Province of the
EASTERN CAPE
HEALTH



IDEAL CLINIC REALISATION AND MAINTENANCE (ICRM) PROGRAMME

NATIONAL SEMINAR

DATE : 05– 06/12/2022

VENUE: HOLIDAY INN HOTEL: BOKSBURG

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Director District Development
Eastern Cape



PRESENTATION OUTLINE

1. Purpose/Back Ground

2. Introduction

3. Road Map on ICRM Progress on Implementation 2015/16 - 2021/22

4. Reasons for the facilities to drop the status and interventions

5. Proposed measures to sustain these achievements

6. The main or stubborn problems for facilities to attain Ideal Status and to sustained the achievements.

7. How the low scoring facilities made progress to reach higher scores even if they are not ideal – from 2015- to date.

8. Functionality of PPTICRM province and district

9. Budget for IC for the province (Overall)

a. Infrastructure plan – routine maintenance

b. Transport management – province and district (Support/monitoring visit).

PURPOSE

Purpose

To reflect on the Eastern Cape Province experiences in the implementation of the Ideal Clinic Realization and Maintenance (ICRM) program and share envisaged plans to sustain the program in the province.

Focus areas:

- Sustaining the facilities that attained Ideal Status
- Bring back facilities that dropped Ideal Status
- Push facilities that were never Ideal to an improved performance score

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INTRODUCTION

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POPULATION

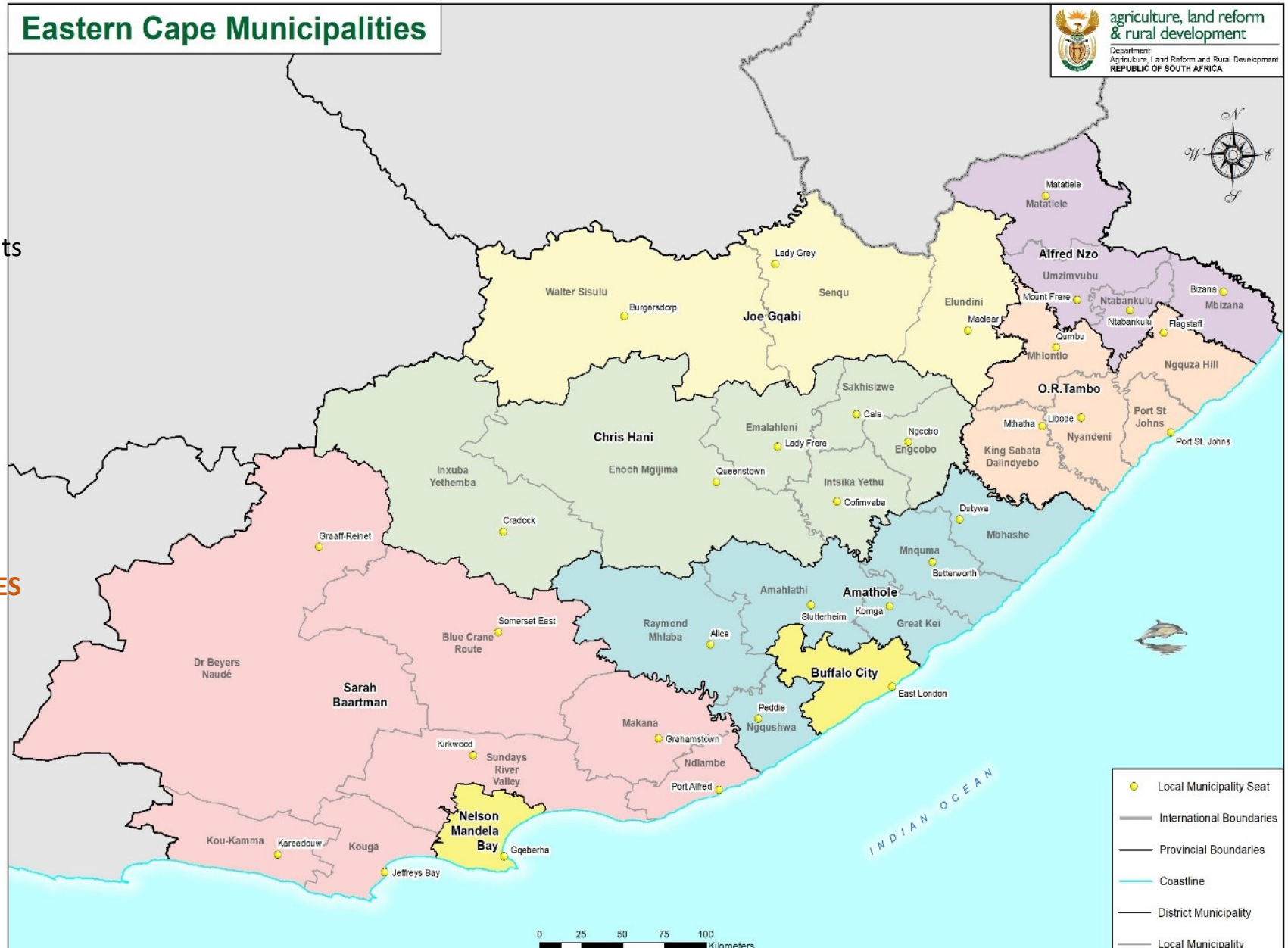
EC. estimated total population of 6 734 002 million constituted largely of a younger population (Stats SA 2020)

MUNICIPALITIES

Districts x 6
Metropolitan x 2
Local M x 31

FIXED HEALTH FACILITIES

CLINICS x 733
CHCs x 42
DH x 65



ROAD MAP
ICRM IMPLEMENTATION PROGRESS

- The province started to implement the ICRM program in 2015/16 financial year, as a health system strengthening program and quality improvement program for better health outcomes and better patient experience of healthcare.
- The year 2016/17 had highest number of facilities that turned ideal, as the province was gaining better experiences on implementation.
- The later years were left with facilities with long term infrastructure challenges, and were hard to turn Ideal
- The sixth year (2020/21), is marked with a severe ICRM program interruption due to Covid-19 pandemic interventions. Despite these challenges the facilities and district teams managed to conduct the baseline assessments and PPTICRM SD, respectively.

▪ The program was initiated and incorporated into several other NHI initiatives, within the PHC environment (HPRS, CCMDD, RPHC, etc.).
▪ Out of 775 PHC facilities, 47% (368) facilities obtained Ideal status accumulatively over the 7 year period. (see table below)
▪ About 190 out of the 368 (51%) lost status accumulatively over the years.
▪ By the end of 2021/22, there were 178 facilities that were still holding an IC status overall. Sliver 23; Gold = 58; Platinum = 79
Only 56 (31%) facilities consistently maintained IC status over the past three years (2019/20 – 2021/22).

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EC ICRM
PROGRESS FROM 2015/16 - 2021/22

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District	No. of facilities	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	TOTAL	%
Alfred Nzo	74	0	2	2	4	0	0	6	**8**	**11%**
Amathole	148	2	25	15	14	4	4	4	**68**	**46%**
BC Metro	79	0	2	6	10	3	0	6	**27**	**34%**
Chris Hani	159	0	24	9	7	1	10	15	**66**	**41.5%**
Joe Gqabi	52	3	17	9	4	0	N/A	4	**37**	**71%**
NMB Metro	48	3	13	5	11	2	4	1	**39**	**81%**
OR Tambo	153	2	34	14	17	1	1	3	**72**	**47%**
Sarah Baartman	62	2	24	4	12	2	0	1	**45**	**72.5%**
Total	**775**	**12**	**141**	**64**	**79**	**13**	**19**	**40**	**368**	**47%**

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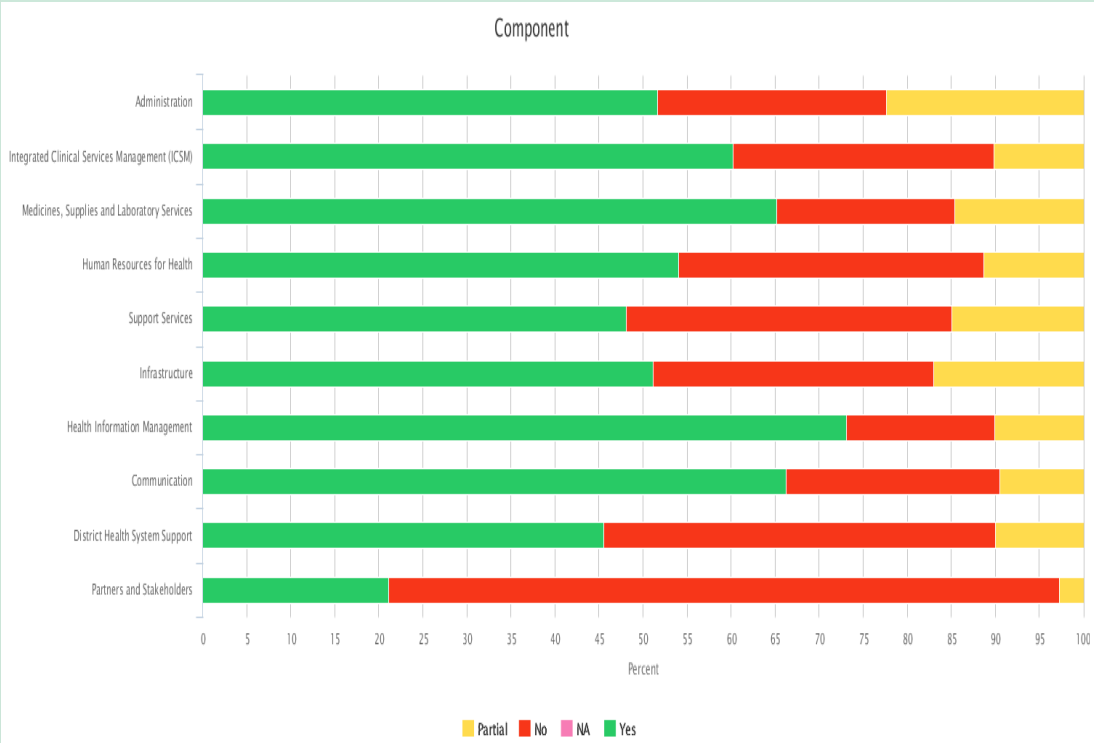
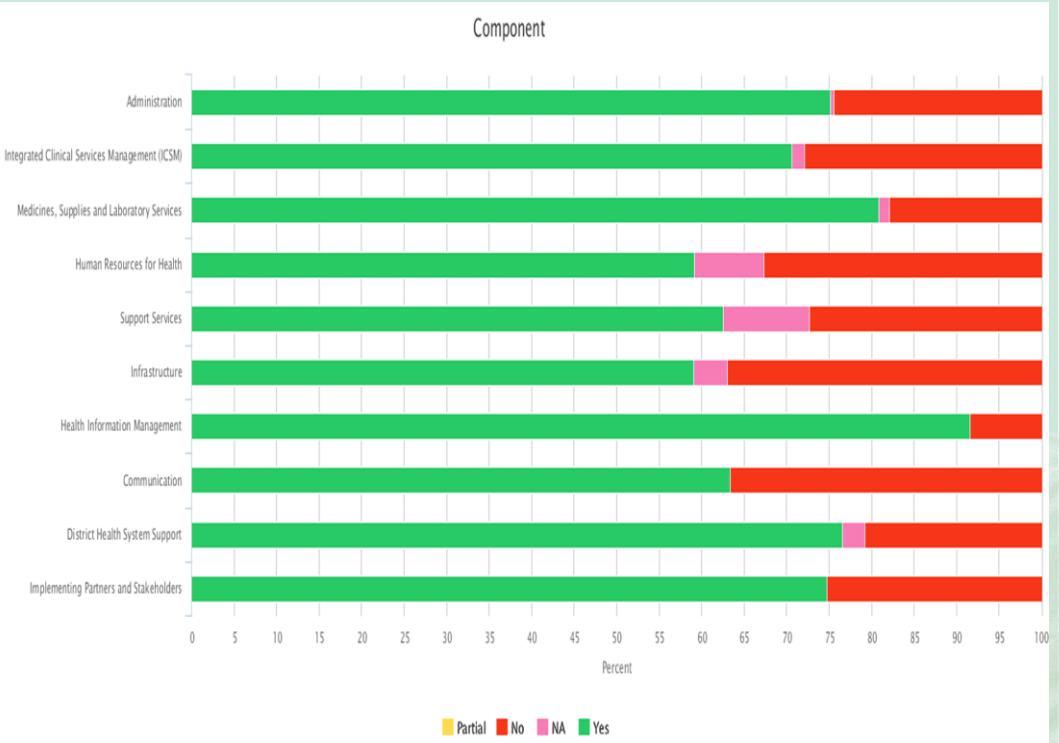
ROAD MAP:
COMPONENT ANALYSIS COMPARISON 2015/16 & 2021/22

2015/2016



2021/22



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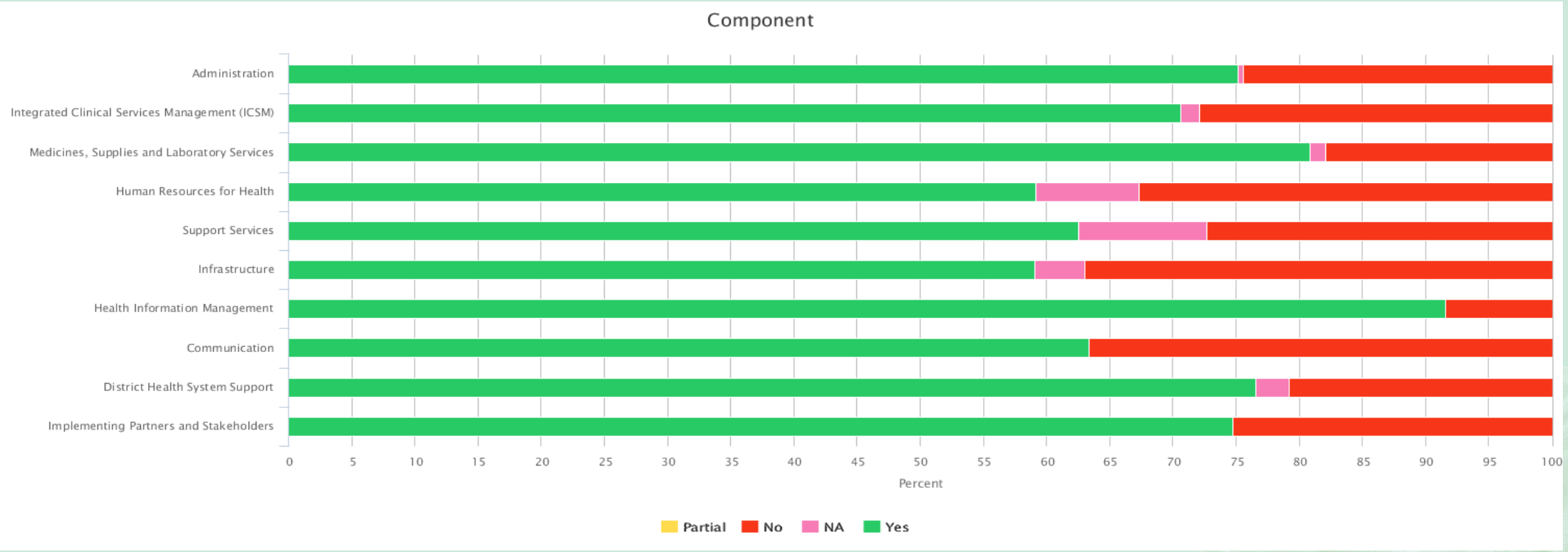
COMPONENT ANALYSIS 2021/2022



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ROAD MAP:

COMPONENT ANALYSIS COMPARISON 2015/16 & 2021/22

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No	ICRM COMPONENT	2015/16	2021/22	Improvement marked
0	Overall Performance	53%	74%	**21%**
1.	**Administration**	52%	75%	**23%**
2.	**Integrated Clinical Services Management**	60%	72%	**12%**
3.	**Medicines, Supplies and Laboratory Services**	65%	83%	**18%**
4.	**Human Resources for Health**	54%	67%	**13%**
5.	**Support Services**	43%	73%	**30%**
6.	**Infrastructure**	51%	62%	**11%**
7.	**Health Information Management**	73%	92%	**19%**
8.	**Communication**	66%	64%	**- 2%**
9.	**District Health System Support**	46%	78%	**32%**
10.	**Implementing Partners and Stakeholders**	22%	75%	**53%**

PROGRAMME PERFORMANCE COMPARISON 2015/16 – 2021/22

ELEMENTS DEFINITIONS	2015/2016	2021/2022	Improvement
TB treatment success rate at least 85% or has increased by at least 10% from the previous year	44%	68%	**24%**
TB (new pulmonary) defaulter rate is <5%	67%	67%	**maintained**
Ante-natal visit rate before 20 weeks gestation is at least 70%	41%	71%	**30%**
Ante-natal clients initiated on ART rate is at least 95%	86%	87%	**1%**
Immunization coverage under one year (annualized) is at least 94%	39%	53%	**14%**
Average	**56%**	**69%**	**13%**

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What are the reasons for the facilities to drop or regress and what has the province or district done.

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REASONS FOR THE FACILITIES TO DROP THE STATUS	INTERVENTIONS
HUMAN RESOURCE RELATED • Leadership change in a facility, facilities without appointed OMs, • Recurring shortage of PNs due to high staff turn over • Lack of cleaners	• Decision has been taken to prioritise Leadership and Management post in health facilities, in the ARP and immediate filling of the vacant posts. • Staff accommodation facilities are prioritise to improve staff retention. Rural allowance is also prioritised. • Budgeting for cleaning services where appointments are delaying.
• High vacancy rate on Supervisors and sub district managers due to transition of the organizational structure of the department over the past 5 years.	• The Service Delivery Model is undergoing review and consideration of strengthening coordination of PHC services at sub district level to improve supervision and mentoring. • Integrated supervision of facilities is encouraged with marked improvement in other districts.
• Persisting skills gap due to high staff turn over which affect continuity and loss of gains in skills. • Training – Saturation issues (BLS , APC, ESMOE)	• PHC induction program to include the ICRM and • Training schedule for the ICRM components.
• Low staff moral – Post Covid -19 trauma	• Wellness program has continuous psychosocial support program; • Staff recognition awards are conducted by all districts for various categories to uplift morale and motivate staff

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What are the reasons for the facilities to drop or regress and what has the province or district done.

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REASONS FOR THE FACILITIES TO DROP THE STATUS	INTERVENTIONS
SUPPLY CHAIN MANAGEMENT RELATED ISSUES	
Medical equipment maintenance plan not implemented adequately. Delayed procurement process on medical equipment	• Service providers engaged by Health technology to do orientation of staff on medical equipment use , handling and maintenance. • Establishment of district maintenance plans on process by Health technology unit • Adherence to annual procurement plan
Surgical consumables – lifespan expiry	Centralization of procurement processes at provincial office meanwhile districts are strengthening the procurement plan for surgical consumables and monitoring the lifespan.
Inefficient infrastructure minor maintenance plan Bulk supplies: inconsistent and interruption on water supply and electricity	Infrastructure minor maintenance plan to be reviewed, due to facilities experiencing delayed response from the maintenance call Centre .
LEADERSHIP AND MANAGEMENT	
Inconsistent support of the ICRM program at district and facility level, resulting on QIPs not monitored timeously only undertaken when assessments are approaching.	The Department is addressing the inefficiencies with the above HR interventions and service delivery optimisation process.

PROPOSED MEASURES TO SUSTAIN THE ACHIEVEMENTS

- Development of ICRM implementation plan with emphasis on maintenance of the ideal status.
- To revise the criteria for Operational Managers post that require Clinical PHC Specialist qualification versus administrative function. It is recommended that a health management qualification and experience in PHC facility services be the main requirement. The request is based on observed performance in some facilities, where the OM is struggling to manage the facility.
- All supervisors to be trained as assessors and their monthly supervision is based on IDEAL clinic principles and QIP.
- Continuous update of SOP's and alignment of ICRM format to OHSC requirements.
- Team building programs at all levels to encourage teamwork at facility level and districts.
- Identifying facilities that are better performing and emphasize benchmarking within different clusters.
- Regular ICRM in-service program
- Encourage consistent involvement of support /Allied officials
- Finalization of ICRM Versions / Manual

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SOME KEY ICRM INTERVENTIONS INITIATED

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ACHIEVEMENTS:

- **ICRM standard is 80% of Professional Nurses in a health facilities trained on Basic Life Support (BLS).**
- Following Accreditation by American Heart Association (AHA), the province has improved on trained BLS Nurse instructors and providers.
- The BLS training is incorporated in the HRD plan of the Department.
- All districts have at least BLS trainers (Drs, Nurses, EMS), though still very few.

CHALLENGES:

- Mannequins recommended by AHA not available in the Province.
- Delays in procurement process of mannequins.

Improving Basic life support in PHC facilities

Table below shows progress of BLS providers in PHC facilities

District	#Nurses	BLS Trained
Alfred Nzo	363	127
BCM	548	27
NMM	478	31
Sara B	252	132
Province	3876	318

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BLS TRAINING IN ACTION

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BLS INSTRUCTORS TRAINING IN PROGRESS

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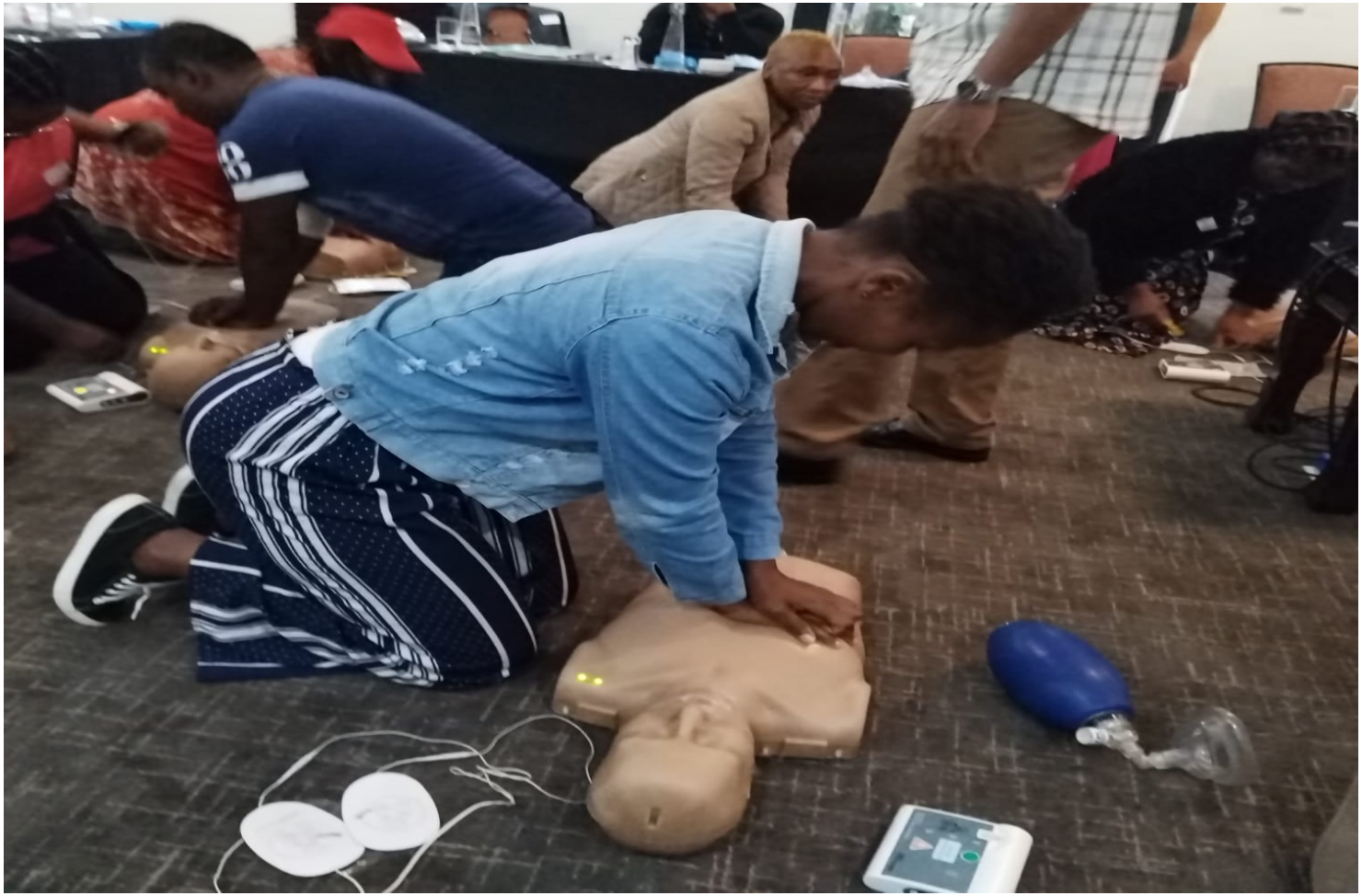
Table below shows practical progress of BLS Instructors training

- The Basic Life Support Instructors training in action.
- Three ECDOH Professional Nurses amongst the group successfully become Instructors
- Mannequins used have feedback devices and are required as per AHA recommendation.



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THE MAIN PROBLEMS FOR FACILITIES TO ATTAIN IDEAL STATUS AND TO SUSTAIN THE ACHIEVEMENTS

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1. HUMAN RESOURCE MANAGEMENT AND DEVELOPMENT

- Vacant leadership positions at facility and at district PHC coordination level
- Lack of leadership capacity and management of facility operations.
- Inadequate supervision of PHC facilities
- Lack of PHC coordinating organizational structure /ICRM at district level.
- Basic Life Support training expiring after every 2years
- Poor ICRM implementation, – an event rather than a quality improvement program
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2. INFRASTRUCTURE

- Signage, Service boards and notices
- Lack of adequate work space- Facility buildings that are still belonging to the municipality, whilst services provincialized.

3. SUPPLY CHAIN MANAGEMENT

- Medical equipment maintenance plan not implemented adequately.
- Delayed procurement process on medical equipment
- Surgical consumables – lifespan expiry
- Inefficient infrastructure minor maintenance plan
- Bulk supplies: inconsistent and interruption on water supply and electricity

4. SAFTEY AND SECURITY

- Security issues which affects functionality and operations of the facilities
  - Theft and burglaries which affects all facilities,
  - High crime rate in Metro and protests by staff citing issues of safety

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HOW THE LOW SCORING FACILITIES MADE PROGRESS TO REACH HIGHER SCORES EVEN IF THEY ARE NOT IDEAL – FROM 2015- TO DATE.

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- Implementation of the DHP and monitoring of worse performing facilities.
- Facility support visits at all levels priorities low scoring facilities.
- Regular meetings with Clinic Supervisors and OMs
- Constant ICRM provincial quarterly review sessions. Quarterly district performance reviews and provincial quarterly reviews.
- Support from the provincial office on procurement of essential equipment
- Integration of supervision with ICRM
- Appointment of OMs gradually improving
- Dedicated budget allocation : Ideal Clinic and NHI
- Involvement of OMs for benchmarking during PPTICRM assessments
- Partner support in contracting Pharmacist Assistants
- Focusing on Administrative processes
- Training of Oms on PHC management and ICSM
- Basic Life Support training
- Improvement of document management system
- Replacement of mud structure building

FUNCTIONALITY OF PPTICRM PROVINCE AND DISTRICT

FUNCTIONALITY	PROVINCE	DISTRICT
COMPOSTION	Leadership: Senior Manager: PHC & District Development Coordinator – Provincial Champion: DHS 1. Clinical branch managers 2. Quality Assurance 3. Human Resources and Corporate Services 4. Infrastructure & ICT 5. Strategic & Organisational Planning & HIMs 6. Finance	Leadership: District Manager Coordinator : District Champion 1. District and sub district health programs 2. Quality assurance manager 3. PHC Supervisors 4. Support services All PN's /OM that maintain the clinic status (and interested) are given the opportunity to be trained as assessors and join the PPTICRM team
APPOINTMENTS	Appointed by HOD with signed letters.	Appointed annually by means of signed letters from DM. Need to strengthen in some districts.
FREQUENCY OF MEETINGS AND MINUTES	Planned Quarterly until it was disrupted over the past years by the pandemic. In the process of reviving the meetings. Currently integrated in the provincial Quarterly ICRM reviews which remained active.	Primary health care meetings include ICRM issues. The district quarterly performance reviews include the ICRM performance and progress on QIPS.

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BUDGET FOR IDEAL CLINIC PROVINCE (OVERALL)

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1.Equitable share for PHC

- Subprogram 2.1: District management
- Sub-program 2.2 : Community Health Clinics
- Sub-program 2.3. Community Health Centres

2.Ringfenced Ideal Clinic budget

3. NHI budget for clinics and CHCs

4. Infrastructure Budget allocated under infrastructure and priorities the facilities on scaleup plan and bad infrastructure facilities.

IDEAL CLINIC BUDGET: 2022/23		
Overall allocation	**18 000 000**	**Equitable share**
Decentralized	R2 500 000	**46 facilities on scaleup plan**
Capital budget	**R10 000 000**	**Bulk filers/ shelving**
Goods & Services	R5 500 000	HPRS (Patient files)
Other budget:-		
NHI	8 723 150	HPRS (PHC Registers)

INFRASTRUCTURE PLAN – ROUTINE MAINTENANCE

- Infrastructure plan is available long term plan and 5year plan that is reviewed yearly, through reprioritization process.

- Under performing infrastructure elements are shared with infrastructure teams after each IC SD.
- Number of Primary Health Care facilities refurbished/ renovated
- Number of health care facilities with active scheduled maintenance contracts concluded.

.TRANSPORT MANAGEMENT – PROVINCE AND DISTRICT (SUPPORT/MONITORING VISIT).

Province

Types of transport system: White fleet/ Pool vehicles, subsidized motor vehicles and hired motor vehicles.

- Provincial managers use both subsidized and own vehicle.

District

- District managers also use own vehicles
- Some district officials use various.
- Subsidized vehicle scheme application open according to the policy, new applications undergoing processing again after are processed.
- Transport is shared with trips combined to maximize use.

Transport Monitoring

- Provincial fleet management unit
- District with fleet management function
- Fleet management meetings
- Monthly fleet reports
- Vehicle tracking system – which is the most effective and efficient currently

Thank you

ACKNOWLEDGEMENT:

- ***National Department of Health continuous ICRM support***
- ***Development Partners supporting districts.***
- ***Other Sector Departments through collaboration***
- ***Private organizations / Business sector support***
- ***Other provinces for shared best practices***
- ***Special Mention to Dr. E. Mthethwa instrumental support to EC.***

RECOMMENDATION

1. The NDOH support on ICRM to continue
2. Financial support and capacitation
3. Support partners that are dedicated in supporting the ICRM

- Facility Leadership and management training and Mentoring
- ICRM trainings, coaching and mentoring
- ICRM analysis and monitoring

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GENGQE CLINIC AND NURSES HOME

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NEWLY BUILD NHI FLAGSTAFF CHC

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Thank you

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THANK YOU