JOURNAL OF MANAGEMENT PERSPECTIVES

https://jmp.regent.ac.za/ | Open Access

From Policy to Practice: Clinical Governance Challenges in a Resource-Constrained Emergency Medical Services System

A. Xeketwana[1] & M. Wadiwalla[2]

distributed under the terms of the Creative Commons Attribution 4.0 International Licence (CC BY 4.0).

1. *Abongile Xeketwana*
Eastern Cape Department of Health: Emergency Medical Services.
Email: abongilexeketwana@gmail.com
2. *Dr Munira Wadiwalla Academic, University of Kwazulu Natal (UKZN), Durban South Africa*

DOI:
https://doi.org/10.64287/jmp.2026.2.6

©2026 Xeketwana A. et al. This is an open access article

ABSTRACT

Clinical governance has been formally embedded within South Africa's health policy and regulatory framework; however, its translation into routine practice remains uneven in resource-constrained Emergency Medical Services (EMS) systems. This study explores the policy–practice implementation gap affecting clinical governance within the Eastern Cape Department of Health (ECDOH) EMS. Using a qualitative descriptive design informed by phenomenological principles, data were collected through electronically administered semi-structured open-ended questionnaire from EMS personnel, supervisors, managers, and academic staff. The findings reveal that although national policies and regulations provide a formal clinical governance architecture, implementation at operational level is constrained by fragmented clinical governance structures, weak monitoring systems, limited leadership activation, unclear accountability, staff shortages, inadequate clinical governance training, and the absence of integrated digital reporting systems. Incident reporting and audit processes were often reactive, inconsistent, and compliance-driven rather than embedded as routine learning and improvement mechanisms. Despite these constraints, participants demonstrated awareness of the value of clinical governance and proposed practical reforms, including standardised audit cycles, clearer reporting lines, designated clinical governance roles, district-level governance structures, and improved feedback systems. The study argues that clinical governance fragility in the ECDOH EMS system is not primarily a result of policy absence, but of structural and operational barriers that prevent policy from becoming practice. Strengthening clinical governance requires leadership activation,

institutionalised audit and reporting systems, clearer accountability mechanisms, and context-sensitive investment in workforce and digital infrastructure. The findings contribute to the limited literature on clinical governance in prehospital care and offer practical insights for strengthening governance in rural and resource-constrained EMS settings.

Keywords: Clinical governance; Emergency Medical Services; Health systems governance; Patient safety; Leadership; Quality Improvement; South Africa

Introduction

Clinical governance is widely understood as the organisational system that integrates accountability, quality improvement, and professional development into routine service delivery (Scally & Donaldson, 1998). Over the past two decades, health systems globally have increasingly adopted clinical governance frameworks as a means of strengthening organisational oversight and improving healthcare outcomes. These frameworks seek to move quality management beyond compliance-based approaches by embedding structured systems of audit, risk management, clinical effectiveness, leadership accountability, and organisational learning into routine service delivery (Macfarlane, 2019).

The importance of clinical governance is particularly evident within Emergency Medical Services (EMS), where care is delivered in complex, time-critical, and unpredictable environments. Unlike hospital settings, EMS personnel provide care in decentralised and often resource-constrained contexts where clinical decisions must be made rapidly and frequently with incomplete information. These operational realities increase the importance of governance systems capable of supporting safe practice, monitoring quality, managing clinical risk, and facilitating continuous improvement (Mehmood et al., 2018; Mould-Millman et al., 2017). Effective clinical governance therefore serves not only as a quality assurance mechanism but also as a critical organisational safeguard against preventable harm and service failure.

In low- and middle-income countries (LMICs), emergency care systems frequently face resource constraints that affect access, quality, and the ability to build mature improvement systems (Kannan et al., 2020). The World Health Organization's (WHO) Emergency Care System Framework emphasises that emergency care functions can be achieved in different ways depending on resources, yet organisations still require clear system functions and accountability mechanisms (Mehmood et al., 2018; World Health Organization, 2018). In South Africa, national regulatory expectations further outline standards for EMS, reinforcing clinical governance responsibilities at system and EMS station levels (Department of Health, 2022). However, regulatory standards do not automatically translate into reliable station-level routines, sustained learning cultures, or functional data systems, which are the operational mechanics that determine whether clinical

governance becomes effective. This disconnect between formally established clinical governance requirements, and their inconsistent operationalisation constitutes a policy–practice implementation gap: the policy architecture defines what should occur, while organisational capacity, leadership, resources and operational processes determine whether these requirements become routine practice. Understanding this gap is particularly important in resource-constrained EMS systems, where competing service demands may constrain the translation of governance requirements into everyday clinical practice.

The Eastern Cape provides a critical lens for understanding these challenges. The province is home to more than 7.2 million people and includes large rural communities where distance and access constraints can amplify the consequences of system weaknesses (Statistics South Africa, 2023). Against this background, this study aimed to explore the barriers to, and opportunities for, effective clinical governance within the Eastern Cape Department of Health (ECDOH) EMS. The specific objectives were to:

- Identify existing clinical governance practices within ECDOH EMS
- Analyse the challenges affecting the implementation and maintenance of clinical governance practices
- Propose key components for a contextually appropriate clinical governance framework.

The article first reviews clinical governance as a concept and considers its relevance to EMS. It then explains the methodological choices used in the study, presents the empirical findings, discusses the policy–practice implementation gap, and concludes by outlining practical recommendations for strengthening clinical governance in resource-constrained EMS systems.

Conceptual and theoretical foundations of clinical governance

Clinical governance emerged as a formalised response to systemic failures in healthcare quality and accountability. It is widely conceptualised as the framework through which healthcare organisations are accountable for continuously improving service quality and safeguarding high standards of care (Scally & Donaldson, 1998). Unlike isolated quality initiatives, clinical governance integrates leadership, audit, risk management, professional development, and patient safety into a coherent organisational system (Macfarlane, 2019).

In the EMS context, clinical governance assumes additional importance. EMS operates in high-risk, time-sensitive, and decentralised environments where variability in decision-making can directly influence patient outcomes (Mehmood et al., 2018; Mould-Millman et al., 2017). As such, structured oversight mechanisms are essential to ensure consistency and accountability. However, while the concept of clinical governance is well developed in hospital settings, there is a paucity of evidence to support its operationalisation within prehospital EMS systems.

The theoretical understanding of clinical governance is frequently anchored in Donabedian's (1988) structure-process-outcome (SPO) model (Donabedian, 1988). According to this framework, organisational structures, including staffing, leadership, policies, and information systems, create the conditions under which care processes occur. The processes, such as clinical audits, incident reporting, supervision, and professional development, subsequently influence patient outcomes *(Figure 1)*.

The SPO model is particularly relevant in examining clinical governance within EMS systems, as it highlights how structural weaknesses may cascade into process variability and outcome vulnerability.



Figure 1 Donabedian's Structure–Process–Outcome Model Applied to Clinical Governance

Donabedian (1988) argued that good outcomes are more likely when robust structures support reliable processes (Donabedian, 1988). Beyond Donabedian, clinical governance theory emphasises the role of leadership activation and regulatory responsiveness. Healy and Braithwaite (2006) argue that effective governance requires visible enforcement and graduated accountability mechanisms (Healy & Braithwaite, 2006). Without structured oversight, policies may exist symbolically

but fail operationally. Similarly, safety culture literature underscores the importance of psychological safety in incident reporting systems. Just culture frameworks suggest that organisations must create environments where frontline staff can report errors without fear of victimisation, thereby enabling learning and system improvement (Boysen, 2013).

Together, these theoretical perspectives suggest that governance effectiveness depends on structural integrity, leadership engagement, and institutionalised learning processes.

Clinical governance policy and implementation in EMS

Clinical governance has evolved into a central pillar of contemporary health system reform, with countries adapting its principles to align with their institutional structures, regulatory environments, and service delivery models. Although the concept originated in the United Kingdom, it has been widely institutionalised across diverse healthcare systems as a mechanism for strengthening accountability, improving quality of care, and enhancing patient safety (Masuku & Houston, 2022). Internationally, clinical governance in EMS is no longer treated as a peripheral quality initiative but is integrated into broader national health system performance and accreditation frameworks (Basu, 2019).

Comparative evidence from high-income health systems demonstrates several recurring structural characteristics of mature governance models. First, governance is embedded within national regulatory and accreditation standards, ensuring external accountability. Second, leadership responsibility is formalised at executive and board levels, reinforcing oversight and organisational ownership of quality systems. Third, audit mechanisms, risk registers, incident reporting systems, and professional development processes are institutionalised rather than discretionary. Finally, governance processes are integrated into routine EMS operations through digital reporting platforms, multidisciplinary review committees, and structured performance monitoring (ACSQHC, 2017; ACT Ambulance Service, 2023; Kennedy et al., 2017; Queensland Government, 2018; SA Health, 2024).

These systems illustrate how nationally articulated clinical governance principles can be translated into context-specific operational frameworks without losing structural coherence. Clinical governance is sustained not merely through policy declaration, but through institutional architecture that aligns leadership

accountability, workforce capacity, data infrastructure, and monitoring systems. Importantly, innovative models have demonstrated that clinical governance principles can be scaled and adapted even in smaller or non-traditional prehospital settings, reinforcing the flexibility of the framework when supported by clear structures and oversight mechanisms (Ambutech & Kirklees College, 2024).

However, these international models operate within comparatively stable and well-resourced health systems characterised by strong digital infrastructure, workforce density, and established regulatory oversight. The structural conditions underpinning governance maturity in such environments may not be readily transferable to rural or resource-constrained EMS systems. Consequently, while global experiences provide valuable lessons on institutional embedding and leadership accountability, their implementation in lower-capacity settings requires contextual adaptation rather than direct replication.

Clinical governance in South Africa is formally anchored in the Policy on Quality in Health Care, which establishes quality improvement, patient safety, and accountability as core pillars of health system performance (Mseleku, 2007). The policy emphasises structured leadership responsibility, continuous quality improvement, and the integration of monitoring and evaluation mechanisms within healthcare institutions.

The National Core Standards (NCS) further operationalise these principles by defining measurable benchmarks for healthcare quality across domains including patient safety, clinical governance, leadership, and operational management (National Department of Health, 2011). The NCS explicitly link governance structures to performance monitoring, requiring health establishments to demonstrate structured oversight, risk management systems, and quality improvement cycles.

In 2014, the clinical governance handbook for District Clinical Specialist Teams (DCSTs) was developed. The DCSTs handbook outlines four pillars of governance, clinical effectiveness, clinical risk management, patient experience, and strategic oversight, and proposes structured activities such as clinical audits, incident reporting, service target setting, staff mentoring, and inter-disciplinary collaboration as enablers of operational governance (Connell, 2014; Oboirien et al., 2018).

Clinical governance in South Africa was formalised as a statutory obligation through the 2018 Regulations under the National

Health Act, requiring health establishments to implement structured systems for risk management, incident reporting, and clinical oversight (Department of Health, 2018). This legislative reinforcement builds on earlier policy instruments, which collectively institutionalised clinical governance expectations within the public health system. However, empirical studies reveal persistent implementation gaps, including limited staff awareness, fragmented accountability structures, weak information systems, and inconsistent enforcement, despite isolated district-level successes (Makumbani & Tsibolane, 2025; Matahela et al., 2023; Mokoena & Naidoo, 2024; Naidoo & Suthiram, 2025; Sithole et al., 2024). These findings suggest that while South Africa's clinical governance is structurally established at policy level, operational embedding remains uneven and capacity dependent.

Clinical governance in South African EMS is formally anchored in national regulatory and policy instruments designed to standardise quality of care, strengthen accountability, and improve patient safety. The NCS designate Clinical Governance and Clinical Care as one of the seven foundational domains applicable across health establishments, including EMS, requiring implementation of structured mechanisms for clinical risk management, incident reporting, audit processes, and adherence to clinical protocols (National Department of Health, 2011). This framework is reinforced by the EMS Regulations promulgated under the National Health Act, which mandate governance standards for both public and private EMS providers, including requirements relating to clinical records, emergency dispatch, interfacility transfers, user safety incidents, infection prevention, and leadership oversight (Department of Health, 2022). Complementing these regulations, the Ideal EMS Framework Assessment Tool was introduced to evaluate governance maturity, leadership accountability, training systems, and alignment with national quality priorities across EMS stations (Govender et al., 2024).

Despite this comprehensive regulatory architecture, empirical evidence reveals uneven implementation and structural fragmentation across provincial EMS systems. Howard et al. (2020) found that while organisational planning structures were present in public EMS, measurement and improvement systems were weak and disproportionately focused on response time metrics rather than clinical quality indicators (Howard et al., 2020). In contrast, private EMS providers demonstrated stronger engagement with

clinical audit and structured quality improvement processes (Howard et al., 2020). Broader assessments of EMS functionality across provinces indicate underperformance in leadership, governance integration, communication systems, and workforce preparedness (Govender et al., 2024). Although efforts have been made to strengthen clinical governance capacity, including the development of capability benchmarking tools, professionalism-oriented leadership models, and context-specific quality indicators for prehospital care, systemic barriers such as limited measurement systems, inconsistent enforcement, leadership gaps, and inadequate integration of information systems continue to constrain governance maturity (Howard, 2020; Mosca & Kruger, 2022; Vincent-Lambert & Stein, 2024). Collectively, the evidence suggests that while South Africa possesses a robust formal governance framework for EMS, effective operational embedding remains uneven and capacity-dependent, particularly within the public sector.

The Eastern Cape represents one of South Africa's most resource-constrained and geographically dispersed provinces, characterised by rural service delivery demands, workforce shortages, infrastructure limitations, and high trauma burdens. While national policies and EMS regulations establish formal governance expectations, provincial capacity to institutionalise structured audit systems, incident reporting mechanisms, and leadership accountability frameworks varies significantly. Given the documented variability in clinical governance maturity across South African EMS systems, the Eastern Cape provides a critical case for examining how statutory governance frameworks function within a structurally constrained prehospital environment. Investigating clinical governance in this context enables a deeper understanding of how policy architecture interacts with operational realities, thereby contributing empirical insight into governance implementation within rural, resource-limited EMS systems.

Justifying methodological choices

A qualitative descriptive design, informed by phenomenological principles, was used to explore how EMS personnel and managers experience clinical governance within the ECDOH EMS. This approach was appropriate because the study sought to understand perceptions, experiences, and operational realities rather than measure predetermined variables. The design allowed participants to describe how clinical governance is understood, implemented, constrained, and potentially strengthened within their working environment.

Purposive sampling was used to select participants who included operational EMS personnel, EMS supervisors and managers, and academic staff involved in EMS training and governance. This ensured perspectives from both frontline delivery and governance functions. Participant categories and experience profiles were documented. Data collection concluded at ten participants (n=10) once thematic saturation was achieved, consistent with qualitative sampling recommendations (Guest et al., 2006).

Data were collected using electronically administered semi-structured open-ended questionnaire, allowing participants to provide detailed accounts of their experiences and perspectives (Creswell & Poth, 2017). The questionnaires were administered digitally using Microsoft Forms to maximise accessibility, ensure data accuracy, and minimise the risk of transcription errors. Data collection was timed to take place between June 2025 and July 2025 to accommodate shift schedules and operational requirements. Participants were contacted via WhatsApp and were provided with information about the study and questionnaire, and consent forms.

Data were analysed using Braun and Clarke's (2006) thematic analysis framework (Braun & Clarke, 2006). Questionnaire responses were anonymised by assigning each participant a unique code prior to analysis. Following familiarisation, initial codes were generated and grouped into themes through iterative review.

Ethical approval was obtained from the Human Research Ethics Committee of Regent Business School (RBSHREC2025/413) as well as gatekeeper approval obtained from the ECDOH EMS. Participation was voluntary, and participants were informed of the study objectives before data collection. Written consent was obtained from participants, and the participants had the right to withdraw from the study at any point with no consequences. The data were stored

confidentially on a password-protected device.

Noting the outcomes

The findings show that clinical governance within the ECDOH is shaped by a clear policy–practice implementation gap. Participants recognised the importance of clinical governance and identified several policy-aligned activities that should be present, including clinical audit, incident reporting, documentation review, guideline monitoring, training, feedback, and accountability structures. However, these activities were not consistently embedded in routine operational practice.

Four interrelated themes emerged: fragmented governance structures, weak leadership and accountability, resource constraints, and frontline readiness for reform *(Figure 2)*.

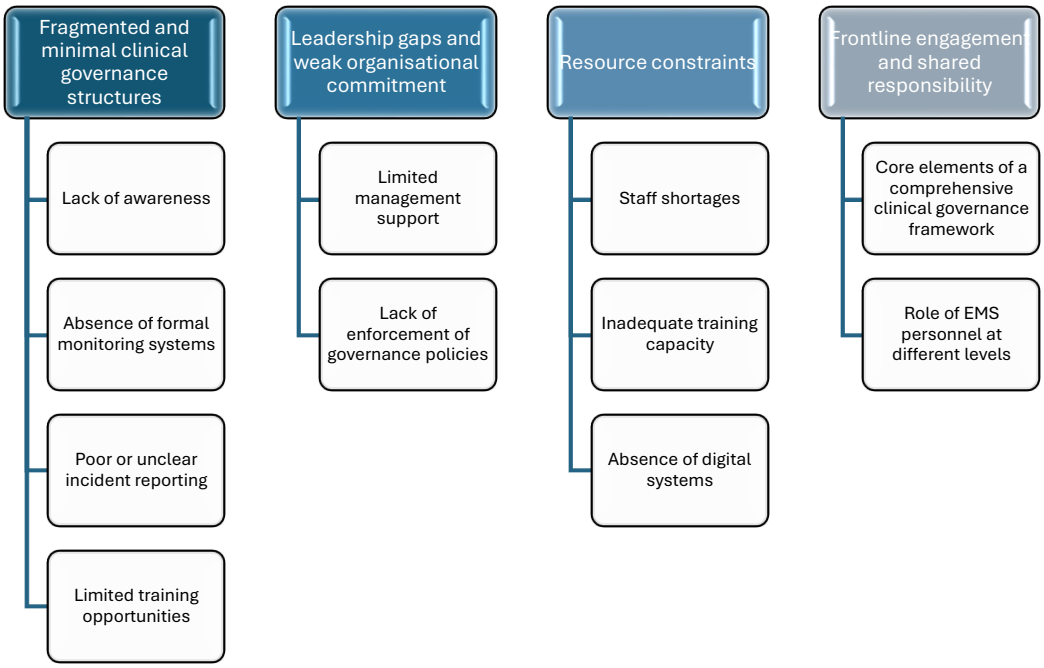


Figure 2 *Thematic map of themes and codes*

Fragmented clinical governance structures

Participants described clinical governance as inconsistently institutionalised across districts. While national policies and regulatory expectations exist, respondents indicated that clinical governance was not experienced as a visible, standardised, and routine operational system at station level. Some participants reported that quality assurance activities, such as patient report form reviews, were performed inconsistently and depended on individual shift leaders rather than a formal departmental standard. One participant stated:

"*There are no clinical governance practices that are implemented in my district. Quality assurance of patient report forms gets done by certain shift leaders and not for all patient report forms. There are no set standards by the department on how to quality assure patient report forms.*"

This reflects a key feature of the policy–practice gap: governance expectations exist, but the operational tools, routines, and standards needed to implement them consistently are underdeveloped. Participants further reported that formal monitoring systems were either absent, irregular, or reactive. Clinical audits and case reviews were often triggered by serious incidents rather than conducted as routine quality improvement processes. One participant explained:

"*In my district, there are no systems established to monitor and improve the quality of care within Emergency Medical Services.*"

Incident reporting was also described as unclear and inconsistently supported. Participants acknowledged that incidents could be reported, but they expressed concern about limited feedback, poor follow-through, and punitive responses. One participant emphasised that frontline staff should be able to report incidents without fear of victimisation, while another stated:

"*There is no system established to report incidents except that when a serious incident has happened which resulted in harm or potential litigation you will be asked to complete a statement and taken for disciplinary hearing.*"

These responses suggest that incident reporting was not consistently experienced as a learning system. Instead, it was often associated with disciplinary action, litigation risk, or reactive investigation. This weakens psychological safety and limits the ability of the organisation to use incidents as opportunities for system improvement. Participants also reported limited formal training on clinical governance processes. While clinical skills

development occurred periodically, governance-specific training on audit, documentation standards, risk management, quality improvement, and reporting pathways was described as insufficient. As a result, clinical governance expectations were often implicit rather than formally embedded in professional development.

Weak leadership activation and unclear accountability

A second theme concerned leadership gaps and weak organisational commitment. Participants indicated that while clinical governance may be recognised in principle, managerial oversight and enforcement were inconsistent. In some districts, clinical governance activities depended on motivated individuals rather than structured organisational systems. Operational performance indicators, particularly response times, were perceived to receive more attention than clinical quality indicators, audit cycles, and documentation review. Participants also described unclear accountability arrangements. Policies and procedures were said to exist, but their implementation was inconsistent. One participant stated:

"*The current policies and procedures are very ineffective when it comes to addressing challenges we face in the Eastern Cape Department of Health Emergency Medical Services. Although some policies exist on paper, their practical application is not consistent, and no one is there to enforce the compliance of those policies.*"

This statement captures the central argument of the study: the weakness is not necessarily the absence of policy, but the limited translation of policy into practice. Without designated clinical governance roles, clear reporting lines, monitoring routines, and feedback mechanisms, accountability becomes diffused. Operational staff may view clinical governance as a management responsibility, while managers may lack the systems and resources required to enforce it consistently.

Resource constraints as barriers to governance implementation

Resource constraints were repeatedly identified as structural barriers to clinical governance. Participants described staff shortages, high call volumes, fatigue, limited vehicle availability, and the need to prioritise emergency response over governance activities. One participant explained:

"*We are currently short staffed and operating with few personnel on shifts, this then results us having to work overtime shifts or operate with few vehicles and having to cover a lot of*

calls that could have been shared with other vehicles. The result of this is fatigue and medical errors."

This finding shows how workforce shortages affect more than operational coverage. They reduce the time, energy, and organisational capacity available for audit, case review, documentation improvement, training, and reflective practice. Clinical governance therefore becomes difficult to sustain when frontline staff are operating under persistent service pressure.

Participants also identified inadequate training capacity as a barrier. One participant noted:

"*There are currently no regular or formal training programs or sessions that are dedicated to clinical governance within Emergency Medical Services in my district. Any ongoing learning is self-initiated by the practitioners, and there seems to be no structured plan from management to ensure that all staff are updated of best practices, clinical guidelines or governance standards.*"

This indicates that clinical governance competence is not being developed systematically. In the absence of structured training, staff may understand the importance of quality care but lack consistent exposure to clinical governance tools, audit methods, documentation standards, and reporting expectations. The absence of integrated digital documentation and reporting systems further constrained clinical governance. Participants reported that reliance on paper-based records limited the ability to aggregate data, monitor trends, analyse incidents, and support evidence-informed decision-making. Without centralised systems, clinical governance remained labour-intensive, inconsistent, and reactive.

Frontline readiness and shared responsibility

Despite the challenges identified, participants did not reject clinical governance. Instead, they demonstrated awareness of its importance and proposed practical reforms. Participants called for a formal EMS-specific clinical governance framework that would define responsibilities, standardise processes, and support consistent implementation across districts. Suggested components included standardised audit templates, routine review cycles, clear incident reporting pathways, district-level clinical governance committees, dedicated governance personnel, and formal documentation standards.

Participants also emphasised the need for clearer role delineation. Clinical governance was viewed as a shared responsibility involving operational staff, supervisors, managers, and designated

governance leads. Suggested clinical governance routines included regular case review meetings, audit feedback sessions, performance monitoring, and escalation pathways for governance concerns. This theme is important because it shows that clinical governance reform is possible. Participants were not resistant to clinical governance; rather, they wanted clearer structures, stronger leadership, predictable processes, and practical tools. This suggests latent organisational readiness for reform, provided that policy expectations are supported by operational capacity.

Policy-practice implementation

The findings demonstrate a clear policy–practice implementation gap in the operationalisation of clinical governance within the ECDOH EMS. South Africa has established a formal policy and regulatory architecture for clinical governance, including the National Core Standards for Health Establishments and the Regulations Relating to the Standards for Emergency Medical Services (Department of Health, 2022; National Department of Health, 2011). However, the findings indicate that the existence of these instruments has not consistently translated into routine clinical governance practices at district and station level.

The study findings suggest that clinical governance within ECDOH EMS is not constrained primarily by the absence of policy, but by limited structural and operational capacity to implement existing policy requirements. This distinction is important because it reframes clinical governance weakness as an implementation and capacity challenge rather than merely a compliance deficit. Participants' responses indicated that governance-related practices such as patient report form audits, incident reviews, case discussions, documentation monitoring, and clinical quality assurance were either inconsistently performed or dependent on local initiative rather than embedded as standardised organisational routines. This finding aligns with Howard et al. (2020), who observed that while South African public EMS systems may demonstrate evidence of planning structures, measurement and improvement processes often remain weak and disproportionately focused on operational performance indicators such as response times rather than broader clinical quality indicators (Howard et al., 2020).

From the perspective of Donabedian's structure–process–outcome model, the findings demonstrate how weaknesses in organisational structures compromise governance processes and, ultimately, quality outcomes (Donabedian, 1988). In

the context of this study, structural limitations included staff shortages, insufficient clinical governance training, limited leadership activation, unclear accountability arrangements, and inadequate digital information systems. These structural deficiencies weakened core clinical governance processes, including clinical audit, incident reporting, documentation review, feedback, performance monitoring, and quality improvement. Consequently, the absence of reliable structures limited the ability of the organisation to use governance processes as mechanisms for patient safety improvement and organisational learning.

The findings further indicate that clinical governance processes in the ECDOH EMS are often reactive rather than proactive. Participants described incident reporting as occurring mainly after serious adverse events or potential medico-legal concerns, rather than as part of a continuous learning system. Such a reactive approach limits the potential of incident reporting to support early risk identification, trend analysis, and preventive quality improvement. This is inconsistent with the principles of a just culture, where reporting should be encouraged in a psychologically safe environment and used to identify system weaknesses rather than to allocate blame (Boysen, 2013). The perception that incident reporting may lead to disciplinary action undermines staff confidence in the reporting system and weakens the learning orientation required for effective clinical governance.

Leadership and accountability emerged as central factors influencing the gap between policy and practice. While clinical governance is formally supported by national frameworks, participants perceived a lack of consistent leadership enforcement and limited organisational commitment to embedding governance practices at district and station level. This reflects the argument by Healy and Braithwaite (2006) that regulatory systems are effective only when supported by visible oversight, enforcement, responsiveness, and accountability mechanisms (Healy and Braithwaite, 2006). In the absence of clearly designated clinical governance roles and structured reporting lines, responsibility for implementation becomes diffused. This diffusion weakens ownership and contributes to inconsistent application of policies across districts.

The findings are also consistent with broader South African evidence indicating that clinical governance implementation remains uneven across public health systems. Sithole et al. (2024) found variability in clinical staff knowledge of

clinical governance protocols and tools in South African hospitals, suggesting that formal policy presence does not necessarily guarantee frontline awareness or practical application (Sithole et al., 2024). Similarly, studies examining health system governance and quality standards implementation in South Africa have reported persistent challenges related to accountability, information systems, leadership, and implementation capacity (Makumbani and Tsibolane, 2025; Matahela et al., 2023; Mokoena and Naidoo, 2024). These studies support the interpretation that the clinical governance gap in the ECDOH EMS system reflects a broader health system challenge in which policy intent is not consistently translated into operational routines.

Resource constraints further intensify the policy–practice gap. Participants indicated that staff shortages, fatigue, high call volumes, limited vehicle availability, and competing operational demands reduced the time and organisational capacity available for governance-related activities. In such conditions, immediate emergency response obligations tend to take precedence over audit, documentation review, case reflection, and quality improvement. This finding is consistent with literature on emergency care systems in low- and middle-income countries, where resource constraints can undermine the development of mature quality improvement and governance systems (Kannan et al., 2020; Mehmood et al., 2018). Within resource-constrained EMS systems, clinical governance cannot be sustained through policy directives alone; it requires protected time, adequate staffing, supervisory capacity, and practical implementation tools.

The absence of integrated digital documentation and reporting systems represents another important structural barrier. Participants reported that reliance on paper-based records limited the ability to aggregate data, identify trends, monitor clinical quality indicators, and conduct systematic audit processes. This undermines evidence-informed decision-making and restricts the ability of managers to detect recurring clinical risks. The finding corresponds with Makumbani and Tsibolane's (2025) analysis of health information system failure, which highlights the gap between system design and operational realities in healthcare environments (Makumbani and Tsibolane, 2025). Without reliable digital infrastructure, clinical governance remains labour-intensive, fragmented, and difficult to institutionalise.

Despite these constraints, the study found evidence of latent organisational readiness

for clinical governance reform. Participants did not reject clinical governance; instead, they articulated practical strategies for strengthening its implementation. These included standardised audit tools, routine case review meetings, clear incident reporting pathways, district-level clinical governance committees, designated governance personnel, regular feedback sessions, and improved training. This finding suggests that the policy–practice gap is not caused by frontline resistance, but by insufficient institutional support and weak operational embedding. Similar conclusions have been drawn in studies of EMS professionalisation and capability development in South Africa, where leadership, structured systems, and context-sensitive implementation approaches are identified as essential for strengthening service quality and governance maturity (Mosca and Kruger, 2022; Vincent-Lambert and Stein, 2024).

The policy–practice gap identified in this study therefore reflects the interaction between structural constraints, leadership weaknesses, accountability diffusion, and limited measurement systems. National regulatory frameworks establish what should occur, but local systems determine whether these requirements become routine practice. The findings demonstrate that clinical governance in resource-constrained EMS systems must be understood as an operational system rather than a policy statement. Effective implementation requires the alignment of policy expectations with staffing capacity, leadership accountability, information systems, training, audit processes, and feedback mechanisms.

Overall, the analysis confirms that the ECDOH EMS operates within a context where clinical governance is formally mandated but inconsistently embedded. The central challenge is to move from policy recognition to practice integration. This requires shifting clinical governance from a compliance-oriented administrative function to a structured, routine, and learning-oriented system that supports patient safety, quality improvement, and organisational accountability.

Delineations and limitations

This study provides important empirical insight into the implementation of clinical governance within a resource-constrained provincial EMS system. Its primary contribution lies in its focus on the operational realities of clinical governance in a decentralised prehospital environment, where clinical governance systems are shaped by workforce capacity, leadership practices, resource availability, documentation systems, and district-level

accountability structures. The inclusion of operational personnel, supervisors, managers, and academic staff enabled the study to capture perspectives from different levels of the EMS system. The qualitative design was appropriate for exploring participants' perceptions, experiences, and interpretations of clinical governance implementation. This approach enabled a contextual understanding of how governance policies are experienced in practice and how frontline and managerial staff interpret the barriers to effective implementation. The use of open-ended questionnaire allowed participants to provide detailed accounts of clinical governance challenges and opportunities within their districts.

However, the study has several limitations. First, it was conducted within a single provincial EMS system, which may limit the transferability of the findings to other provinces, private EMS providers, or differently resourced health systems. While the challenges identified may reflect broader issues within South African EMS, contextual differences across provinces and service models should be acknowledged. Second, the study relied on self-reported participant accounts rather than direct observation of clinical governance processes. As a result, the findings reflect participants' perceptions and experiences of governance implementation rather than independently verified measures of clinical audit performance, incident reporting rates, or quality improvement outcomes. Future studies could strengthen the evidence base by incorporating direct observation, document review, or routine audit data. Third, the use of electronically administered open-ended questionnaire limited opportunities for real-time probing and clarification. Although this method was practical given EMS shift patterns and operational demands, traditional qualitative questionnaire may have allowed for deeper exploration of participants' lived experiences. Future research could therefore use in-depth interviews, focus groups, or longitudinal case studies to examine clinical governance implementation more comprehensively.

Despite these limitations, the study contributes to the limited literature on clinical governance in South African prehospital care. It provides a context-specific analysis of how national governance expectations interact with operational constraints in a rural and resource-constrained EMS environment.

Defining the Way Forward

The findings of this study indicate that strengthening clinical governance within the ECDOH EMS requires more than the existence of policy and regulatory standards. The central requirement is to convert policy expectations into practical, routine, measurable, and accountable operational systems. The recommendations below respond directly to the policy–practice implementation gap identified in the study.

i. Routine clinical audit and measurement systems should be institutionalised across districts. Clinical governance should extend beyond response-time indicators and include clinical quality indicators, documentation standards, guideline adherence, adverse event trends, patient safety indicators, and quality improvement outcomes. Standardised audit templates, structured review cycles, and district-level audit committees would support consistency and reduce variability in governance practices. This recommendation aligns with Howard et al. (2020), who emphasised the need to strengthen clinical quality and performance measurement in South African prehospital EMS (Howard et al., 2020).

ii. Accountability structures for clinical governance should be clarified. Designated clinical governance leads or quality assurance officers should be appointed at district and station level to coordinate audit processes, incident reporting, documentation review, clinical guideline monitoring, feedback sessions, and quality improvement initiatives. Clearly defined reporting lines would reduce accountability diffusion and support operational ownership of clinical governance. This would also align with the principles of responsive regulation, which emphasise the importance of visible oversight, accountability, and graduated enforcement mechanisms (Healy and Braithwaite, 2006).

iii. Incident reporting should be redesigned as a learning-oriented system. A standardised, non-punitive incident reporting process should be implemented to promote early reporting, trend analysis, and system improvement. Incident reviews should focus on identifying contributory factors and preventing recurrence rather than allocating blame. This approach would be consistent with the principles of just culture, which promote balanced accountability and psychological safety in patient safety systems (Boysen, 2013).

iv. Clinical governance training should be incorporated into continuous professional development for EMS personnel, supervisors, and managers. Training should include clinical audit methods, documentation standards, risk management, quality improvement tools, incident review processes, patient safety principles, and governance responsibilities. Participants' accounts suggest that clinical governance competence cannot be assumed; it must be deliberately developed and reinforced through structured organisational learning.

v. Digital documentation and reporting systems should be strengthened. Integrated electronic systems would improve data availability, support routine audit, enable trend monitoring, and strengthen evidence-informed decision-making. While full digital transformation may require phased implementation, even basic electronic reporting tools could improve consistency, reduce fragmentation, and support district-level monitoring. This is particularly important because weak information systems are a recurring barrier to effective health system governance and quality improvement (Makumbani and Tsibolane, 2025).

vi. Clinical governance should be embedded into operational planning and performance management. Clinical governance indicators should be incorporated into provincial and district performance plans, and regular feedback loops should connect frontline data with managerial decision-making. Clinical governance should not function as an administrative add-on, but as a core operational function linked to patient safety, service quality, workforce development, and accountability.

vii. The ECDOH EMS should develop an EMS-specific clinical governance framework. Such a framework should define clinical governance roles, audit processes, incident reporting pathways, documentation standards, training requirements, committee structures, feedback mechanisms, and escalation procedures. A context-specific framework would help translate national policy expectations into practical district-level routines and support more consistent implementation across the province.

Collectively, these recommendations emphasise that clinical governance reform in resource-constrained EMS systems requires structural reinforcement, leadership activation, workforce development, digital support, and routine measurement. Policy alone is insufficient unless supported by the organisational capacity to make governance operational.

Conclusion

This study examined clinical governance challenges in a resource-constrained EMS system, using ECDOH EMS as a critical case. The findings demonstrate that South Africa has a formal clinical governance policy and regulatory framework, but that implementation within provincial EMS remains inconsistent. The central challenge is therefore not the absence of policy, but the gap between policy and practice.

Participants described fragmented clinical governance structures, weak monitoring systems, unclear incident reporting processes, limited leadership activation, diffused accountability, staff shortages, inadequate clinical governance training, and the absence of integrated digital documentation systems. These constraints weakened the ability of the organisation to institutionalise clinical audit, reporting, feedback, and continuous quality improvement. The findings therefore suggest that clinical governance fragility in the ECDOH EMS should be understood as a structural and operational capacity challenge rather than simply a compliance failure.

At the same time, the study identified important opportunities for reform. Participants demonstrated awareness of the value of clinical governance and proposed practical interventions, including standardised audit tools, clearer clinical governance roles, district-level governance committees, regular case review meetings, non-punitive incident reporting, structured training, and improved digital systems. This suggests that the organisation has latent readiness for clinical governance improvement, provided that policy expectations are supported by practical implementation mechanisms.

The study contributes to the limited body of knowledge on clinical governance in South African prehospital care by demonstrating how national clinical governance mandates interact with the operational realities of a rural and resource-constrained EMS system. It argues that effective clinical governance requires deliberate alignment between policy, leadership, accountability, workforce capacity, information systems, and quality improvement processes. Strengthening these domains is essential for improving patient safety, service quality, organisational learning, and public trust in EMS.

REFERENCES

ACT Ambulance Service (2023) *ACT Ambulance clinical governance framework 2023–2026*.

Ambutech and Kirklees College (2024) *Guide to clinical governance: An internal first responder model*.

Australian Commission on Safety and Quality in Health Care (2017) *National model clinical governance framework*.

Basu, D. (2019) 'Clinical governance in South African health systems', *Southern African Journal of Public Health*, 3(3), p. 42. doi: 10.7196/SHS.2019.v3.i3.95.

Boysen, P.G., Jr. (2013) 'Just culture: A foundation for balanced accountability and patient safety', *Ochsner Journal*, 13(3), pp. 400–406.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp. 77–101. doi: 10.1191/1478088706qp063oa.

Connell, L. (2014) *A clinical governance handbook for district clinical specialist teams*. Durban: Health Systems Trust.

Creswell, J.W. and Poth, C.N. (2017) *Qualitative inquiry and research design: Choosing among five approaches*. 4th edn. SAGE Publications.

Department of Health (2018) *Norms and standards regulations applicable to different categories of health establishments*.

Department of Health (2022) *Regulations relating to the standards for emergency medical services, 2022*. Government Notice No. 2819. Available at: https://lawlibrary.org.za/akn/za/act/gn/2022/2819/eng@2022-12-02 (Accessed: 2 May 2025).

Donabedian, A. (1988) 'The quality of care: How can it be assessed?', *JAMA*, 260(12), pp. 1743–1748. doi: 10.1001/jama.1988.03410120089033.

Govender, S., Khaliq, O.P., Naidoo, R. and Moodley, J. (2024) 'The current state of emergency medical services in South Africa: A review', *South African Journal of Science*, 120, article 16138. doi: 10.17159/sajs.2024/16138.

Guest, G., Bunce, A. and Johnson, L. (2006) 'How many interviews are enough? An experiment with data saturation and variability', *Field Methods*, 18(1), pp. 59–82. doi: 10.1177/1525822X05279903.

Healy, J. and Braithwaite, J. (2006) 'Designing safer health care through responsive regulation', *Medical Journal of Australia*, 184(S10), pp. S56–S59. doi: 10.5694/j.1326-5377.2006.tb00364.x.

Howard, I. (2020) *Clinical quality and performance measurement in the prehospital emergency medical services in the low-to-middle-income country setting: Developing clinical quality and performance indicators as a measure of care in South Africa*.

Howard, I., Cameron, P., Wallis, L., Castrén, M. and Lindström, V. (2020) 'Understanding quality systems in the South African prehospital emergency medical services: A multiple exploratory case study', *BMJ Open Quality*, 9, article e000946. doi: 10.1136/bmjoq-2020-000946.

Kannan, V.C., Tenner, A., Sawe, H.R., Osiro, M., Kyobe, T., Nahayo, E., Rasamimanana, N.G., Kivlehan, S. and Moresky, R. (2020) 'Emergency care systems in Africa: A focus on quality', *African Journal of Emergency Medicine*, 10(Suppl. 1), pp. S65–S72. doi: 10.1016/j.afjem.2020.04.010.

Kennedy, M., Elcock, M., Ellis, D. and Tall, G. (2017) 'Pre-hospital and retrieval medicine: Clinical governance and workforce models', *Emergency Medicine Australasia*, 29(4), pp. 467–469.

Macfarlane, A.J.R. (2019) 'What is clinical governance?', *BJA Education*, 19(6), pp. 174–175. doi: 10.1016/j.bjae.2019.02.003.

Makumbani, H. and Tsibolane, P. (2025) 'Design-reality gap analysis of health information systems failure', *Procedia Computer Science*, 256, pp. 949–956. doi: 10.1016/j.procs.2025.02.199.

Masuku, N.J. and Houston, C. (2022) *Clinical governance*. University of KwaZulu-Natal, School of Clinical Medicine, Discipline of Anaesthesiology and Critical Care. Available at: https://anaesthetics.ukzn.ac.za/wp-content/uploads/2022/05/2022-05-13-Clinical-Governance-real-N-Masuku.pdf.

Matahela, S.R., Adekola, A.P. and Mavhandu-Mudzusi, A.H. (2023) 'Exploring quality standards implementation at a South African municipality's health facilities', *Curationis*, 46(1), article a2416. doi: 10.4102/curationis.v46i1.2416.

Mehmood, A., Rowther, A.A., Kobusingye, O. and Hyder, A.A. (2018) 'Assessment of pre-hospital emergency medical services in low-income settings using a health systems approach', *International Journal of Emergency Medicine*, 11, article 53. doi: 10.1186/s12245-018-0207-6.

Mokoena, S.V. and Naidoo, P. (2024) 'A quantitative study to evaluate the controls and accountability measures in place to alleviate the leadership and governance challenges impacting the realization of the National Health Insurance (NHI) in South Africa',

Health Research Policy and Systems, 22, article 173. doi: 10.1186/s12961-024-01251-2.

Mosca, C.G. and Kruger, J.P. (2022) 'Adopting a "system of caring" as a leadership strategy toward professionalisation within South African emergency medical services: A grounded theory', *African Journal of Emergency Medicine*, 12, pp. 489–497. doi: 10.1016/j.afjem.2022.11.001.

Mould-Millman, N.-K., Dixon, J.M., Sefa, N., Yancey, A., Hollong, B.G., Hagahmed, M., Ginde, A.A. and Wallis, L.A. (2017) 'The state of emergency medical services (EMS) systems in Africa', *Prehospital and Disaster Medicine*, 32(3), pp. 273–283. doi: 10.1017/S1049023X17000061.

Mseleku, M.T.D. (2007) *Policy on quality in health care for South Africa*.

Naidoo, M. and Suthiram, K.T. (2025) 'Optimising clinical governance and risk management in resource-limited hospitals: A family medicine model', *African Journal of Primary Health Care & Family Medicine*, 17(1), article a4876. doi: 10.4102/phcfm.v17i1.4876.

National Department of Health (2011) *National core standards for health establishments*.

Oboirien, K., Harris, B., Goudge, J. and Eyles, J. (2018) 'Implementation of district-based clinical specialist teams in South Africa: Analysing a new role in a transforming system', *BMC Health Services Research*, 18, article 600. doi: 10.1186/s12913-018-3377-2.

Queensland Government (2018) *Allied health clinical governance framework in Queensland Health*.

SA Health (2024) *Clinical governance framework*.

Scally, G. and Donaldson, L.J. (1998) 'Clinical governance and the drive for quality improvement in the new NHS in England', *BMJ*, 317(7150), pp. 61–65. doi: 10.1136/bmj.317.7150.61.

Sithole, N., Chitha, W.W., Mnyaka, O.R., Ncinitwa, A.B.A., Nomatshila, S.C., Ntlongweni, X., Maake, K., Mkabela, B.E., Khosa, N.V., Ngcobo, Z.B., Chitha, N., Masuku, K. and Mabunda, S.A. (2024) 'Clinical staff reported knowledge on the existence of clinical governance protocols or tools utilised in selected South African hospitals', *PLOS ONE*, 19, article e0312340. doi: 10.1371/journal.pone.0312340.

Statistics South Africa (2023) *Eastern Cape home to over 7.2 million people*. Available at: https://www.statssa.gov.za/?p=16760 (Accessed: 9 February 2026).

Vincent-Lambert, A. and Stein, C. (2024) 'A consensus-based tool for capability benchmarking of emergency medical services in South Africa', *African Journal of Emergency Medicine*, 14(2), pp. 75–83. doi: 10.1016/j.afjem.2024.03.003.