2018

Draft National Quality Improvement Plan

DRAFT PLAN FOR CONSULTATION 24 AUGUST 2018

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1 Executive Summary

Purpose

This document sets out a proposed overarching National Quality Improvement Plan for South Africa, which seeks to transform existing service delivery challenges into learnings and opportunities for quality improvement and to pull together quality of care initiatives into a coherent 5-year plan.

The focus of this document is to propose a systematic improvement programme within the context of the national quality framework, building on existing quality improvement initiatives and regulatory requirements to develop a process of independent, external quality evaluation for health establishments to meet the requirements of the NHI.

It is imperative that there be a national plan to improve and maintain the quality of health system. ***This plan should have as a goal to prepare each health facility to be accredited to provide NHI personal health services. It is a requirement that all health facilities designated for NHI meet the quality standards set by the Office of Health Standards Compliance. Thereafter, 25% of facilities will need to achieve accreditation as set out in the draft NHI Bill within a year.***

Whereas the development of this draft plan was inspired by the work of the South African Workstream of the international Lancet Commission, this plan is meant for the local audience, policy makers, health management at all levels of the health system and health care providers.

Background

The upcoming report of the South African Lancet Commission on Quality Health Systems provides a succinct diagnosis of the health system, demonstrating the impact of the failure of the private health sector on the already poor public health sector services. It puts the quality of the public health system in context of the overall system. In the private sector quality of care is currently hampered by various factors such as the *lack of coordination between healthcare practitioners,* a 'Fee for Service' (FFS) tariff system that pays providers for processes (consultations, and procedures) rather than disease outcomes and practice models that favour single discipline practices rather than multi-disciplinary teams. In essence this model promotes *fragmentation of care delivery rather than teamwork and* produces sub-optimal quality of care with gaps in needed care, duplication of effort, low productivity and inefficient utilization of highly skilled human resources. Fragmentation and FFS leads to *over-servicing* by individual practitioners, each separately striving to meet a 'threshold income' that will ensure the economic viability of their practice. Due to a chronic shortage of most health care professions and perceived higher income potential in the private sector an oversupply of health care professionals has developed compared to the number of medical schemes funded patients. Inappropriate practices due to an FFS environment result in high medical insurance premiums, shrinking membership and variable quality of care. Most of these patients who cannot afford to pay the high premiums end up in the public sector, which itself is under-resourced. The people centred health care will only be provided through integration of services across public and private sector, across the levels of care and across the types of services (preventive, promotive curative, rehabilitative) through establishment of a seamless whole system.

In the public-sector quality of care is hampered by ineffective management, poor accountability systems and the absence of incentives for salaried employees to provide quality healthcare. This situation is compounded by the fact that state employed healthcare professionals have access to private medical insurance and receive care in the private sector rather than in the public sector where they are employed, which could serve as a disincentive for some to improve the sector in which they work. Various other factors contribute to poor quality such as overcrowding of facilities, a severe shortage of various professional cadres, especially at primary care level, poor or no clinical governance and supply chain constraints such as shortages of equipment and drug stock outs.

The major regulatory measure was the establishment of the Office of Health Standards Compliance through National Health Amendment Act in 2013. This is a body mandated, inter alia, to inspect and certify public and private health establishments as compliant or non-compliant with prescribed norms and standards or, where appropriate, withdraw such certification and make recommendations for intervention by national, provincial or municipal health departments or by individual health establishments to ensure compliance with prescribed norms and standards. The 2016 /17 report to the Portfolio Committee on Health demonstrated that on average, the public health facilities inspected met less than 50% of the required quality health standards. What is of major concern was the failure of health facilities to implement quality improvement plans, suggesting that managers must be held accountable.

In addition to many disease specific improvement programmes, one of the responses by the National Department of Health to implement quality improvements was the introduction of the Ideal Clinics programme and from that developed Integrated Chronic Disease Management (ICDM) and Integrated Clinical Services Management (ICSM). The programme is described in section 3.2.

The Department of Health with the support of some of the members of the Lancet National Commission developed a Plan of Action to improve the health system at the end of August 2018. To correct the broken health system requires the development of a detailed and adequately funded quality improvement plan and guideline, with a road map specifying clear objectives to improve the health system (including quality accreditation of facilities and providers), targets, and indicators to monitor the performance of health establishments. With the move towards NHI, the plan needs to include both the public and private healthcare providers to develop best practice.

2 Introduction

South African public healthcare services are responsible for meeting the physical and mental health care needs of working, unemployed and needy South Africans in the face of an HIV and AIDS epidemic, rampant tuberculosis, malaria, childhood diarrhoea and malnutrition. Poverty, substance abuse, violence and related trauma seriously impact on these services.

The degree to which the needs of the public are met varies from excellent to extremely poor and the capacity to meet the needs varies from institution to institution and by district and province.

Feedback from the High-Level Panel Assessment of Key Legislation and the Acceleration of Fundamental Change (HLP) commissioned report on access to quality health care and a recent series of inspections by the National Department of Health (NDOH) of two hundred hospitals have found that the capacity of South African healthcare services to meet the needs of the citizens of South Africa is impaired by:

- variable leadership and management skills across the system;
- failure or inability to act on identified deficiencies;
- unsatisfactory maintenance and repair services;
- poor technology management;
- ineffective supply chain management systems;
- lack of accountability;
- poor disciplinary procedures and corruption;
- staff attitudes, absenteeism and presenteeism

Management and leadership is variable across the health system. Where it is lacking, this can be one of the reasons for losses of key staff, which exacerbates the low staff /high patient ratios. This has caused low staff morale and feelings of helplessness.

There are significant problems in clinical areas, which affect direct patient care. These relate to critical staff shortages, inadequate training and the poor attitudes of staff. The following examples of how patients have been put at risk were found using an incident monitoring system that was part of a patient safety programme:

- vital equipment and consumables are not at hand when they are needed;
- delayed emergency surgery because surgical staff are not available;
- inadequate preparation for surgery and surgical errors;
- drips run dry during the night and are not replaced, even on patients in the post-surgery phase.

The views of patients and service users are a critical factor in terms of the quality of health services. One way of assessing the experience of patients is through the complaints that are logged by the healthcare facilities on a new national web-based information system that was launched in April 2018. The top five categories of complaints received to date, from highest to lowest are:

- Patient care
- Waiting list for operations
- Staff attitude (Respect and dignity)
- Waiting times (Casualty and Out-patients)
- Access to information

Patients also complain about un-kept entry areas and poor communication regarding procedures and the functioning of casualty departments and about overcrowding in maternity and neonatal wards.

The case study in Figure 1 describes how the challenges are lived out in a regional hospital – similar situations can happen daily across South Africa.

Case Study

Impact of poor resource allocation on waiting lists and waiting times

At 15.00 on the Wednesday before a long weekend a young man was admitted to a regional hospital with a serious hand injury. On Friday evening he was still in casualty. The ward to which he should have been admitted to was full and admissions overflowed to two other wards. The bottleneck was theatre. There was one anaesthetist working between two theatres for both General Surgery and Orthopaedics. This meant a backlog for both disciplines and patients needing surgery were delayed, staying longer in the ward increasing the chances of complications. The beds were blocked so that new admissions were stuck in casualty, leaving very little space there for new patients who needed to be seen. All this due to poor allocation of resources. Young doctors and nurses working really hard to deliver good service to their patients while at the same time being frustrated by lack of critical staff. Both the general surgery and Orthopaedic lists then had to be stopped as the anaesthetist was called away to attend to two emergency obstetric cases.

Figure 1: Case study on challenges in South African hospitals

3 Context

To make the best use of resources and to build on existing successes, the quality improvement plan should be based on the inspection results from the Office of Health Standards Compliance, the Ideal Clinic Realisation and Maintenance Programme (ICRM), including the Integrated Clinical Services Management (ICSM) and recent site visits of the National Department of Health to hospitals across provinces with the support and investment in quality improvement. Most importantly, this centrally driven approach also factors in the experiences of frontline service delivery managers and health care providers who experience on a daily basis, the challenges of service delivery. This is done to augment the view from the top with the perspectives from below.

3.1 Development of legislated regulatory Standards

The promulgation of the National Health Act amendment in 2013 established the OHSC as an independent regulator of health services responsible for ensuring safe, quality health services for all South Africans in both the public and private health care sectors.

Following this, the National Core Standards (NCS) were reviewed to provide a regulatory framework against which service delivery at health establishments could be evaluated. This framework had to take into account the necessity for data collected during an inspection to withstand legal scrutiny, which requires more rigorous objectivity and validity than evaluative processes that do not incur legal consequences.

The first subset of regulated standards was promulgated in terms of the Government Gazette Vol. 632 of 2 February 2018 No.41419 and will come into effect 12 months from promulgation. The OHSC legislated mandate requires that it is responsible for the certification of establishments that meet the regulated standards. The areas covered by the legislated regulated standard include:

User Rights

1. Access to care

Clinical Governance

1. User records and management
2. Clinical management
3. Infection prevention and control programmes
4. Waste management

Clinical Support Services

1. Medicines and medical supplies
2. Diagnostic services
3. Blood services
4. Medical equipment

Facilities and Infrastructure

1. Management of buildings and grounds
2. Engineering services
3. Transport and management
4. Security services

Governance and Human Resources

1. Governance and human resource management ns
2. Human resource management
3. Occupational health and safety

General Provisions

1. Adverse events
2. Waiting times

The plan is to enhance the rigor and depth of the regulated standards as experience is gained in the field. As set out in the Government Gazette the OHSC must commence its inspection programmes using the regulated standards in February 2019. In addition to the promulgated regulated standards, the procedural standards for inspections have also been promulgated and are thus also now in law and have to be met, by both the OHSC and healthcare establishments.

The legislated inspection procedures include the following processes:

- Initiating an inspection
- Conducting back ground document review
- Preparing for on-site inspection activities and the associated logistical requirements
- On-site inspection activities
- Preparing, approving and distributing inspection reports
- Completing the inspection findings
- Conducting inspection follow-up

Inspections cover what managers are expected to deliver in health establishments and reflect the policy context based on legislation, policies, clinical guidelines and protocol and the requirements of the National Treasury and the Department of Public Service Administration.

To meet the standard requirements, staff are required to carry out their routine functions of planning, executing, checking and acting on the bases of the results. Supervision is key to performance.

The inspection of the OHSC for the period 2016 /17 were conducted using the NCS which were drafted in 2008 as policy initiated by the Minister of Health, and regularly updated as forerunners to a set of Regulated Standards[1]. The OHSC has acknowledged that some of its measures require some revision in order to be more specific on what they measure.

The results of the OHSC inspections 2016/17. Figure 2 shows the overall compliance achieved.

Standards compliance of Public Sector facilities 2016-17

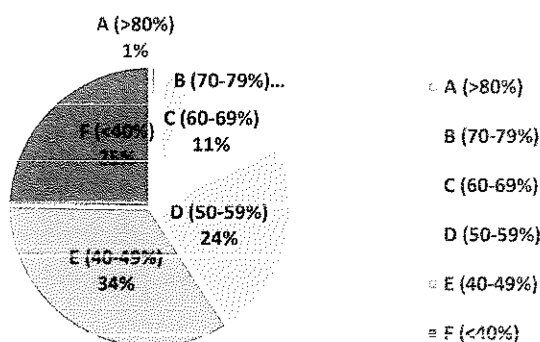

Figure 2

Table 1 shows that there was a lack of management in many of the health facilities inspected. There is hardly any strategic management of health services. Oversight and holding people accountable for their action is extremely poor with not a single province meeting the standard. Leadership is sorely lacking, without it, services cannot be well managed. One province, Northern Cape, had no risk management at all among the facilities inspected. Operational management was also very poor, which is a clear indication that the health system is in need of urgent attention. The results indicate that staff are not treated as valuable assets and hence their attitude would be expected to be negative and affect how they treat patients. To create a caring health service starts with caring for the staff who provide the service.

Table 1: Performance of health facilities in management

Area	Lowest (%)	Highest (%)
Strategic Management	18 LP	32 GP
Oversight accountability	18 NC	59 WC
Effective Leadership	19 NC	53 KZN

[1] At times definition of measures require refinement to ensure their validity.

Risk Management	0 NC	80 MP
Quality Improvement	21 WC	82 NW
Operational Management	32 LP	47 NW
Staff welfare & employee wellness	15 LP	31 WC
Supply Chain & asset management	18 EC	34 WC

LP=Limpopo, NC=Northern Cape, WC= Western Cape, GP=Gauteng, MP=Mpumalanga, NW=North West, KZN=Kwazulu-Natal, EC=Eastern Cape

The OHSC inspected the facilities to determine if they meet the six priority standards of service provision (Table 2). None of the provinces met the score of 80%, suggesting that they would not be certified as meeting the requirements.

Table 2: Performance score of six priority areas that need to be improved to a score of at least 80%

Province	Availability of Medicine & Supplies	Cleanliness	Patient Safety	Infection Control	Values& Attitudes	Waiting Times
Eastern Cape	45	38	42	46	56	61
Free State	50	42	42	49	55	62
Gauteng	60	60	61	65	68	76
Kwazulu-Natal	58	65	55	59	67	68
Limpopo	41	38	42	45	51	64
Mpumalanga	51	42	49	51	58	58
Northern Cape	57	49	48	52	65	56
North West	54	45	49	55	60	65
Western Cape	51	60	55	57	66	65

3.2 Ideal Clinic Realisation and Maintenance programme

The Ideal Clinic Realisation and Maintenance (ICRM) programme is designed to address current deficiencies in the quality of PHC services. The first two phases have been completed, the focus is now on implementation. 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 (non-compliant) elements into green (compliant) 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. First, the requirements for well-functioning clinics are clearly listed and defined in the form of the elements under the sub-components and components. Second, 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 meant for current cost of employment and operations, additional funding has had to be obtained to

address the backlog in infrastructure and for staffing shortfalls. Three key lessons have been learned from the programme to date:

- The main bottleneck areas are infrastructure, staffing and supply chain management
- It is imperative for quality improvement that PHC facilities have a dedicated manager
- Peer reviews serve as additional training for district scale-up teams

Figure 3 illustrates how the Ideal Clinic relates to other organisations within the local health system.

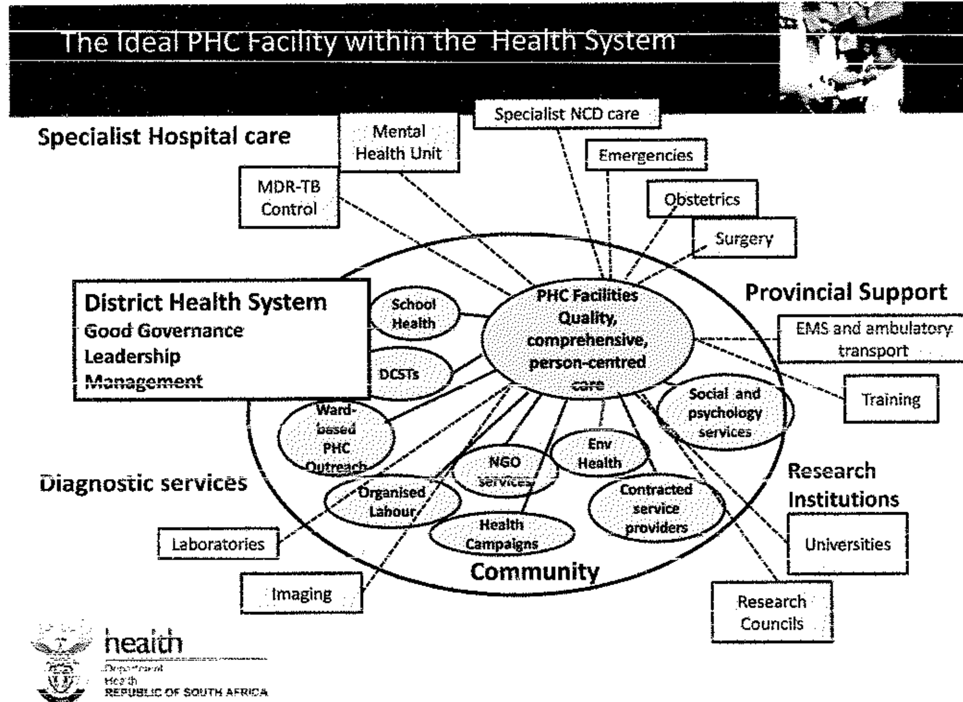

Figure 3: Ideal Clinic Realisation and Maintenance Programme components and sub-components (J Hunter NDoH)

Table 3: The number of clinics that have achieved and maintained Ideal Clinic status 2015 - 2018

Province	Total Number of Facilities	No of Ideal Clinics in 2015/16	2015/16 IC status maintained in 2017/18	No of Ideal Clinics in 2016/17	2016/17 IC status maintained in 2017/18	Ideal Clinics in 2017/18	Total Ideal Clinics Achieved	% Ideal Clinics
Eastern Cape	772	14	9	127	74	77	160	20.7%
Free State	223	22	19	58	41	26	86	38.6%
Gauteng	370	89	82	130	115	106	303	81.9%
KwaZulu-Natal	602	141	120	192	160	78	358	59.5%
Limpopo	479	27	16	38	32	67	115	24.0%
Mpumalanga	288	19	10	47	27	31	68	23.6%
North West	313	7	5	86	57	25	87	27.8%
Northern Cape	163	3	3	64	52	23	78	47.9%
Western Cape	268	0	0	41	32	90	122	45.5%
South Africa	3478	322	264	783	590	523	1377	39.6 %

Table 3 shows the number of clinics that achieved Ideal status between 2015 and 2018. Further progress has been made, i.e. 43% of clinics (1507/3478), as at the end of March 2018, being transformed into ideal facilities. The Ideal Clinic Realisation and Maintenance Programme is an important intervention to strengthen the quality of PHC services. This is in accordance with the mantra of the country's NHI policy that stipulates that PHC will be the backbone of service delivery.

4 National Health Insurance

To ensure the quality of services provided under the Fund, the NHI White Paper[1] (section 38) and the draft NHI Bill sets out that there will be two processes in assessing a provider's suitability to provide services under the NHI. The first, certification by the OHSC; the second, accreditation by the NHI Fund. The OHSC certification provides a regulatory measure of the minimum acceptable level of quality. The regulations and associated standards are now law, and as such they have to be met by both public and private healthcare establishments. The OHSC has the power to enforce compliance on establishments that seriously lag behind and endanger the safety of patients and staff, including requesting the National Prosecuting Authority to intervene if necessary.

In addition to the regulatory standards, the Ideal Clinic Realisation and Maintenance Programme and Integrated Clinical Services Management programmes there are many disease specific and other improvement initiatives, often supported by NGOs and donors. The NDOH has recently inspected 50 hospitals and identified common problems that need to be addressed. It is clear that in many areas healthcare workers are trying their best to deliver services in very difficult and resource-constrained circumstances. To these staff, the

improvement initiatives are seen as a burden and extra work. The national quality improvement plan needs to bring all these initiatives together, identify those that are working well and review the implementation of those with poor results. To move towards overall improvement across the health system and to develop the platform for the required high-quality services and accreditation for the NHI, critically there needs to be significant improvement in the systems and process to ensure that any quality improvements are sustained. This will require a clear plan of action, which should include training the management of health facilities to improve their performance in management, the six priority areas and to monitor the performance consistently.

Developing this national quality improvement plan that builds on the platform established by the OHSC, ICRM programme and other quality initiatives and moves facilities towards sustained quality and accreditation for NHI will have multiple benefits. First, it will lay out the roadmap to improve the quality of the health system in an incremental fashion in an agreed time frame, recognising that some establishments will need more time and investment. Second, it will enable an accreditation process to be tested as an integral part of the quality improvement in preparation for the implementation of the NHI. Third, it could enable facilities to be ready for testing contracting for the provision of services under NHI. This should not be business as usual.

There is already an internationally recognised healthcare facility accreditation organisation in South Africa that could offer the NHI an accreditation system. The move towards accreditation should be a trajectory towards excellence for all providers. We recommend that there be recognised, accredited steps on the trajectory to enable providers to progress to excellence over time. This system should be tested for suitability for the NHI.

Healthcare facilities provide a wide spectrum of services: from complex high-tech interventions to save the lives of severely ill patients and which are conducted by a multi-disciplinary team with advanced skills in an urban academic hospital to equally important preventive immunisations administered by competent nurses in a rural clinic. The range of levels of healthcare facilities in South Africa should be seen as a necessary gradation of increasingly sophisticated services, each designed to manage the patient's journey from settings of promotive, preventive care to necessary high-end interventions when they reach a stage of critical illness. The challenge of ensuring that these diverse services all achieve high quality provision and over time are able to be accredited by the NHI is great but with concerted, coordinated effort using well-tried and tested quality assurance and improvement methods we can meet the challenge.

5 Conceptual framework for Quality Improvement

The focus of this document is to propose a systematic improvement programme within the context of the national quality framework including a process of independent, external quality evaluation for health establishments to meet the requirements of the NHI.

The Lancet National Commission on High Quality Health Systems defined a quality health system as follows:

A high-quality health system achieves equitable health outcomes and a long and healthy life for all. Such a health system is:

- ✓ Designed to prioritise health promotion and protection, the prevention, treatment and rehabilitation of conditions that constitute South Africa's disease burden.
- ✓ *Accountable* through effective leadership and governance
- ✓ *People-centred* in its approach to realising good health by facilitating patient, provider and community participation in health attainment
- ✓ *Responsive* to patient needs by providing comprehensive care in a timely and safe manner resulting in quality outcomes
- ✓ Adaptive to changing health needs through the collection, analysis and dissemination of *information*
- ✓ *Equitable* allocation and distribution of resources ensuring quality health service delivery to all regardless of gender, sexual orientation, socio-economic status and/or geographic location
- ✓ Collaborates with other sectors to address the social determinants of health

To achieve this consistently across the South African health system there will need to be significant effort dedicated to quality assurance and improvement.

Quality assurance is a set of activities carried out to:

- ➢ set standards
- ➢ monitor standard compliance
- ➢ ensure the service provided is effective and safe

"Quality improvement is the effort to improve the level of performance of a key process. It involves measuring the level of current performance, finding ways to improve that performance and implementing new and better methods."[1] Quality improvement is a continuous process that includes internal monitoring and external evaluation.

Accreditation is a self-assessment and external review process used by healthcare organisations to accurately assess their level of performance in relation to established standards and to implement ways to continually improve.' (Rooney & Van Ostenberg 1999)

Figure 4 shows how quality improvement and quality assurance are related and together help to move a system towards excellence and sustain improvement.

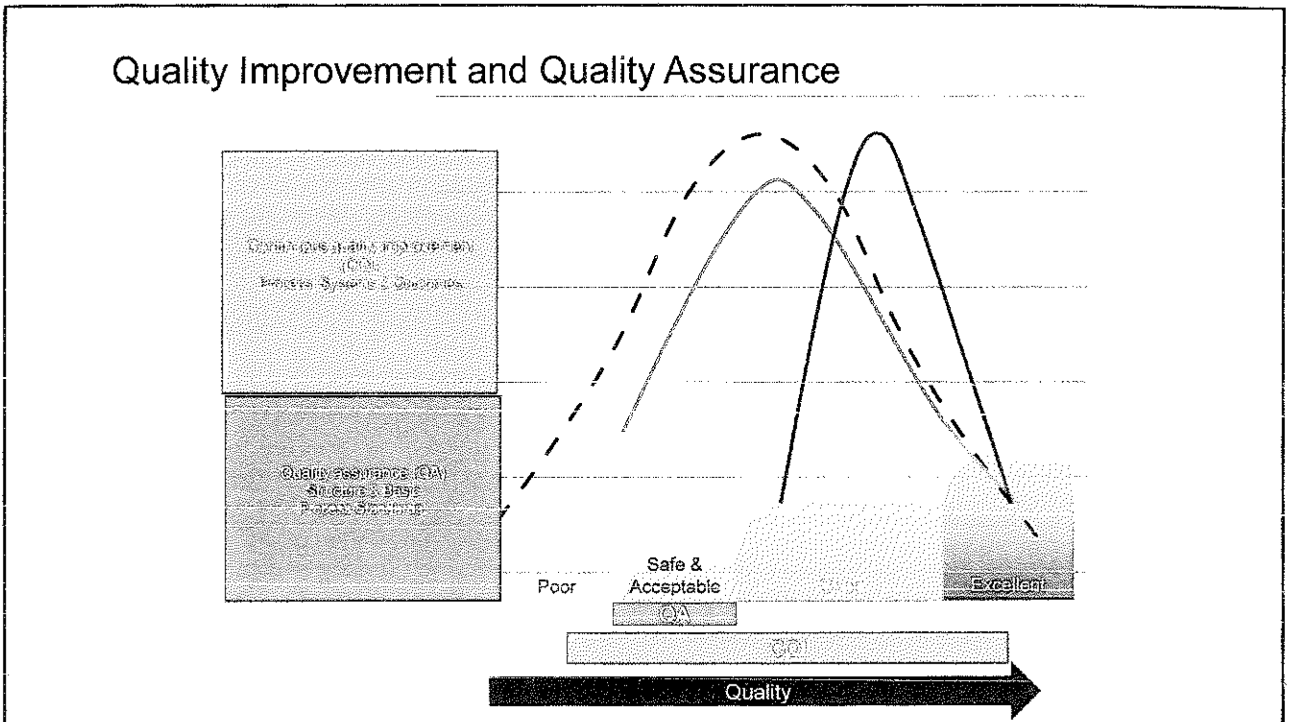

Figure 1

Improving quality is achieved through a variety of tools and approaches. It is recommended that the underlying approach is standards-based to ensure that the systems and processes are in place to support effective clinical practice. This includes improving operations through better management systems; building capacity for team work and problem solving at district and facility levels, through training, coaching and mentoring to ensure effective dissemination and scale-up. To deliver the NHI requirements all the following areas must be addressed:

- Improved physical environment and systems within and through which care is delivered
- Strengthened management skills and systems; improved accountability
- Effective planning for improved access and effectiveness
- Patient care management
- Information and measurement systems
- Improved outcomes for conditions that are major contributors to our burden of disease; through prevention / promotion, clinical care and safety
- Human Resource Performance Improvement
- The important role of organised labour in quality improvement
- Value based contracting

All quality improvement interventions must be formally monitored in an iterative manner with timeframes and responsible persons identified explicitly. For implementation of quality improvement in the health system, stakeholders such as labour, nurses, allied health care workers, support staff, doctors, management and patients, as well as independent professional bodies should participate in the monitoring process.

Fundamental to this process is the implementation of standards that meet the needs and expectations of patients, staff and citizens – the first level being the OHSC regulatory standards followed by the standards required for the NHI. This process includes the

evaluation of the degree to which standards are met and the introduction of quality improvement activities designed to address identified areas of non-compliance to the required standards. It will be critical to build the capacity of staff at facility, local, provincial and national levels, to understand the intent of the requirements of the standards and how to implement improvements using a cascade approach.

The types of facilities included in this proposal are hospitals, clinics, emergency services, and family practitioners. The same process of standard implementation, evaluation and quality improvement followed by accreditation awards is followed in each of these facilities. Over time the model of care should move towards multi-disciplinary patient-centric teams.

The quality improvement approach will be systems-based – that is ensuring that the systems, functions and processes are in place to support quality care and ensure that evidence-based medicine is practised and that clinical guidelines and protocols are followed. The implementation of clinical protocols is assessed by clinical audits, which ensures good clinical systems. This is to ensure sustainable change.

We recommend that the implementation of the standards and their monitoring at facility, local, provincial and national levels be supported by a suitable, integrated and interoperable web-based information system that:

- provides continuous access to current standard compliance data;
- allows facilities to input their own data and monitor their own performance in terms of key NHI agreed indicators, such as health outcomes, patient satisfaction
- enables management at all levels to monitor the improvement and make informed decisions;
- and supports the facilities to manage the process to reach and maintain accreditation standards;

This information system would become the foundation of the quality improvement, monitoring and accreditation activities and would be essential to the success of the programme. There needs to be discussion as to how existing systems can be used to meet these requirements to avoid duplication and unnecessary expenditure.

This proposal outlines how quality improvement may be carried out most effectively in South Africa in the future. The key elements of the proposed quality improvement programme focus on:

- Strengthening capacity within the National Department of Health to oversee and monitor the quality improvement work across the country;
- Building capacity within provinces, districts and health establishments to embed and maintain continuous quality improvement programmes beyond compliance with the OHSC regulations;
- Providing training locally to healthcare facilities on quality improvement methodology and monitoring and evaluation using an appropriate information system;
- Linking public and private healthcare facilities to share experience and learning.

6 Governance, Management and Leadership

With the move towards NHI, effective governance systems need to be established to ensure accountability at all levels of the health system. The King IV report provides world class guidance on this. It will be critical as in the NHI all providers will be held accountable for their services and actions.

The need for effective leadership and management at all levels of the health system has been identified and articulated clearly. It is critical if the quality of services is to be improved consistently and sustainably. Although some good efforts have already been made, there needs to be a wholesale transformation of the management system with decentralisation. Hospital management needs to be strengthened fundamentally to ensure there is accountability and authority for the operational management of the facility. This will allow managers to take responsibility for the provision of efficient and cost-effective services to patients. Provincial health departments will need to delegate decision-making to hospital managers, giving them greater control and flexibility to manage daily operations, including the authority to make decisions relating to personnel, procurement and financial management. To ensure the implementation of basic management processes, we recommend the creation of business units in each clinical department consistent with the model developed at Chris Hani Baragwanath Hospital by labour, the hospital management team and academic staff.

There will need to be a strong performance management system that focuses on good governance, targets, outcomes and the quality of services provided. There will need to be highly effective and relevant management development and training for senior and mid-level managers.

For the NHI to be effective, healthcare facility managers need to be managers rather than administrators. They will lead be contracted by the NHI to provide services for a defined community and will be held accountable for such service provision.

7 Guiding principles

Quality improvement requires a continuous, collaborative, participatory, systems approach, integrating QI into management functions. This approach regards quality improvement as a progressive and gradual process that relies on the guiding principles of teamwork, systems and processes, patient–centeredness and measurement [2]:

a) Person-centeredness

Person-centeredness emphasises that services should be designed so as to meet the needs and expectations of patients and the community. This principle recognises that what the patient brings into an interface with the health system is as important as the skills and knowledge possessed by the healthcare service providers.

b) Systems and Processes

Systems and processes recognise that providers of healthcare services must understand the service systems and the key service processes in order to improve them. Developing and

[2] James R. Heiby, 2001, *Quality Assurance and Performance Improvement : Important Approaches in Improving Health Systems,* Quality Assurance Project *(USAID).*

implementing tools of process engineering will allow simple visual images of the processes and systems. Resolving the problem of unclear, redundant, or incomplete processes or systems will yield better results than placing the blame on individual workers. As has been demonstrated with ICDM and ICSM, systems and processes can be improved and streamlined through the application of evidence based healthcare. This will ensure that appropriate interventions to achieve quality health outcomes are implemented. Systematic review of available research and evidence on the effectiveness of specific clinical and healthcare interventions should inform the development of clinical guidelines and clinical audits and adverse side effects.

c) Team Work

This is a collaborative approach which recognises that team members bring valuable insights regarding the process to be improved because of their knowledge of and experience in it, and are more likely to implement improvements they helped to develop.

Representatives of organised labour through trade unions, staff associations and professional associations are critical to the process of quality improvement. Effective systems and processes are equally important for the safety of personnel as they are for the safety of patients. The involvement of these stakeholders will bring their inputs and experience to the understanding of changes that need to be made and to the effective implementation of the appropriate processes, as well as to the development of ownership of the improved processes and systems. Quality improvement activities that involve health teams in the collection and analysis of data and the determination of standards and priorities will also assist in team-building and developing local cultures of quality improvement.

The goal of the programme must be to ensure the best possible outcomes for the South African health system, as reflected in improved health status, satisfied patients and staff and best use of resources; through quality assurance and improvement strategies.

d) Measurement

Measurement is essential once problems are identified, to measure performance through pre-agreed upon indicators and ensure that all action is based on evidence. It is a continuous feed-back loop and ensures that changes that have been implemented can be tested and the resulting data analysed to verify that the changes have actually led to improvements.

8 Programme Strategy and Methodology

8.1 Integrated Approach to Quality Improvement

This approach will enable the building of capacity across the health system to strengthen the improvement efforts at all levels. Within the context of a national framework, local capacity will be developed to support the local implementation and sustainability. The regulatory certification by the OHSC sets a specific minimum level of achievement and should be the start of the trajectory towards excellence, with the quality improvement and full NHI accreditation being the aim

A carefully planned, organised, articulated, and documented approach is required. It should be systematic and incorporate the setting of priorities for improvement through a performance assessment process that uses sound methodology. All improvements need to be underpinned

by robust systems that will support a number of programmes and sustain quality improvement activities right across the health system.

It is essential that the approach be organisation-wide involving both clinical and non-clinical leaders. The improvement process should be collaborative, using an interdisciplinary, cross-functional approach organised around the flow of patient care and involving all services, settings and disciplines as illustrated in Figure 5.. The multidisciplinary approach needs to be guided by multidisciplinary standards that provide a blueprint for quality service provision. For management and staff, the focus must be on active involvement with the team. Of paramount importance is capacity building and skills transfer at all levels across the health system.

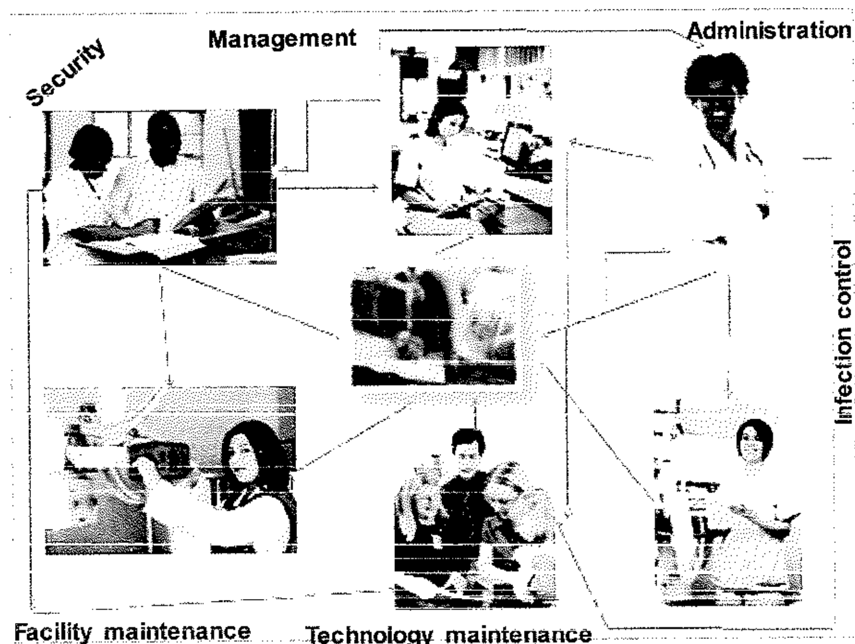

Figure 2: The interconnectedness of all departments and personnel in a health establishment

The importance of peer review and benchmarking is emphasised as the chosen mechanisms to share best practice, which is essential if variations between establishments, districts and provinces are to be reduced.

The systems required to provide coordinated care include managerial, clinical, clinical support and hotel systems. Standards are set for each system and healthcare service. The standards should be designed to measure the degree to which health service provision complies with agreed standards and these standards should aim to meet the expectations of patients, health professionals and the community.

8.2 Essential requirements to enable improvement

For the quality improvement programme to be successful there are some immediate, practical interventions that are required within the health system. These include:

- lifting the moratorium on the filling of critical and essential clinical and administrative posts as there is a critical shortage of staff in many facilities;

➢ dealing with basic maintenance and repairs to make facilities operational.

These two issues are the factors that health workers say cause them the most stress.

To reduce congestion in hospitals, referral pathways need to be reviewed and implemented together with community information and education on available services and how to access the best care.

To improve efficiency and reduce variation, standard operating procedures need to be implemented in all facilities.

For the NHI to be successful, there is a need to move towards a centralised electronic medical record(EMR), however there are existing EMRs already deployed and thus alternatives should be considered. One solution could be a portable patient-owned record as an app, to which key information such as laboratory results, ICD 11 diagnosis codes and prescribed medication could be exported. Alternatively, the data could be exported to a centralised e-register that is accessible to all health care providers.

Over time the key influencer of quality will be through using contracting by the NHI on a team based remuneration mechanisms with the right incentives for promoting good healthcare in the population and ensuring quality care of the sick. The needs to a tariff schedule that promotes high productivity and prevents underservicing by carefully balancing all interests: good care for patients; viability and autonomy for healthcare professionals and sustainability for the NHI. The unique identifier project needs to be rolled out to all South Africans.

8.3 Standards and measurement

The National Core Standards have been developed and the specific standards that are part of the regulatory framework have been through the parliamentary process and published in the Government Gazette.

The NHI accreditation will require higher standards to ensure that health establishments are able to provide the full range of services safely and effectively. To expedite the implementation of the quality improvement and accreditation programmes required to improve the performance of healthcare organisations, standards currently in use, that meet international principles and requirements could be used with modifications if necessary.

In addition to the system standards, ensuring the systems, functions and processes are in place, there is a need to have true outcome measures that shift from measuring volume of services provided to measuring the value provided to patients (value defined as outcomes achieved relative to the cost). The Health Market Inquiry recommended reporting and measurement of key health outcomes for the private sector and now is the opportunity to harmonise this process across the public and private sectors in preparation as we move to a single health system. Assessing Standard Compliance

At the facility level, healthcare organisations (hospitals, primary health clinics, emergency services and family practitioners) are evaluated against the appropriate standards to obtain a baseline assessment of the organisation. Deviations from the standards can be prioritised

according to the impact they have on quality and patient and staff safety. Based on the detailed analysis of prioritised deficiencies, an integrated quality improvement programme for the organisation is developed with input from the multidisciplinary team.

The quality information should be available on dashboards that are accessible to the public and linked to the patient complaint system. There should also be a whistle blowing system for healthcare personnel built into the system.

8.4 Model for Implementation

The plan needs to be set in the national context and to ensure full implementation there needs to be capacity building at a local level to develop a bottom up approach and local buy in and commitment.

Provincial quality assurance units do not have the capacity to do all the training and implementation and should rather be tasked with oversight and enabling functions of quality improvement units established within healthcare establishments. However, there are aspects of improvement, especially capital expenditure, that are outside the scope of responsibility of the unit manager and require district or provincial authorisation. For the programme to be successful it will be critical for these functions to be optimised at provincial level to avoid any delays in the programme.

To establish multidisciplinary quality improvement within provinces, local authorities and the establishments they support, and the private sector, it is proposed that four Quality and Learning Centres be established in each province to be the focal point of learning and development in the province to ensure that there is local capacity. These will incorporate a regional, district and private hospital, three primary care facilities, including family practitioners and emergency medical services, to spread shared learning through the various healthcare sectors. Figure 6 illustrates the model for an urban area and Figure 7 the model for a rural area. The centres will be linked to offer peer support and review and to share best practice and learning. Existing expertise and good practice should be built upon and used to leverage improvement. (The number and the locations may be revised according to the needs and resources available in each province). It is proposed that in Gauteng, which has the highest number of central hospitals, two of these be included in the process and become quality and learning centres for that level of hospital.

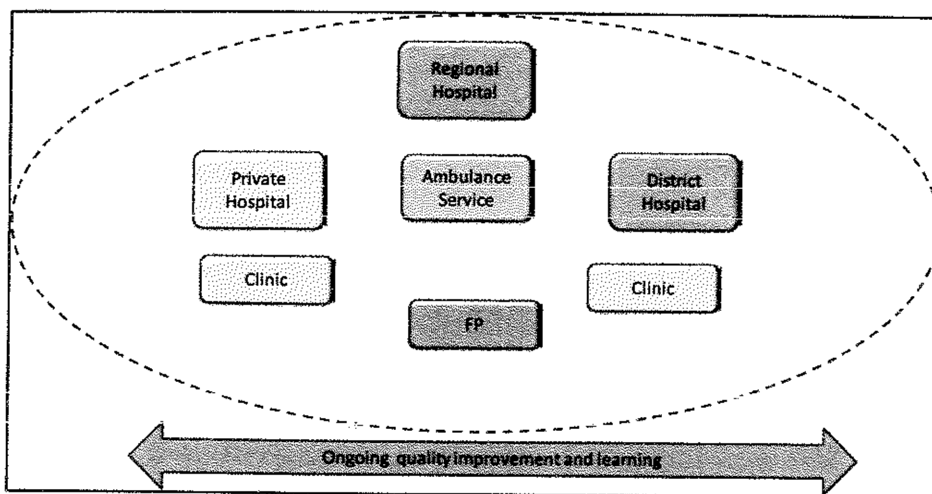

Figure 3 Quality and Learning Centre – Urban

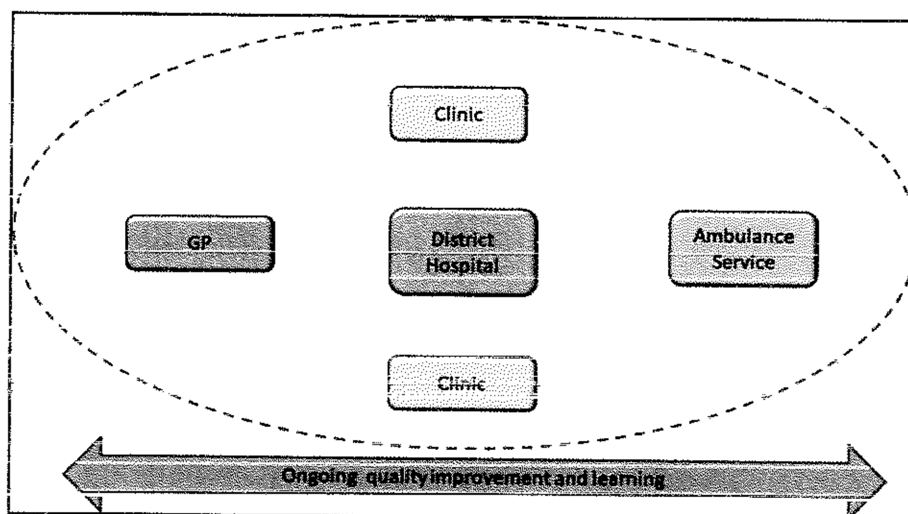

Figure 4 Quality and Learning Centre - Rural

We propose that sites are identified that have been certified by the OHSC and where successful improvement programmes, including ICRM, ICDM and ICSM, are being implemented, which could provide the basis for a centre of quality and learning.

Capacity-building will take place across the system, in both the public and private sectors. It will be important that roles and responsibilities are clarified at each level within the system to ensure that there is leadership of the process. It would seem logical that the key leadership role should be placed at the district level or whatever level is proposed to be the key unit for the NHI. The programme of learning will be based on the following guiding principles:

- Person-centred
- Effective systems and processes to sustain improvement
- Multi-disciplinary team approach
- Sound leadership
- Clear indicators to allow accurate measurement

At all levels, personnel will be trained to understand multi-disciplinary standards, quality improvement methods, quality data collection and analytical systems and to transfer the knowledge and skills. There will be recognised coaches for leadership and management skills as well as for the various technical skills, such as supply chain, hotel, healthcare technology and maintenance. Dedicated trainers will be identified to receive training and they, in turn, will be coached to train all personnel in quality improvement techniques. It will be important to develop strength and depth in the teams to ensure that the learning process will be sustained. The Academy for Leadership and Management will be consulted.

Each of the centres will become the centre of quality and learning for their part of that province, to disseminate quality improvement skills and establish a province-wide culture of continuous quality improvement. The centres will be the key to rolling out quality improvement methods aimed at delivering safe, quality care and thereby empowering all the districts in a province to do likewise and thus build networks of excellence. The systematic approach will facilitate sharing of learning and good practice. Peer review and benchmarking will be essential to reduce variations across facilities, district, provinces and the country.

The centres will need to take account of the reality of patient activity within the health system. While many patients receive care in hospitals, most are treated in the primary health care sector. Many patients move between the different levels of care and the emergency medical services are often a key player in these moves. It is critical that the health system functions optimally and recognises patient flows, up and down referrals and communication between the sectors. Consideration needs to be given to the functions that may be centralised in the public sector, which may be different in the private sector, for example, procurement, human resources, capital planning and disease-specific programme management.

All the facilities in the centres will have completed the process of achieving compliance with the Norms and Standards for all Health Establishments as required by the Office of Health Standards Compliance. Thereafter, each healthcare organisation within the centre of quality and learning (public and private hospitals, primary healthcare clinics, emergency medical services and family practitioners) will be assessed against the accredited standards to obtain a baseline position. Any non-compliance with the standards will be prioritised according to the impact they may have on patient and personnel safety. The multidisciplinary team within the organisation will be assisted to develop an integrated quality improvement plan for the organisation to move the organisation towards full compliance with the standards. This process is critical to the learning and development of training strategies for all other facilities within the province. The quality improvement plan will be reassessed and dated as the deficiencies are addressed.

External support will be provided as required. We propose that membership of the improvement/coaching team becomes a one or two-year step on a human resources development plan towards senior operational leadership. It is important that capacity is developed across the system to avoid the notion of 'super heroes' who rescue and advise, or worse, 'a quality police force' to become part of the future structure of a world class SA healthcare system.

An online database will be used to track the progress of all the quality improvement interventions and the remedial actions taken to ensure compliance with the standards. This

information will be critical to the roll-out of the programme to ensure that learning and good practice are shared.

8.5 Self-assessment and External Evaluation

Once the quality and learning centres have been established and are running well the programme will be rolled out across the provinces. To be cost effective, we recommend that a self-assessment mechanism be agreed upon, whereby facilities can submit an online self-assessment and may then undergo a random onsite survey. The support from the quality and learning centres to ensure that health establishment teams are well equipped and able to implement the standards and quality improvement activities, will be critical. This is to enable all healthcare personnel to understand the importance of internal quality assurance and to be able to implement continuous improvement to optimise patient care and safety. External evaluation is necessary to give an objective assessment of the standards and quality and to ensure consistency across the country.

The facility must first comply with the Norms and Standards for Health Establishments, certified by the OHSC. Then there will be four levels of achievement within the NHI accreditation; Progress, Entry, Intermediate and Full as illustrated in Figure 8 below. The NHI will permit the delivery of specific services at each level of compliance. Facilities that achieve full compliance will be permitted to provide the complete range of services offered in the NHI.

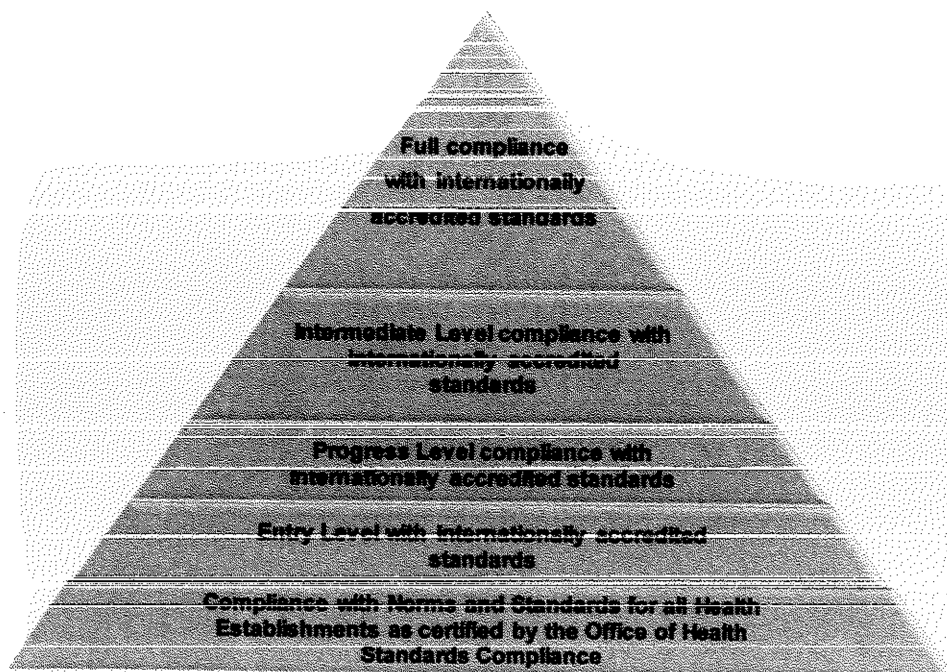

Figure 8

The intention of the programme is to ensure that all health establishments first meet the minimum regulatory requirements and then move along a trajectory towards excellence and sustained high, quality.as shown in Figure 9.

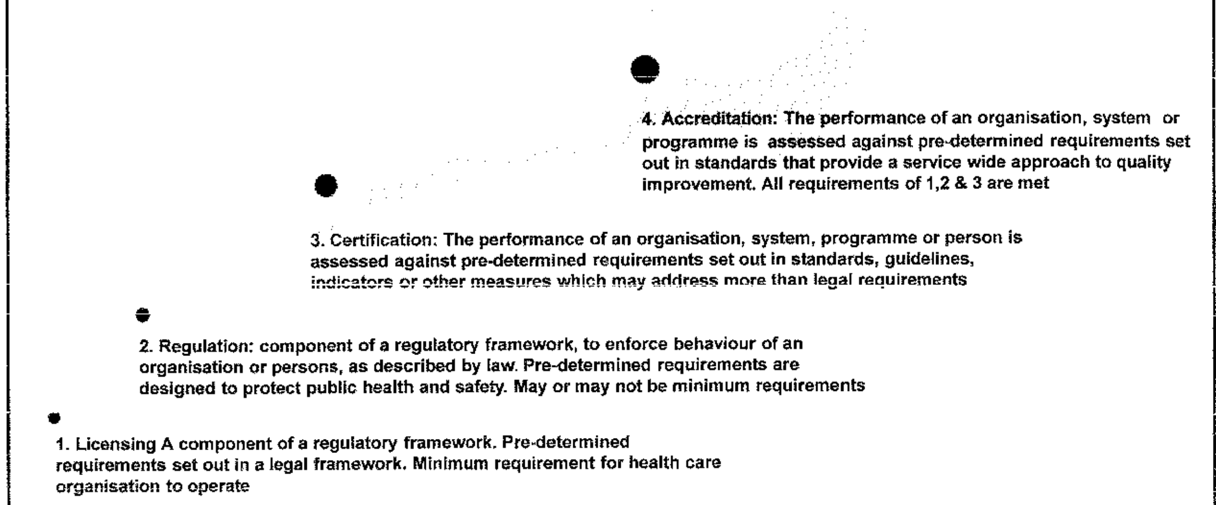

Figure 9

9 Work plan for each Quality and Learning Centre

We propose that an eighteen-month programme be developed to establish the Quality and Leaning Centres.

National	Strategic Meeting • Approve and issue national framework • Strategic oversight
Province	Strategic Introduction of the programme with representatives from all Quality and Learning Centres, located within one province. • Clarify roles and responsibilities for province, districts and facility personnel • Identify team to lead and drive the process at provincial level and within each Quality and Learning Centres • Enabling role of provinces • Monitoring and oversight
Quality and Learning Centres	• Phase 1: Standards Interpretation, quality improvement and assessor training workshop for appropriately skilled personnel from each of the participating organisations delivered over three days at each of the Quality and Learning Centres. Initial joint session, then separate workshops for hospital, clinic, Family Practitioners and Emergency Service teams.
All hospitals within each Quality and Learning Centre (including two central hospitals)	• Phase 2: All hospitals conduct self-assessment against the accreditation standards over four weeks • Phase 3: Baseline Evaluations carried out by external team (Five days on site). • Phase 4 - Baseline data used to identify shortcomings and develop QIP which will be supported with training and capacity building in facilitation and coaching skills. Training on the information system will be done. This will take place jointly with all facilities in each Learning Centre (three days on site). • Phase 5 - After two months, review progress made, provide support and coaching to identified service leads (champions) to continue with programme, until necessary capacity is reached (three days on site). • Phase 6 - After a further two months, review progress made, provide support and coaching to identified service leads to continue with programme, until necessary capacity is reached. (three days on site). • Phase 7 - After a further three months, review progress made, provide support and coaching to identified service leads to continue with programme, until necessary capacity is reached. (three days on site). • In between the review phases, the facilities carry out self-evaluation and submit data electronically • Build support structures in Quality and Learning Centres.

	• Phase 8 External Evaluation for accreditation
Clinics & Health Care Centres	• Phase 2 - the PHCs and CHC conduct self- assessment against t accreditation standards over four weeks • Phase 3 - validated baselines in the facilities with personnel that were train PHC (two days on site). • Phase 4 - Using baseline data to identify shortcomings and develop Q supported with training and capacity building in facilitation and coaching sk Training on the information system will be done. This will take place jointly w all facilities in each Learning Centre (three days on site). • Phase 5 - After two months, review progress made, provide support a coaching to identified service leads to continue with programme, u necessary capacity is reached. (two days on site). • Phase 6 - After a further two months, review progress made, provide supp and coaching to identified service leads to continue with programme, u necessary capacity is reached. (two days on site). • Phase 7 - After a further three months, review progress made, provide supp and coaching to identified service leads to continue with programme, u necessary capacity is reached. (two days on site). In between the revi phases, the facilities carry out self-evaluation and submit data electronicall • Build support structures in Quality and Learning Centres. • Phase 8 External Evaluation for accreditation
Family Practitioner Practices	• Phase 2 - Practices conduct self- assessment against the accreditati standards over four weeks • Phase 3 - Validated baselines in practices with above staff on site (one day • Phase 4 - Using baseline data to identify shortcomings and develop Q supported with training and capacity building in facilitation and coaching sk Training on the information system will be done. This will take place jointly w all facilities in each Learning Centre (three days on site). • Phase 5 - After two months, review progress made, provide support a coaching to identified service leads to continue with programme, u necessary capacity is reached. (one day on site). • Phase 6 - After a further two months, review progress made, provide supp and coaching to identified (one day on site). • Phase 7 - After a further three months, review progress made, provide supp and coaching to identified service leads to continue with programme, u necessary capacity is reached. (one day on site). • In between the review phases, the practices carry out self-evaluation a submit data electronically

	• build support structures in Quality and Learning Centres. • Phase 8 External Evaluation for accreditation
Emergency Medical Services	• Phase 2 - EMS Stations conduct self-assessment against the accreditation standards over four weeks • Phase 3 - Validated baselines in EMS stations with above staff on site (two days onsite). • Phase 4 - Using baseline data to identify shortcomings and develop QIP, supported with training and capacity building in facilitation and coaching skills Training on the information system will be done. This will take place jointly with all facilities in each Learning Centre (three days on site).. • Phase 5 - After two months, review progress made, provide support and coaching to identified service leads to continue with programme, until necessary capacity is reached. (one day on site). • Phase 6 - After a further two months, review progress made, provide support and coaching to identified service leads to continue with programme, until necessary capacity is reached. (one day on site). • Phase 7 - After a further three months, review progress made, provide support and coaching to identified service leads to continue with programme, until necessary capacity is reached. (one day on site). • In between the review phases, the facilities carry out self-evaluation and submit data electronically. • build support structures in Quality and Learning Centres. • Phase 8 External Evaluation for accreditation
Province and District	• Strategic review of progress made and challenges faced with representatives from all Quality and Learning Centres. (Two days on-site) • Identify actions requiring province or district intervention • Regular feedback to provincial authorities • Action plan developed for Province and districts

10 References

Access to quality health care in South Africa: Is the health sector contributing to addressing the inequality challenge? D. McIntyre, J. Ataguba, Health Economics Unit, University of Cape Town. High Level Panel Commissioned Report

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