OPERATION PHAKISA: SCALING UP THE IDEAL CLINIC
PROGRESS REPORT
1 April 2016- 30 June 2016

EXECUTIVE SUMMARY

To date we have 322 IDEAL CLINICS and have in the past year, within the group of 1139 clinics for 2015/16, increased the number of clinics scoring over 70% from 139 to 513 and reduced the number of clinics scoring less than 40% from 213 to 13. The progress with regards to the Ideal Clinic programme has been slow during the first year of implementation. In the 2016/17 year, we need to speed up the infrastructure and staffing improvements as well as correct the procurement processes that see many clinics functioning without the required medication, consumables, equipment and furniture. With regard to staffing, the appointment of clinic operational managers will continue to receive the priority attention that we assigned to it in 2015/16. We are confident that the programme will yield better results in this financial year (its second year of implementation) for the following reasons:

- District scale up teams have been orientated to the programme and the peer review exercise in February 2016 served as further training for district scale-up teams in this regard.
- The manual for Ideal Clinic Realisation and Maintenance has been completed.
- Dedicated funding has been obtained from Treasury for the management of this programme at a national level. This is a small amount of R10 000 000, but will assist as a start.

Whilst we have selected an additional 1008 clinics for 2016/17, provinces have been encouraged to increase the number of facilities for scale-up, in order to ensure that the three year target of 3 538 is achieved by end of March 2019. The clinics that were selected for 2015/16 that did not reach Ideal Clinic status will be added to the 2016/17 clinics. In 2016/17 we will deliberately focus on ensuring that all the NHI pilot district facilities achieve ideal status, while working with the provinces to enable a positive knock-on effect to other districts. Filling of clinic manager posts, infrastructure and correcting supply chain systems will remain priorities for 2016/17.

Most of the activities in this first quarter are aimed at ensuring that provinces complete the process of status determinations for all their facilities using the latest manual (version 16). Once this is completed each province will confirm with National Department of Health the

facilities for enrolment in the 2016/17 cohort. The effort of implementing the quality improvement plans per facility based on the results of the status determination process will begin at all enrolled facilities. The first round (1st 500 facilities) of peer-to-peer assessments are planned for September 2016, where the ideal status of the 2016/17 cohort clinics will be confirmed. The second round (2nd 500 facilities) of peer-to-peer assessments are planned for February 2017. It is only after these assessments that the ideal status of all the clinics in the 2016/17 cohort will be confirmed and declared.

The activities for the rest of the financial year will be devoted at ensuring that:

- Those facilities that achieved ideal status in 2015/16 are supported to maintain their status;
- Those facilities that did not make ideal status in the 2015/16 are supported to achieve the ideal clinic status
- Those facilities that achieved very low scores in the 2016/17 status determination are declared to the provinces, so that quality improvement plans are developed and implemented in order to improve their chances of achieving ideal status when they are enrolled into this programme in the subsequent years

1. INTRODUCTION

This report starts with a brief background of the Operation Phakisa Ideal Clinic Programme and describes the progress since implementation after the launch in November 2014.

2. BACKGROUND

In 2013 the National Department of Health came up with the concept of an Ideal Clinic, as preparation for the National Health Insurance (NHI). An Ideal Clinic defines a type of clinic with features such as infrastructure, management, supply chain, governance, etc, whose service will satisfy every member of the population regardless of their status.

To achieve this Ideal Clinic Realization and Maintenance (ICRM), the Presidential concept of Operation Phakisa, which has already been applied in the Oceans Economy, was adopted.

A laboratory was held between 13 October 2014 and ended on 21 November 2014. It was launched by the President on 18 November 2014. The lab had eight workstreams namely:

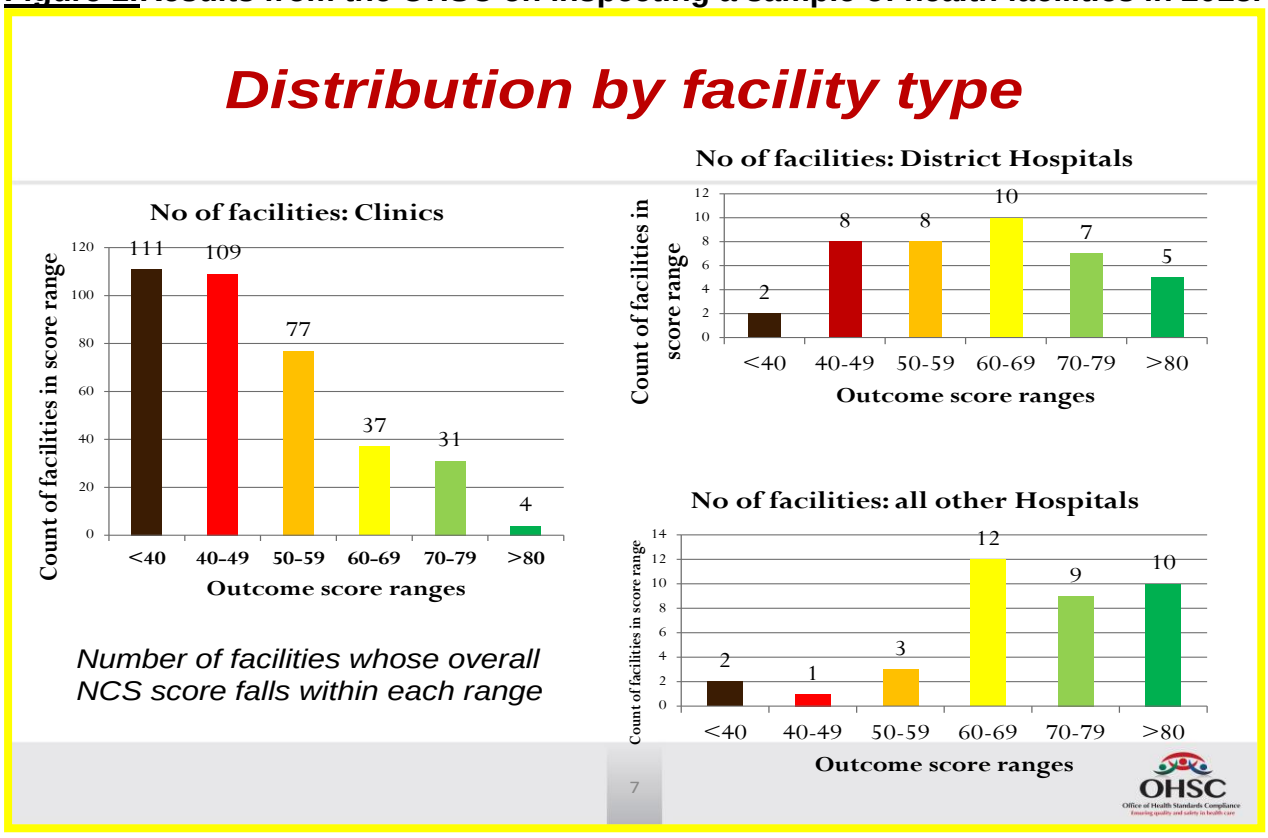
1. waiting times
2. infrastructure
3. human resources for health
4. service delivery
5. financial management
6. supply chain
7. sustainability
8. institutional arrangements

3. PROGRESS TO DATE

The progress of Operation Phakisa Ideal Clinic must be gauged against the findings of the baseline facility survey of 2011 and the results of the Office of Health Standards Compliance (OHSC) in 2013.

The baseline facility survey (2011) showed significant weaknesses pertaining to priority areas such as infrastructure, staffing, availability of medicine, cleanliness, security and waiting times. Figure 1 below shows results from the OHSC on inspecting a sample of health facilities in 2013. Out of a sample of 369 clinics, 111 (30%) scored under 40%, 109 (29%) scored between 40% and 49%. This effectively means that out of the 369 clinics 60% had a score of less than 50%, while only 4 clinics (1%) had a score of 80% and above. This indeed was a sad state of affairs since a clinic has to score at least 70%, to be compliant with the standards of the Office of Health Standards Compliance. You will also note that although the scores for district and other hospitals are far from ideal, the clinics are doing much worse than district and other hospitals. It is for this reason that the Ideal Clinic programme was started as the National Department of Health's (NDoH) internal mechanism for improving the quality of health services.

Figure 1:Results from the OHSC on inspecting a sample of health facilities in 2013.



This progress report is divided into two sections namely Section 1 which describes the general progress and Section 2 which describes progress with regard to the specific Operation Phakisa, Ideal Clinic work-streams.

Section 1: General Progress

The steep target of turning all clinics into the IDEAL by 2019, was set to create an urgency in this regard. However, focus is required to achieve success and the resources available annually for this work is limited. For this reason each of South Africa's 52 districts (except the Western Cape who will come on board in April 2016), assigned their clinics by name into the year during which they plan to turn them into IDEAL CLINICS.

The selected clinics are supported by the NDoH, provinces and districts as described in Sections 2 and 3 below.

Section 2: Progress pertaining to specific Operation Phakisa work-streams

1. Waiting times

Under Operation Phakisa Ideal Clinic:

- Long queues have been reduced by decreasing Primary Health Care (PHC) data collection registers from 56 to only 6. This decreased staff's administrative burden allowing them more time for patient care and have been implemented in 2 595 clinics and will be rolled out to the remaining clinics in due course.

- To further reduce waiting times, NDoH installed and activated the Health Patient Registration System (HPRS) in 657 PHC facilities in the NHI Pilot Districts. The remainder of the facilities in NHI pilot districts (about 90 facilities) experienced among others infrastructure problems and the system will be installed once these are resolved. In preparation of Phase 2 of the implementation of the HPRS, during 2016/17 6221 computers were purchased for an additional 1210 PHC facilities. During 2015/16 the Standardised Patients Records were finalised and the electronic patient filing systems were successfully piloted. The implementation will be completed in 2016/17 in the 657 facilities where the HPRS is functional.

- Central Chronic Medicine Dispensing and Distribution (CCMDD) programme:

    - This is the medicine distribution programme for stable patients who need not see a doctor or a nurse, but are just coming to collect their monthly supply. Their supplies are delivered to them at pick-up points agreed to by both Government and patients.

    - As at end of February 2016, the number of patients who are stable on their chronic medication and no longer need to queue for repeat medication are 347 750.This is up from 246 320 on 18 September 2015 and 210 840 at the end of July 2015.

- We are in the process of writing up good practices with regard to waiting time reduction into a guide for waiting time reduction to be implemented in all PHC facilities.

2. **Infrastructure**

Architectural designs for the Ideal Clinic have been finalised.
These are of three types, small, medium and large as well as for community health centers.
These designs will be used in the building and/or refurbishment of Ideal Clinics.

Of the 700 clinics in the NHI Pilots, condition assessments have been completed in 529 up to 310 March 2016. Four hundred and fifty (450) clinics and bills of quantities for implementation are being prepared to start major refurbishment programmes using the Ideal Clinic designs. NDoH has compiled tenders for 290 facilities which will be consisting of a total of 71 contracts with a corrected estimated value of R 955 million which resembles 54% of the assessment information up to 31 March 2016.

Two hundred and sixteen (216) new clinics are going to be built between now and 2019. Currently there are a total of 44 clinics and CHCs that are currently being constructed and revitalised. In 8 clinics in OR Tambo district (an NHI district), contractors are already on site. In another 8 clinics, contractors are to go on site (5 clinics in Vhembe District and 3 Clinics in Thabo Mofutsanyane District).

Progress on the abovementioned 8 clinics is summarized as follows:

- Nolitha Clinic:
  - Clinic is located in the sub district of Nyandeni.
  - Physical progress is 34% and total expenditure to date is R 7,8 million on construction only.
  - Remaining planned expenditure to end of project = R 15, 07 million.
  - Completion date is anticipated to be March 2017.
- Lotana Clinic:
  - Clinic is located in the sub district of Mhlonto.
  - Physical progress is 64% and total expenditure to date is R 17,22 million for construction only.
  - Remaining planned expenditure by end of project = R 9,46 million.
  - Completion date is anticipated to be March 2017.
- Lutubeni Clinic:
  - Clinic is located in the sub district of King Sabata Dalindyebo.
  - Physical progress is 45% and total expenditure to date is R 11,8 million for construction only.
  - Remaining planned expenditure by end of project = R 14,67 million.
  - Completion date is anticipated to be March 2017.
- Maxwele Clinic:
  - Clinic is located in the sub district Nyandeni.
  - Physical progress is 52% and total expenditure to date is R 12,38 million for construction only.
  - Remaining planned expenditure by end of project = R 11,67 million.
  - Completion date is anticipated to be March 2017.
- Gengqe Clinic:
  - Clinic is located in the sub district King Sabata Dalindyebo.
  - Physical progress is 27% and total expenditure to date is R 6,57 million for construction.
  - Remaining planned expenditure by end of project = R 17,18 million.
  - Completion date is anticipated to be March 2017.
- Nkanga Clinic:
  - Clinic is located in the sub district Nyandeni.

- Physical progress is 66% and total expenditure to date is R 17 million for construction only.
- Remaining planned expenditure by end of financial year = R 8,66 million.
- Completion date is anticipated to be March 2017.

- Sakhele Clinic:
  - Clinic is located in the sub district King Sabata Dalindyebo.
  - Physical progress is 48% and total expenditure to date is R 12,48 million.
  - Remaining planned expenditure by end of financial year = R 13, 35 million.
  - Completion date is anticipated to be March 2017.
- Lusikisiki Clinic:
  - Clinic is located in the sub district of Ingquza Hill.
  - Physical progress is 27% and total expenditure to date is R16,29 million.
  - Remaining planned expenditure for project = R 43 million.
  - Completion date is anticipated to be March 2017.

610 additional doctors consulting rooms are already completed to ensure that doctors are comfortably attending to patients in clinics.

3. Human Resources for Health

The staffing need for PHC facilities have been determined using the World Health Organizations' (WHO) Workload Indicators for Staffing Need (WISN) tool. PHC guidelines for staffing need has been developed with the assistance of the WHO. The provinces are now in the process of verifying the actual staff numbers in each PHC facility in order to determine and cost the gap that needs to be filled.

4. Service Delivery

We are scaling-up the **Integrated Clinical Services Management (ICSM)** to integrate service delivery at PHC level to ensure that patients are not made to return to clinics on different days of the week or being sent from one consulting room to another within a clinic because they suffer from more than one condition. For example, the patient is HIV positive and is also a diabetic. Patients will be screened, examined and treated holistically. To achieve this the following elements appear on the Ideal Clinic dashboard:

- The facility has been re-organised with designated consulting areas and staffing for acute, all chronic health conditions and preventative health services.
- An ICSM compliant client appointment system for clients with stabilised chronic health conditions and MCWH clients is in use.
- The records of booked clients are pre-retrieved 72 hours before the appointment.
- Pre-dispensed medication for clinically stable chronic patients is prepared for collection 48 hours prior to collection date.
- The ICSM compliant package of clinical guidelines is available in all consulting rooms.

To ensure that doctors, nurses and other health practitioners have the equipment needed for service provision, all equipment needs will be determined for the clinics to be scaled up this year as soon as clinics have completed and captured their status determination. Provinces then have to support the districts to provide the required equipment to the clinics.

5. Financial Management

We are in the process of planning for decentralised financial management to ensure that clinics have the required resources for the full duration of a financial year.

6. Supply Chain

One of the biggest complications arising from running the biggest Antiretroviral Treatment (ART) Programme in the world is the logistics of supply of medicines to all the clinics and hospitals. We continue to work with provinces and districts to improve.

In order to eliminate medicine stock-outs at our clinics we have partnered with Vodacom to develop and implement a mobile phone application. This innovative system uses mobile phones to manage the stock. This allows us to know when a clinic is low on stock and to ensure that orders are placed before the clinic runs out of stock. This system has been implemented in all 605 clinics in KwaZulu-Natal, 478 clinics in Limpopo, 50 facilities in the Eastern Cape and 114 facilities in Gauteng - a total of 1,252 facilities. We will expand this project to every clinic in the public health sector over the next two years.

7. **Sustainability**

To ensure sustainability:

- The web based monitoring and evaluation software has been developed and is being used since April 2015 by PHC clinics and the health districts to monitor and record their progress. This software enables tracking of progress at national, provincial, district and facility levels. This ability is being used to scale up improvements on a larger scale.

- We have developed an Ideal Clinic Realisation and Maintenance manual that provides standard operating procedures (SOP) for ensuring functional clinics. This manual describes a SOP for each of the elements of the ideal clinic and was tested in the clinics from September to December 2015. Feedback from PHC facilities assisted to complete the manual and it is now ready for use.

8. Institutional Arrangements

Officials at district level who were previously responsible for quality assurance and clinic supervision have been reorganised into district scale-up teams. Each province has an ICRM champion and a team of managers give impetus to the programme at national level. The ICRM progress report is a standing item on district, provincial and national executive meetings.

The district scale-up teams received orientation to ICRM at a national level from 14 to 17 September 2015. District teams conducted a peer review during February

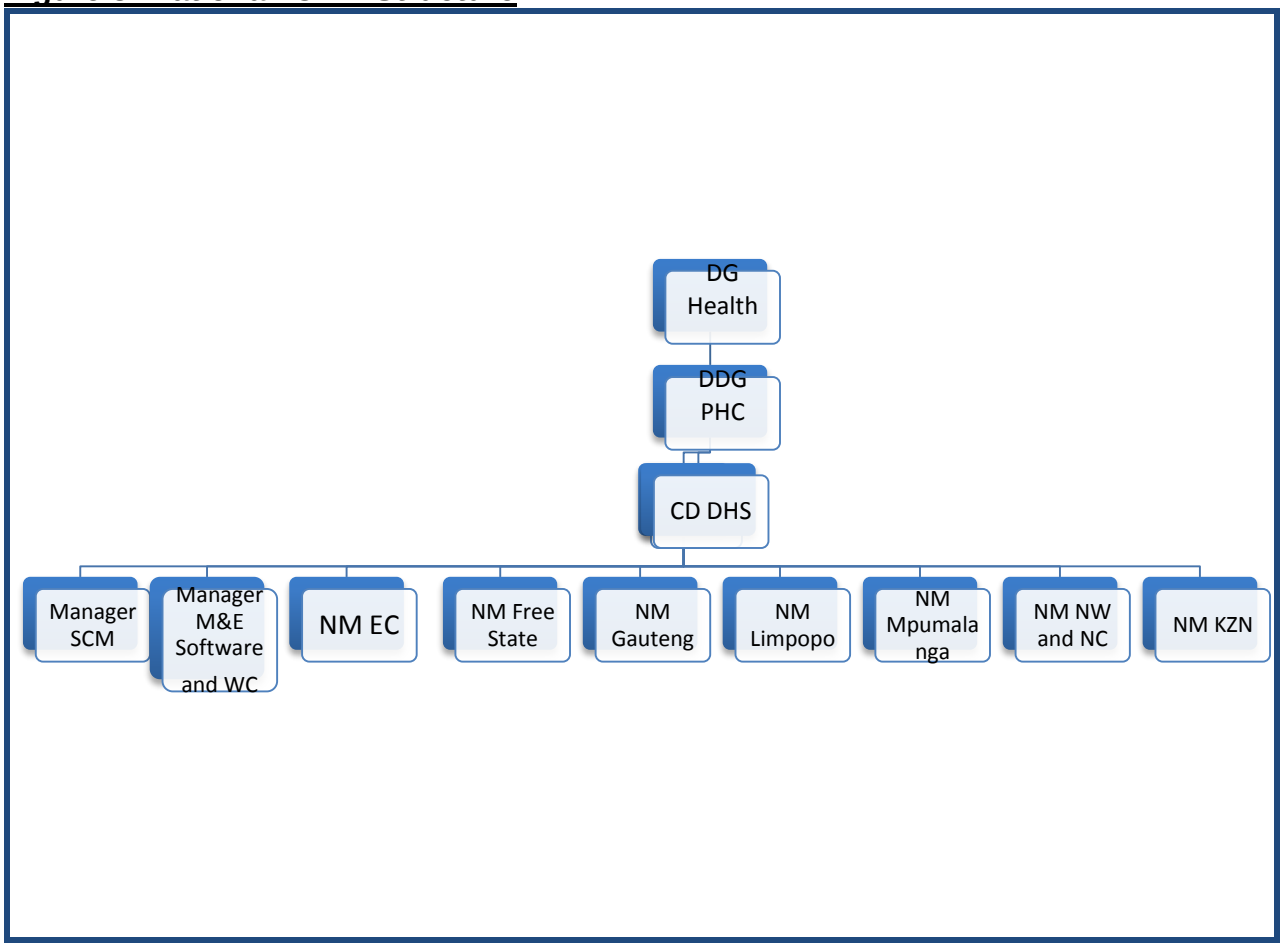
2016. The results of the peer reviews enables confidence in the progress described in this report.

The implementation structure is as follows:

National level

The Director General of Health provides direction to the Deputy Director General of Primary Health Care who is assisted by a project manager (daily operations) and the Chief Director District Health Services who in this regard is responsible for communication to provincial ICRM champions. The CD DHS manages two other directorates with district health system strengthening responsibilities. There are seven national ICRM managers who provide support and impetus to implementation in the provinces. The team is supported by a manager for the monitoring and evaluation software as well as someone dedicated to address supply chain issues. See Figure 3 below.

Figure 3: National ICRM Structure



The national ICRM managers are assisted by national managers from Physical Infrastructure, Essential Health Technology, Human Resources for Health, Financial Management, Health Information Management, Pharmaceutical Services, Supply Chain Management and Health Programmes as required. A presentation on progress is made at every meeting of the Technical Advisory Committee of the National Health Council (DG and provincial Heads of Health) as well as to the National Health Council (Minister of

Health, provincial MECs for Health, DG and provincial Heads of Health). Recommendations from the Tech NHC are taken to the NHC for approval. Quarterly progress reports are sent to the Department of Monitoring and Evaluation in the Presidency.

Provincial and district levels

Every province has a provincial ICRM champion. The Western Cape Department of Health is coming on board from 1 April 2016. District scale-up teams drive the process of turning clinics Ideal at the district level. District Scale-up teams are composed of staff who were previously responsible for clinic supervision and quality improvement. Scale-up teams are also supported by pharmaceutical, supply chain, finance, human resources and information communication and technology managers at district level.

Section 3: Monitoring, Evaluation and Re-planning

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3.1 Ideal Clinic Scale up Plan 2016/17

Table 1: Number of clinics planned for scale up in 2016/17

Province	Number of Facilities planned for 2016/17 Scale up	Number of Ideal Clinic (June 2016)
Eastern Cape	235	0
Free State	52	3
Gauteng	117	18
KwaZulu-Natal	196	7
Limpopo	158	1
Mpumalanga	97	2
North West	98	0
Northern Cape	55	0
Total	**1,008**	**31**

Table 1 above indicates that to date 1008 clinics have been enrolled for the 2016/17 cohort and already 31 of them have been assessed as ideal through the baseline status determination process. The remaining clinics, still need their status to be converted to ideal through intensive quality improvement interventions, led by the facilities and districts.

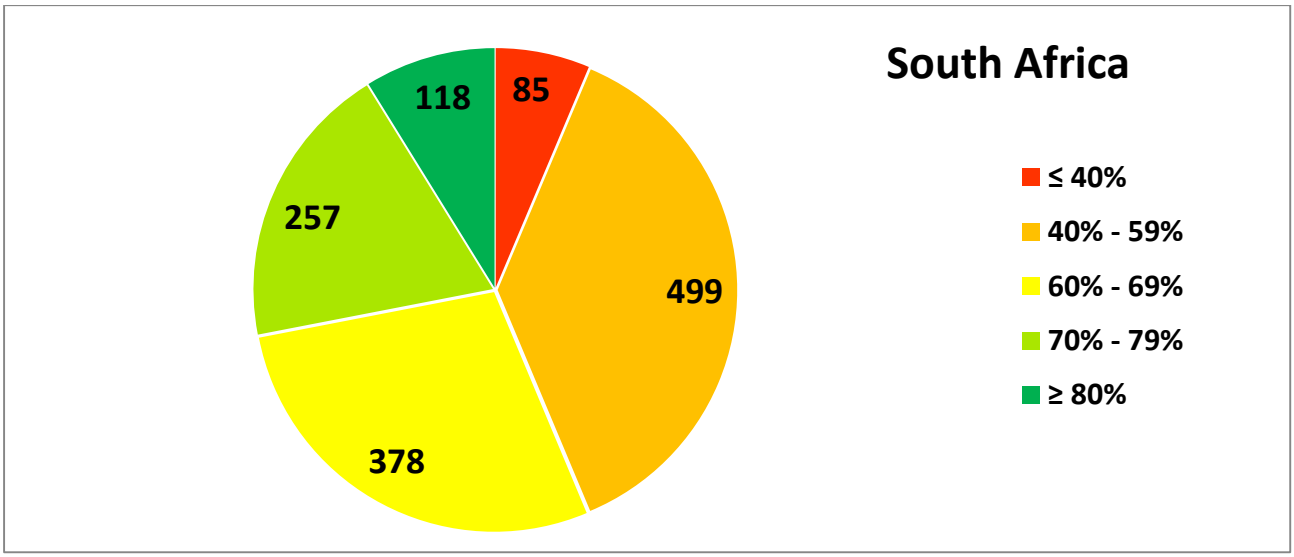
3.2 Status Determination results

Table 2: Performance (Overall Score range) of facilities that have already done their status determination for 2016/17

Province	≤ 40%	40% - 59%	60% - 69%	70% - 79%	≥ 80%	Total
Eastern Cape	19	144	85	54	25	327
Free State	15	52	13	17	10	107
Gauteng	0	35	43	51	35	164
KwaZulu-Natal	18	70	65	39	11	203
Limpopo	14	72	94	26	7	213
Mpumalanga	7	60	30	13	12	122
North West	11	48	29	42	6	136
Northern Cape	1	18	19	15	12	65
Western Cape	0	0	0	0	0	0
National	**85**	**499**	**378**	**257**	**118**	**1,337**

Table 2 above, indicates the different average overall scores achieved by the facilities from different provinces. An observation of great concern, is the high number (584) of facilities that were assessed to have average overall scores that are less than 59%, as it is these facilities that are unlikely to achieve the ideal status, if no concerted effort is directed at them. It is however encouraging to note that 375 of the enrolled clinics already have average overall scores that are greater than 70%. It is these high scoring facilities that are likely to achieve the ideal status soonest. In the subsequent quarterly reports we will track the progress of all the enrolled clinics towards the achievement of their ideal status.

Figure 4: Status of clinics that have to be turned into Ideal for 2016/17 financial year



3.3 Peer to peer assessments

There will be peer to peer assessments that will be conducted in September 2016 and February 2017 to determine the final ideal status of the facilities that have been enrolled for the 2016/17 cohort. The results of these peer to peer assessments will be reported in the third and fourth quarterly reports.

4. CHALLENGES

4.1 Slow progress in the status determinations

The process of status determinations for all the facilities using Version 16, has not been as easy as anticipated. Status determination provides you with an early indication of whether a facility will ultimately achieve ideal status or not. Those facilities whose average overall scores are greater or equal to 70%, have a higher probability of achieving ideal status compared to the low scoring ones. The provinces that are struggling with this process in the main are Western Cape and Limpopo**.**

Western Cape is entering the ICRM programme for the first time in 2016/17 and are in the process of establishing its structures. Their challenges will be addressed with the support of the NDOH team. Limpopo on the other hand, is having challenges that are due to lack of leadership and non-functional structures at facility, sub-district district and provincial level. These challenges are being addressed by the executive authority of the province.

4.2 Provinces without dedicated structures:

Provinces that do not have dedicated appointees and structures to carry out the main functions of implementing the Ideal Clinics will fail in this programme. Provinces have been encouraged to appoint dedicated operational managers for clinics with a headcount of 150 patients and more per day Without these managers clinics will struggle to become ideal.

Where PPTICRM structures are not implemented fully and are dysfunctional, the failure to achieve ideal status by those clinics, is a natural consequence. Provinces need to ensure that these structures exist and are functional.

4.3 Supply chain management

Supply chain management is one of the major bottle-necks in the conversion to ideal status owing to poor procurement and delivery of medicines, consumables, equipment and furniture. Efforts by NDOH to address this challenge is beginning to bear fruits, but the challenges on the ground remain. The largest contributory causes to supply chain failures is a lack of connectivity of clinics rendering them inaccessible with current modern supply chain systems that are efficient. NDoH and provinces are working with national and provincial treasuries to address this problem comprehensively and systematically.

5. CONCLUSION

Clinics that score below 40% have extensive infrastructure and staffing problems, those scoring between 40% and 69% need to have staffing, supply chain and processes addressed while those scoring above 70% simply need to ensure that the vital elements are present and functional at all times. Plans are in place to progressively address the infrastructure and staffing problems over the next three years. The challenge will be to obtain the budget required for infrastructure needs.