The Ideal Clinic in South Africa: Planning for implementation

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The Ideal Clinic initiative is one of the various strategies designed to respond to the current deficiencies in the quality of PHC services and lay a strong foundation for the successful implementation of National Health Insurance.

Described as a clinic with good infrastructure (i.e. physical condition and spaces, essential equipment, and information and communication tools), adequate staff, adequate medicine and supplies, good administrative processes and adequate bulk supplies that use applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community, the Ideal Clinic will lay the foundation for the successful implementation of National Health Insurance and provide a community-based, comprehensive range of integrated diagnostic, curative, preventive, promotive, rehabilitative and palliative services.

The process is designed to allow the South African health system to gain the required knowledge, test responses, and outline the necessary modifications to existing systems and processes to arrive at and maintain the desired clinic status. The success of this programme depends on implementing the scale-up plan, securing the required resources, continued innovation and sustaining leadership.

This chapter reports on developments in the Ideal Clinic Realisation process since June 2013, in particular the deliberations and developments arising out the Operation Phakisa Ideal Clinic Realisation and Maintenance (ICRM) Laboratory which took place late in 2014. The authors also provide an overview of the Ideal Clinic dashboard, report on efforts to create synergies and enabling environments for implementation and share some of the lessons learnt during the early stages of implementation.

The success of this programme depends on implementing the scale-up plan, securing the required resources, continued innovation and sustaining leadership.

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Introduction

This chapter is a follow-up to the chapter on 'Innovations in Primary Health Care: Considerations for National Health Insurance' published in last year's edition of the *South African Health Review*[1] and is intended to provide an update on developments that have taken place in the Ideal Clinic initiative from July 2013 to March 2015.

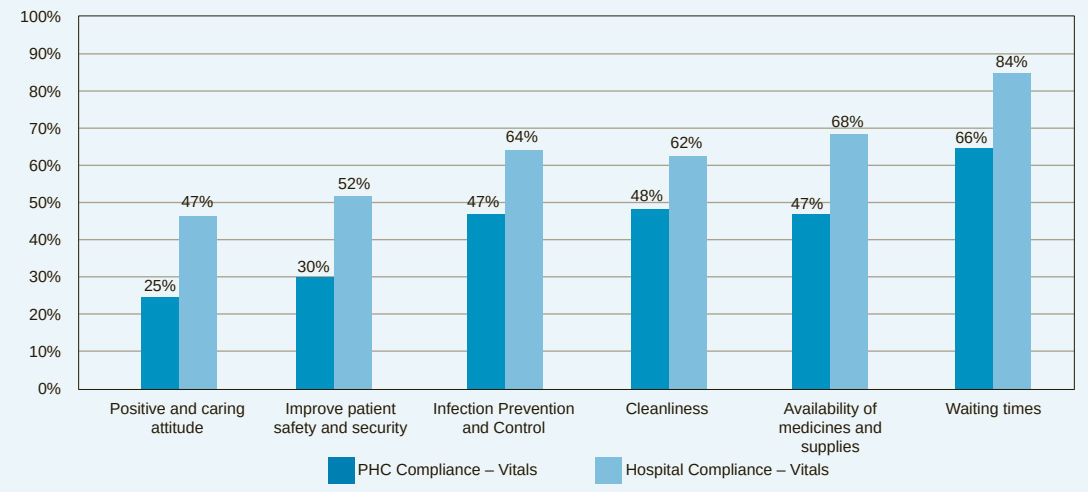
Central to South Africa's plans to implement National Health Insurance (NHI) is its primary health care (PHC) system consisting of about 3 500 PHC facilities[a] supplemented with community-based services such as environmental health services, school health teams and community health workers. South Africans are using clinics in increasing numbers. PHC visits increased from 67 million in 1998 to 128 million in 2013.[2] The achievements in PHC in South Africa over the past 20 years include improving immunisation coverage for children younger than one year to nearly 100%,[b] and supporting more than 2.8 million patients on antiretroviral medication (ARVs). Despite these achievements, PHC in South Africa faces serious challenges which have led to negative patient experiences of care, thus compromising the important role that PHC services could play in health promotion and disease prevention.

The Ideal Clinic initiative is one of the various strategies designed to respond to the current deficiencies in the quality of PHC services. The concept of the Ideal Clinic aims to provide a community-based, comprehensive range of integrated diagnostic, curative, preventive, promotive, rehabilitative and palliative services. The implementation of the initiative has its roots in the findings of a Baseline Audit commissioned by the National Department of Health (NDoH) in 2011.[3] The audit showed that public health facilities in South Africa collectively scored less than 50% compliance with vital measures, scoring 34% in patient safety and security and 30% in the area of positive and caring attitudes. On average, PHC facilities scored lower than hospitals in all priority areas (see Figure 1). The audit also showed that PHC facilities often did not provide the full range of services; essential drug supplies were unreliable; staffing was inadequate, and the poor quality of physical infrastructure was having a major impact on the functioning of services and clients' satisfaction with services.

In preparation for the introduction of National Health Insurance (NHI), the Ideal Clinic project is setting in place a systematic approach to transform all PHC facilities to conform to NHI standards, as defined by the Office of Health Standards Compliance (OHSC). The National Health Act (61 of 2003) contained the provision for a unit such as the OHSC within the NDoH to oversee the issuing and monitoring of standards.[4] However, in 2010, the NDoH's 10-Point Plan, as articulated in its strategic plan for that period, expressed the objective of working towards an independent national quality management and accreditation body.[5] To this end, in 2011, South Africa's Cabinet approved a draft Amendment Bill for public comment. After completing the required parliamentary processes, including public hearings in all provinces during 2012, the National Health Amendment Act (12 of 2013) enabling the establishment of the OHSC, came into effect on 2 September 2013.[6] The OHSC is mandated to protect and promote the health and safety of health service users through monitoring and enforcing compliance with prescribed norms and standards. The Ideal Clinic initiative is the NDoH's internal mechanism for ensuring PHC facilities' compliance with these norms and standards, and towards developing well-functioning PHC facilities that will satisfy the needs of South African communities.

The Ideal Clinic initiative is therefore a central vehicle for delivering quality primary health care services. The process is designed to allow the South African health system to gain the required knowledge, test responses, and outline the necessary modifications to existing systems and processes to arrive at and maintain the desired clinic status.

Figure 1: Baseline audit - PHC and hospital facilities



Source: National Department of Health, 2012.[2]

a District Health Information System

b South African Health Review 2013/14; District Health Information System data as reported by Health Systems Trust

When the Ideal Clinic initiative was commenced in July 2013, the model was described as follows:

> a clinic with good infrastructure (i.e. physical condition and spaces, essential equipment, and information and communication tools), adequate staff, adequate medicine and supplies, good administrative processes and adequate bulk supplies that use applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community.[7]

The rationale was to explore if the experience of social franchising of health services could be used to "provide incentives for the roll-out of services of standardised quality as part of a broader set of changes in the health sector".[1] The model draws on international good practice for integrated primary care services[6] (see Figure 2). The aim is for a systematic response to the deficiencies in PHC services being detected through inspections conducted by the Office of Health Standards Compliance, as mandated by the National Health Act Amendment.[7] The Ideal Clinic initiative is structured into three phases: Phase 1 – developing the concept; Phase 2 – planning for implementation, and Phase 3 – implementation. This chapter deals with Phases 1 and 2.

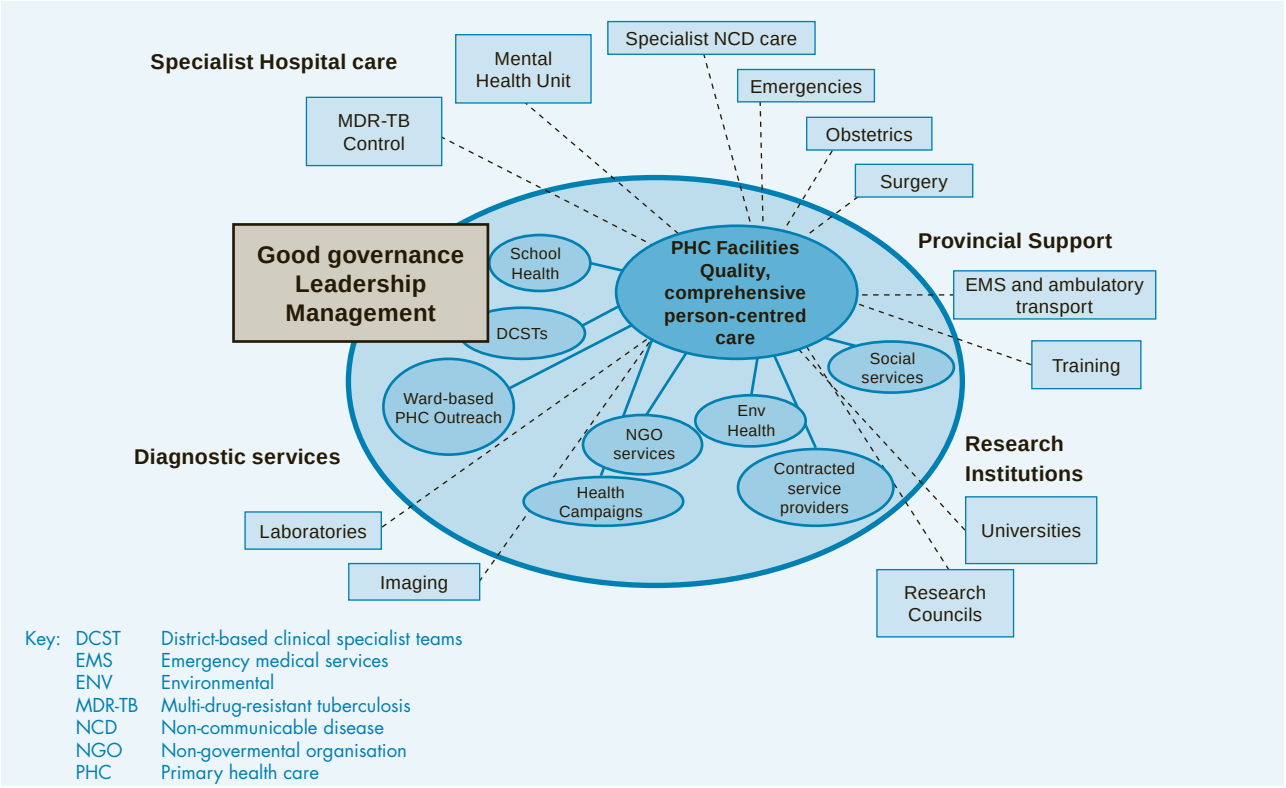
Developing the concept

A departure point for the Ideal Clinic was to adopt action research approach to overcoming the many problems recognised. Action research can be described as:

> research initiated to solve an immediate problem or a reflective process of progressive problem-solving led by individuals working with others in teams or as part of a 'community of practice' to improve the way they address issues and solve problems… Action research challenges traditional social science by moving beyond reflective knowledge created by outside experts sampling variables, to an active moment-to-moment theorizing, data collecting and inquiry occurring in the midst of emergent structure.[8]

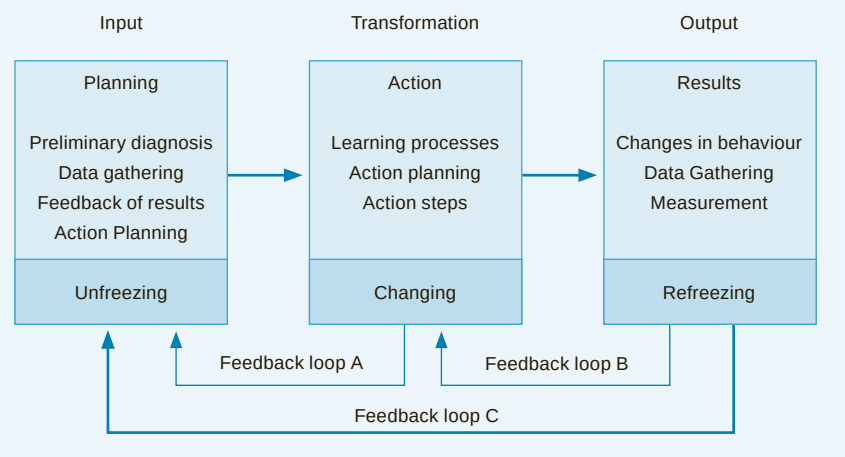
The initiative was deliberately championed at a senior level, namely at the level of the Director-General of the NDoH, to overcome the entrenched or 'frozen' bureaucratic behaviours that led many managers in the public health sector to feel that change was not possible. The theoretical construct about making change happen in the face of 'frozen' behaviours has been articulated in many approaches to organisational development and change management. One example by Lewin is depicted in Figure 3.[9]

Figure 2: The PHC Ideal Clinic concept



Key:
DCST District-based clinical specialist teams
EMS Emergency medical services
ENV Environmental
MDR-TB Multi-drug-resistant tuberculosis
NCD Non-communicable disease
NGO Non-govermental organisation
PHC Primary health care

Figure 3: Action research model



Source: Lewin, 1958.[9]

The Ideal Clinic dashboard

A dashboard using the standard traffic-light colours was developed. Figure 4 below depicts the arrangement of 32 sub-components under 10 components. Elements are assigned a green colour when they are fully functional, an orange colour if they are partly functional and corrective actions are under way, and a red colour if the element is absent or non-functional. The process of developing the dashboard was included in discussions and meeting with PHC facility managers and staff as well as with clinic committee members. These initial meetings identified elements that facilitate or hamper quality service delivery. This process was complemented by the content of the Clinic Supervisor's Manual, and resulted in approximately 200 elements being organised into components and sub-components. The dashboard's elements were constantly improved over the eight month-long concept design phase from July 2013 to March 2014. The last three months of this phase was dedicated to achieving alignment between the Ideal Clinic components, sub-components and elements, and the OHSC domains and measures.

During the concept design phase, four teams, each consisting of a doctor and a nurse with public health PHC experience, worked with 10 PHC facilities in four NHI pilot districts in four different provinces. Using the dashboard, the nurse–doctor teams identified weaknesses in the clinics and worked with facility, sub-district, district, provincial and NDoH managers to make changes and improvements. The process of determining the weaknesses became known as the clinic 'status determination'. This term was deliberately applied to overcome the past practice of supervisory staff undertaking assessments and writing reports of findings without doing anything to improve identified weaknesses. The clinic's status against the Ideal Clinic requirements is thus determined for the specific purpose of addressing the weaknesses systematically. This approach made the initial work done by the NDoH and provinces through the Facility Improvement Teams[c] more specific and measurable.

c Facility Improvement Teams were multi- disciplinary teams set up by the national and provincial departments of health to respond to the findings of the Baseline Audit.

Figure 4: The structure of the Ideal Clinic dashboard

Figure 5: Elements under the sub-component of 'Management of client records'

National Core Standards	Component	IDEAL CLINIC REALISATION AND MAINTENANCE DASHBOARD						
		Sub Component	ELEMENTS		Weight	Measurement	Performance	Level of responsibility.
DOMAIN 6: OPERATIONAL MANAGEMENT	1. Administration	4. Management of client record: Monitor whether clients' record content is organised according to Integrated Clinical Services Management (ICSM) prescripts, whether the prescribed stationery is used and whether the client records are filed appropriately						
			16	There is a single client record irrespective of health conditions	I	😐📖		HF
			17	Client record content adheres to ICSM prescripts	E	😐📖		HF
			18	There is a single location for storage of all client records	I	😐		HF
			19	Client records are filed in close proximity to client registration desk	I	?😐		HF
			20	There is a standardised client record filing system in place	I	😐		HF
			21	The retrieval of a client's file takes less than five minutes	I	?😐		HF
			22	There is an SOP for archiving and disposal of clients' records available	I	📖		NDoH
			23	The SOP for archiving and disposal of clients' records is adhered to	I	😐		HF
			24	Priority stationery (clinical and administrative) is available at the facility in the right quantities	I	📖		HF

HF: Health Facility

Figure 5 depicts as an example of the elements under the sub-component "Management of client records". As can be seen elements have a weight as in either being vital (V), essential (E) or important (I). The measurement column in Figure 5 refers to how measurement will be done. The book symbol indicates that a document must be present, the face symbol indicates that the element must be observed, the question mark symbol indicates that a question must be asked and some elements have a finger indicating that a test must be conducted.

Transversal levers

After several months of iterative learning and problem-solving, it became apparent that some of the bottlenecks identified were persistent and would require extensive planning and collaboration with technical experts in the private sector, non-governmental organisations (NGOs), other government departments and managers at different levels of the health sector. The interventions required to resolve these persistent bottlenecks were developed into specific projects and became known as the 'transversal levers'.[d] Each of these required intensive co-ordination, specific objectives, agreed milestones and regular communication between relevant stakeholders. Regular monitoring of process was linked to escalating unresolved problems to higher levels until they were resolved. Key transversal levers which were identified are as follows:

- Development of a standard structure for the District Health Management Office: standard job profiles is an imperative for sustained support to attain and maintain optimal functionality of PHC facilities
- Development and implementation of a change management model: crucial to achieving sustained desired improvements to the PHC facility environments and operations.
- An Ideal Clinic Manual: a blueprint for changing Ideal Clinic elements from red and orange to green.
- Integrated clinical services management (ICSM): a key focus within an Ideal Clinic is to ensure integrated chronic disease management, encompassing the full value chain of continuum of care and support.
- Supply chain management: to be improved to ensure the availability of medicines, consumables and equipment in clinics.
- Patient record storage and retrieval: to be improved to shorten the excessively long waiting times in clinics.
- Standardisation of staffing norms using Workload Indicator Staffing Needs (WISN): to be applied to address staffing requirements in clinics.
- A web-based monitoring and evaluation system: required to help PHC staff, managers and their supervisors keep track of progress in upgrading their facilities.
- A branding strategy: required to standardise the environment within clinics, as well as how patients are treated in clinics.
- A communication strategy: essential to ensure regular and appropriate updates with regard to the programme.
- Costing required: to provide evidence as a basis for motivating for the required resources.

The level to which the different transversal levers are complete and functional varies.

d In the Ideal Clinic context, 'transversal levers' are tools required across all provinces to speed up the attainment of fully functional primary health care facilities.

Creating synergies and enabling environments

Implementation of the Ideal Clinic concept will see the Ideal Clinic at the centre of a community-based PHC service, including school health, ward-based outreach teams and environmental health. Of particular importance is the need for an effective service delivery platform for the national strategic programmes such as the integrated plan for HIV and TB, family planning, and maternal and child health services. Ideal Clinics complemented by well-functioning community-based services are thus required to deliver the country's PHC package under NHI.

A well-functioning district health system is the bedrock for sustaining Ideal Clinics. The national District Health System (DHS) policy,[10] which provides the enabling environment for delivering the PHC package of services creates a framework for rendering comprehensive quality health services through an efficient, effective and equitable resource allocation model. This is meant to take place within a DHS that is accountable to service users and regulatory structures ensuring, through inter-sectoral collaboration, that social determinants of health are progressively addressed. Its objectives are to:

- improve district governance and strengthen leadership and management of the DHS;
- improve the governance of PHC facilities;
- improve management of PHC facilities;
- facilitate the establishment of a service delivery platform for provision of PHC services within the DHS;
- improve the integration of services at all levels of the health system and between the private sector and other government departments to address the social determinants of health;
- organise health services in the community and in PHC facilities optimally to meet the OHSC standards and to achieve targets for population health outcomes; and
- strengthen the provision of environmental health services.

Lessons learnt

Key to scaling up the programme was the need to learn from the concept design phase, and to adapt approaches in the transformation required elsewhere. A facilitated discussion with the nurse–doctor teams involved in the design phase provided useful insights into some of the early lessons (see Box 1).

Box: 1: Responses from Nurse–Doctor teams

1	What facilitated progress during the pilot phase?	Collective design and uniform use of the tool to determine status of facilities in relation to findings
		Appointment of the Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) to spearhead the project on district level
		Elevation of responsibility per sub-component in the dashboard to ensure that every level of the health service takes full responsibility for performance of facilities
		Active support by the NDoH
		Active participation of all district team members in taking responsibility for the findings of the status of facilities
		Districts taking responsibility and sharing their experience and lessons learnt with other provinces and districts.
2	Name what could be improved in relation to how the pilot was designed and run?	Adopt a revised status determination tool as the national tool that will be used to monitor progress of performance of facilities
		Develop an explicit official job description of members of PPTICRM and determine their reporting channels as well as monitoring mechanisms
		Development of software that allows for real-time reporting of progress to be implemented so as to avoid delays that are related with exporting data to NDoH
		Ensure that monitoring of facilities' performance runs concurrently with service delivery improvement
3	What were the lessons learnt from the pilot?	Improvement of facilities to' ideal status' does not always require additional funding
		If managers in facilities, sub-districts or districts are ordered to respond to deviations and anomalies in areas that they oversee, Ideal Clinic status can be achieved as demonstrated by the experience of Ideal Clinic concept pilot
		Managers need tools to guide their practice
		Managers need a flawless system that allows for urgent responses to needs
		Managers whose appointment and placement is backed by required qualifications, technical and managerial experience, expertise and a positive track-record of outputs and outcomes in previous employment and proof of having stayed in one job for a significant time (to gain proper experience) yield positive results in improving situations
		Managers whose performance is thoroughly monitored and improvements based on consideration of various indicators, produce better performance than those whose performance is not properly monitored
		Operational staff members are "crying out loud" to be supported and to get required resources to safely execute their work; however, this is seldom coming through
4	Where did you face the greatest points of resistance?	District Managers' scepticism and fear of losing their powers of control – [they] thought that NDoH is taking over their roles
		Embedded fear of exposure by the NDoH of known poorly performing service areas that were not attended to by responsible managers in due course. Manipulation of data prior to sharing it with NDoH to give a positive outlook
		Lack of district / provincial accountability of the outcomes
5	Where were the greatest bottlenecks and how did you address them?	Used acquired mechanisms of winning the co-operation of people
		Active and regular participation and verification of findings before adoption of information
6	What factors distinguished the most successful clinics from the others?	A facility with [an] exceptional manager who is able to grasp the concept, apply it and demand support and access it
		Facilities with good infrastructural capacity
		Properly staffed facility

Planning for implementation

The work done since July 2013 and the method applied in its execution is part of "Operation Phakisa" (meaning 'hurry up' in Sesotho), which has been adopted from the Malaysian Big Fast Results approach. The approach was used by the Malaysian government to achieve rapid transformation within a short space of time to address national priorities such as poverty, crime and unemployment.[11,e] The approach includes planning in '3 feet laboratories (Labs)' resulting in the development of detailed plans for implementation. The *Operation Phakisa Ideal Clinic Realisation and Maintenace* (ICRM) Lab ran from 12 October to 21 November 2014.

Lessons learnt during the concept design phase guided the scope and content of the Lab. The Labs were attended by 164 participants from national government departments, provincial health departments, metropolitan municipalities, public health schools, statutory councils, trade unions, development partners, NGOs and the private sector. Eight workstreams were created which then undertook clinic visits and held meetings with external experts, with detailed analyses being undertaken as necessary. Each workstream focused on specified activities and outputs and a final report was prepared after six weeks.

- Service delivery[12] focused on solutions to ensure that all PHC facilities deliver health care of optimal quality, including a comprehensive and standardised package of services delivered through the ICSM full availability of medicines and supplies, and a clean and safe environment.
- Waiting times[13] focused on solutions to reduce patients' waiting times at clinics and to set and communicate clear expectations of the waiting time to improve patients' experience of care. The targets that were defined included a maximum total waiting time of three hours for patients in all clinics, as well as 80% of patients reporting a positive experience of care.
- Infrastructure[14] focused on developing an effective infrastructure roll-out plan to ensure that all PHC facilities have world-class infrastructure that is delivered on time and well maintained for the future.
- Human Resources for Health[15] focused on creating an equitable distribution of well-trained workers with the required capabilities to ensure professional, efficient, effective, cost-effective and sustainable delivery of health care.
- Financial management[16] focused on developing a realistic budgeting process that accurately forecasts the funding requirements of PHC facilities, allocates resources equitably, and improves financial accountability.
- Supply chain management[17] focused on steps to ensure the continuous availability of medicines and supplies, and reduction of the cost of procurement and distribution of commodities, and to improve turnaround times for the delivery of non-standard stock items.
- Institutional arrangements[18] focused on developing effective institutional arrangements and intergovernmental agreements to support the realisation and maintenance of Ideal Clinics in South Africa.
- Scale-up and sustainability[19] focused on developing a national scale-up framework and an implementation plan to enable all 3 500 PHC facilities in South Africa to achieve Ideal Clinic status.

All 10 components of the Ideal Clinic Realisation and Maintenance framework were fitted into these eight work-streams along with the transversal levers. Costing was done across all eight work-streams. Each work-stream considered the case for change, South Africa's aspirations for the Ideal Clinic, the issues hampering optimal health care and the root causes thereof, and how these could be resolved through specified solutions and initiatives. Some examples of the analysis that took place accross some of the 8 work-streams are provided below.

Waiting times

A frequently cited problem within the public health sector is that of waiting times. Box 2 below provides an overview of plans to dramatically reduce waiting times while improving the overall patient experience of care.

Box 2: Waiting times: aspirations and targets

Domain	Aspiration	Target
Waiting Times	• Patients will spend less time in total at the clinic	• 3 hours maximum by 30 October 2017
Patient Experience of Care	• Patients will be satisfied with waiting times in a PHC facility	• 90% of patients by 30 October 2017
	• Patients will report a positive experience of care as defined in the six Ministerial Priority Areas	• 80% of patients by 30 October 2017

Financial Management

To obviate the problem of clinics running out their budgets early in the financial year, the following seven key initiatives which combine the principles of realistic budgeting and adherence to budgets have been developed. These are as follows:

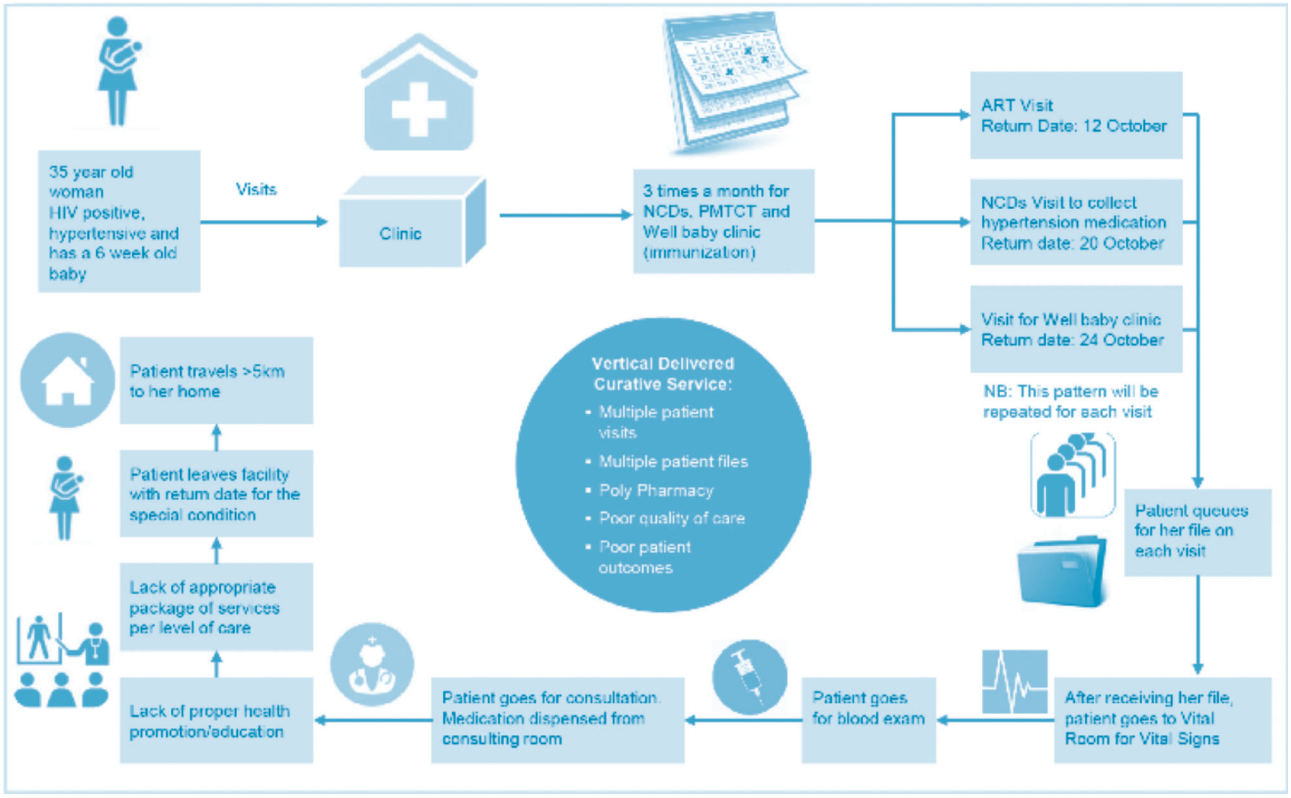
- Move to an equitable and activity-based budgeting process;
- Include facility managers in the budgeting process'
- Strengthen or establish sub-districts
- Align planning and budgeting cycle to ensure funding of new directives
- Ring-fence funds for non-negotiables
- Implement clinic-level audits; and
- Delegate optimal level of budget control to facilities.

Service delivery

Currently patients experience services that are vertically delivered and curative focused, making it time consuming, costly and unpleasant for the patient. Figure 6 provides a pictorial representation of how one person would have to make three different trips to the clinic in one month due to the vertical delivey of services.

e '3 feet laboratories' refers to planning close to where services are delivered and was the term used for the Government of Malaysia's Big Fast Results initiative.

Figure 6: Representation of the vertical delivery of services



Institutional arrangements

Co-ordination and co-operation of committees at district and sub-district level is currently very poor. Figure 7 provides an overview of the difficulties in enabling community participation and proposed plans to deal

Figure 7: Institutional arrangements

Current situation	• Clinic committees do not currently exist in all provinces and where they do exist, they are not effective (e.g. they do not liaise effectively between the community and clinics or with other levels of the health system. • There is an urgent need to put in place a co-coordinating mechanism to ensure greater co-operation at grassroots level.
Proposal	• Establish hospital boards and clinic committees where they do not exist. • Create District Health Committee comprising of representatives from hospital boards and clinic committees.
Impact	• Provide a platform for hospital boards and clinic committees: • Co-ordination of health issues at local level and the district. • Enhance accountability and participation of communities in governance structures. • Advise the District Health Council on issues of governance.

Scale-up

Box 3 presents an overview of the intended approach and impact of current scale-up plans

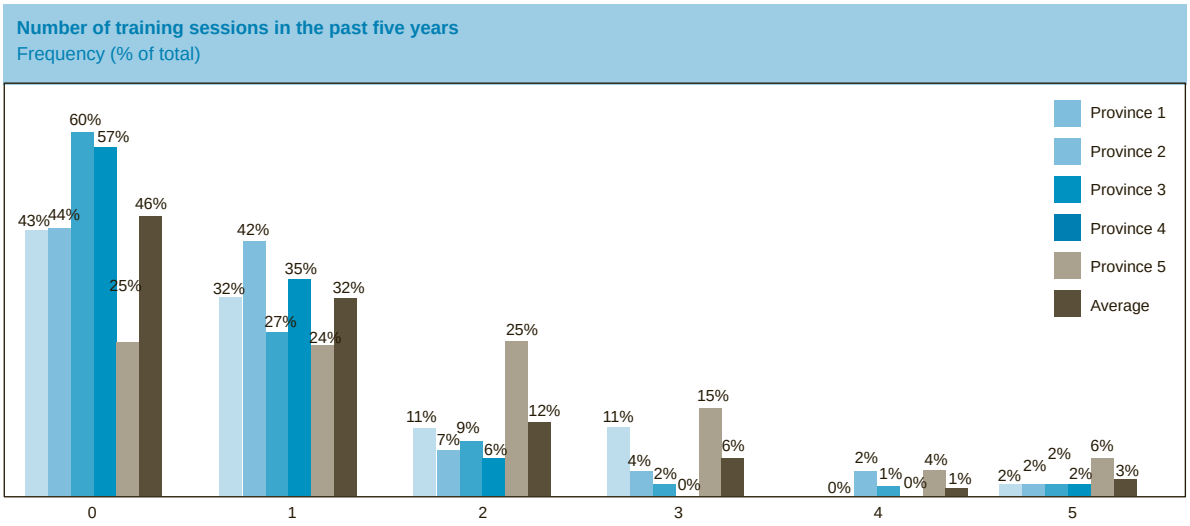
Box 3: Scale-up Plan

Approach	Impact
• **Qualification:** a clinic will become an Ideal Clinic after achieving a score of 80% on an OHSC audit. • **The Commitment:** clinics must sign a partnership agreement with NDoH and their province to maintain their status until the next audit (including signage, uniform, training courses). • **Support:** NDoH and the provinces commit to provide ongoing support to the clinic via delivery units. • **Maintenance:** Quality Assurance and performance monitoring include site inspections (2 years) and self-assessments (1 year).	• **Improved public perception** about the quality of health service provision in the public sector leading to **increased demand.** • **Standardisation** of the provision of services, quality of services and look and feel of clinics across South Africa. • **Increased pride** in public health for clinic staff and communities.

Training

Nearly half of the managers interviewed had not attended a training session in the past five years

Figure 8: Training



Across these eight work-streams, the ICRM Lab developed more than 80 initiatives, of which 46 were prioritised. Detailed implementation plans at the '3-feet' level of detail have been developed for each of the 46 priority initiatives, mapping the activities to be carried out by responsible parties at national, provincial, district and facility level. Seven breakthrough initiatives that would make the most substantial difference were identified in the following areas:

- Patient 'demand management' by devising alternative points of access to the PHC system for more accessibility and reduced clinic congestion;
- A well-communicated standardised service package that would result in a patient knowing what to expect from PHC facilities;
- Paperless and connected facilities across the country through an automated patient information system;
- Optimal levels of clinical and non-clinical staff;
- Integrated infrastructure delivery resulting in well-functioning and well-maintained facilities;
- Decentralisation of authority as a key enabler, empowering facility managers in supply chain management, financial management and human resource management; and
- Consistent availability of essential supplies and medicines through innovative approaches to supply chain management.

Next steps

The National Health Council (NHC) approved the Operation Phakisa Ideal Clinic report in May 2015 with amendments. Many but not all of the 80 initiatives were accepted by the NHC. The budget required for specific interventions is still being finalised. The process of determining specific activity based cost is facilitating further refinement of the initiatives. Training is being conducted on provincial and district level on an online self-assessment system that has already been piloted for use in the scale-up process.[20] An Ideal Clinic manual covering all elements and how they should be assessed and rectified is being piloted and will form the basis of routine training and orientation for all PHC facility managers.

Conclusion

South Africa's PHC system, consisting of about 3 500 PHC facilities[f] supplemented with community-based services such as environmental health services, school health teams and community health workers, must function optimally because it plays a central role in health promotion and disease prevention. Teamwork and collaboration among managers at different levels of the health system resulted in the Ideal Clinic concept which guided deliberations in the Operation Phakisa Ideal Clinic Lab for the purpose of developing a detailed costed implementation plan for scale-up, towards ensuring that all South Africa's PHC facilities function optimally. The success of this programme depends on implementing the scale-up plan, securing the required resources, continued innovation and sustaining leadership.

f District Health Information System

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