REPUBLIC OF SOUTH AFRICA

OPERATION PHAKISA

IDEAL CLINIC REALISATION AND MAINTENANCE

FINAL LAB REPORT

MAY 2015

Contents

Disclaimer

This document is the final Lab report which includes observations, findings and recommendations developed in Operation Phakisa's Ideal Clinic Realisation and Maintenance (ICRM) Labs. Included in this report are also some of the initiatives already on-going or planned by the National Department of Health (NDoH), as they are an important component of the strategy to achieve impact.

This report aims to consolidate the results of the work of the eight Lab - workstreams in one single document. Beyond this report, the full suite of materials available to support implementation is composed of:

- Individual reports for each of the eight Labwork-streams
- "3 feet" plans, containing activities and tasks to be carried out to implement each initiative mentioned in this report
- Key Performance Indicators (KPIs) and targets, comprehensive of baseline, deadline and trajectory to achieve the target, to monitor and evaluate the success of each initiative mentioned in this report
- Suggested next steps to launch implementation, including a draft implementation guide (playbook)

Any detail which has not been consolidated in this report is available in the corresponding Labwork-stream report in power point.

Data for this report have been selected from various sources believed to be the most reliable at the time of the ICRM Lab (12 Octoberto21 November 2014).

These include online and print versions of documents from government and non-government organisations, including but not limited to:

- NDoH
- National Health Care Facility Systems Baseline Audit 2012
- Public Service Commission
- Health Systems Trust
- WHO
- UNAIDS
- World Bank
- Medical Research Council of South Africa

The most updated version of **published** data has been used; however, this may not necessarily be the most recent. The Lab team recognises that some of the reports (e.g. Health Systems Trust) have originally sourced the data from the NDoH.

Abbreviations and acronyms

APP	Annual Performance Plan
CCMDD	Central chronic medication dispensing and distributions
CFO	Chief Financial Officer
CHC	Community Health Centre
CMA	Change management approach
CMH	Clinic Maintenance Hub
CMMS	Computerised Maintenance Management System
CoGTA	Cooperative Government and Traditional Affairs
COO	Chief Operating Officer
COU	Central Oversight Unit
CSIR	Council for Scientific and Industrial Research
DDG	Deputy Director-General
DG	Director General
DHC	District Health Council
DHCo	District Health Committee
DHER	District Health Expenditure Reviews
DHIS	District Health Information System
DHMIS	District Health Management Information System
DHP	District Health Plan
DHS	District health services
DIRCO	Department of International Relations and Cooperation
DMPU	Demand Management Procurement Unit
DMT	District management team
DoH	Department of Heath
DPME	Department of Planning, Monitoring and Evaluation
DPSA	Department of Public Service and Administration
DTPS	Department of Telecommunications and Postal Services
DPW	Department of Public Works
eHR	Electronic health record
EMS	Emergency Medical Services
FM	Facility Manager
FPD	Foundation for Professional Development
GCIS	Government Communications and Information services
GDP	Gross Domestic Product
HANIS	Home Affairs National Identification System
HIE	Health Information Exchange
HIS	Health Information System
HISP	Health Information System Programme
HMIS	Health Management Information System
HOD	Head of Department
HPCSA	Health Professions Council of South Africa

HPRS	Health Patient Registration System
HR	Human resources
HRD	Human Resources Development
HRIS	Human Resources Information System
HSRC	Human Sciences Research Council
HST	Health Systems Trust
ICDM	Integrated Chronic Diseases Model
ICRM	Ideal clinic realisation and maintenance
ICSM	Integrated clinical service management
ICT	Information and Communication Technology
ID	Identification document
IEC	Information Education Communication
IGRFA	Intergovernmental Relations Framework Act
IHPF	Integrated Health Planning Framework
IMC	International Marketing Council of SA
ISHP	Integrated School Health Programme
IPC	Infection prevention and control
IT	Information technology
KPA	Key performance area
KPI	Key performance indicators
LAN	Local Area Network
M&E	Monitoring and Evaluation
MEC	Member of the (Provincial) Executive Council
MMC	Members of the Mayoral Committee
MOA	Memorandum of Agreement
MPI	Master Patient Index
MTSF	Medium Term Strategic Framework
NCOP	National Council of Provinces
NDoH	National Department of Health
NGO	Non-governmental organisation
NDP	National Development Plan
NHA	National Health Act
NHC	National Health Council
NHI	National Health Insurance
NIDS	National Indicator Data Set
NSDA	Negotiated Service Delivery Agreement
NSG	National School of Government
NSSI	Non-Standard Stock Items
OHSC	Office of Health Standards Compliance
PAAB	Patient Administration and Billing system
PDoH	Provincial Department of Health
PERSAL	Personal and Salary System
PFMA	Public Finance Management Act
PHC	Primary health care

PHCIS	Primary Health Care information System
PHCos	Provincial Health Councils
PIDS	Provincial Indicator Data Set
PMI	Project Management Institute
PMPU	Provincial Medicine Procurement Unit
PPP	Public-private partnership
PPTICRM	Permanent Perfect Team for Ideal Clinic Realisation and Maintenance
SABS	South African Bureau of Standards
SALGA	South African Local Government Association
SALRC	South Africa Law Reform Commission
SANC	South African Nursing Council
SAPC	South African Pharmacy Council
SATS	South African Triage Score
SCM	Supply chain management
SLA	Service-level agreement
SSI	Standards Stock Items
SWPU	Sector Wide Procurements Unit
TB	Tuberculosis
TBD	To be decided
UHC	Universal Health Coverage
WHO	World Health Organisation
WISN	Work Load Indicator of Staffing Needs
WP-NHI	White Paper on National Health Insurance
XDR-TB	Extensive drug resistant TB

Introduction

This report presents the outputs of the Ideal Clinic Realisation and Maintenance (ICRM) Lab held under the auspices of Operation Phakisa and led by the National Department of Health (NDoH) and the Department of Planning, Monitoring and Evaluation (DPME) in the Presidency.

The ICRMLab was an exercise of unprecedented depth, intensity and focus. It brought together 164 senior participants from across the health system to craft detailed, sustainable solutions to address the greatest challenges in South Africa's primary healthcare (PHC) system – with detailed implementation plans developed to realise these solutions in all 3,507 PHC clinics.

The ICRM Lab builds on a number of reforms that have been implemented since 1994 to strengthen PHC. In 1996 a new South African Constitution was adopted to guarantee the right of every South African to have access to health care. In 2004 a new National Health Act was promulgated to provide a framework for a structured uniform health system. In 2008 a health road-map was designed to map out key systemic challenges as precursor to the government's 10-point reform plan which followed in 2010.

In 2011 the concept of National Health Insurance was announced, with the aim of achieving universal health coverage for all South Africans. In addition, the Human Resources for Health strategy was launched to identify the human resource challenges and recommend strategies to remedy them. In 2013 the Ideal Clinic Initiative was launched to address deficiencies in primary health care clinics systematically – Operation Phakisa, the subject of this report, aims to scale up this initiative across South Africa. In 2014 the Office of Health Standards Compliance (OHSC) was established as a statutory body. The OHSC will be tasked with monitoring compliance with the norms and standards of health care delivery, including factors covered the by the Ideal Clinic Initiative.

The ICRMLab was divided into eight workstreams:

- Service Delivery
- Waiting Times
- Infrastructure
- Human Resources for Health
- Financial Management
- Supply Chain Management
- Institutional Arrangements
- Scale-up and Sustainability

Across these workstreams, the ICRM Lab developed more than 80 initiatives which have been aggregated and prioritised into 46 high priority initiatives. The Lab also prepared an implementation plan for the scale-up of the Ideal Clinic to all 3,507 facilities nationwide as well as a sustainability plan, as part of a coordinated transformation programme.

The following document sets out, in detail, the findings and initiatives developed by each of the workstreams. All initiatives have corresponding implementation plans at the “3 feet” level of detail, which map out the activities to be carried out by responsible parties at national, provincial, district and facility level. The sequencing of the implementation of these initiatives at district and clinic level will be informed by their cost, which is still being estimated by the NDoH.

It is envisaged that this scale-up can be completed by 2018/19.

In addition to this report, the work streams produced detailed presentations and a dedicated power point report.

Executive Summary

This report presents the outputs of the Ideal Clinic Realisation and Maintenance (ICRM) Lab held under the auspices of Operation Phakisa and led by the National Department of Health (NDoH) and the Department of Planning, Monitoring and Evaluation (DPME) in the Presidency.

The ICRMLab was an exercise of unprecedented depth, intensity and focus. It brought together 164 senior participants from across the health system to craft detailed, sustainable solutions to the greatest challenges in South Africa's primary health care (PHC) system.

CONTEXT: THE IMPORTANCE OF STRENGTHENING PRIMARY HEALTH CARE

At the core of the South African health system are 3,507 PHC facilities[1] across the country, offering free services to 54 million people[2]. South Africans are using clinics in increasing numbers: primary health care visits increased from 67 million in 1998 to 128 million in 2013[3] driven by a higher frequentation of the system (1.6 visits per capita per year in 1998 as against2.4 visits per capita per year in 2013). The achievements of PHC in South Africa over the past 20 years include improving immunisation coverage for children below one year of age to nearly 100%[4] and supporting more than 2.8 million patients on anti-retroviral medication (ARVs), the largest such programme in the world[5].

Despite these achievements, PHC in South Africa faces several serious challenges, which could jeopardise the essential role it plays in the country – and which have led to negative public perceptions that undermine trust across the rest of the system. In particular:

- A **negative patient experience** is common: facilities scored poorly relative to compliance with vital measures against priority areas in the National Health Care Facility Baseline Audit 2012.
- **Access** to services is **variable** across provinces, as reflected in indicators of accessibility, such as antenatal first visits before 12 weeks of age[6].

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1 NDoH: Public Health Facilities in South Africa

2 Statistic South Africa: Mid-year estimate 2014

3 NDoH, Medium Term Strategic Framework2014-2019

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

5 Johnson L., Access to Antiretroviral Treatment in South Africa, 2004 - 2011. Southern African Journal of HIV Med. 2012; 22-27

6 District Health Information System data as reported in the Health Systems TrustDistrict Health Barometer Report 2013/14

- Patients' total **waiting time** in clinics **ranges from two to seven hours** with, on average, 76% of patients' time in the clinic spent waiting[7].
- **Infrastructure** in clinics is often inadequate; in all, 80% of clinics are not fit for purpose[8].
- Essential (medical) supplies are often missing at clinic level, because of a poorly responsive **supply chain**. For example, requisition for a non-standard stock item (NSSI) may take up to 63 days[9].
- A lack of strong **financial management** causes many PHC facilities to run out of funds early in the year[10].
- Implementation of improvement initiatives is uneven, partly as a result of inadequate **institutional arrangements** between provinces and national government.

The ICRM initiative aspires to transform PHC in line with broader national priorities, as set out in Chapter 10 of the National Development Plan 2030, the Medium Term Strategic Framework (MTSF) 2014-2019, and the National Health Insurance policy. The initiative is also aligned with the increasing global focus on primary and community-based care, which is seeing many developed and developing countries revise their models of the primary health clinic.

Ultimately, the ICRM initiative aspires to ensure that, by 2019, every one of South Africa's 3,507 PHC facilities displays the elements of the "Ideal Clinic". In the words of the President of South Africa, the Ideal Clinic has the following characteristics[11]:

- It opens on time in the morning, according to its set operating hours, and does not close until the last patient has been assisted, even if this is beyond the normal closing hours.
- It is staffed by health care providers who treat people with dignity, and observe the Batho Pele principles of Access, Consultation, Courtesy, Information, Service Standards, Openness and Transparency, Redress and Value for Money.
- It provides community-based health promotion and disease prevention programmes in collaboration with the community.
- It is very clean, promotes hygiene and takes all precautionary measures to prevent the spread of diseases.

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[7] NDoH: Lean Diagnostic in Ideal Clinic Pilot Sites

[8] The National Health Care Facilities Baseline Audit 2012

[9] Supply Chain Management work stream analysis

[10] Financial Management work stream analysis

[11] President Jacob Zuma , Operation Phakisa launch, 18 November 2014, accessed at:http://www.thepresidency.gov.za/

- It has reasonable waiting times, and community members do not have to sacrifice their entire working day to seek health care.
- It provides a comprehensive package of good quality health services every day, and community members do not have to return on different days for different services.
- It has the basic necessities available, such as essential medicines.
- It refers people to higher levels of care timeously when this is required.
- It works together with the community it serves, with diverse stakeholders, in promoting health and socio-economic development.
- Community members would say an Ideal Clinic is one of which it is possible to feel pride, calling it “our own clinic”, rather than a “government clinic” or a “state health facility”.

In 2013, 10 clinics were designated as study sites to test the Ideal Clinic concept. The pilot clinics were closely monitored and assisted by an ICRM Team to reach Ideal Clinic status over the course of 2013 and 2014. The team consisted of representatives from the clinics, districts, provinces, NDoH, National Health Insurance (NHI) and the Office of Health Standards Compliance (OHSC).This pilot phase showed that progress is possible, but also that there are fundamental challenges that will require transformational solutions. The project also needed a scale-up plan for all 3,507 facilities. For these reasons, The President’s “Operation Phakisa Programme” has made the Ideal Clinic initiative its second major area of focus in fast-tracking national priorities.

OPERATION PHAKISA AND THE IDEAL CLINIC REALISATION AND MAINTENANCE LAB

Operation Phakisa, which launched in early 2014 with an initiative to unlock the economic potential of South Africa’s oceans, uses a methodology that involves setting clear targets, detailed implementation plans, on-going monitoring of progress and making the results public. Drawing on successful implementation efforts in several other countries (particularly Malaysia), the methodology will be used to accelerate delivery of national priorities.

The Phakisa methodology galvanises delivery through participation, detailed planning and a shared commitment to deliver. It brings together the essential stakeholders in one room, and invites them to take full ownership of the aspirations, decisions and initiatives generated during a full-time, six-week-long “delivery Lab”. The Lab develops detailed, step-by-step execution plans at the “3 feet” level of detail. There is weekly involvement in the Lab by Ministers and provincial heads, and an end-of-Lab commitment by the President.

The ICRMLab convened from 12 October to 21 November 2014 and brought together practitioners and experts from multiple National Departments, provinces and metros across South Africa's public health system. Key players from outside government were also involved – including participants from Statutory Councils, trade unions, Schools of Public Health, non-governmental organisations (NGOs), development partners and the private sector.

With 164 participants, and facilitated by external consultants, the Lab's purpose was to develop an implementation plan to transform 100% of PHC facilities across the country to Ideal Clinic status (from a base of 0 in 2014)[12].

The ICRMLab was divided into eight work streams, as follows:

- **Service Delivery** focused on solutions to ensure all PHC facilities deliver optimal quality health care, including a comprehensive and standardised package of services, 100% availability of medicines and supplies and a clean and safe environment.
- **Waiting Times** 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 three-hours-maximum total waiting time for patients in all clinics as well as80% of patients reporting a positive experience of care.
- **Infrastructure** focused on developing an effective infrastructure roll-out plan to ensure all PHC facilities have world-class infrastructure that is delivered on time and well maintained for the future.
- **Human Resources for Health** focused on creating an equitable distribution of well-trained workers with the required capabilities (leveraging the private sector as well) to ensure the professional, efficient, effective, cost-effective and sustainable delivery of health care.
- **Financial Management** focused on developing a realistic budgeting process that accurately forecasts the funding requirements orphic facilities, allocates resources equitably and improves financial accountability.
- **Supply Chain Management** focused on steps to ensure the continuous availability of medicines and supplies, to reduce the costs of procurement and distribution of commodities and to improve turnaround times for the delivery of non-standard stock items.
- **Institutional Arrangements** focused on developing effective institutional arrangements and inter-governmental agreements to support the realisation and maintenance of Ideal Clinics in South Africa.

[12] The committed target, as per MTSF 2014-2019, is 1,500 PHC clinics.

- **Scale-up and Sustainability** focused on developing a national scale-up framework and an implementation plan to enable all 3,507 PHC facilities in South Africa to achieve Ideal Clinic status.

Across these eight work streams, the ICRM Lab developed more than 80 initiatives and prioritised 46 of these. Detailed implementation plans at the “3 feet” level of detail have been developed for each of the 46 initiatives, which map out the activities to be carried out by responsible parties at national, provincial, district and facility level. The sequencing of the implementation of these initiatives at district and clinic level will be informed by their cost, which is still being estimated by the NDoH.

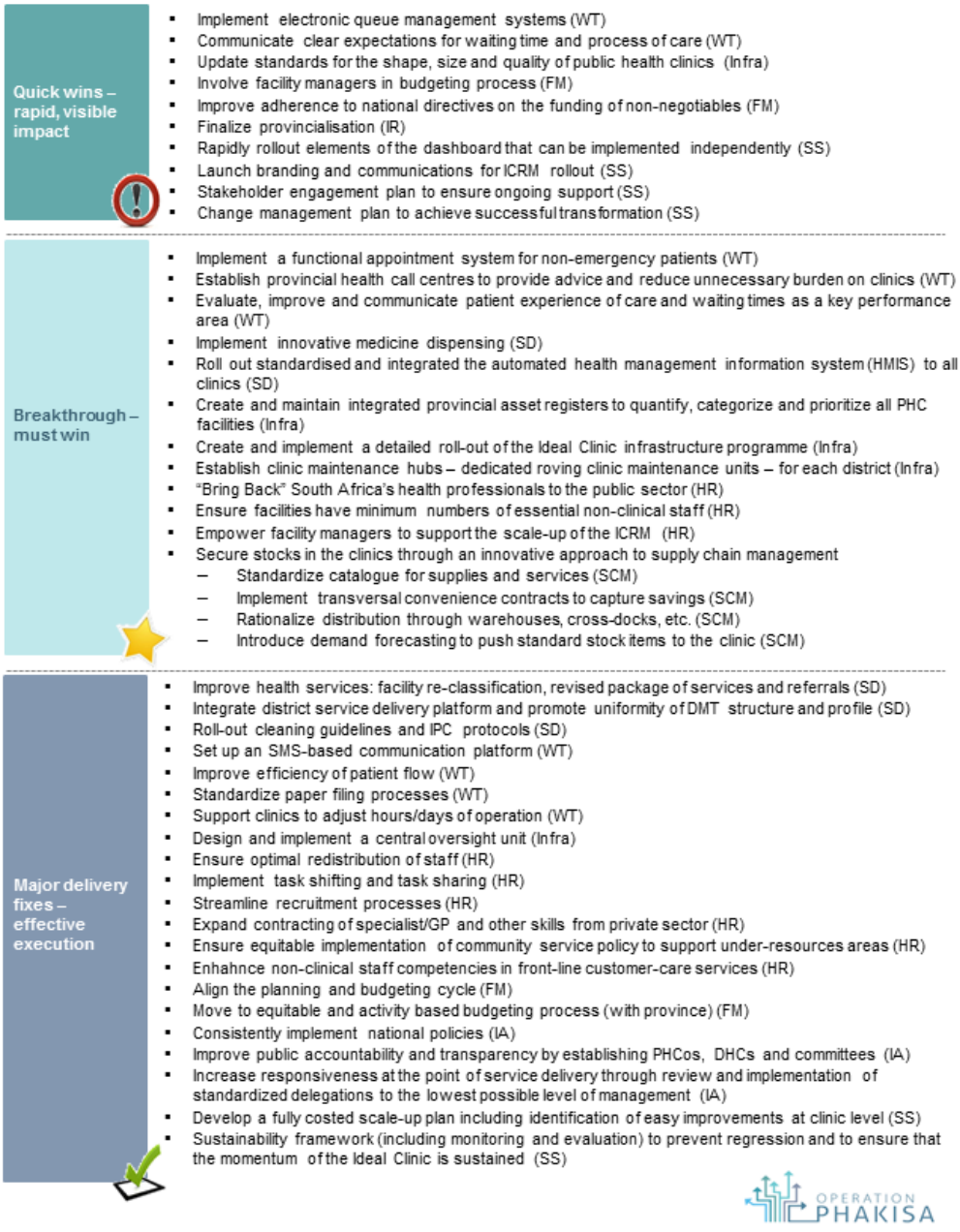
Subsequently, National and Provincial Departments of Health have prepared implementation plans for the scale-up of the Ideal Clinic to all 3,507 facilities nationwide, as part of a coordinated transformation programme.

The 46 initiatives fit into three types: 10 quick wins, 15 breakthrough initiatives and 21 major delivery fixes (Exhibit 0.1). These46 initiatives together address the four overarching themes defined as strategic for achieving Ideal Clinics across the PHC.

In this Executive Summary four strategic themes to achieve Ideal Clinics are identified, and the 15 breakthrough initiatives are summarised. Details on all the 46 initiatives are described in the following eight chapters, corresponding to each of the eight ICRM Lab workstreams.

EXHIBIT 0.1

Full list of selected initiatives by the ICRM Labs



STRATEGIC THEMES AND BREAKTHROUGH INITIATIVES

Together, the 46initiatives developed and prioritised in the ICRM Lab advance four strategic themes for achieving Ideal Clinics across PHC. These themes are:

- **Patient-centric approach** – focusing on patient health, patient experience and ensuring that patients are treated with dignity. Key initiatives to drive this theme include adjusted clinic opening hours; developing new ways of accessing PHC; strengthening community service; evaluating, improving and communicating patient experience; and reinforcing health services.
- **Back to basics in the clinics** – ensuring all clinics have acceptable infrastructure and are equipped for service and maintained over time. Key initiatives to drive this theme include refurbishing and rebuilding infrastructure; and standardised maintenance practices, including maintenance services "on call".
- **Career of choice** – ensuring the best and brightest come and work in the PHC facilities. Key initiatives to drive this theme include creating more attractive conditions for staff; developing clearer lines of accountability for clinic managers; and strengthening clinics' operational efficiency, so ensuring that staff spends more time with patients.
- **Effective processes** – ensuring all processes are streamlined and focused on improving the outcomes of the system and the experience of patients and staff. Key initiatives to drive this theme include improving procurement processes; strengthening management capabilities; and putting in place better information systems.

To deliver tangible, wide-scale, sustainable improvement against these themes, 15 recommended breakthrough initiatives were selected:

1. Implement a functional **appointment system** for non-emergency patients.
2. Establish **provincial health call centres** to provide advice and reduce unnecessary burden on clinics.
3. **Evaluate**, improve and communicate patient experience of care and **waiting times** as a key performance area (KPA).
4. Implement **innovative medicine dispensing.**
5. Roll out standardised and integrated health management information system (**HMIS**) to all clinics
6. Create and maintain integrated provincial **asset registers** to quantify, categorise and prioritise all PHC facilities.
7. Create and implement a detailed roll-out of the **Ideal Clinic infrastructure programme**.

8. Establish **clinic maintenance hubs**– dedicated roving clinic maintenance units – for each district.
9. "**Bring back" South Africa's health professionals** to the public sector.
10. Ensure facilities have **minimum numbers of essential non-clinical staff.**
11. **Empower facility managers** to support the scale-up of the ICRM.
12. Secure stocks in the clinics through an **innovative approach to supply chain management** (includes four supply chain management initiatives).

Each of these breakthrough initiatives is detailed below.

1. IMPLEMENT A FUNCTIONAL APPOINTMENT SYSTEM FOR NON-EMERGENCY PATIENTS

To drive improvements in patient and staff experience and to reduce waiting times, this initiative will ensure that every clinic has a functional appointment system for non-acute, non-emergency patients. The system will help patients avoid unnecessary visits, and ensure they are referred to the right level of care.

Presently there is no appointment system in place to allow equal access without extended waiting times. Appointments are booked in individual consulting rooms, leading to high variability in the number of patients booked per day (for example, all nurses might schedule their patients for the same dates).

The ICRM Lab proposed that appointments will be handled centrally at each clinic, following standard criteria:

- Each clinic will determine daily targets for each date and time, informed by patients' conditions and needs as well as staff capacity per day.
- To balance patient influx and staff workload under the new process, each clinic will have a well-structured, centralised appointment-booking system.
- Appointments will be agreed with patients, based on their clinical requirements, and given for specific times.
- Appointments for medication pickup will be given at designated alternate sites where available.
- Non-booked patients will be seen on the same day but waiting times may be longer as priority will be given to patients with a regular appointment.
- The appointment system will be linked to the automated patient identification system once this is operational.
- Patients will receive SMS reminders once an appropriate system has been developed (leveraging experiences like MomConnect).

Target implementation dates for the appointment system are March 2016 for clinics that already have the required infrastructure, and 2018/19 for all other clinics.

2. ESTABLISH PROVINCIAL HEALTH CALL CENTRES TO PROVIDE ADVICE AND REDUCE UNNECESSARY BURDEN ON CLINICS

An initial diagnostic undertaken by Lab members showed that many patients go to the clinic with requests that could easily be solved remotely (e.g., asking if it is normal that their urine changes colour when on TB medications), or who go there as a first choice when the clinic is not the right level of care (e.g., requesting an HIV test). To address these issues, the Lab proposed that a health call centre be established in each province – to improve access to health care, reduce unnecessary clinic visits, and assist patients in ensuring that their first visit is to the appropriate level of care. This call centre will not be used for medical consultations or appointment systems. They will build on the positive experience of existing call centres in several municipalities (e.g., the City of Cape Town 107 Centre).

Trained operators will take patients' calls, and direct them either:

- To **health care professionals**, as a first point of contact to give advice on simple medical related questions (e.g., what are side effects of a certain treatment for people that cannot read, whether the specific situation is best solved at community or at clinic level); or
- To **existing operators**, to resolve questions about PHC and other health care services (e.g., opening and geographic location of clinics).

In the longer term, call centre services could be expanded to include triage and emergency medical services (EMS) advice, to schedule appointments and to provide better health access in rural areas through virtual lines. This may require approval from the Health Professions Council of South Africa (HPCSA)for any service that could be considered as teleconsultation.

Implementation will begin by identifying and integrating the lessons learnt from existing call centres and the EMS initiative. The next step will be to analyse existing health call centre services in every province and plan for integration into a provincial health call centre. This includes exploring the infrastructure and human resource requirements for a province-based setup. Following this, standardised health care professional and operator scripts will be developed, and operators trained. Finally, the new channel will be marketed to patients.

Target dates for implementation are to operationalize a pilot call centre by April 2016, and to operationalize call centres in all provinces by March 2017.

3. EVALUATE, IMPROVE AND COMMUNICATE PATIENT EXPERIENCE OF CARE AND WAITING TIMES AS A KEY PERFORMANCE AREA (KPA)

An excellent patient experience is an important element of the Ideal Clinic. Despite several previous initiatives to improve the way patients are treated in clinics, only 30% of South African facilities have a reasonable score on a positive and caring attitude[13]. This challenge has several root causes, including demand overload, insufficient staff, poor working conditions and insufficient training.

The initiative seeks to ensure that waiting times and the patient experience are monitored for improvement. Relevant standardised tools to measure these must be employed. Findings based on these measurements will lead to quality improvement strategies which will eventually lead to a sustained system for monitoring waiting times as well as of patient satisfaction surveys.

The Lab team selected and revised the South African National Patient Experience of Care Tool to roll out country-wide. The Tool has been scientifically tested by the Human Sciences Research Council (HSRC). It measures priority factors that influence the patient experience of care. Tailor-made to address PHC facility needs, it is easy to apply and allows for a basic, descriptive analysis approach. Data analysis can then be conducted using any appropriate software for data analysis. The Tool is comprehensive and includes both patient experience of care and waiting times.

This initiative will provide a guide to assessing patient experience of care, which will be measured nationally each year.

4. IMPLEMENT INNOVATIVE MEDICINE DISPENSING

This initiative, already launched under the leadership of the NDoH, will improve patient experience and waiting times, by enabling millions of chronic patients to collect their medication from alternate sites, closer to their homes or their place of work. As a result of this initiative, stable patients requiring medications for chronic conditions will only need to visit PHC for a consultation to issue a new prescription, unless there is a change in the health condition of the patient or the patient moves away. This will avoid the congestion incurred by patients having to return to the PHC facility every month for a repeat prescription.

Three existing options will be piloted, assessed and – depending on their effectiveness – rolled out across South African PHC. These are:

- **Central chronic medication dispensing and distributions (CCMDD).** Currently CCMDD enables dispensing of prescriptions for patients with certain chronic conditions, and distribution of previously-dispensed patient medicine

[13] The National Health Care Facility Baseline Audit 2012

parcels to pick up points. Once its feasibility is proven, this system could be expanded to include all chronic conditions.

- **Direct deliveries.** This option entails direct deliveries from an institutional or community pharmacy, the consultation rooms of a licensed dispenser or PHC or from satellite clinic to places where patients can conveniently collect their medication.
- **Mobile dispensing unit.** In terms of this option, pharmaceutical services are provided from a mobile pharmacy (in compliance with applicable legislation), following a pre-determined route, date and time.

The plan for roll-out of these innovative dispensing and distribution options is to pilot in 10 initial PHC centres by June 2015, and then to implement in three phases to June 2018.

5. ROLL OUT STANDARDISED AND INTEGRATED HMIS

The objective of this initiative is to improve the patient experience and quality of care, by reducing the administration burden through the development of standardised data collection and reporting tools and establishing a standardised filing system. This includes the development and implementation of standardised data collection and reporting tools that respond to reporting requirements for measuring health indicators. This initiative will build on the work piloted by the "700 facility project", which aims to digitalise 700 facilities across the country as a model to be rolled out throughout South African PHC.

This initiative will be implemented in four stages:

- **Efficient manual system.** During 2015, the first steps will be taken, including organising and streamlining patient records; fully implementing the District Health Management Information System (DHMIS) policy and procedures; and conducting a baseline study of administrative personnel.
- **Digitalise aggregated data.** Between 2015 and 2017, steps taken will include ensuring that all PHC centres have telephone, internet and email; implementing daily data reporting using the District Health Information System (DHIS); and automating patient identification using a health patient registration system (HPRS).
- **Automate operations.** In 2017 and 2018, digitisation will be expanded beyond patient ID – and will encompass the electronic health record (eHR), appointment scheduling, and stock management and prescriptions.
- **Shared electronic health records**. In 2019, a national interoperability platform will have been established with a Health Information Exchange (HIE), so eHRs are shared across facilities.

6. CREATE AND MAINTAIN INTEGRATED PROVINCIAL ASSET REGISTERS TO QUANTIFY, CATEGORISE AND PRIORITISE ALL PHC FACILITIES

The objective of this initiative is to create verified asset registers in every province covering both facilities and equipment. These provincial registers will contribute to the creation of a single database at national level in which each facility will have a unique identifier. This database will be regularly updated and include references to the condition and ownership of the assets.

The asset register will help to categorise the requirements of facilities (for example, those requiring additional space); prioritise which facilities need attention and in which order; and determine the extent of the financial commitment required for the Ideal Clinic delivery roll-out. The register will also enable greater transparency and the efficient monitoring and control of all assets – thus facilitating future planning and helping ensure effective maintenance.

The information in the asset register will be integrated into a single repository in a standard format. This information will be accessible to the NDoH, provincial health departments and districts.

As a first step in implementing this initiative, each provincial health department will develop its own asset register, verify the data and share this with the NDoH. Health System Trust (HST) reports and DHIS information will be used as a starting point. The NDoH will then consolidate the information and develop the required policies and processes for the access, use and updating of the register. The Lab also proposed that provinces and the NDoH could leverage expertise from other national departments – particularly the Department of Public Works (DPW) – and tertiary education teams to update and consolidate the asset register.

7. CREATE AND IMPLEMENT A DETAILED ROLL-OUT OF THE IDEAL CLINIC INFRASTRUCTURE PROGRAMME

The physical state of the infrastructure of health care facilities in South Africa is often poor, due to unequal development and poor maintenance. Findings of The National Health Care Facilities Baseline Audit conducted by the NDoH in 2012 are that less than 20% of the public health clinic in districts have infrastructure that is fit for purpose. The key drivers of this outcome were poor design, sub-standard build quality, inappropriate use of materials, inadequate build services and lack of maintenance in many facilities.

Against this backdrop, the ICRM Lab set the aspiration to design and roll-out “100% fit-for-purpose” facilities by 2018/19. This will be set out in a clearly-defined infrastructure roll-out plan underpinned by national technical specifications for the Ideal Clinic facility. Within the overall layout and technical specifications, there will be a focus on improving access, maximising infection control and improving the patient experience, especially with regard to privacy.

Key elements of this initiative include:

- Segmenting the infrastructure requirements of all facilities, from current state to Ideal Clinic state
- Outlining the key infrastructural requirements – including new builds, reconfiguration for lean, light touch upgrades and maintenance
- Finally, creating a detailed project plan to implement the Ideal Clinic roll-out plan to realise “100% fit-for-purpose” facilities; prioritise quick wins, ensuring that 20% of all clinics are compliant by 2016

8. ESTABLISH CLINIC MAINTENANCE HUBS– DEDICATED ROVING CLINIC MAINTENANCE UNITS – FOR EACH DISTRICT

This initiative proposes the establishment of clinic maintenance hubs (CMHs) in each district to improve the maintenance of all facilities and equipment. The hubs will consist of a call centre, workshop, stores and term contractors, and be run by a hub manager. The CMHs will include dedicated roving clinic maintenance units to improve maintenance and turnaround times. The vision of the ICRM Lab is for each district to have an operational clinic maintenance hub.

Each of the CMHs will be a cost centre for a number of PHC clinics, and will not fall within hospital maintenance budgets. In order for the hubs to function optimally, it will be necessary to develop the skills required (including store manager, artisans and operation contractors).

To support the hubs in achieving fast turnaround times, an iMaintenance app is proposed. This will facilitate distance diagnostics for maintenance, and help avoid a build-up of backlogs. The app will allow staff to take a picture at a facility and transmit it to the hub, where a technical expert will diagnose the problem and send out a contractor to repair the defect.

A further step to speed up maintenance turnaround times will be to streamline supply chain management to address the requirements of the hubs. At the same time, stores management will be optimised to unlock bottlenecks across the entire maintenance value chain.

The Lab expected all the districts to establish their maintenance hubs in 2015.

9. “BRING BACK” SOUTH AFRICA’S HEALTH PROFESSIONALS TO THE PUBLIC SECTOR

The objective of this initiative is to bring back into the public health care system thousands of doctors and professional nurses (either on a part-time or full-time basis), as well as pharmacists, dentists, pharmacy assistants, dental therapists and physiotherapy assistants. The initiative will target the more than 12,000 South

African doctors and nearly 7,000 South African nurses abroad; retired nurses and pharmacists; and the 65,000 nurses, 12,000 doctors and 9,000 pharmacists who are active professionals outside the public sector[14].

It is recommended that the NDoH set up a Bring Back Our Professionals Campaign task team. This team will drive the campaign, and will include representatives of NDoH and provincial health departments, other departments, organised labour and civil society partners.

A clear two-pronged communication and marketing strategy will be developed in partnership with Government Communications and Information services (GCIS), the International Marketing Council of SA (IMC), the Department of International Relations and Cooperation (DIRCO) and the Presidency. The President and Minister of Health should be patrons of this campaign. One part of the campaign should focus on the international market and another internally on attracting retired health professionals and those in the private sector.

To support the initiative, the NDoH and provincial health departments will need to put in place a series of incentives to encourage professionals to return to the sector, including:

- Revised financial incentives, following the example of other countries (notably Turkey)that offer salary increases if professionals switch to a family practice track.
- Flexible and more attractive working arrangements, including part-time work for those in private practice, increased training opportunities, dedicated research time, and protocols that allow work in other private and public sector facilities.
- Improved management of doctors, including improved performance management and career development systems.

10. ENSURE FACILITIES HAVE MINIMUM NUMBERS OF ESSENTIAL NON-CLINICAL STAFF

Today, South Africa's PHC faces a series of staff shortfalls. Across the 3,507 clinics, there are currently some 46,000 vacancies. The personnel shortfall per clinic ranges from 3% to 84%[15]. The challenge is as serious among non-clinical staff as it is among clinical staff. For example, 21% of clinics in 2012 had no manager, 79% of clinics had no information management staff and 84% of clinics had no pharmacist or assistant[16]. This shortfall is further accentuated by a sub-

[14] Calculated as professionals registered with the South African Nursing Council (SANC), HPCSA orSouth African Pharmacy Council (SAPC), but not included in the Personal and Salary System (PERSAL) system

[15] WISN norms, Headcount/opening hours of 3,093 facilities, 2012: National Health Facilities Baseline Audit, 2012

[16] WISN norms, Headcount/opening hours of 3,093 facilities, 2012: National Health Facilities Baseline Audit, 2012

optimal distribution of existing resources, with some clinics being overstaffed while others remaining understaffed[17].

The objective of this initiative is to ensure that all facilities have minimum numbers of essential non-clinical staff. The current gap in non-clinical staff has been estimated using available data sources[18] but a detailed assessment in all facilities through the workload indicators of staffing need tool (WISN) is recommended to calculate exact needs. This initiative focuses on the following key categories of staff:

- **Facility managers (FMs).** The minimum requirement is one manager for each larger facility, with smaller facilities able to share one manager. It is estimated that, to meet this requirement, up to 740 additional managers would need to be appointed.
- **Pharmacist's assistants**. The minimum requirement is one pharmacist's assistant or pharmacy technician per clinic. To meet this requirement, an additional 2,950 staff would need to be appointed.
- **Data capturers.** The minimum requirement is one data capturer per clinic. To meet this requirement, an additional 2,800 staff would need to be appointed.
- **Security officers and cleaners.** The minimum requirement is three security officers and one cleaner per clinic. To meet this requirement, 14,000 staff would be required. Most of the currently employed cleaners and security officers are outsourced hence the number of staff to be appointed in case of full in-sourcing would be approximately 14,000.

To ensure these minimum requirements are met, it is proposed that the following steps are taken:

- Clean up the Personal and Salary System (PERSAL) database and link it with the Department of Home Affairs to avoid "ghost active workers" (e.g., deceased).
- Determine accurate staffing requirements according to an assessment based on WISN.
- Identify and cost vacant posts for the different profiles in each clinic.
- Request funding from Treasury for additional posts.
- Recruit and appoint the required staff for every clinic.

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[17] National Health Care Facilities Baseline Audit, 2012; HRH work stream analysis based on minimum staffing criteria for Ideal Clinics

[18] Nationwide PHC needs for cadres with defined WISN ratios extrapolated on the basis of available information on headcount and opening hours for 3,093 facilities; lack of staff based on National Baseline Audit, assumed homogeneous throughout clinics; gap to current delivery model according to lack of staff and estimated PHC needs

An Initiative in the NDoH to enhance security services in all public sector facilities is already on-going and it is therefore suggested to link the two initiatives.

11. EMPOWER FACILITY MANAGERS TO SUPPORT THE SCALE-UP OF THE IDEAL CLINIC

The ICRM Lab developed a strong view that decentralisation of authority is a prerequisite for the successful scale-up to the Ideal Clinic. The objective of this initiative is to empower FMs through delegation of general management, human resources (HR) and financial management functions; and to provide them with training in integrated health management.

Decentralising powers to FMs can result in speedier processes, particularly for HR. Delegation to FMs will need to be formalised through a policy on the new PHC management structure that provides for management delegations to operational managers (clinic heads). Also required for this are amendments to the current sub-district and district management system to ensure the existence of all necessary sub-districts.

To empower FMs, a peer network will need to be put in place to enable them to share best practices and provide them with a network to discuss common issues. A pre-condition for empowerment is to ensure FMs receive structured training and coaching to strengthen their capacity. This training should focus on four competencies: supply chain management, financial management, HR and staff management, and stakeholder management. A trained manager will in turn be able to train their team to improve patient experience in the clinic. The training could be delivered through various platforms, including mobile and online training, in-person training or on-the-job training. Much of this training will form part of an Ideal Clinic accelerator package.

12. SECURE STOCKS IN CLINICS THROUGH AN INNOVATIVE APPROACH TO SUPPLY CHAIN MANAGEMENT

This initiative draws on the recommendations of the Supply Chain Management work stream of the ICRM Lab, and proposes to put in place four key initiatives to ensure clinics are consistently stocked. Together, the recommendations of the Lab can reduce requisition time by an estimated 70% – and deliver annual savings of more than R100 million by rationalising logistics and reducing expiries, waste and damages[19]. The four initiatives are set out here.

1. A **standardised catalogue for supplies and services** will be put in place. This will include a nationwide, codified list of supplies and sub-catalogues tailored to clinic categories. It will also include a database of approved service providers.

[19] Supply Chain Management work stream analysis

The catalogue will be managed by a "catalogue committee" under the NDoH chief financial officer (CFO) and with the participation of the provinces, which will set the PHC Essential Drug List; the Standard Stock Items list; the Non-standard Stock Items list (with minimum specifications and maximum prices); and a database of approved service providers and prices. Representatives from the province will participate in the catalogue committee, with the opportunity to bring in existing lists or catalogues of supplies and services. At the clinic level, a catalogue specific to the type of clinic (depending on its functionality, size and location) will be loaded into the mobile stock-taking tool from which clinics can choose. Clinics will have the ability to upload feedback via the tool.

2. **Improved contract management through transversal contracts to capture procurement savings.** Transversal supplier contracts for all supplies will be used to ensure savings in the procurement. Although these "umbrella contracts" reside at provincial or national level, district warehouses and facilities can procure within their context from local vendors.
3. **Sound demand forecasting to push standard supplies to clinics**. A cellphone-based stocktaking tool will be rolled out at clinic level, and demand forecasting units will be established at district level to forecast demand based on clinic stock data.
4. **Rationalised distribution through direct delivery, cross-docks and warehouses**. Current warehouses will be converted to cross-docks, the number of sub-depots will be rationalised, and a push system will be created to ensure reliable weekly supply from cross-docks to clinics. No inventory will be kept in depots, eliminating costs and waste.

These four recommendations are in the process of being aligned with current initiatives undertaken by the Central Procurement Office at National Treasury.

IMPLEMENTATION APPROACH

The ICRM Lab developed a scale-up model to expand the ICRM to all PHC facilities as an integrated part of the health system, and to implement all the 45 prioritised initiatives identified in the Lab. This model proposes a customised roll-out for each segment of initiatives:

- **Quick wins** – interventions that can be implemented quickly, independently and unilaterally in all facilities. These will be coordinated by a central project team and rolled out in 2015.
- **Ideal Clinic accelerator** – interventions that will be implemented at the clinic level, with support from a team of change agents who will take the facility through a predefined journey of change. These interventions are likely to be rolled out on a geographic basis, with all provinces starting in 2015/16.

- **District booster** – interventions that will be implemented at the district level, with implementation supported by existing supervisory structures. These are likely to be rolled out on a geographic basis, with all provinces starting in 2015 in prioritised districts.
- **Overarching interventions** – interventions that will be coordinated at provincial or national level and rolled out at the optimal pace and sequence, depending on needs and performance of each clinic.

A system of Delivery Units will be set up at national, provincial and district levels to lead the implementation. At the facility level, change will be supported by ICRM teams made up of members of the district Delivery Unit and sub-district management team (preferably a nurse-doctor team). PPTICRM teams) will report to or be part of the district Delivery Units. Each PPTICRM team will support a cluster of three to four clinics as they implement quick wins and clinic accelerators; they will also ensure best use of resources at a local level.

For the infrastructure upgrade and maintenance of the facilities, a separate system of Delivery Units has been proposed, which will be decommissioned once all facilities have reached ideal status. Maintenance activities will be under the responsibility of the newly created Clinic Maintenance Hubs.

Key performance indicators (KPIs) and targets defined during the Labs will be the basis on which to evaluate the success of the programme. The “3 feet” plans for each initiative will be the guide to implement the 46 initiatives and to monitor milestone achievement. The system of Delivery Units will leverage upon the Labs’ outputs to monitor and support delivery.

A major change management programme has been proposed by the Scale-up and Sustainability work stream, which will be under the responsibility of the system of Delivery Units. The on-going work of sustainability will be supported by a specific reward and recognition programme for clinics, districts and provinces – with “gold” awards conferred upon clinics that maintain ICRM status for 24 consecutive months and upon districts and provinces which have seen at least 80% of their clinics achieve ICRM status.

Chapter 1: Service Delivery

SUMMARY

Improvements to service delivery in the PHC of South Africa are needed to improve accessibility of services, quality and range of the services offered and patient experience.

The **aspiration** of the service delivery work-stream is that all PHC facilities in South Africa deliver optimal quality healthcare from the perspective of both the patient and healthcare provider by 2018/19.

This aspiration translates into five specific **targets** to be achieved by 2018/19; namely, that:

- All 52 districts in the country will provide an enabling environment that supports the delivery of care, including community engagement and intersectoral collaboration, to improve access and awareness.
- All clinics will provide uniform, comprehensive, holistic and integrated clinical care through a defined package of services.
- All clinics will be supported by an integrated HMIS.
- All clinics will have 100% availability of medication, supplies, essential equipment and essential laboratory tests.
- All clinics will provide health services in a clean and safe environment.

To achieve the Ideal Clinic status for all clinics by 2018/19, five high-impact **initiatives** were identified by the work-stream, namely:

- Improve and integrate health services: facility re-classification, revised package of services and referrals
- Integrate district service delivery platform and promote uniformity of District Management Teams' structure and profile
- Implement innovative medicine dispensing
- Roll out cleaning guidelines and IPC protocols
- Roll out standardised and integrated HMIS

CONTEXT AND CASE FOR CHANGE

South Africa's PHC serves 50 million people in nine provinces and 52 districts. As a foundation of health, all people of South Africa have the right to equitable access to PHC.

Despite significant investments and successes since 1994, the South African health system has been beset by challenges. These may be summarised under three headings:

1. **Accessibility**. Health care indicators that reflect access to primary health care are below target levels, with marked variability between the provinces. As an illustration, the South African average for antenatal first visits is 17% below target[20], and for Vitamin A coverage for infants aged between 12 to 59 months is 26% below target[21].
2. **Quality and range of services**. Indicators that reflect PHC quality of care show marked inter-provincial variability. TB successful treatment rates range from 65% to 82%[22], and rates of fatality from child diarrhoea vary from 0 to 7%[23].
3. **Patient experience**. Patient surveys and the public service commission reflect variable and sometimes negative patient experience in certain areas. The National Health Facilities Baseline Audit 2012 scored cleanliness, infection prevention and control, positive and caring attitudes and patient safety at 50% or below the standard that is a priority for hospitals and PHC centres.

Also, demographic changes are anticipated in the country; namely a growth in the share of the population over 65 years of age with a simultaneous drop in the share of the population under 15 years of age[24]. These changes will exacerbate the challenges faced by PHC, increasing the burden of chronic disease over the next 20 years, with additional deaths and complex and costly multi-morbidity.

All these elements have been previously highlighted by the NDoH Strategic Plan 2014/15 to 2018/19, the recommendations of the National Health Facilities Baseline Audit 2012, and the Ideal Clinic Dashboard defined by the NDoH. The Service Delivery work stream focused on evolving some of their critical recommendations.

ASPIRATIONS

The aspiration set by the Service Delivery workstream is that all PHC facilities in South Africa deliver optimal, quality, integrated health care from the perspective of the patient, health care provider and the community by 2018/19. The aspiration for service delivery translates into five specific targets for 2018/19 that relate to accessibility, health outcomes and the patient experience, as follows:

- All clinics will provide integrated clinical care via a defined package of service that is adjusted to their classification.

[20] DHIS data as reported in HST-District Health Barometer Report 2013/14

[21] ibid

[22] ibid

[23] ibid

[24] World Population Prospects 2010, United Nations

- All 52 districts will provide an enabling environment that supports the delivery of care including community engagement and intersectoral collaboration to improve the patient experience.
- All clinics will have 100% availability of medication, supplies, essential equipment and essential laboratory tests[25].
- All clinics will provide health services in a clean and safe environment.
- All clinics will be supported by an integrated HMIS.

ISSUES IDENTIFIED

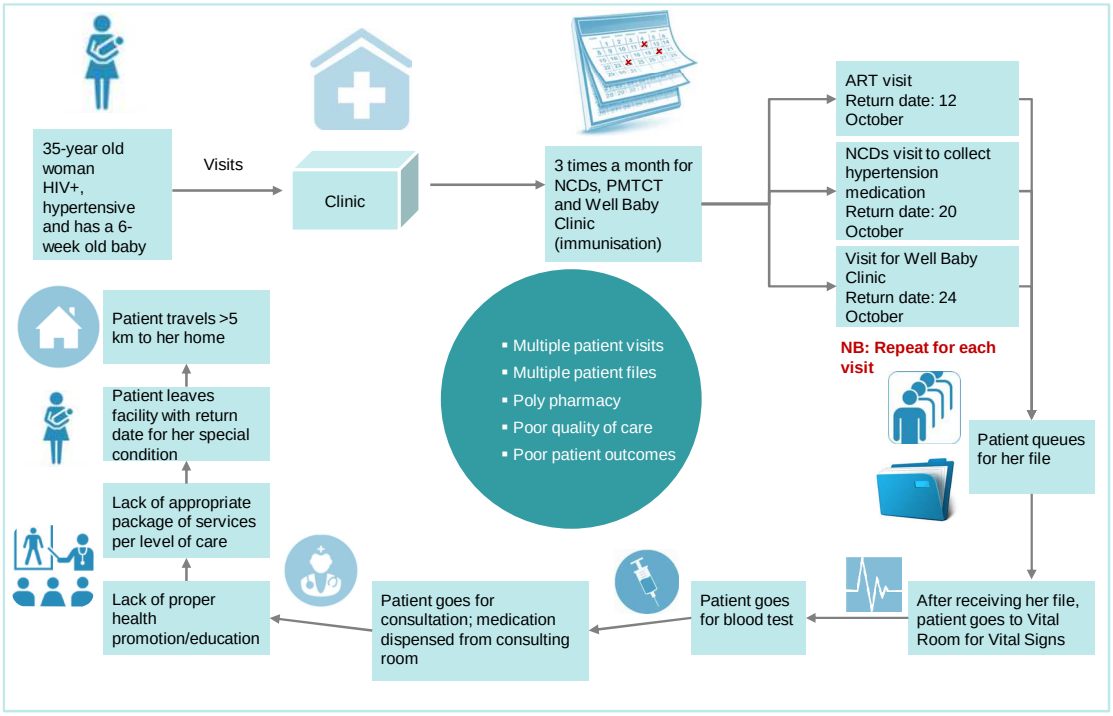
The following issues were identified as priority areas that need to be addressed to improve access to clinics, improve the patient experience of PHC and deliver quality health care from the perspectives of both patients and providers.

Health Services

Services are currently delivered through inadequately defined and fragmented, vertical and disease-specific programmes that are curative focused. This is inefficient, time-consuming, costly and unpleasant for the patient (Exhibit1.1).

[25]Except for the alternative medicine dispensing options, all the elements of the supply chain have been discussed by the Supply Chain Management work stream.

EXHIBIT 1.1



Additionally, the current PHC package does not take into consideration recent developments, such as the service challenges imposed by the burden of disease (for example, from HIV and non-communicable diseases).Basic services are not standardised across clinics, as “all PHC facilities do not provide the full spectrum of PHC services”[26]; as examples, only 93% offered immunisation and TB services, and only 75% offered anti-retroviral therapy.

Despite policy statements and statutes calling for the cross referral of patients, implementation remains poor, forming another issue that requires attention. The provincial boundaries cause delays in service provision as they are either ignored by referring staff or circumvented by patients as they seem impractical, with poor health outcomes the result. About 23% of facilities do not have a referral policy to guide their referrals. Referral policies are not standardised and vary according to facilities and districts. Also, there is no standard definition or policy[27]. For example, standard operating procedures, guidelines or policies are all described as “policy” by provinces, with further variances in districts and facilities. The lack of institutional

[26] The Health Care Facilities Baseline Audit National Summary Report 2012

[27] Results from a survey of 35 hospitals and clinics run during the Lab

arrangements including arrangements between the private and public sector negate efforts to implement a formalised referral system.

District Health Service

District Health Services (DHS) are not providing an enabling environment that supports the delivery of optimal care. There is a need on many levels for strengthening DHS. Without well-structured and capacitated DHS, for example, a clinic will not have the appropriate support and resources it requires to operate.

Causes of health and well-being lie in and outside the health sector and are socially and economically formed. A lack of leadership at the district level for effective multisectoral collaboration limits the ability to address the social determinants of health. There is currently no properly-structured, multisectoral collaboration to ensure the prompt provision of resources and delivery of a quality health service to address the social determinants of health, despite compelling evidence of the benefits of a multisectoral approach with community engagement on health outcomes[28].

Clinical medical support services and supplies[29]

A third issue is the lack of consistently available, appropriate and adequate medication, consumable supplies, equipment and laboratory services. Stock-control management, ordering and delivery are poor and fragmented and not standardised. There is also a lack of demand planning and forecasting. The essential equipment list is poorly-defined, including for non-medical supplies as well as for laboratory testing. The lack of appropriate and adequate staff, including financial and contract management skills, is a cross-cutting issue affecting almost all clinics.

Cleaning, infection and prevention control

Dirty, unhygienic and unsafe facilities adversely impact on patient and staff experiences. Currently, there are neither guidelines on cleaning nor standardised cleaning materials and equipment in place. In addition, staff is inadequate and untrained around the need to promote general hygiene and cleanliness at the facility level. Infrastructure too is inappropriate and poorly designed and maintained. In addition, infection prevention and control guidelines are hospital-centric, with ineffective monitoring and evaluation systems in place.

Health Management Information System (HMIS)

There is a lack of an integrated HMIS to support the delivery of quality health care. Patient records and filing systems are inadequate. There is no single data recording

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[28] For example, with the help of a one-year community-based participatory educational intervention, delivered through monthly women's group meetings convened by local women in the Makwanpur district, Nepal reduced neonatal mortality by 30% (Balabanova D. et al. Good Health at Low Cost 25 Years On. 2011).

[29] Issues related to stocks have been dealt with by the Supply Chain Management work stream.

and reporting tool in place and there is a lack of infrastructure and support for information and communication technology (ICT). With limited knowledge and understanding of data use, it is not possible to enhance the quality of clinical care, including service and commodity needs. The lack of a standardised, integrated health information exchange means that patient follow-up cannot be ensured. Information systems are also non-compliant with the health normative standards framework. Thus patients require multiple visits to the clinic, costing them time and travel, which results in a decreased numbers of visits by patients who need them.

To deal with these issues, the following initiatives have been proposed by the service delivery work stream. Together, they will ensure integrated, quality health service delivery.

INITIATIVES

To achieve the Ideal Clinic status for all 3,507 PHC facilities by 2018/19, five high-impact initiatives were identified by the service delivery work stream; namely:

- Improve and integrate health services: facility re-classification, revised package of services and referrals
- Integrate district service delivery platform and promote uniformity of District Management Teams structure and profile
- Implement innovative medicine dispensing
- Roll out cleaning guidelines as well as infection, prevention and control (IPC) protocols
- Roll out standardised and integrated HMIS

The initiatives will now be considered in detail.

Initiative 1: Improve and integrate health services: facility re-classification, revised package of services and referrals

The initiative to integrate and implement primary care services includes proposed adjustments to the classification of clinics, revisions to the package of services, and the development a streamlined, standardised referral policy.

South Africa has evidence from the Integrated Chronic Disease Model (ICDM) pilot which supports efforts at improved service delivery. The key findings of the ICDM baseline study show that 33% of facilities have shown a decrease in median waiting time for all patients 12 months after implementation of the ICDM. It further notes that between 65% and 82% of survey respondents would prefer medication to be dispensed via courier. It also finds that more than 90% of survey respondents across three facilities were satisfied with facility reorganisation post ICDM implementation, and that integration of services improves clinical outcomes.

The Service Delivery workstream proposed **a revised classification of clinics**. This classification was defined based on the headcount per annum that determines the workload. Clinics will be defined as Small, Medium or Large Clinics[30]. This segmentation will inform the resources required, including human resources and equipment.

The effective implementation of a package **of services** that is adjusted to this classification will provide consistent levels of patient experience, service and outcomes across clinics. As a first step, the existing package of services (adjusted to the classifications proposed below) must be consistently implemented across all PHC facilities. The **package of services** will inform the referral pathways between facility and community structures. In this regard, community structures are reflective of primary health care re-engineering processes including ward-based outreach teams and the integrated school health programme.

For the future, the Lab proposed the package of services should evolve to ensure a comprehensive set of services guided by the principle of dealing with the whole life-cycle (from pre-birth to death). There should be a continuum of care from health promotion to palliative care. There should, also, be a level of care from within the community up to the district hospital.

The major changes anticipated in the new package of services will include:

- A comprehensive, community-based approach which underpins the service package (for example, offering vaccinations in centres which provide early childhood development)
- Rehabilitative and palliative care from the facility to the community, in selected PHC facilities, based on their size and location
- Oral and dental services, in selected PHC facilities, based on their size and location
- Therapeutic services that are today limited to hospitals (such as audiology, speech therapy and psychology), with the variety of services provided based on the classification of the clinics according to their size

The service delivery work stream also proposed the following guidelines to achieve this initiative:

- Ensure effective delivery of the existing service package to all clinics
- Establish change teams comprised of doctor-nurse teams effectively to roll out the package at clinics that are not currently using it
- Set deadline for complete uptake of the adjusted package of services to December 2015

[30] Still under discussion – proposed sizes are Small (<40,000), Medium (40,000 – 72,000), and Large (>72,000)

- Once all clinics are delivering a standard package of services, select 10 clinics across the country to analyse for gaps in service and improvement areas
- Adjust elements of the current package prior to piloting an overhaul of the entire system
- If large areas for improvement still exist within the current package then it is proposed that a revised package be developed

Currently, 23% of facilities (hospital and clinics) do not have **referral guidelines**. Referral policies are not standardised and vary according to facilities and districts. There is a lack of a detailed strategy for referral across provinces and also districts. Finally, there are inadequate mechanisms for referral. An effective and seamless referral system ensures a close relationship between all levels of the health system and helps to ensure people receive the best possible care closest to home[31]. A functional referral system that enables prompt and speedy management of patients in need of secondary or tertiary care is an integral part of the PHC service. For the referral process to work effectively, the following is necessary:

- Timely access to relevant patient information
- Effective communication between all organisations along the continuum of care
- Available resources (human and other) across the continuum of care
- Universal implementation of the process, using the system tools

As a first step, detailed mapping of health facilities, including location and the services offered, is needed in order to determine the most appropriate referral pathways for districts.

The National Patient Referral Policy of 2008 has still not been adopted. This initiative thus proposes a revised national policy and framework for patient referral that:

- Supports the proposed package of services that reflects the PHC re-engineering streams and other community-based structures
- Defines pathways for emergency care services
- Defines pathways for planned patient referrals within the overall health system
- Supports movement across the geographical boundaries of districts and provinces without comprising health care quality

District managers must engage with the health managers of the referral sites in order to reach agreement on referral protocols and guidelines. As provinces and

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[31] WHO, accessed at: http://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=11&ved=0CBsQFjAAOAo&url=http%3A%2F%2Fwww.who.int%2Fmanagement%2FReferralnotes.doc&ei=VrxrVOGXM8zeOMC6gIgE&usg=AFQjCNFSqT8jYZhcpmzQj2rqFvpnVu-l9g

districts in South Africa are individually funded, cross-boundary referrals might have to include a cost-recovery mechanism so that the referral site can ensure and maintain financial resource equity.

According to the ICDM, referrals from PHC to secondary levels of care should be able to occur from either a community level or a PHC facility level. Also, in terms of the ICDM, it is necessary that district and provincial boundaries not impede access to the closest health facility where appropriate care could be provided; this will avoid the detrimental effects of delaying patients' access to care. With effective cross-referrals, and the involvement of community-based services, patients will have faster, cheaper access to health care.

Initiative 2: Integrate district service delivery platform and promote uniformity of District Management Teams' structure and profile

The aspiration behind this initiative is to integrate district health systems, including structures and services, in order to provide comprehensive, holistic, person- and community-centred quality care. The anticipated outcome will be a unified service delivery vehicle, addressing community needs, across various government departments (health services, public works and education, etc.). This initiative represents a major delivery fix for effective execution of PHC services.

There is currently a lack of decision-making authority at district and sub-district levels. This initiative thus proposes to enable delegation of authority with a built-in accountability mechanism.

Clinical coordinators are now focused on multiple programmes to deliver care within vertical services. To overcome this, it is proposed that district hospitals be integrated within the sub-district structure.

Reporting lines are confused and require reorganisation. There are also different management structures with poorly defined roles and responsibilities. Under this initiative, hospital CEOs will continue to run their respective hospitals, but will participate in sub-district level activities to ensure a collaborative approach to health services.

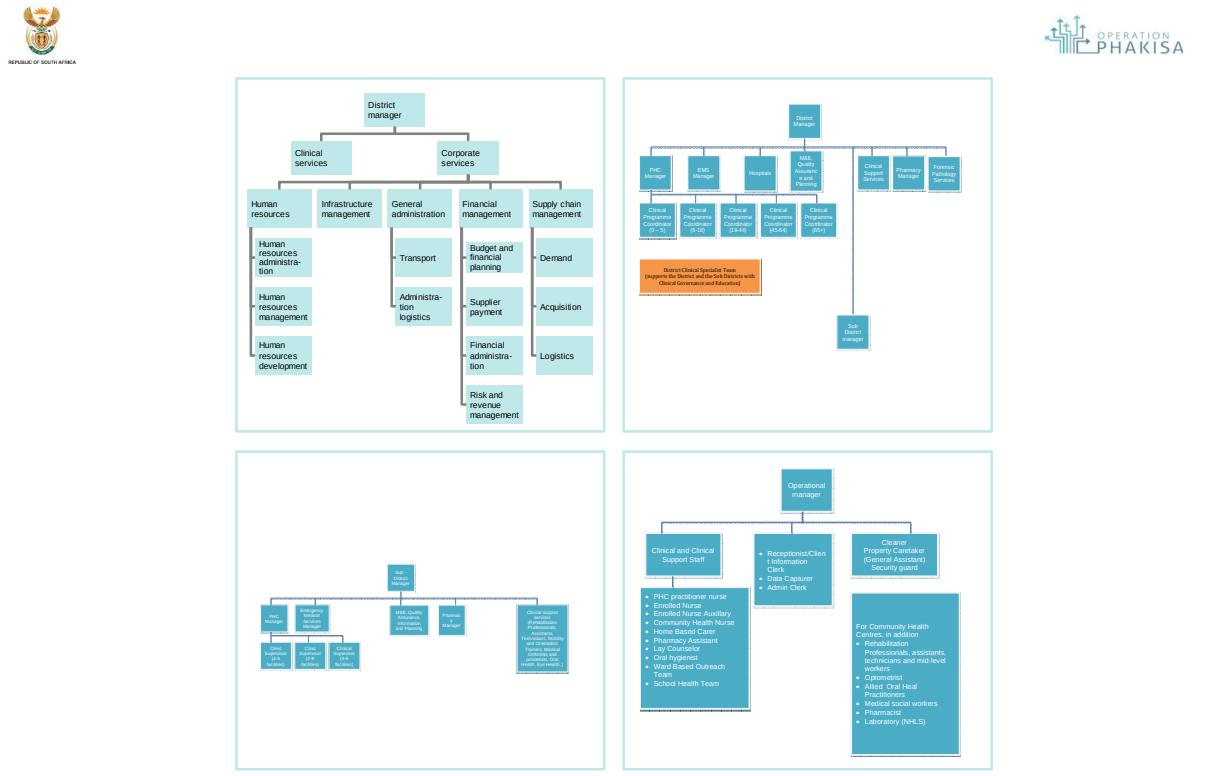
DHS are not currently in a position fully to support service delivery. Mechanisms and structures are also inadequate to facilitate the multisectoral and intersectoral collaboration that is required to address the social determinants of health. This initiative thus proposes that programmes be integrated in accordance with the life stage/course approach. It is also proposed that the document on classification of services and up-skilling of the district management team (DMT) be finalised.

The Lab team proposes that district, sub-district and facility structures be revised. Under the revision, district hospitals will fall under the district manager and form part of the sub-district team. It will also be necessary to ensure functional

integration to eliminate the current silo-based approach. Programme managers will thus be set up to manage programmes according to age group rather than disease. The work stream also proposes the appointment of clinic supervisors at the sub-district level to oversee and provide mentorship to a maximum of four clinics. They will be trained in all areas and provide both clinical and administration support, in effect operating in a way that is similar to that of an area manager. Meanwhile, clinic managers will take responsibility for their own facility, much like the functioning of an operational manager.

Exhibits 1.2 illustrates the organisational changes that are proposed to revise the district, sub-district and facility structures.

EXHIBIT 1.2



SOURCE: Life Course Health Development: An Integrated Framework for Developing Health, Policy, and Research, 2002.
A New Agenda for MCH Policy and Programmes: Integrating a Life course perspective, 1996

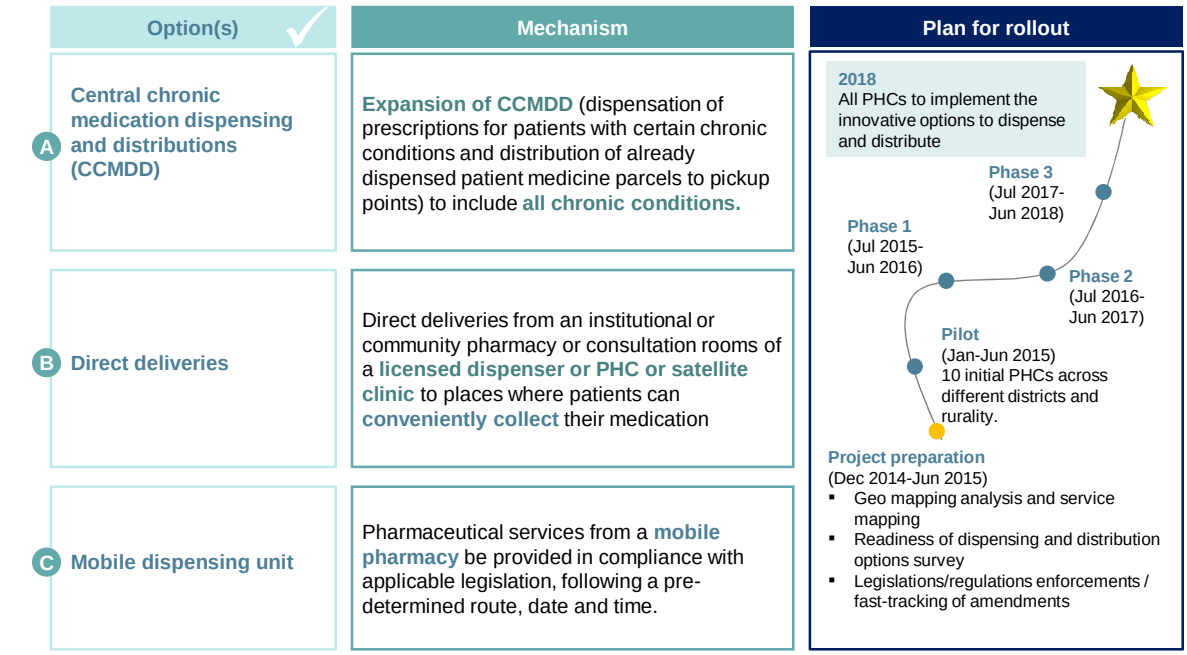
The impact of this initiative will be to have a more holistic approach to patient care; improved facility performance through improved supervision and support; cost effectiveness through improved district management; and greater local control over health activities of the district health system.

Initiative 3: Implement innovative medicine dispensing

The objective of this initiative is to allow for multiple ways of dispensing prescribed medications for patients with chronic conditions to suit their own convenience without them having to go to the PHC clinic every month, depending on the geographic locations of the patients.

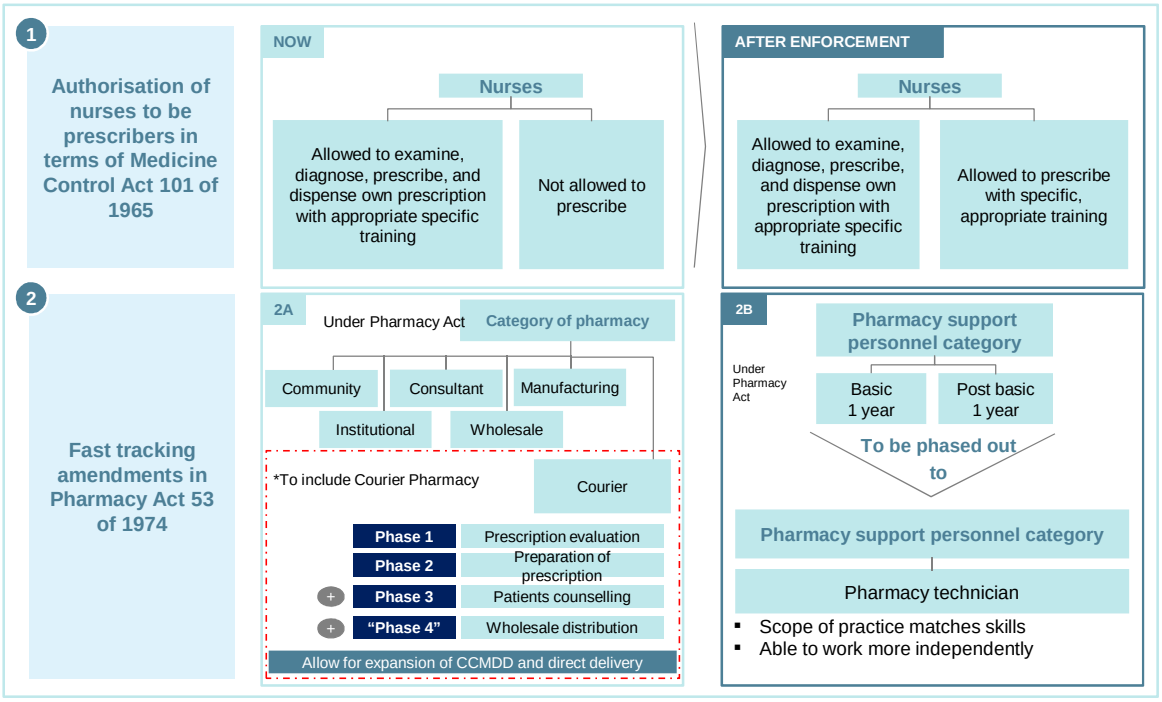
There are various viable options available for patients to receive their medication. These are outlined in Exhibit 1.3, which also sets out a plan for rolling out this initiative. The first is through a CCMDD system, either with direct delivery to the patient or to a pick-up point where the patient can collect it. The second option for receiving medication by patients would be via simple direct delivery to them. Finally, the delivery of medication is possible via a mobile pharmacy. Here, a mobile unit arrives in terms of a pre-determined route, date and time. This service can also take the form of an outreach where a certain community is offered the service in a predetermined area for a pre-determined period.

EXHIBIT 2.3



To allow for these innovative modes for the dispensing and delivery of medication, it is necessary to enforce and fast track existing amendments. These are set out in Exhibit 1.4.

EXHIBIT 1.4



As a result of this initiative, stable patients requiring medications for chronic conditions will only need to visit PHC facilities once every six months for a consultation to issue a new prescription, unless there is a change in the health condition of the patient or the patient moves away. This will avoid the congestion incurred by patients having to return to the PHC facility every month for a repeat prescription.

Initiative 4: Roll out cleaning guidelines and IPC protocols

South African is failing in terms of cleanliness, IPC and general waste management at PHC facilities. Less than 50% of clinics are compliant with infection and control and cleanliness standards. Only 83% of facilities are compliant in waste management processes[32]. Sample cases of nosocomial infection have been

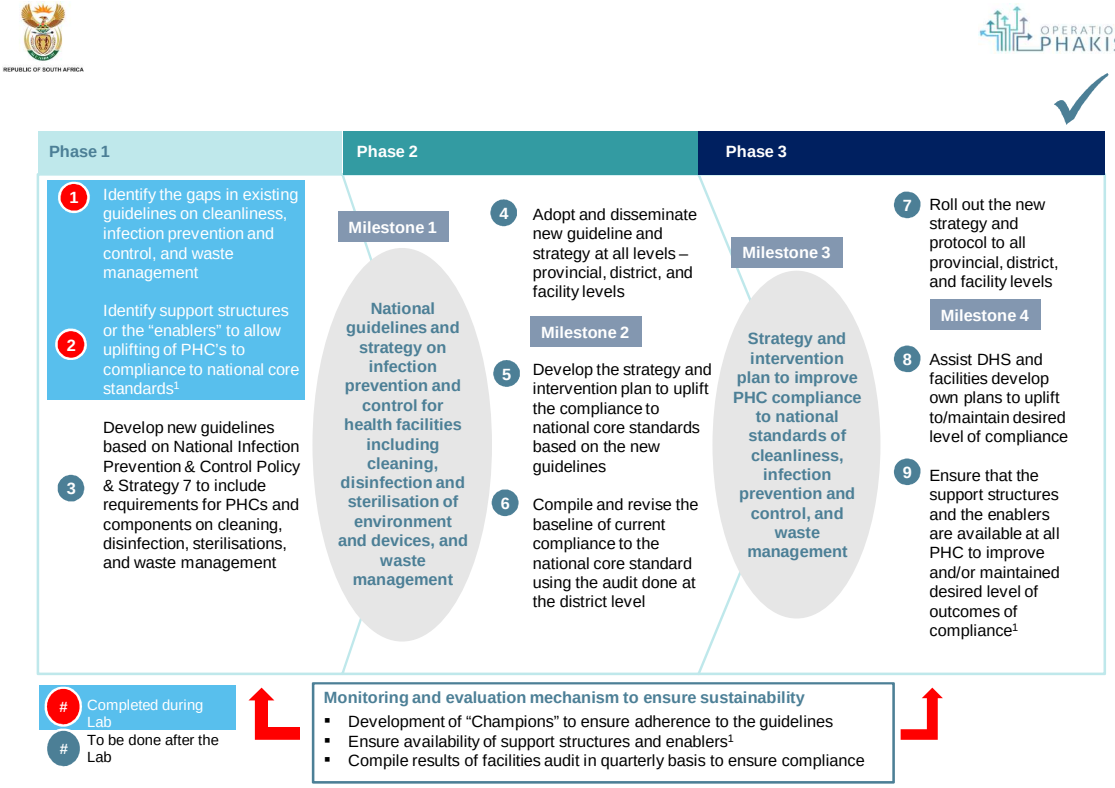
[32] The National Health Care Facilities Baseline Audit, National Summary Report 2012

reported recently. In the Eastern and Western Cape, between 1996 and 2008, for example, 10 out of 334 patients treated for extensive drug resistant TB (XDR-TB) were health care workers, and all had received an average of 2.4 courses of TB treatment before their diagnosis with XDR-TB. Eight out of 10 were HIV negative and four out of 10 died despite receiving treatment.

Implementation of this initiative will ensure adequate PHC cleaning guidelines and IPC protocols, with the necessary training programmes to ensure compliance.

A tight schedule of change is required to achieve 100% compliance. Four to five months into the implementation of the ICRM, guidelines, standard operating procedures and protocols for cleaning, IPC and waste management should be developed. After nine months, an intervention strategy for facilities to meet the required standards should be developed. By at most 18 months into implementation, 100% PHC facilities will be compliant with cleanliness, IPC and general waste management guidelines**.** A three-step approach was proposed by the Lab members to achieve these deadlines (Exhibit 1.5).

EXHIBIT 1.5



1 To be taken up by Infrastructure, Supply Chain Management, and Human Resources workstreams

SOURCE: Lab discussion

To finalise the new guidelines, the workstream has made several recommendations. In the first place, the process must be driven by the directorate of the OHSC under the NDoH. Members of the multisectoral team must come from

NGOs, universities, the NDoH Health Quality Assurance unit, the Waste Management unit, the PHC unit, the OHSC and the Department of Environmental Affairs, with two provincial representatives from quality and infection control, one representative from the districts and one representative from the private sector. The team must create benchmarks, based on WHO IPC, waste management and cleaning guidelines, the 2007 National IPC Policy and Strategy, as well as on private sector guidelines. The guidelines to be developed must integrate IPC, cleanliness and waste management in one document. The guidelines must be aligned with the level of care as per the proposed package and classification of facilities (for example, community, mobile clinic, health post, satellite clinic, clinic and community health centre).

With regard to budget, the guidelines must detail how the budget for IPC, waste management and cleanliness should be managed, including the procurement procedure and the forms that need to be completed. With regard to management, the guidelines must specify supervision and the key performance indicators that are to be used to monitor the implementation of the guidelines and the assessments that need to take place. With regard to the materials to be used, the guidelines must cover equipment, consumables and supplies. As to methods, the actual procedure on how to conduct cleaning, IPC and waste management must be included. Finally, as regards manpower, the guidelines must detail the staff that are needed to perform the various duties, including the training manual and performance management.

This initiative will drive full compliance to National Core Standards on IPC, Cleanliness and Waste Management by 2016.

Initiative 5: Roll out standardised and integrated HMIS

The objective of this initiative is to improve the patient experience and quality of care, by reducing the administration burden at PHC and district level through the development of standardised data collection and reporting tools and establishing a standardised filing system. This includes the development and implementation of standardised data collection and reporting tools that respond to reporting requirements for the measurement of health indicators.

This initiative builds on the work of the 700 facilities project that is currently being developed by the NDoH.

Under this initiative, the existing disease-centric, patient-based health information systems will be integrated to eliminate duplication. Manual and electronic methods of uniquely identifying/verifying patients will be introduced to prevent multiple patient files, and to establish a national patient registry. Data generated at the community level will be streamlined into a single repository. At the facility level, data will be aggregated digitally on a daily basis to minimise errors and enable the

generation of facility reports. Finally, comprehensive patient-based information system(s) will be introduced to improve health service delivery.

These changes could be achieved in several ways. In the first place, information needs at all levels should be integrated to reduce the number of data collection tools in existence (across DHS). This will serve to standardise data collection processes. Next, it will be necessary to integrate the existing, vertical information systems that are in place; namely, the HPRS, Tier.net, ETR.net and MomConnect. Next, the HPRS should digitalise patient demographic details and strengthen a unique patient identification/verification system. It will, further, be necessary to integrate mHealth systems with the DHIS to ensure that ward-based data generated at community level is available in a single repository. In addition, it will be necessary to implement the DHIS at the facility level to digitalise the submission of aggregated service delivery data, thereby minimising calculation errors. Finally, it is necessary to implement a patient-based PHC information system[33] in all PHC facilities, which will include, for example, the appointment system, basic digitalised heath record and e-prescriptions.

Based on the Health Normative standards Framework to achieve data interoperability, the following activities are recommended for the implementation of the HIE.

In the first place, it is necessary to define and adopt appropriate software architecture, coupled with comprehensive and rigorous information standards[34], in order to ensure interoperability over the long term. The result of this activity will be a system design for the HIE. In the second place, it is necessary to define shared demographic and clinical repositories as well as security and audit services (i.e., the roles and responsibilities for capturing, processing and accessing information). This activity will produce a detailed system description of all demographic repositories (patient, provider and facility) and clinical repositories (for radiology and pharmacy, as well as a shared electronic health record). The third activity will be the preparation of Master Patient Index (MPI) software for matching, cleansing and profiling of individual entities, ensuring that data is capable of being retrieved regardless of how many systems reference this entity with different identifiers or names. This activity will result in a functional MPI for the country. The fourth activity will be the development of appropriate integration software based on Health Normative Standards[35] to enable information exchange between different information systems. The output from this activity will be a HIE for South Africa that integrates various patient-based information systems. Finally, it is necessary to implement a Health Normative Standards Framework by identifying a certification

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[33] The PHC information system must provide the desired functionality, be cost effective and compliant to the Health Normative Interoperability Standards Framework.

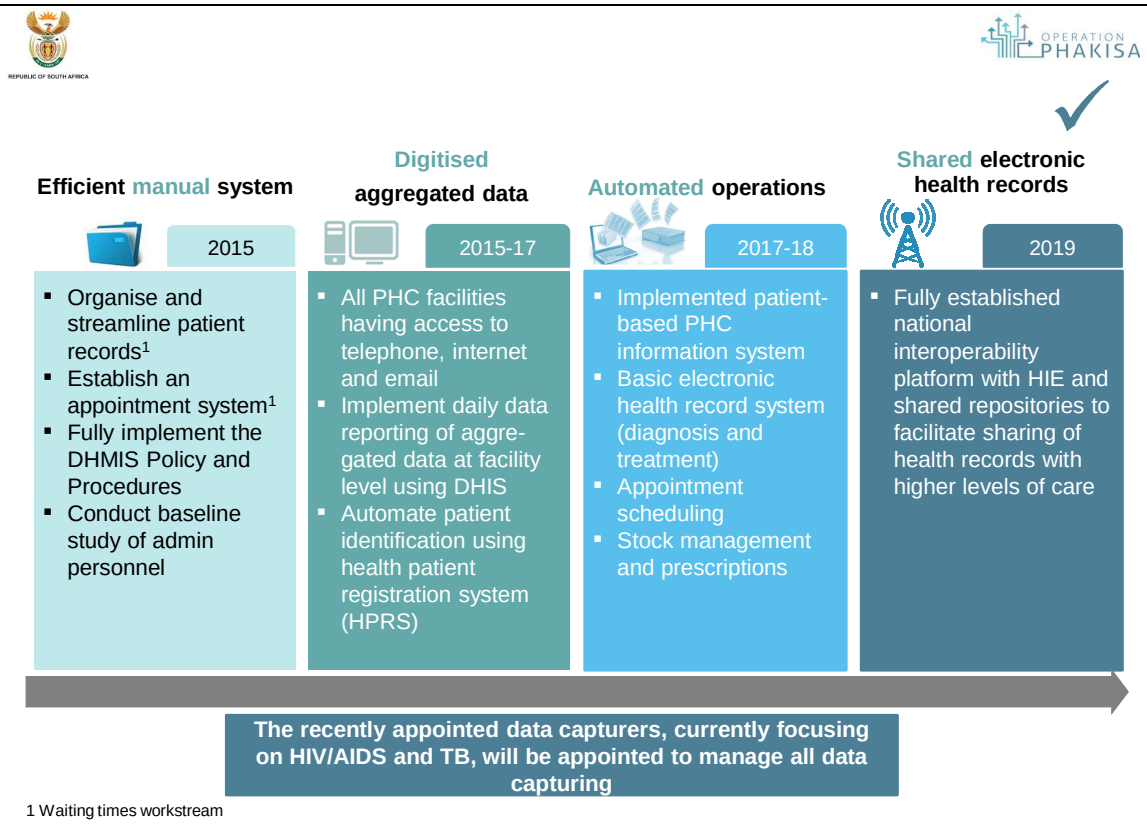
[34] The Health Normative Interoperability Standards Framework was approved by the National Health Council and subsequently gazetted by the National Department of Health in April 2014.

[35] ibid

mechanism so that information system vendors can test their system(s) against it. In this case, the output of the activity will be the establishment of a certification mechanism to test compliance against the Framework.

Exhibit 1.6 illustrates the anticipated progression from efficient manual systems to shared electronic health records in South Africa that will result from the implementation of this initiative.

EXHIBIT 1.6



1 Waiting times workstream

PROPOSED KEY PERFORMANCE INDICATORS

Table 1.1contains a sample of KPIs for service delivery. The full list of proposed KPIs, including suggested reporting frequency, sources of baseline and supporting documentation, is available in the Lab's Excel templates output on KPIs. These KPIs will require final syndication with all relevant stakeholders during the implementation phase.

Table 1.1: KPI selection for the Service Delivery work stream

			Cumulative target (March of the year)					
Initiative	**KPI description**	**Base-line**	**2015**	**2016**	**2017**	**2018**	**2019**	**KPI Owner**
Integrated Primary Health Service: Development and implementation of a revised package of services	Completed 1st draft service package	New	100%					NDoH
	Completed of the 2st draft service package	New	100%					NDoH
	Finalised service package	New		100%				NDoH
Integrated district service delivery: Conduct in-depth population profile, disease burden analysis	Number of working committees established	New			52			NDoH
	Number of committees trained	New			52			NDoH
	Number of surveys conducted in each district	New			52			
	Number of reports submitted	New			52			NDoH
Develop and Implement a Framework for Innovative Medicine Dispensing and Delivery Services	Number of patients benefitting from this initiative of innovative dispensing and delivery system	New		2 335 000 (enrolled in Phase 1)	19 070 00 (new patients in Phase 2 and Phase 3)			NDoH
	Improvement of Patient satisfaction index	New		10%	10%	10%	10%	NDoH
	Improvement of staff morale	New		10%	10%	10%	10%	NDoH

Table 1.1 (continued): KPI selection for the Service Delivery Work stream

			Cumulative target (March of the year)					
Initiative	**KPI description**	**Base-line**	**2015**	**2016**	**2017**	**2018**	**2019**	**KPI Owner**
Develop and implement Primary Health Facilities relevant cleaning guidelines and Infection Prevention and Control protocol with appropriate training programs	% of PHC facilities receiving the new completed National Guidelines on Cleaning, Infection Prevention and Control, and Waste Management	New		100%				Office of Standards Compliance, NDoH
	Completion of the National Strategy and Protocol to improve compliance to NCS standard on Cleaning, Infection Prevention and Control, and Waste Management	New		100%				Office of Standards Compliance, NDoH
	% of PHC facilities receiving the new National Strategy and Protocol to improve compliance to NCS standard on Cleaning, Infection Control, and Waste Management	New		100%				Office of Standards Compliance, NDoH

Chapter 2: Waiting Times

SUMMARY

Waiting times is one of the major causes of poor patient experiences. In South Africa, 75% of patients wait more than two hours in the clinic, and for 7% of them the waiting time could be more than seven hours.

The **aspirations** set out by the Waiting Times workstream, together with **targets** to be met by March 2018, are as follows:

- Patients will **wait for less time** – both before and between receiving services. The target is **two hours maximum** waiting time.
- Patients will **spend less time in total** at the clinic. The target is **three hours maximum** spent at the clinic.
- Patients will be **satisfied with waiting times**. The target is that **90%** will be satisfied with their waiting time at the clinic.
- Patients will **report a positive experience of care**. The target is that **80%** will report a positive experience.

Further, there will be a consistent mechanism for patients to report on their experience, which will lead to transparency throughout the system.

Nine **initiatives** were identified by the work stream which would, in a relatively short period of time, together improve the entire end-to-end patient experience of care, including waiting times. The initiatives are:

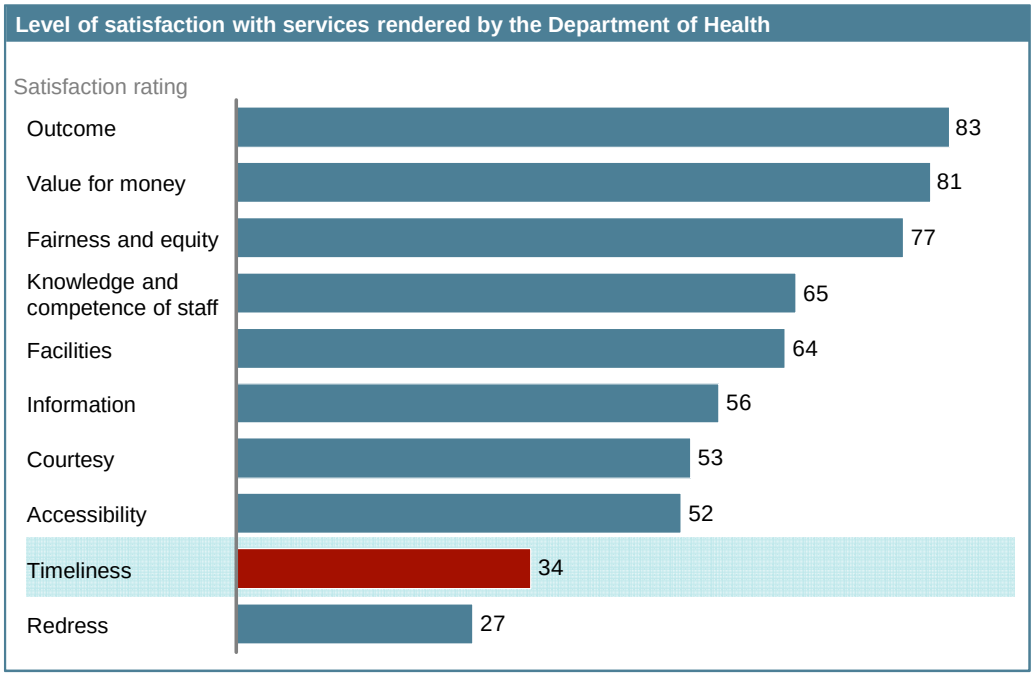
- Implement a functional appointment system for non-emergency patients
- Establish provincial health call centres to provide advice and reduce unnecessary burden on clinics
- Set up an SMS-based communication platform to enable the communication of individualised patient information, such as appointment reminders
- Improve efficiency of patient flow
- Standardise paper filing processes
- Support clinics to adjust hours/days of operation
- Implement an electronic queue management systems
- Communicate clear expectations for waiting times and process of care
- Evaluate, improve and communicate patient experience of care and waiting times as a Key Performance Area

CONTEXT AND CASE FOR CHANGE

Patients in South Africa are broadly satisfied by the "outcomes" and "value for money" of the public health services provided (83% and 81% respectively)[36].

Despite this, patient experience is commonly poor. One of the greatest sources of this patient dissatisfaction is the time spent waiting to receive a service, as evidenced by only 34% of patients being satisfied with the "timeliness" of services (Exhibit 2.1).

EXHIBIT 2.1



SOURCE: Public Service Commission, July 2011

OPERATION PHAKISA

The opportunity for improvement is big. In a study made during the Lab preparation phase over four clinics, patients spent on average 79% of their time in the clinic waiting. Also, most of the patients waited an unreasonable amount of time, with 68% waiting between two and five hours, and 7% waiting more than seven hours[37]. This means that an average patient will lose at least half a day of work when going to a PHC facility.

The Waiting Times workstream focused on finding ways to reduce the amount of time spent waiting to receive care in PHC facilities. Waiting times are also a significant component of the overall patient experience. As such, the work stream

[36] Public Services Commission, July 2011, Citizens Talk: A Citizen Satisfaction Survey Report

[37] Lean diagnostic in Ideal Clinic pilot sites

also focused on interrelated ways to improve patient experience overall, for example, by rolling out a system to measure patient satisfaction and waiting times more regularly to create accountability.

Patient experience of care refers to patients' experience when they interact with the health care system to have their health care needs met. Patient experience incorporates patient expectations and goes beyond what is covered in the patient's satisfaction surveys that are conducted currently.

ASPIRATIONS

Given the long waiting times and the poor patient experience of care, the Waiting Times work stream has set up several aspirations to be achieved, with specific targets set to be achieved by 30October 2017.

Patients will wait for less time before and between receiving services: the most time a patient will spend in the clinic is three hours, with no more than two hours of that time spent waiting for services.

Waiting time is also one of the drivers of patient experience of care in general: the Waiting Times work stream set up an aspiration that 90% patients will be satisfied with waiting times in a PHC facility. Also, patients will report a positive experience of care; the target here is 80% of patients.

To be able to achieve this aspiration, the work stream started by analysing the full range of issues affecting waiting times and other aspects of the patient experience. These will be considered in the next section.

ISSUES TO BE ADDRESSED

The investigation of the issues led the Lab members to identify those which had the most serious impact on waiting times and the patient experience. These are set out below.

Existing appointment systems are poorly managed and services are fragmented. Whilst most clinics have developed some type of appointment system, these suffer from various shortcomings. First of all, patients are only provided with dates and no appointment time; this often results in most patients arriving early in the morning and over-crowding the facilities. They are often given multiple appointments by multiple nurses for the different conditions from which they suffer– often on different days (for example, a multi-morbid patient may need to visit the clinic three to four times per month to receive care for specific conditions). Patients can only receive appointments if they are physically present at the clinic (since available technologies are not being harnessed effectively). There is no reminder system which means that patients often miss their appointments. Finally, patients are not

offered a choice or indeed any flexibility in the timing of their appointments. All of this results in very poor patient satisfaction and extremely inefficient logistics/operations in the clinic.

Patient flow is sub-optimal. Poor patient flow results in the patients not receiving the right care at the right place and time. This contributes to the long waiting times, and negatively affects the safety of patients. For example, patients may be left to wait in poorly ventilated areas and exposed to the risk of cross infections.

Filing systems are inefficient. Multiple sets of records are held for the same patient. Filing systems are poor, which leads to low staff productivity, patient dissatisfaction and in some cases, abuse of staff by the users of the service.

There is also lack of agreement on the definitions and clear metrics of what constitutes an optimal patient experience and optimal waiting times; for example, across different facilities across the country. This makes it very difficult to measure consistently and to implement appropriate improvements. The use of different tools also results in inconsistencies, making comparison of patient experiences across facilities difficult. Without standardised tools, facilities face the challenge of choosing the appropriate ones.

There is a lack of systematic data collection in most clinics, which compounds the other challenges. As many as 70% of clinics are unable to report reliably on waiting times and on any improvements achieved[38].

Mechanisms to communicate consistently and systematically with patients and to share with communities the results and the progress of quality improvement initiatives are lacking. This leaves patients feeling despondent and believing that government does not care about their input and that nothing is being done to improve the situation. Patients become confused by recent changes that are not communicated to them. They also develop higher expectations than can be delivered. This leads to patients “shopping around” in the hope of finding a better service, and results in loss of confidence in PHC. This, in turn, results in patients either giving up or seeking better but more costly alternatives which cannot be sustained.

INITIATIVES

The Lab team identified nine initiatives which would, in a relatively short period of time, begin to address excessive waiting times, namely:

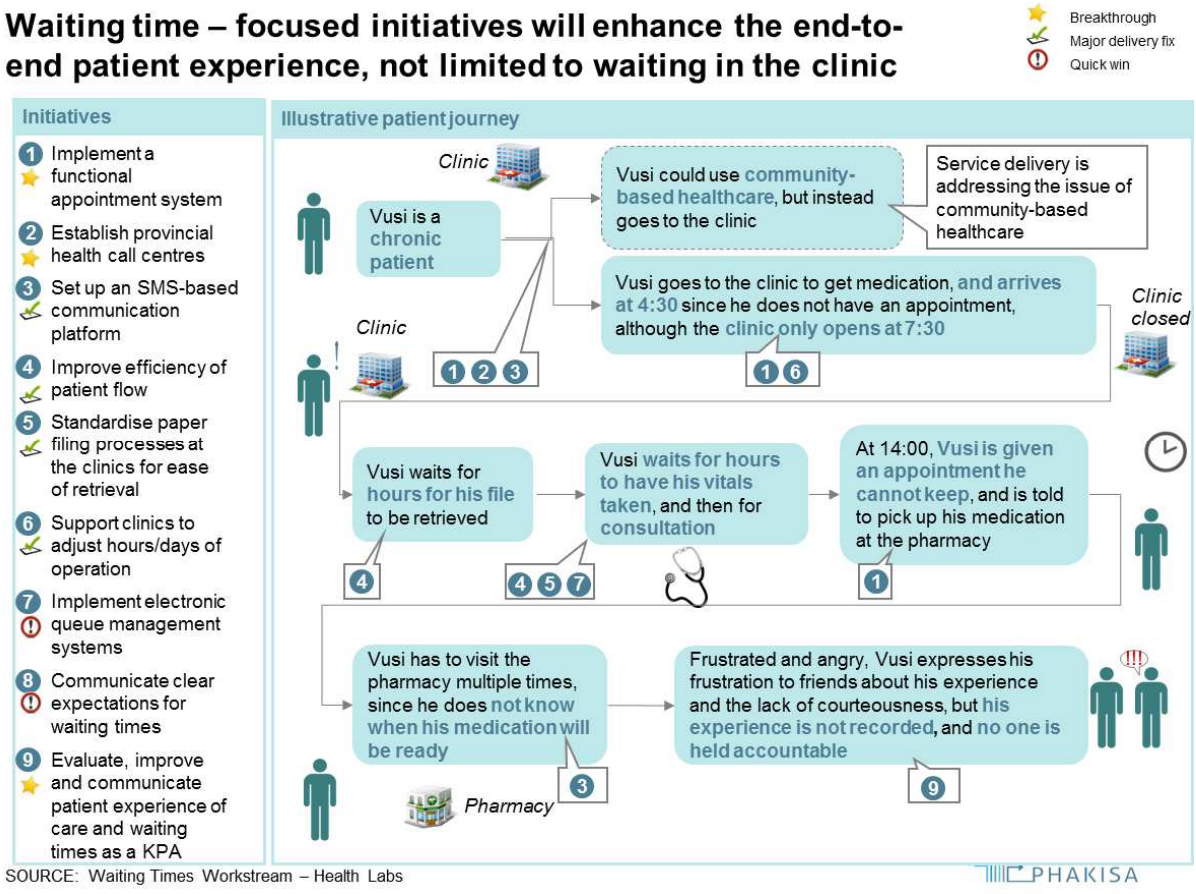
- Implement a functional appointment system for non-emergency patients
- Establish provincial health call centres to provide advice and reduce unnecessary burden on clinics

[38] National Health Care Baseline Facility Audit 2012

- Set up an SMS-based communication platform to enable the communication of individualised patient information, such as appointment reminders
- Improve efficiency of patient flow
- Standardise the paper filing processes
- Support clinics to adjust hours/days of operation
- Implement electronic queue management systems
- Communicate clear expectations for waiting times and process of care
- Evaluate, improve and communicate patient experience of care and waiting times as a key performance area (KPA)

Together these initiatives are expected to contribute to the improvement of the entire end-to-end patient experience of care, as illustrated in Exhibit 2.2.

EXHIBIT 2.2



SOURCE: Waiting Times Workstream – Health Labs

These initiatives initiative will be considered separately below.

Initiative 1: Implement a functional appointment system for non-emergency patients

This initiative seeks to reduce waiting times and contribute to an improved patient experience of care through an effective appointment system for non-acute/non-emergency patients.

At present, most of the PHC facilities lack an effective appointment system. Appointments are booked in individual consulting rooms without predetermined numbers to inform the maximum number of bookings possible per day, leading to high variability in the number of patients booked per day (for example, all nurses might schedule their patients for the same dates). It is thus important to create a single, centralised appointment system for each clinic. Patients are currently given only the date of their next appointment with no time provided so as to reduce waiting.

The aim of this initiative is to reduce waiting times through balancing workload throughout the day and week, while patient experience of care will be improved by allowing patients to have a say in their appointment date and time. The appointment system will facilitate tracing of defaulters, loss to treatment and those who have died.

In addition, this initiative will be closely tied to the use of community-based care, working within a system of referrals to ensure that patients are aware that they can schedule appointments outside of the clinic as well, such as to pick up chronic medication. For instance, if a stable HIV-positive patient is on medication for longer than one year, and has a suppressed viral load, they will then be referred to community-based care, and will no longer be required to come to the clinic for medication[39].Patients will only be required to visit clinic for set clinical reviews or other acute complaints. This will reduce the number of patients who have to spend time going to a clinic to receive services, and reduce the waiting times for those patients who do need to go to the clinic.

By handling appointments centrally in each clinic, it will be possible to accommodate all patients. While the system will be basic to begin with, it will become automated in the future. Appointments will, moreover, be negotiated with patients to suit their convenience and based on clinic capacity to ensure that all patients can be seen. At the same time, waiting times will be reduced by setting specific times for appointments. Appointments offering all services will be spread throughout the week to enable all services to be offered every day. In addition, patient files will be retrieved two to three days before the appointment date, with any chronic medication pre-packed.

[39] 2013 ART Guidelines 4.3

The target set by Lab team members is to achieve 80% of booked patients keeping their appointments in the second year of implementation (April 2015 to March 2016), 90% in the following year, and 100% thereafter.

The implementation of this initiative will be led by a change agent team through a series of clinic-level interventions (including the implementation of new filing systems and appointment processes and by reorganising patient flow). These interventions will all be designed to reduce waiting times rapidly, and to improve the overall patient experience. The main activities involved in the implementation of this initiative include: approving guidelines for the revised appointment systems, filing process and patient flows; securing a budget for the changes; assembling and operationalising change agent teams to roll out the initiative and identify district implementation teams; procuring equipment and recruiting and appointing staff according to the needs that are identified (for example, queue marshals); and conducting pilot projects in facilities identified in accordance with whatever criteria are predetermined. The appointment system, filing system, and patient flow will be rolled out as a single implementation programme. Target implementation dates for the appointment system are March 2016 for clinics that already have the required infrastructure, and 2018/19 for all other clinics.

Initiative 2: Establish provincial health call centres to provide advice and reduce unnecessary burden on clinics

Many patients travel to clinics unnecessarily and then wait in a queue for a few hours – only to receive advice that they could have gotten quickly and easily over the phone. One common example are patients arriving at the clinic because they are experiencing minor side effects of chronic medication, but who do not realise this is the case because they cannot read the information.

In addition, some patients visit the clinic when they could have been served more quickly and efficiently by some other means (such as through community-based forms of care) on which they do not have the information.

To address these issues, the Lab proposed the setting up of provincial call centres to address health-related issues.

A call centre will improve the accessibility of the system to patients. It will allow patients to ask generic questions (e.g., what are the side effects of the medication the patients are taking) or to explain their circumstances and receive advice on the most appropriate level of care (e.g., community versus clinic), avoiding unnecessary visits and waiting times.

In addition, the call centres will provide information on the location of PHC facilities, as well as on health promotion and preventive measures. This will reduce the unnecessary burden on patients visiting facilities with questions that can be resolved over the phone.

In the longer term, call centre services could be expanded to include triage and EMS advice, the scheduling of appointments and to provide better health access in rural areas through virtual lines. This may require approval from the HPCSA for any service that could be considered as tele-consultation.

In order to implement this initiative, preparations must be made for the launch of call centres between 2015 and 2016 by leveraging facilities that already exist in many municipalities, such as the City of Cape Town 107 centre[40]. Over the period 2016 and 2017, adequate staffing needs must be considered and met; corporate social investment must be sought to support staffing of call centres; call centre duties will be incorporated into internship programmes of medical schools to increase availability of staff; staff will be recruited for dedicated PHC lines in centres; and on-going training and a development programme will be set up for all call centre staff. Over this period, pilot centres will be set up; a marketing plan will be developed and implemented to introduce the service to the community; and call centre services will be operationalised.

The primary impact of the call centres will be to direct patients to the correct level of care, reducing unnecessary visits to and waiting at the clinic.

Initiative 3: Set up an SMS-based communication platform to enable the communication of individualised patient information, such as appointment reminders

The penetration of cell phones in the South Africa population is very high. In fact, there are more cell phones connections used in South Africa than there are people, with 147 connections for every 100 people[41]. Leveraging this type of communication can increase the accessibility and effectiveness of the system, as proven by existing health sector initiatives like MomConnect.

An SMS-based platform would allow for the communication of individualised information to patients, including appointment reminders, which will help manage and balance the workload at the clinic and assist in managing waiting times whilst reducing defaulter rates for booked appointments. A feedback mechanism to allow for cancelling appointments and to comment on the quality of care received can be included, along with an opt-out possibility for those who do not want this communication.

The SMS systems should be able to send short health messages, including individualised messages, on the status of medication for pickup, reminders of appointments and also general information such as health calendar days, the importance of screenings, and advice for health problems and other health

[40] Accessed at: http://www.capetown.gov.za/EN/EMERGENCYSERVICES/Pages/Home_09.aspx

[41] World Bank Global Competitiveness Index 2014-15

promotion messages. Each facility will have an SMS patient register with patient personal details, health condition and signature for patient consent to receiving SMS messages. Clinic staff will record appointments in the SMS system.

Implementation of this initiative will begin with a three-month pilot, as some of the functionality requires systems integration and functionality far beyond what MomConnect is already using. A project steering committee will be set up to conduct a feasibility study. Then the pilot stage will begin with a suitable service provider at selected facilities with different case mixes over a three-month period. After approval for the SMS communication concept, the policy on SMS communication will be formulated and an SMS communication roll-out strategy will be developed as the basis for seeking approval and budget allocation for the roll-out. The activities of this piloting stage will be completed in 2016. By the end of 2017, the second stage will be completed, including selecting service providers for up-scaling and roll-out to all clinics, evaluating proposals and awarding the tender, mobilising resources for the roll-out (for example, additional staff and infrastructure) and finally, rolling out SMS systems across other facilities through the creation of clinic change agent teams.

The impact of this initiative will be to enable the healthcare system to communicate to patients directly, thereby reducing the influx of patients at clinics by avoiding some unnecessary visits and by directing them to the appropriate level of care (for example, to using community-based pickup points for medication) as well as helping to coordinate patient activities better (for example, to ensure adherence to appointments, or to ensure that patients only coming to pick up medication at the pharmacy when it is ready), which will ultimately reduce waiting times. Encouraging patients to use health services is also an important service that could be enhanced through an SMS-based communication platform, as in the case of pregnant women through MomConnect.

Initiative 4: Improve efficiency of patient flow

Poor patient flow has been identified as a contributory aspect to long waiting times. This is due in part to old infrastructure and a failure to take the patient's journey into consideration.

This initiative will reduce waiting times by ensuring that patients go to one service point for all services in one day without experiencing bottlenecks and unnecessary call-back.

This initiative will require implementation of several changes to improve efficiency. To this end, several potential interventions have been considered. A separate queue can be set up to fast-track patients with quick service needs (for example, chronic patients, family planning and immunisations). At the moment, there are unnecessary steps for chronic patients who are stable, as they must form part of the single queue at clinics. Under a new flow, they would have no waiting at a

common reception, their files would be retrieved the day before and they would have no waiting in the pharmacy queue. Another intervention would be to implement three separate queues and streams of care across all PHC facilities. This has been shown to reduce waiting times overall by segmenting patients between those with chronic, acute or maternal/child health needs through the ICDM process. Though significant variability exists, Ideal Clinic pilot sites were able to decrease the median total time spent by chronic patients by around 30% by implementing some of these guidelines.

Another intervention would be to ensure that there are a prescribed number of queue marshals appointed to streamline patients efficiently and manage queues. It is also considered that facilities should be supported to implement a triage system, specifically the South African Triage Score (SATS), which has been shown to reduce under- and over-triaging. Queue marshals will be monitored continuously by FMs for effectiveness.

To make sure that this initiative is feasible, a baseline survey will be conducted for each facility to determine client demand so that necessary adjustments to operating hours or staff shifts may be implemented. Other possible efficiencies to clinic operations will be identified through the baseline survey and implemented through improved operations management processes and improved staff utilisation which could be incorporated in KPIs included in staff performance plans.

Support teams will implement changes under the supervision of PHC managers. Queue marshals will be hired and trained on the system. District teams will support the implementation of the plan by ensuring quarterly monitoring and reporting. The initiative will be fully rolled out by March 2016.

The impact of this initiative is that by 2016 all clinics will implement a standardised patient flow system, involving the roll-out of revised appointment systems and filing processes. A plan to implement a standardised patient flow system will be developed. It will be necessary to develop a process map template for specific conditions and this will take the form of a clinical pathway for each person and condition. Every patient will then be provided with a map of the process flow for their condition.

Initiative 5: Standardise the paper filing processes

The current state of filing is disorganised and congested. Patients have multiple files, and this causes significant bottlenecks. The focus of this initiative is to transform the current filing system into one that is well-managed, easy-to-use and customer-centric by the year 2016. The Lab team has endorsed the on-going initiatives already tackling this issue, namely the 700 Health Facilities Project and the Rationalisation of Registers.

The first aspect of this process will be to avoid multiple files in favour of a single but comprehensive record for each patient. This will be inclusive of diseases and programmes for which the patient seeks care.

The second aspect will be to organise files according to Home Affairs identity numbers. A bar-coded record will enable the health workers to verify details of the patients. All patients without a bar-coded ID or smart card, who are in the country requiring care, will be consulted on the production of any documentation, visa or letter of asylum. All patients will be seen and no patients will be turned away without conducting a basic examination and the offer of assistance and relevant advice regarding future consultations. Beyond 2016, the electronic system will be based on biometric information. This process requires the participation of the Service Delivery work stream and for this reason syndication of these work streams has taken place to clarify the issues.

Files will initially be labelled using patients' birth months with the use of colour-coded labels to facilitate retrieval of all records for chronic patients. This colour coding is based on groupings of patients pursuant to the ICDM.

The activities for implementing this initiative include formulating and approving guidelines for file management to guide the filing process. The new process will be adopted and rolled out to all clinics. The project plan regarding the filing system will include change management. Best practices and lessons learnt during the pilot will inform improvements to be incorporated in the system, which will be fully rolled out by March 2016 to all clinics.

The impact of this initiative will be felt in the short and the long term, pursuant to a two-fold process. In the short term, the disorganised filing system will be transformed into an organised system with one single file per patient. All dormant files will be treated appropriately, according to guidelines. Streamlining filing will reduce time spent by the patient waiting for the file. One study shows[42] that out of 88 minutes spent by the patient waiting for services, 17 were spent waiting for their file. In the long term, there is the potential for a second stage in the process to reduce waiting times still further by shifting from paper to an electronic system (roll-out of HMIS). This will be facilitated by the use of identity numbers on files. Based on the impact achieved in a lean diagnostic at four of the Ideal Clinic pilot sites, simple interventions to improve filing and appointments were found to be able to reduce the time spent waiting for files by around 50%. A comprehensive electronic patient record system will address not only waiting times but address clinical management of the patients as well.

[42] Lean diagnostic at four of the Ideal Clinic pilot sites during the preparation phase of the Health Labs

Initiative 6: Support clinics to adjust hours/days of operation

Adjustment of hours refers to the planning of the work hours of clinic staff while still ensuring a day's work for a day's pay, in such a way as to ensure that all services are rendered at hours to suit patients. It seeks to ensure that no patient is turned away without receiving services.

Current policies already allow for the adjustment of operating hours based on flexi-time, where shifts can start earlier and end earlier, or start and end later. This initiative will ensure that appropriate advantage of this policy is taken to allow for flexible working hours for staff.

Some staff should thus come earlier or leave later to accommodate those patients who work, scholars and those with school-aged children, extending operating days/hours to accommodate the demand (for example, over Saturdays/Sundays and/or from the current eight hours to 12 hours).

Baseline assessment of targeted clinics will be based on the existing data of clinic service use. Community needs will be identified and the results used for determination of how to adjust the hours of service. Adjustment will then be made in consultation with the staff and relevant stakeholders, with outcomes communicated to all stakeholders. This initiative can be completed in one year.

The impact of this initiative will be to help districts rapidly assess demand and adjust the hours/days of working to service patients, to improve the patient experience and decongest clinics in the mornings. One study undertaken in the Western Cape found that 80% of patients arrived before clinics open, and in four of the Ideal Clinic pilot sites 60% of patients arrive before or within the first hour of the clinic opening. Even though the appointment system would already avoid people coming outside opening hours, in order to provide a better service to patients, it important to align opening hours with patients' needs and habits in the particular region.

Initiative 7: Implement electronic queue management systems

In terms of this initiative, simple electronic queue management technology will be installed that will enable patients to check-in and receive a number which places them in order in an appropriate queue – according to one of the three streams of care (chronic, acute, and maternal/child health). Electronic queue management systems are used in many countries to address issues of efficiency and increase satisfaction.

On arrival, patients will check in at a terminal which will give them a number for their place in the appropriate queue. These numbers are displayed on a screen and called out on a public address system as numbers come to the front of their queue.

The impact of this initiative is that patients can check the screen to have a clearer idea of where they are in the queue at clinics, giving them better planning opportunities and clarity in terms of the time they have to wait, allowing them to adjust their expectations of waiting times. Implementation of this initiative requires the establishment of a working group to develop the implementation programme for the electronic queue management system across all facilities. Installation will be piloted in around 10 clinics which operate with high volumes of patients. The system will then be rolled out to all high-volume clinics. The success of this initiative will be facilitated by the training of personnel. This quick win will be rolled out in the form of a national campaign by November 2015.

Initiative 8: Communicate clear expectations for waiting times and process of care

This initiative will involve the rolling out of a communication campaign to outline clear service standards for waiting times and the process of care. Existing media will be utilised for communicating inside and outside the clinic (for example, ward committees and local community newspapers), and clear service standards and expectations will be communicated, as required also by Batho Pele principles.

If patients understand what the process entails for their condition, then they will adjust their expectation and be more satisfied with the experience of care offered. Thus the next piece of the communication strategy will be to provide a “process map” for patient conditions. Patients will receive a clear checklist, as part of their appointment card, which outlines the visits required for their condition and what care they should expect to receive at each visit. At least for patients able to read, having their own checklist will empower them as a partner in the care process to speak up for their own care, prompting discussions with medical professionals when those expectations are not met. These checklists will improve dramatically the experience of chronic patients, in particular to help them take ownership of the process of their care, as well as increase adherence to appointments and treatment. Internal and external signage will follow standardised usage that is internationally recognised. These will be at all service points. Communities will be educated from time to time in order to ensure that time is not wasted looking for the PHC clinic.

Implementation of this initiative will include the roll-out of a general communications campaign, which will, for example, be able to educate patients on operating hours, service agreements (for example, waiting times) and the core values of public service and PHC. Messages will include communications encouraging patients to utilise channels to express their satisfaction or otherwise (for example, the “rate my clinic” tool, complaints/suggestions procedure). This initiative concentrates on rolling out a condition process flow map to patients and the installation of standardised signage across all facilities. The success of this initiative will be facilitated by training of personnel. For signage outside the clinics, joint ventures

will be established with other departments like road and transport. This quick win will be rolled out in the form of a national campaign by November 2015.

The impact of this initiative is that patients and the wider community will be informed of waiting times, patient experiences and expectations. Community members will participate and be involved in the management of their disease conditions. PHC facilities will be decongested of clients that might be better managed at home. Members of the community will be encouraged to use other available health facilities or institutions. These changes will lead to patient and community satisfaction while FMs and staff will be clear on their responsibilities and accountability.

Initiative 9: Evaluate, improve and communicate patient experience of care and waiting times as a key performance area (KPA)

This initiative seeks to ensure that waiting times and patient experience are monitored for improvement. Relevant standardised tools to measure these must be employed. Findings based on these measurements will lead to quality improvement strategies which will eventually lead to a sustained system for monitoring waiting times as well as for conducting patient satisfaction surveys.

Various tools have been used in different studies that were considered by the work stream for review, adaptation and adoption. Based on this review, the Lab team selected and revised the South African National Patient Experience of Care Tool to roll out country-wide. The Tool has been scientifically tested by the HSRC. It measures priority factors that influence patient experience of care. Tailor-made to address PHC facility needs, it is easy to apply and allows for a basic, descriptive analysis approach. Data analysis can be then conducted using any appropriate software for data analysis. The Tool is comprehensive and includes both patient experience of care and waiting times.

This initiative will provide a guide to assessing patient experience of care, which will be measured nationally each year.

The NDoH will develop guidelines for conducting surveys on the patient experience of care and waiting times in PHC facilities. The daily results of the Rate My Clinic Tool (an SMS-based survey currently being piloted by the OHSC) and complaints trends from current complaint-filing mechanisms will be used to inform service delivery improvements on a monthly basis. This will be integrated into the entire data management system for easy analysis and the implementation of corrective measures. A paper-based data collection process will be used initially. Then, by the end of 2015, an electronic data capturing and analysis process will be employed. For the purposes of objectivity, researchers or institutions of higher learning will be employed to conduct annual surveys.

A mechanism to provide feedback to patients and other stakeholders will also be developed by the NDoH. Management of this information will include, but not be limited to, the dissemination of information at all levels of care up to the facility level, determining levels of accountability and responsibility and, on a broader scale, the inclusion of survey results in service delivery improvement activities.

In addition to the annual survey based on the National Patient Experience of Care Tool, there will be daily data collection, based on clinic staff completing waiting time monitoring forms (i.e., recording the time of the beginning and the end of the interaction), captured electronically, and patients reporting on their experience via SMS (Rate My Clinic Tool). There will also be the opportunity for ad-hoc feedback when a complaint is lodged. Queue marshals can play an important role to manage this increased demand for monitoring and evaluation.

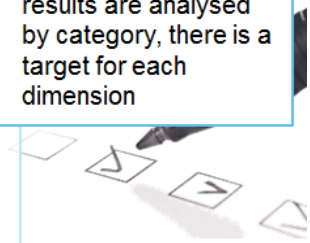
This work stream has defined targets across key dimensions, as shown in Exhibit 2.2, and the Lab team aspires to attain overall patient satisfaction with regard to waiting times.

EXHIBIT 2.2

We aspire to attain 80% of patients reporting a positive experience of care

Dimension	Target Percentage	Description
Access to care	100	To determine if all the patients have the required access to healthcare services
Availability of medicine	95	To determine the extent of availability of essential medicines
Patient safety	80	To determine the level of safety of care in the facility
Cleanliness and IPC	80	To determine status of cleanliness and IPC practices
Values and attitude	90	To determine staff attitude towards patients
Patient waiting time	90	To determine if the time the patient spends waiting for services is in line with the policy target

- If a patient answers "yes" to >80% of questions across all categories, they are considered to be reporting a "positive experience of care"
- Moreover, when results are analysed by category, there is a target for each dimension



1 Percentage calculated on the basis of recommendations from the pilot study that was conducted in NHI clinics by HSRC (2012) for the NDoH: QA Directorate

The impact of this initiative will be to track progress by common measurements against overall aspirations on waiting times and patient experience of care, and provide transparency to guide performance.

The implementation of this initiative will involve the piloting of identified tools using seasonal researchers (i.e., staff hired for a limited amount of time to conduct this specific activity). The Rate My Clinic Tool will be implemented continuously to monitor progress and to compare against the results of the annual survey. The first national annual survey results will be published by 2017. It is envisaged that this initiative will be implemented in more than 90% of clinics by 2017. Performance reviews will be conducted at all levels, and issues of concern will be attached to the KPAs of district managers and FMs.

PROPOSED KEY PERFORMANCE INDICATORS

Table 2.1contains a sample of KPIs for waiting times and overall patient experience. The full list of proposed KPIs, including suggested reporting frequency, sources of baseline and supporting documentation, is available in the Lab's Excel templates output on KPIs. These KPIs will require final syndication with all relevant stakeholders during the implementation phase.

Table 2.1: KPI selection for the Waiting Times workstream

			Cumulative target (March of the year)					
Initiative	KPI description	Base-line	2015	2016	2017	2018	2019	KPI Owner
Overall KPIs	% of patients spending less than three hours in a PHC facility	New	Linear improve-ment	Linear improve-ment	Linear improve-ment	100%	100%	Facilities Managers (FMs)
	% of patients who wait less than two hours for service	New	Linear improve-ment	Linear improve-ment	Linear improve-ment)	100%	100%	FMs
	% of patients <90% reporting satisfaction with waiting times	New	Linear improve-ment	Linear improve-ment	Linear improve-ment	90%	90%	NDoH
	% of patients who report <80% satisfaction with experience of care in a facility	New	Linear improve-ment	Linear improve-ment	Linear improve-ment	80%	80%	NDoH quality assessmen t
Use appointment system	% of booked patients keeping their appointments	No base-line		80%	90%	100%	100%	FMs

Table 2.1 (continued): KPI selection for the Waiting Time work stream

			Cumulative target (March of the year)					
Initiative	KPI description	Base-line	2015	2016	2017	2018	2019	KPI Owner
Expand existing public call centre	Number of call centres equipped with Telkom lines	0	0	2	6	10		Head of department (HOD), provincial health departments (PDoHs)
	Number of PHC call centre lines in operation	0	0	2	6	10		HOD, PDoHs
Roll out SMS-based platform	Number of provinces that have appointed a project steering committee	0	9					HOD, PDoHs
	Number of clinics implementing SMS system	0		100%				Operational managers, PHC
	Number of personnel trained on the SMS system	0		100% by 30 April 2016	100 %	100 %	100 %	Director of Training
	Percentage of patients with appointments that are sent appointment reminders	0%		100% by 30 May 2016	100 %	100 %	100 %	Operational managers, PHC
	Percentage of patient adhering to set dates of appointments	65%		100% by 30 June 2016	100 %	100 %	100 %	Operational managers, PHC
Patient Flow	Median time (minutes) spent waiting for number in the queue at the door	New	Base-line	Linear improve-ment	2	2	2	Facilities Managers

Table 2.1 (continued): KPI selection for the Waiting Times work stream

			Target (March of the year)					
Initiative	KPI description	Base-line	2015	2016	2017	2018	2019	KPI Owner
Patient flow (continued)	Median time spent waiting for screening (using SATS tool)	New base-line	Base-line	Linear improve-ment	10	10	10	FMs, DHS
	Median time (minutes) spent waiting for clinical consultation (three streams of care) and other service areas	New base-line	Base-line	Linear improve-ment	45	45	45	FMs
	Median time (minutes) spent waiting for pharmaceuticals to take home (where applicable)	New base-line	Base-line	Linear improve-ment	10	10	10	FMs
Filing system	Median time (minutes) spent waiting to receive a file	New base-line	Base-line	Linear improve-ment	15	15	15	FMs, DHS
Support clinics to adjust hours/days of operation	Percentage of patients which report positive experience of care regarding access to care	New base-line	40%	>60%	>80%	>80%		District Research Team Leader, DoH
	Percentage of patients presenting at clinic before it opens across clinics with extended hours/days	New Base-line	<20%	<8%	0%	0%	0 %	District Research Team Leader, DoH

Table 2.1 (continued): KPI selection for the Waiting Times work stream

			Target (March of the year)					
Initiative	KPI description	Base-line	2015	2016	2017	2018	2019	KPI Owner
Support clinics to adjust hours/days of operation (continued)	Percentage of patients waiting less than two hours across clinic with extended hours/days	New base-line	Linear improve-ment	Linear improve-ment	Linear improve-ment	100%	100%	FM/ district
Electronic queue management	Percentage of qualifying clinics with electronic queue management system installed	0	0%	90%	100%	100%	100%	Chief Director, National Direct-orate
Communicate clear expectations for waiting times and experience of care	Median time (minutes) spent waiting for pharmaceuticals to take home (where applicable)	New base-line	0%	Linear improve-ment	10	10	10	FM
	Percentage of clinics with condition-based flow maps rolled out and implemented	0	0%	100%	100%	100%	100%	Chief Director, National Direct-orate
Evaluate, improve and communicate patient experience of care	Percentage of district managers with patient experience of care and waiting times as a KPA	0%	0%	100%	100%	100%	100%	NDoH
	Percentage of FMs with patient experience of care and waiting times as a KPA	0%	0%	100%	100%	100%	100%	NDoH
	Percentage of clinics which have been surveyed by the annual patient experience of care survey	0%	100%	100%	100%	100%	100%	NDoH

Chapter 3: Infrastructure

SUMMARY

The infrastructure of a clinic refers to its physical structure, medical and non-medical equipment, ICT, security and bulk services. Apart from human resources, this is the most important component required for a PHC facility to function optimally. Findings of the National Health Care Facilities Baseline Audit conducted by the NDoH in 2012 indicate that less than 20% of the public health clinics in districts have infrastructure that is fit for purpose.

The aspiration of the Infrastructure work stream is to develop an effective infrastructure roll-out plan to ensure 100% world-class sustainable Ideal Clinics for PHC by 2018/19. Its specific aspirations are:

- To design and roll-out "100% fit-for-purpose" facilities by 2018/19. This will be set out in a clearly-defined infrastructure roll-out plan underpinned by national technical specifications for the Ideal Clinic facility. Within the overall layout and technical specifications, there will be a focus on increased medical access, improved infection control and optimal patient experience.
- To ensure that all public health clinics sustain world-class standards by defining world-class maintenance measures and monitoring standards which will inform both the implementation plan and maintenance strategy. Here, the focus will be on utilising appropriate and robust materials with minimum maintenance requirements.
- To define the supply chain management processes that will provide a value-for-money capital infrastructure delivery programme to reduce procurement turnaround times. Key to this will be defining clear governance structures and processes to ensure accountability.

Five key **initiatives** were prioritised by the Infrastructure work stream to address bottlenecks to the delivery of the Ideal Clinic so that 100% of public health clinics would be fit-for-purpose. The aim is for the key drivers to ensure continuous improvement with a specific focus on planning, construction, maintenance and implementation. The five work stream initiatives that have been identified are to:

- Create and implement a detailed roll-out plan of Ideal Clinic infrastructure programme
- Update standards for the shape, size and quality of public health clinics
- Establish clinic maintenance hubs (CMHs) – dedicated roving clinic maintenance units – for each district
- Create and maintain an integrated asset register to quantify, categorise and prioritise all PHC facilities
- Design and implement a Central Oversight Unit (COU)

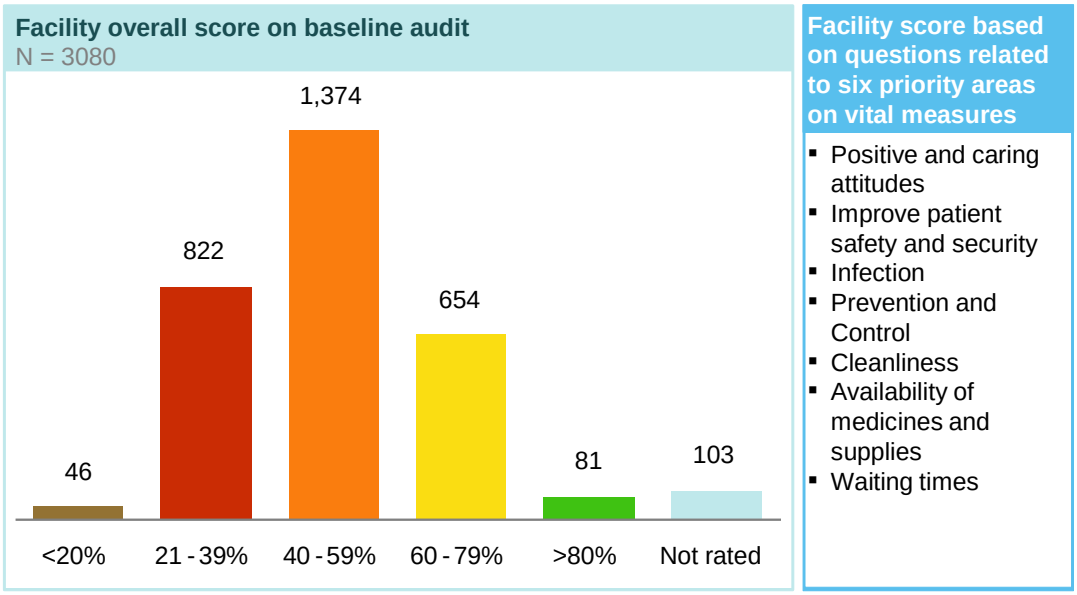
CONTEXT AND CASE FOR CHANGE

The infrastructure of a clinic refers to its physical structure, medical and non-medical equipment, ICT, security and bulk services. Apart from human resources,

this is the most important component required for a PHC facility to function optimally. The aim of the Infrastructure work stream is to strengthen PHC infrastructure to enable the facility personnel to deliver effective, safe and quality services. Its focus is to review critical issues, prioritise them and outline the root-causes inhibiting sustainable infrastructure maintenance; create an infrastructure roll-out programme for the realisation of an Ideal Clinic; and align refurbishment plans with the NDoH, provincial health departments and the DPW.

A report by the NDoH and the HST indicates that the physical state of the infrastructure in health care facilities in South Africa is poor, owing to unequal development and the general lack of maintenance. Findings of the National Health Care Facilities Baseline Audit conducted by the NDoH in 2012 are that less than 20% of the public health clinics in districts have infrastructure that is fit for purpose (Exhibit 3.1). The report was based on the assessment of two broad objectives: first, to audit facility infrastructure, including but not limited to the condition of land and buildings, access to water and electricity, condition of medical equipment, condition of surrounding roads and access to transport routes; second, to audit service delivery, including operational times, work load, allocation and availability of personnel and compliance to quality standards in the six priority areas. The key drivers of the poor audit results were inadequate design, sub-standard build quality, inappropriate use of materials, insufficient bulk services and lack of maintenance.

EXHIBIT 3.1



SOURCE: The National Health Care Facilities Baseline Audit 2012

Based on these critical findings, there is a need for a coordinated renovation of PHC facilities in the delivery of new buildings, refurbishment, lean reconfiguration and light-touch upgrades which are in line with acceptable standards, while ensuring that population dynamics are addressed. The Infrastructure work stream proposed best-fit models to address the infrastructural gaps, aligned with the National Core Standards and Infrastructure Unit Support Systems specifications and guidelines for the planning and design of existing and new facilities.

ASPIRATIONS

The overall aspiration of the Infrastructure work stream is to deliver effective infrastructure roll-out to ensure 100% world-class sustainable Ideal Clinics by 2018/19. Specific aspirations are:

- To design and roll-out “100% fit-for-purpose” facilities by 2018/19. This will be set out in a clearly-defined infrastructure roll-out plan underpinned by national technical specifications for the Ideal Clinic facility. Within the overall layout and technical specifications, there will be a focus on increased medical access, improved infection control and optimal patient experience.
- To ensure that all public health clinics sustain world-class standards, by defining maintenance measures and monitoring standards that inform both implementation and the maintenance strategy. Here, the focus will be on utilising appropriate and robust materials with minimum maintenance requirements.
- To define the supply chain management (SCM) processes that will provide a value-for-money capital infrastructure delivery programme to reduce procurement turnaround times. Key to this will be defining clear governance structures and processes to ensure accountability.

Before considering which initiatives would be necessary to achieve these aspirations, the work stream analysed the issues behind the infrastructural shortfalls in PHC facilities. These will be considered in the next section.

ISSUES TO BE ADDRESSED

The work stream identified challenges that are the primary cause of clinics not being fit for purpose. These key challenges fall into four main themes.

In the first place, there is a **lack of adherence to governance procedures**. Overall, there is fragmented coordination and decision making across the construction and maintenance value chain. This is driven by the lack of a single body to manage, maintain and upgrade facilities. Additionally, the unclear appropriation of funds and prioritisation of projects creates inconsistency in accountability and leads to poor service delivery. This in turn reduces the likelihood

of the completion of projects in terms of time and quality. It also causes delays and backlog in maintenance.

In the second place, there is **no integrated asset delivery plan in place**: limited strategic planning and clinical input at the conceptual stage as well as a limited integrated approach for infrastructure reconditioning lead to poor asset delivery performance. In addition, there is a lack of standardisation and use of conventional design, leading to a protracted building process resulting in inappropriate configuration of facilities for the package of services they are required to provide. There are also no consistent and standardised facility designs and specifications in place, leading to continuous design revisions and/or improvements.

In the third place, there is a l**ack of comprehensive SCM and construction management**. In general, procurement is cumbersome since the financial delegation is not standardised at provincial level, leading to a prolonged turn-around time for procurement. There is neither a clear process nor set of requirements for commissioning, quality control and handover of facilities, and there are no effective bid specifications, evaluation or adjudication.

Finally, there are **only limited quality assurance and maintenance measures in place**. Limited finalisation of the documentation (policies, guidelines, norms and standards) has led to poor process and progress for maintenance requirements and routines. This has severe implications for risk mitigation, leading to legal disputes, non-completion of projects and attendant cost escalations. Poor planning and limited performance management increase the backlog of new building and maintenance projects.

These challenges leads to problems and bottlenecks at every stage of the construction value chain, from identifying and prioritising projects to their design and specifications, including management of procurement and commissioning, oversight of construction, project management, quality assurance and, ultimately, monitoring facility requirements and maintenance. The effectiveness of any large-scale infrastructure programme that the NDoH or provinces embark on is compromised by these challenges.

These issues were scrutinised by the Lab team to arrive at several initiatives for implementation so that the team's aspirations could be achieved. These are considered in the following section.

INITIATIVES

Five key initiatives were prioritised by the Infrastructure work stream, namely:

- Create and implement a detailed roll-out plan of the Ideal Clinic infrastructure programme.
- Update standards for the shape, size and quality of public health clinics.

- Establish clinic maintenance hubs– dedicated roving clinic maintenance units – for each district.
- Create and maintain integrated provincial asset registers to quantify, categorise and prioritise all PHC facilities.
- Design and implement a Central Oversight Unit.

These initiatives are designed to address bottlenecks in the delivery of the Ideal Clinic infrastructure, so that all public health clinics can be fit for purpose.

Initiative 1: Create and implement a detailed roll-out plan of the Ideal Clinic infrastructure programme

The objective of this initiative is to transform existing PHC facilities into Ideal Clinics, complying with the norms and standards for effective service delivery. An infrastructure roll-out plan will assist in streamlining detailed project plans to implement the Ideal Clinic roll-out plan to realise 100% fit-for-purpose clinics. This plan will prioritise quick wins, ensuring that 20% of all clinics are compliant by March 2016. The infrastructure plan will focus on segmenting all facilities based on their infrastructure requirements to transition them to the state of an Ideal Clinic. In terms of broad categories, the plan will include the construction of new facilities, rehabilitation of those that have been poorly maintained and the refurbishment and repair of those that are in good condition.

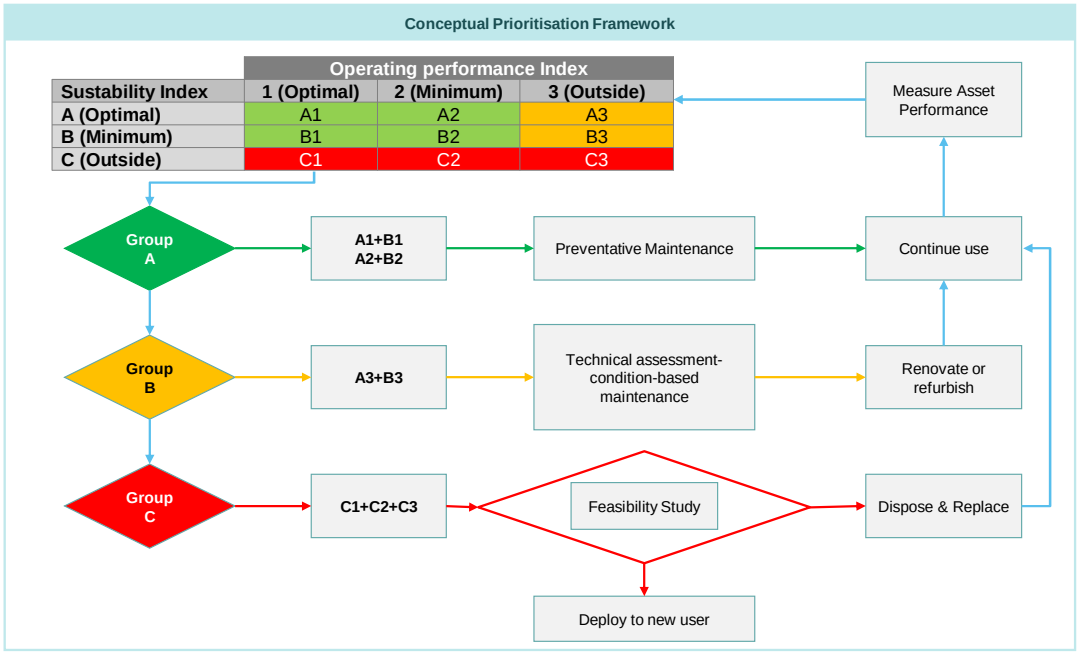
A basic requirement at all facilities will be to ensure the delivery of bulk services; namely, electricity, sanitation and water. Essential to this will be back-up services for all facilities, particularly those where normal bulk service provision is unavailable or intermittent (for example, generators and water tanks, etc.).

A key element that will be required in the Ideal Clinic infrastructure roll-out programme will be the provision of reliable broadband connectivity to each clinic. This is the cornerstone of an effective ICT system. Reliable connectivity should ideally be supplied by several service providers that could form a partnership and subsidise connectivity for all clinics. The roll-out programme will enable the NDoH to maintain an overview of all facilities and maximise their life span, with the support of CMHs (see Initiative 3 in this section). This will exist in parallel to the delegation of authority from national to provincial level, standardised across all provinces. It is necessary to undertake research and evaluate connectivity standard specifications. Clear up- and down-time standards for broadband connectivity should be specified in any contract, along with bandwidth requirements. This will ensure that accountability for services lies with the implementing agent rather than only delegating responsibility when problems arise with their output.

As to the process of the roll-out, this will be undertaken in a systematic manner. The first step will be categorising clinics into different groups based on detailed

information on their condition and a functional assessment. This categorisation will inform the scope of work and the time to completion (see Exhibit 3.2).

EXHIBIT 3.2



SOURCE: DPW-Guidelines for Users

Group A includes those clinics which are suitable and operate optimally (based on condition, performance and accessibility). These would require preventative maintenance and minor reconfiguration only, and can immediately be handed over to the CMHs. Group B includes those clinics that meet the minimum suitability requirements, but are not operating optimally and would require refurbishment or upgrade to get to Ideal Clinic status. Group C includes those clinics that are not suitable to perform their required function and are in a dilapidated condition beyond repair. These would need to be disposed and replaced with an Ideal Clinic.

The Infrastructure work stream has estimated that approximately 165 PHC facilities fall into Group C. The proposed procurement strategy for this category is a traditional procurement contract with independently-sourced projects managed by each province. It is estimated that 2,192facilities require refurbishment or upgrades. For this group of facilities, a framework contract is proposed, with all the required expertise procured as part of a single package. A further 723 facilities only require light-touch maintenance and minor reconfiguration, for which a management contract is recommended. A detailed assessment clinic by clinic is required to appropriately categorise the clinics in the three buckets.

Once clinics have had their infrastructure brought up to Ideal Clinic status, they will be transitioned to the maintenance hub (see Initiative 3 in this section) for on-going maintenance.

The question of risks is important: in order for the roll-out to be successful, these will have to be mitigated. In the first place, as regards to capacity and capability, business-as-usual will not be able to provide the capacity required for a big, fast infrastructure roll-out. Risks include coordination of the decanting process ahead of major work, the ability of districts and provinces to staff the building and maintenance units, and the limited capacity and technical expertise of the implementing agents.

The second area of risk to be mitigated concerns the issue of governance: notably, the issue of provincialisation and the performance of implementing agents (for example, the DPW, State Information Technology Agency, etc.) have been identified as potential obstacles in the roll-out.

The next risk area has to do with regulations. In particular, lengthy assessment processes, heritage regulations and land acquisition processes could also add to delays in the implementation of the Ideal Clinic infrastructure plan.

There are some key aspects, however, that will make this roll-out different; such as the decentralised procurement directly supervised by provinces, the establishment of a pre-qualified panel of service providers to fast-track the roll-out and the use of consortia to avoid delays in the procurement processes.

The Ideal Clinic infrastructure roll-out will require substantial capital investment. Partnerships with the private sector could help to reduce the capital expenditure required. These have the potential to leverage technical expertise and substantial construction and maintenance efficiencies to improve value for money. They can thus help accelerate the roll-out and support the delivery of the national goals of improved health care. They can also provide additional resources and innovative technology. An example of such a partnership is a public-private partnership (PPP), which is a contractual arrangement with a consortium, structured through a dedicated Special Purpose Vehicle to undertake a particular project or programme. Here, the private sector partner could potentially take responsibility for the construction of new infrastructure; partially manage a long-term lease or concession over existing assets; and/or partially manage a long-term contract to operate or manage the infrastructure and or undertake its maintenance. Currently, there is limited ability to control construction and subsequent maintenance cost overruns. In the PPP arrangement proposed above, construction and maintenance would be linked, allowing the consortium to spend more capital upfront, as they are incentivised to consider the total cost of ownership of the asset.

Turning to financial models, the NDoH with National Treasury can draw on several wide-spectrum finance options to fund the infrastructure roll-out. Direct government

financing, where government has the highest level of control, can be funded through taxes, subsidies or government loans. The first two can take the form of driving procurement, utilising outsourcing or exploiting contracting, while loans are often at low or zero interest. At the next highest level of government control, debt financing may be funded through a bank loan (requiring a government guarantee) or bonds (requiring a credit rating and coming with an interest rate risk). The model with least government control is the PPP arrangement. Based on discussions and syndication with National Treasury, the “design, finance, build, maintain and transfer model”, under a PPP, has been identified as highly effective, with minimal risk. The model addresses maintenance issues by stipulating that maintenance should be covered for a specific contract period following construction. At the conclusion of the contract, the facilities’ management takes over these responsibilities.

In considering the procurement strategy to be followed, ICT and medical equipment specifications need to be revised to include quality standards. Procurement legislation aims to reduce bias and optimise the delivery of product quality. To emphasise this quality, it is suggested that a technical team evaluate products to assess the average time they last before failing. Furthermore, additional procurement criteria must be set, establishing a threshold for quality and reliability to limit costly equipment failures.

The recommended procurement strategy for new, larger refurbishments and upgrades is through single sourcing through one contractor (or a consortium) to construct a number of projects in parallel. This will enable a “big bang” implementation approach, prevent multiple tender rounds and allow for an efficient levelling of resources.

For minor refurbishments and upgrades, as well as maintenance, the ideal procurement strategy is to have a management contractor providing coordination, working with multiple, small sub-contractors. This approach is aimed at maximising local economic development and job creation. A professional design team providing designs and overall oversight will remain the responsibility of the DoH.

As to the timeline involved, by 2018/19, all facilities are expected to have reached Ideal Clinic status. To complete this initiative the Lab suggested a separate set of Delivery Units to coordinate the programme and grasp economies of scale. The delivery system to upgrade clinic facilities should be composed of a national Central Oversight Unit (COU) with a terms of reference, provincial support units (for each of the nine provinces) and district programme support units (in each of the 52 districts). Maintenance hubs will also need to be established in each district. The next step will be to obtain the register of assets (pursuant to Initiative 4 in this section) and develop a model for deciding the sequence of facilities to be upgraded. A procurement strategy should be developed and the Ideal Clinics delivered in due course. It is anticipated that 20% of clinics will become compliant by March 2016, 40% by 2017, 60% by 2018 and the remaining 40% by 2019.

Initiative 2: Update standards for the shape, size and quality of public health clinics

The objective of this initiative will be to develop comprehensive minimum standards in terms of functionality and quality to synthesise and modify existing functional design standards and material specifications across all provinces to simplify the roll-out process.

These standards will ensure that the new, Ideal Clinic design is fit-for-purpose and energy efficient. In addition, the initiative will develop a range of standard retro-fit options that are appropriate for different clinical needs (including infection control, waiting times and patient flow), which can be rapidly implemented.

Key to the development of sustainable facilities will be the development of design models that respond to climate and clinical needs in different provinces, while maximising the use of alternative building technologies. Expert teams will accelerate the process to create national standards. The teams will consist of subject matter experts in PHC facility design, operations and quality assurance. They will work on data that is provided by provincial departments to consolidate technical standards and best practices across various sources and conduct a gap analysis on the data being collected and the existing norms and standards. The development of updated standards will incorporate specific technical requirements based on, inter alia, climate, catchment areas and population migration.

To implement this initiative, a task team will be established and relevant data collected regarding the facilities (for example, a schedule of rights/zoning certificates for each site, existing conditional assessments done by the Chief Works Inspector and asset registers). The next step will be one of analysis and prioritisation, consolidating data across categories to allow for an investigation of data at national as well as provincial and district level. The size, shape and quantity of equipment and material will be reviewed and standardised before finalisation and approval of a priority list.

The timeframe for implementing this initiative is 5 January 2015 to 31 March 2015. By July 2015, a standard draft is anticipated. By August 2015, an acceptance workshop will have been held, and by August 2015 the initiative will be rolled out.

Initiative 3: Establish clinic maintenance hubs– dedicated roving clinic maintenance units – for each district

The objective of this initiative is the establishment of CMHs to improve the maintenance of all facilities in each province. This will be achieved by establishing dedicated roving clinic maintenance units to improve maintenance and turnaround times. The maintenance hubs will need to be established in parallel with the infrastructure roll-out plan (Initiative 1 in this section) in order to ensure that completed clinics can immediately be transitioned to the appropriate hub for

maintenance. The maintenance hub will consist of a call centre, workshop, stores and term contractors, and will be run by a hub manager. The vision is for each district to have an operational CMH.

The maintenance unit will evaluate all the immovable and movable assets of each province, undertake assessments on the condition of existing and new assets, and draw up maintenance plans. The work stream proposes that the DoH take responsibility and ownership for its maintenance programme to allow for improved monitoring, evaluation and accountability. The CMHs must be a cost centre for a number of PHC clinics and not fall within hospital maintenance and workshop/fleet. In order for the hub to function optimally and achieve the desired goals, it will be necessary to employ and develop the skills required (including store manager, artisans and operation contractors). To retain and attract the technical skills of artisans within health care facilities, the CMHs will explore market-related remuneration pay packages.

To support the hub in achieving fast turn-around times and response, the Lab team proposes the development of a diagnostic app, iMaintenance, to facilitate remote diagnostics for maintenance. “iMaintenance” refers to integrated, intelligent and immediate maintenance, which can be made possible by integrating various maintenance functions, and connecting these to handheld devices (tablet or smart phone) using mobile communication technologies. The app allows for technical drawings of buildings, with specialist features to be captured on an X-ray-enabled tablet. A picture can be taken at a facility and transmitted to a control centre, located within the hub, where a technical expert will diagnose the problem and immediately send out a contractor to repair the defect. The app will thus enable maintenance to be proactive and avoid the build-up of backlogs. The app will also support self-diagnosis, helping clinics take ownership of their own facility management. It will also strengthen quality assurance by reviewing work completed using an inspector. The app will be developed as a module of the Computerised Maintenance Management System (CMMS). The system will be used for the whole infrastructure portfolio, including clinics, community health centres, hospitals, emergency service bases, forensic mortuaries, administration buildings and all other buildings for health.

By collaborating with the private sector it will be possible to utilise their expertise and the latest cost-effective solutions to roll-out the required level of IT infrastructure quickly and more easily. Investigating these opportunities is thus strongly recommended.

It is also important to have a maintenance exchange system in place for ICT and medical equipment. The purpose of this is to provide rapid ICT support to limit downtime and improve the reliability of ICT systems. This will be possible by having a stock of functional equipment that can be exchanged for damaged components and thus limit service downtime. Currently, these facilities have under-utilised ICT infrastructure due to a want of maintenance of ICT systems that require more

frequent support. Currently, patient waiting times are severely affected by equipment-associated bottlenecks. This downtime needs to be reduced from days and weeks, even months, to mere hours.

The Infrastructure work stream identified a number of deliverable/outputs regarding the establishment of maintenance hubs. To launch the maintenance hubs, capacity will be built, as per the specific requirements. The maintenance approach will be reviewed and standardised, based on maintenance best practices according to the processes of the Infrastructure Delivery Management System and operations and maintenance. Clinics will be quantified and categorised according to the dashboard. Best practices will be refined to establish a draft CMH guideline and develop key performance indicators. A standard maintenance management framework and approach will be developed, including broad requirements for a computerised maintenance management system, processes and tools. Finally, validation processes and tools for quality assurance and handover will be developed.

To complete the development of the iMaintenance app, the concept will be refined and the key requirements outlined. Potential funders will be identified and sponsorship secured to drive a pilot and the roll-out. Relevant software developers will be engaged to assess cost and functionality. The option to develop iMaintenance as a tool or as part of CMMS will be considered. Relevant stakeholders will be engaged on the concept version and their feedback incorporated. A test version of the app will be created for the central committee and maintenance team and this will be continually refined. The app will then be tested and piloted within the CMH and its use will be refined. Finally, the app will be rolled out in parallel to the establishment of the CMHs and refined based on user experience.

Initiative 4: Create and maintain integrated provincial asset registers to quantify, categorise and prioritise all PHC facilities

The objective of this initiative is to create verified asset registers in every province covering both facilities and equipment. These provincial registers will contribute to the creation of a single database at national level in which each facility will have a unique identifier. This database will be regularly updated and will include reference to the condition and ownership of the assets.

Each asset register will help to categorise the requirements of facilities (for example, those requiring additional space); prioritise which facilities need attention and in which order; and determine the extent of the financial commitment required for the Ideal Clinic delivery roll-out. The register will also enable greater transparency and the efficient monitoring and control of all assets – thus facilitating future planning and helping ensure effective maintenance.

The information in the asset register will be integrated into a single repository with a standard format. This information will be accessible to the NDoH, provincial health departments and districts.

As a first step in implementing this initiative, each provincial health department will develop its own asset register, verify the data and share this with the NDoH. The National Health Care Baseline Audit along with DHIS information will be used as a starting point. The NDoH will then consolidate the information and develop the required policies and processes for access, use and updating of the register. The Lab team has also proposed that the provinces and the NDoH could leverage expertise from other national departments (particularly the DPW) and even tertiary education teams to update and consolidate their register.

In order to complete and maintain the consolidated asset registers with conditional and functional assessments, it is critical that capacity and funding be found. Initial capacity can be sourced through the use of teams from tertiary institutions including Further Education and Training (FET) colleges, universities and universities of technology, with built environment courses that require practical work as an element of students' course requirements. The NDoH can partner with the Department of Higher Education and Training to create programmes for students to work as interns to complete technical drawings of facilities.

A second set of experts could be seconded from various departments that have people with the critical skills required to consolidate the asset registers. Finally, provincial departments can contract private service providers to fill remaining capacity gaps.

To complete this initiative, a task team will be established with a terms of reference for its operations; conditional assessment data will be collected from provinces; asset registers will be collected from provinces; the data received will be reviewed and analysed and gaps identified; and a priority list will be created based on prioritisation model criteria. The timeframe for implementing this initiative is 2015.

Initiative 5: Design and implement a Central Oversight Unit

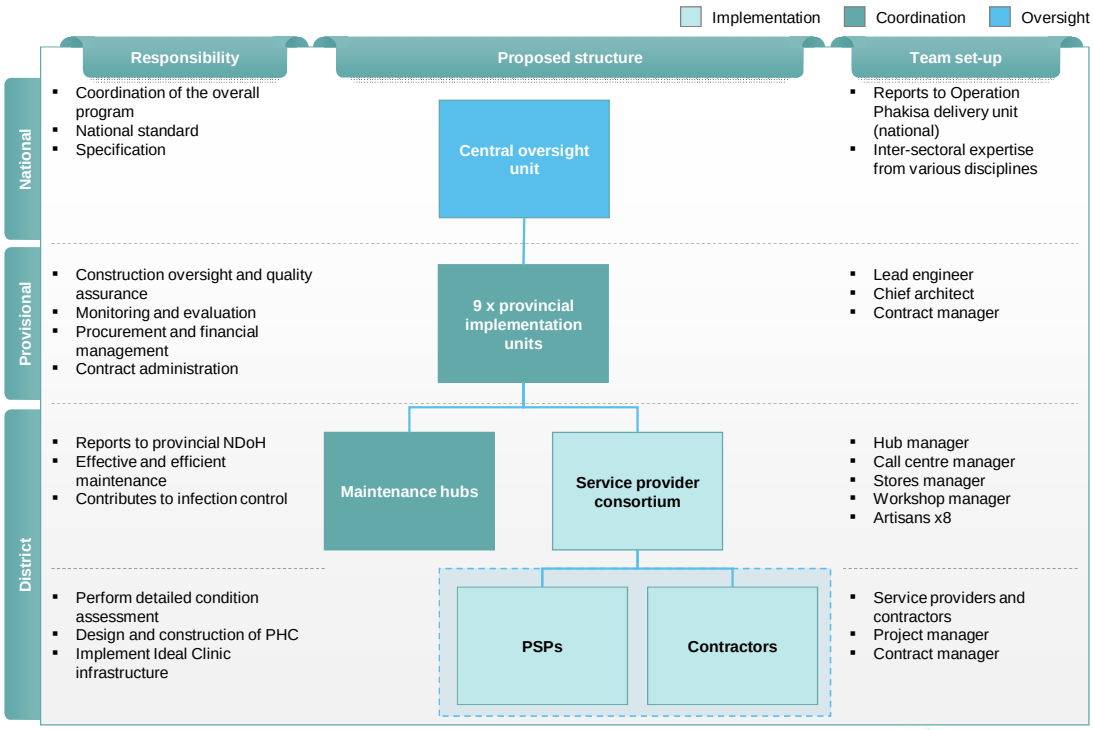
The various initiatives in the Ideal Clinic programme will need to be very well managed to achieve effective implementation. For this reason it is necessary to establish oversight units. The first tier will be the COU at national level. This unit will be responsible for the overall coordination of the infrastructure programme and will report to the Delivery Unit for Operation Phakisa.

Nine provincial units will be established for programme management, and procurement will be decentralised to the provinces. It will be important to ensure that these provincial units are capacitated with the required technical expertise. These units will report to the national COU.

The special delivery vehicles will consist of service providers that are able to perform detailed assessments on the condition of infrastructure. They will also be able to design and construct PHC clinics and to deliver Ideal Clinics on time.

The maintenance hubs will operate at a district level, but report directly to the provincial units. Exhibit 3.3 graphically presents this operational structure.

EXHIBIT 3.3



SOURCE: Infrastructure Workstream – Health Labs

The steps to complete this initiative include the establishing of the COU with a terms of reference, establishing provincial delivery support units (for each of the nine provinces), establishing district delivery support units (52 of these) and establishing CMHs per district. In addition, the asset register will be obtained and a prioritisation model and procurement strategy developed. Once the facilities have reached Ideal Clinic status, responsibilities initially vested to the district Delivery Units will be permanently assigned to maintenance hubs. The national programme support unit will, finally be decommissioned.

The timeframe for completion is December 2017. By mid-2015, it is anticipated that the provincial and district procurement committee will be established and operational and that by March 2016 all procurement and contracting will have been finalised.

PROPOSED KEY PERFORMANCE INDICATORS

Table 3.1 contains a sample of KPIs for Ideal Clinic Infrastructure. The full list of proposed KPIs, including suggested reporting frequency, sources of baseline and supporting documentation, is available in the Lab's Excel templates output on KPIs. These KPIs will require final syndication with all relevant stakeholders during the implementation phase.

Table 3.1: KPI selection for the Infrastructure work stream

			Target (March of the year)					
Initiative	**KPI description**	**Base-line**	**2015**	**2016**	**2017**	**2018**	**2019**	**KPI Owner**
Infra-structure roll-out programme	% of new PHC facilities completed	N/A	0%	20%	40%	60%	100%	COU
	% of PHC facilities refurbished	N/A	0%	20%	40%	60%	100%	COU
	% of PHC facilities upgraded	N/A	0%	20%	40%	60%	100%	COU
	% of PHC facilities maintained	N/A	0%	20%	40%	80%	100%	COU
	Number of facilities with broadband connectivity	0	50	650	3300	3507		NDoH
CMHs	Percentage of CMHs with all staff appointed with defined roles and responsibilities according to the suggested CMH organogram	0	20%	50%	70%	90%	100%	NDoH
	Percentage of ideal clinics handed over to the CMH	0	10%	30%	50%	70%	100%	NDoH
	Percentage of facilities with functional iMaintenance tool	0	10%	30%	50%	70%	100%	NDoH
Asset register	Number of provinces with complete asset register	0		9				NDoH

Chapter 4: Human Resources for Health

SUMMARY

Human resources for health (HRH) are the backbone for the delivery of health services, providing support to the core services. Although more than 80% of South Africans depend on the public health system, only about 30% of the human resources for health in the country are employed in the public sector. Human resource issues impact South Africa's PHC clinics in serious ways. As examples, according to the National Health Facilities Baseline audit of 2012, 21% of clinics in 2012 had no manager, and 47% of clinics had no visits from doctors. The National Treasury estimates that the system has 46,000 vacancies.

In view of these challenges, the overarching aspiration for the HRH workstream is to ensure, by 2018/19, an equitable distribution of well-trained health workers with the required capabilities that will ensure the professional, efficient, effective, cost-effective and sustainable delivery of health care.

Achieving these aspirations will mean that:

- No patient goes home unattended due to a lack of staff
- No employee feels that going the extra mile is not worthwhile
- All workers are engaged and ready to perform at their best
- No clinical professional is overburdened with administrative tasks

The HRH workstream prioritised nine **initiatives** to optimise the management of HR in primary health clinics and to address the negative impact on health outcomes that result from shortages. These initiatives are:

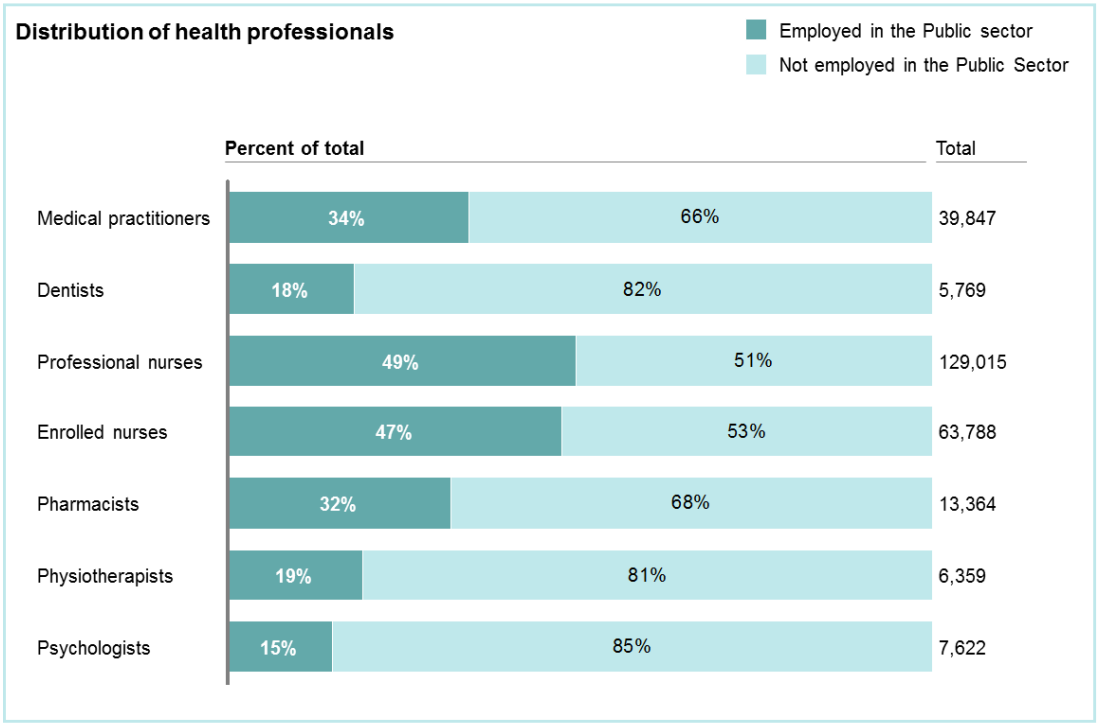
- Redistribution of staff
- Task shifting and sharing (amending job descriptions)
- Contract clinical staff from the private sector
- "Bring back" South Africa's health professionals to the public sector
- Ensure facilities have the minimum numbers of essential non-clinical staff
- Develop more effective community service policy and practices to supply more clinical practitioners to rural areas
- Lean and effective recruitment process
- Empower FMs to support scale-up to the Ideal Clinic
- Enhance non-clinical staff competencies in front-line customer-care services

CONTEXT AND CASE FOR CHANGE

Human Resources for Health (HRH) are the backbone for the delivery of care. Despite the efforts made by the provinces and the NDoH in the last 20 years, there are still important gaps in the number and skills of HRH in the country.

South Africa's public health sector is severely under resourced. As of 2014, 82% of South Africa patients depend on the public sector[43] while only 30% of the health professionals in the country work in it (Exhibit 4.1). As a result, PHC suffers from severe shortages of clinical and non-clinical staff. As an example, 21% of the PHC facilities do not have a FM, 47% do not receive doctor visits and 84% lack any input from a pharmacist or equivalent[44]. Shortages are especially concerning in rural areas, where gaps can be up to 60% larger. It is estimated that 46,000 posts are vacant across the system[45].

EXHIBIT 4.1



1 Population in 2014: patients in "Public sector" defined as public sector dependent population
2 Health professionals registered with applicable professional councils minus workers in the public sector
SOURCE: South African Health Review 2013/14, HST; HST Health Indicators; WHO - Bulletin of the World Health Organization: *"Bridging the gap in South Africa"* - Volume 88, Number 11, November 2010, 797–876

OPERATION PHAKISA

In addition, the skills that are available in public HRH are in many cases insufficient. In a study performed by HST, on average less than half of the managers were able to calculate ratios and interpret graphs that would empower them for better administration of the facilities[46]. Continuous training is largely neglected. In the

[43]Patients in "public sector" are defined as the public sector dependent population. Health Systems Trust – South African Health Review 2013/2014

[44]National Health Facilities Baseline Audit 2012

[45] National Treasury: Vulindlela Persal analysis

[46]HST – HSR Unit and Change Management Group: Review of structures, competencies and training interventions to strengthen district management in the National Health System, Byveld S, R Haynes and R Bhana, 2008

same study, nearly half of the managers interviewed had not attended a training session in the past five years.

Finally, satisfaction among HRH is very low as shown by the fact that over 40% of South African health workers are actively seeking other employment[47].

In this context the Lab team has come up with several aspirations, which will ensure optimal HRH in PHC facilities. These are set out in the following section.

ASPIRATIONS

In view of the above challenges, the overarching aspiration for the HRH work stream is to ensure, by 2018/19, an equitable distribution of well-trained health workers with the required capabilities that will deliver professional, efficient, effective and cost-effective care. This aspiration can be further broken down into three main pillars:

- **Match supply to demand.** To ensure that South Africa has "the right skills in the right place" by 2018/19 – and to provide an equitable distribution of health workers to attend to the existing burden of disease – the distribution of existing resources will be optimised to ensure there are no understaffed or overstaffed facilities. The productivity of clinical workers will also be increased, and partners' efforts coordinated.
- **Increase capabilities and skills.** Critical missing capabilities will be identified and addressed, both for clinical and non-clinical workers, to ensure that by 2018/19 the optimal set of skills is available to deliver the required services effectively.
- **Provide incentives and promote positive behaviours to increase satisfaction.** The public PHC will be transformed into an employer of choice, by improving working conditions and through specific HRH initiatives (for example, empowering managers, training non-clinical staff and redistributing staff to lower workloads, etc.). This will result in increased staff satisfaction, improved retention rates and the attraction of experienced employees.

Overall, the results of achieving these aspirations should mean that no patient goes home unattended due to a lack of staff, that no employee feels that going the extra mile is not worthwhile, that all workers are engaged and ready to perform at their best and that no clinical professional is overburdened with administrative tasks.

The Lab team identified the issues which are in the way of achieving these aspirations. These are discussed in the next section.

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[47] Blaaw, Global Health Action, 2013

ISSUES TO BE ADDRESSED

Before the aspirations set by the HRH work stream can be achieved, the Lab team began by identifying those issues that contribute to the lack of sufficiently skilled resources in South Africa's PHC facilities. The issues identified relate to the mismatch between supply and demand for services, the lack of capabilities and skills and poor incentives and behaviour. Each of these will now be considered.

South Africa suffers from a relevant mismatch between the demand for PHC services and the supply of HRH. While 82% of the population is mainly dependent on public health, only 30% of health professionals offer their services in public facilities.

Several root causes are worsening this situation. Firstly, the distribution of resources does not match the needs. In 2012, the National Health Facilities Baseline Audit found that 80% of facilities are either under or overstaffed, as a result of HR not adequately considering front line inputs in their planning.

Secondly, there is too slow a lag in filling vacant posts; the 2012 Audit estimated that 46,000 posts are vacant. However, not even the available and budgeted for posts are filled rapidly, as this takes an average of 4.5 months[48].

Finally, the pipeline of current and future HRH is not well balanced. Health and clinical studies graduates are not being produced in sufficient numbers (for example, only 1,200 doctors graduate each year, which equates to around 2.2 medical graduates per 100,000 inhabitants[49]). There is also a mismatch of capabilities due to the lack of co-coordination with the education sector. The result is an over-production of certain health worker categories to the detriment of others[50]. It also leads to an imbalance in the system with professionals performing below their level of practice. This represents an opportunity cost for applicants to the NDoH, as well as potential duplication of efforts.

In relation to capabilities and skills, the work stream found that, in general, preparation is lacking on the right topics at the right time. For example, many health workers abandoned rural areas a result of their lack of training to work in under-served areas. Orientation and induction are not systematically provided when people are deployed to facilities. In general, FMs are considerably underprepared to perform to the requirements of their posts.

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[48] Department of Public Service and Administration

[49] In 2011, the OECD average for medical graduates per 100,000 of the population was 10.6. OECD Health Statistics 2011

[50] A relevant example concerns the numbers of pharmacists and pharmacy assistants. The fact that the number of pharmacy support personnel registered in South Africa is less than the number of pharmacists implies that pharmacists still have to spend considerable parts of their working hours performing tasks suited for the assistants. SAPC, Pharmacy Human Resources in South Africa (2011)

In relation to incentives and behaviour, employees in the public health system are profoundly dissatisfied, exacerbating the general lack of sufficient resources, and contributing to the low performance of the systems. There is no attractive value proposition for staff to join PHC facilities. This includes inadequacy of financial incentives, lack of flexibility in the profession and lack of career progression opportunities. There is, however, also a lack of communication on the relevance of the profession and insufficient role-modelling from senior management. In addition to that, the system is not able to promote desired behaviours. There is no sense of accountability across all levels (which leads to employees engaging in moonlighting, as happens with 35% of nurses[51]), especially in ensuring a healthy and safe working environment for the health workers as well as a safe environment for the community. The impact of not promoting the desired behaviours translates directly into worse patient experience and poorer clinical outcomes.

In the light of these issues, several initiatives have been proposed to overcome them and to achieve the aspirations set out above. These initiatives are considered in the next section.

INITIATIVES

The HRH work stream has proposed nine initiatives to deal with the challenges and achieve the aspirations discussed in the previous sections. These are:

- Redistribution of staff
- Task shifting and sharing (amending job descriptions)
- Contract clinical staff from the private sector
- "Bring back" South Africa's health professionals to the public sector
- Ensure facilities have the minimum numbers of essential non-clinical staff
- Develop more effective community service policy and practices to supply more clinical practitioners to rural areas
- Lean and effective recruitment process
- Empower FMs to support scale-up to the Ideal Clinic
- Enhance non-clinical staff competencies in front-line customer-care services

Each of these initiatives will now be considered in turn.

Initiative 1: Redistribution of staff

The objective behind this initiative is to initiate a process to improve the distribution of employees, by reassigning them from overstaffed to understaffed facilities within

[51] Bhengu et al, Exploring Critical Care Nurses Experiences Regarding Moonlighting, 2010

the same province. Currently there are an estimated 46,000 vacancies as identified through the Vulindlela PERSAL analysis from National Treasury. However, this shortage could be alleviated through the redistribution of personnel from overstaffed to understaffed facilities[52].

The starting point for this initiative would be the implementation of WISN nationwide so there is a real assessment of the 3,507 PHC facilities in 2015. This analysis should be completed with an estimation of the cost as a result of the number of employees that could be potentially redistributed, and the financial package offer to them.

The NDoH should develop a policy on the redistribution of staff to provide for the preference of employees. Consideration should, moreover, be given to ensure that no one is unfairly discriminated against when implementing these recruitment practices. Once the assessment and policy are finalised, the provinces should engage affected employees and organised labour to ensure that all labour relations matters related to the movement of staff are addressed on an annual basis, starting with the 2015/16 financial period.

Initiative 2: Task shifting and sharing (amending job descriptions)

The objective behind this initiative is to eliminate inconsistency across job profiles, skills requirements and roles and responsibilities, and to define the scope of accountability.

Specific activities will start with a review and assessment of the current job descriptions of district managers, sub-district managers, financial managers, FMs, community outreach teams, data capturers[53], mid-level workers and clinical associates by March 2015. The establishment of job descriptions[54] and job evaluations using the equate system and competency assessments for each staff category will be done by the NDoH in partnership with the Department of Public Service and Administration (DPSA) by March 2015.

Identification of gaps in the current workforce and job loads, identified through the use of the WISN as the basis for motivating for task shifting, will be conducted by the NDoH in the 2015/16 financial year. This will inform task sharing and shifting to provide health care that could be delegated to ward-based outreach teams, administration that could be delegated to clerks and data capturers and management functions that could be delegated to other team players.

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[52] WISNassessment; WISN User's manual, Dec. 2010, accessed at:http://www.who.int/hrh/resources/wisn_user_manual/en/

[53] Data capturers can also manage queues through new technologies and manage the appointment system with SMS confirmations and reminders of appointments.

[54] Alternately described as “job profiles” or “job content”

Advocacy for task shifting and sharing should be facilitated through agreement with organised labour, the DPSA and the NDoH to ensure alignment with remuneration and conditions of employment benefits.

Training and individual in-service capacity development within the group to whom new tasks have been transferred will be delivered in partnership with the National School of Government (NSG), the NDoH, nursing colleges, universities and regional training centres, with effect from 1 April 2016.

Initiative 3: Contract clinical staff from the private sector

The objective behind this initiative is to increase the number of health care professionals in public PHC by contracting private sector workers. Of the health care professionals practicing in South Africa, 82% are outside the public sector. This means that up to 65,000 nurses, 12,000 doctors, 9,000 specialists and 9,000 pharmacists[55] could potentially be contracted to provide services in public PHC facilities.

The Lab team proposed starting this initiative by fast tracking the existing programme being initiated by the NDoH and assisted by the Foundation for Professional Development to contract general practitioners[56]. This will help to define best practices within the first year of implementation of the Ideal Clinic initiative 2015-2016, and subsequently to develop a strategy for other health professionals.

The DoH Legal Services Unit will have to optimise contracting guidelines (including standardising fees and consultation hours) and form partnerships with developmental partners.

This initiative will contribute to reducing the overall shortage of health care professionals in the public sector.

Initiative 4: "Bring back" South Africa's health professionals to the public sector

The objective of this initiative is to bring thousands of doctors and professional nurses back into public health care (either on a part time or full time basis) – as well as pharmacists, dentists, pharmacy assistants, dental therapists and physiotherapy assistants. The initiative will target the more than 12,000 South African doctors and nearly 7,000 South African nurses abroad. The initiative will also target retired nurses and pharmacists. In addition, the initiative will also target the 65,000 nurses,

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55 Calculated as professional registered with SANC, HPCSA, SAPC but not included in the PERSAL system

56 FPD, Broadreach, Africa placements, Right to Care, Aurum institute, Wits, Reproductive Health

12,000 doctors and 9,000 pharmacists who are active professionals outside the public sector[57], as already noted.

It is recommended that the NDoH set up a Bring Back Our Professionals Campaign task team. This team will drive the campaign, and will include representatives of the NDoH, provincial health departments, other departments, organised labour and civil society partners. A clear two-pronged communication and marketing strategy will be developed in partnership with GCIS, the IMC, DIRCO and the Presidency. One part of the campaign should focus on the international market and another internally on attracting health professionals in the private sector and retired health professionals. For the international component, the campaign should leverage the pre-existing services of BrandSA, the IMC and the Home Coming Revolution to craft a compelling message to South African professionals abroad.

To support the initiative, the NDoH and provincial health departments will need to put in place a series of incentives to encourage professionals to return to the sector. These incentives should include revised financial incentives, following the example of other countries that offer salary increases to those who switch to the family practice track (namely, Turkey). Another incentive that should be included is flexible and more attractive working arrangements, including part-time work for those outside the health system (e.g., retired or professionals employed outside of health), increased training opportunities, dedicated research time, and protocols that allow work in other private and public sector facilities. Finally, there should be improved management of doctors, including improved performance management and career development systems.

Initiative 5: Ensure facilities have minimum numbers of essential non-clinical staff

This initiative focuses on non-clinical staff, and its objective is to ensure that all facilities have minimum numbers by 2018/19. Today, South Africa's PHC services face a series of staff shortfalls. Across the 3,507 clinics, there are currently some 46,000 vacancies. The personnel shortfall per clinic ranges from 3% to 84%[58]. The challenge is as serious among non-clinical staff as it is among clinical staff. For example, 21% of clinics in 2012 had no manager, 79% of clinics had no information management staff and 84% of clinics had no pharmacist or assistant. The lack of support staff is a huge burden for clinical professionals; this has implications for the functioning of the clinics and the motivation of professionals (who end up performing tasks that are not meaningful to them or for which they are not qualified).

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[57] Professionals registered with SANC, HPCSA or SAPC, but not included in the PERSAL system

[58] Lab team analysis based on results from WISN pilot

Current gaps in non-clinical staff have been estimated using available data sources[59] but a detailed WISN assessment in all facilities is recommended to calculate exact needs.

This initiative focuses on four key categories of staff. As regards FMs, the minimum requirement is one for each larger facility, with smaller facilities able to share one manager. It is estimated that, to meet this requirement, up to 740 additional managers(or 21% of the total need) would need to be appointed. For pharmacist assistants, the minimum requirement is one pharmacist assistant or pharmacy technician per clinic. To meet this requirement, an additional 2,950 members of staff (84% of the total need) would need to be appointed. For data capturers, the minimum requirement is one data capturer per clinic. To meet this requirement, an additional 2,800 staff (79% of the total need) would need to be appointed. Finally, the minimum requirement is three security officers and one cleaner per clinic. To meet this requirement, 14,000 staff would be required. Most of the currently employed cleaners and security officers are outsourced hence the number of staff to be appointed in case of full in-sourcing would be approximately 14,000.

To ensure these minimum requirements are met, it is proposed that the following steps are taken. It will be necessary to clean up the PERSAL financial tool database and link it with the Department of Home Affairs to have more accurate figures over the current clinics staffing (e.g., ensuring deceased are not counting as active staff). It will also be necessary to determine accurate staffing requirements according to the WISN assessment. One will also have to identify and cost any vacant posts in the clinics. Finally, funding must be requested from Treasury for the additional posts.

An initiative in the NDoH to enhance security services in all public sector facilities is already on-going and it is thus suggested that these two initiatives be linked.

Initiative 6: Develop more effective community service policy and practices to supply more clinical practitioners to rural areas

The objective behind this initiative is to improve the equitable distribution of community service practitioners. The South African Health Review identified the uneven distribution of service professionals with a disparity of up to 46% in the number of community service professionals between provinces[60]. It is to be noted that some provinces receive fewer community service professionals than others despite having a lower ratio of medical doctors per 100,000 inhabitants.

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[59] Nationwide PHC needs for cadres with defined WISN ratios extrapolated on the basis of available information on headcount and opening hours for 3,093 facilities; lack of staff based on National Baseline Audit, assumed homogeneous throughout clinics; gap to current delivery model according to lack of staff and estimated PHC needs

[60] South African Health Review 2013/14

The HRH work stream proposed a series of initiatives to reduce this gap. First of all, policy implementation should be reviewed when budgeting for community service posts to prioritise under-served areas and to create more placement posts in these areas. Secondly, the Lab team proposes the incorporation of incentives in the current policy to motivate community service professionals in under-served areas to accept a permanent position. The Lab team further proposes an evaluation of possible transport subsidy, Wi-Fi/internet, flexi-hours, training and conferences (amongst other things). It is also suggested that focus groups be used to better understand which conditions would lead to community service professionals accepting permanent positions in under-served areas.

Initiative 7: Lean and effective recruitment process

The objective behind this initiative is to streamline the recruitment process down to three months and to standardise ownership of the process at district level. The aim here is to ensure that experienced employees and graduating students are hired. The gap in the number of human resources is partly due to the fact that funded posts currently take an average of four-and-a-half months to be filled.

The policy framework should ensure the decentralisation of HRH recruitment to FMs. This policy should provide for the use of different approaches, for advertising of positions, for the interviewing of identified candidates via the use of IT and tele-communication systems and for communicating the commencement date.

Initiative 8: Empower FMs to support the scale-up to the Ideal Clinic

The objective of this initiative is to empower FMs by delegating to them general management, HR and financial management functions; and to provide them with training in integrated health management. The Lab team developed a strong view that such decentralisation of authority is a prerequisite for the successful scale-up of the Ideal Clinic.

Decentralising powers to FMs can result in speedier processes, particularly for HR. Delegation to FMs will need to be formalised through a policy on the new PHC management structure that provides for delegations of management issues to operational managers (clinic heads). Also required for this are amendments to the current sub-district and district management system to ensure the existence of all necessary sub-districts.

To empower FMs, a peer network will need to be put in place to enable them to share best practices and provide them with a network to discuss common issues. A pre-condition for empowerment is to ensure that FMs receive structured training and coaching to strengthen their capacity. This training should focus on four competencies: SCM, financial management, HR and staff management and stakeholder management. A trained manager will in turn be able to train their team

to improve patient experience in the clinic. The training could be delivered through various platforms, including mobile and online training, in-person training or on-the-job training. Much of this training will form part of the Ideal Clinic accelerator package.

Initiative 9: Enhance non-clinical staff competencies in front-line customer-care services

The objective of this initiative is for the NDoH to identify training courses for customer care and emergency triage to improve patients' safety, patient experience and the efficiency of patient care, paving the way for a "health awareness" culture in the country.

The NDoH should identify the non-clinical staff essential for the improvement of patient experience. The target group here will include security guards, groundsmen, queue marshals, administrative clerks, data capturers and all other staff with category levels ranging from level one to five (numbering some 31,600 members).

Basic health and customer-focused training will be provided to these front-line workers of the PHC, creating a ripple effect among several spheres of influence. First, individual health workers' awareness will be raised on health issues, improving their understanding of how the pieces of the puzzle fit together. They will also develop a sense of responsibility leading to the delivery of a better service. Staff will benefit from enhanced coordination between clinical and non-clinical staff, driving productivity increases through fast-tracking. Facilities themselves will be better placed to improve their approach to addressing the burden of disease, contributing to enhanced patient experiences. Finally, the community will also benefit from increased levels of awareness. Newly-trained staff will be in a position to recognise signs of alarm or emergency, as well as promote healthier lifestyles. The NDoH should work with the NSG and other training service providers in the different provinces, to standardise and implement the training within the 2015/16 financial year. Districts will enrol the target group for the training, establish quarterly training schedules and conduct continuous coaching and mentoring of the trained staff. Districts will determine the schedules of training for all target workers to ensure that this does not disrupt service delivery.

Districts will also be required to monitor improved customer care at the clinics to demonstrate the effectiveness of the training. Improved customer care will be validated by improved patient experience and productivity indicators for the efficient triage of patients.

PROPOSED KEY PERFORMANCE INDICATORS

Table 4.1contains a sample of KPIs for the HRH work stream. The full list of proposed KPIs, including suggested reporting frequency, sources of baseline and

supporting documentation, is available in the Lab's Excel templates output on KPIs. These KPIs will require final syndication with all relevant stakeholders during the implementation phase.

Table 4.1: KPI selection for the HRH workstream

			Cumulative target (March of the year)					
Initiative	**KPI description**	**Base-line**	**2015**	**2016**	**2017**	**2018**	**2019**	**KPI Owner**
Reallocation of staff	% of understaffed facilities	40%	30%	20%	10%	0%	0%	National WISN Coordinators, NDoH
	% of overstaffed facilities	40%	30%	20%	10%	0%	0%	National WISN Coordinators, NDoH
	% of facilities with reviewed job descriptions	0%	50%	100%				NDoH
Task sharing/shifting	% of non-clinical staff identified for task shifting/ sharing opportunities	0%	50%	100%				NDoH
	% of clinical staff identified for task shifting/ sharing opportunities	0%	50%	100%				NDoH
	Number of clinics with assigned typology	0%	50%	100%				NDoH
	Number of clinics with revised organograms	0%	50%	100%				NDoH
Contracting	% of health care workers accepting the contractual conditions	0%	80%	80%	80%	80%	80%	CEO FPD and Consortium Partners, Deputy Director-General (DDG) Primary Health
	% of health care workers reached by contracting campaign	0%	25%	50%	75%	100%	100%	CEO Foundation for Professional Development (FPD)and Consortium Partners, DDG Primary Health

Table 4.1 (continued): KPI selection for the HRH work stream

			Cumulative target (March of the year)					
Initiative	**KPI description**	**Base-line**	**2015**	**2016**	**2017**	**2018**	**2019**	**KPI Owner**
Contracting (continued)	Number of general practitioners contracted	0	400	625	625			CEO FPD and Consortium Partners, DDG Primary Health
	Number of doctors/10,000 population	3.7	4	4.5	5	6	7	DDG Primary Health, NDoH
	Number of pharmacist's assistants/10,000 population	0.22	0.8	2	3	4	5	DDG Primary Health, NDoH
"Bring back" our professionals	Number of doctors abroad brought back	12,136	0	275	734	1,376	1,835	NDoH
	Number of nurses abroad brought back	6,844	0	150	400	750	1,000	NDoH
	Number of retired nurses	6,679	0	81	216	405	540	NDoH
	Number of retired pharmacists	1,702	0	100	220	382	532	NDoH
Non-negotiables	% of non-negotiable vacant posts not funded posts for FMs	TBD*		0%	0%	0%	0%	NDoH

**Data unavailable during Lab*

Table 4.1 (continued): KPI selection for the HRH work stream

			Cumulative target (March of the year)					
Initiative	**KPI description**	**Base-line**	**2015**	**2016**	**2017**	**2018**	**2019**	**KPI Owner**
Streamlining processes	Average number of days taken to appoint an employee	140	60	60	60	60	60	Head of HR of the province, PDoHs
	Percentage of facilities with access to either a copy of new recruitment policy or intranet policy	0	79%	21%	100%	100%	100%	Heads of M&E of the province, PDoHs
	Percentage of facilities implementing IT recruitment system	0	79%	21%	100%	100%	100%	FMs, districts and sub-districts
	Number of FMs trained on IT recruitment system	0	2,865	642	0	0	0	FMs, districts and sub-districts
Empowering managers	Number of empowered managers (i.e., trained on all topics and with decentralised responsibilities)	0%	25%	50%	75%	100%		NDoH
Up-skilling of non-clinical workers	% of security guards trained	0%	25%	50%	75%	100%		NDoH
	% of groundsmen trained	0%	25%	50%	75%	100%		NDoH
	% of queue marshals trained	0%	25%	50%	75%	100%		NDoH
	% of administrative clerks trained	0%	25%	50%	75%	100%		NDoH
	% of data capturers trained	0%	25%	50%	75%	100%		NDoH

Chapter 5: Financial Management

SUMMARY

The aspiration set by the Financial Management work stream was to achieve a realistic budgeting process that creates an accurate forecast of the funding required by different facilities to provide the PHC package, adherence to budget and improved accountability. The work stream set the following targets:

- Achieve equitable funding, with no more than 10% discrepancy between spend per uninsured capita between districts
- Limit accruals to under 2% in 95% of districts
- Keep discrepancies between budget and actual to under 5% in 95% of districts
- Decrease unauthorised expenditure by 80%
- Achieve an unqualified audit in 100% of provinces

For an equitable and adequate budget to become reality and be adhered to, the Financial Management work stream identified four **initiatives**:

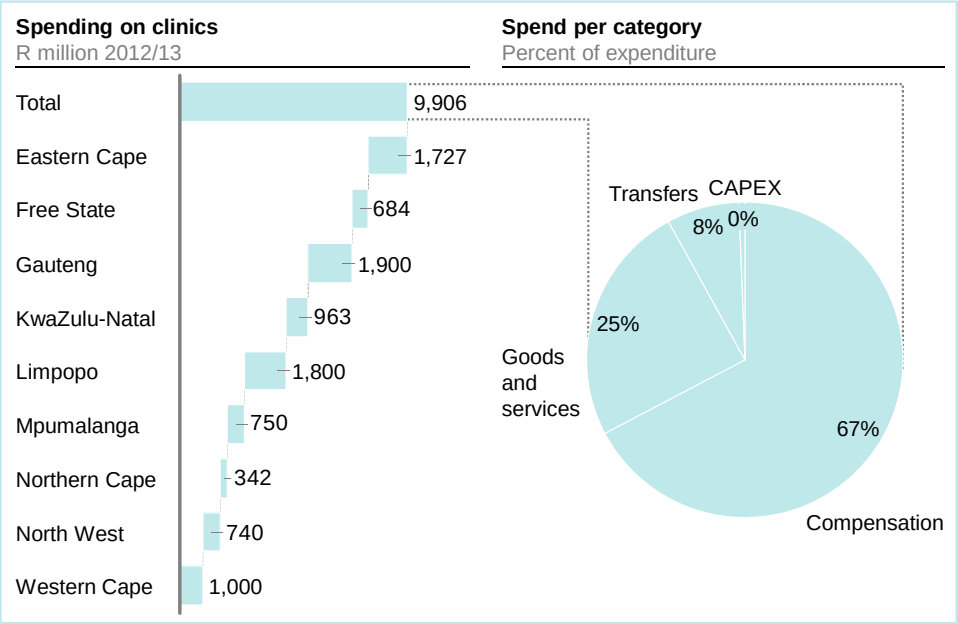
- Move to an equitable and activity-based budgeting process.
- Include FMs in the budgeting process.
- Align planning and budgeting cycle to ensure funding of new directives.
- Enforce adherence to national directive on the funding of “non-negotiables” such as medicines and vaccines

These initiatives will impact positively on the delivery of good quality healthcare, through the more equitable allocation of funds, improved payment of suppliers with subsequent improved availability of supplies and services, along with a clean audit.

CONTEXTAND CASE FOR CHANGE

Finances are among the most important resources of health services. Financial resource allocation for district health services is a key input that enables districts to render health services to improve health status. Total spending on clinics was almost R10 billion in 2012/2013 (Exhibit 5.1).

EXHIBIT 5.1



SOURCE: Vulindlela report, 2012/13

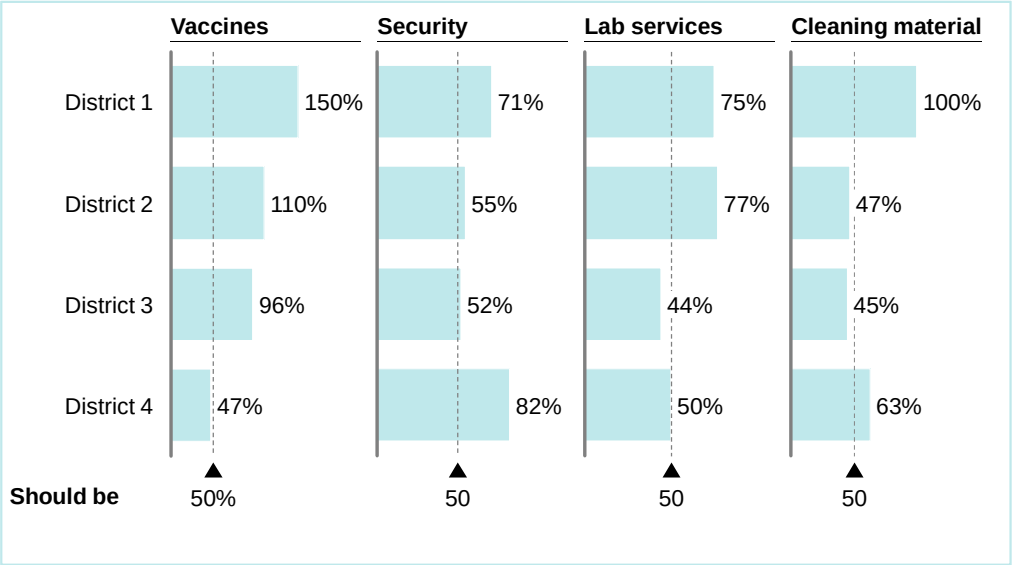
There are currently several significant challenges in financial management in South Africa's PHC services. Financial management is intended to occur through a process of quarterly reviews of expenditure against budget, but districts have limited mechanisms to manage over- and under-expenditure, except for reallocating funds between budget line items. Reallocation between facility budget lines sometimes takes place without consulting the affected FM.

While districts conduct an annual budgeting process, including District Health Expenditure Reviews (DHER) linked to the development of District Health Plans (DHPs), generally FMs have no control over or even visibility on their budgets. Currently, allocations are made on the basis of historical-based budgeting rather than on the budget needs presented by the facility and districts.

It is against this backdrop that provinces, districts and facilities start to experience cash flow problems long before the end of the year. This leads to the absence of key equipment, services and supplies at the clinics, which results in sub-standard care. Districts across provinces frequently spend over 100% of their budget in the first half of the financial year (Exhibit 5.2), and allocations across districts seem to be random and inequitable (Exhibit 5.3).

EXHIBIT 5.2

Percent of budget already spent 6 months into the year

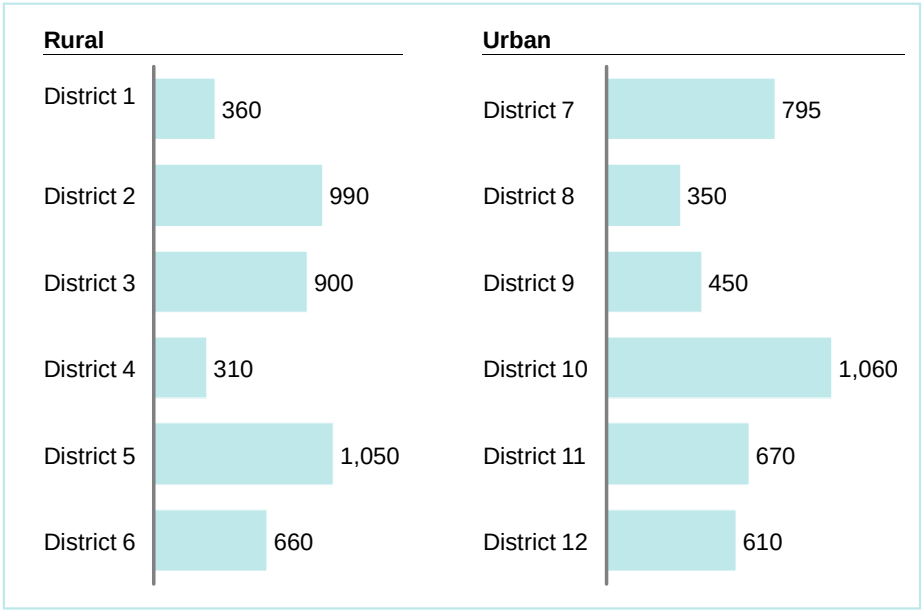


SOURCE: Vulindlela report, 30 September 2014; selected sample

OPERATION PHAKISA

EXHIBIT 5.3

R primary health spending per uninsured capita



SOURCE: DHER; selected sample

OPERATION PHAKISA

Analysing the current budgeting process, a picture emerges of a process with serious challenges. Budgets are based on the previous year's expenditure without provision for accruals, which means that up to 10% of each budget is spent on accruals in the first month of the financial year, without having budgeted for these.

Similarly, the Lab team has found that budgets are consistently increased with below-inflation percentages (in 2014, pharmaceuticals inflation in Gauteng was 24% while the budget in the same year only increased by 10%)[61], and unauthorised spending is subtracted from the following year's budget without planning for unauthorised spending in the next year. An historical budget which underestimates inflation and ignores accruals when forecasting expenditure and takes previous year's costs (accruals and irregular expenditure) out of the current year's budget cannot possibly be used as a realistic management tool.

With budgets not made to be a realistic forecast, districts and clinics often opt for unauthorised and irregular expenditure. In the light of these challenges, the Financial Management work stream has arrived at several aspirations towards the achievement of the Ideal Clinic, as set out in the following section.

ASPIRATIONS

The work stream aspires to achieve a realistic budgeting process that constitutes an accurate forecast of the funding required by different facilities to provide the PHC package and ensure adherence to budget and improved accountability, within the following targets:

- Achieve equitable funding with no more than a 10% discrepancy between spend per uninsured capita between districts.
- Limit accruals to below2% in 95% of districts.
- Keep discrepancies between budgeted and actual spending to under 5% in 95% of districts.
- Decrease unauthorised expenditure by 80%.
- Realise an unqualified audit in 100% of provinces.

To achieve these aspirations and targets, the work stream has arrived at several initiatives, which will be considered in the next section.

[61] Allocation (black book) Gauteng and notes for price increase 2014

INITIATIVES

For an equitable and adequate budget to become reality and for this to be adhered to, the Financial Management work stream has identified four initiatives, as follows:

- Move to an equitable and activity-based budgeting process.
- Include FMs in the budgeting process.
- Align planning and budgeting cycle to ensure funding of new directives.
- Enforce adherence to national directive on the funding of “non-negotiables” such as medicines and vaccines.

These initiatives will impact positively on the delivery of good quality health care, through the more equitable allocation of funds, improved payment of suppliers with subsequent improved availability of supplies and services, along with a clean audit.

The initiatives will now be considered in detail.

Initiative 1: Move to an equitable and activity-based budgeting process

Activity-based budgeting is a complex and resource-intensive process. It will, however, lead to significant cost savings, since FMs will need to justify budgeting for each line item based on the clinical activity of the facility. More importantly, activity-based budgeting will lead to equity across the country, using the same cost drivers and corresponding price guidelines for all facilities, and matching budgets to the services provided by the facility. Finally, the new process will lead to improved adherence to the budget, with FMs feeling more ownership over the budget that they themselves have helped to construct and justify.

Key target dates for this initiative include developing an activity-based budgetary model for sub-district managers by 2016; training these managers to use the model during 2016-17; and designating clinics as cost centres in 2017-18.

Initiative 2: Include FMs in the budgeting process

Currently, FMs’ involvement in the budgeting process is very limited or inexistent. FMs should be included in the budgeting process with the objective of formalising their participation. Including the FM in the budgeting process is an important element for successful activity-based budgeting, and will increase ownership of and adherence to the budget at clinic level.

The Lab looked at the budgeting process and suggested the following touch points (Exhibit 5.4):

- **Submit data** – Every year, between April and May, the FM submits financial and non-financial data into district DHER, providing a real perspective of what has happened during the previous financial cycle.

- **Set next year's goals based on data** – During the elaboration of the Departmental budget proposals (July-August), joint analysis is undertaken of the DHER outcomes, including setting the following year's district priorities and allocations).
- **Collaborative re-prioritisation** – Finally, after finalisation of the budget, there will be a collaborative re-prioritisation of resources (for example, HR shifts).

EXHIBIT 5.4

The Lab also proposed several actions to be completed in 2015to facilitate participation of FMs in the planning and budget process. First, a number of key frameworks should be designed – for performance agreements for FMs, collaborative prioritisation meetings and joint analysis of the DHER. Second, a handbook should be written for a provincial FMs' forum, and forum organisers appointed in each district. Third, financial management should be included in the FM training plan (see Initiative 8 in Chapter 4 on empowering FMs).Once the first FMs' forum has taken place, feedback should be collected and the playbook optimised. Finally, an expenditure report should be made a standing item in clinic committee meetings.

Initiative 3: Align planning and budgeting cycle to ensure funding of new directives

The implementation of new initiatives without these being funded creates serious disruptions in financial management across the PHC. To avoid unfunded directives, the work stream proposed a combination of leadership pledges and Treasury control mechanisms, together with a process to align the planning and budgeting

cycles. In particular, the work stream proposed the introduction of the following actions by 2016:

- Ministers, provincial Premiers and Members of the Executive Council (MECs) commit to a "**Strong Leadership Pledge**", reading:"I commit to present to National Treasury, in May of every year, a consolidated, integrated plan and budget proposals on the Ideal Clinic and non-emergency directives going forward".
- A **Treasury instruction note** is issued – within the Public Finance Management Act (PFMA)– describing how new directives should be costed and funded.
- **Conditional grant allocation** is decentralised to the PHC level.

Once these reforms are implemented, new directives will be accommodated only through formal amendments to DHP objectives, based on the actual resources allocated. Explicit exceptions for emergency directives (for example, the Ebola response) will need to be included in both the proposed pledge and the Treasury instruction note.

Initiative 4: Enforce adherence to national directive on the funding of "non-negotiables" such as medicines and vaccines

Failure to ring-fence certain funds results in a suspension of services which are critical to patients. Non-negotiables are a carefully composed list of supplies and services critical to the PHC package, including infection control and cleaning; medical supplies (including dry dispensary); medicines; children's vaccines; TB and HIV/AIDS treatment; medical waste; laboratory services; blood supply and services; food services and relevant supplies; security services; and laundry services. These funds are ring-fenced as per the resolutions of the National Health Council. Essential equipment and maintenance of equipment should also be ring-fenced, as should infrastructure maintenance.

The aim of the ring-fencing initiative is to strengthen the implementation of the National Health Council (NHC) resolution on the ring-fencing of non-negotiables, eliminating the shifting of funds away from non-negotiable elements completely by 2018, through the following measures:

- New guidelines will instruct CFOs to enforce a policy stating that the budget office is not allowed to shift funds away from non-negotiables during the financial year.
- A directive will ensure that the sub-district managers approve facility shifts only *within* non-negotiables or *to* non-negotiables.
- Shifting of funding will be incorporated into financial delegations.
- FMs' access to funds will be limited to the appropriate cost centre.

Shifting of funds during the financial year is inevitable, and an important part of sound financial management; however, ring-fencing ensures that funds can only be shifted to or within non-negotiables, but never away from them.

PROPOSED KEY PERFORMANCE INDICATORS

Table 5.1contains a sample of KPIs for the Financial Management work stream. The full list of proposed KPIs, including suggested reporting frequency, sources of baseline and supporting documentation, is available in the Lab's Excel templates output on KPIs. These KPIs will require final syndication with all relevant stakeholders during the implementation phase.

Table 5.1:KPI selection for the Financial Management work stream

			Cumulative target (March of the year)					
Initiative	KPI description	Base-line	2015	2016	2017	2018	2019	KPI Owner
Move to equitable and activity-based budgeting	Number of Provincial Treasuries allocating 28% of equitable share for Health services.	6			7	8	9	Provincial CFOs
	Percentage deviation in budget allocation on funding model	0%	1%	2%	3%	4%	5%	Provincial CFOs
	Percentage of clinics designated as cost centres	12%	20%	40%	60%	80%	100%	Provincial CFOs
	Percentage of facilities attaining 80% performance on National Core Standards	0%	20%	40%	60%	80%	100%	District manager
	Percentage of PHC facilities in deprived districts with additional 2.5%budget allocation	0%	20%	40%	60%	80%	100%	District manager/ Provincial CFO
Include FMs in budgeting	Percentage of PHC facilities submitting monthly expenditure reports	New	20%	40%	60%	80%	100%	Facility/sub-district manager
	Percentage of facilities submitting verified data to DHER	0%	20%	40%	60%	80%	95%	FMs
	Percentage of clinic committees with expenditure report as standing item on their agenda	0%	20%	40%	60%	80%	100%	FMs
	Percentage of FMs submitting costed budget inputs	0%	30%	60%	100%	100%	100%	FM/sub-district manager
	Percentage of PHC facilities compliant to internal control checklist	0%	20%	40%	60%	80%	100%	FMs
Align planning and budgeting cycles	Percentage of NDoH and provinces complying with the Instruction Note on unfunded mandates/directives	0	2	4	6	8	9 and NDoH	HOD/DGs, NDoH

Chapter 6: Supply Chain Management

SUMMARY

The Supply Chain Management (SCM) workstream focused on fulfilment of the following principles:

- Full availability of essential supplies
- Low-cost procurement
- Minimal work burden to the clinics
- Speedy delivery of non-standard items

This workstream set the **aspirations** of: improving access to Standard Stock Items (SSIs) and medical supplies; procuring SSIs, medical supplies and standard services at low cost; creating world-class SCM that will reduce the work burden for clinics, increase speed with quick turnaround of and Non-Standard Stock Items (NSSIs) and speed up requisition and reconciliation.

With these aspirations, the following **targets** were set:

- To achieve 100% continuous availability of medical supplies and SSIs in all clinics
- To reduce the costs of procurement and distribution by 10%
- To lower the work burden at clinic level, no longer requiring demand forecasting from the FMs, and providing visibility on delivery times to the FMs
- To speed up the turn-around time of NSSIs, with real time reconciliation of every requisition against budget

The SCM workstream identified four critical **initiatives**:

- Standardised catalogue for supplies and services
- Improved contract management through transversal contracts to capture procurement savings
- Sound demand forecasting to push standard supplies to clinics
- Rationalised distribution through direct delivery, cross-docks and warehouses

CONTEXT AND CASE FOR CHANGE

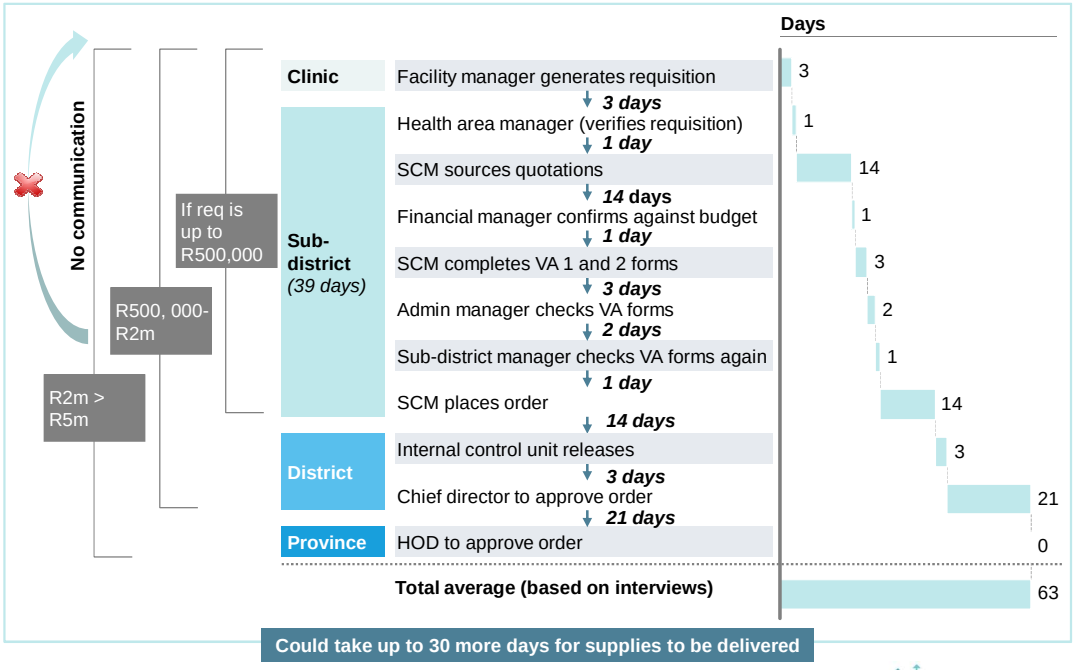
The Supply Chain Management (SCM) work stream considers that effective SCM would enable full availability of essential supplies, low-cost procurement, minimal work burden to the clinics and speedy delivery of non-standard items.

Currently, medical and non-medical supplies and services are regularly unavailable at clinic level, FMs spend a significant amount of their time on SCM duties, procurement is often out of contract and distribution is slow and wasteful. The non-availability or shortage of both Standard Stock Items (SSI) and Non-Standard Stock

Items (NSSI) in PHC facilities has become a major challenge and one which has had a negative impact on service delivery and the quality of care that facilities can provide. The outdated and complicated distribution system leads to enormous losses of approximately R145 million a year from goods that are damaged, lost or expired. It also leads to the lock up of enormous value in the stock levels that are needed, with an inventory of around R1.3 billion kept in stock. Distribution to clinics is slow, with an average turnaround time to clinics after requisition of 18 days. Requisition from clinics can take up to 63 days to be approved (Exhibit 6.1). Prices for non-negotiable supplies vary widely; for example, the medication Citalopram is sometimes purchases for over 12 times the contract price.

EXHIBIT 6.1

Process of requisition of non-medical, non-standard items



SOURCE: Lab analysis, questionnaire

The Lab team also found that the delegation of SCM duties varies widely. Interviews with clinics around the country indicate wide discrepancies between spending delegation: some districts allow discretionary spending at clinic level within the PFMA framework, while other facilities are forced to rely on SCM support over 200 km away.

Lab team members identified the key issues of the broken SCM system within health. The team summarised the root causes as being the lack of proper demand planning; an inadequate SCM support function for PHC facilities; the lack of rational procurement delegations; and the inadequacy of transversal contracts on all NSSIs

and SSIs. The work stream aims to improve the situation with the aspirations and targets set out in the following section.

ASPIRATIONS

In the face of these issues, the work stream aspires to improve access to SSIs and medical supplies, procure low cost SSI, medical supplies and standard services, create world-class SCM that will reduce the work burden for clinics and increase turnaround speed of NSSIs and speed-up requisition and reconciliation.

With these aspirations, the Lab team set the following targets:

- Achieve 100% continuous availability of medical supplies and SSIs in all clinics.
- Reduce the costs of procurement and distribution by 10%.
- Lower the work burden at clinic level, no longer requiring demand forecasting from the FMs, and providing visibility on delivery times to the FMs.
- Speed up the turn-around time of NSSIs, with real time reconciliation of every requisition against budget.

INITIATIVES

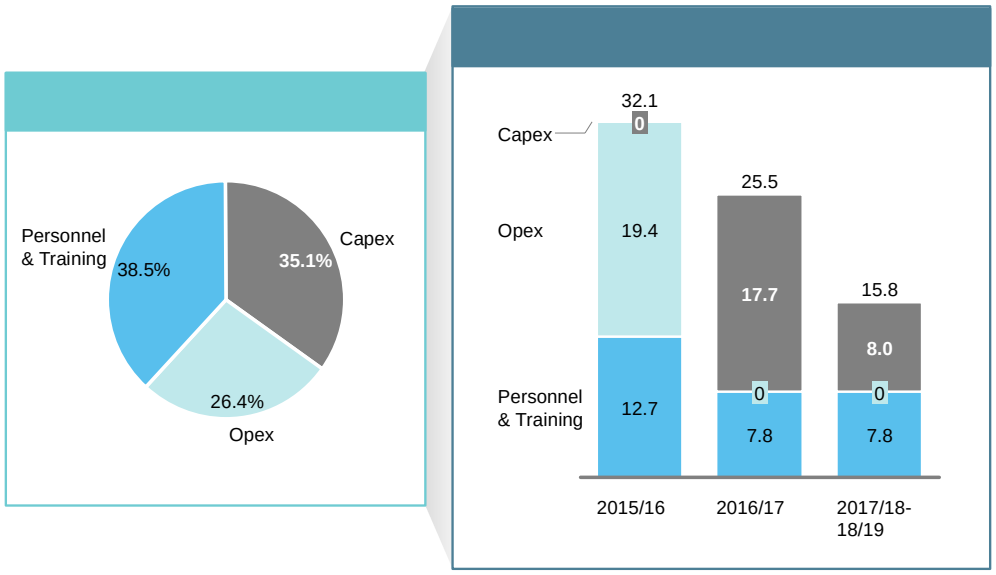
Based on the issues identified and the aspirations evolved by the Lab team, several solutions were considered. Among these, the SCM work stream prioritised four critical initiatives to address the unavailability of NSSIs and SSIs in PHC facilities and create a world-class PHC supply chain that will mean significant savings. These are:

- Standardised catalogue for supplies and services
- Improved contract management through transversal contracts to capture procurement savings
- Sound demand forecasting to push standard supplies to clinics
- Rationalised distribution through direct delivery, cross-docks and warehouses

Exhibit 6.2 provides an overview of the total budget required for implementing the SCM initiatives proposed by the SCM work stream.

Budget overview – SCM

Total budget
R million



Each of these initiatives will now be considered in detail.

Initiative 1: Standardised catalogue for supplies and services

The basic cornerstone of the SCM will be to have a standardised procurement catalogue in all PHC facilities that describes the specifications and price of NSSIs and SSIs for the Ideal Clinic. This requires the creation of a master catalogue of all NSSIs and SSIs that can be procured by clinics. The catalogue will be led by a national committee, with provincial representatives including pharmacists, clinicians and finance and commodity experts. The catalogue will by no means be a static list – suppliers, minimum specifications, prices and items on the list must be reviewed at least annually. The catalogue will also include sub-catalogues tailored to the specific needs of clinics that function differently or which are of different size and geography. Finally and critically, each item in the catalogue needs to be codified and included in clinic-level mobile requisition tools, so that the FM is able to request from a set list, instead of each facility ordering different brands against different prices and specifications.

In assessing the feasibility and need for a national catalogue, evidence reveals that few provincial departments currently have standardised catalogues, notably the KwaZulu-Natal, Mpumalanga and Northwest Departments of Health. Where they do exist, however, catalogues do not always adequately set out specifications and regulate the maximum price for commodities.

Implementation of this initiative will begin with a communiqué sent to all provinces requesting submissions on the NSSIs and SSIs Procurement Catalogue in order to benchmark available standards. In the next instance, a catalogue specification committee will be established. Market research on the final list of NSSIs and SSIs will then be conducted and minimum specifications and maximum prices for all NSSIs set. Finally, a draft catalogue will be submitted for approval.

Initiative 2: Improved contract management through transversal contracts to capture procurement savings

The objective of this initiative is to ensure savings in the procurement of NSSIs and SSIs by engaging in transversal supplier contracts for all supplies. Although these "umbrella contracts" reside at provincial or national level, district warehouses and facilities can procure within their context from local vendors.

The SCM stream seeks to improve contract management by upholding and supporting best SCM practices, including fairness, healthy competition, value for money, equity and high-level transparency. An analysis was conducted on the availability of transversal contracts at both national and provincial level. The outcome, which is based on selected samples in various provinces, clearly shows that a number of provinces procure SSIs and NSSIs on a quotation basis: this compromises the reliability of supply and value for money. The work stream strongly recommends the establishment of transversal contracts at a national and provincial level to achieve the reliability of supplies at a facility level.

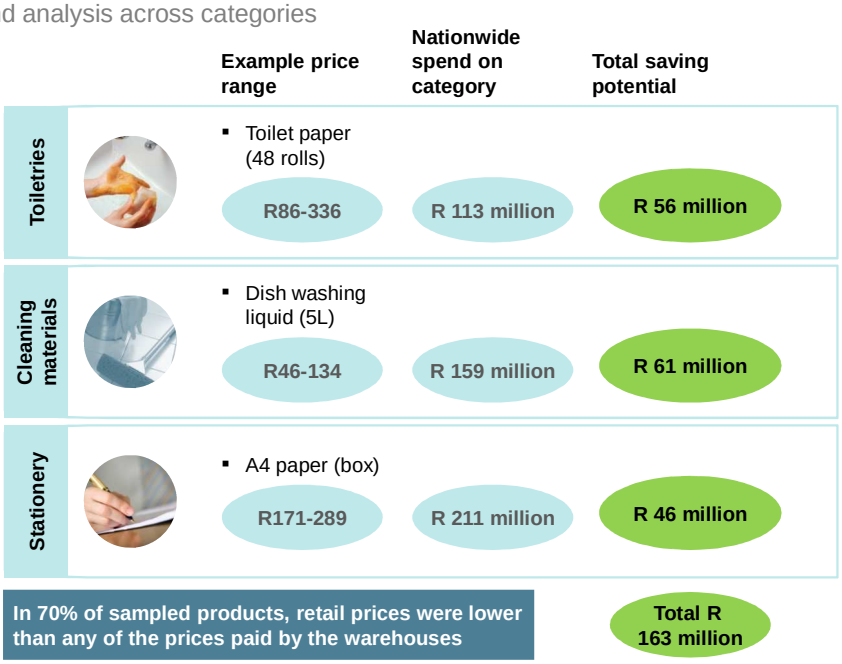
An initial spend analysis indicates that this contracting and standardisation of procurement could lead to significant savings. Today it is evident that without apparent reason, different warehouses pay vastly different prices for identical commodity items such as toilet paper or dish washing liquid. Furthermore, the Lab team found that in 70% of sampled products, the warehouses pay prices higher than even non-negotiated retail prices. The impact of this initiative would mean an annual savings from non-medical supplies of R163 million in just three expenditure categories, as shown in Exhibit 6.3.

Encouraging better adherence to pharmaceutical contracts will capture further procurement savings – the Lab team has found that warehouses buying out of contract pay on average 3.3 times as much for pharmaceuticals, with extremes of up to 22 times as much.

To implement this initiative a contract management unit (known as a Sector-Wide Procurement Unit)will be established at provincial level. Different contracts through which goods and services can be procured will then be developed. Finally, it will be necessary to ensure that FMs have SCM delegations for certain goods and services.

EXHIBIT 6.3

Spend analysis across categories



SOURCE: Lab analysis, questionnaire across 3 provinces

OPERATION PHAKISA

Initiative 3: Sound demand forecasting to push standard supplies to clinics

The objective of this initiative is to move from a reactive to a proactive supply chain – introducing a "push" system of supplies to the clinics. This initiative requires a stock management solution to monitor and forecast clinic supply demand, based on collected clinic data, to avoid stock shortfalls.

Currently, there is no visibility on stock levels at the clinics, and FMs are often too caught up in clinical duties to do careful demand forecasting or predict stock-outs. The Lab team proposes an innovative system that will create full visibility on clinic stock levels, making it possible to push the exact supplies the clinic needs to the clinic on a weekly basis. At the clinic, they will simply bar-code-scan stock levels on a weekly basis, which will then automatically be uploaded to a demand forecasting unit at district level. The clinic will then be replenished with the exact amount consumed the previous week. With the clinic stock data, the Lab team believes the unit can also do more sophisticated demand forecasting, for example predicting increased consumption at a clinic based on seasonal or population growth patterns. This initiative will reduce the work burden at the clinic, and at the same time guarantee optimal stock levels tailored to each clinic. To implement this initiative it

will be necessary to develop a standardised demand management framework per category of product. An electronic inventory management system will also be needed; this must be defined and then implemented. Finally, Procurement Units must be established at district level. The Lab team recommends that the forecasting packages and capabilities already available on the market should be leveraged as much as possible, while the coordination of demand forecasting should be kept in house.

Initiative 4: Rationalised distribution through direct delivery, cross-docks and warehouses

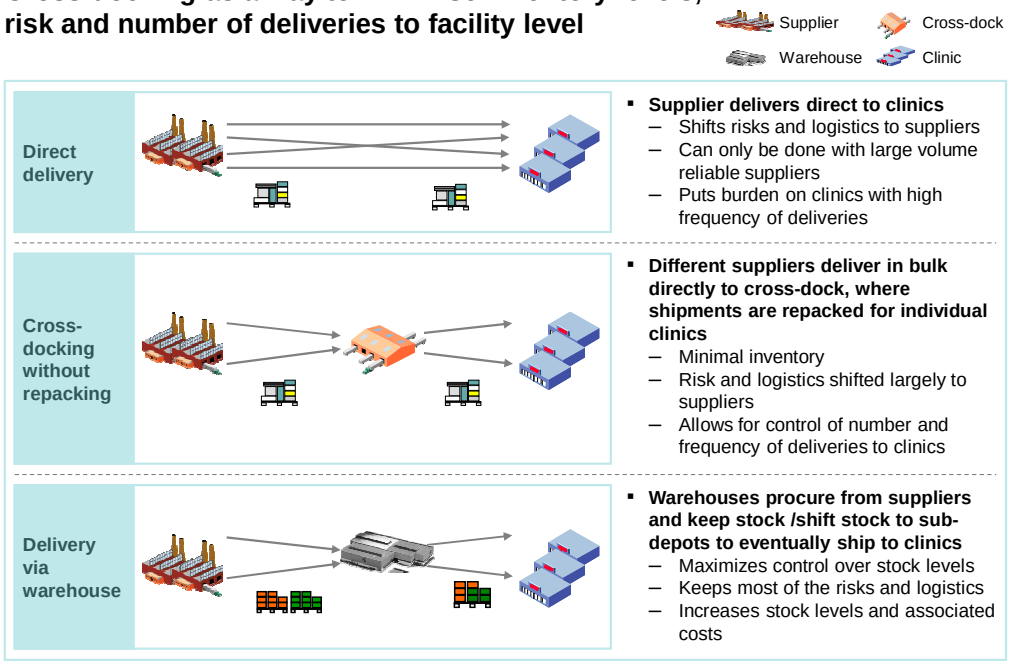
The objective of this initiative is to avoid waste and stock-outs at warehouses by achieving a more effective distribution network that is responsive and economical. The Lab team proposes to change distribution radically, shifting most of the risk and costs of logistics to the private sector by supplying clinics through “cross-docks” or direct supplier delivery.

The Lab team found that although direct supplier delivery may be the preferred model to supply facilities, few clinics are actually in a position to receive the many individual deliveries that this model requires, as the vast majority do not have the SCM capabilities in house to receive the inbound supplies. Other clinics may be in a rural locality where reliable direct delivery cannot be guaranteed. The “cross-dock” model, however, captures most of the advantages of direct delivery (for example, no inventory is held, and the risk of distribution is shifted to the private sector) while consolidating and keeping control of facilities’ inbound logistics. In this model, all suppliers deliver directly to a warehouse that does not keep stock, but merely rearranges the supplies to transport to individual clinics. Stock may spend as little as one day in this type of warehouse, called a cross-dock.

Exhibit 6.4 illustrates how various cross-docking systems can minimise inventory levels and lower the risk and the number of deliveries to facilities.

EXHIBIT 6.4

Cross-docking as a way to minimise inventory levels, risk and number of deliveries to facility level



An initial geo-analysis suggests that by converting the current 10 warehouses to cross-docks, it will be possible to ensure reliable supply to 50% of all clinics. This calculation assumes that vendors are able to guarantee a three-day turnaround to a cross-dock location, and clinics need to be within a 150 km radius of the cross-dock that will supply the facilities on a weekly basis. By expanding the geo-analysis, the Lab team found that by outsourcing to a further six private sector cross-docks, services can be expanded to 80% of all clinics. If two more cross-docks are built in a strategic location, the reach will extend to 90% of all clinics. The remaining 10% of clinics can be served by the same 18 cross-docks with bi-weekly instead of weekly deliveries.

This initiative assumes that it will be possible to close down all current sub-depots (around 250 of them), which would lead to significant cost savings and the freeing up of around 90 pharmacists and around 200 pharmacist assistants for clinical duty, facing patients.

The impact of this initiative would be an annual saving of R116.3 million, a one-time capital release of R724 million and significantly greater availability of pharmacists to clinics.

In implementing this initiative, key milestones will be: reduced supply chain costs, an improved “one time in full” service and forecast able supply chain cost. The first step in implementation would be to analyse private sector “reach” (i.e., how many clinics can be serviced through the private sector by direct deliveries). Each and

every clinic must also be analysed for its capacity to receive direct deliveries as well as regarding its storage capacity. A network optimisation study must be undertaken to determine cross-dock/depot locations. The distribution model must then be categorised according to each clinic's geographical location. Nominated Delivery Days must also be agreed (i.e., how often deliveries are made). A track and trace IT system with visibility to clinics must also be implemented. A request for proposal per province/district distribution must then be developed. A costing model must be developed and reviewed for the direct delivery distribution. It will also be necessary to analyse and determine whether cross-dock locations will be served through current DoH facilities or through the private sector. Finally, the implications of warehouse closures and conversions must be considered (i.e., whether it is done by public works or another agency).

PROPOSED KEY PERFORMANCE INDICATORS

Table 6.1contains a sample of KPIs for SCM proposed by the Lab work stream. The full list of proposed KPIs, including suggested reporting frequency, sources of baseline and supporting documentation, is available in the Lab's Excel templates output on KPIs. These KPIs will require final syndication with all relevant stakeholders during the implementation phase.

Table 6.1: KPI selection for the Supply Chain Management work stream

			Cumulative target (March of the year)					
Initiative	**KPI description**	**Base-line**	**2015**	**2016**	**2017**	**2018**	**2019**	**KPI Owner**
Overall KPIs	Turnaround time for procurement of NSSIs per province/district	42 days	30 days	21 days	11 days	11 days	11 days	CFO, NDoH
Demand forecasting	Percentage of clinics with demand forecast aligned with the budget	None	10%	50%	80%	90%	100%	District manager, district
	Percentage of clinics within districts with electronic inventory management	None	10%	60%	90%	95%	100%	District manager, district
	Percentage of clinics per district receiving medicine and SSIs through a push system and NSSIs through the sub-district procurement unit	None	0%	50%	75%	80%	90%	District manager, district
	Percentage of clinics per district with medicine availability visible	None	15%	60%	90%	100%	100%	District manager, district
	Percentage of clinic orders per district for non-standard stock items not processed through the sub-district procurement unit	100%	90%	50%	10%	5%	5%	District manager, district
	Percentage availability of non-negotiable SSIs per facility	85%	85%	85%	85%	85%	85%	FM, facility
	Percentage availability of medicine items per facility	90%	90%	90%	90%	90%	90%	FM, facility

Table 6.1 (continued): KPI selection for the Supply Chain Management work stream

			Cumulative target (March of the year)					
Initiative	KPI description	Base-line	2015	2016	2017	2018	2019	KPI Owner
Distribution	Percentage of all clinics (with the capacity -staffing, storage space, receiving area and geographical location) who are receiving deliveries of medicines and SSIs directly from suppliers	5%	25%	50%	75%	85%		Chief Director NDoH Sector Wide Procurement Unit (SWPU), DoH
	Percentage of all clinics where all medicine supplies are still supplied exclusively from a warehouse/depot	95%	75%	50%	25%	15%		District Manager, DoH
	Percentage of all clinics receiving all supplies through a cross-docking facility	0	10%	15%	25%	50%		Chief Director NDoHS WPU, DoH
	Distribution costs as a percentage of value of goods supplied to all facilities in the district	5%	5%	5%	4%	4%	4%	FM, DoH
	Percentage of orders delivered on scheduled date	50%	80%	90%	90%	90%	90%	DM, DoH
	Percentage of facilities able to track progress of all procurements	0	0%	10%	25%	40%	50%	DMPU, Chief Director NDoHSWPU
Catalogue	Percentage of SSIs and NSSIs procured included in the national catalogue	0	10	10	10	10	10	CFO, NDoH
	Number of SSIs and NSSIs not covered in contracts for which maximum prices have been determined not more than 12 months ago	0	1	1	1	1	1	CFO, NDoH
Contracting	Number of provinces with established functional SWPU	0	0	9	9	9	9	Head of national SWPU, NDoH
	Percentage of high-spending goods and services for which contracts have been awarded	0	0	40%	80%	100%	100%	Head of SWPUs, PDoH and NDoH

Chapter 7: Institutional Arrangements

SUMMARY

Responsibility for health services in South Africa is overlapping and complex.

This workstream set the **aspiration** to build effective institutional arrangements and mechanisms to realise and maintain the Ideal Clinic. Its targets in this regard were to ensure:

- Agreement on norms regarding the quality of service delivery and the implementation of national health policies by provinces
- Measurement and monitoring of adherence to such norms
- Effective use of political and administrative oversight structures
- Functioning intersectoral structures(intersectoral, intergovernmental and interdepartmental)
- Consequence management by leadership if targets of signed intergovernmental agreements are not met
- Public accountability at all levels for the quality of service delivery
- The establishment of District Health Committees (DHCos) to bring together representatives of clinic committees and hospital boards with other government departments at implementation level to coordinate efforts at addressing the social determinants of health
- Enhanced ethical conduct
- Delegation of authority to the lowest possible level of management
- The establishment of governance structures at all spheres of government to provide effective oversight

The Institutional Arrangements workstream identified four **initiatives**:

- Consistently implement national policies.
- Bring provincialisation to completion.
- Improve public accountability and transparency by establishing PHCos, DHCos and committees in all provinces.
- Increase responsiveness at the point of service delivery through review and implementation of standardised delegations to the lowest possible level of management.

CONTEXTAND CASE FOR CHANGE

Responsibility for health care services in South Africa is overlapping and complex. At the highest level, health care services are a matter of consensual decision making between national and provincial governments, pursuant to the terms of Schedule 4 (Part A) of the Constitution of South Africa. Notwithstanding this and the fact that resolutions may be reached by agreement at the NHC, these are not

always implemented at provincial level; this results in an inconsistent implementation of national policies. Moreover, while publicly accountable for the quality of service delivery at clinics, the Minister does not have direct executive authority over the provincial health departments to ensure this. When decisions that are taken at the NHC level, on a consensus basis, are not implemented at sub-national level, there are, significantly, no consequences. This impacts health care service delivery, and manifests in inequities and competing priorities across different provinces.

Though the competency for health care services rests at both national and provincial level, some municipalities are also involved in providing certain PHC services. Schedule 4 (Part B) of the constitution also indicates that municipal health services are the competency of local government. Municipal health services, meanwhile, are defined in the National Health Act (NHA) (No 61 of 2003) as a basket of environmental health services that includes the monitoring of water quality, food control, waste management, health surveillance of premises, surveillance and prevention of communicable diseases (excluding immunisation), vector control, environmental pollution control, disposal of the dead and chemical safety, but excluding port health, malaria control and the control of hazardous substances.

The Minister of Health, as the custodian of health and health care services, is, moreover, accountable for the operations of the health sector, as mandated by the NHA of 2004, including national and sub-national successes and failures in health. MECs and Members of the Mayoral Committees (MMCs) for health are supposed to be equally responsible and accountable. MECs and MMCs responsible for health are accountable to the Provincial Legislatures and Municipal Councils, respectively.

In the face of these different government levels of involvement in health services, the Intergovernmental Relations Framework Act of 2005 (IGRFA) provides for the establishment of structures to encourage and enhance cooperative governance. These structures are outlined in the NHA as the NHC, Provincial Health Councils (PHCos) and District Health Councils (DHCs). The NHA further provides for the roles and functions of DHCs to be enacted in the Provincial Health Acts; these do not, however, exist in some provinces at the moment.

Community participation and involvement is one of the key principles of the PHC approach. The NHA of 2004 provides for the establishment of governance structures to enhance interaction between the department and citizens. The absence and dysfunction of these structures has stifled the attainment of this ideal, however, resulting in a lack of buy-in by communities in health initiatives.

On a broader level, the World Health Organisation (WHO) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This implies that there are other determinants of health in the social environment, and that health cannot be improved by intervention within the

formal health sector alone. Other sectors, equally important in promoting the health and self-reliance of communities, include agriculture, education, communication, housing, public works, rural development, industry and community organisations. Thus intersectoral collaboration in addressing these challenges is a necessity. In the light of this and related needs, the work stream has several aspirations to improve PHC, as set out in the following section.

ASPIRATIONS

The work stream aspiration is to build effective institutional arrangements and mechanisms to realise and maintain the Ideal Clinic. In creating this enabling environment the Lab team further aspires towards a health system that has clear, functional intergovernmental relationships, within the ambit of the existing legislation. To this end, the team aspires to have clearly defined roles and responsibilities for each sphere of government in the health sector to ensure collective (horizontal and vertical) intergovernmental accountability and collaboration, both political and administrative. The target here is to have agreements in line with the NHA of 2004 and IGRFA to be drawn up between the different spheres of government to give effect to unitary health care via an Ideal Clinic. This work stream also aspires to support the development of comprehensive and detailed agreed-upon minimum norms and standards for the quality of service at health care facilities, as well as process norms where necessary.

Endeavours will be made to have functional NHCs, PHCos and DHCs, collectively implementing national guidelines, norms, standards and health policies for the delivery of quality health services, by ensuring that each province has a Provincial Health Act aligned to the NHA. In 2005 the NHC took the decision to provincialise all personal PHC services, in the interest of bringing the services under one authority, the province, and consolidating the services until 2015 when the decision would be reviewed. The decision was accepted and endorsed by PHCos and other relevant bodies. The Lab team therefore also has the aspiration to ensure that this process of provincialisation is completed.

The targets set by the Lab team to achieve these aspirations are to ensure that:

- There is agreement on norms regarding the quality of service delivery and the implementation of national health policies by provinces.
- Measurement and monitoring of adherence to such norms takes place.
- There is effective use of political and administrative oversight structures.
- There are functioning intersectoral, intergovernmental and interdepartmental structures.
- Consequence management takes place by leadership where the targets of signed intergovernmental agreements are not met.

- There is public accountability at all levels for the quality of service delivery.
- District Health Committees (DHCos) are established to bring together representatives of clinic committees and hospital boards with other government departments to coordinate efforts at addressing the social determinants of health.
- Ethical conduct is enhanced.
- Authority is delegated to the lowest possible level of management.
- Governance structures are established at all spheres of government to provide effective oversight.

Finally, the Lab team will explore mechanisms for improving cooperation and implementation of policy directives for the Ideal Clinic.

Note that the team has concluded that a constitutional amendment is not practical and has instead thus chosen to work only within current legislation to strengthen accountability and governance.

Before the above aspirations can be met, the implementation of various initiatives will be necessary to overcome significant issues which at the moment stand in their way. These issues will be examined in the following section.

ISSUES IDENTIFIED

As the intergovernmental landscape has evolved over the past two decades, managing concurrent functions has become challenging for national departments. This leads to service delivery challenges, which are further exacerbated at the local level by various issues. These will be considered under the following sub-headings.

Norms and standards

While provinces must manage their health functions within national legal and policy frameworks, there is uneven implementation of these frameworks, and decisions are not always implemented at the sub-national level. The development of agreed norms and standards will enhance a more consistent implementation of national policy.

Concurrent legislative competence results in a disparity between standards of service, a failure to realise and deliver the required standard of performance for ICRM, and poor monitoring of accountability, ethics and governance, with government officials subsequently acting with impunity.

Considering how this issue has been dealt with previously, norms and standards for municipal health services were published in February 2013. In addition, the Department of Basic Education negotiated norms and standards with civil society,

which resulted in a more cooperative manner of holding the department accountable for the delivery of text books.

Roles and responsibilities of health councils, clinic health committees and hospital boards

Clinic health committees, hospital boards and health councils are intended to act as a link between communities and health services and to provide a conduit for dealing with the health needs and aspirations of the community, represented at various local, districts, provincial and national levels. Provincial, district and other health committees do not currently exist in all provinces. Where these do exist, they are often not effective (for example, they neither liaise effectively between the community and clinics nor with the MEC and higher levels of government). There is a need to put a coordinating mechanism in place to ensure greater cooperation at grassroots level.

The impact of this issue is that the lack of understanding of the different roles and responsibilities by health committees affects their functioning, and limits the performance of clinics when status determination towards ICRM is done. Poor functioning also results in a lack of liaison between the community and clinics for information sharing and feedback, thus limiting support for establishing and sustaining the Ideal Clinic. Poor functioning also leads to poor coordination of health issues at the local and district level. It also means poor community participation in clinic matters leading to limited accountability. In addition, there is limited or no advice to the DHC and PHCos on issues of governance.

Intersectoral collaboration

The Minister is held publicly accountable for the quality of service delivery at clinics, but does not have direct executive authority over the provincial health departments to ensure this quality, because health service delivery is a concurrent function between national and provincial government: Schedule 4 of the Constitution. While provinces must manage the health function within national legal and policy frameworks, experience has shown that there is uneven implementation of these frameworks and agreed-to decisions are not always implemented at sub-national level. Intersectoral collaboration is required to address the social determinants of health, but this is not currently taking place sufficiently.

The failure to complete the provincialisation process as per the NHC resolution of 2005 has meant that the planned consolidation of services under a single government authority, the province, has not happened, with duplication and fragmentation of health care services persisting. A lack of vertical accountability across departments has resulted in a failure of provinces to implement NHC resolutions. For example, the Western Cape has declined to implement the PHC reengineering stream of NHI piloting (Draft APP 2015/16 of WCG DoH), and they

are resistant to a takeover of central hospitals by the NDoH[62]. In addition, intersectoral collaboration is required to address the social determinants of health but this is not currently taking place sufficiently. There should thus be agreements between the DoH and departments in other sectors for the effective delivery of health care services.

The impact of weak vertical accountability between provincial and local government spheres will result in the slow roll-out of ICRM. Meanwhile, the weak horizontal accountability between departments leads to inefficiency in dealing with the social determinants of health.

A model for interdepartmental and intergovernmental collaboration may be found in operation Sukuma Sakhe, which was implemented in the province of KwaZulu-Natal.

Priority setting

The different needs and agendas of the different spheres of government result in competing priorities which in turn has resulted in a number of other challenges that have constrained the successful delivery of PHC services. These challenges include poor intergovernmental collaboration and different budgeting cycles for the different spheres of government. Other challenges include inconsistency in management capacity, which negatively influences the capacity to delivery consistently on priorities. Finally, there are differences in staffing levels and staffing costs, as well as differences in conditions of services for staff.

Delegation of authority

Delegation of authority means entrusting authority and powers downwards from the highest to the lowest possible level. Delegated responsibilities can cascade from province to district to sub-district down to institutional level. Delegation relates to HR, SCM and financial management. In the process of delegation, powers are given to HODs by the Executive Authority (i.e., MECs) and further by one of the HODs to the district office or district hospitals. The threshold of delegation, however, is different in different provinces and there is, currently, an uneven delegation of powers across the different provinces. In some cases, delegation is to the district level, while others limit delegations to provincial offices. No province delegates down to the PHC facility level.

The lack of delegation results in an inability of lower levels of managers to initiate interventions timeously and to take accountability. In addition, there is no

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[62] *DA will fight transfer of hospitals,* IOL News, 22 Jan 2013 and *Cape Health Boss warns hospital takeover*, Business Day Live, 21Jan 2013

standardisation of delegations across provinces, districts, sub-districts and health establishments. The empowerment of provincial and district management would enable prompt and effective decision making, and encourage innovation that will improve patients' experience of health service delivery.

As an example of this issue being dealt with, where services are managed by municipalities, especially the metropolitan municipalities, authority is delegated to the FMs, where they are able to manage their own budget, albeit on a limited scale, to good effect.

These issues were considered by the Lab team in arriving at several initiatives for implementation. These initiatives will be considered in the next section.

INITIATIVES

Two options were explored by the Lab team to address the issues identified above. On the one hand, one could give the Minister of Health the authority to accompany the political responsibility. This would involve making health a national function (removing it from Schedule 4 and removing ambulance services from Schedule 5of the Constitution). However, to do so would be politically controversial and it could take a long time. There are both pros and cons to this option, and it would take a political decision to pursue it. The option has not been pursued due to the risk of political fallout and the tedious nature of the process to realise it.

On the other hand, there is scope to make better use of existing Constitutional provisions for intergovernmental cooperation, and there is thus a need to utilise intergovernmental cooperation structures more effectively to ensure more consistent implementation of national legal and policy frameworks. This option, relying on the existing constitution and legislation, has been found to provide sufficient room for facilitating effective intergovernmental cooperation. In this context, four initiatives are recommended by the Institutional Arrangements work stream for more effective utilisation of intergovernmental cooperation structures. These are:

- Consistently implement national policies.
- Bring provincialisation to completion.
- Improve public accountability and transparency by establishing PHCos, DHCos and committees.
- Increase responsiveness at the point of service delivery through review and implementation of standardised delegations to the lowest possible level of management.

Each of these initiatives will now be considered in turn.

Initiative 1: Consistently implement national policies

This initiative seeks to establish institutional arrangements where leadership in all three spheres of government will mutually account for the competencies constitutionally bestowed upon them. This mutual accountability will be enhanced through the development of negotiated norms and standards which will inform agreements to be signed between all such leaders. This initiative consists of a focus on the development of comprehensive and agreed-upon norms and standards; intergovernmental agreements signed by premiers and MECs, based on those norms; and reporting on and adherence to those norms to be monitored, along with public accountability.

This same arrangement will be extended to manage the relationship within the NDoH at all levels, as well as between the DoH and other sector departments, in terms of how health services are to be provided.

While some of the issues may currently be catered for in various policies, the coordination and implementation of these is not well structured, and responsibility for who leads and ensures implementation is not clear. Also, the Constitution and the IGRFA allow for cooperative governance but do not set a framework for mutual accountability.

The institutionalisation of the operation of the Sukuma Sakhe model in KwaZulu-Natal is a progressive step in bringing government departments (at both provincial and local levels) together jointly to plan and deliver services in consultation and with the involvement of the communities they serve. This helps to ensure more comprehensive and effective service delivery.

Under this initiative, intergovernmental agreements should include agreed upon norms and standards, the packages of services to be delivered, the process for implementation of the package of services, performance indicators, an internal accounting framework as well as a framework for accounting to the public, incentives/consequences management and provision for the oversight of health service delivery.

The current arrangements are informal and not adhered to. While diagonal accountability exits in the current arrangements there is no vertical or horizontal mutual accountability. For concurrent functions, mutual accountability is vital and thus the proposed structure set out in Exhibit 7.1shows formal agreements vertically, horizontally and diagonally.

EXHIBIT 7.1

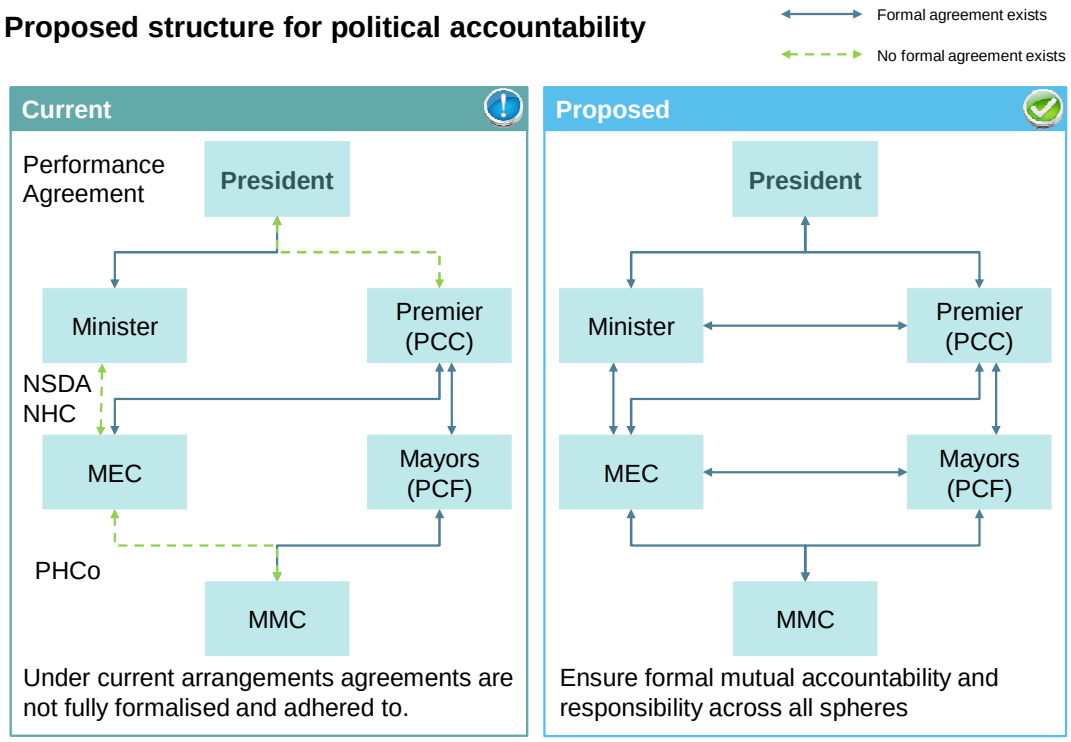
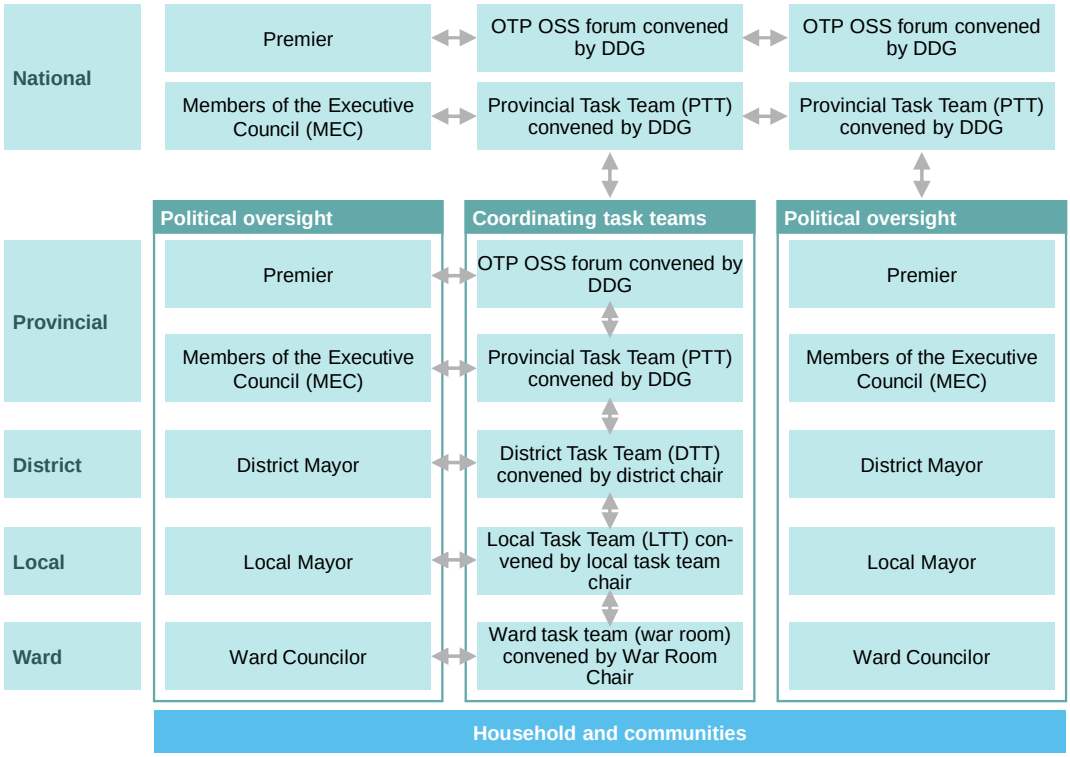


Exhibit 7.2 illustrates the proposed intersectoral collaboration of this initiative. This approach links initiatives implemented by the departments of different sectors and the various spheres of government. This means that the delivery of services will require partnership between the community, stakeholders and government. This or a similar model could be replicated at a national level and implemented across all provinces.

EXHIBIT 7.2



The challenges anticipated in setting up this initiative are resistance to signing the agreements and non-adherence to the signed agreements.

The impact of this initiative will be to have agreed upon norms for the quality of service delivery and the implementation of national health policies by provinces. There will be measurement and monitoring of adherence to those norms. There will also be effective use of political and administrative oversight structures. Intersectoral structures will be put in place that function to better address the social determinants of health. There will, further, be public accountability for the quality of service delivery at all levels of government. Ethical conduct will be enhanced. Finally, there will be improved planning and allocation of resources as well as improved health outcomes and increased coverage of health care services.

The initiative will also benefit national government. The Minister of Health will have the assurance that collective decisions on health services that are arrived at nationally will be implemented across the country. It will also guarantee that health services are delivered to similar levels of care and more equitably across the country. It will be easier to account for public resources spent on health across the country and to show how these provide equitable benefits for all citizens. This will help to provide a strong basis for bids on the national budget to treasury.

Provinces will also benefit by having the assurance that their programmes have the full backing of national and local government. This will also provide for the guarantee that all programmes collectively agreed upon are appropriately resourced for implementation across the country, and ensure that there will be no unfunded mandates.

Benefits to local government will include participation in the development of the national health agenda, and local government will have the assurance that service standards for their communities will be equitable and of a similar standard to other communities across the country.

Benefits for citizens will include the assurance that norms and standards will be implemented at all health facilities across the country, and people will know what to expect from service providers. This will also lead to an improved quality of health services and improve patients' experience of health service delivery, thereby increasing their confidence in the system. There will also be public reporting on adherence to the norms agreed upon.

Initiative 2: Bring provincialisation to completion

In 2005 the NHC took the decision to provincialise all personal PHC services. This decision was taken in the interests of bringing the services under one authority, the province, and consolidating the services until 2015 when the decision would be reviewed. The decision was accepted and endorsed by PHCos and other relevant bodies. However, only the Free State, Eastern Cape and Mpumalanga have completed the process. In the case of KwaZulu Natal and Northern Cape, the process is 88% complete. In the Western Cape, the process is 78% complete, while in the North West, the process is 70% complete, and in Gauteng, the process is only 48% complete.

Completing the process would consolidate PHC services, counteract the current lack of capacity in many municipalities to render the services and eliminate fragmentation by bringing PHC services under one management authority, the province.

It is anticipated that provincialisation will be completed by March 2016 in the case of category B municipalities. In the case of category A municipalities, signed SLAs will be in place with Metros by March 2015 as an interim resolution, pending their complete provincialisation by March 2018.

The challenges anticipated in setting up this initiative are a lack of funding for the takeover of municipality staff and assets, a reluctance of staff to change employers for fear of loss of benefits and, further, that municipalities, especially Metros, might use their assets as surety to borrow funds.

Initiative 3: Improve public accountability and transparency by establishing PHCos, DHCs and committees

The establishment of PHCos and DHCs across the provinces is uneven, resulting in limited advice to MECs on health matters. This also limits interaction between the MEC and MMCs on health matters of common interest.

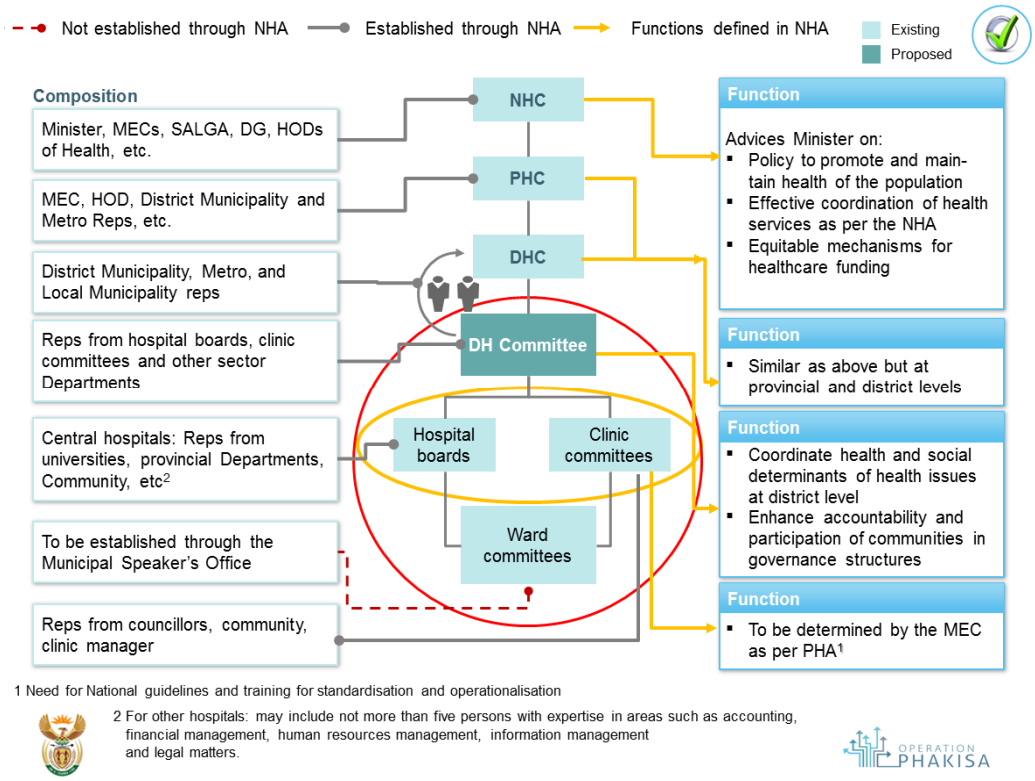
The current situation is that most of the districts have hospital boards and clinic committees that function independently, with the result that both report directly to the MEC for Health without consolidating the health issues identified by communities or health facilities. Another issue is that the two governance structures have different recognition in that the hospital boards get incentives and clinic committees do not. This creates tension and leads to the frequent resignation of clinic committees. In addition, where these committees exist they are not effective when they do not liaise effectively between the community and clinics or with the MEC and higher levels of government.

A further issue is that these governance structures have little or no interaction or linkage with other community structures, such as ward committees and local health committees, thus they may not be aware of all health-related issues in the community.

The operation of this initiative will mean that there will be ward committees and local municipal structures at the community level where community needs and social issues are discussed and interventions planned, implemented and monitored. Ward committees will be the accounting structure at the community level for both hospital boards and clinic committees. Representatives of clinic committees and hospital boards, together with other sector departments, will comprise the DHCo, where health-related matters are addressed at a district level, and which can be escalated up to the DHC and further on to the PHCo and NHC.

The proposed governance structure for this is illustrated in Exhibit 7.3.

EXHIBIT 7.3



The benefit of this initiative will be that the strengthening of and establishment of new governance structures will help to fortify liaison between the community and clinics for the purposes of information sharing and feedback, thus enhancing support for the establishment and sustainability of the Ideal Clinic. In addition, it will improve coordination of health issues at local and district level, thereby addressing needs and the social determinants of health as identified by communities. It will also facilitate and enhance community participation in clinic matters, leading to increased levels of accountability. The establishment of the proposed DHCos will ensure the coordination of health issues at district level and their communication to clinics. This proposal will strengthen the relationships between health governance structures and ward committees, as well as the departments of other sectors, which will ensure that not only health issues but the broader social determinants of health are addressed.

The challenges anticipated in setting up this initiative include resource constraints, especially where these have not previously been established and for which no budget has been planned. A lack of willingness of the community to participate, could present another challenge to be overcome. Finally, a lack of capacity on the part of community members to deal with health-related matters may be another concern.

Initiative 4: Increase responsiveness at the point of service delivery through review and implementation of standardised delegations to the lowest possible level of management

Delegated responsibilities should cascade downwards from province to district, to sub-district and down to the health facility level. Delegations can take place in relation to HR, SCM and financial management. Currently, there is no standardisation of delegations between provinces, nor within provinces from provincial level down to facility level.

In two provinces for example, the HOD is given the power by the Executive Authority (i.e., MEC) to manage all the delegations in the Department, and the HOD may further delegate down to the level of the district office or hospitals, with specific conditions attached. The delegation does not filter further down to clinics, however.

There is no standard of delegations across the clinics of the country across provinces, districts, sub-districts and health establishments. This means that lower levels of managers are unable to initiate timeous interventions and take accountability. In cases where delegations do exist, there is inadequate implementation and monitoring. According to a recent media release[63], among the many challenges that PHC faces is the lack of delegations. The indication is that districts have little money or control to do their jobs properly.

For these reasons delegations need to be rethought because they foster efficiencies and effectiveness at an operational level.

Table 7.1 sets out the envisaged system of delegations and the responsible person.

Table 7.1: System of delegations

	Delegation Management System	Responsible person
1.	Develop policies and procedures for delegation.	HOD or delegated Heads of affected areas (finance, HR and SCM)
2.	Disseminated policies and procedures to all staff and regularly review and revise them where appropriate.	Provincial CFO, HR and SCM managers
3.	Determine and approve delegations of authority and responsibility to individuals appropriately.	HOD
4.	Advise staff formally of their delegated authority limits.	CFO
5.	Review and update delegations of authority and responsibility on a timely basis.	District manager
6.	Develop internal controls to protect delegated authority.	District manager
7.	Encourage staff to report inabilities to execute the delegation of authority at any time .	FM

[63] Saturday Star, Gonzalez, 2014

This initiative has several benefits. In the first place, decisions with regards to HR, financial management and SCM will be made at the lowest level of care. In addition, there will be enhanced innovation, enhanced turnaround time for processes, higher productivity, the development of employees, the use of existing expertise and the ability to make speedy decisions. The impact of this initiative to improve the effectiveness and efficiency of health establishments and the delegation of authority to the lowest possible level of management will be to eliminate disparities in the delegations from province to province, thus ensuring uniformity. It will also empower others to make decisions independently and assume responsibility for certain tasks. It will empower provincial and district management for prompt and effective decision making and to encourage innovation. The impact of these will improve patients' experience of health service delivery.

The challenges anticipated in setting up this initiative that will need to be guarded against are abuses of trust, possible fraud, absence of proper monitoring and deviation from the core mission and objectives of the facility.

Due to the nature of this work stream no KPIs were defined, whilst activities and milestones for each initiative are defined in the "3 feet" plans as in all other work streams

Chapter 8: Scale-up and Sustainability

SUMMARY

The **aspiration** of the Scale-up and Sustainability work stream was to develop a scale-up framework and implementation plan that achieves sustainable Ideal Clinic status in all PHC facilities by 2019. Specific aspirations include:

- Developing a comprehensive plan to implement and sustain system-wide change, ensuring success of the Ideal Clinic initiative. The aim is for Ideal Clinic initiatives to be implemented fully to strengthen district health and sustain change throughout the implementation period.
- Ensuring that the the DoH and key stakeholders embrace a culture of quality service delivery. The target is for every staff member to understand what is required to implement and sustain Ideal Clinic status by mid-2015 and to subscribe to Ideal Clinic ideals.
- Improved health outcomes through transformation and maintenance of Ideal Clinic status in all PHC Facilities. The target is increased health promotion and prevention at the primary level, resulting in reduced morbidity and mortality across South Africa.

A scale-up model was developed to expand the ICRM to all 3,507 PHC facilities as an integrated part of the health system. To support this model, five specific **initiatives** were developed by the workstream:

- Development of a fully costed scale-up plan, including identification of improvements quickly achievable at clinic level
- Sustainability framework to prevent regression and to ensure that the momentum of the Ideal Clinic is sustained
- Stakeholder engagement plan to drive engagement and ensure on-going support
- Branding and communication plan to create awareness and excitement for the Ideal Clinics
- Change management plan to achieve successful transformation

CONTEXT AND CASE FOR CHANGE

The Health Act of South Africa, Act 61 of 2003, lists equity amongst the principles of district health. This means that all South Africans should receive quality health care services in line with their need. All PHC facilities should thus be similarly ideal regardless of their location.

The Ideal Clinic programme has been piloted in 10 study sites. However, a structured plan for scaling up to the 3,507 PHC facilities is required.

ASPIRATIONS

The aspiration of the Scale-up and Sustainability work stream is to develop a scale-up framework and implementation plan that achieves sustainable Ideal Clinic status in all PHC facilities by 2019. Aspirations for the results of a successful scale-up and sustainability plan are:

- Develop a comprehensive plan to implement and sustain system-wide change, ensuring success of the Ideal Clinic initiative. The aim is for the Ideal Clinic initiatives to be fully implemented to strengthen the district health system and sustain change throughout the implementation period.
- To ensure that the DoH and key stakeholders embrace a culture of quality service delivery. The target is for every staff member to understand what is required to implement and sustain Ideal Clinic status by mid-2015 and to subscribe to these ideals.
- Improved health outcomes through transformation and maintenance of Ideal Clinic status in all PHC facilities. The target is increased health promotion and prevention at the primary level in South Africa, resulting in reduced morbidity and mortality across the country.

To be able to achieve these aspirations, the work stream started by considering which potential factors could negatively impact scale-up and sustainability. The outcome of its investigation is given in the following section.

ISSUES IDENTIFIED

It has been estimated that 70% of change programmes fail because management and employees do not adopt new behaviours to support the changes[64].

In the last five years, South Africa has had many successful health transformation initiatives. These include HIV Counselling and Testing, Preventing Mother-to-Child Transmission of HIV, Nurse Initiated Management of Anti-retroviral Therapy, and the Campaign for Accelerated Reduction of Maternal Mortality in Africa. From these, the work stream has distilled the key success factors and challenges that might be faced during scale-up towards the achievement of the Ideal Clinic.

The key success factors include evidence-based planning, stakeholder engagement (including communication strategy), political leadership, governance, ownership and buy-in, dedicated resources (HR, financial management and SCM) and strong monitoring and evaluation with clear targets and outcomes.

On the other hand, the key challenges faced include poor change management, poor integration of health initiatives into existing health systems, competing

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64 Scott Keller and Colin Price, Beyond Performance: How Great Organizations Build Ultimate Competitive Advantage, 2011; McKinsey Quarterly Transformational Change survey, January 2010

priorities, launching health programmes without the necessary guidelines and toolkits, non-development of accompanying information systems during the design phase, and the poor documentation of lessons and good practices.

Having identified those success factors and risks, the Lab team highlighted several issues as most likely to present challenges to the successful scale-up and sustainability of the Ideal Clinic. These included limited stakeholder engagement, lack of a change management plan for ICRM, resistance to change, inadequate scale-up guidelines, insufficient implementation capacity, a poorly implemented accountability mechanism, no sustainability framework and a lack of continuity in political leadership.

These issues were then prioritised according to how critical they are to scale-up and sustainability and their ease of resolution. While all are found to be highly critical, some are too complex to resolve within the context of Operation Phakisa. After prioritisation, the Lab team addressed those issues that could be resolved with ease. These are set out under the following sub-headings.

Scale-up plan

The aim is to scale up the ICRM Initiative to transform 100% of PHC clinics in the 52 districts into Ideal Clinics by 2019.

Inadequacy of the scale-up guidelines would lead to a lack of direction, with disorganised and localised implementation. The lack of documentation of high-impact interventions and lessons learnt from study sites can delay the scale-up process. Other challenges that might hamper the scale-up include the fact that the health personnel is working within a changing health care environment. If the scale-up occurs without integrating it with other reforms in the health care sector (for example, with core standards), it might lead to the common challenge of having a highly vertical programme whose impact remains limited. Lack of continuity and the institutionalisation of the ICRM could hamper the scale-up process.

Sustainability

If there are no long-term plans for sustainability, the initiatives that are implemented and scaled-up will be short-lived. In the case of ICRM, sustainability is critical to ensure that there is no regression of accredited clinics and there is achievement and maintenance of new Ideal Clinic status.

Aspects that might hamper the resolution of this issue include fragmentation of the public health service delivery platform (for example, local government health services); constrained financial, human and material resources; lack of buy-in by stakeholders; and change fatigue.

Monitoring and evaluation

An accountability mechanism is crucial for the sustainability of the ICRM initiative, and currently there is no tangible evidence of any consequence management based on performance. The NDoH has received audit reports from the Auditor General for the past three years, supported by financial and non-financial performance indicators[65]. The baseline audits for all facilities conducted in 2011 by the HST and the OHSC audit reports show that about 60% of the facilities are scoring below 50% in compliance with national standards.

The experience of poor accountability mechanisms for facilities can be due to the lack of enforcement of employment contracts or of performance agreements or to the lack of enforcement of KPIs. Some of the factors contributing to poor accountability are the lack of a monitoring and evaluation framework and the lack of a programme performance management framework.

The lack of accountability mechanisms may challenge wide-scale implementation of ICRM. The challenges that might hamper resolution of this issue include not keeping accountability as a continuous focus area of concern, fragmented management on accountability issues and a lack of internalisation of monitoring and evaluation findings into performance management.

Stakeholder engagement

When stakeholder engagement is done effectively, it can produce positive outcomes. There has been no documented stakeholder engagement undertaken to date. Limited stakeholder engagement is due to limited or no stakeholder analysis, poor communication and the lack of an inclusive, integrated planning process. If stakeholder engagement is not done there will be no buy-in or ownership of the initiatives by the relevant stakeholders. This will lead to poor implementation support and delays in meeting deadlines or in achieving the desired results.

Change management

Change management is essential for the successful scale-up and sustainability of the ICRM. Currently, crisis management supersedes change management, and there are no allocated ICRM change management agents. There is some change management work done by the HST, mainly in the Change Management Model, but the full report is not yet available.

The root causes of poor change management processes are the lack of a framework for it, no culture of change management and resistance to change. Resistance to change is a result of change fatigue, lack of change agents and competing priorities.

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[65] 2011/12 and 2012/13 PFMA general report, Auditor-General of South Africa

If change is not handled appropriately or if there area lack of change management processes, the ability to change will be hampered, resistance to change will not be mitigated, lack of ownership or buy-in will emerge and the impact will not be delivered.

In the light of these issues, the Lab team arrived at several initiatives for implementation to achieve the aspirations set. These are set out in the following section.

INITIATIVES

With the issues outlined in the previous section in mind, the Lab work stream has prioritised five initiatives to tackle the issues and risks typically hampering delivery, namely:

- Development of a fully costed scale-up plan including identification of improvements quickly achievable at clinic level
- Sustainability framework to prevent regression and ensure momentum of Ideal Clinic is sustained
- Stakeholder engagement plan to drive engagement and ensure on-going support
- Branding and communication plan to create awareness and excitement for the Ideal Clinics
- Change management plan to achieve successful transformation

Initiative 1: Development of a fully costed scale-up plan including identification of improvements quickly achievable at clinic level

A scale-up model was developed to expand the ICRM to all 3,507 PHC facilities as an integrated part of the health system. The scale-up plan model is based on a set of guiding principles informing the thinking on implementation. The scaling-up of ICRM will be undertaken over a period of four years from 2015 to 2019.

In considering the scale-up plan, several approaches are possible for prioritising the facility selected. The overarching initiatives will be rolled out in different ways depending on the needs of the community and on what is being rolled out. Selection may be based, in the first place, on a geographic sample across provinces or health districts (for example, percentage of total facilities/population). Secondly, the choice could be based on workload, measured on the basis of headcount so that the busiest clinics get prioritised. Thirdly, prioritisation could be based on the disease burden of certain diseases/conditions (for example, ART or antenatal care patients). Fourthly, the selection may be based on the size of facilities, choosing a variety of small, medium and large facilities to gain insights from these prior to further roll-out at a national level. Finally, the selection may be

based on a baseline assessment of those clinics that scored highest on the core standards audit. Different timelines and approaches are likely to apply depending on which element of the Ideal Clinic is being rolled out. For example, infrastructure might be rolled out nationally in one big bang across the country. On the other hand, the ICRM package of services being rolled out at a local clinic level might occur incrementally.

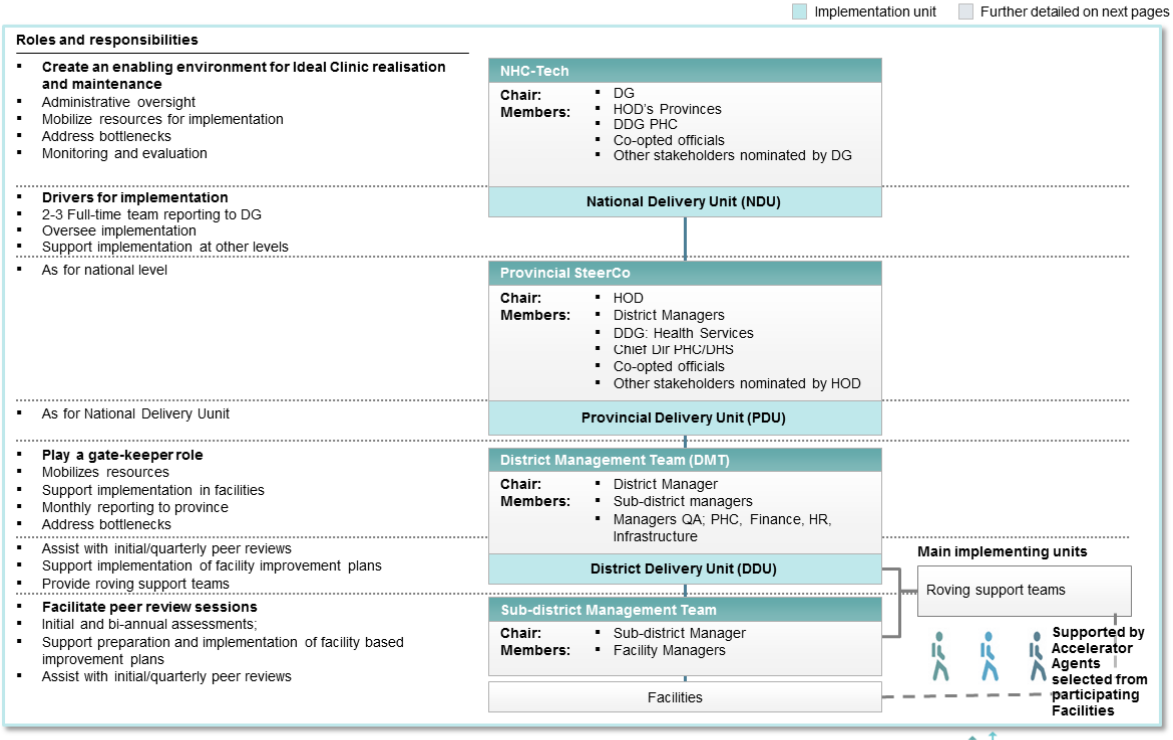
Scaling up includes rolling out the initiatives at clinic and/or district level. Thus it is quite critical to identify areas of the scale-up that will need provincial and national support. As clinics implement the ICRM they need to work to improve their status from their assessed baseline until they reach that of Ideal Clinic.

The owners of the process are the NDoH and Department of Planning Management and Evaluation. The stakeholders that were identified are provinces, districts and facilities, development partners, the DPW and National and Provincial Treasuries.

The NDoH will track progress and measure results, building on existing systems. An important component of the scale-up plan will be a system of Delivery Units to be set up at national, provincial, and district level, with the objective of monitoring and supporting implementation of all the initiatives. Exhibit 8.1 below shows the proposed delivery system.

EXHIBIT 8.1

Overall implementation of the Ideal Clinic Initiative will be coordinated by a national structure, supported by delivery units at every level



SOURCE: Operation Phakisa Health Lab –Scale-up and Sustainability Lab

Change agents (see Initiative 5) should be included in the Delivery Units to implement the change management plan. A different set of coordinating units is suggested to roll out the infrastructure programme to upgrade facilities (dealt with in Chapter 3).

The Ideal Clinic dashboard will be used to record changes in the status of facilities. Meanwhile, the DHIS and other sources will be used to demonstrate improved clinical outcomes and health system strengthening. The monitoring and evaluation plan created will follow results-based management principles. This will demonstrate how the existing monitoring and evaluation system will be leveraged to support effective monitoring and evaluation of ICRM. It will also show the value that implementation of ICRM will deliver to the health care system. In addition, both governance and reporting structures can support accountability for the realisation of improved health outcomes and patient experience. The principles that will be applied to sequencing the scale-up relate to various elements. As to the budget, identifying existing programs and ensuring big ticket items are spaced out in time will avoid long blockages to initiatives with delayed budget flows. Some restrictions may also be needed on starting too many initiatives at the same time, to reduce the burden on implementers, minimise disruptions at the clinic level and avoid

overwhelming the system. As to preparation, it is important to allow for lead times. Overall direction will be set by the NDoH, while implementation at the various levels will be the responsibility of the accounting officers and FMs.

An important part of the scale-up plan is the identification and rapid implementation of quick wins with the aim of gaining credibility and momentum for Ideal Clinics. These include initiatives identified as quick wins by the Lab work stream as well as simple improvements at clinic level which are easily achievable. These improvements should be selected based on whether they can be implementable independently and quickly by a clinic or district – without requiring additional money, people or support. Identifying these rapid improvements will form part of the process of developing the scale-up plan and will be completed in 2016.

A quick win selected by this work stream is the rapid rollout of elements of the dashboard that can be implemented independently by the clinics.

Initiative 2: Sustainability framework to prevent regression and ensure momentum of Ideal Clinic is sustained

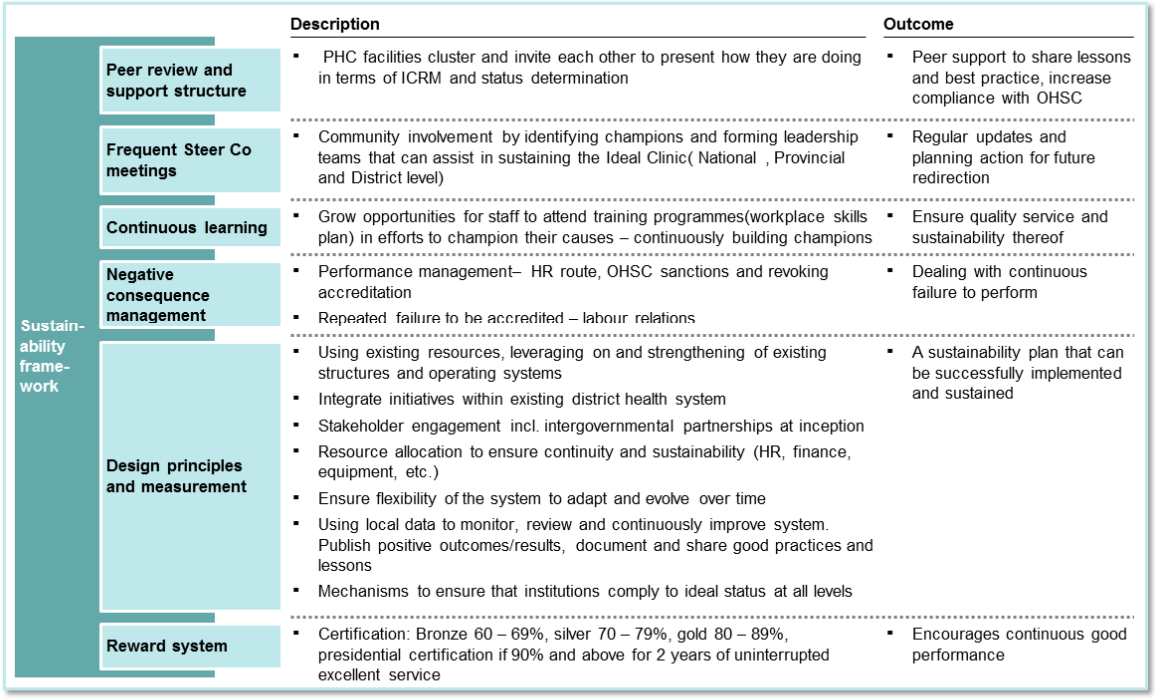
Sustainability is critical to ensure that there is no regression of accredited clinics as well as to secure the achievement and maintenance of new Ideal Clinic status. Sustainability should form part of every component of implementation and scale-up, and continue beyond the scale-up period. Peer review and feedback loops can be used as mechanisms to ensure sustainability.

The owners of this initiative are the province, district, sub-districts and facilities. The stakeholders that were identified are the NDoH, development partners, local NGOs, community and local structures, organised labour and other government sectors like the DPW.

The sustainability framework has been designed considering the framework developed by the DPSA for the public service that also covers the Ideal Clinic. The adaptation for ICRM scale-up is set out in Exhibit 8.2.

EXHIBIT 8.2

The sustainability framework is the backbone for the design of several critical initiatives that will ensure sustainability of Ideal Clinics



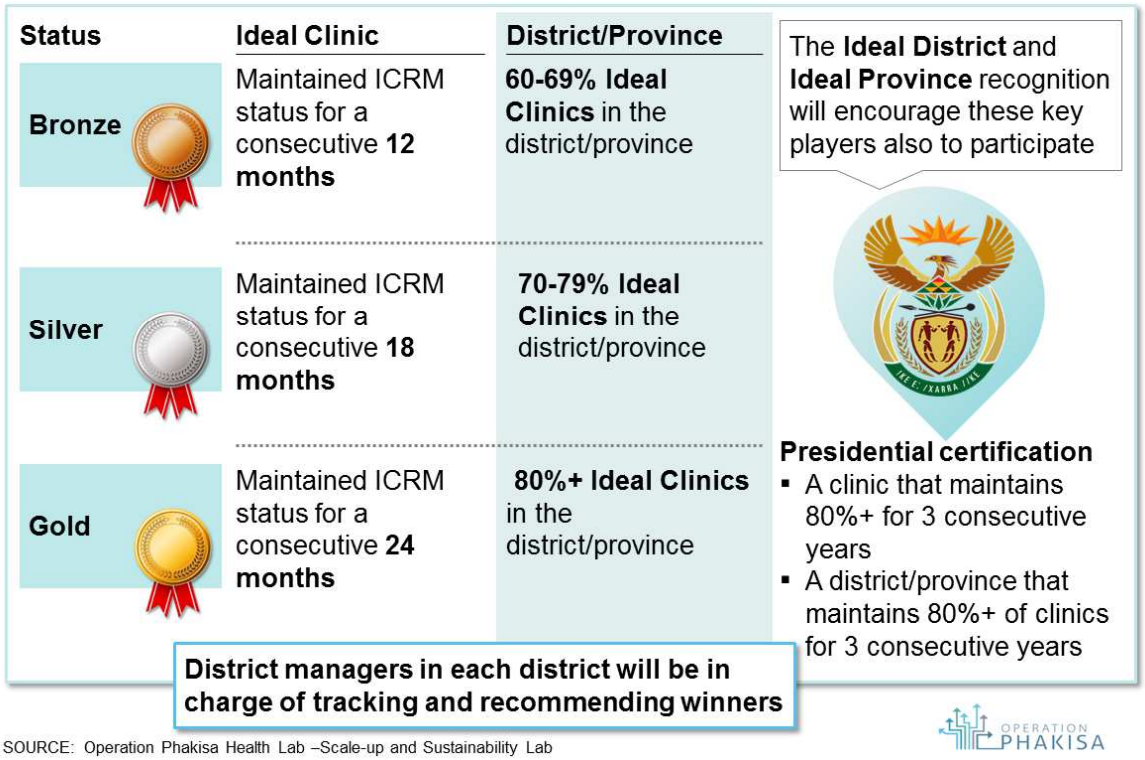
		Description	Outcome
Sustain-ability frame-work	Peer review and support structure	▪ PHC facilities cluster and invite each other to present how they are doing in terms of ICRM and status determination	▪ Peer support to share lessons and best practice, increase compliance with OHSC
	Frequent Steer Co meetings	▪ Community involvement by identifying champions and forming leadership teams that can assist in sustaining the Ideal Clinic(National , Provincial and District level)	▪ Regular updates and planning action for future redirection
	Continuous learning	▪ Grow opportunities for staff to attend training programmes(workplace skills plan) in efforts to champion their causes – continuously building champions	▪ Ensure quality service and sustainability thereof
	Negative consequence management	▪ Performance management– HR route, OHSC sanctions and revoking accreditation ▪ Repeated failure to be accredited – labour relations	▪ Dealing with continuous failure to perform
	Design principles and measurement	▪ Using existing resources, leveraging on and strengthening of existing structures and operating systems ▪ Integrate initiatives within existing district health system ▪ Stakeholder engagement incl. intergovernmental partnerships at inception ▪ Resource allocation to ensure continuity and sustainability (HR, finance, equipment, etc.) ▪ Ensure flexibility of the system to adapt and evolve over time ▪ Using local data to monitor, review and continuously improve system. Publish positive outcomes/results, document and share good practices and lessons ▪ Mechanisms to ensure that institutions comply to ideal status at all levels	▪ A sustainability plan that can be successfully implemented and sustained
	Reward system	▪ Certification: Bronze 60 – 69%, silver 70 – 79%, gold 80 – 89%, presidential certification if 90% and above for 2 years of uninterrupted excellent service	▪ Encourages continuous good performance

SOURCE: Operation Phakisa Health Lab –Scale-up and Sustainability Lab

In order to incentivise clinics, districts and provinces to sustain good performance, the certification mechanism in Exhibit 8.3 will be implemented to recognise excellent performance at clinic, district and province level.

EXHIBIT 8.3

The ongoing work of sustainability will happen via a specific reward and recognition programme for clinics, districts and provinces



SOURCE: Operation Phakisa Health Lab –Scale-up and Sustainability Lab

Appropriate planning, monitoring and evaluation are also essential elements of the sustainability framework. It includes the compiling of KPIs for the ICRM scale-up and its sustainability; processes for KPI data collection; and a cascading governance structure to track implementation and sustainability of the ICRM. The owner of this process is the DoH. The stakeholders identified are Premiers, MECs, MMCs, HODs and other government departments, clinic committees, Statutory Professional Councils and organised labour. An accountability mechanism (such as consequence management for poor performance and recognition of good performance) is crucial for the sustainability of an initiative. Accountability mechanisms should be strengthened across all levels of the health system.

Monitoring and evaluation will be the responsibility of the system of Delivery Units. The basis for monitoring and evaluation of activities are the KPIs and targets linked to each initiative, which will aid an understanding of whether the initiatives are being successful, and the activities and tasks for each initiative which will help track actual implementation. These have been proposed by each Lab work stream and needs to be finalised by the Delivery Units.

A plan for data collection, data analysis, reporting and corrective action has been created by the Lab work stream.

The data collection or acquisition plan details several elements. In the first place, it includes the instruction, or step-by-step plan of how data is to be collected. It also specifies the instrument to be used for data collection, the source of the data and the frequency and timing of its collection. The Delivery Units at district level will update on weekly progress of ICRM implementation, detailing achievements against the specific KPIs for the facilities they support. Also included in the plan is the individual responsible for data collection, how the data is to be stored and how the quality of the data will be ensured (through data verification).

Data analysis and reporting then involves the analysis of data to assess the progress of ICRM implementation in order to identify bottlenecks and gaps early so that these may be remedied to avoid ICRM implementation delays. Analysis and reporting entails consolidating, validating and analysing implementation and the sustainability of progress. This process channels or distributes implementation progress to the various entities that are accountable for delivery. The outcomes of implementation are to be evaluated periodically. The process is useful for understanding the root causes impacting on implementation and service delivery.

Finally, it is necessary to take corrective measures by setting a turn-around time for issues to be resolved and ensure the sustainability of such resolution. This process attempts to deal with those issues which are within the ambit of control and escalates those issues that cannot be resolved to the relevant level.

The creation of linkages between data collection systems in use (namely, DHIS, PERSAL, BAS, LOGIS and Vulindlela, etc.) will be necessary to facilitate monitoring and evaluation activities.

Initiative 3: Stakeholder engagement plan to drive engagement and ensure on-going support

The aim of the stakeholder engagement is to have a well-structured, inclusive and comprehensive interaction with stakeholders for the successful implementation of ICRM.

Stakeholder engagement includes stakeholder identification, analysis, mapping and the creation of a database of stakeholders. Stakeholder mapping will assist in understanding the audience, stakeholder interests and other objectives. The objectives of stakeholder engagement include developing a coherent and customised stakeholder engagement plan to drive understanding and commitment from all stakeholders (a change management plan), as well as to develop a branding and communication plan.

The Lab team identified four groupings that will be critical to the success of the initiative; namely municipalities, other government agencies, the media and organised labour (trade unions). Engaging these groupings should begin immediately.

Municipalities and other government agencies (outside health) may show some resistance to change as the Ideal Clinic will require additional activities from them. The proposed approach for dealing with municipalities is to schedule meetings with their leadership to communicate the initiative and to organise joint workshops and facilitation sessions. The proposed approach for dealing with other government agencies is to engage them in service Delivery Unit meetings, and to escalate issues to the relevant ministry for assistance where there is no improvement.

For media, the key issue will be their current view that the health care system is broken. As they have the ability to shape public opinion, the approach proposed here is to schedule meetings and press conferences, and continuously prepare media statements on the launch and progress of the ICRM. In addition, strategic placement of successful stories will be needed.

Finally, with organised labour, the main objective of the engagement will be to protect the workforce, as the unions are the major influencer of the labour force needed for the success of the ICRM.

Implementation of stakeholder engagement will begin in 2015. Refining the stakeholder analysis and refining and developing the engagement strategies will be concluded in 2016. Over the period 2016 to 2017, feedback will be monitored and the engagements adjusted as necessary. The stakeholder engagement process necessary for the implementation of this initiative is outlined in Tables 8.1, 8.2 and 8.3, including the meetings and communication processes involved. These are broken down into the activities to be undertaken prior to and during the process of implementation.

In order to engage these stakeholders a series of meeting should be carried out at provincial level, at district level and with external stakeholders. The provincial meetings listed in Table 8.1 are required to sensitise the provinces to the project mandate, activities, timelines and roles and responsibilities.

Table8.1: Stakeholder engagement plan to provinces

Responsible office or person	Target audience	Rationale/activities	Expected outcome
Minister	MECs	Political leadership	(National team overseer)
NDoH	DG, DDGs, Senior managers for all programmes	Meeting with Senior Management Team, Present outcomes from Operation Phakisa, Assignment of provincial leadership by DG	Provinces to take ownership and be accountable for the successful implementation of the ICRM in the province
Provincial HODs	All provincial programme managers, District managers	Chaired by provincial HOD, Present high-level expression of outcomes from Operation Phakisa, Present the ICRM vision and implementation strategies for the province, Assign provincial programme and district managers to take leadership	Provincial programme and district managers to take ownership and be accountable for the successful implementation of the ICRM in the districts (provincial implementation team formation)

The district meetings listed in Table 8.2 are required to communicate the project mandate, activities, timelines and roles and responsibilities to the districts.

Table 8.2: Stakeholder engagement plan to districts

Responsible office or person	Target audience	Rationale/activities	Expected outcome
District managers	All programme managers within the district, Sub-district managers, All municipality managers, Organised labour	Chaired by district manager, Present outcomes from Operation Phakisa, Present the ICRM vision and implementation strategies for the district, Assign district programme and sub-district managers to take leadership	District programme and sub-district managers to take ownership and be accountable for the successful implementation of the ICRM in the districts (district implementation team formation)
Sub-district managers	FMs, Programme coordinators, Facility health committees	Chaired by sub-district manager, Present outcomes from Operation Phakisa, Present the ICRM vision and implementation strategies for the sub-district, Assign FMs and programme coordinators to take leadership	FMs and programme coordinators to take ownership and be accountable for the successful implementation of the ICRM in the sub-districts and facilities (sub-district team formation)
FMs	Clinic staff	Chaired by FM, Present outcomes from Operation Phakisa, Present ICRM vision and implementation strategies for the sub-district, Assign facility staff and implement activities for the realisation of the ICRM	Clinic staff to take ownership and be accountable for the successful implementation of the ICRM in the facility (clinic team formation)

The district meetings listed in Table 8.3 are required to sensitise external stakeholders to the project mandate, activities, timelines and roles and responsibilities.

Table 8.3: Stakeholder engagement plan for external stakeholders

Responsible office or person	Target audience	Rationale/activities	Expected outcome
MEC for health	All MMCs, Provincial DHS manager, district managers	Chaired by Health MEC, Present outcomes from Operation Phakisa, Present the ICRM vision and implementation strategies for the province, Assign MMCs to take leadership and ownership	Increase awareness and ownership of the programme
MMCs	Ward councillors, District health managers	Chaired by MMC, Present outcomes from Operation Phakisa, Present the ICRM vision and implementation strategies for the sub-district, Assign ward councillors to take leadership	Increase awareness and ownership of the programme
Ward councillors	Ward committee members, Sub-district managers, FMs	Chaired by FM, Present outcomes from Operation Phakisa, Present the ICRM vision and implementation strategies for the sub-district, Assign ward committee members to implement activities for the realisation of the ICRM	Increase awareness and ownership of the programme
Ward committee members	Community members, FMs, Ward-based outreach teams	Chaired by ward committee member. Present outcomes from Operation Phakisa, Present the ICRM vision and implementation strategies for the sub-district, Inform community members about the ICRM to encourage them to support the implementation of activities for the ICRM	Increase awareness and ownership of the programme

Initiative 4: Branding and communication plan to create awareness and excitement for the Ideal Clinics

The Lab team believes it is important to re-shape customers' perceptions about the services provided in PHC facilities. To restore the image of PHC facilities, the Lab team proposes the appropriate branding of Ideal Clinics. Branding is an approach that can help to develop the kind of recognition and resources needed to ensure changes that will help the organisation grow, prosper and serve its target population better.

A brand embraces the organisation's reputation and represents a promise for the future. It addresses issues related to the nature of an organisation, what it does, how it is done and why anyone should care. A name becomes a brand when people link it to other things. It is about differentiating the services offered at Ideal Clinics as superior and relevant to the target population. Some reasons for branding include supporting standardisation and consistency, creating clear expectations on the part of clients, differentiating the product from others, attaching recognition and value, supporting motivation and direction for staff and generating referrals of clients.

The overall impact of the branding initiative is to increase the visibility of Ideal Clinics in the community and create positive associations among staff and within the community.

The commitment and involvement of the team in charge of defining the brand and the communication plan will be critical to successful implementation. It will be necessary to conduct a brand situational analysis or audit, by undertaking a Strengths, Weaknesses, Opportunities and Threats analysis to assist in assessing the organisation's competitive position in the marketplace. The brand will be tested in a focus group situation, and a message pack will be created guided by the findings of the focus group. This process will be completed by 2016. Over the period 2015 to 2016, it will also be important for all levels of the organisation to "live the brand", by embodying the principles which the brand implies, and the brand will be incorporated into performance evaluations.

Within the communication plan, beyond all the meetings to engage different stakeholders (see Initiative 3), the Operation Phakisa methodology includes an open day in which the programme will be explained to the public. Participants from local governments, civil society, academia, NGOs, the private sector and international organisations, etc., will be invited and will have an opportunity the give feedback on the programme. This will also create commitment over the achievement of the targets communicated to the public.

Part of the communication plan is also to engage the different implementing teams.

Table 8.4 proposes the process of communication with the implementation teams while the initiative is being implemented, including the messages to be communicated.

Table 8.4: Communication plan for implementing teams

Team name	Methods of implementation	Message to be communicated
Provincial team	Meetings, In-service training, Emails, Newsletters, Internet	Outline roles of provincial managers on district support, and the monitoring and evaluation on implementation of the ICRM.
District	Meetings, In-service training, Emails, Newsletters, Internet	Inform sub-district programme manager and organised labour what Ideal Clinic is all about, including the advantages of the ICRM, the dashboard indicators and how the ICRM will be rolled out. Outline roles of district manager on facility preparation, implementation, support and monitoring and evaluation. Get inputs on proposed roll-out plan.
Sub-district	Meetings, In-service training, Emails, Newsletters, Internet	Inform FM what Ideal Clinic is all about, including the advantages of the ICRM, the dashboard indicators, how the ICRM will be rolled out, and outline the roles of the FM on implementation. Get staff inputs on proposed roll-out plan.
Facility	Meetings, In-service training, Emails, Newsletters, Internet	Inform staff what Ideal Clinic is all about, including the advantages of the ICRM, the dashboard indicators and how the ICRM will be rolled out. Get staff inputs on proposed roll-out plan.
Ward	Meetings	Inform communities what Ideal Clinic is all about, including the advantages of the ICRM, what they should expect, what form of support is needed from them and how the ICRM will be rolled out.
Communities	Imbizo, SMS, National and local newspapers, National and community radio stations, Television, Billboards, Pamphlet	Inform communities what Ideal Clinic is all about, including the advantages of the ICRM, what they should expect, what form of support is needed from them, and how the ICRM will be rolled out.
Development partners	Meetings	Inform partners what Ideal Clinic is all about, including the advantages of the ICRM, what form of support is needed from them and how the ICRM will be rolled out.
NGOs	Meetings	Inform NGOs what the Ideal Clinic is all about, including the advantages of the ICRM, what form of support is needed from them and how the ICRM will be rolled out.

Initiative 5: Change management plan to achieve successful transformation

Managing change is about handling the complexity of the process. It is about evaluating, planning and implementing operations, tactics and strategies and making sure that the change is worthwhile and relevant. Managing change is a complex, dynamic and challenging process, essential for the achievement of quality health services in the Ideal Clinic.

The change message chosen is “Masiphumelele Sonke – Let’s Achieve Together”.

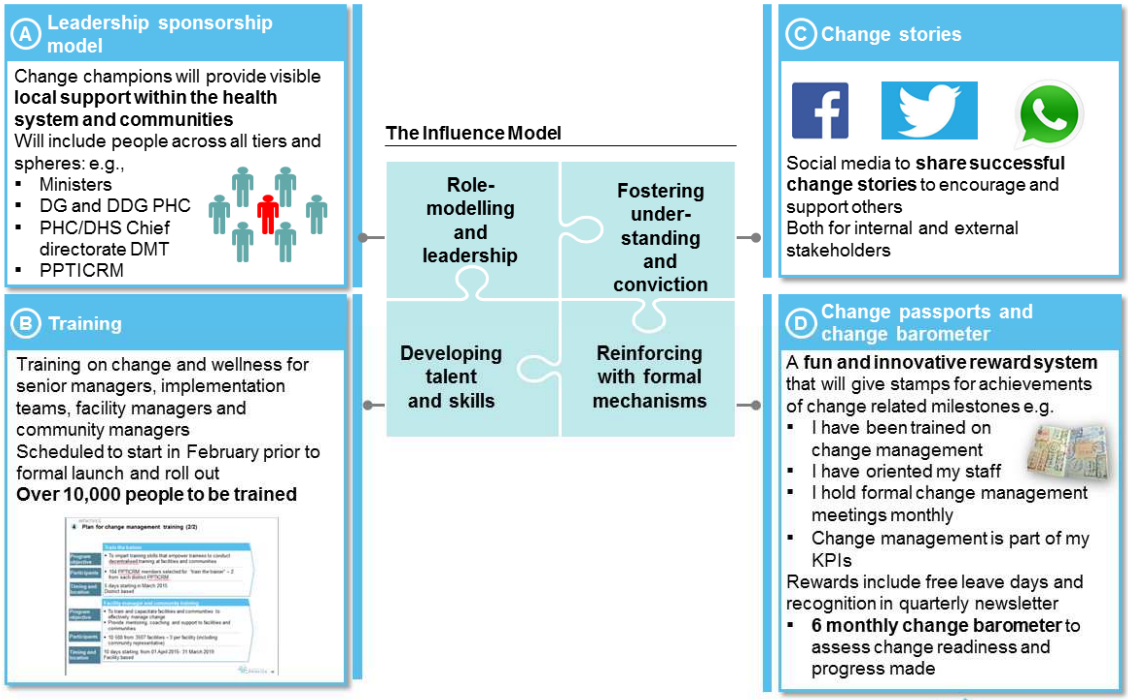
Change management interventions currently being implemented in the public sector are being considered and aligned to this change management plan. The approach is intended to bolster and augment current NDoH efforts, and is multi-faceted and comprehensive. The core values contained in the approach are: ownership, impactful branding, pervasive and sustained communication, transparent and monitored progress, accountability and sustainable organisational culture change. The vision of the plan is to instil an organisational culture within the public health sector that embraces change and manages change successfully. The purpose of the change management sub-stream is to develop a change management plan that can be implemented in 3,507 public-sector, fixed PHC facilities. The goal of the change management plan is the positive transformation of the health system, and improved quality of care.

The specific objectives of the plan are to improve receptivity to change and to improve ownership and buy-in of the changes among health care workers, to improve the sustainability of change in the public health sector health facilities, to provide guidance on change management initiatives initiated across all levels of the public health sector, to improve attitudes and sensitivity to the impact of change, to improve the involvement of communities in change initiatives and, finally, to measure and evaluate the implementation of change initiatives.

The influence model provides four levers with which to drive successful shifts in mind sets and behaviours. Central to the model are the shifts in the employee’s mind-set and behaviour that the change management aims to achieve. In Exhibit 8.4, the change management activities planned are illustrated for each of the four dimensions of the model. The four dimensions are discussed below.

EXHIBIT 8.4

We have designed initiatives in each quadrant that will drive successful shifts in mindsets and behaviours



SOURCE: McKinsey Quarterly Transformational Change survey; January 2010

OPERATION PHAKISA

Dimension 1: Role modelling

Organisations in which leaders role model the desired changes are four times more likely to succeed than organisations where leaders are not involved[66]. The development of the Leadership Sponsorship Model will therefore provide the platform for transforming role modelling among leadership, as well as for the successful implementation and sustainability of the Operation Phakisa ICRM at national and provincial departments. The purpose is to extend the reach of leadership sponsorship, or role modelling, at provincial, district, facility and community level.

Provincial executive leadership will be responsible mainly for role modelling change as an integral part of sustainable transformation. They will also be responsible for unblocking system bottlenecks to advance an enabling environment for change, including the re-engineering of business processes and reviewing or developing the appropriate policies. In addition, the leadership will be responsible for escalating the ICRM agenda to cabinet, through the inclusion of clear deliverables – that will be monitored and reported through governance and administrative lines of

[66] McKinsey Quarterly Transformational Change survey, January 2010

communication – in provincial cabinet makgotla that inform the Provincial Plan of Action.

The model makes provision for interdepartmental and partner involvement and integrated reporting through structures to the Office of the Premier to Cabinet, which will provide weight to the urgency of implementation and performance. This will also ensure that the change agenda is aligned with the departmental vision and ensure inclusion in strategic plans, annual performance plans and district health plans, to ensure sustainability.

At the district level the model makes provision for the implementing agents and PPTICRM team, who will monitor change and manage bottlenecks reported through district, facility and community structures. District leadership, including district management teams and governance structures (for example, DHCs), will also assume the role modelling function as part of district structures.

Change champions will be identified across the tiers of the health system, and will actively include and involve community representatives to ward level, including ward counsellors and opinion leaders at community level.

The Leadership Sponsorship Model will target national, provincial and district leadership, including governance structures, as well as opinion leaders identified through stakeholder analysis.

Dimension 2: Fostering understanding and conviction

Stakeholder involvement in crafting messages for change, through conventional and digital interventions, will ensure understanding of and buy-in to the change agenda. Transformations with a compelling “change story” are about four times more likely to succeed, supporting stakeholder involvement in the development of appropriate messaging.

Change stories will therefore be based on stakeholder experiences, focussing on people, systems and processes that can contribute towards more effective interventions for the re-engineering of business processes as part of strategic leadership.

Led by the national and provincial executive leadership, including the DoH and DPME DDGs, dialogues for change will commence with the launch of Operation Phakisa followed by an open day where basic messages will be communicated to stakeholders as an essential part of transparency. Current and future data will be collated further to inform the management of ICRM implementation and change management expectations and gauge the readiness for change. Departmental communications will be used to ensure the sustainability of the communication strategy by including them in both internal and external communication strategies.

Dimension 3: Developing talent and skills

Once the Delivery Units are established, they need to be capacitated, and a change management training plan is being developed in this regard. The training model includes widespread training on change management, targeting mainly the PPTICRM team, and the training of selected trainers to enable the cascading of change.

Key themes covered during the training will include employee wellness, the change management approach (CMA), action plans, risk analysis and stakeholder management. The two main training modules will be:

- **Wellness for effective leadership** (four sessions over a four-month period): A personal development programme for managers in the public sector to support each other to improve their wellness, develop their emotional intelligence, personal and interpersonal competencies and to deal effectively with stress and the risk of burnout.
- **Change management approach** (CMA) (six sessions over six months): The programme includes sessions for orientation, the CMA, action planning and strategic technical support (risk management and stakeholder management, etc.).

Before the training of PPTICRM teams and based on current functioning, some teams need to be reviewed and reconstituted. The existing pool of functional PPTICRM teams can be used as a pool for recruiting those that will be trained as trainers. The trainers will then continue with training in change management in all 52 districts.

Nationally the DDG for PHC will provide change-related oversight and support to provincial and district reports, with added support from the NHI and PHC/DHS chief directors. At facilities, the FM or a facility-based change agent will drive change, actively involving community representatives from the ward level.

Dimension 4: Reinforcing mechanisms

Levels of accountability still need to be determined and will be informed by the finalisation of the structures that will coordinate implementation. Currently, the various spheres of health delivery, including the communities, are important components that will be considered when defining and positioning the Delivery Units, the change agents and their functioning.

As implementation proceeds, specific change management indicators will be monitored and evaluated continuously according to the change management monitoring and evaluation framework that will be developed. “Change passports” will be used as a reward and incentive mechanism that motivates the achievements and maintenance of the Ideal Clinic status. Beyond the “change passport”, a “change barometer” will be updated by clinic employees and shared across

provinces and districts in the form of a newsletter to create transparency and accountability among the people responsible for managing change.

Implementation of the change management initiative will take place in stages. In the period up to 2016, dialogues for change will be conducted, the leadership sponsorship model will be implemented to ensure on-going visible support, **the Delivery Units will be identified and established**, the change training programme will be implemented and the change management monitoring and evaluation and sustainability system will be implemented. From 2016 to 2017 there will be an expansion of change management training and there will be continued implementation of the change management monitoring and evaluation and sustainability system. Over the period 2017 to 2018 there will again be continued implementation of the change management monitoring and evaluation and sustainability system.

PROPOSED KEY PERFORMANCE INDICATORS

Table 8.5contains a sample of KPIs for the Scale-up and Sustainability work stream. The full list of proposed KPIs, including suggested reporting frequency, sources of baseline and supporting documentation, is available in the Lab's Excel templates output on KPIs. These KPIs will require final syndication with all relevant stakeholders during the implementation phase.

Table 8.5: KPI selection for the Scale-Up and Sustainability work stream

			Cumulative target (March of the year)					
Initiative	**KPI description**	**Base-line**	**2015**	**2016**	**2017**	**2018**	**2019**	**KPI Owner**
Change manage-ment	Number of established district Delivery Units	0	52	52	52	52	52	Provincial Delivery Unit, PDoH
	Number of PPTICRM team members who completed the standard CMA training	35	780	1014	1248	1482	1716	Training IA, IA and PDoH
	Number of senior managers orientated and trained on CMA and business re-engineering	0	45	58	71	84	97	Training IA, IA and PDoH
	Number of selected trainers trained in the CMA train the trainer training package	0	104	135	166	197	228	Training IA, IA and PDoH
	Number of service providers trained in CMA	0	0	2,625	5,250	7,875	10,500	ICRM Trainers, PDoH
	Number of CMA Trainers who completed the refresher training for CMA	0	0	104	104	104	104	ICRM Trainers, PDoH
	% of clinics showing minimum 10% improvement in ICRM Dashboard Compliance	0%	20%	40%	60%	80%	80%	Provincial ICRM project manager, PDoH
	% of clinics that sustained Ideal Clinic Status for 12 consecutive months	0%	20%	40%	60%	80%	80%	Provincial ICRM project manager, PDoH
	Number of staff that scores 4 at more than 85% of elements in the Change Barometer	0	0	2,625	5,250	7,875	10,500	Provincial ICRM project manager, PDoH
	Number of service providers who fully complied with all the Change Passport milestones	0	780	2,625	5,250	7,875	10,500	PPTICRM team, PDoH

Table 8.5 (continued): KPI selection for the Scale-Up and Sustainability work stream

			Cumulative target (in March of the year)					
Initiative	KPI description	Base-line	2015	2016	2017	2018	2019	KPI Owner
Communications and branding	Number of Ideal Clinic imbizos held	0	2	2	2	2	2	Head of Communications at national, provincial and district levels, DoH
	Number of radio slots on Ideal Clinic acquired	0	4	4	4	4	4	Head of Communications at national, provincial and district levels, DoH
	Thousands of staff member strained on ICRM initiative	0	0	10	33	56	79	FM, DoH (PHC facility)
	Proportion of meetings where ICRM is discussed	0	50%	75%	90%	100%	100%	FM, PHC facility
	Number of ICRM self-assessments using dashboard indicators	N/A	1	2	2	2	2	FM, PHC facility
	Proportion of activities implemented from the quality improvement plans	N/A	60%	70%	75%	85%	90%	FM, PHC facility
	Proportion of clients who recognise the Ideal Clinic brand	0	25%	50%	60%	75%	85%	Sub-district manager
	Proportion of branding elements implemented	0		50%	75%	85%	100%	Sub-district manager