Western Cape Government
Health

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5th PROVINCIAL HEALTH RESEARCH DAY 2015

Venue: Stellenbosch University, Medicine and Health Sciences Campus

Date: 5 November 2015

2015-2018 Provincial Health Research Committee (PHRC):
L to R: Ms Y. Valentine (NGO), Prof T. Douglas (UCT), Dr T. Naledi (DoH), Prof T. Rehle (HSRC), Dr N. Leon (Chairperson) (MRC-SA), Dr A. Hawkridge (Deputy chair) (DoH), Dr S. Fourie (DoH), Dr K. Jennings (CoCT).
Not in picture: Prof N. Gey van Pittius (SU), Dr D. Pienaar (DoH), Dr H. Visser (CoCT), Prof P. Engel-Hills (CPUT)

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Introduction

The theme for the 5th Annual Provincial Health Research Day was "*Retention in Care, Adherence and Continuity of Care*". It was a unique opportunity for members of the health research community to meet, discuss and exchange research findings conducted in Provincial and City of Cape Town health facilities.

Researchers from local universities, scientists from the national research councils, members of non-profit organizations, Provincial and City of Cape Town managers discussed issues highlighted and reflected on the importance and value of research conducted and its dissemination. Feedback through such a research day enables research translation and the development of guidelines.

Judging by the impromptu feedback and formal feedback from the delegates, it is clear that most attendees had a wonderful experience and regard the Provincial Research Day highly. It provided not only food for thought but allowed participants to network.

The 2015 event, held at the Stellenbosch University, *Medicine and Health Sciences Campus, Parow* 2015, attracted 139 participants from four Universities, two national Research Councils, academics, and non-government organizations (NGOs). It was organized by the Western Cape Provincial Health Research Committee (WCPHRC) and the Health Impact Assessment (HIA) directorate of the Western Cape Department of Health. This was the first research day to be held at a stakeholder facility, and may indicate its value given by research partners..

Feedback from delegates suggests that the meeting was well organized, fruitful and a worthwhile event to attend and prioritise. Some linked up with 'old' colleagues from the services and networked with new potential future collaborators in health research.

This accords well with the aim of this event - to bring together a diverse audience of researchers, service managers, health care providers and community representatives with a view to promoting:

- Awareness and understanding of research carried out in health services in the Western Cape;
- Collaboration between researchers, services and other interested parties;
- An agenda for research of direct interest to the services;
- the translation of research findings into policy and practice.

Opening address

The proceedings of the day started with a welcoming address by Dr Tracey Naledi, acting chairperson of the WCPHRC and Chief Director of health programmes in the Western Cape, who reflected on the importance of the research day in the annual calendar. This was followed by the head of department's input.

Departmental context for research

Dr Beth Engelbrecht, Provincial Head of Department set the scene by providing a departmental context for research. She outlined complexities of service delivery. She highlighted drivers of mortality:- that HIV remains a major cause of death; 99% of maternal deaths occur in developing countries including South Africa; and TB cure remains a difficult target. She reflected that preventable conditions need new and different response models as the current ones have limited impact and do not influence behavior change. These demand, structural and systemic policy changes.

She noted that primary, secondary, tertiary prevention models are required for impact at a population level. Research gaps highlighted was that whilst patient centred care models and patient agency strategies are key policy priorities, these are not well researched. In addition, empirical evidence to strengthen the resilience of the health system is required.

Dr Engelbrecht reminded the delegates about centrality and the importance of health research in guiding improvement in the functioning of health systems and in developing new interventions to address disease burden. The quadruple disease burden calls for innovative and effective approaches to contain challenges. Dr Engelbracht noted that "The approach of Healthcare 2030 of increasing wellness necessitates an understanding of social determinants of ill-health and an interdisciplinary approach to research that includes the social sciences as well as

participatory methodologies that include the communities we serve". Importantly, the culture of using research and evidence in the Department to improve the quality of health services also needs to be entrenched. This becomes all the more important in managing a complex system such as health.

She provided key strategies to improve research in the Department which are:

1. Building a culture of using research to improve services;

2. Development and dissemination of a research agenda;

3. Capacity development of staff on the utility of research and conducting research especially operational research;

4. Structured processes to collaborate with researchers on strategic research questions such as trials to evaluate the effectiveness of complex interventions aimed at behaviour change; and

5. Dissemination and translation of research findings into policy and practice to positively impact on service delivery and health outcomes.

Dr Engelbrecht shared research plans under consideration by the Province namely:

- promote evidence based health service delivery, by encouraging and supporting service providers to identify and make use of research findings that use the application of rigorous, systematic and objective procedures to obtain knowledge.
- support the conduct of relevant research by raising funds to commission research to address Provincial research priorities.
- support the utilization of research findings for improved practice and policy by holding meetings and workshops to assist service managers incorporate research recommendations in addressing operational problems.

Dr Engelbrecht Provincial Head of Department setting the scene and providing a departmental context for research. Emphasing the importance of the interdisciplinary approach to research that includes the social sciences as well as participatory methodologies that include the communities we serve.

Her concluding remarks highlighted challenges faced in developing the culture of research and its utilization. These include:

- research approval capacity at PHC level is limited,
- the lack of a dedicated budget to commission research,
- Research is often not linked to implementation strategy or does not address priority system challenges and
- research outcome interventions or recommendations are often not possible in resource constraint environments and disillusion may follow.

Keynote address

The *keynote address* delivered by Ms Wilkinson and Dr Grimsrud from Médecins Sans Frontières(MSF) and UCT's School of Public Health and Family Medicine arose from research conducted in Khayelitsha and Guguletu. Their topic was "*Retention across the HIV cascade in the Cape Metro"*. They outlined the scale of the sub-Saharan HIV epidemic and the size of the anti-retroviral programme Although 15 million people in 2015 receive treatment in sub-Saharan countries, retention in care in Africa is poor retention compared to Asia and Latin America. Close to 80 % of HIV positive South African adults, however, remained in ARV treatment during 2012/13.

Key note speakers: Lyn Wilkinson (MSF) and Anna Grimsrud (School of Public Health & Family Medicine; UCT)

UNAIDS' ambitious goal to control the HIV epidemic by 2020 has three ambitious goals: - '90-90-90'. This is that 90% of the population must be tested for HIV; 90% of

those testing positive must be on ARV therapy; and, 90% of those on therapy must have undetectable viral load by 2020.

The presentation reviewed local service models which have enabled retention in care. The By 2009 14 900 patients were recruited into care, with the Khayelitsha-Eastern sub-structure having the largest load. More recently the Rapid ART initiation and counselling model, to reduce pre-ART loses and prepare for long term adherence, achieved 85.9% retention in care after 6 months of treatment initiation.

These research findings formed the basis of the adoption of the Western Cape's 2016 roll-out model. The National Department of Health will adopt it in soon to be released adherence guidelines. International funding bodies such as PEPFAR and Gates foundation have shown interest in this model.

Other useful models for adherence derived from local research are the ART Adherence Club model which was compared with individual treatment. In 'Clubs', a group of 30 clinically stable clients led by a lay health care worker (HCW), meet 5 times per year for less than 45 minutes where they receive pre-packed medication and discuss any problems they may have encountered. Treatment buddies are allowed to collect treatment on behalf of clients. A clinician reviews their status annually. Club participation reduced loss to follow-up (LTFU) by 57% and viral load rebound by 67%. Scale up of the model to more than 30, 000 stable ART clients is underway in the Cape Metro, and 77% ART service points use the Club model.

Variations in service models designed to enhance adherence were presented. These include ART dispensing strategies, eligibility criteria, location treatment site, various patient populations, cadres of staff facilitating clubs, and services provided. The club model was extended to the management of children living with HIV/AIDS in Khayelitsha. In 2013 good retention rates (74%) and high (95%) suppression were reported for this model.

Lost to follow up is a risk in chronic disease programmes. Research has shown that community based care clubs reduced the risk of LTFU by 67% compared to standard of care.

Another research showed that there was no difference between 4 and 2 month treatment supply treatment in LTFU. Other encouraging research showed that the on the Club model was effective amongst adults on second line ART as well as for those those with adherence problems in Khayelitsha.

In conclusion, they emphasised the importance of trust – that health care providers should trust patients. Patients should be trusted to adhere to treatment, and be provided with longterm pre-packed treatment in conjunction with the necessary support.

Overview of research in the Western Cape

The Provincial and City of Cape Town health authorities gave an overview of new research conducted in 2015 on both the Provincial and City service platforms. They highlighted the gaps in research and challenges experienced with research approval processes and research result feedback from researchers.

Both authorities now use online application processes to process and approve research applications. The Provincial Health Research Committee's (PHRC) Mutual Courtesy Guideline, a tool to guide the relationship between researchers and services was highlighted. Highlighted was that whilst operational priorities of researchers and services may differ, positive working relationships between service staff and researchers need to be fostered.

The roundtable discussions

Round table discussions: delegates listening and exchanging ideas

The round tables are an opportunity for researchers, managers and service providers to engage around topics of mutual concern for which there are no easy answers. Four round tables related to the overall research day theme, facilitated by local experts on each topic, were held this year. The topics and their conveners were:

1. Improving post-discharge retention in care for patients with serious mental illness discharged from Valkenberg Hospital - facilitated by Dr P. Milligan, University of Cape Town.

2. Managing children and adolescents with HIV treatment failure: results from a pilot project in Khayelitsha, - facilitated by Dr J. Bernheimer, Médecins Sans Frontières, Khayelitsha, Cape Town.

3. Assessing non-adherence and wastage of chronic disease medicines by patients: underlying reasons and strategies to improve patient adherence to chronic medicines,- facilitated by Mr JJ. Hattingh, Eden Health District South Africa.

4. Non communicable disease retention in care at primary health care level – by Prof B. Mash, University of Stellenbosch

Each delegate had an opportunity to participate in any two round table(s) of his/her choice.

Summary of key points from Round Table discussions

Round Table	Topic
1	***Improving post-discharge retention in care for patients with serious mental illness discharged from Valkenberg Hospital (VBH) .***
	Important issues regarding the retention in care for patients with mental illness discharged from Valkenberg are: • Demand for psychiatric care continues to increase; • Non-adherence to medication results in relapse and re-admission of patients; • Historically follow-up of clients is passive and ineffective; • Evidence exist that active follow-up systems improve adherence and reduce re-admissions. **-What makes VBH system work better:** • The key is to include all appropriate stakeholders i.e. pharmacist, family physicians, facility managers and others; • System is co-designed and inclusive; • All hospital treatment team members make collective decision regarding patient management; • If a patient is stable in care for 3 months, then he/she is referred to other levels of care. However many patients are reluctant to change facilities; • Psychosocial rehab clubs seen as another support source to make better use of in retaining patient in care; **Points raised in the discussion:** • There are numerous continuity of care projects using participatory research methods, champions and so on. However, these need scaling-up and their sustainability is less clear; • A key consideration is that specialist patients are only "tip of the iceberg". There is a need to improve mental health care at primary level through the mental health care nurse cadre of caregivers. - Integration of mental health in primary care is key; - The ART Club idea may not work as it need more active intervention; - Role of CCWs need further interrogation – adherence support may be a start; - Many CCW's are apprehensive to visit home of mental health patient,

	• The need to put resources where needed most. Each mental health patient is different in terms of experience, support structure etc. An Anthropological approach may provide more solutions. Bulk of patient's family members may be trustworthy enough to provide and assist in care. • Adaptation of ARV clubs e.g. buddy system may work. HIV programme had similar challenges in early phases e.g. stigma, reluctance and so on. Gradual approach in similar manner may help; • A rural Mental Health Campaign has been launched – need to link up with NGO level for further support.
2	***Managing children and adolescents with HIV treatment failure: results from a pilot project in Khayelitsha,***
	The important issues identified with children and adolescents with HIV treatment failure in a Khayelitsha ART pilot programme are: • Poor adherence to treatment is due to difficulty in getting children to take medicines twice a day for life; • Simple interventions based around providing proper adherence education can lead to high rates of re-suppression in children and adolescents; • These programmes take place at Kuyasa and Ubuntu Clinic and comprise individual and group counselling and support groups (led by an MSF counsellor) and home visits by community health workers; • Most children failing NNRT-based regimens did not re-suppress with adherence support and showed resistance to the NNRTI requiring switching to PI-based regimen; • Most children on PI regimen re-suppressed with adherence support, indicating the robustness of PIs. Only 4 out of 14 patients failing a PI regimen demonstrated significant resistance requiring change to 3rd line ART; • Rates of re-suppression have been lower for adolescents than for younger patients and have required innovative support strategies such as Teen Club support groups to attain durable re-suppression. Questions for the group were: 1. How can counselling services during paediatric ART initiation be strengthened so as to avoid high rates of treatment failure? 2. How can you develop a system in your clinic to 'flag' children failing ART? 3. How can Western Cape clinics provide dedicated services for children and adolescents failing ART? 4. Does each facility need a paediatric champion (medical officer or nurse) to ensure high quality paediatric care?

3	***Assessing non-adherence and wastage of chronic disease medicines by patients; underlying reasons and strategies to improve patient adherence to chronic medicines***
	The key issues associated with non-adherence and wastage of medication pointed out in this round table were patient, medicine, financial and health systems related factors and were as follows: • Patients forget to take medication; • Medication has side-effects; • Long distance to clinic and cost of transport; • Health system factors, such as long waiting time at health facilities is a problem; • individual relationship between patient and provider are important. Potential solutions may be patient education and self-management skills development done at CBS level in groups. Sole responsibility should not be the clinicians; Novel solutions proposed were: • Experience indicates that clinic fees have improved adherence; • Continuity of care: Patients prefer to be seen by the same person, but this is not an identified priority. Patients are often unhappy with medication changes made by a different doctor; • More training needed for clinicians e.g. motivational interviewing skills; • Multiple interventions preferred - no single-focussed intervention will work; • Need to focus on constitutional mandate to provide access to healthcare; • A focus on preventative medicine will decrease need for adherence strategies; • The relationship between state grants and patient adherence: Many patients are reluctant to take medication for fear of losing disability grant if healed.
4	***Non communicable disease retention in care at primary health care level***
	The key issues associated with non-communicable disease retention in care at primary care level were: In Cape Town - there have been interventions to improve education offered to patients including a *brief behaviour change counselling* on smoking offered by midwives and lay counsellors. There were significant improvements on quitting and reducing smoking and also on blood pressure. Some of the key lessons have fed into the development of a chronic care model which has shown that critical success factors for retaining patients in care at primary care level include: • Embedding the approach into organization's framework of care; • Group education process; • Brief behaviour change counselling.

	The big question is: How to retain large numbers of patients in PHC and offer them adequate support of self-management (patient education and counselling)? **The following themes were identified as crucial in retaining patients in care at PHC level:** 1. Patient empowerment - health workers guide patients rather than directing them i.e. collaborative process which encourages patients to talk about issues that they want to bring up; 2. Recognition that health providers perspectives are different from patients. They don't facilitate patients understanding the consequences of disease and ultimately why they should invest in lifestyle adjustments; 3. The sustainability of the courses of actions that health providers propose to patients is questionable. There may be short or longer-term actions that could produce better outcomes; 4. Patient retention is a common concern amongst stakeholders but their networking is poor 5. Use of electronic communication technology is important: Patients can be guided to the reliable sources of information by putting up information centres at facilities. 6. Stable patients require different strategies to remain in care. But, definitions of 'stabile' need to be clarified – for example are patients living with co-morbid conditions defined as stable if one or some of his/her conditions is under control while others are not?; 7. Communication with providers and patients is central to patient management. When this relationship is poor then the unreliable informal advice dominates; 8. Changing practice starts at the top: -We cannot change clinicians' and health worker practice until we change the organizational culture; - The organizational culture within the Department does not value communication, and cascades down to health care workers not sharing information with patients.

5	**Retention in care at the Primary Care Level**
	1. Presentation on how to retain patients in case and support self-management 2. Review of research on the burden of disease being managed on the primary care platform, and of trials of interventions of group education and counselling, brief behaviour change counselling, and

	strategies to improve patient provider interactions in order to support existing health education initiatives (and materials.) Limited evidence of clinical benefit of group education or motivational interviewing. Studies mostly not powered on clinical outcomes. 3. And 4. Important issues - Difficult to measure "retention in care" - Multi-morbidity is common and challenging - Move from hospi-centric to community centric model of care and great focus on healthy living (DOH messaging on this) - Room for a patient-held record and case management plan - Clinician inertia, and differences in understanding of the term "goal" [learning from HIV experience] 5. Animated discussion with input from variety of health care workers (HIV, NCD, and psychiatry)
6	**Non-adherence and wastage of CDU medicines**
	1. Topic: Report of findings from a research project in Eden district to describe common barriers to adherence, quantify wastage of CDU packed medicines and associated costs 2. Mr Hattingh presented the findings from an NHI funded research project exploring non-adherence and medicines wastage of CDU packed medicines. 12 clinics in the Eden health district were sampled and a total of 621 patients were interviewed. Adherence to treatment was assessed using self-report (Morisky and Visual Analogue Scale). Common barriers to adherence were identified at patient, medicines, financing, and health systems levels. Cost of CDU-associated wastage is around ZAR 63 000.00/month. 3. Important to quantify non-adherence and associated costs particularly in reference to CDU initiative 4. The presentation generated discussion and questions about, - Methods used, especially sampling frame - Perceptions of "malicious non-compliance" in order to stay on disability grant

	- How this project was funded - Waiting times and focus on waiting times as part of improving patient experience - Mismatch between patient and provider expectations and communication 5. Lots of interest in the project, the findings, and the action plan as a result of the findings. Also, a lot of interest in the funding model for such projects

Facilitated poster session

The tried and tested **facilitated poster session** followed the round tables. Twenty six posters were presented, almost double the number presented in previous years. They were presented by researchers from universities, research councils, health districts, Provincial and the City of Cape Town health departments. They were divided into five themes which covered diverse areas such as ***Continuity of Care*** to ***Models of Care*** and ***Packages of Care.*** Presentations facilitated animated discussion between presenters and the delegates. Although the poster presenters had limited time, 4 minutes to present and 3 minutes question time, the sessions were exciting and informative. Delegates were able to engage the presenters after the set period for the sessions to get clarity on issues that were not clear or fully addressed.

Research day delegates attending a facilitated poster session

Panel discussion

Dr Tony Hawkridge from the Department of Health's Health Impact Assessment (HIA) directorate facilitated the afternoon's panel discussion. Panellists debated the question of "*How much effort should we put into retaining people in care for chronic conditions?*" The panellists were:

1) Prof A. Boulle, University of Cape Town (UCT)– School of Public Health and Family Medicine
2) Ms M. Maredza, University of Cape Town (UCT)– Health Economics Unit
3) Dr V. de Azevedo, City of Cape Town (CoCT)– Khayelitsha Sub-District
4) Dr A. Kengne, Medical Research Council (SA-MRC) – Chronic Disease Unit

Panel discussion: (L to R) Dr A. Hawkridge (facilitator)(DoH), Dr V. de Azevedo(CoCT), Prof A. Boulle (UCT/DoH), Dr M. Maredza (UCT/DoH), Dr A. Kengne (MRC-SA)

A lively discussion ensued between the speakers with each panelist addressing the question from their discipline's perspective. Prof Boulle argued the question from a epidemiologist perspective and proposed a trade-off between preventing morbidity and mortality and providing a service to those with chronic ailments. He questioned whether it is better to focus interventions on population needs or spent them on individual client needs. He raised whether it is worthwhile for the health department to focus on primary enrolment of new clients as opposed to retaining patients that are already in the system. He proposed that if morbidity and mortality

are low in the community then loss to follow up (LTF) maybe less important and this may conversely be true as well.

Prof Boulle suggested that even with low event rates retention may have secondary benefits such as the prevention of HIV spread. One other crucial factor is the screening and linking of clients to care compared to retaining them in the service. He pointed out that most morbidity and mortality is driven by clients who have dropped out of care –for example, 50% of HIV associated mortality in patients were those who have been on anti-retroviral therapy (ART).

He provided some caveats to amplify his argument such as the need to triage or fast track clients at risk who visit service points, and the need to prioritise re-engaging those at higher risk of events after loss to treatment. Using of information systems to ensure that the Department does not try to trace untraceable clients would also save cost.

On the other hand Ms Maredza took a conditional stance on the question and argued that we should put as much effort as we can, explore all possible courses of actions even if the impact is modest because the cost of saving a human life is immeasurable. Her main argument centred on budgetary constraints and she emphasized that the effort we put in retaining patients in care should be guided by our ability to finance and sustain those efforts. Efforts should give us the best benefit (longevity, quality of life) for every Rand spent. Although understanding costs versus impacts would be ideal, there is very limited information on what it costs to implement what seems to work making it challenging to determine which course of action to take to retain patients in care. She argued that the effort we place to retain patients in care requires building a strong evidence base to inform decision making, and the lack of data should not be an excuse for doing nothing as there are interventions shared during the course of the Research Day that have proven cost-efficient and could be implemented.

Looking at the topic through a non-communicable diseases (NCD) lens, Dr Kengne argued that retention in care is a possible area of action to improve

outcomes of NCD care. The small number of people with NCD in care, and the lack of evidence to support actions to improve retention in care argue against its prioritization as a key area of intervention. He highlighted that research is needed to identify modifiable factors which can be targeted using locally relevant solutions to improve retention in care. A focus on community and population-based approaches, and increasing awareness and treatment of common NCDs will be cheap and translate into more benefits than investing on retention in care.

Arguing the question from a service provider point of view, Dr Azevedo took a pragmatic approach to retention in care and stated that if service providers consumed resources for the diagnosis and treatment initiation, it followed that not ensuring retention in care would make that expenditure fruitless. It is thus public health services obligation to develop and implement strategies for retention in care. Facilities are frequently overwhelmed by the number of clients that present for services and do not have effective systems to promptly track defaulters. A nuanced approach to those that return to care needs attention.

Task shifting to staff with lower levels of education and the use of SOPs to ensure a comprehensive standard approach to counselling are useful. There is a risk, however, of counsellors focusing attention on ticking boxes rather than engaging with the client circumstances. This is ineffective system which may result in the client abandoning treatment.

Dr de Azevedo pointed out that assessing the size of the retention in care problem is highly dependent on complete data capturing and automated reports that check for early defaulters. Exacerbating this problem is that there are no norms for clerical staff for primary health care (PHC) facilities or criteria for performance assessment of clerical work. Data submission is frequently late and incomplete and automated reports are a good reflection of retention in care.

She concluded by saying that public health services are obliged to ensure retention in care, but we do not have enough evidence of what works, and therefore further research in the area is required. However success requires the engagement of the clients, their families and the community at large.

OUTCOMES:

1) 139 Delegates

2) 26 Research posters presented

3) 4 Round Tables convened

4) 4 local tertiary institutions [CPUT, SU, UCT,UWC] represented

5) 2 National Research Councils (MRC, HSRC) represented

6) 3 Non Government Organizations, 1 international and 2 local (MSF, HST, Mfesane)

7) 13 Volunteers

8) 5 poster facilitators

9) Provincial, District, and sub-district senior managers participated

COST:

POSTER PANELS = R 2 314. 20

Catering = R19, 000

Venue hire = R 0, 000

Poster Prestik and adhesive tape = R40.00

All smiles, volunteers from the DoH's Health Impact Assessment (HIA) ready to assist research day delegates. (L to R): Mandy Maredza, Mieke Willems, Glynis Denicker, and Sinazo Vilakahle

Research Day Volunteers

As with past research days, the 2015 research day attracted a highly motivated and enthusiastic group of volunteers drawn from the Universities of Cape Town and Stellenbosch, and from the Health Impact Assessment (HIA) Directorates. The level of enthusiasm and desire to help is shown by some of the volunteers presenting themselves on the day while in the middle of exam preparations. Volunteers assisted with packing research day packs, registration of delegates, loading of presentations on laptops, guiding and channeling research day delegates, taking notes during round table discussions, assisting poster presenters hanging posters, time keeping, providing water to speakers and photography.

They assisted with the setting up of chairs and tables for registration, prepared name tags for late registered delegates. They displayed a true spirit of volunteerism.

Closure and vote of thanks

The proceedings of the day were brought to an end by the closing address and vote of thanks from Dr Krish Vallabhjee, Chief Director Strategy and Health Support, Western Cape Department of Health. He thanked the Provincial Health Research Committee (PHRC) and the Health Impact Assessment (HIA) directorate for planning, co-ordinating and implementing a successful research day. The day was enlightening and facilitated constructive conversations on a well chosen theme. Specifically: Chronic conditions are a priority for Department

- Presenters were thanked for their work presented for the plenary, round table and posters. They enabled relevant research to be surfaced for engagement
- The day accords well with the Departmental focus on improving the Health systems, looking at continuity of care, life course of patients – Healthcare 2030
- The operational research presented was so pertinent and raised some very important questions such as the models of care in the light of an escalating burden of chronic diseases.
- Resource constraints are a reality and impact on quality, efficiency and improved health outcomes. These factors cannot be treated as mutually exclusive.
- The theme: **Retention in Care, Adherence and Continuity of Care",** is in all our interests as patients and the community, health service providers and the health department/system as a whole.

He remarked that site visits to facilities along this continuum of care provides useful information. For example challenges raised by St Joseph's Hospital about the lack of full information retarded discharge planning which in turn impacted on their ' average length of stay' (ALOS) and their ability to place patients. There are pressures on clinicians who need to empty beds as the next patient is waiting, and they need to consider the implications of discharge decisions down the system for the next facility.

Previous conversations about the translation of evidence to policy and practice have implied that there is a gap. The operational research presented demonstrated that there was in fact good collaboration between researchers, clinicians, and the department with co-creating the research. This augurs well for translation of research into practice for the services.

The Department can be proud of the good work / research being undertaken in the province. The quality is world class and provides lessons for the rest of South Africa and globally.

He thanked the Head of Department, COO and other senior managers/clinicians for making the time to be present given their busy schedule. This sends an important signal that we value the research being done, we value the opportunity to engage around the findings and are committed to seeing how we can apply it in policy and practice whilst recognizing resource and political challenges.

The MEC for health could unfortunately not attend the event but has a keen interest in research and its application to health services. She suggested that we consider the ***patient centred experience and quality*** as a theme for the next research day, but that can be taken forward by the PHRC and HIA.

Dr K. Vallabhjee closing the day

The Chief Director thanked each one of the delegates for their contribution to making the gathering a valuable and enriching engagement and thanked the University of Stellenbosch for kindly hosting the Provincial health research day.