Southern African HIV Clinicians Society

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Our Issues, Our Drugs, Our Patients

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Quality of care – for users

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HIV Clinicians Society Conference – April 2016

SA quality initiatives – a framework

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

Accountability
Regulatory consequences
User concerns and complaints

DHIS monitoring (e.g. deaths)
Audits of deaths; avoidable factors
Hospital governance
MNCH: District clinical specialist teams
Adverse events reporting and response

Leadership development
Specify and ensure inputs
Strengthen management

Outreach, inreach
Ideal clinics
Improvement initiatives

Batho pele – "people first"

Batho Pele and quality of care for citizens wrt HIV	Status - user perspective
1. Consultation consulted re level and quality of public services received, choice re services offered	NSP, TAC
2. Service Standards told level and quality of public service will receive, aware of what to expect	**OHSC IC; DPSA - compliance? Clinical standards?**
3. Access equal access for all to services to which they are entitled	**Equity esp. wrt quality, effectiveness**
4. Courtesy be treated with courtesy and consideration.	**All initiatives - effective? Professional ethics, support**
5. Information given full, accurate information re public services they are entitled to receive	OHSC and professions – limited
6. Openness and Transparency Told how national and provincial departments are run, how much they cost ,who is in charge	Available but not very accessible
7. Redress 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	**In theory – OHSC Ombud, NDOH complaints**
8. Value for Money Public services provided economically and efficiently to give best possible value for money	Disputed

1. The Office of Health Standards Compliance

The OHSC - Section 3A public entity established in terms of the National Health Amendment Act of 2013

- 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.

NHA as amended 2013

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

What behavior / culture does regulation seek to change - through introduction of consequences?

Promote and recognise

- Systems to assess and control risks to safety and quality
- "User focus" - compassionate, respectful, available
- "Provider focus" - effective, efficient
- Proactive, problem-solving
- Accountable

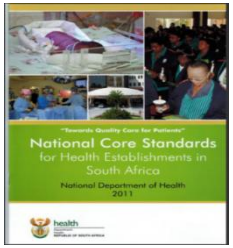
Discourage and penalise

- Ad-hoc and arbitrary actions / activities
- Impunity - for abuse of power, negligence, non-delivery
- Mediocrity
- "Its not my fault"
- Covering up / loyalty
- The bottom line / the budget as the primary goal

Making it more comfortable to do the right thing than not to do it

OHSC Board

(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 & infrastructur

Adapted OHSC

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**

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

Strategic direction

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

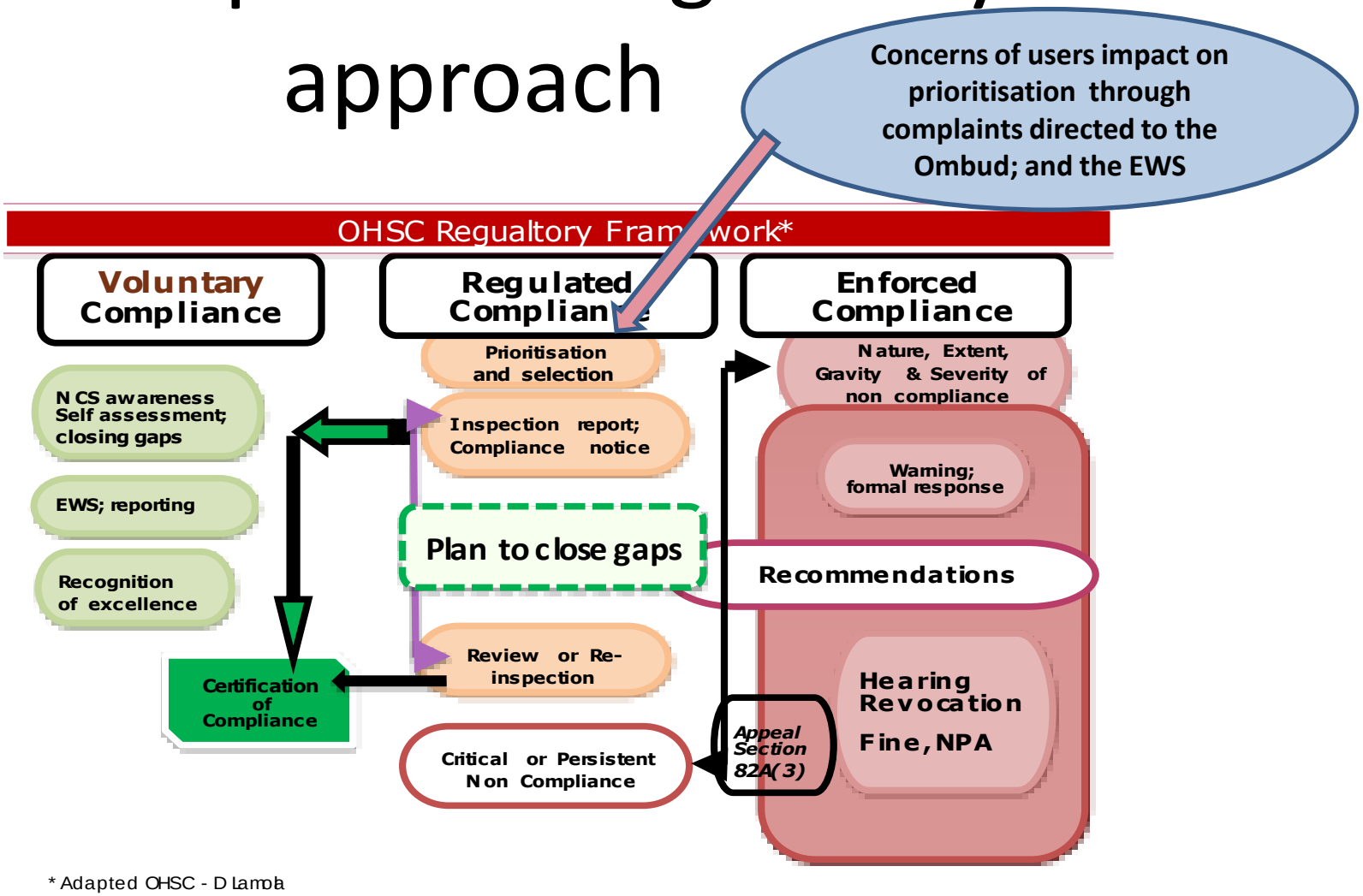
Operations

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



* Adapted OHSC - D Lamola

2. Clinical quality and clinical governance

The example of MCH

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

Analyse
Benchmark
Support / train
Report

Pillar	Components
Clinical effectiveness	Reliability and 6 R's (Right care, patient, time, clinician, skills, way) for every patient every time
Safety and clinical risk	Risk to patient (avoidable deaths, adverse events) Risk to HC provider Risk to organisation
Staff development and support	Clinical leadership – facility and system-wide Professional development and management Clinical skills, outreach, inreach
User involvement	Responsiveness and respect Patient / user experience of care Community-level prevention, demand

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…….