomes in Dr KK District – Chapter 8.

This chapter provides an integrative discussion of the findings of these discrete studies in order to address the overall aim of the thesis, which was to evaluate the Performance Management and Development System in an NHI district in South Africa and its impact on quality of care amongst professional nurses and frontline nurse managers within the context of the current health systems reforms of re-engineered PHC, NHI and ICSM. Limitations of the overall thesis are also outlined in this chapter. This chapter concludes with recommendations for interventions as well as suggestions for future research. A table depicting the overall synthesis of the study findings is presented in Table 8.1.

Table 8.1.

Synthesis of Research Conclusion and Recommendations

Objectives	Data utilised	Conclusion	Recommendations
1. To map existing evidence of the influence of performance management (PM) methods and practices on quality of care amongst nurses in primary healthcare settings.	Scoping review presented in Chapter 3.	• Poor implementation of PM has been found to impact both directly and indirectly on quality of care. • There exists substantial evidence that suggested that PM and appraisal systems are contested worldwide. • These systems are accepted as effective when they are relevant, valid, free of bias and accepted by users (Cardy & Korodi, 1991; DeNisi & Murphy, 2017). • There is no agreement on universal best methods for assessing and managing performance of nurses specifically. However, there is evidence of best practice on managing performance and on	• Further research on international best practices on PM is needed. In particular, there is a need for research on the continuous engagement of PM activities as a mechanism to assist meet PHC objectives. • There is a need for further investigation on incentivisation of nurses – in particular, a comparison between non-financial and financial incentives for good performance. • Research on interventions centred on PM and development systems in PHC settings is needed, such as the impact of setting performance goals, team-based performance and providing feedback on performance and quality of care. This is particularly the case for LMIC settings.

		characteristics of effective PM systems (Heather et al., 2018).	

2. To conduct a survey on the implementation of the Performance Management and Development System at Dr Kenneth Kaunda District.	Quantitative data results presented in Chapter 5.	• The findings indicated the PMDS has been implemented to some extent.
		• The major flaws highlighted in its implementation threaten its usefulness as a managerial tool.
		• Negative perceptions of the PMDS's fairness and objectivity emerged.
		• Nurses were ambivalent on participation in setting performance standards, feedback received post appraisal and lack of remedial action to improve performance for under-performing staff.
			There is a need to:
			• Assess organisational readiness for a PM system.
			• Facilitate a performance-based culture established under principles of openness, professional work ethic and accountability.
			• Establish key gaps in implementation across districts.
			• Re-evaluate the current PMDS to ensure it is aligned with the current health systems reforms. This re-evaluation should:
			  • Allow for input from all those who are subjected to the current PMDS.
			  • Link PMDS with patient-centred indicators and measures of quality of care.
			• Improvement is required in all PMDS processes. These include: accurate job analysis, clear and communicated performance standards and indicators, ratees' awareness of performance

reviews, feedback on performance and managing under-performance effectively.

3. Qualitative objectives.

3.1 To understand nurses' perceptions and experiences of the current Performance Management and Development System within the context of re-engineered PHC, NHI and ICSM.

3.2 To understand frontline nurse managers' perceptions and experiences on the current Performance Management and Development System within the context of re-engineered PHC, NHI and ICSM.

- Qualitative data results for professional nurses' presented in Chapter 6.
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- Qualitative data results for frontline nurse managers presented in Chapter 7.

- There exist various loopholes in the implementation of the current PMDS which threaten the accuracy and transparency of the system. This promotes perceived organisational injustice and unfairness.

- Nurse managers currently object to the PMDS at PHC. Managers shared great concerns against discrepancies in the PMDS implementation, the appraisal processes and managing its outcomes, such as providing feedback and rewarding good performance. Furthermore, facility managers admitted the system is

- The current PMDS should be aligned with current health systems reforms towards comprehensive care and the provision of quality of care.
- It should be more participatory.
- Training is recommended for nurses as ratees, as well as written guidelines to promote standardisation of implementation of the PMDS.
- There should be greater openness and transparency through improving opportunities for appealing performance decisions.

Training of nurse managers in the following:

- The purpose of PMDS, how to motivate participation and best practices;

		prone to counter-productive practices such as favouritism, subjectivity and unfairness. Therefore, at present, the system does not serve as a managerial tool; thus, its value is not optimised – instead, it causes division and friction amongst colleagues.	• Effective leadership including soft skills such as communication, interviewing, providing feedback and conflict resolution; • Managing change in relation to current health reforms.
3.3 To understand nurses' attitudes towards the Performance Management and Development System within the context of current health systems reforms.	• Qualitative data results for professional nurses' presented in Chapter 6.	• Nurses reported feeling mostly discouraged by the financial incentives given to a selected few, and the processes followed to determine those 'deserving' was questioned. Nurses indicated the PMDS impacted negatively on job satisfaction and team spirit, and exacerbated organisational politics. Interestingly, nurses did not oppose the PMDS outright, and saw the potential value of it, if implemented correctly.	For nurses and nurse managers: There is a need for professional nurses and facility managers to regain confidence and ownership of the PMDS as a system designed to assist them. As recommended above, there is a need for greater participation and training to achieve this. For nurses: It is recommended that performance planning and goal-setting be used to identify training needs for professional development so that HCPs are better equipped to deal with complex patient needs.

3.4 To understand frontline nurse managers' attitudes to how performance is evaluated within the context of current health systems reforms	• Qualitative data results for frontline nurse managers presented in Chapter 7.	• Due to its poor implementation, the PMDS at present does not encourage frontline nurse managers to fully utilise the process of managing performance. So managers continue to encourage nurses to participate in appraisals, regardless of their own opinions on the system failing to do what is intended.	For nurse managers: Training policy and written guidelines are needed to improve frontline managers' capacity to implement the PMDS fairly and in a standardised way at a facility level.
3.5 To explore nurses' views on what hinders performance and quality of care within the context of re-engineered PHC, NHI and ICSM.	• Qualitative data results for professional nurses presented in Chapter 6.	• Findings indicated organisational factors beyond individual factors impeded performance outcomes, for example, shortage of staff, lack of equipment, overpopulated clinics and poor working conditions. In light of these factors, nurses were reportedly not motivated to participate in the PMDS. • Over-emphasis on quantitative targets (e.g. 500 pap smears per facility) overshadows any hope for	For both nurses and nurse managers: • Performance indicators should include 'qualitative indicators' such as measures of patient-centred care and quality of care, to reflect the current health reform and its objectives. • Government should prioritise providing adequate resources to health facilities at PHC settings. • Greater managerial and leadership capacity is necessary to oversee PHC facility progression and performance. There is a need to capacitate the existing management structures with leadership qualities necessary for the task.

quality care. Nurses admitted they push the queues, and so patients'unique needs or patient-centredness is overlooked.

- Nurses also mentioned organisation/structural factors such as the need to increase staffing, lack of resources and lack of managerial support as acting as barriers to quality care.

3.6 To explore frontline nurse managers' views on what hinders performance and quality of care within the context of re-engineered PHC, NHI and ICSM.	• Qualitative data results for frontline nurse managers presented in Chapter 7.	• Nurse managers identified key barriers to improvement in performance and quality of care as poor infrastructure and human resource capacity. Managers expressed great concern on nurse-patient ratios doubling and sometimes tripling the ratio approved by the South African Nursing Council. Managers shared concerns of poor staff attitudes and

lack of teamwork. They admitted poor performance management has contributed to the inability to manage under-performance and provide training as and when needed.

3.7 To identify nurses' suggestions on improving the quality of services and job performance within the context of re-engineered PHC, NHI and ICSM.	• Qualitative data results for professional nurses presented in Chapter 6.	All the above-mentioned recommendations would assist improve how performance is managed so as to increase job performance and motivation, as well as improve the quality of services at PHC level.
		
		 Ideal outcomes:
		 • Re-evaluation of PMDS at all PHC facilities;
		 • Participation of all users at individual, group and organisation level in:
		     • Setting performance standards;
		     • Clear and well-communicated performance expectations;
		     • Performance planning and agreement phase implemented to the satisfaction of all parties;
		     • Continuous performance monitoring, review and assessment;
		     • Clear written guidelines on performance management and the performance moderation process;

		• Effective performance appraisals, guided by written guidelines and trained support structures;
		• Immediate and constructive performance feedback at individual, group and organisation level.
		• Clear reward system – financial and non-financial incentives;
3.8 To examine frontline nurse managers' suggestions on improving the quality of services and job performance within the context of re-engineered PHC, NHI and ICSM.	• Qualitative data results for frontline nurse managers presented in Chapter 7	• Systems evaluation and review conducted every three years to determine if the PMDS is functioning effectively and appropriately to advance current health systems reforms that include creating a service-orientated culture;
		• Increasing staff motivation, job satisfaction and overall attitudes towards performance management;
		• Creating training workshops on the PMDS for all users with refresher courses every three years;
		• Training on the PMDS from induction so that all staff are aware of what the PMDS is and its purpose;
		• Link performance indicators with PCC and quality of care measures to create a better fit with health reforms (i.e. re-engineered PHC, NHI and ICSM).

8.2 Findings per objectives

Objective 1: To map existing evidence on the influence of performance management (PM) methods and practices on quality of care amongst nurses in primary healthcare settings.

The scoping review revealed performance management methods and practices had the potential to promote improved quality of care, directly and indirectly. Directly, methods include linking PM methods and practices to national health objectives and continuous monitoring and review of healthcare providers' performance in relation to these set objectives. Countries like the UK linked PM methods and practices to professional development, as stipulated by the National Nursing Council, and so used the process to determine nursing competences for practice nursing. Although there is a strong developmental component to practices such as revalidation, there are also legal repercussions for those who fail to demonstrate evidence of development.

Indirect methods have linked PM systems to HR outcomes such as job satisfaction, motivation and turnover intention. The findings on existing evidence reviewed in the scoping review (Chapter 3) revealed that poorly implemented appraisal and PM systems were generally contested by users worldwide and were only accepted as effective if they were perceived as relevant to professional development and improving nurses' competencies. Moreover, they were accepted by users when they were considered to be free of bias and mismanagement. This is consistent with the PM system review (in Chapter 2), as well as findings from the qualitative studies (Chapters 6 and 7).

The findings of the scoping review revealed that much published research on PM systems focused on practices (that is, effective versus ineffective practices), while a few included studies that provided specific methods for PM. Furthermore, from those that focused on methods of assessment, a few of the included articles provided a critical analysis of the methods used. The most popular methods discussed were the strengths and weaknesses of peer reviews and self-evaluations. Various authors (Aird et al., 2016; Durcho et al., 2016; Horman et al., 2014) contended that there was a lack of focus on the actual methods used in PM systems in healthcare settings; this was due to contextual factors that should be considered in advocating for one method over another. Secondly, the type of method used is also influenced by the purpose of the PM system in that particular country (DeNisi & Murphy, 2017). Therefore, the focus is not on the method used but rather on if the method used is accurate in measuring performance and/or is accepted by users. This was also mentioned in previous chapters (2, 5, 6 and 7); effective PM systems must be considered fair and accepted by their users. If this is

not the case, the system is jeopardised and proven to impact negatively on nurses' motivation, well-being and the provision of quality care.

Objective 2: To conduct an evaluation by nurses at Dr KK District on the implementation of the PMDS.

The findings of the quantitative study revealed performance management was implemented to some extent. However, it was found to be flawed in its implementation, with participants indicating gaps in the nurses' awareness of performance expectations at district and national level. A majority of nurses indicated that there is a lack of communication on performance standards, and to exacerbate this problem, they were not provided with opportunities to participate in setting performance standards. Noticeably, the importance of a PM system that has clear written guidelines about what is expected from employees and how these expectations ought to be met, as well as a PM system that is open and transparent to its users, was mentioned in Chapter 2.

These results suggest that nurses did not feel included in decisions regarding setting performance standards. This is in direct contradiction of the first phase of the PM cycle, which is the performance planning and agreement phase. In this phase, nurses together with their line managers are meant to discuss jointly in planning performance, so to ensure clear and well-communicated performance standards. Therefore, this phase is an integral component of planning performance and forms the basis for later performance appraisal and review. The notion that well-communicated performance standards, well-developed performance measurements, and a regular reporting and feedback system are crucial elements to a good PM system, is also depicted by the conceptual model used by this study (in Chapter 2). Poor planning and agreement may be the reason for nurses' lack of awareness on the process used to measure performance and their expressed negative responses on questions regarding the fairness of the system's measure of performance.

Objective 3: To explore nurses' and nurse managers' perceptions and experiences on the current PMDS within the context of re-engineered PHC, NHI and ICSM.

Both nurses and nurse managers spoke against the use of the PMDS. Most nurses claimed that there were various gaps in its implementation (confirming the quantitative results findings in Chapter 5), which questions the accuracy and transparency of the system. Moreover, nurses and nurse managers maintained that the system was vulnerable to perceived organisational

injustice and unfairness. Importantly, nurse managers admitted that the system is prone to counter-productive practices such as favouritism, subjectivity and unfairness. Therefore, at present, the system does not serve as a helpful managerial tool; thus, its value is not optimised and, instead, it causes division and friction amongst colleagues. Indeed, a number of authors (Aguinis, 2013; DeNisi & Murphy, 2017; DeNisi & Pritchard, 2006; Lee & Steers, 2017; Lutwama et al., 2013; Nxumalo et al., 2018; Skinner et al., 2017; Swaartbooi, 2016) all emphasise the need for a PM system that is aligned to strategic objectives and is contextually relevant to its users. These authors also mentioned the need for a PM system that is accurate, practical, meaningful, clear and valid to its users. This was proven to be linked to acceptability of the system and perceived fairness, which are crucial to creating a conducive work environment that is free from organisational politics and counter-productive behaviour.

Objective 4: To explore the influence of the PMDS on nurses' and nurse managers' attitudes to how performance is evaluated within the context of re-engineered PHC, NHI and ICSM.

Findings indicate nurses' feelings of discouragement in terms of the financial incentives such as pay progression and performance bonuses which were afforded to a selected few; nurses felt that the process followed to determine those 'deserving' was questionable. Therefore, nurses indicated the PMDS's negative impact on job satisfaction, team spirit and organisational politics. These findings are consistent with findings from the scoping review – Chapter 3 – and findings from the primary study reported in Chapters 5, 6 and 7. Interestingly, some nurses did not oppose the PMDS totally; rather, they identified the value in using it as a tool which should be implemented correctly.

Due to its poor implementation, the PMDS at present does not encourage frontline nurse managers to fully utilise the process of managing performance. Some managers continue to encourage nurses to participate in PM activities, especially during the appraisal period, regardless of their own opinions on the system failing. The current attitude to the PMDS by nurses and nurse managers is not sustainable and so is likely to yield the negative outcomes of a poorly implemented system (mentioned in Chapter 2). For example, the turnover rate amongst nurses is increasing; nurses are leaving the district and relocating to other provinces or tiers higher than PHC. There is currently no standardisation of how the PMDS is implemented, and that has contributed a distortion in real performance. Those who are receiving rewards are not those who are considered to be truly performing well. As a consequence, there is current tension

amongst nurses, with some nurses calling for team-based PM activities and processes. These same challenges are shared by South African studies such as Semakula-Katende et al. (2013), Du-Plessis (2015), Swaartbooi (2016) and Nxumalo et al. (2018).

Objective 5: To explore nurses' and nurse managers' views on what hinders performance and quality of care within the context of re-engineered PHC, NHI and ICSM.

The findings of the study indicated that, beyond organisational factors such as shortage of staff, lack of equipment, overpopulated clinics and poor working conditions, nurses are not motivated by the PMDS to enhance their performance; instead, it has resulted in negative practices such as counter-productive work behaviour and organisational politics. Both nurses and nurse managers admitted there is an over-emphasis on quantitative outcomes. One nurse illustrated an example of the number of pap smears that must be done per facility. In an effort to chase these performance targets, quality of care is overlooked. Many nurses admitted they 'push the queues' and patient's unique needs or any form of patient-centredness are neglected. Importantly, nurses indicated that in efforts to meet performance demands, there is a compromise of the service provided to patients; this conflicts with the values of PCC that seeks for nurses to provide care that is centred on the patient's needs (Jardien-Baboo et al., 2016). Nurses also admitted there are various organisational barriers to performance and quality of care. These include staffing, lack of resources and lack of district managerial support.

Nurse managers further confirmed key barriers in improving performance and quality of care, such as infrastructure and human capacity. In addition, managers expressed great concern on nurse-patient ratios doubling and sometimes tripling the ratio approved by the South African Nursing Council. Some managers also shared apprehensions about poor staff attitudes and lack of teamwork. They admitted poor performance management has contributed to the inability for managers' to manage under-performance and to provide training to staff as and when it is required.

Objective 6: To explore nurses' and nurse managers' suggestions on improving the quality of services and job performance within the context of re-engineered PHC, NHI and ICSM.

A vast majority of participants suggested that improving quality of care and job performance were centred on the need to create accountability for individual, group and facility performance. They proposed that the PMDS must be re-evaluated to capture and reflect what

truly occurs in facilities. Eliminating current barriers to improving performance and quality of care will facilitate a better work environment in which bias, favouritism and unfairness will not be tolerated. An integral part of improving the current status quo is to re-align key national and district health objectives with opportunities to further nurses' professional development and competencies, and to remove linking the PMDS to performance bonuses, in order for the system to be valued as more than an administrative tool but as a system that is beneficial for HCPs.

A common strand across all findings is that, initially, the PMDS was introduced as a tool for managing and developing employees. However, due to poor implementation, the system has 'unintentionally' impacted on quality of care (proven influence on quality of care is mentioned throughout this dissertation), and it further remains a challenge for health reform initiatives as there is currently no incentive to change the manner in which health services are presently provided. At present, nurses are unhappy, demotivated and wedged in organisational politics over the PMDS and the rewards in terms of financial incentives. Thus, there is a need to re-evaluate and revalidate the use of the PMDS in South African PHC settings, in line with current health reforms. A synthesis of the discussion is detailed further in the section below.

8.3. The performance management and development cycle revisited

8.3.1 Establishing performance standards

As previously discussed in Chapter 2, the performance management cycle commences with performance planning and agreement. This phase is considered the cornerstone of the PMDS as it forms the foundation for the rest of the PM cycle. It is also considered essential since it requires employees to engage with their line managers in discussions on planned performance. The outcome of this phase is a performance agreement between the employee and manager. This agreement consists of agreed-on performance expectations and how performance will be measured. It also consists of personal development plans and updated job descriptions.

In terms of this process in the PMDS cycle, most participants were aware of the DoH's commitment towards universal coverage and the provision of quality healthcare. However, a majority of participants revealed that they did not participate in setting performance standards. Many admitted that performance standards were not clear, and standards are not distinctly communicated to all healthcare workers. The quantitative findings are supported by qualitative findings from the interviews with nurses. When nurses were questioned if there is planning

towards performance standards and goals, they indicated that while they were aware of performance standards stipulated by the DoH, they did not participate in setting of performance goals. They also mentioned that while their job descriptions captured the day-to-day activities of a professional nurse, they were of the opinion that these descriptions failed to consider contextual factors that hinder the performance on tasks as stipulated. Also, the job description should reflect tasks beyond nursing activities, such as administrative tasks. Frontline nurse managers also indicated performance standards were not realistic given current challenges confronted by healthcare workers.

As early as 1993, researchers such as Buechlein-Telutki et al. stipulated that nursing practice is extremely complex, and the job description and actual practice expectations are different. These findings were confirmed nationally (Du-Plessis, 2015; Swaartbooi, 2016) and internationally (Lutwama et al., 2013). As noted in Chapter 2, in discussing the implications of poorly implemented PM systems, one key characteristic of a good system was the need for the system to be meaningful to users. Involving employees during this first phase of performance management ensures that the performance standards set are important and relevant to all staff. It ensures that the user feels in control of the process and allows for a discussion between the employee and nurse manager on potential barriers to performance.

At this stage, the specifications of the system are meant to be interrogated for clarity, and to provide clear guidance to employees on what is expected and how they can meet these expectations, as mentioned in Chapter 2 (Aguinis, 2013). If not, then ambiguity and uncertainty around the system builds. Further, there is no commitment from employees to achieve certain expectations (Aguinis, 2013). Some authors have even offered that if this phase is incomplete, the rest of the cycle is invalid and of little effectiveness in managing performance (Aguinis, 2013; DeNisi & Murphy, 2017; Swaartbooi, 2016).

8.3.2 Performance measures

According to DeNisi and Kluger (2000), there is a need for the process of performance measurement to be clear, transparent and well-communicated throughout healthcare facilities. In addition, the instruments used to measure performance should be valid and objective; this means the measures used to assess performance must not be influenced either by internal or external factors, so as to ensure legitimacy and accuracy in ratings (DeNisi & Murphy, 2017). The results of the quantitative study (Chapter 5) indicated that most participants were not aware

of the processes used to measure performance, with less than twenty percent believing performance was measured fairly. These findings are supported by findings in Chapter 6, where it was reported that professional nurses perceived the PM system to lack fairness, transparency and accountability, resulting in negative attitudes towards the PMDS (amongst other challenges). Nurse managers held a similar view (Chapter 7), suggesting the system was riddled with mistrust, perceived organisational injustice, and organisational politics.

Various authors have maintained that effective PM systems place greater importance on ensuring the measuring processes are correctly implemented/applied consistently (Kruk et al., 2018; Kamati et al., 2014). Poor implementation of PM systems has been found to have lasting effects on individual, team and organisational performance, with proven links to poor HR outcomes such as high turnover, conflict at work and other counter-productive behaviours like absenteeism and theft (DeNisi & Gonzalez, 2017; DeNisi & Smith, 2014). The results of these studies further reiterate the need for a reliable and valid system that is free of error. The current system is not accepted or perceived as fair by participants. If the present status quo remains, the system will continue to be ineffective and fail to motivate positive change in behaviour.

8.3.3 Performance review and feedback

The findings of these studies collectively indicate irregular performance reviewing, reporting and provision of feedback. The quantitative data revealed that the majority of nurses indicated they did not receive constructive feedback. In some instances, nurses reported not receiving feedback or receiving feedback but not immediately or regularly. More so, most nurses indicated they did not have the opportunity to engage in discussion regarding their performance results. From the scoping review, best practice demands that nurses be able to appeal performance outcomes. This finding therefore acts against the notion of openness and transparency that is expected in PM systems. Furthermore, the lack of feedback mentioned by nurses connected with nurses' complaints of lack of remedial action taken for under-performing staff.

The qualitative phase of the study confirmed the above findings. Most nurses indicated that, once performance outcomes have been released, there is no action taken to facilitate corrective action against under-performance. Therefore, most nurses further questioned the relevance of identifying under-performance, if no feedback or discussion is provided or investigation conducted to establish barriers to performance and to assist nurses to overcome the identified

challenges. Thus, most nurses questioned the usefulness of having PM systems if the review and feedback process is partially or poorly implemented.

Nurse managers also confirmed that they do not provide feedback to nurses. Most managers attributed this to incapacity to provide feedback because they are not trained on the PMDS, and they do not know what is considered to be ineffective or effective performance. They admitted that once ratings are moderated, they are also not sure how to communicate or justify the outcomes of appraisals. In addition, the majority of nurse managers were also unaware of the PM process and often relied on previous reviews when completing appraisals for themselves and when assessing others; this is in direct contradition of the guidelines provided by the Public Service Commission and the public service regulations on the PMDS and its use by departments. Managers mentioned that the only feedback provided to nurses on performance is a letter from HR indicating if the nurse had received performance bonuses or other rewards. Therefore, nurse managers argued that the PMDS is poorly implemented, and thus, its true value is not recognised. Evidently, the lack of feedback on performance appraisals has contributed to nurses' feelings of injustice, favouritism and bias (Adejoka & Bayat, 2014; Lee & Steers, 2017).

8.3.4 Rewards and other incentives

The findings of the study indicated a strong association of the PMDS with the process of administering bonus rewards. Collectively, the findings reported no clear link with rewards and outstanding performance. This could contribute to low satisfaction, poor motivation and overall lack of commitment to organisational goals (Skinner et al., 2017). Findings from the scoping review indicated a trend towards the provision of financial incentives to promote improvements in quality of care, visible in the form of pay-for-performance in the UK and the USA. However, there were conflicting findings on whether these incentives for performance actually work. Research by Kurtzman et al. (2011) and Mackey et al. (2009) provides evidence that financial incentives do not necessarily produce positive healthcare outcomes, more specifically, improved patient outcomes. Maffei et al. (2008) and Maisey et al. (2008) also suggested that financial incentives in the healthcare field often promote quantity, with less of a focus on the quality of care.

A negative view of financial incentives was also evident in this study, where the PMDS being linked to financial incentives created animosity between colleagues, and promoted

individuality as opposed to team efforts in pursuit of improving quality of care. Each facility is provided with what nurses viewed as 'unrealistic performance targets', and those who receive bonuses against these odds were considered to be favoured. These perceptions and experiences were used as justification for not putting in the effort to improve work performance. A common narrative from the qualitative findings was: *Why should I work hard when I will not receive a bonus anyway?* Perceived injustice in the distribution of rewards is a common challenge of PM systems, and the PMDS is no different (Du-Plessis, 2015; Mello, 2015; Swaartbooi, 2016).

8.4 Linking PMDS with health reforms

With the introduction of National Health Insurance (NHI) and the re-engineering of primary health care (PHC) to promote integrated clinical services management (ICSM) of acute and multi-morbid chronic conditions, the South African health system is presently witnessing several reforms. Such reforms have emphasised the need for person-centred care as a means to improve quality and outcomes of healthcare (Jardien-Baboo et al., 2016). These authors defined person-centred healthcare as healthcare that is designed and practised with the patient/person at the centre, being sensitive to patients'/persons' preferences for information and shared decision-making, and responding appropriately to these. The success of any reforms in health systems depend on the skills, motivation and performance of healthcare professionals such as professional nurses, who are at the forefront in the provision of health services in South Africa.

Findings from this study suggest that nurses and nurse managers did not find any direct link between the PMDS and current health reforms. Instead, nurses claimed that the way the PMDS was implemented worked against the principles of improving the quality of care towards person-centredness. Nurses and nurse managers maintained that improvement in the quality of care is only possible once current barriers to job performance and quality of care are considered. Evidently, there are great flaws in how nurses are managed, and this has impacted on HR outcomes such as motivation, job performance and intention to leave (Aguinis, 2013; Du-Plessis, 2015; Nxumalo et al., 2018; Saravanja, 2010; Swaartbooi, 2016). Without a systemic change in the current climate of performance management, measuring nurses' performance will not be a true reflection of actual progress, training needs and professional development (DeNisi & Murphy, 2017; Saravanja, 2010).

Besides the current challenges with the implementation and application of the PMDS in PHC settings, the system also works against the notions of quality of care and patient-centred care. Collectively, the findings of this study indicated that the PMDS focuses on targets and other quantitative measures and does not consider qualitative measures of improving healthcare services. As long as the PMDS is concentrated on targets and the reward of bonuses, there is no motivation towards improving the quality of care. There is, rather, the motivation to push queues and see as many patients as possible in order to achieve the required number of patients per day. Beyond this, the PMDS must be reviewed regularly to ensure it remains relevant to the health reform initiatives (Jardien-Baboo et al., 2016; Swaartbooi, 2016).

8.5 Recommendations for improving the PMDS system and its application at PHC level

Based on the findings of this study, the following strategies are recommended for improving performance management at district level.

8.5.1 Recommendation one: Linking the PMDS with current health system reforms

With the current health reforms such as the re-engineered PHC, NHI and ICSM, district-level professional nurses are at the forefront of facilitating changes in the way care is provided. The current PMDS needs to be overhauled to reflect these current reforms. In particular, there is a need to develop indicators that move away from the sole focus on numbers, towards measuring the person-centred care that is necessary to address the multi-morbidity epidemic in South Africa (Lalkhen & Mash, 2015; Smith et al., 2016). Kruk et al. (2018) mentioned the need for performance measurements to reflect health outcomes beyond performance indicators; these would include patient confidence in the health system, and health and other measures of quality of care. If left as at present, quality of care will suffer the consequences of poorly managed and developed staff, who do not have the capacity to respond to the needs of an evolving PHC system, although this is an unintended consequence of the PMDS.

8.5.2 Recommendation two: Organisational readiness for performance management

In redesigning the current PMDS, it would be imperative that nurses be included at all levels, in order to promote improved motivation and sustained commitment to the process. Increasing employee participation in the design and implementation of the PMDS will to some extent increase its effectiveness, due to increased acceptance and support of the system. Without this, district managers will continue to witness dissatisfaction with its usefulness and with how the

system is implemented, notwithstanding any changes made to reflect greater emphasis on person-centred care.

Further, systemic changes in the design, measurement and implementation of the PMDS should be accompanied by opportunities for continuous learning and development at all levels of the system. These interventions should consider both technical and behavioural skills that influence performance. Ultimately, all employees should have the necessary knowledge, skills and attitudes to drive health reform. Key person-centred care enablers such as strong communication skills, and trust between the patient and practitioner, can be cultivated and evaluated.

Confirming organisational readiness to change will also require a re-evaluation of the PMDS across the health district. It is vital that the PMDS is re-evaluated to identify system challenges impeding optimal implementation. Tools used for the PMDS should be designed to address specific needs. The review must include key role-players, especially future users. The review should be consultative and interactional in nature. Those who participate in the design must be experts in both performance management and using PM systems in the healthcare setting. Those involved must consider current health reforms and interrogate the validity of the current system in line with the reforms and its objectives (DeNisi & Gonzalez, 2017).

An evaluation of the validity and accuracy of the current PMDS implementation is necessary, by revisiting discussions on the type of measurements used in the PMDS and its systemtic implications. Therefore, the review must be at a systems level involving all stakeholders. It should be consultative and promote participation from health workers from all categories. Thus, the outcome of this systems review must outline challenges experienced at all levels that have resulted in the flawed implementation of the PMDS. More so, the outcomes of the review must also include a detailed action plan on how to change the current status quo and improve the manner in which performance is planned, measured and managed at district level.

Importantly, aside from the annual evaluation of the PMDS, which is advised by the EPMDS guidelines, an external audit of the PMDS (every three years) must be undertaken to evaluate it early for challenges that may pose potential threats to the management of performance and to proactively update the system, so that it is not obsolete and so that it remains relevant to the health system's objectives at that particular time.

8.5.3 Recommendation three: Cultivating a culture of openness and accountability

A successful PMDS requires a two-pronged engagement in the performance cycle between the employee and employer. The performance agreement phase of the PMDS must be fully utilised and employees must be given the opportunity to discuss individual performance and to plan performance for the next cycle. In this phase, employee participation should occur in the form of setting personal development areas and key indicators of performance. This will result in greater acceptance of the results of performance appraisals, as well as accountability. This approach will also promote employees feeling they are part of the process of determining the standards on which they are evaluated. Currently, indicators and targets are set higher up the management chain without consultation with staff at the front line of implementing reforms and without addressing systemic barriers to performance, such as poor working conditions and inadequate staffing (Awases et al., 2013; Du-Plessis, 2015; Lutwama et al., 2013). Indeed, a change in the current organisational culture and climate is necessary. It is therefore imperative to re-establish shared performance goals from individual, group and organisational levels. This will require an investigation and evaluation of readiness to change, as well as interventions that focus on managing change effectively at district level.

8.5.4 Recommendation four: Improving communication and the provision of feedback

Communication is one of the crucial elements that determine the success of a PM system. Existing evidence indicates a lack of communication concerning the PMDS, with mixed results on knowledge of key PMDS processes. A proactive communication strategy should be followed throughout the process of PM (DeNisi & Kluger, 2000). During the monitoring and evaluation phase, undoubtedly, good communication is key to providing constructive feedback to employees. This requires that managers are capacitated in effective communication, so that feedback is delivered timeously and in a manner that is professional and developmental in nature. A manager should possess the skills and necessary qualities to be able to facilitate successfully a discussion on performance with his or her subordinates, and to provide them the opportunity to reflect on their performance and to fully engage in the process (Nikpeyma, Abed, Azargashb, & Alavi, 2014).

Part of improving the above process requires providing training on the system for all its users. As the core implementer of the PMDS at facility level, nurse managers should be capacitated

to implement the system efficiently and effectively. This requires that they understand the context of performance management in the health sector, are able to set performance expectations, ensure that performance decisions are accurately identified, provide effective performance appraisal, manage under-performance, ensure outstanding performance is rewarded fairly, and provide ongoing feedback. The training of nurse managers should include but not be limited to: i) rater and ratee relationships; ii) avoiding bias in rating performance; iii) emotional intelligence; iv) relational leadership; v) providing constructive feedback; and vi) counselling (Swaartbooi, 2016).

There is a need to identify key soft skills that nurses and nurse managers must be trained in that will enable effective behaviour. Training should not only be limited to frontline nurse managers; nursing staff, performance panel committees, health district management and HR practitioners should also be exposed to such training on the PMDS, so as to improve its acceptance, implementation and use.

Such training should also include:
- The roles and responsibilities of all personnel as suggested by the Public Service Commission (2007) and EPMDS (Republic of South Africa, 2007) guidelines;
- Accountability chains to ensure all personnel are aware of their specific roles and responsibilities, and how these will be monitored;
- The purpose of the PMDS, how performance is measured, providing and receiving feedback, and the relevance and benefit of the system.

8.5.5 Recommendation five: Beyond financial incentives

The reward system of the PMDS needs to be reviewed so that high performance is rewarded and under-performance discouraged. Further, a comprehensive reward system should not only promote monetary incentives such as bonuses and pay progression, but it should promote other means of rewards and recognition such as public acknowledgments, merit rewards, promotion, and learning and study opportunities. Importantly, staff should be able to witness a clear link between rewards and good performance. Performance management systems that are riddled with favouritism and organisational injustice result in poor performance emanating from low levels of satisfaction, motivation and commitment towards improving performance (DeNisi & Murphy, 2017; Lutwama et al., 2013; Saravanja, 2010; Skinner et al., 2017).

8.6 Limitations of the study

No study is without its limitations, and some of these are acknowledged in this section.

- The use of non-probability sampling as opposed to probability sampling technique is advocated by quantitative theorists. The sampling population was a confined pool of participants who were registered nurses within an NHI pilot site; this was the best sample for the objectives of the study to be met.

- The study participants were limited to professional nurses and facility managers who were registered professional nurses/midwives at the Dr Kenneth Kaunda District Municipality. Other health worker categories such as enrolled nurses, pharmacy staff and community health workers were not included in this study. These HCWs might have different experiences from those expressed by the participants of this study.

- In addition, the study was limited to one NHI pilot site, namely, Dr Kenneth Kaunda District. Given variations in resources across provinces and districts in South Africa, the results may therefore not be generalisable to other districts or provinces.

8.7 Recommendations for future research

- Both quantitative and qualitative research should be conducted on the implementation of the PMDS in other provinces and districts, to establish if the results of the study are generalisable across the country. Moreover, this would provide a holistic scenario within the South African context.

- A further investigation is required on performance standards and measurements employed globally that are best suited for PHC and patient-centred care, in light of the global shifts to multi-morbid chronic care that have become evident.

- The study should be expanded to include all PHC staff, as well as district management teams, as the health reforms (NHI, ICSM, PCC and quality improvement) promote a team-based approach to care. Accordingly, an examination of the impact of the PMDS on other staff who form part of PHC teams should be considered, in order to offer a holistic scenario within the South African context.

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APPENDIX 1: ETHICAL APPROVAL UNIVERSITY OF KWAZULU-NATAL

UNIVERSITY OF
KWAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

11 April 2016

Ms Cynthia Zandile Madlabana
Discipline of Psychology
School of Applied Human Sciences
madlabana@ukzn.ac.za

Protocol: The public service Performance Management and Development System (PMDSpetersen)
and its influence on job performance and quality improvement in re-engineered Primary Health
Care (PHC) Health facilities.
Degree: Phd
BREC reference number: BE064/16

EXPEDITED APPLICATION

The Biomedical Research Ethics Committee has considered and noted your application received on 01
March 2016.

The study was provisionally approved pending appropriate responses to queries raised. Your responses
dated 04 April 2016 to queries raised on 21 March 2016 have been noted and approved by a sub-
committee of the Biomedical Research Ethics Committee. The conditions have now been met and
the study is given full ethics approval.

This approval is valid for one year from 11 April 2016. To ensure uninterrupted approval of this
study beyond the approval expiry date, an application for recertification must be submitted to BREC
on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be
approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research
Ethics Guidelines (2015), South African National Good Clinical Practice Guidelines (2006) (if
applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of
Reference and Standard Operating Procedures, all available at http://research.ukzn.ac.za/Research-
Ethics/Biomedical-Research-Ethics.aspx.

BREC is registered with the South African National Health Research Ethics Council (REC 290408 009).
BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be RATIFIED by a full Committee at its meeting taking place on 10
May 2016.

We wish you well with this study. We would appreciate receiving copies of all publications arising
out of this study.

Yours sincerely

Professor J Tsoka-Gwegweni
Chair: Biomedical Research Ethics Committee

cc supervisor: petersen@ukzn.ac.za
cc postgrad: ntuli@ukzn.ac.za

APPENDIX 2: ETHICAL APPROVAL: DEPARTMENT OF HEALTH, NORTH WEST PROVINCE

APPENDIX 3: QUANTITATIVE BOOKLET

SCHOOL OF APPLIED HUMAN SCIENCES

DEPARTMENT OF PSYCHOLOGY

INSTRUCTIONS

Dear Research Participant, you are requested to answer all the questions in this booklet. You will also need to sign an consent form to show that you agreed consent to participating in this study. Please answer all the questions.

Your participation is much appreciated.

INFORMATION SHEET

Dear research participant,

My name is Cynthia Zandile Madlabana and I am a PhD candidate studying at the University of KwaZulu-Natal, Howard College in Durban, KwaZulu-Natal. My contact details are as follows: madlabana@ukzn.ac.za Tel: 031 260 8389.

You are being invited to participate in a study that looks at the current Performance Management and Development System (PMDS) implemented in healthcare. The aim and purpose of this research is to identify the current challenges and opportunities with performance management and quality improvement in the re-engineered primary healthcare system. The study is expected to enroll 250 professional nurses within the Dr Kenneth Kaunda District in the North West province. The study is divided into two phases and will therefore involve the following procedures: the first phase involves a completion of a questionnaire on your evaluation of the current PMDS and the second phase, in which a few participants will be selected to participate, will include interviews on nurses' perceptions on performance management, quality improvement and job performance in light of the changes currently occurring in primary healthcare. The duration of your participation, if you choose to enroll and remain in the study, is expected to be 45 minutes for the completion of the research booklet and 60 minutes for an interview (if you are selected). The study is funded by the National Research Foundation (NRF) Thuthuka Programme, as well as the National Institute for Humanities and Social Sciences (NIHSS).

1. **How will you benefit from participating in this study?**

This study aims to investigate the public service PMDS, how it is implemented in the healthcare system, and how it impacts on job performance and quality improvement in the care provided by staff. Currently, there is no study that investigates performance management and improving quality of care. Although a few studies have evaluated the public service PMDS, none has evaluated the system in light of the current changes occurring in the health system. Identifying the current challenges and opportunities within performance management and quality improvement will assist in developing strategies to minimise the negative effect of poor performance. It will also assist policymakers in creating better systems to manage performance and improve quality of care initiatives in the healthcare system.

With that said, there will be no direct benefit to you if you participate in this research, but your participation is likely to help generate knowledge and a greater understanding of the effectiveness of the PMDS in relation to promoting job performance and quality improvement.

This study has been ethically reviewed and approved by the UKZN Biomedical Research Ethics Committee (approval number BE 084/16) as well as the Provincial Health Department.

In the event of any problems or concerns/questions, you may contact the researcher (Cynthia Zandile Madlabana), the research supervisor or the UKZN Biomedical Research Ethics Committee, contact details are as follows:

For questions related to the study	For your rights as a research participant
Researcher:	**Biomedical Research Ethics Administration**
Cynthia Zandile Madlabana	Research Office, Westville Campus
Tel: 27 31 260 8389	Govan Mbeki Building
Email: madlabana@ukzn.ac.za	Private Bag X 54001
	Durban
Research Supervisor:	4000
Professor Inge Petersen	KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 260 7970	Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: Peterseni@ukzn.ac.za	Email: BREC@ukzn.ac.za

It is important to note:

1. **What if you decide you do not want to participate in this study?**

Your participation is voluntary and your identity will be protected throughout the research study. Please be advised that you may choose not to participate in this research study and should you wish to withdraw at any stage, you have the full right to do so, and your action will not disadvantage you in any way.

2. **Will you incur any cost if you choose to participate in this study?**

No, all the costs of this research study are borne by the researcher.

3. **How will your identity be protected? / How will confidentiality be maintained?**

It is the ethical duty of the researcher to ensure that the confidentiality of the respondent as well as the privacy of the information provided is maintained. Thus, participants are given letters of consent which will give a summary of the purpose of the study, and information regarding the research being confidential and voluntary.

To make sure that participants are aware of their rights, the researcher will be sure to inform all participants before each session that their identity is protected, that the confidentiality of the data will be safeguarded as well as that participation is strictly voluntary and thus participants may withdraw from the study at any time.

To further safeguard the collected data, which includes the questionnaires and records from the taped interviews, these will be stored in a secure vault for five years, and thereafter, will be destroyed by means of questionnaires being shredded and the tape recordings being erased.

Thank you for your time.
****

CONSENT FORM

I ………………………………………………………… (full name of participant) have been informed about the study entitled: 'The public service Performance Management and Development System and its influence on job performance and quality improvement in re-engineered primary health care (PHC) health facilities' by Cynthia Zandile Madlabana. I consent to participating in the research project.

Please tick
or initial

I understand the purpose and procedures of the study.

I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.

I understand that if I decide at any time during the study that I no longer want to take part, I can notify the researchers and withdraw without having to give a reason and without any consequences to me.

I agree that the research team may use my data (information) for future research, publications in journals and other research outputs. I understand that any such use of identifiable data would be reviewed and approved by a research ethics committee. In such cases, as with this project, my identity would not be identifiable in any report.

I consent to the research team contacting me via an agreed method such as telephone, home-visit or any other agreed method for follow-up interviews

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

For questions related to the study	For your rights as a research participant
Researcher: Cynthia Zandile Madlabana Tel: 27 31 260 8389 Email: madlabana@ukzn.ac.za **Research Supervisor:** Professor Inge Petersen Tel: 27 31 260 7970 Email: Peterseni@ukzn.ac.za	**Biomedical Research Ethics Administration** Research Office, Westville Campus Govan Mbeki Building Private Bag X 54001 Durban 4000 KwaZulu-Natal, SOUTH AFRICA Tel: 27 31 2604769 - Fax: 27 31 2604609 Email: BREC@ukzn.ac.za

_____   _____

Signature of Participant   **Date**

_____   _____

Signature of Witness   **Date**
(Where applicable)

****

BIOGRAPHICAL DATA SHEET

Please complete the following biographical data sheet.

INSTRUCTIONS: (Please answer the following questions by marking the appropriate boxes)

Gender

MALE	FEMALE

Age Group

20 - 30	31 - 40	41 - 50	51 - 60	61+

Marital Status

Single	Married	Divorced	Widow	Remarried

Race

Black	White	Coloured	Indian	Other

Number of Dependants

None	1	2	3	3+

HIGHEST QUALIFICATION OBTAINED: _____

NUMBER OF YEARS WORKING FOR THE ORGANISATION: _____

WHAT PREVIOUS POSITIONS HAVE YOU HELD WITH THE ORGANISATION?

_____

WHAT IS YOUR JOB TITLE? _____

HOW LONG HAVE YOU HELD YOUR CURRENT POSITION? _____

SIGNATURE OF PARTICIPANT………………....   DATE…………………………

PERFORMANCE MANAGEMENT SCALE

Performance standards	Disagree	Undecided	Agree
1. All healthcare workers are familiar with the organisation's mission towards clients.	1	2	3
2. I have a clear job description.	1	2	3
3. The performance standards are clear	1	2	3
4. There are appropriate performance indicators to assess the health care worker's performance.	1	2	3
5. Targets are set for activities to be achieved in a given period.	1	2	3
6. The performance standards, indicators, and targets are communicated to all departments to ensure that health workers understand them.	1	2	3
7. This organisation regularly reports the performance of standards, indicators and targets to the external stakeholders.	1	2	3
8. All the stakeholders in this organisation participate in setting performance standards	1	2	3
Performance measures	**Disagree**	**Undecided**	**Agree**
9. Objectives to be achieved are known by individuals to be assessed.	1	2	3
10. The performance standards expected from the staff are clear and understood by all.	1	2	3
11. The district clearly defines how to measure individual activity performance.	1	2	3
12. This organisation has a system for collecting and tracking staff performance data.	1	2	3
13. The organisation measures most of the established individual performance standards and targets.	1	2	3

	Disagree	Undecided	Agree
14. Individual healthcare worker's performance is measured regularly.	1	2	3
15. I am fully aware of the process used to measure my performance.	1	2	3
16. My performance is evaluated based on my job description.	1	2	3
17. My performance is fairly measured.	1	2	3
Performance reporting	**Disagree**	**Undecided**	**Agree**
18. This organisation documents the progress related to performance standards and targets.	1	2	3
19. This organisation has a specific system that regularly reports the performance of healthcare workers.	1	2	3
20. Constructive feedback on performance appraisal is provided on a regular basis.	1	2	3
21. This organisation always reports the healthcare workers' performance information to the external stakeholders.	1	2	3
22. The healthcare workers' performance data is analysed and reviewed according to the set performance standards, indicators and targets.	1	2	3
23. The healthcare workers are given an opportunity to make comments on the results of their performance.	1	2	3
Performance improvement	**Disagree**	**Undecided**	**Agree**
24. Timely action is taken when performance falls below the acceptable levels.	1	2	3
25. The performance reports are effectively used for decision-making.	1	2	3
26. The healthcare workers' performance information is used to set priorities for personal development.	1	2	3
27. The staff is involved in decisions about performance improvement.	1	2	3

28. The organisation has specific processes to manage changes in policies, programs or infrastructure.	1	2	3
29. My supervisors encourage me to use different ways to improve my performance.	1	2	3
30. Rewards and sanctions are based on performance results.	1	2	3
31. The analysis of employees' training needs is based on the performance appraisal reports.	1	2	3
32. There are procedures to collect suggestions for performance improvement from the employees.	1	2	3
33. I always have access to my supervisors when I need support.	1	2	3
Performance reward	**Disagree**	**Undecided**	**Agree**
34. I am paid according to my experience.	1	2	3
35. My salary is according to my job responsibilities.	1	2	3
36. Hard work is acknowledged and rewarded accordingly.	1	2	3
37. All healthcare workers know their fringe benefits.	1	2	3
38. I am satisfied with the fringe benefits I get from my organisation.	1	2	3
Staff training and development	**Disagree**	**Undecided**	**Agree**
39. This organisation has a staff training and development policy.	1	2	3
40. Opportunities exist for career advancement in this organisation.	1	2	3
41. Appropriate training is conducted to ensure that healthcare workers carry out their duties well.	1	2	3
42. Job-specific refresher courses are provided on a regular basis.	1	2	3
43. The in-service training provided is adequate to deal with the existing skills gap	1	2	3

44. Healthcare workers who are less competent are provided with the necessary support to improve their knowledge and skills.	**1**	**2**	**3**
45. Healthcare workers participate in identifying their career development needs.	**1**	**2**	**3**
46. In the last six months my supervisors discussed my career development prospects with me.	**1**	**2**	**3**
47. I have received the training required to succeed in my position.	**1**	**2**	**3**
Performance data is used for:	**Disagree**	**Undecided**	**Agree**
48. Training of staff	**1**	**2**	**3**
49. Promotion in service	**1**	**2**	**3**
50. Demotions of staff	**1**	**2**	**3**
51. Rotation of staff	**1**	**2**	**3**
52. Rewards	**1**	**2**	**3**
53. Not used at all	**1**	**2**	**3**

****

APPENDIX 4: QUALITATIVE BOOKLET

BIOGRAPHICAL DATA SHEET

Please complete the following biographical data sheet.

INSTRUCTIONS: (Please answer the following questions by marking the appropriate boxes)

Gender

MALE	FEMALE

Age Group

20 - 30	31 - 40	41 - 50	51 - 60	61+

Marital Status

Single	Married	Divorced	Widow	Remarried

Race

Black	White	Coloured	Indian	Other

Number of Dependents

None	1	2	3	3+

Name of facility: _____

Highest Qualification Obtained

None	Diploma	Degree	Postgraduate

Number of Years working as a Professional Nurse/ Facility Manager

0-5 years	6-10 years	11-15 years	16-20 years	21-25 years	26 years +

Please specify number of years_____

PLEASE INDICATE YOUR POSITION IN THE ORGANISATION: _____

WHAT PREVIOUS POSITIONS HAVE YOU HELD WITH THE ORGANISATION?

_____

WHAT IS YOUR JOB TITLE?

Professional Nurse	Nurse Manager

HOW LONG HAVE YOU HELD YOUR CURRENT POSITION? _____

SIGNATURE OF PARTICIPANT………………...... DATE…………………………

INTERVIEW SCHEDULE 1 – Professional Nurses

Introductory questions:

1. In your opinion, why is it important to have a performance management system?
2. When was the last time you did the PMDS?
3. Have you ever attended a workshop/training on the PMDS
4. What is your opinion on the current PMDS?

Questions on performance standards:

1. Do you believe you have a clear job description (i.e. you understand your role as a professional nurse and the expectations set by the health department)?
2. In your opinion, how has the change that has been happening in the health system (e.g. PHC, ICDM, and NHI) influenced how you do your job?

Questions on performance measures:

1. In your opinion, is your performance measured fairly?
    - Why do you say so?
2. If you could change how you are measured, what would you include/remove from the current system?
3. Do you believe all nurses from all sub-districts of Dr Kenneth Kaunda are measured the same?

Questions on performance reporting:

1. When it comes to receiving feedback on your performance, do you believe that the feedback you receive is useful for improving your performance in the future?
2. If you could improve how feedback is given, what would you change/include?

Questions on performance improvement:

Based on your experience, when nurses are under-performing,

1. Are they given the opportunity to make decisions on how to improve performance?
2. Do you think your performance information is used to set priorities for personal development?
3. With regard to management support, what is your opinion of the support you receive from your supervisor when it comes to improving your performance?
4. What can be done to overcome challenges that hinder nurses' performance?

Questions on performance reward:

1. In your opinion, are you rewarded accordingly for the job you do (i.e. in terms of salaries, fringe benefits and career advancement/promotions)?

Question on staff training and development:

1. Do you believe nurses are adequately trained to function effectively within the changing healthcare system (i.e. with PHC, ICDM, NHI)?

Question on the use of performance data:

1. In your view, what should performance data be mainly used for?

Questions on quality improvement and quality of care:

Performance management has been linked to the objectives of ensuring quality improvement in healthcare facilities.

1. What is your understanding of quality improvement?
2. What do you believe is the biggest challenge that affects quality improvement in healthcare facilities?
3. What suggestions would you recommend to achieve better results with regard to quality improvement initiatives?
4. For quality of care to be achieved, there needs to be an element of teamwork. Do you believe that the PMDS encourages working as a team or does it encourage working individually?
5. We have noticed a huge drop in the number of nurses per facility; in your opinion, why are nurses leaving KK district?

INTERVIEW SCHEDULE 2 – Facility Manager/Acting Facility Manager/Operational Manager/Acting Operational Manager

Introductory questions:

1. In your opinion, why is it important to have a performance management system?
2. When was the last time you did the PMDS?
3. Have you ever attended a workshop/training on the PMDS
4. What is your opinion on the current PMDS?

Questions on performance standards:

1. Do you believe you have a clear job description (i.e. you understand your role as a facility manager and the expectations set by the health department)?
2. In your opinion, are performance standards expected from staff clear and understood by all?
3. In your opinion, are nurses given the opportunity to participate in setting performance standards? How so?

Questions on performance measures:

1. In your opinion, is performance measured fairly?
2. Why do you say so?
3. If you could change how you are measured, what would you include/remove from the current system?
4. Do you believe all nurses from all sub-districts of Dr Kenneth Kaunda are measured the same?

Questions on performance reporting:

1. When it comes to giving feedback on performance, do you believe that the feedback you provide is useful for improving performance in the future?
2. If you could improve how feedback is given, what would you change/ include?

Questions on performance improvement:

Based on your experience, when nurses are underperforming,

1. Are they given the opportunity to make decisions on how to improve performance?

2. Do you think your performance information is used to set priorities for personal development?

3. With regard to management support, what is your opinion of the support you receive from your supervisor (area manager) when it comes to improving staff performance?

4. What can be done to overcome challenges that hinder nurses' performance?

Question on performance reward:

1. In your opinion, are nurses rewarded appropriately for the job you do (i.e. in terms of salaries, fringe benefits and career advancement/promotions)?

Question on staff training and development:

1. Do you believe nurses are adequately trained to function effectively within the changing healthcare system (i.e. with PHC, ICDM, NHI)?

Question on the use of performance data:

1. In your view, what should performance data be mainly used for?

Questions on quality improvement and quality of care:

Performance management has been linked to the objectives of ensuring quality improvement in healthcare facilities.

1. What is your understanding of quality of care?

2. What do you believe is the biggest challenge that affects quality improvement in healthcare facilities?

4. What suggestions would you recommend to achieve better results with regard to quality improvement initiatives?

5. For quality of care to be achieved, there needs to be an element of teamwork. Do you believe that the PMDS encourages working as a team or does it encourage working individually?

6. We have noticed a huge drop in the number of nurses per facility; in your opinion, why are nurses leaving KK district?

APPENDIX 5: MMAT FOR QUALITY APPRAISAL

Mixed Methods Appraisal Tool (MMAT) – Version 2018

Author and date

_____

_____

_____

_____

_____

S1. Are there clear research questions?

( ) Yes

( ) No

( ) Can't tell

Comments for S1

_____

_____

_____

_____

_____

S2. Do the collected data allow the researcher to address the research questions?

( ) Yes

( ) No

( ) Can't tell

Comments for S2

_____

_____

_____

_____

_____

11 Qualitative approach

Q1. Is the qualitative approach appropriate to answer the research question?

- ( ) Yes
- ( ) No
- ( ) Can't tell

Comments for Q1

_____

_____

_____

_____

_____

Q2. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?

- ( ) Yes
- ( ) No
- ( ) Can't tell

Comments for Q2

_____

_____

_____

_____

_____

Q3. Are the qualitative data collection methods adequate to address the research question?

- ( ) Yes
- ( ) No
- ( ) Can't tell

Comments for Q3

_____

_____

_____

_____

_____

Q4. Are the findings adequately derived from the data?

○ Yes

○ No

○ Can't tell

Comments for Q3

_____

_____

_____

_____

_____

Q4. Is the interpretation of results sufficiently substantiated by data?

○ Yes

○ No

○ Can't tell

Comments for Q4

_____

_____

_____

_____

_____

Q5. Is there coherence between qualitative data sources, collection, analysis and interpretation?

○ Yes

○ No

○ Can't tell

Comments for Q5

_____

_____

_____

_____

_____

12 Quantitative randomised controlled (trials)

Q1. Is randomisation appropriately performed?

◯ Yes

◯ No

◯ Can't tell

Comments for Q1

_____

_____

_____

_____

_____

Q2. Are the groups comparable at baseline?

◯ Yes

◯ No

◯ Can't tell

Comments for Q2

_____

_____

_____

_____

_____

Q3. Are there complete outcome data (80% or above)?

◯ Yes

◯ No

◯ Can't tell

Comments for Q3

_____
_____
_____
_____
_____

Q4. Are outcome assessors blinded to the intervention provided?

- ( ) Yes
- ( ) No
- ( ) Can't tell

Comments for Q4

_____
_____
_____
_____
_____

Q5. Did the participants adhere to the assigned intervention?

- ( ) Yes
- ( ) No
- ( ) Can't tell

Comments for Q5

_____
_____
_____
_____
_____

Quantitative non-randomised

Q1: Are the participants representative of the target population?

- ◯ Yes
- ◯ No
- ◯ Can't tell

Comments for Q1

_____

_____

_____

_____

_____

Q2: Are measurements appropriate regarding both the outcome and exposure/intervention?

- ◯ Yes
- ◯ No
- ◯ Can't tell

Comments for Q2

_____

_____

_____

_____

_____

Q3: Are there complete outcome data?

- ◯ Yes
- ◯ No
- ◯ Can't tell

Comments for Q3

_____

_____

_____

_____

_____

Q4: Are the confounders accounted for in the design and analysis?

○ Yes

○ No

○ Can't tell

Comments for Q4

_____

_____

_____

_____

_____

Q5. During the study period, is the intervention/exposure administered as intended?

○ Yes

○ No

○   Can't tell

Comments for Q5

_____

_____

_____

_____

_____

Quantitative descriptive

Q1: Is the sampling strategy relevant to address the research question?

( ) Yes

( ) No

( ) Can't tell

Comments for Q1

_____

_____

_____

_____

_____

Q2: Is the sample representative of the target population?

( ) Yes

( ) No

( ) Can't tell

Comments for Q2

_____

_____

_____

_____

_____

Q3: Are measurements appropriate?

( ) Yes

( ) No

( ) Can't tell

Comments for Q3

_____

_____

_____

_____

_____

Q4: Is the risk of non-response bias low?

- ◯ Yes
- ◯ No
- ◯ Can't tell

Comments for Q4

_____

_____

_____

_____

_____

Q5. Is the statistical analysis appropriate to answer the research question?

- ◯ Yes
- ◯ No
- ◯ Can't tell

Comments for Q5

_____

_____

_____

_____

_____

13 Mixed Methods

Q1: Is there an adequate rationale for using a mixed-methods design to address the research question?

( ) Yes

( ) No

( ) Can't tell

Comments for Q1

_____

_____

_____

_____

_____

Q2: Are the different components of the study effectively integrated to answer the research question?

( ) Yes

( ) No

( ) Can't tell

Comments for Q2

_____

_____

_____

_____

_____

Q3: Are the results adequately brought together into overall interpretations?

Mark only one oval.

( ) Yes

( ) No

( ) Can't tell

Comments for Q3

_____

_____

_____

_____

_____

Q4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?

( ) Yes

( ) No

( ) Can't tell

Comments for Q4

_____

_____

_____

_____

_____

Q5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?

( ) Yes

( ) No

( ) Can't tell

Comments for Q5

_____

_____

_____

_____

_____