



# GPs contracting with the NDoH: The Role in Context

Richard Cooke

Wits Centre for Rural Health

Technical Advisor to the National Technical Task Team

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# “Contracting in”: Duties of the GP



- **These include:**
  - provision of promotive and preventive services as per PHC package: services **taking into consideration the burden of disease of the community being served by the clinic**
  - Use of clinical algorithms as per **PC101 Clinical Guidelines** for the management of chronic NCDs and of chronic communicable diseases such as HIV/AIDS and TB
  - Give **in-service training and support to nurses** employed in the health facility
  - Compliance with, and support of, clinical governance requirements, such as **appropriate record keeping and referral**
  - GPs shall be required to **attend training and orientation** (especially as it relates to new guidelines)

# “Where is it at...”



- Health Professionals Contracting National Technical Task team (since April 2013 – includes NHI Project Managers)
- NDoH: HP Contract Management Unit established
- Claims and Payment Administration outsourced
- GPs: National Contract plus a Service Level Agreement
- Approximately 60 GPs contracted by mid–Oct 2013); 130 to date
- Most: Tshwane (>30), least: OR Tambo (0)

# The challenges

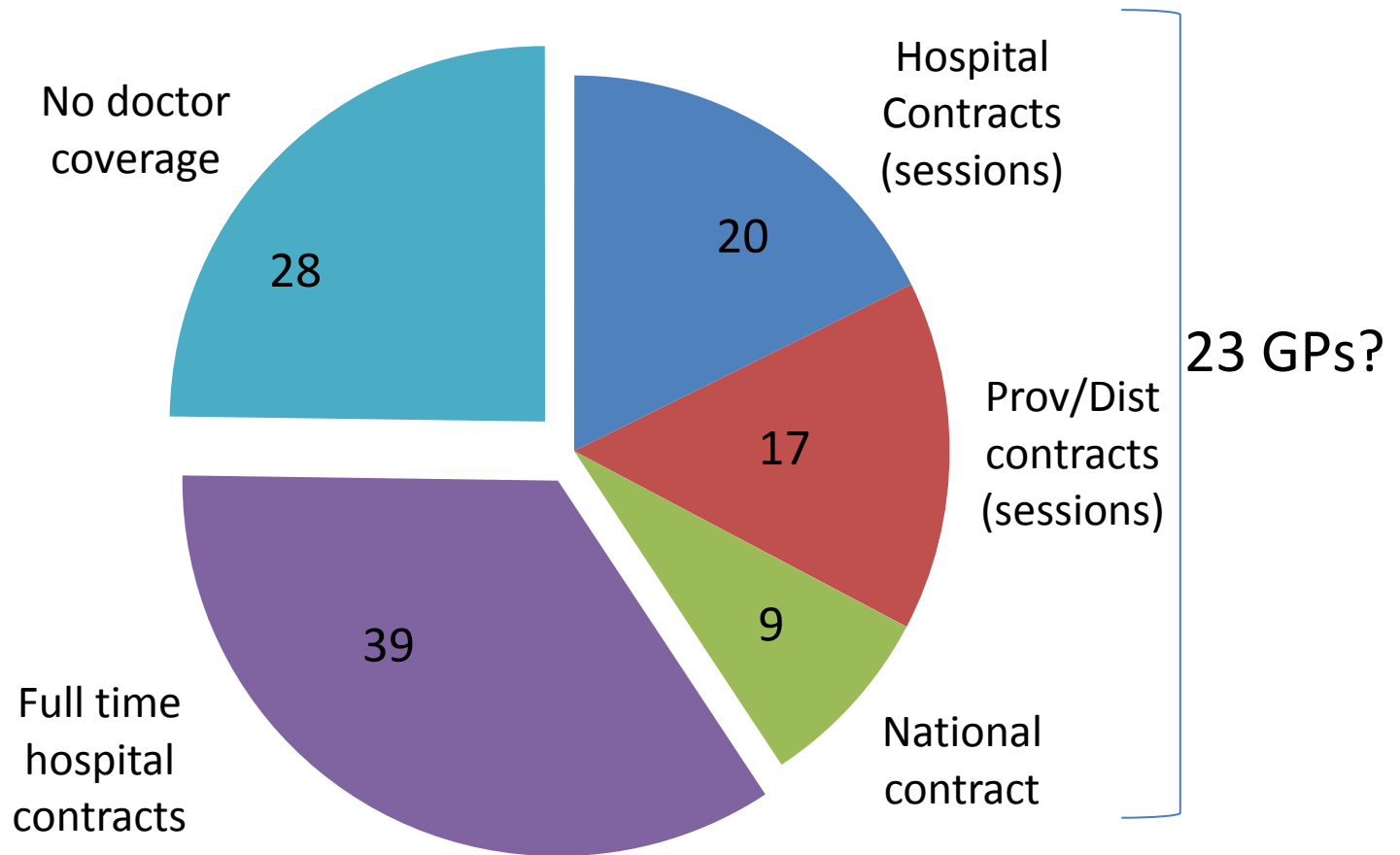


1. Recruitment in the context of the DHS (e.g. Vhembe and Pixley)
2. Matching district/community need with GP preference
3. Sustainability past the pilots and ideal clinics
4. Rates: limited by the DPSA framework
5. Performance of the PHC team, not just GPs
6. Management and supervision  
- operational managers? DCSTs?

# VHEMBE DISTRICT



# Of Vhembe's 113 clinics...



# Pixley Ka Seme District



# Pixley Ka Seme



## Emthanjeni LM

Clinic name	Doctors	Employment	Distance from home
Britstown	Drs K, K, W and D all live in De Aar	Full-time employed by Province, working at Central Karoo Hospital	<b>50 kms from De Aar</b>
De Aar			<b>In De Aar</b>
De Aar Town			
Kholekile Edward T			
Montana			
Hanover	Dr V lives in De Aar	Private GP (district session)	<b>60 kms from De Aar</b>

## Kareeberg LM

Clinic Name			
Carnarvan	Dr VZ lives in Victoria West	GP (national contract)	<b>110 kms from Victoria West</b>
Vanwyksvlei			<b>40 kms from Carnarvan (gravel)</b>



# Rates: coal face quotes



1. *The rate is far too low, and we won't be covering overheads if doing DoH clinic sessions (SAMA GPPP sub-committee)*
2. *"Basically it (higher sessional rates) would send the message that the career MO at the rural district hospital is the real bottom feeder" (Medical Officer Umgungundlovu)*
3. *"they cannot pay more than that otherwise there will be an exodus of doctors out of the hospitals to the clinics" (DH Clinical Manager OR Tambo)*
4. *"Maybe an exodus of doctors out of hospitals to clinics is just what we need!" (Wits Centre for Rural Health Family Physician)*

# DCSTs managing GP clinical performance?



- Not a burden, rather utilise GPs as an “arm of clinical governance” on-site (not just seeing patients off the bench)
- Win-Win “colleagial relationship”
- DCST team approach to performance management – No doctors; Dr-Nurse hierarchies
- Supervise performance of PHC team, not just GPs
- Start with DCST involvement with inductions

# NDoH – praiseworthy intent



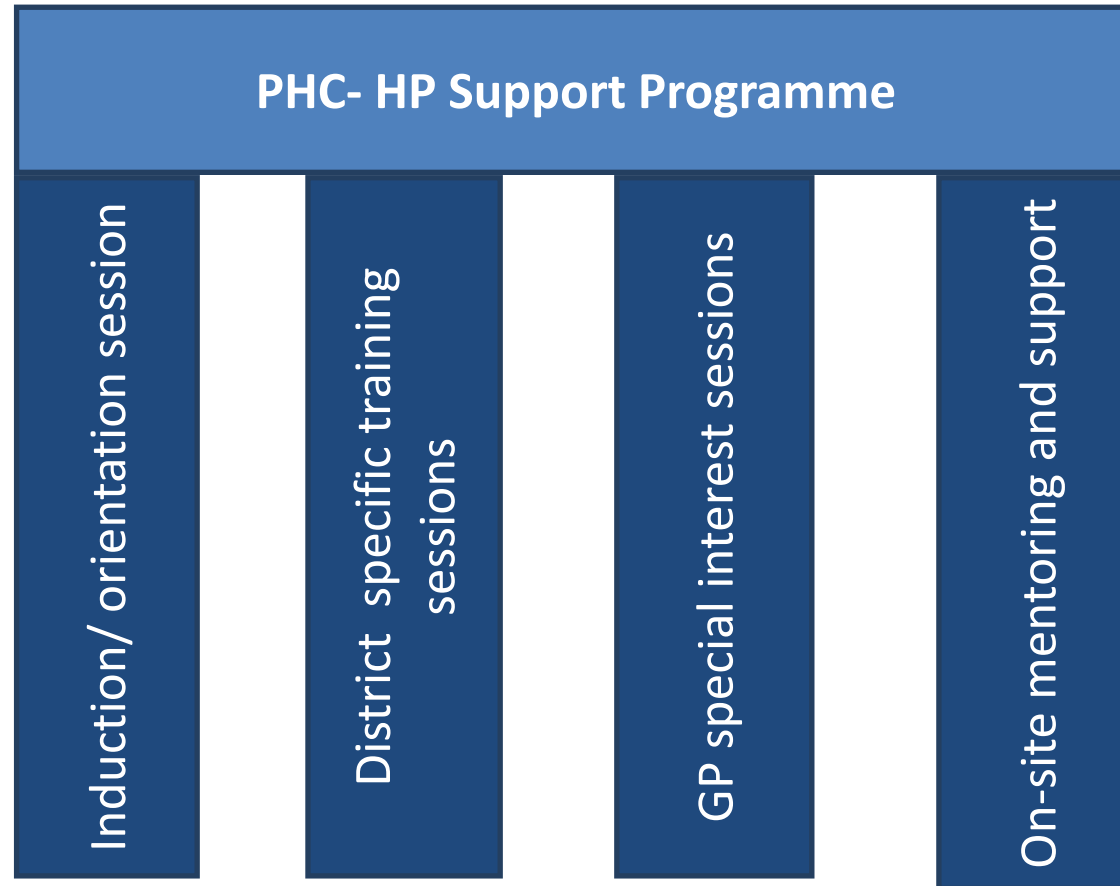
1. **National Technical Task Team: Terms of Reference**
2. **HP Contracting Research Forum**
3. **PHC-HP Support Framework**
4. “Hybrid” contracting model of sessions in Hospitals and Clinics
5. Rate paid at highest DPSA bracket
6. Travel time paid to clinics paid at the sessional rate
7. Attendance by GPs at induction programme is paid at the sessional rate
8. Ideal Clinics – policy meets implementation

# NTTT Terms of Reference

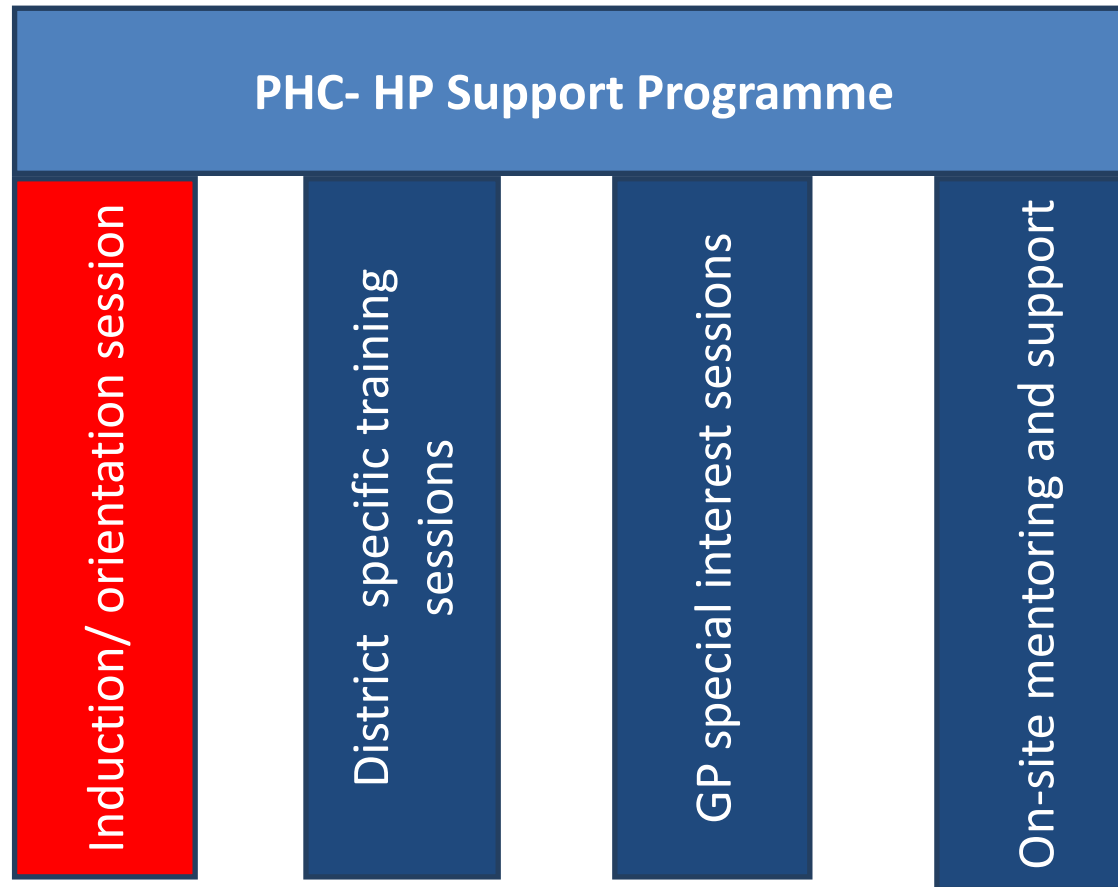


- **Ensure** that the exercise of GP contracting is guided by a rational and costed plan
- **Pilot** the provision of packages of services
- **Pilot** the implementation of novel service configurations
- Ensure the **mitigation of negative risks** through the development of a monitoring system that provides early warnings.
- Commission an **annual independent evaluation** of the functioning and result of GP contracting. Include in the evaluation report positive and negative lessons learned and how these lessons will inform the design of future interventions

# 4 pillars of the PHC-HP Support Framework



# 4 pillars of the PHC-HP Support Framework





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Department of Health  
Mpumalanga province

**Gert Sibande**  
**Induction Session**  
**Primary Health Care - Health Professionals'**  
**Support Framework**  
**(PHC-HP)**  
**30<sup>th</sup> May 2014**



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Supported by the **European Union**

# Task 1: Plenary Report Back - district profile

Each group is to identify the 3 most important inputs:

- 3 most important priorities
- 3 biggest challenges to address
- 3 greatest successes to harness
- 3 most effective actions to implement

Please refer to electronic resource pack!

*The GP's role as part of a collective  
in improving the DHS*



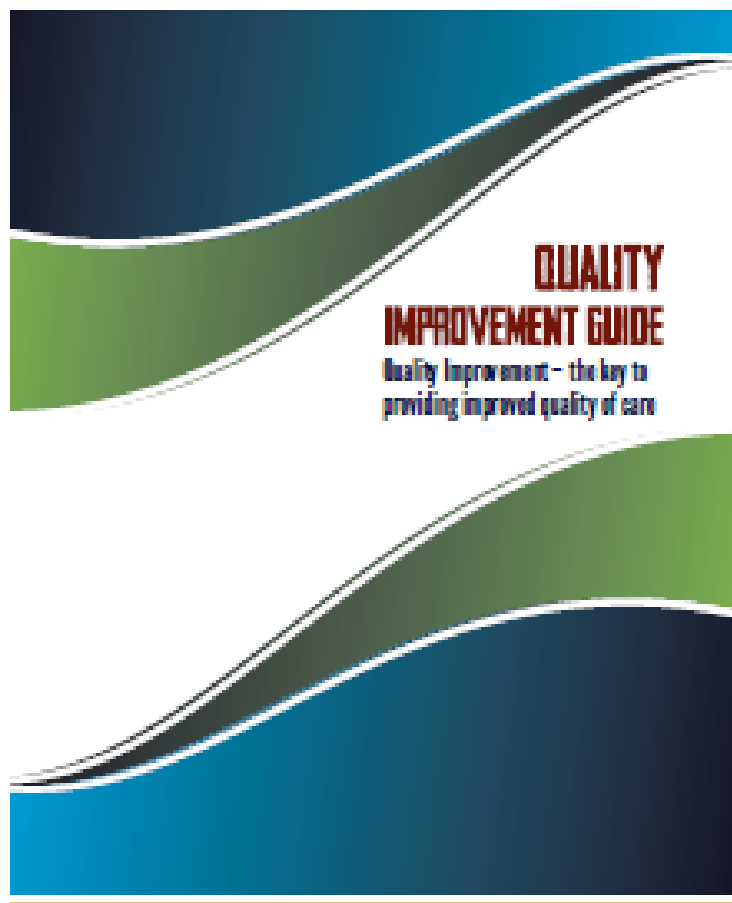




# Task 2: Roles, responsibilities and processes towards strengthening the PHC team

Focus on Quality Improvement

# QI Guidelines

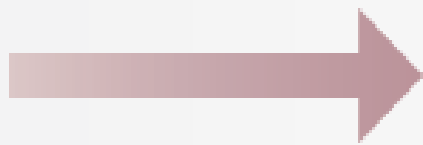


1. Context and NCS
2. 5 foundation stones
3. Practical application
4. QI tools and methods
5. PDSA – Plan, Do , Study, Act
6. Scaling up and sustaining change

[Clinical Guidelines and policies Gert Sibande](#)

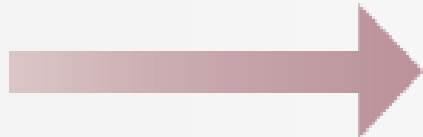


Focus on the client



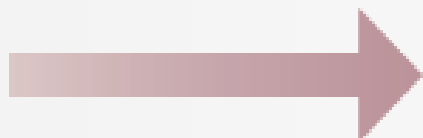
Services should be designed/restructured to meet the needs of the patient, family and the community

Focus on teamwork



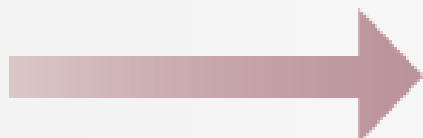
QI is best achieved through a team approach. Teams bring together varied understanding and insight into various components of the system, problems and possible solutions.

Focus on data



Data provides insight into the extent of the problem; assists in identifying gaps, and enables the measurement of performance. Also reflects improvements in service delivery and health outcomes.

Focus on systems and processes



Poorly designed systems generate inefficiency, waste, poor health care quality and negative health outcomes. Services cannot be improved if we do not understand and change the systems supporting the health service.

Communication and feedback: effective communication and feedback on issues and progress essential to sustainable QI activities. Communication and feedback to staff, management, leadership, clients, community.

# Meet Nondumiso

A 2 year 3 month old girl called Nondumiso is brought in by her mother, with a cough for 4 days. The mother was worried that the child is so small and has discussed this with a Community Care Giver during a home visit, who referred her to the clinic for this consultation.

Mother and child live in an informal settlement. The mother is HIV+ on ARVs. Nodumiso tested PCR- for HIV at 6 weeks. She was fed with formula milk.



# In your groups:

1. What are their (N and her mother) needs/expectations concerning the visit that you (PHC team) will need to meet?
2. Who is involved in Nondumiso's management and how are they involved? (teamwork/conflict)
3. Identify the data recording points in the patient process flow. What information needs to be reported?
4. What kind of possible challenges arise with regard to our existing systems and processes when managing her?
5. What communication and feedback issues do we need to be aware of?

**1hr duration. Please refer to your electronic resources!**

**GP role in building a client focus, teamwork and communication, use of information, and quality improvement**



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# National Health Act



## Government Gazette

REPUBLIC OF SOUTH AFRICA

Vol. 469 Cape Town 23 July 2004 No. 26595

### THE PRESIDENCY

No. 869 23 July 2004

It is hereby notified that the President has assented to the following Act, which is hereby published for general information:—

No. 61 of 2003: National Health Act, 2004.



AIDS HELPLINE: 0800-123-22 Prevention is the cure

SECOND EDITION

# THE NATIONAL HEALTH ACT

A GUIDE



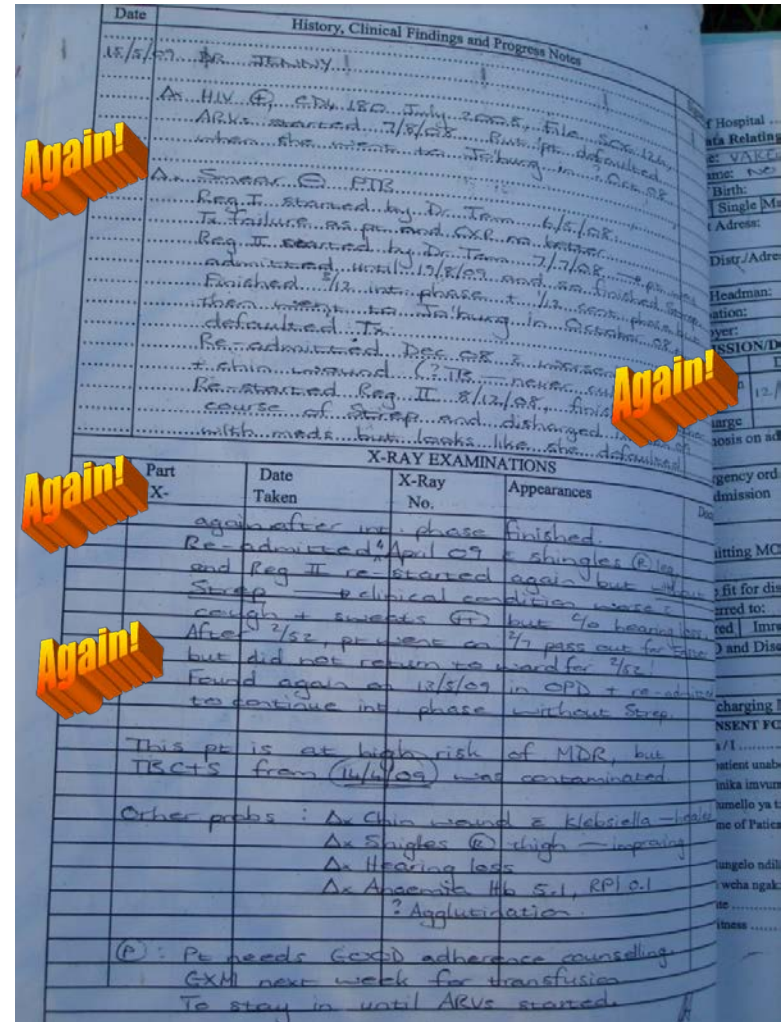
SiberInk

+SECTION27  
social justice for social justice



# Patients Rights Charter

1. HEALTHY AND SAFE ENVIRONMENT
2. PARTICIPATION IN DECISION-MAKING
3. ACCESS TO HEALTH CARE
4. KNOWLEDGE OF ONE'S HEALTH INSURANCE/MEDICAL AID SCHEME
5. CHOICE OF HEALTH SERVICES
6. TREATED BY A NAMED HEALTH CARE PROVIDER
7. CONFIDENTIALITY AND PRIVACY
8. INFORMED CONSENT
9. REFUSAL OF TREATMENT
10. A SECOND OPINION
11. CONTINUITY OF CARE
12. COMPLAINTS ABOUT HEALTH SERVICES



# Complaints management



**Complaint:** dissatisfaction/ displeasure/disapproval/ discontent expressed verbally or in writing by any person about the actual health services being rendered and/ or care being provided within the public health sector

# National Core Standards and six priorities

## National core standards

**1. Patient rights**

**2. Safety, clinical risk**

**3. Clinical support services.**

**4. Public health**

**5. Leadership & corporate governance**

**6. Operational management**

**7. Facilities & infrastructure**

## 6 Priorities

### Patient Rights:

1. Values and attitudes
2. Waiting times
3. Cleanliness

### Patient Safety, Clinical Governance & Care:

4. Patient safety
5. Infection prevention and control

### Facilities & infrastructure

3. Cleanliness/infection control
4. Patient safety and security (e.g maintenance, waste management)

### Clinical Support Services:

6. Availability of medicines and supplies

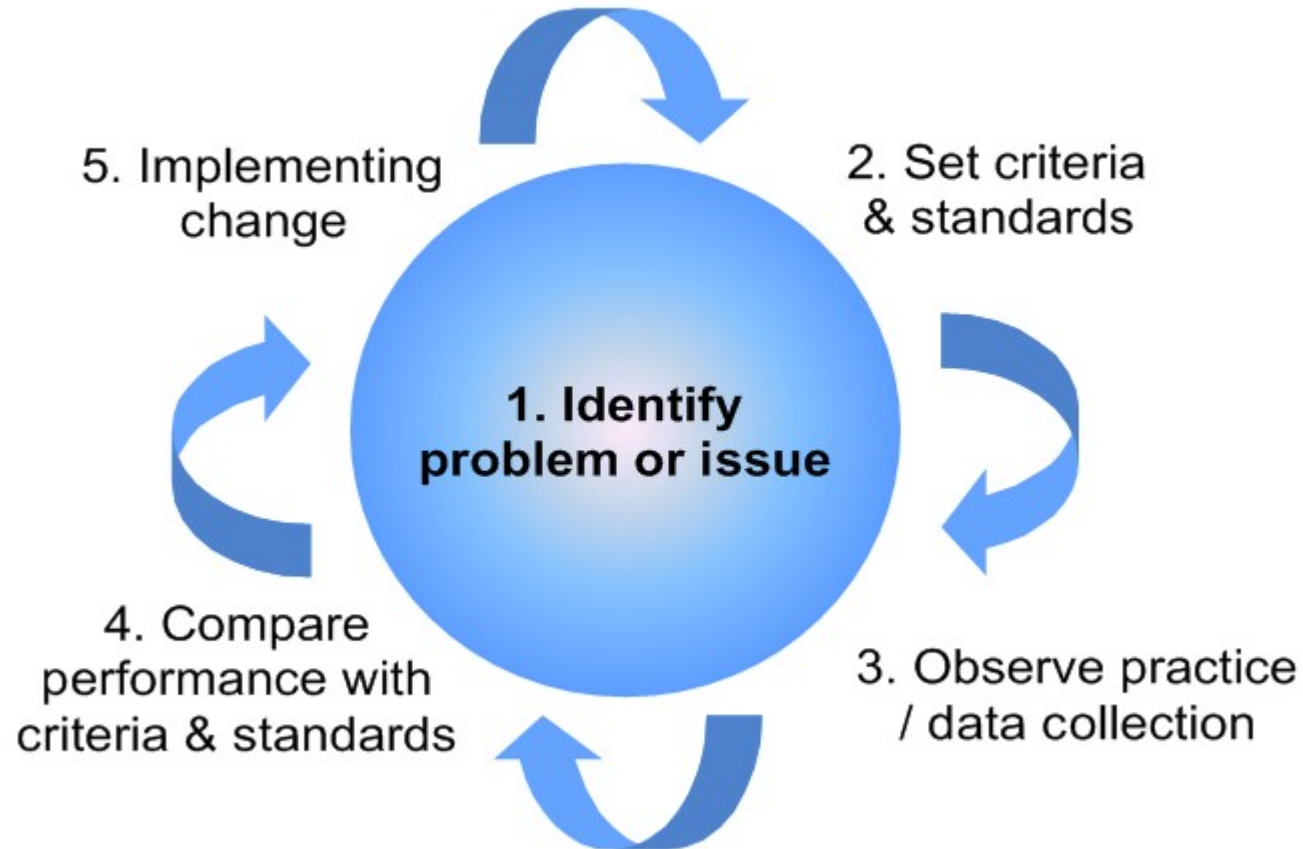


# Recording keeping, data sets and reporting

- Audit tools for keeping of clinical records and registers
- Data sets: NIDS, DHIS and others
- Cascades/Dashboards of Indicators
- Electronic versus paper records

[Operation Sakhume Sakhe KZN.docx](#)

# Quality Improvement Cycle



# IDEAL CLINIC INITIATIVE

## 10 FOCUS AREAS

Administration	Infrastructure and (bulk) support services
Implementation of clinical guidelines and ICSM	Health Information Management
Management of medicines, supplies and laboratory services	Communications
Staffing and Professional standards	District Health Systems
Availability of a doctor	Engagement with partners and stakeholders

# ICDM / ICSM

## INTEGRATED CHRONIC DISEASE MANAGEMENT Manual



## Clinical Guidelines and policies Gert Sibande



# Task 3: Clinical Management

## Group discussion

Your case study patient has arrived at the clinic.

### Task:

- Choose the appropriate protocol (s) or guideline(s) to follow in the clinical management of your patient.
- Discuss the clinical management of the patient based on the chosen clinical guideline

*GP Role in providing top-quality clinical care  
Reference point – evidence and research*



# Nondumiso

## INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

### SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

<b>Assess, Classify and Identify Treatment</b>	<b>Extra Fluid for Diarrhoea and Continue Feeding</b>
General Danger Signs.....2	Plan A: Treat for Diarrhoea at Home.....17
Cough or difficult breathing.....2	Plan B: Treat for Some Dehydration with ORS.....17
Wheezing.....2	Plan C: Treat Severe Dehydration Quickly.....18
Diarrhoea.....3	
Fever.....4	<b>Counsel the Mother</b>
Measles.....5	Counseling skills.....20
Ear problem.....6	Feeding assessment.....20
Malnutrition and Anaemia.....7	Feeding Recommendations in sickness and health.....21
HIV infection.....8	Feeding advice for child with persistent diarrhoea.....21
TB.....9	Iron-rich foods.....21
Immunization status.....9	Vitamin A and C rich foods.....21
Other problems.....9	Feeding Recommendations in HIV positive mother.....22
	Feeding Problems.....23
	Increase fluid during illness.....24
<b>Rational Drugs</b>	When to return.....16-17
Amoxicillin.....10	Diarrhoea.....37
Ciprofloxacin.....10	Fluid replacement.....16-17
Cotrimoxazole.....10	Immunize Every Sick Young Infant.....37
Erythromycin.....10	Local Infections at Home.....37
Antimalarials.....11	Correct Positioning and Attachment for Breastfeeding.....38
Prescriptions for Recurrent Wheeze.....11	Replacement (formula) feeds.....39
Salbutamol for Wheeze.....11	General home care.....40
INH Preventive therapy.....12	When to Return.....40
Treat for TB.....12	
Antiretroviral Drugs.....12	<b>Give Follow-up Care</b>
Zinc.....13	Local Bacterial Infection.....41
Iron.....13	Thrush.....41
Paracetamol.....13	Feeding Problem.....41
Mebendazole.....13	Poor Growth.....41
Vitamin A.....19	
	<b>Provide Anti-retroviral Therapy (ART)</b>
<b>treatment for Local Infections</b>	Initiating ART in Children.....43
Dry the Ear by wicking and give eardrops.....14	Eligibility criteria: Who should receive ART?.....44
Mouth Ulcers.....14	WHO Clinical Staging.....44
Thrush.....14	ART: Starting regime for children less than 3 years old.....45
Soothe the Throat, relieve the cough.....14	ART: Starting regime for children 3 years or older.....45
Eye Infection (measles).....14	Follow-up care for children on ART.....47
	Give Nevirapine to all HIV EXPOSED newborns.....49
	ART regime for children who are stable on Stavudine.....50
<b>treatments in Clinic Only</b>	
Ceftriaxone.....15	<b>Recording Forms</b>
Diazepam.....15	Growth Monitoring Charts.....ANNEXURE A
Salbutamol for wheeze & severe classification.....15	ANNEXURE B
Nebulised adrenaline.....15	
Prescriptions for stridor or recurrent wheeze.....15	
Prevent low blood sugar.....16	
Treat low blood sugar.....16	
Oxygen.....16	

### SICK YOUNG INFANT (BIRTH UP TO 2 MONTHS)

<b>Assess, Classify and Identify Treatment</b>	
Possible Bacterial Infection and Jaundice.....30	
Diarrhoea.....31	
HIV infection.....32	
Feeding and Growth in Breastfed Infants.....33	
Feeding and Growth in non-Breastfed Infants.....34	
Special Risk Factors.....35	
Immunization Status.....35	
Other Problems.....35	
Mother's Health.....35	
	<b>Treat the Young Infant and Counsel the Mother</b>
Erythromycin.....36	
Ceftriaxone.....36	
Diarrhoea.....37	
Fluid replacement.....16-17	
Immunize Every Sick Young Infant.....37	
Local Infections at Home.....37	
Correct Positioning and Attachment for Breastfeeding.....38	
Replacement (formula) feeds.....39	
General home care.....40	
When to Return.....40	
	<b>Give Follow-up Care</b>
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World Health Organization  
Division of Child Health and  
Development (CHD)

unicef



South Africa 2011



**IMPORTANT: Always bring this booklet when you visit any health clinic, doctor or hospital**

# ROAD TO HEALTH BOYS

Child's first name and surname:

Date of Birth:

DD/MM/YYYY

This booklet must be issued at birth by the health services concerned. If both fathers place at issue, the first opportunity after delivery should be used to issue the booklet. The booklet must be issued **FREE OF CHARGE** irrespective of delivery taking place at a public or private health facility.



## PROTOCOL FOR THE IN-PATIENT MANAGEMENT OF CHILDREN WITH SEVERE ACUTE MALNUTRITION IN SOUTH AFRICA

*"Severely malnourished children are different from other children; so they need different treatment."*

CONDITION	PREVENTION	WARNING SIGNS	IMMEDIATE ACTION
<b>3 Hypoglycaemia (Low blood sugar)</b> Hypoglycaemia is a blood glucose < 2.6mmol/L	For all children: 1. Feed immediately "babbling" feed (FTS) every 2 hours (2 feeds), day and night. Start immediately. Is on arrival at hospital and within 30 minutes after admission. (Use feeding chart to find amount to give). 2. Encourage mothers to stay with their children to watch for any deterioration, help feed and keep child warm.	1. Low temperature 2. Lethargy 3. Poor appetite 4. Irritability 5. Convulsions 6. Coma	Perform: Declassify, test in duplicate quickly, and on admission in all patients. If convulsions and blood sugar is below 2.6mmol/L: 1. If hypoglycaemic, feed 2 hourly (12 feeds in 24 hours). Use feeding chart to find amount to give. Start immediately. 2. Give 50 ml of 10% glucose (10 ampoules) over 30 minutes (use 40ml sterile water) or sugar solution (1 rounded teaspoon sugar in 2 teaspoons of plain water) orally until blood resolves, use nasogastric tube (NG tube) if 10% glucose is not available, give sugar solution or FTS when then able to swallow. Test again 30 minutes after treatment. If blood sugar is still low, repeat oral 50ml 10% glucose or sugar solution. Consider putting up a shot (if the child is unresponsive, give decrease IV (20mg of 10% glucose, prepare feeding 50% dextrose mixed with feeding sterile water), followed by oral 50ml of 10% glucose or oral sugar solution on the NG tube. Monitor response to treatment. 3. Monitor blood sugar 2 hourly until stable (usually) in the afternoon. If blood sugar is persistent low, review feed and look for infections.
<b>2 Hypothermia (Low temperature)</b> Hypothermia is Axillary temperature < 36°C	For all children: 1. Feed immediately, and then every 2-3 hours, day and night. 2. Keep room: Cover with a blanket. Lie mother and child with one to keep child warm. 3. Keep room warm, no draughts. 4. Feed bedding/clothes dry. Dry carefully after bathing (do not bathe if very ill). 5. Avoid exposure during examinations, bathing.	1. Cold extremities 2. Lethargy 3. Poor appetite 4. Irritability 5. Convulsions 6. Coma	Take temperature in duplicate quickly, and on admission. (Ensure thermometer is well shaken down). If the temperature is below 36°C: 1. Begin re-warming. Put the child on the mother's bare chest (skin-to-skin contact) and cover the child. Cover the child's head, cover the child, apply a warm blanket and place a heater or lamp nearby. 2. Feed 2 hourly (12 feeds in 24 hours). Monitor during re-warming: • Take temperature every two hours stop active re-warming when temperature rises above 36°C. • Take temperature every 20 minutes if heater is used because the child may become overheated.
<b>3. Some or severe Dehydration (Without shock)</b> (Without shock)	1. When a child has watery diarrhoea, give 20ml Oral Rehydration Solution (ORS) after each loose stool to replace loss.	Profound watery diarrhoea, sunken eyes, sunken fontanel, absent tears, dry mouth, very dry	See Emergency Treatment (see Chart) for feeding shock! If there is some or severe dehydration: 1. Give ORS, oral or by NG tube, 5 ml/kg every 20min for 2 hours using 'rehydration small sip'. 2. Then give ORS (5-10ml/kg) and FTS in alternate hours for up to 4-10



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# Sipho

STANDARD TREATMENT GUIDELINES  
AND  
ESSENTIAL MEDICINES LIST  
FOR  
SOUTH AFRICA

PRIMARY HEALTH CARE LEVEL

2008 EDITION

primary care



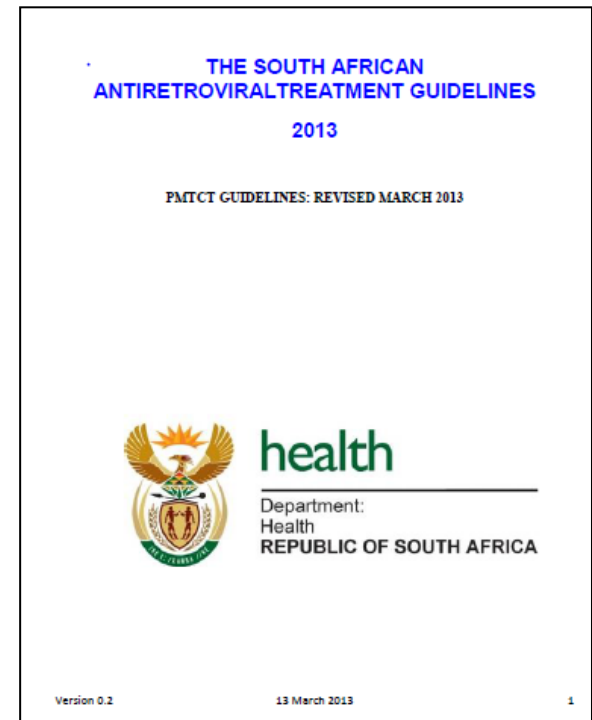
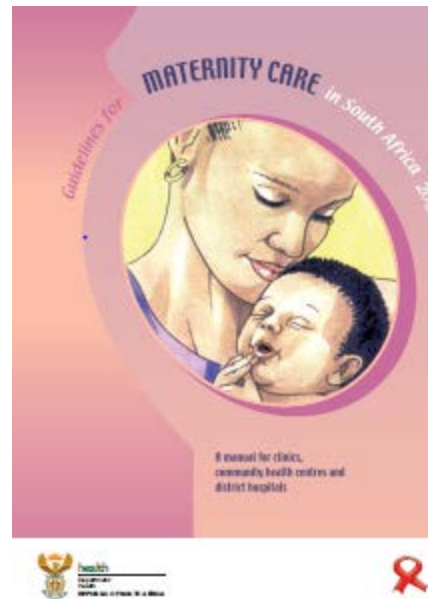
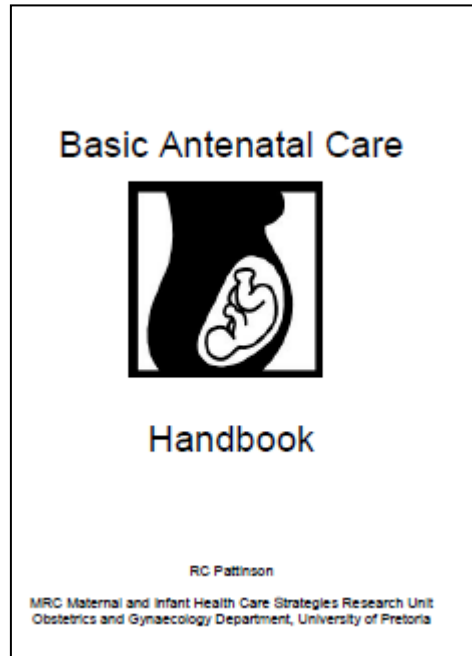
Symptom-based integrated approach to the adult in primary care

TB  
HIV  
Asthma/COPD  
Cardiovascular disease  
Diabetes  
Mental health conditions  
Epilepsy  
Musculoskeletal disorders  
Women's health



2013/14

# Thandi







Keshnee  
Janita

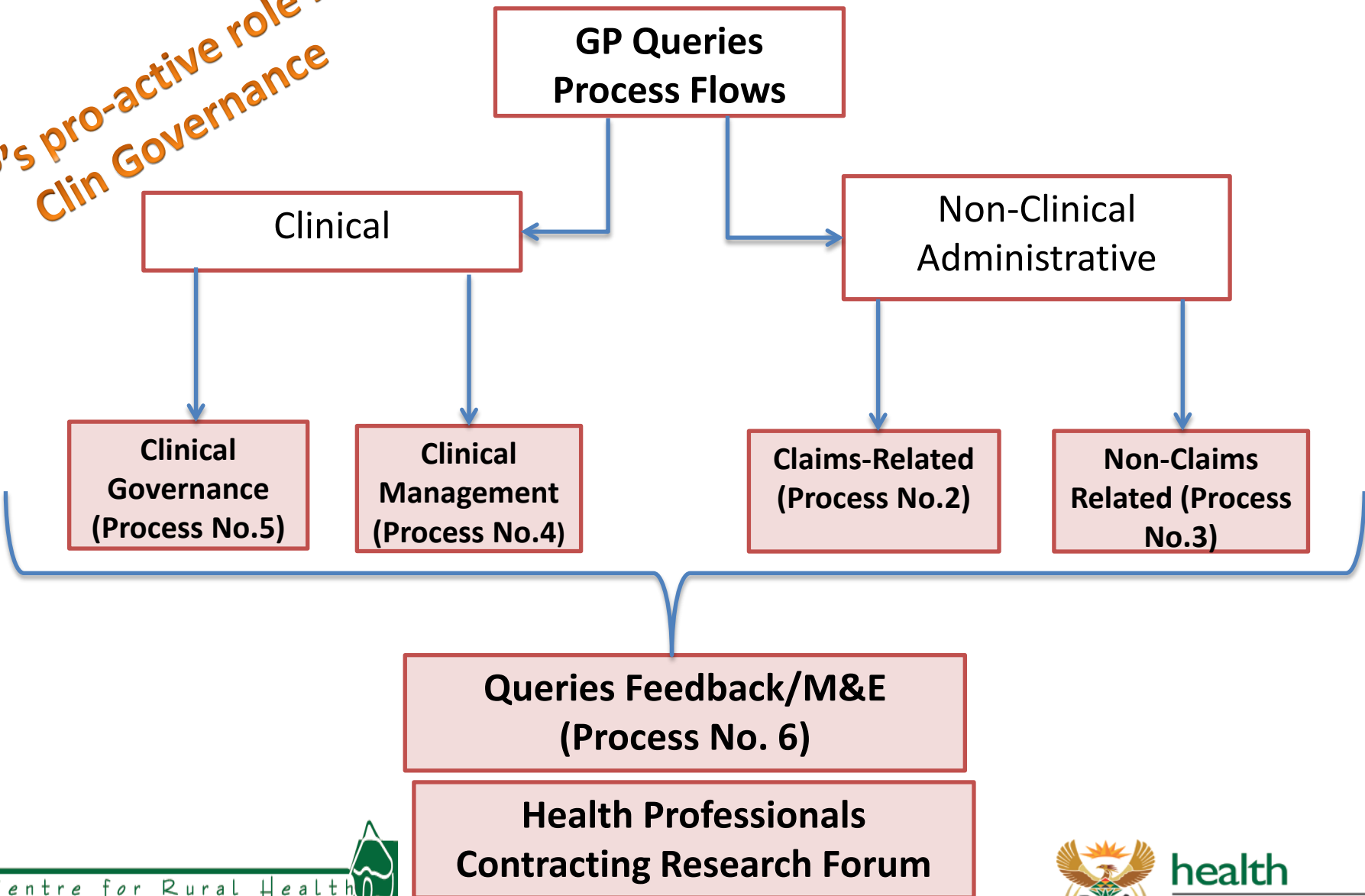
BETTY

HOPE  
to share info with GPs on  
Do it yourself guidelines  
to encourage positive  
to get views/perceptions/experience  
of GPs

TASKS  
GPs will be discouraged

# HP CONTRACTING PROCESSING OF QUERIES No. 1 OF 6

*GP's pro-active role in Clin Governance*



# HP CONTRACTING QUERIES PROCESSES No. 4 OF 6

## GP CLINICAL Queries

**Clinical Governance** – If your query is, or might be, related to issues about excellence and quality in your workplace then see separate query process on clinical governance (no. 5 of 6)

**Clinical Management**  
Your question is related to a clinical assessment, investigation or management.

Self Help - these are the ways that you can use help that is close to you.

PHC clinic team – there may be others in the clinic that can help.

Peer Support

The GP e-mail group set up at the induction process. Will include 1) e.g [TshwaneHPcontract@health.gov.za](mailto:TshwaneHPcontract@health.gov.za) and 2) [NHIdrcontract@health.gov.za](mailto:NHIdrcontract@health.gov.za)

DCST (District Clinical Specialist Team) who have specialist knowledge and experience. They may call on other colleagues for help.

Consult additional specialist expertise, if required.

Partner Organisations – mentoring, support on specific programmatic areas (e.g. PEPFAR partners)

PHC-HP Resource Pack

Clinical Guidelines

Policies

Internet

Protocols

Question answered/resolved

Unresolved

Clinical Gov. Query process

Administrative query process

Queries Feedback/M&E process  
query flow No. 6

# HP CONTRACTING PROCESSING OF QUERIES No. 5 OF 6

## Clinical Governance (CG) queries

Clinical Audit

Clinical effectiveness

Research

Openness

Risk management

Information Management

Education and Training

The GP e-mail group set up at the induction process. Will include 1) e.g. [TshwaneHPcontract@health.gov.za](mailto:TshwaneHPcontract@health.gov.za) and 2) [NHldrcontract@health.gov.za](mailto:NHldrcontract@health.gov.za)

DHMT

NGO Partners and other stakeholders

Queries Feedback/M&E process query flow (No.6)







Thank you



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