1. Department of Health on Ideal Clinic initiative progress report

2. Chairperson: Ms M Dunjwa (ANC)

3. Date of Meeting: 02 March 2016

4. Summary

The Department of Health (DoH) briefed the Committee on the concept, background and implementation of the Ideal Clinic initiative. In 2009 an assessment had first been done of the facilities at clinics and hospitals around the country. South Africa had wanted to move quickly towards implementing the National Health Insurance (NHI) but recognised that it could work only if primary healthcare (PHC) clinics as well as hospitals could provide quality services. Assessments had been carried out in 2011 and 2013, to assess where the country was in terms of a number of components in the clinics. This had highlighted that clinics had problems, both of under and over-staffing, may not have been constructed in the right places or the right size to serve the communities properly, and suffered in many cases from poor management, lack of managers, lack of facilities and equipment. Reports that were drawn at the time had been shared with clinics, who showed patchy responses with many weaknesses persisting, with only four clinics scoring over 80% in assessments in 2013, with 109 between 40 and 49% and 111 under 40%. The decision was then taken for the Department to actively progress the Ideal Clinic initiative. Those clinics performing well were asked to contribute their ideas and a booklet had been produced in August 2015, that would be used as guidance and training material. Whilst the booklet specified what was ideally needed in an Ideal Clinic, further specifications would be made over time, such as guidelines on waiting times, sound administration, and other areas.

The elements of an Ideal Clinic were described and it was noted that this would not only provide good clinical care, but cooperate and consult with the community it served. It would show good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and adequate bulk supplies, and use acceptable clinical policies, protocols and guidelines. It would make use of partner and stakeholder support, cooperate with other government departments and the private sector. Maintenance was vital and integrated services management would be a key focus area. School health outreach teams would offer support, as well as environmental health officers, and the clinic manager must be able to provide access to social and physiological services, laboratory services and training institutions. Over time, standardisation would be encouraged for the clinics through good organograms, job descriptions, training and support. Clinics were to be included in Operation Phakisa, and the initiatives taken in 2014 and 2015 were described. The Big Fast Result Methodology used successfully in Malaysia had been adapted to improve service nationwide. Assessments done by peer reviews in the previous month had shown KwaZulu Natal to be achieving well and the Western Cape had, from this year, joined the initiative. At the moment there was a focus on the top 600 clinics. The main challenges were infrastructure, human resource issues (including staff numbers, skills, management and leadership), supply chain, and the budget. A national workshop would be held in April 2016. Dedicated funding had been provided and details of partner funding were given.

Members were happy to hear that primary healthcare was getting more attention. Members’ questions focused on the staffing issues, the need to educate and involve the public, the impact of the cost-cutting measures and how this might affect this programme, and what monitoring and evaluation was being carried out. Members queried what was holding up implementation, questioned how
qualifications were to be improved and how to empower officials, deal with poor attitude, correct some of the simpler problems, and whether audits had been done to try to fill the gaps. The reasons for good and poor performance were outlined, and the suggestion made that staff should be moved. Members also noted good results in Brazil on emergency medical training and suggested that lessons could be taken from that, and asked for breakdowns of the statistics, how staff inadequacies could be addressed and thought that a workshop would be useful.

5. Minutes

**Ideal Clinic initiative: Department of Health (DoH) implementation and progress report briefing**

Ms Janet Hunter, Deputy Director General: Primary Health Care, Department of Health, explained that the two key components of what should be present in any health facility were staff and space. The summary of the Health Systems Trust (HST) baseline assessment showed under staffing in 573 out of the 2 272 clinics assessed, and that the space for providing services was too small. Ms Hunter stated that even though there might be enough staff, there were not enough consulting rooms, so the patients still had to wait while staff sat around waiting also for space to do their jobs.

Ms Hunter then set out the following additional findings:

- 51 clinics were over-staffed but the space was adequate
- 38 clinics were over-staffed but were also too large for the population the clinics were supposed to service
- 738 clinics was staffed properly but were too small
- 67 clinics have right space and right number of staff
- 38 clinics had staff numbers right but these clinics were too large
- 624 were short-staffed and these clinics were also too small
- 18 clinics were short-staffed even though the space was adequate
- 131 clinics were short-staffed but had large spaces.

She summarised that some clinics were small in proportion to the population they served, the population growth and also increased burden of diseases such HIV. There were indicators, from the size and staffing that in some case the planning was poor; this often happened where a large clinic was built to service a small community. The assessment also looked at how clean the facilities were, availability of medicine, whether the clinics had the right equipment, whether the clinics had running water and electricity, and other aspects. The Department of Health (the Department or DoH had found that there were some clinics with no clinic manager.

When a field worker had completed the assessment on a clinic, the Department would share the report with clinic management as well as the district management, and expected that weaknesses identified would be corrected. The work was done in 2011 and the report was issued in 2012, but when the Office of Health Standards Compliance (OHSC) had tried to start implementing again in 2013, it found that many of the weaknesses still persisted. The report received from the OHSC had shown that, in 2013, 111 clinics scored under 40%, 109 clinics scored between 40-49% and only four clinics scored over 80%.

The Department was now shocked to note that two years after the situational analysis, things seemed to be getting worse and not better. Therefore the decision was taken that the national level of the DoH should try to find ways to improve the situation. Therefore an analysis was done to see where the
The problem was, and some steps were taken to improve the situation, which included visiting the clinics. The visits started with the clinics that scored highly – over 80% and then those in the 70% to 79% category, and they were asked what they did to ensure that they performed well. Through those interactions, the idea was mooted of trying to draw up pointers for the \textit{deal Clinic} – and this evolved from a one page points guideline, to a booklet, which was produced in August 2015. The top four clinics gave their insight into the following: Integrated treatment, good administration, good relationship with labs, adequate HR, support services, infrastructure, water supply, electricity, health information management system, communication systems down to the community and districts levels, medicine and supply, support from the districts, and the need to use NGOs and the private sector in the community. Specific definitions were needed in order to know exactly what must be in the clinics. Because broad descriptions can be hard to interpret these ten main components were broken down into 32 sub-components in the booklet. Research revealed that managers were overwhelmed and the department realised that it takes a comprehensive set of elements to provide good service, and this then was encompassed in the notion that all elements were equally important.

The booklet specified what is ideally needed for a clinic. However, further specifications would also be needed - such as guidelines on waiting times and other areas in order to then allow the Department to measure the changes and provide specific of areas in which changes needed to be implemented. Page 65 in the booklet, elements 129-131 spoke to the process for administration. This programme could also then be viewed as a training tool for clinic staff as it provided step by step details of how certain functions need to be perform. Clinics will need to maintain the level attained during the \textit{deal Clinic} drive, in order to avoid any drops in the level of service and quality that they were encouraged to bring up during the campaign. Ms Hunter noted that sustainability would be achieved through training and accountability. If performance agreement and job description were in place, staff would know what was expected, training would be provided and in the event that wrongdoing at the clinics persisted, then counselling could be provided, and failing any improvements after that, then disciplinary action and other measures could be taken. This would show staff that the Department was very serious about what was expected from the clinics.

The main point with the Ideal Clinic project was if one clinic can look good and provide good service, then in theory all the clinics can do the same. Ms Hunter gave the example of two clinics, both in Mpumalanga, one in a very good state and provided good service, whilst the other was extremely poor, with bad ablution facilities even though these were still being used daily.

Ms Hunter then posed the question: \textit{What is an Ideal Clinic?}

She said that an ideal clinic will be a clinic that provides good clinical care to the patients it serves and also gives the patients good experience of care. It will do this in part because it cooperates and consults with the community it serves. It has good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and adequate bulk supplies. It will use applicable clinical policies, protocols and guidelines. It will make use of partner and stakeholder support to ensure the provision of quality health services to the community. An Ideal Clinic will cooperate with other government departments, as well as with the private sector and non-governmental organisations, to address the social determinants of health.

She then went on to say that Primary Health Care (PHC) facilities must be properly maintained, so that they will function optimally and remain in a condition that can described as the \textit{deal Clinic} . Integrated clinical services management (ICSM) will be a key focus within an Ideal Clinic. ICSM is a health system strengthening model that builds on the strengths of the HIV programme to deliver integrated care to patients with chronic and/or acute diseases, or those who come for preventative services, by taking a patient-centric view that encompasses the full value chain and continuum of care and support.
She tabled a diagram to show that each component in the primary health system in the clinic must provide quality comprehensive and patient-centric care, that the district health system must be led by a team that is capable of good governance, leadership and management. The clinic must be supported by a school health outreach team and must have a district clinical special team. It must also have a healthcare campaign, and work with environmental health officers as well as with contract service providers such as security. The clinic manager must be able to provide the client with access to social and physiological services. She also said that it must have a good referral system and have good secondary and higher levels of care, such as a mental health unit, and good emergency services and good surgery facilities. Finally, it must have good training for staff.

She noted that within the district, clinics must maintain a good relationship with training institutes such as colleges and have access to laboratory services.

Ms Hunter said that in future presentations to the Committee, the Director General of the Department of Health would be referring to the six work-streams that she had set up to bring faster realisation to the National Health Insurance (NHI) implementation. The district health system's main function was to act to address the burden of diseases, and this would require all the 52 districts to have good management. South Africa must move to standardise the organograms as this would help many hospitals to achieve clean audits, with experienced management and skilled staff in place. A more regulated job description was also needed, because if the clinics' image was to be standardised so must be the job descriptions. All of this would have to be achieved in order to maintain good service.

Ms Hunter noted that within the district, clinics must maintain a good relationship with training institutes such as colleges and have access to laboratory services.

She also added that the Ideal Clinic would not operate in isolation but it would be part of a system. For the purposes of NHI, a description was needed around the configuration of services. All provinces were on board with the Districts Clinical Specialist team, except the Western Cape, in 46 out of the 52 districts. Support was provided to the clinics. However, she stressed again that nothing can be done without the community engagement and this was why a clinic committee needed to be active in the community. A graph from 2013 provided clear indications whether or not the clinics had improved and case studies had been done. The Presidency had then decided to include the idea of the Ideal Clinic in the Presidential Priority programme of Operation Phakisa.

Ms Hunter noted that President Zuma had made a statement on this on 20 June 2014. Next month, South Africa would be launching an adaptation of the Big Fast Result Methodology that had been discussed with the government of Malaysia. This methodology involved setting clear targets and following up with on-going monitoring of progress and making the public aware. The government of Malaysia had used this implementation methodology to register impressive results within a short period. In South Africa, the project would be regarded as deliverables of the priorities included in the National Development Plan 2030. The pilot of this methodology was essentially aimed at improving service delivery in clinics nationwide, in further promotion of Minister of Health Aaron Motsoaledi's Ideal Clinic Initiative.

She noted that although the process had started back in October 2014, implementation had begun in April 2015. The National Health Council had considered the implementation plan. The instruction was to turn around all 3 500 clinics into Ideal Clinics. The programme was divided into three parts, and each of the provinces had committed to changing a certain number of clinics.

The plan was for the programme to work on 1 077 clinics in the 2015/16 year, but it had worked on 1 139 clinics. Clinics needed to comply with certain elements to be awarded silver, gold, platinum and diamond status. Competition was encouraged to increase compliance and the category weightings were divided into vital, essential and important services. Certain elements were not part of the clinics' responsibility, where there was reliance on other service providers, such as the Departments of transport or roads in the provinces.
Ms Hunter pointed out that Operation Phakisa had actually started after the beginning of the financial year and for this reason, the graph showed that few clinics were actually assisted. In September 2015, when slow progress was noted, the DoH agreed with the provinces that it would instead now focus on the top 600 clinics. From 01 to 12 February 2016 there had been peer review assessments done on them, taking district teams from one province and sending them to other provinces, to avoid the situation in the past where the clinics had done self-assessments that were not accurate. The peer review teams consisted of 92 teams, or two members each. Results showed that KwaZulu Natal was the best-performing province, and Eastern Cape the lowest performer. The last week's results showed that KwaZulu Natal registered 14 Ideal Clinics, Gauteng registered 6 and Mpumalanga registered 1. Mpumalanga was a fine example of what could happen when top officials took a project seriously, for it had raised itself in its rankings. Some clinics had potential to score high points but their scores would drop because of small elements; all the elements needed to be met well for a clinic to score highly.

Ms Hunter finally outlined the challenges, as infrastructure, human resource issues (including staff numbers, skills, management and leadership), supply chain, and the budget. She was confident that the DoH could do better in 2016/17. The plans were already in place. There would be a national workshop in first week of April 2016 to ensure that the National Department, nine provinces and 52 districts all understand the plan and how it should be executed. The peer review served as additional training for district scale-up teams, and there was an ICRM manual, and dedicated funding for ICRM.

Ms Hunter tabled slides on the funding and support partners, and catalytic funding for patient registration and filing systems, procurement of equipment, financial management assistance, pharmaceutical supplies, and visual analytics networks (see attached presentation for full details). Assistance included the European Union, USAid, Global Fund, Gates Foundation and CDC. Funding received from the National Treasury (NT) was condition as there was a need to focus on the NHI pilot sites. The Provinces would decide which of their approximately 740 clinics to prioritise.

Discussion
Ms L James (DA) welcomed the report and was happy that primary health care was getting the attention it needed. She enquired about the clinics that were over-staffed, saying a breakdown was needed of the different categories. She emphasised that education of the public was very important when it came to prevention and early detection.

Mr H Volmink (DA) welcomed the report but wanted to hear about the impact of the cost-cutting measures announced by the President and the Minister of Finance on this programme. He wanted to know if the DoH itself had developed any detailed cost-cutting programme, particularly in the run-up to the presentation of the budget allocations. He asked if there were monitoring and evaluation programmes, given the indications of slow implementation and non-compliance. He wanted to know the outputs and outcomes and wondered if there was not a different way of reporting.

Mr S Jafta (AIC) also questioned the slow progress of implementation. He asked what the Department was doing with infrastructure, and the balance between the clinic and community. He also asked what the Department was doing to deal with staff attitudes.

Mr D Khoza (ANC) had issues with senior officials having low qualifications, and asked what plans there were to empower them, and within what time frame. There were indications of facilities without dedicated managers, but he asked why the Western Cape was not mentioned under that section.

Dr P Maesela (ANC) asked if the Department had started any audits to identify and fill any gaps, and if it was planning forward, as the Department must be able to finish what it had started in the time
Ms C Ndaba (ANC) questioned if KwaZulu Natal was used as a pilot, and what had been the reason why it was adjudged the best of the provinces. She was surprised to hear that some of the clinics reported over-staffing because on the ground it seemed that most were under-staffed. She asked why training could not be provided to those in over-staffed clinics and then move them to areas of staff shortage. She asked why the Western Cape had not participated; it seemed that it was not always becoming involved in projects of the national Department despite the fact that communities here also needed services. She agreed with the notion of the Ideal Clinic, but pointed out that many of the issues were really basic- such as fixing toilets. She asked if there were monitoring committees to follow up on progress of clinics.

Dr Janet Hunter replied that where there were reports of over-staffing, this related to clinics with nurses only, and it referred back also to 2011; in future the reports should set out better statistics. In regard to costing she said that PHC was funded on a continuous basis and the money allocated was essentially to fix clinics. This costing was presently being considered by National Treasury but would be shared with the Committee once approved. In the process of fixing the clinics, the idea was to bring all elements in line. In regard to the assessments, she said that the Office of Health Standards Compliance had 800 measuring standards and although the pass rate on some elements was as high as 75%, there was room for some negotiation around the findings. The District Information Health Systems set out the outcomes and outputs and ratios.

From 1994 onwards, the DoH had been considering outputs. The burden of disease had increased and infrastructure had not grown at a pace that it could cope with all diseases and population growth. She causes of slow progress included bureaucracy, and supply chain issues. The process was moving faster now on the infrastructure, but three quotations were still required and this slowed it down. There was a need for better and faster planning and service.

She noted the request to move staff from one clinic to another but said that this would have to be done in line with union and HR policies and the staff would have to be informed and consent. A procurement process was in place. In relation to the comment on poor attitude she said that now staff were being trained and should know what to do. In relation to training staff who had lower than ideal qualifications, she said that standardisation of jobs and the organogram would be prescriptive, and set standards that the nine provinces could all adhere to. HR Units at the National and provincial levels provided bursaries. Training and further education in the field would improve and further the staff members' career paths.

Ms Hunter reiterated that the Western Cape had agreed to come on board. The reason why it had sometimes not participated in national initiatives was because the Constitution gave the provinces concurrent functions; the national Department would try to persuade it to participate. Funding was being researched and the Department was trying to find and fund the gaps. Monitoring was being done by a team at the national level who was responsible for the nine provinces, plus a team at provincial level and facility managers.

Ms Hunter wanted to confirm that KwaZulu Natal was not the pilot study because the pilot was actually run across all eight provinces. The best quality services were found where there was good management and the political environment was stable. Initially, people had tended to not take the prospect of the Ideal Clinic seriously.

Another official from the Department of Health explained that in KwaZulu Natal it had been found that there was a very dedicated provincial manager who was keen to implement the Ideal Clinic, and had set up teams of enablers, trainers and done orientation. This manager had implemented most recommendations and the results were taken positively, with staff being keen and involved.
Mr Volmink asked about the emergency care training, and suggested that the Department could research and learn from Brazil's mobile emergency care unit. He asked if the clinic management had purchasing power. He asked if the training was in line with elements of the Manual

Ms James also asked about training and upskilling of professional staff. She asked if training was provided to detect early signs of drug abuse, to ensure quick responses on that.

Ms Ndaba asked if the clinics could afford outside training for emergency services, or use current EMS workers. She suggested that site visits by the Committee to some clinics and hospitals might be useful.

The Chairperson asked that the DoH provide a breakdown of statistics, including those with no managers in Free State and Eastern Cape. She asked if the wrong people had been appointed to positions in the past. The Department may need to provide training specifically on health sector issues for instance for staff who might have more general training in public management. She was concerned about empowerment of staff. She suggested that a workshop would be useful before going on any site visits.

Dr Hunter said that any training would be geared to the health sector, and that universities could assist in providing clearer career path training for those to be associated with clinics. Emergency Medical Services staff were trained in basic components of life support and this training was also geared to South African conditions. Dr Carter would be able to give more details on EMS training through the Office of the Minister. She agreed that early drug use detection was needed, and practitioners working with drug issues needed skills other than purely clinical skills. She acknowledged Mr Volmink's suggestions. She noted the comments on purchasing power and said that unfortunately corruption was a reality and so a balance would have to be found, and controls implemented. Ms Hunter said that she took note on comments of the Chairperson and would take them forward. She finally indicated that the website was www.idealclinic.org.za.

The Chairperson said that the DoH needed to market the Ideal Clinic concept to the community and treat patients with respect.

The meeting was adjourned.