

The Ideal Clinic in South Africa: progress and challenges in implementation

Authors:

Jeanette R Hunterⁱ

Shaidah Asmallⁱⁱ

Ntshengedzeni Margaret Ravhenganiⁱ

Thoovakkunon M Chandranⁱ

Jeanne-Marie Tuckerⁱⁱⁱ

Yvonne Mokgalagadiⁱ

The Ideal Clinic Realisation and Maintenance (ICRM) programme was designed in response to the current deficiencies in the quality of primary health care services and to lay a strong foundation for the implementation of National Health Insurance.

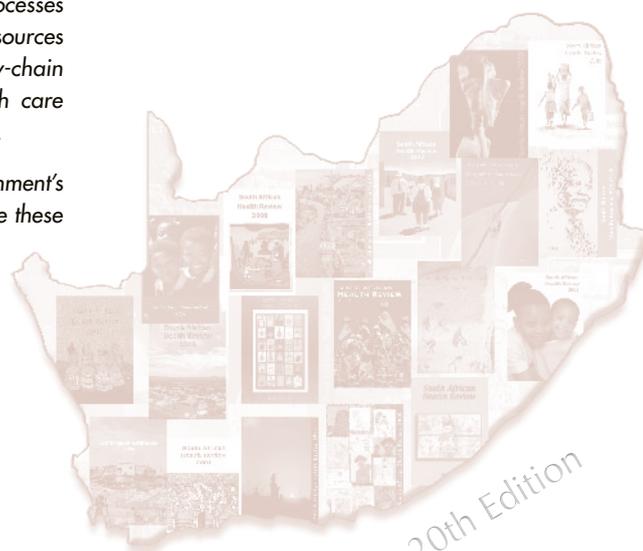
An 'Ideal Clinic' is defined as a clinic with good infrastructure (i.e. physical condition and spaces, essential equipment, and information and communication tools), adequate staff, adequate medicines and supplies, good administrative processes, and adequate bulk supplies; such a clinic uses applicable clinical policies, protocols and guidelines, as well as partner and stakeholder support, to ensure the provision of quality health services to the community.

The 'Ideal Clinic' initiative is structured in three phases: development of the concept (phase one), planning for implementation (phase two), and implementation (phase three). This chapter deals with the implementation phase.

The ICRM scale-up process continued to use an implementation research model and 322 Ideal Clinics were accredited in one year. In addition, the number of clinics that scored over 70% increased from 139 to 445, while the number that scored less than 40% dropped from 213 to 90. This was achieved by focusing on processes to improve integrated clinical-service management, infrastructure, human resources for health, service-user waiting times, financial management, and supply-chain management. However, given that the country has 3 477 primary health care facilities, an achievement of only 322 Ideal Clinics leaves much to be desired.

This chapter reports on implementation progress and challenges for government's 2015/16 financial year, and includes a description of strategies to overcome these challenges, and progress in this regard.

The Ideal Clinic Realisation and Maintenance programme was designed in response to the current deficiencies in the quality of primary health care services and to lay a strong foundation for the implementation of National Health Insurance.



i South African National Department of Health

ii BroadReach Healthcare

iii Clinton Health Access Initiative

Introduction

Central to South Africa's plans to implement National Health Insurance (NHI), is the country's primary health care (PHC) system. This includes 3 477 fixed PHC facilities¹ supplemented with community-based services such as Environmental Health services, School Health teams and community health workers (CHWs). Recent information shows that South Africans are using clinics in increasing numbers.² In the 2015/16 financial year alone, over 127 million PHC consultations were provided, over 160 000 deliveries took place, and more than 3.4 million patients on antiretroviral therapy (ART) were supported in clinics and community health centres (CHCs).² Additionally, immunisation coverage of over 90% and an 'antenatal first visit before 20 weeks' rate of 62.8% were achieved.³ Despite these achievements, many PHC facilities in South Africa still face serious challenges such as long waiting times and insufficient space to attend comfortably to service users.⁴ This has led to negative experiences of care, thus compromising the important role that PHC services play in health promotion and disease prevention.

The Ideal Clinic initiative (now developed into the Ideal Clinic Realisation and Maintenance (ICRM) programme) is designed to address current deficiencies in the quality of PHC services. The programme includes three phases: development of the concept (phase one), planning for implementation (phase two), and implementation (phase three).⁵ Phases one and two, as well as the findings of the Baseline Audit,⁶ were described in the 2014/15 edition of the *South African Health Review*. This chapter focuses on developments since that publication and provides an account of the implementation phase of the Ideal Clinic programme.

Overview of phases one and two

Implementation of the Ideal Clinic programme has its roots in the findings of a Baseline Audit commissioned by the National Department of Health (NDoH) in 2011.⁶ The audit revealed that only one health facility in South Africa's public-health sector – a hospital in North West Province – fully met the required health-facility standards, as per the audit tools. The audit showed that on average, PHC facilities scored lower than hospitals in all priority areas: essential drug supplies were unreliable; staffing was inadequate; and the poor quality of physical infrastructure was having a major impact on the functioning of services and client satisfaction with services.

The Ideal Clinic programme aims to systematically transform all PHC facilities in order to meet national standards in preparation for the introduction of NHI. To this end, facilities are inspected by the Office of Health Standards Compliance (OHSC). The National Health Amendment Act (12 of 2013) mandates the OHSC to protect and promote the health and safety of health-service users through monitoring and enforcing compliance with prescribed norms and standards.⁷ The Ideal Clinic programme is the NDoH's internal mechanism for ensuring PHC facility compliance with these norms and standards in order to satisfy the needs of South African communities.

An Ideal Clinic is defined as a clinic with good infrastructure (i.e. physical conditions and spaces, essential equipment, and information and communication tools), adequate staff, adequate medicines and supplies, good administrative processes and adequate bulk

supplies; such a clinic uses applicable clinical policies, protocols and guidelines, as well as partner and stakeholder support, to ensure the provision of quality health services to the community.⁸

Figure 1 shows the relationship between the Ideal Clinic and communities, community-based services, support services, diagnostic services, higher-level health services within the district health system (DHS), and higher-level health services outside the DHS. The Ideal Clinic framework aims to ensure comprehensive^a person-centric services of an acceptable quality, starting with community PHC service settings, and moving on to include clinics, CHCs, district hospitals, secondary hospitals and tertiary hospitals. Services within health facilities are complemented by non-governmental organisation (NGO), academic and private-sector services. District, provincial and national-level management must ensure systematic collaboration with other government departments that are critical in addressing the social determinants of health.

The DHS remains the vehicle for making a positive impact on the health status of a given community as it plans for and implements services in relation to the specific burden of disease in that community.

The NDoH's District Health System Policy Framework and Strategy 2014–2019 describes the interventions required to improve the current functioning of the DHS.⁹ The District Health Management Team (DHMT), supported by provincial management, is responsible for leading the activities of each district. The DHMT is also responsible for managing the facilities (clinics, CHCs and district hospitals) within that district in order to provide communities with access to the agreed service package. The guidelines for standardising DHMT organograms and job descriptions are in the process of being finalised. Services provided at health facilities are complemented by community-based services delivered through environmental health practitioners, School Health teams and CHW teams. Community access to required health services is ensured through a configuration of complementary service sources from different government departments, as well as from sources outside of government. Service quality must be improved continuously through good knowledge management, appropriate training, interventions designed and led by the District Clinical Specialist Teams (DCSTs), and input from clinic committees and hospital boards.

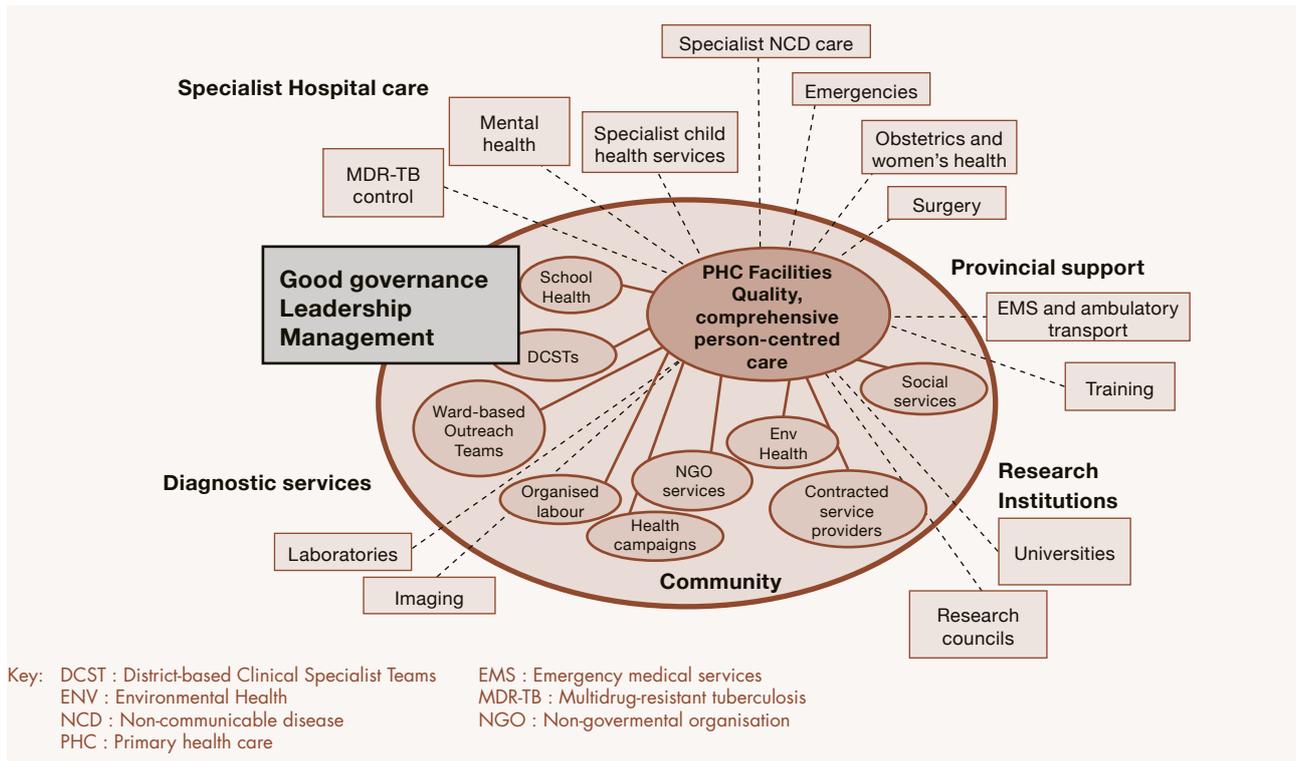
The Ideal Clinic Laboratory

Beginning in July 2013, the NDoH spent eight months testing and developing the Ideal Clinic framework in collaboration with provinces, districts and PHC facility management and staff. A 'dashboard' was developed, using the standard traffic-light colours, and including 10 components and 32 sub-components (Figure 2). Elements are assigned a green colour when they are fully functional; an orange colour if they are partially functional and corrective actions are under way; and a red colour if the element is absent or non-functional.

The framework was then taken into the 'Operation Phakisa' (meaning 'hurry up' in Sesotho) Ideal Clinic Laboratory, which

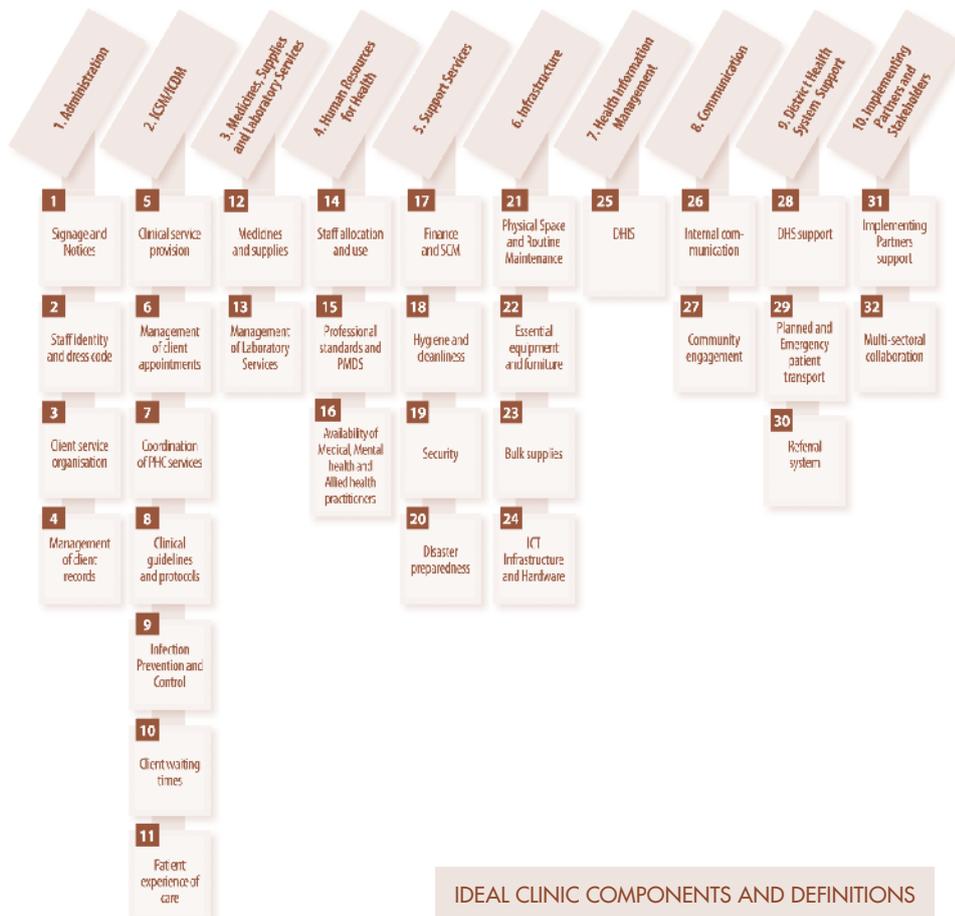
^a In this context 'comprehensive' means a range of integrated community- and facility-based health-promotion, disease-prevention, diagnostic, curative, rehabilitative and palliative services.

Figure 1: Relationship between the Ideal Clinic and other components of the health system in South Africa



Source: Fryatt and Hunter, 2015.⁵

Figure 2: South African Ideal Clinic Realisation and Maintenance Programme components and sub-components (version 16), 2016



Source: South African National Department of Health, 2016.⁸

Figure 3: Section of the South African Ideal Clinic Realisation and Maintenance Programme, illustrating level of responsibility per ICRM element

| NATIONAL CORE STANDARDS | COMPONENT | SUB-COMPONENT | ELEMENTS | WEIGHT | METHOD OF MEASUREMENT | LEVEL OF RESPONSIBILITY | CHECKLIST | PERFORMANCE |
|--|--|---|--|--------|-----------------------|-------------------------|-----------|-------------|
| | | | | | | | | |
| DOMAIN 5: LEADERSHIP AND CORPORATE GOVERNANCE | 9. District Health Systems Support | 29. Emergency patient transport: Monitor the availability of planned and emergency transport for patients | | | | | | |
| | | 170 | There is a predetermined EMS response time to the facility. | I | ? | D | | |
| | | 171 | EMS respond according to the predetermined response time. | I | | D | | |
| | | 30. Referral System: Monitor whether patients have access to appropriate levels of health care | | | | | | |
| | | 172 | The National Referral Policy is available. | I | | NDoH | | |
| | | 173 | The facility's standard operating procedure for referrals is available and sets out clear referral pathways. | I | | HF | | |
| | 174 | There is a referral register that records referred patients. | I | | HF | | | |
| | 10. Implementing Partners and Stakeholders | 31. Implementing Partners' support: Monitor the support that is provided by implementing partners | | | | | | |
| | | 175 | There is an up-to-date list (<i>with contact details</i>) of all implementing partners that support the facility. | I | | HF | | |
| | | 176 | The list of implementing health partners shows their areas of focus and business activities. | I | ? | HF | | |
| | | 32. Multi-sectoral collaboration: Monitor the systems in place to respond to the social determinants of health | | | | | | |
| | | 177 | There is an official memorandum of understanding between the PDoH and SAPS. | I | | P | | |
| | | 178 | There is an official memorandum of understanding between the PDoH and the Department of Education. | I | | P | | |
| | | 179 | There is an official memorandum of understanding between the PDoH and the Department of Social Development. | I | | P | | |
| | | 180 | There is an official memorandum of understanding between the NDoH and the Department of Home Affairs. | I | | NDoH | | |
| | | 181 | There is an official memorandum of understanding between the PDoH and the Department of Public Works. | I | | P | | |
| | | 182 | There is an official memorandum of understanding between the district management and Cooperative Governance and Traditional Affairs (CoGTA). | I | | P | | |
| | 183 | There is an official memorandum of understanding between the PDoH and the Department of Transport. | I | | P | | | |

Key: D : District HF : Health Facility P : Province NDoH : National Department of Health.

Source: South African National Department of Health, 2016.⁸

ran from 12 October to 21 November 2014. Lessons learnt during the concept-design phase guided the scope and content of the Laboratory, which was attended by 164 participants from national government departments, provincial health departments, metropolitan municipalities, public health schools, statutory councils, trade unions, development partners, NGOs and the private sector. Eight work-streams were created, which then undertook clinic visits and held meetings with external experts, with detailed analyses being undertaken as necessary. Each work-stream focused on specified activities and outputs, and a final report was prepared after six weeks.^{b,10}

The underlying rationale informing the focus on bringing PHC services in facilities to an acceptable standard is that this will also improve community-based services and the functioning of district, provincial and national programmes, as some elements in the ICRM framework have to be addressed at all these levels in order to improve clinic functioning.

b The eight work-streams were service delivery, waiting times, infrastructure, human resources for health, financial management, supply-chain management, institutional arrangements, and scale-up and sustainability.

Figure 3 shows a section of the ICRM framework. The letters in the column labelled 'level of responsibility' indicate who is responsible for turning a specific element from red/orange to green (the health-facility manager, district manager, provincial manager or national manager). It is envisaged that the NDoH will complete similar frameworks for CHCs, in collaboration with the provincial Departments of Health, district management and technical staff.

Implementation of the ICRM framework

The ICRM framework does not demand anything new in terms of the requirements for a well-functioning clinic. As such, the resources required at clinic level to turn orange and red elements into green should be budgeted for routinely by clinics and districts as part of provincial Health Department budgets. However, there are three innovations in the ICRM framework. Firstly, the requirements for well-functioning clinics are clearly listed and defined in the form of the elements under the sub-components and components. Secondly, standard operating procedures are available in the form of the ICRM Manual,¹¹ which is a compilation of detailed specific standard operating procedures to turn orange and red ICRM

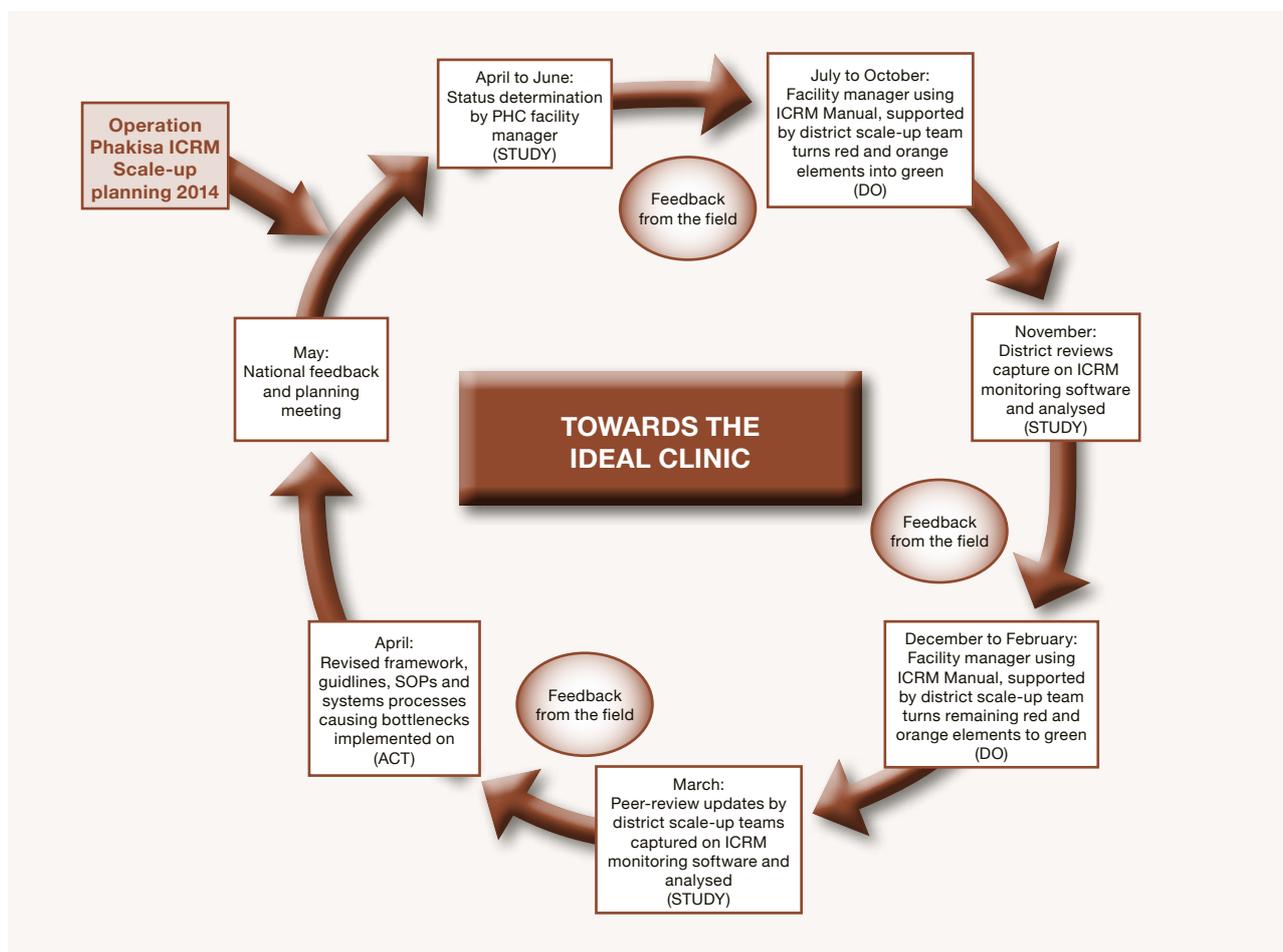
elements into green; the manual can also be downloaded for use as a mobile application on smartphones. The third innovation is the focus and level of specificity with which the ICRM framework is applied to improve the quality of services at poorly functioning clinics. However, since the annual district budgets are for current cost of employment and operations, additional funding has had to be obtained to address the backlog in infrastructure and for staffing shortfalls. The intervention had to be costed before funding could be obtained from National Treasury for its implementation. This process began at the Operation Phakisa Ideal Clinic Laboratory in October 2014, where participants were assigned to the eight work-streams, each focused on a key area such as supply-chain management or service delivery, for which they were expected to develop an implementation plan and associated budget. Support for the budgeting process was provided by the Clinton Health Access Initiative, which developed a methodology for aggregating the budgets submitted by the work-streams.

Countrywide clinic implementation of version 15 of the ICRM framework began in line with the South African Government's financial year on 1 April 2015. The framework has undergone a number of iterations from the first version, and based on comments from health professionals in the field, it is revised before the beginning of each government financial year. For example, April 2017 saw the implementation of version 17. This constant improvement and refining of the framework is based on the theory of implementation research,¹² which provides guidance on how to bring promising

strategies to scale and how to sustain such strategies over the long term. Implementation research is premised on understanding what is not working, understanding how and why implementation is going wrong, and testing new approaches to improve implementation.

The ICRM Programme implementation is also linked to the Plan-Do-Study-Act (PDSA) cycle.¹² Figure 4 depicts the annual ICRM PDSA cycle. Operation Phakisa ICRM planning in 2014 is depicted in a box at the top left (outside of the cycle) because it was a once-off large-scale planning exercise. In general, the cycle starts with status determinations by PHC facility managers (from April to June) and a re-planning session in May. This is followed by the correction of weaknesses (turning red and orange elements into green from July to October). In November, district peer reviews are conducted and then captured on the web-based ICRM monitoring software tool for the purpose of result analyses (study). District scale-up teams then assist clinic managers and staff to turn the remaining orange and red elements into green (from December to February). In March, peer-review updates are done to determine achievement for the financial year. The NDoH receives continuous feedback from managers and staff at provincial, district and facility levels about changes required to guidelines, standard operating procedures, and systems processes that currently cause bottlenecks. The results are used to re-plan the implementation for the next year. Planning for the following year includes amendments to the framework, resulting in a revised version.

Figure 4: Annual ICRM Plan-Do-Study-Act cycle, South Africa



Achievements

Peer reviews of clinic performance were conducted in February 2016.^c To ensure confidence in the final results, each of the top-scoring 659 clinics was peer reviewed by a district scale-up team from outside that province. Table 1 shows the definitions for the three weight categories and the scores for the weight categories used in the ICRM peer-review process, while Table 2 shows the results of the peer reviews.

As shown in Table 2, the NDoH closed the 2015/16 financial year with 322 Ideal Clinics.³ In that year, 1 139 clinics were targeted; the number of clinics scoring over 70% increased from 139 to 445 and the number of clinics scoring less than 40% dropped from 213 to 90.

Key lessons learnt from the 2015/16 implementation process

Lesson 1: The main bottleneck areas relate to infrastructure, staffing and supply-chain management.

Clinics that score below 40% have extensive infrastructure, staffing and supply-chain management problems; those scoring between 40% and 69% should have staffing, supply-chain and processes addressed, while those scoring above 70% should simply ensure that through addressing their supply-chain management, the vital elements are present and functional at all times.

Lesson 2: It is imperative for quality improvement that a Professional Nurse is assigned as the clinic manager.

Table 3 shows that there is an inverse correlation between the presence of clinic managers and the performance of clinics. For example, on average, the provinces with the highest vacancy rates for clinic managers also perform the worst in getting clinics to function optimally.

Table 1: Weighting and scoring categories used in the South African ICRM peer-review process

| Weights | | Silver | Gold | Platinum |
|----------------------------|--|---------------|---------------|----------------|
| Vital (12 elements) | Extremely important (vital) elements that require immediate and full correction. These are elements that affect direct service delivery and clinical care of patients and that may have immediate and long-term adverse effects on the health of the population. | 100% | 100% | 100% |
| Essential (84 elements) | Very necessary (essential) elements that require resolution within a given time period. These are process and structural elements that indirectly affect the quality of clinical care given to patients. | 70% | 80% | 91% |
| Important (82 elements) | Significant (important) elements that require resolution within a given time period. These are process and structural elements that affect the quality of the environment in which health care is given to patients. | 65% | 76% | 87% |
| AVERAGE | | 70–79% | 80–89% | 90–100% |

Source: South African National Department of Health, 2016.⁸

Table 2: Results of South African ICRM peer-review process for the 2015/2016 financial year^d

| Province | All facilities, Version 15 PR | Platinum | Gold | Silver | Not achieved | Total number of Ideal Clinics |
|---------------|-------------------------------|-----------|------------|-----------|--------------|-------------------------------|
| Eastern Cape | 90 | 1 | 10 | 3 | 76 | 14 |
| Free State | 46 | 5 | 14 | 3 | 24 | 22 |
| Gauteng | 124 | 17 | 50 | 22 | 35 | 89 |
| KwaZulu-Natal | 185 | 25 | 87 | 29 | 44 | 141 |
| Limpopo | 77 | 5 | 19 | 3 | 50 | 27 |
| Mpumalanga | 48 | 5 | 12 | 2 | 29 | 19 |
| North West | 57 | 0 | 3 | 4 | 50 | 7 |
| Northern Cape | 32 | 0 | 3 | 0 | 29 | 3 |
| Total | 659 | 58 | 198 | 66 | 337 | 322 |

Source: Ideal Clinic Monitoring and Evaluation Software.

^c This timeframe does not correspond with the timeframe given in Figure 4. This is because 2015/16 was the first year of implementation and it took longer to get implementation logistics in place. The description above Figure 4 describes the future cycle timeframes which had already been implemented in the 2016/17 financial year.

^d Note that the Western Cape Department of Health did not join the ICRM Programme in the 2015/16 financial year, but began participating from 1 April 2016.

Table 3: Percentage of Ideal Clinics compared with percentage of clinics without a dedicated manager, per province, 2015/16

| Province | Total number of primary health care facilities | Number of Ideal Clinics | Percentage of Ideal Clinics | Percentage of clinics without dedicated managers |
|---------------|--|-------------------------|-----------------------------|--|
| | 2015/16 | 2015/16 | 2015/16 | 2015/16 |
| Eastern Cape | 771 | 14 | 2% | 60% |
| Free State | 221 | 22 | 10% | 53% |
| Gauteng | 367 | 89 | 24% | 21% |
| KwaZulu-Natal | 600 | 141 | 24% | 23% |
| Limpopo | 477 | 27 | 6% | 49% |
| Mpumalanga | 288 | 19 | 7% | 29% |
| North West | 314 | 7 | 2% | 49% |
| Northern Cape | 164 | 3 | 2% | 47% |
| Western Cape | 275 | - | - | - |
| South Africa | 3 477 | 322 | 9% | 41% |

Source: Ideal Clinic Monitoring and Evaluation Software.

Lesson 3: Peer reviews serve as additional training for district scale-up teams.

Feedback received from peer reviewers in April 2016 indicates that the evaluation process was experienced positively as an opportunity for district ICRM scale-up teams to learn from each other and to learn from facilities visited in the districts being reviewed.

Overcoming the challenges

Although 322 clinics achieved Ideal Clinic status and the number of clinics scoring over 70% increased from 139 to 513, progress in the first year of the Ideal Clinic programme has been slow. Three main challenges must be addressed by the national and provincial departments of health in order to improve the rate of scale-up: these are poor infrastructure, inadequate staffing, and poor supply-chain systems. The following section summarises some of the steps that have been taken in these areas. Full descriptions of interventions with regard to these three main bottleneck areas will be the subject of subsequent chapters in future Reviews.

Infrastructure

Figure 5 illustrates the infrastructure-related elements of the ICRM and shows that in March 2015, compliance with the element 'clinic space accommodates all services and staff' was low (13%). Although the rate more than doubled by March 2016, compliance remains low at 28%.

Improvement of clinic infrastructure began with the requirement for PHC facilities to be adequate with regard to both capacity/size and functional layout and flow. This is of particular importance for implementation of the Integrated Clinical Services Management (ICSM) model. The latter is a health-system strengthening model that employs a patient-centric approach encompassing the full value chain of the continuum of care and support. Comprehensive care is delivered via the four streams of care rendered at PHC facilities, namely acute care; chronic care; preventive and promotive services for maternal, child and reproductive health; and health-

support services (physical rehabilitation, oral health, etc.). The implementation of ICSM involves two distinct facility-level processes, namely facility re-organisation towards achieving operational efficiencies, and clinical management support to improve the quality of care rendered.

The challenge in implementing facility re-organisation has been inadequate and inappropriate facility infrastructure to support the four streams of care. Recommendations from the Operation Phakisa Ideal Clinic Laboratory were: to develop a standard blueprint for the construction of all new proposed facilities, as well as for existing facilities needing major refurbishment; and to develop maintenance hubs in districts to ensure that proactive planned maintenance is carried out promptly.

During 2015, a team consisting of health-facility planners, public-health specialists and built-environment professionals was tasked with developing the Ideal PHC facility blueprint. This team developed a draft broad standard configuration of facility sizes, using data obtained during the 2011 National Facility Audit. The team then developed the layout guided by the underpinning philosophy of the ICSM, namely to render services in four distinct streams of care in facilities that: provide comfort for users, are well ventilated, have natural light and good acoustics to keep sound levels down, are accessible to physically disabled users, and are both user- and staff-friendly. Room sizes were determined by identifying all the required equipment and furniture per specific room type. In this manner, a complete room list with key features was developed for each of the proposed facility sizes. Table 4 provides a snapshot of a room list.

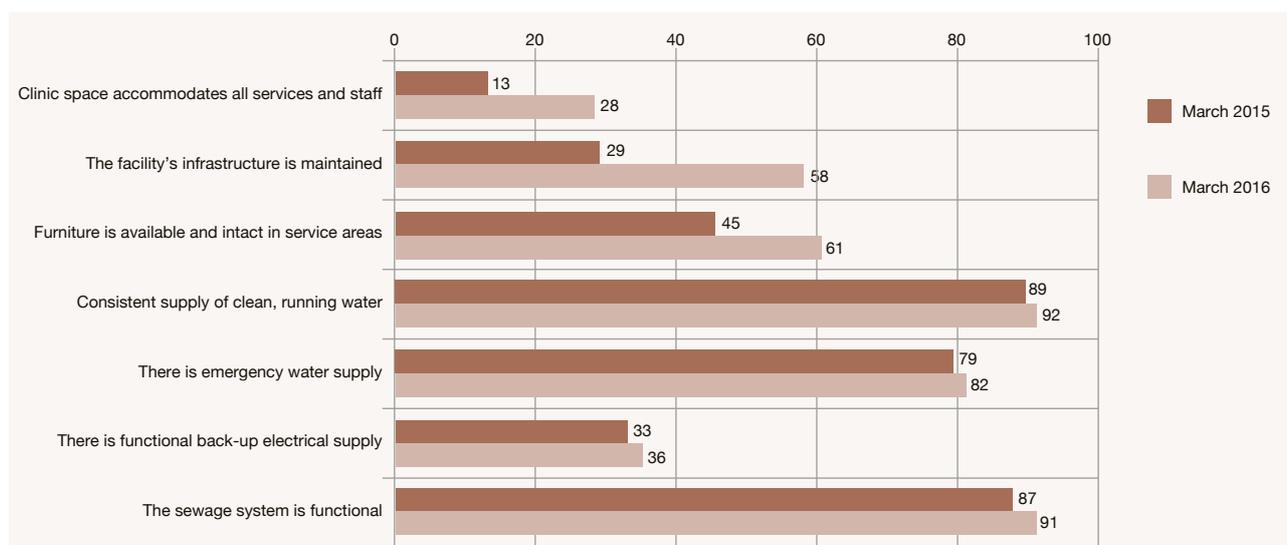
Nonetheless, each facility will have a level of uniqueness determined by geographical location, present and projected future population to be served, referral routes, public-transport routes, specific industries in the area, e.g. mines, and specific health needs in the area, e.g. schools for visually impaired learners. For this reason, a detailed infrastructure and clinical brief template was developed to assist districts in determining the ideal size and configuration of the facility based on services to be delivered, taking into account expected population.

Further to this, while keeping affordability in mind, an attempt has been made to include green technologies in the design of facilities, and finishing schedules have been provided for exteriors and interiors to ensure that products used are durable, easy to maintain and provide a standard appearance in public-health facilities. The NDoH, in collaboration with provinces, is in the process of completing schedules for PHC facilities that need major refurbishment or that need to be re-built.

Staffing

Problems relating to human resources for health in South Africa, and the resultant weaknesses in the health system, have been well documented in South Africa's Human Resources for Health Strategy.¹³ In 2012, the National Health Council (NHC) decided that staffing requirements should be determined across the country in a uniform manner. The World Health Organization (WHO) method – Workload Indicators of Staffing Needs (WISN) – was adopted to determine staffing requirements based on workload.¹⁴ The WISN studies were conducted at selected PHC facilities in 10 NHI pilot sites and the results from these pilot facilities were interpreted and used to develop a PHC implementation guideline containing

Figure 5: Percentage of South African clinic facilities compliant with infrastructure-related elements of the ICRM, March 2015 and March 2016



Source: Ideal Clinic Monitoring and Evaluation Software.

Table 4: Room list for different facility sizes in the South African Ideal Clinic blueprint

| Room Description | Total sq.m | IDEAL CLINIC SMALL | | | IDEAL CLINIC MEDIUM | | | IDEAL CLINIC LARGE | | |
|---------------------------------------|------------|--------------------|-----------|------------|---------------------|-----------|------------|--------------------|-----------|------------|
| | | No. | Area sq.m | Total sq.m | No. | Area sq.m | Total sq.m | No. | Area sq.m | Total sq.m |
| Guardhouse | 18 | 1 | 18 | 18 | 1 | 18 | 18 | 1 | 25 | 25 |
| Adjacent Pedestrian Screening walkway | | | | | | | | | | |
| Outside covered area | 36 | 1 | 36 | 36 | 1 | 50 | 50 | 1 | 50 | 50 |
| Multipurpose meeting rooms | 25 | 1 | 25 | 25 | 1 | 36 | 36 | 1 | 36 | 36 |
| External toilet | 4 | 1 | 4 | 4 | 2 | 4 | 8 | 2 | 4 | 8 |
| MAIN CENTRAL AREA | | | | | | | | | | |
| Help Desk | 6 | 1 | 6 | 6 | 1 | 6 | 6 | 1 | 6 | 6 |
| Admission counter/Reception | 9 | 1 | 9 | 9 | 1 | 16 | 16 | 1 | 16 | 16 |
| Records room | 12 | 1 | 12 | 12 | 1 | 20 | 20 | 1 | 20 | 20 |
| Waiting area | 50 | 1 | 50 | 50 | 1 | 75 | 75 | 1 | 75 | 75 |
| CCMDD collection kiosk | 12 | 1 | 12 | 12 | 1 | 20 | 20 | 1 | 20 | 20 |
| Play area | 9 | 1 | 9 | 9 | 1 | 16 | 16 | 1 | 16 | 16 |
| Toilet and WHB-male | 4 | 2 | 2 | 4 | 4 | 4 | 16 | 6 | 4 | 24 |
| Toilet and WHB-female | 4 | 2 | 2 | 4 | 4 | 4 | 16 | 6 | 4 | 24 |

normative guides and standards. The implementation guideline includes a PHC staff benchmarking template and application procedures. The process of benchmarking the current clinic staff situation against the PHC normative guides and standards in the implementation guideline was completed for all fixed PHC facilities. The benchmarking process involves determining staffing shortages and surpluses based on clinic workload. The next step is to get clinic staff establishments approved in line with the WISN results and to obtain funding to progress incrementally to the required staffing mix. Provincial Heads of Health Departments are currently prioritising the funding for dedicated clinic manager posts to reduce the high vacancy rates in this regard. There is already an average improvement from 66% in March 2015 to 75% in March 2016.

Figure 6 shows that compliance with the element 'Staffing is in line with WISN' is low (7%). This could imply either an under- or over-supply of the different staff categories.

Supply-chain management

The peer-review results showed that it is possible for clinics to reach average scores as high as 80% or more and still not achieve Ideal status. This is because there is a minimum requirement for 'vital elements'. Figure 7 is an excerpt from the dashboard of a clinic, showing the vital elements that are commonly failed, leading to clinics being unable to achieve Ideal status. These elements, as well as the most failed 'essential' elements, are linked to issues of supply-chain management.

Figure 6: Percentage of South African clinic facilities compliant with human resource-related elements of the ICRM, March 2015 and March 2016

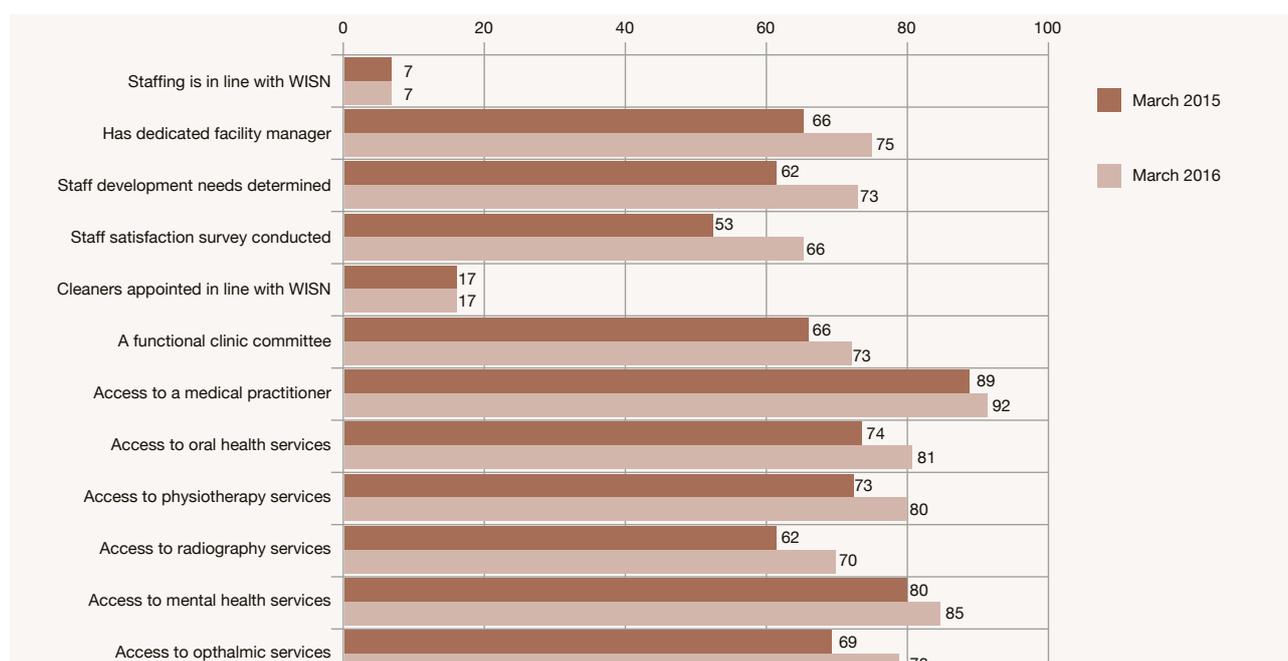


Figure 7: Commonly failed 'vital elements' in the South African ICRM peer-review process

| Sub-component | | | | Eastern Cape | Free State | Gauteng |
|--|--|---|-----------|--------------|------------|-----------|
| Element | | | Weighting | Control | | |
| 9. Infection prevention and control | | | | 85 | 84 | 94 |
| 54 | Sharps containers are disposed of when they reach the limit mark. | V | HF | 99 | 100 | 100 |
| 55 | Sharps are disposed of in impenetrable, tamper-proof containers. | V | HF | 99 | 99 | 100 |
| 12. Medicines and supplies | | | | 70 | 77 | 91 |
| 74 | There is at least one functional wall-mounted room thermometer in the medicine room/dispensary. | V | HF | 84 | 78 | 98 |
| 75 | The temperature of the medicine room/dispensary is recorded daily. | V | HF | 83 | 80 | 98 |
| 76 | The temperature of the medicine room/dispensary is maintained within the safety range. | V | HF | 85 | 80 | 98 |
| 77 | There is a thermometer in the medicine refrigerator. | V | HF | 96 | 98 | 99 |
| 78 | The temperature of the medicine refrigerator is recorded twice daily. | V | HF | 95 | 96 | 99 |
| 79 | The temperature of the medicine refrigerator is maintained within the safety range. | V | HF | 95 | 95 | 100 |
| 80 | 90% of the tracer medicines are available. | V | HF | 72 | 70 | 94 |
| 13. Management of Laboratory Services | | | | 53 | 48 | 68 |
| 85 | Required functional diagnostic equipment and concurrent consumables for point-of-care testing are available. | V | HF | 47 | 38 | 82 |
| 22. Essential equipment and furniture | | | | 37 | 32 | 63 |
| 141 | The resuscitation room is equipped with functional basic equipment for resuscitation. | V | HF | 14 | 7 | 52 |
| 142 | The emergency trolley is restored daily or after every time it was used. | V | HF | 11 | 5 | 46 |
| 143 | There is a sterile emergency delivery pack. | V | HF | 35 | 40 | 73 |
| 145 | An oxygen cylinder with pressure gauges available in resuscitation/emergency room. | V | HF | 92 | 92 | 99 |
| 23. Bulk supplies | | | | 53 | 46 | 80 |
| 147 | There is a constant supply of clean, running water to the facility. | V | HF | 78 | 82 | 99 |

Figure 8: Operation Phakisa Laboratory recommendations for supply-chain management in South African Ideal Clinics

5 Key initiatives to ensure world-class SCM for all clinic supplies and services

|  |  |  |  |  |
|---|---|---|--|--|
| Standardised catalogue for supplies and services | Streamlined SSIs, NSSIs and services procurement processes | Demand forecasting to push standard supplies to the clinics | Rationalised distribution through direct delivery, cross-docks and warehouses | Transversal convenience contracts to capture procurement savings |
|  |  |  |  |  |
| <ul style="list-style-type: none"> Nationwide codified list of supplies <ul style="list-style-type: none"> Minimal specs Maximum price Sub-catalogues tailored to clinic categories Database of approved service providers | <ul style="list-style-type: none"> Petty cash at facility level to enable fast procurement of simple non-standard items Improved procurement capabilities at district level | <ul style="list-style-type: none"> Mobile phone stocktaking tool at clinic level Demand forecasting units at district level to forecast demand based on clinic stock data | <ul style="list-style-type: none"> Convert current warehouses to cross-docks Rationalise number of sub-depots Reliable weekly supply from cross-docks to clinics in a push system | <ul style="list-style-type: none"> Transversal convenience contracts with major suppliers Adherence encouraged through inclusion in catalogue Procurement possible at lower levels, within framework contract |
| <p>Key: SSIs : Standard stock items NSSIs : Non-standard stock items</p> <p> Breakthrough  Quick win  Major delivery fix</p> | | | | |

Source: Operation Phakisa Ideal Clinic Lab Report.¹⁰



Table 5: Matrix of Operation Phakisa work-streams, Ideal Clinic components, and Transversal Lever projects

| ICRM component | Operation Phakisa work-stream | Transversal levers |
|---|---|--|
| 1. Administration | | <ul style="list-style-type: none"> Automation of patient registration and patient record filing system Guideline on filing, archiving and disposal of patient records National Policy for Patient Safety Reporting and Learning Primary Health Care security specifications Policy for complaints management |
| 2. Integrated Clinical Services Management | <ol style="list-style-type: none"> Service delivery Waiting times | <ul style="list-style-type: none"> Integrated Clinical Services Management roll-out plan Clinical tools on health promotion National Patient Referral Policy Infection Prevention and Control Policy Clinical Audit Guidelines Patient Experience of Care Guideline Patient Waiting Time Policy |
| 3. Medicines Supplies and Laboratory Services | | <ul style="list-style-type: none"> Medicines stock control system PHC laboratory guideline |
| 4. Human Resources for Health | 4. Human resources for health | <ul style="list-style-type: none"> Facility staffing – resource plan based on WISN findings Basic Life Support Training |
| 5. Support Services | <ol style="list-style-type: none"> Financial management Supply-chain management | <ul style="list-style-type: none"> Supply-chain management Costing of national Ideal Clinic roll-out plan Cleanliness Guidelines Linen management policy |
| 6. Infrastructure | 3. Infrastructure | <ul style="list-style-type: none"> Infrastructure renewal Plan Essential equipment plan Branding of the 'Ideal Clinics' District Infrastructure Maintenance Hubs |
| 7. Health Information Management | | <ul style="list-style-type: none"> Patient information systems design Ideal Clinic indicators for National Indicator Dataset |

| ICRM component | Operation Phakisa work-stream | Transversal levers |
|--|--------------------------------|---|
| 8. Communication | | <ul style="list-style-type: none"> • Ideal Clinic Realisation and Maintenance Manual • Ideal Clinic Index and guide • Communications plan – internal and external |
| 9. District Health System Support | | <ul style="list-style-type: none"> • District Health Management Office Framework and Profile • Review configuration of the PHC service delivery platform • District Health Committees Guidelines |
| 10. Implementing Partners and Stakeholders | | <ul style="list-style-type: none"> • Development of Memorandum of Understanding |
| | 7. Scale-up and sustainability | <ul style="list-style-type: none"> • Change Management Model • Capturing lessons and implementation research |
| | 8. Institutional arrangements | <ul style="list-style-type: none"> • NDoH 'Ideal Clinic' unit established |

The fact that it is difficult for clinics to achieve 'green' status for supply-chain management elements was already evident during the study phase. For this reason, supply-chain management was allocated a work-stream in the Operation Phakisa Ideal Clinic Laboratory. The Laboratory recommendations are summarised in Figure 8.

The following steps have been taken towards implementing some of these recommendations.

- A national supply-chain management forum has been established, chaired by the NDoH Chief Financial Officer (CFO) and composed of provincial CFOs and national and provincial supply-chain management professionals.
- Progress has been made in terms of medicines provisioning and further implementation of the Stock Visibility System (SVS) to all PHC clinics. The SVS enables effective monitoring of stock-outs at facility level. The plan is to link the SVS with Rx Solution (an electronic pharmaceutical stock-management system used at PHC facilities and hospitals) and to feed information for monitoring of minimum and maximum stock. Rx Solution will immediately advise the procurement system to replenish stock. The Rx solution roll-out will be done in phases. To date, more than 3 000 PHC facilities have functional SVS devices, and the rate of medicine stock-outs has been reduced.
- In collaboration with National Treasury, a national catalogue has been drafted, with specifications for all equipment and supplies needed in the Ideal Clinic.
- In collaboration with National Treasury and provinces, the NDoH is in the process of setting up valid transversal tenders for all equipment and supplies needed in the Ideal Clinic.
- The NDoH is in the process of working with provinces where there are particular weaknesses to strengthen their supply-chain structures.

In addition to removing the three key barriers to scale-up as discussed above, plans have also been put in place to address the transversal levers required to improve the rate of scale-up. In the Ideal Clinic context, 'transversal levers' are tools required across all provinces to speed up the attainment of fully functional PHC facilities. In this regard:

- district scale-up teams have been oriented to the programme, and the peer-review exercise in February 2016 served as further training for district scale-up teams;
- dedicated funding has been obtained from Treasury for management of this programme at national level;

- the change-management approach has been piloted and the results are being used to define the approach to be scaled up;
- the development of monitoring and evaluation web-based software has been completed and is fully functional;
- the ICRM manual has been completed and published. It describes how each element can be turned into 'green'; it also includes measurement tools;
- the branding strategy is being piloted, and results will be used to develop the branding guidelines; and
- a proposal for a standardised District Health Management Office structure has been converted into guidelines, which are yet to be approved.

An initiative to pilot improved financial resourcing at district level is in the concept phase.

Table 5 provides an overview of how the transversal levers are linked to the ICRM components and the Operation Phakisa Ideal Clinic Laboratory work-streams.

Conclusion

Implementation of the Ideal Clinic programme will see the Ideal Clinic at the centre of a community-based PHC service, including School Health, Ward-based Outreach Teams and Environmental Health. Of particular importance is the need for an effective service-delivery platform that will facilitate the achievement of population health targets for national health programmes. The ICRM scale-up process continues to use an implementation research model, and 322 Ideal Clinics were accredited in one year. In addition, the number of clinics that scored over 70% increased from 139 to 445, while the number that scored less than 40% dropped from 213 to 90. This achievement is an indication that attention and corrective interventions focused on specific weaknesses in PHC facilities do have the desired effect. This was achieved through focusing on processes to improve Integrated Clinical Service Management, infrastructure, human resources for health, service-user waiting times, financial management, and supply-chain management. However, given that the country has 3 477 PHC facilities, an achievement of only 322 Ideal Clinics leaves much to be desired.

National and provincial Health Departments, with the assistance of national and provincial Treasuries, must speed up infrastructure and staffing improvements and 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 managers will continue to receive the priority attention assigned to this in 2015/16. We are confident that with concerted effort to strengthen the transversal levers, the programme will continue to yield good results.

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