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Our Issues, Our Drugs, Our Patients

www.sahivsoc.org
www.sahivsoc2016.co.za
Quality of care – for users

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HIV Clinicians Society Conference – April 2016
SA quality initiatives – a framework

- **OHSC**
  - Accountability
  - Regulatory consequences
  - User concerns and complaints

- **Clinical governance**
  - Audits of deaths; avoidable factors
  - Hospital governance
  - MNCH: District clinical specialist teams
  - Adverse events reporting and response

- **Health system strengthening**
  - Leadership development
  - Specify and ensure inputs
  - Strengthen management

- **Quality improvement**
  - Outreach, inreach
  - Ideal clinics
  - Improvement initiatives

**Standards, assessment, Enforcement**
- Standards, assessment
- Enforcement

**Efficacy / reliability**
- Safety
- Staff support
- User involvement

**Ensuring inputs**
- Improving processes
- Removing bottlenecks

**PDSA. Lean**
- 3-feet approach
- Drills, checklists
- Risk Mx
## Batho Pele – “people first”

<table>
<thead>
<tr>
<th>Batho Pele and quality of care for citizens wrt HIV</th>
<th>Status - user perspective</th>
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<tbody>
<tr>
<td><strong>1. Consultation</strong>&lt;br&gt;consulted re level and quality of public services received, choice re services offered</td>
<td>NSP, TAC</td>
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<tr>
<td><strong>2. Service Standards</strong>&lt;br&gt;told level and quality of public service will receive, aware of what to expect</td>
<td>OHSC IC; DPSA - compliance? Clinical standards?</td>
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<tr>
<td><strong>3. Access</strong>&lt;br&gt;equal access for all to services to which they are entitled</td>
<td>Equity esp. wrt quality, effectiveness</td>
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<td><strong>4. Courtesy</strong>&lt;br&gt;be treated with courtesy and consideration.</td>
<td>All initiatives - effective? Professional ethics, support</td>
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<td><strong>5. Information</strong>&lt;br&gt;given full, accurate information re public services they are entitled to receive</td>
<td>OHSC and professions – limited</td>
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<tr>
<td><strong>6. Openness and Transparency</strong>&lt;br&gt;Told how national and provincial departments are run, how much they cost, who is in charge</td>
<td>Available but not very accessible</td>
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<td><strong>7. Redress</strong>&lt;br&gt;if promised standard of service not delivered, be offered an apology, a full explanation and a speedy and effective remedy; when complaints made, receive a sympathetic, positive response</td>
<td>In theory – OHSC Ombud, NDOH complaints</td>
</tr>
<tr>
<td><strong>8. Value for Money</strong>&lt;br&gt;Public services provided economically and efficiently to give best possible value for money</td>
<td>Disputed</td>
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1. The Office of Health Standards Compliance

NHA S47 - All establishments must comply with the quality requirements and standards prescribed by the Minister after consultation with the Office.
- May relate to human resources, health technology, equipment, hygiene, premises, the delivery of health services, business practices, safety, and the manner in which users are accommodated and treated.

NHAA S 78 - Objects of the Office
The objects of the Office are to protect and promote the health and safety of users of health services by:
- Monitoring and enforcing compliance by health establishments with prescribed norms and standards
- Ensuring consideration, investigation and disposal of complaints relating to breaches of norms and standards

NHA as amended 2013
What behavior / culture does regulation seek to change - through introduction of consequences?

<table>
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<tr>
<th>Promote and recognise</th>
<th>Discourage and penalise</th>
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<tr>
<td>• Systems to assess and control risks to safety and quality</td>
<td>• Ad-hoc and arbitrary actions / activities</td>
</tr>
<tr>
<td>• “User focus” - compassionate, respectful, available</td>
<td>• Impunity - for abuse of power, negligence, non-delivery</td>
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<tr>
<td>• “Provider focus” - effective, efficient</td>
<td>• Mediocrity</td>
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<tr>
<td>• Proactive, problem-solving</td>
<td>• “It's not my fault”</td>
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<tr>
<td>• Accountable</td>
<td>• Covering up / loyalty</td>
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<td></td>
<td>• The bottom line / the budget as the primary goal</td>
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Making it more comfortable to do the right thing than not to do it
(Existing) National Core Standards (2011)

2. Safety, clinical risk
3. Clinical support services.
4. Public health
5. Leadership & corporate governance
6. Operational management
7. Facilities & infrastructure

7 Domains with sub-domains = areas of risk
Standards with explanatory criteria specify performance required / expected to reduce risk

Evidence required to show that standards are met specified in measures, for different functional areas of a health establishment

Captured on-site into database for immediate reporting

Regulations published for comment prior to promulgation:
- Prescribed Norms and Standards
- Procedural regulations including role of Ombud

Adapted OHSC
Domains & sub-domains (revised)

Core business

Domain 1: Patient / user rights:
1.1 Respect, and Dignity
1.2 Information for users
1.3 Systems of referral
1.5 Access to care
1.6 User experience

Domain 2: Clinical care & governance:
2.1 User Health records
2.2 Reliability of clinical management of national priority health conditions
2.3 Clinical leadership and clinical risk
2.4 Prevention and control of infections

Domain 3: Clinical support services:
3.1 Medicines and Medical Supplies
3.2 Diagnostic and Blood Services
3.3 Therapeutic support services
3.4 Health Technology
3.5 Mortuary services

Domain 4: Public health:
4.1 Outreach services
4.2 Health promotion and disease prevention
4.3 Outbreaks, health emergencies and disaster preparedness
4.4 Environmental controls

Domain 5: Leadership & Corporate governance:
5.1 Oversight, leadership & accountability
5.2 Strategic and Risk Management
5.3 Quality improvement

Domain 6: Operational management:
6.1 Human resource management & wellbeing
6.2 Financial management
6.3 Supply chain & asset management
6.4 Transport safety management
6.5 Information management
6.6 Health records storage and retrieval

Domain 7: Facilities & infrastructure:
7.1 Maintenance of buildings and grounds
7.2 Building engineering services
7.3 Safe and Secure Environment
7.4 Hygiene and cleanliness
7.5 Waste Management
7.6 Linen Services
7.7 Food services

Regulation: “the use of power of the state to change behaviour”
Developmental regulatory approach

**OHSC Regualtory Framework**

**Voluntary Compliance**
- NCS awareness
- Self assessment
- closing gaps
- EWS; reporting
- Recognition of excellence

**Regulated Compliance**
- Prioritisation and selection
- Inspection report
- Compliance notice
- Review or Re-inspection

**Enforced Compliance**
- Nature, Extent, Gravity & Severity of non compliance
- Waming; formal response
- Critical or Persistent Non Compliance
- Appeal Section 82A(3)
- Hearing
- Revocation
- Fine, NPA

**Plan to close gaps**

* Adapted OHSC - D lamph

Concerns of users impact on prioritisation through complaints directed to the Ombud; and the EWS
2. Clinical quality and clinical governance

Many different initiatives:
• Based on clinical guidelines for different disease categories
• “Coordinators” or managers at all levels
  • Attempt to strengthen hospital governance and accountability
• Occasional audits as well as poor outcomes have suggested poor implementation

Ministerial Advisory Committees
• 3 Committees appointed by the Minister to improve maternal, newborn and under-5 outcomes
• Confidential enquiry into maternal deaths (NB HIV & TB); mortality audit tools
• many recommendations including the DCSTs

DCSTs (District Clinical Specialist Teams)
• Specific initiative to focus on MDGs: (MNNCH) to improve outcomes
• Teams of full-time specialist advisors at district level: doctors, nurses (not always complete)
• Clinical governance role and training felt to be impacting positively on behaviour of staff and on mortality figures
Clinical governance approach used

<table>
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<tr>
<th>Pillar</th>
<th>Components</th>
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<td>Clinical effectiveness</td>
<td>Reliability and 6 R’s (Right care, patient, time, clinician, skills, way) for every patient every time</td>
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<td>Safety and clinical risk</td>
<td>Risk to patient (avoidable deaths, adverse events)</td>
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<td>Risk to HC provider</td>
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<td>Risk to organisation</td>
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<td>Staff development and support</td>
<td>Clinical leadership – facility and system-wide</td>
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<td>Professional development and management</td>
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<td>Clinical skills, outreach, inreach</td>
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<td>User involvement</td>
<td>Responsiveness and respect</td>
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<td>Patient / user experience of care</td>
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<td>Community-level prevention, demand</td>
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3. “Health system strengthening” - the challenges

- General emphasis on improving health system functioning and conditions of work (including compliance)
- Hospitals generally more functional than clinics (although variable), however quality of care in District hospitals a challenge
  - Generally poor OHSC inspection scores – some are below 40%
  - Some operating in reality as CHCs; 24% unable to perform basic emergency surgery
- Clinics often found to not provide actual effective care (send home OR refer)
- Managerial effectiveness low
  - Absenteeism a challenge over and above vacancies
  - Bottlenecks in ensuring basic inputs, often in spite of existence of medication and supplies
  - Underspending of budgets, plans not implemented
Some critical health system responses

- Ring-fenced budgeting for “non-negotiables” in provinces
- Attempt to improve District Service Plans
- CEOs job descriptions to cover quality, NCS
- Ideal clinics to ensure functional platform, excellence
- Hospital governance and delegations
- Supportive supervision and outreach, inreach, training
- Specific disease condition dashboards on outcomes
- Primary healthcare streams:
  - DCSTs (MCH)
  - WBOTS
  - ISHP
- Complaints management systems (Quality Assurance, MomConnect)
4. Quality improvement - the key factor

**QI Methodologies in use** *(also for closing compliance gaps)*

- Lean
- Risk management / clinical risk control systems
- Patient safety, learning from adverse events
- “3-feet approach” – concrete local level planning and monitoring
- Quality Improvement Guide (OHSC) *(root cause analysis, PDSA cycles etc.)*
- Improvement collaboratives, “Best Care Always”

**On the horizon / new thinking:**
Patient-centred care by design
“Safety I and safety II” / resilience; Positive deviance
Batho Pele?

• Major decline in HIV-linked mortality and morbidity through effective interventions delivered at scale

BUT

• Service standards and **clinical** quality very variable
  – missed opportunities for **best** care **all** the time for **every** patient
  – safety - preventing **avoidable** harm or loss

• Access – to what?
  – Still inequality in effective access and quality services; still discrimination

• Courtesy remains elusive
  – Staff attitude – reflects staff ethics? Staff circumstances? Role models?
  – System itself is not patient-centred nor respectful

• Redress – sympathetic, positive response?
  – An apology, an explanation, redress not common within routine services
  – Allegations of victimisation, abuse of complainants and the vulnerable

**Quality is a journey, not an event…….**