DRAFT

……. MISSION HOSPITAL/HEALTH FACILITY (Location)

Self-Assessment Tool, Health Facility Adaptation- Vision, Mission, Ways of working

(Health Services, Local Community Response, Human Resources)

February 2013

STRATEGIC AREA 1. VISION, MISSION & LOCAL COMMUNITY/OTHER PARTICIPANTS/STAKEHOLDER RELATIONSHIPS

VISION				
1	2	3	4	5
We have a Vision Statement written by our predecessors, the knowledge of which is sketchy	We believe Vision to be an important tool in Strategic Planning and would like to be actively engaged in creating a Vision Statement	We are creating a Vision for the Hospital though it is very much a draft that requires lots more work	Our Vision Statement is guiding our thinking and planning and is uniting our effots in determining our mission	Our Vision Statement is complete and is known by our stakeholders and is increasingly being used by the wider hospital community as a guide to our work. We will revise the Vision in 5 years time.

MISSION				
1	2	3	4	5
Our mission is to do good service in the hospital, with care and integrity	We believe in health work and in evangelism, but these are not connected	Some of us do SALT and understand that the grace of God is in the communities and in us also	Our mission is in community as well as in hospital/clinic	Spiritually aware staff and community: Staff finding Christ in life and work; Holistic healing and transformation in communities. Community conversation, SALT and facilitation team development are seen as part of Christian incarnational lifestyle.

LOCAL COMMUNITY/OTHER PARTICIPANTS/STAKEHOLDER RELATIONSHIPS				
1	2	3	4	5
We are uniquely a hospital/clinic based health care provider. This is our focus.	We have some links with local community. We try to have relationship, but community is not interested or does not trust us. We know about other potential participants and stakeholders but we are not connected at all.	We receive invitations from community, but do not follow up fully. We hear from other groups and faith bodies and other stakeholders but we are not following these links.	We are responding to invitations, and health work is developing in communities. Local partnerhips are developing with faith bodies and other local health programmes and other stakeholders. Trust based relationships are developing.	Communities are fully involved. We are learning from them too: transfer between us and between communities. SALT is happening regularly-at least once per month , and all staff have opportunity for at least one SALT visit per year. Local partnerships are genuine and attract other potential partners and stakeholders. Trust between local partners and local communities and the hospital staff is high, and enables new opportunities for shared learning and action to happen.

STRATEGIC AREA 2: GOVERNANCE, MANAGEMENT, SUSTAINABILITY

GOVERNANCE				
1	2	3	4	5
All decisions made by an individual who holds responsibility for standards and ownership	Meetings of the governing body happen occasionally. The chairman and hospital administrator talk to each other, and decide policy	Meetings of the governing body happen occasionally (at least once every three months), the management board meets separately	Inclusion of independent advisors with a shared **vision.** The management board meets with the governing body at least twice a year	The governing body shares responsibility for the purpose, mission, standards, ethics and **vision** (which embraces integrated mission). The governing body meets regularly (at least once per quarter),

				and the management boar d views are effectively inclu ded and discussed. Mem bers of governing body part icipate in community expos ure visits (SALT – support, ap preciation, learning, transfer)
				regularly (at least twice per year)

MANAGEMENT				
1	2	3	4	5
Decisions taken without consultation with those affected, staff, commun ity, THQ	Some degree of consult ation on specific issues with those involved and affected	Issues and decisions are shared by the manage ment board. The management Board meets at least once per month to agree on poli cy and implementation processes	Internal teams and worki ng groups inform and re commend to the board. The members of the Ma nagement Board are re presentative of all the pri mary work areas of the hospital/clinic and com munity	Board decisions are discussed and implemented with appr opriate accountability. Hospi tal and community support th e shared vision. **Management board member s participate in SALT visits reg ualrly (at least twice a year)**

SUSTAINABILITY & FUND-RAISING				
1	2	3	4	5
We expect income from USPG and donors and a nd patients, although b ed occupancy is low	85% of income from inp atient level care.	Some income from proj ects We plan financially bas ed on forecast budgets	Patient fees + projects + training opportunities ho sted in community and i n hospital Implement income gen erating activities. The ho spital has made some pr ovision for asset manag ement	Multi-faceted programme wit hin hospital and community a llows stable running costs and income to match costs. With provision for future repla cements and growth. A dyna mic asset maintenance plan i s in place and is regularly revi ewed, actioned and practic al
We have donors other t	We are beginning to de	We are actively engage	We are succesfully recei	We are evaluting our current

han traditinal donor gro ups to whom we turn sp oradicaally	velop a formal Fundraisi ng structure within the h ospital (team, technolo gy for fund-raising, websi te, data base etc)	d in researching and soli citung funding opportun ities and are developing proposals	ving responses from don ors (major and minor) an d our fundraising team is well established	succesful fundraising progra mme and developing a seco nd-generation programme fo r further developments in clu ding an endowment fund

STRATEGIC AREA 3: PROGRAMMES, SERVICES, TRAINING & LEARNING

PROGRAMMES				
1	2	3	4	5
Hospital departments ea ch function as traditional in-hospital programme	Community programme exists, but not interlinked to hospital departments	Interest within different d epartments to develop programme links betwee n themselves and in com munity.	Working groups, includin g people from both hosp ital and community prog rams, develop and ada pt programmes for parti cular issues.	Effective continuum of care a nd prevention in all health pro grammes/ departments. Mutual support and initiative b etween depts. SALT visits are a normal part of programme design by progra mme teams and planners –be fore during and after impleme ntation.
PROGRAMME TRAINING AND LEARNING				
1	2	3	4	5
Training is there but with minimal linkage to patie nt care	Training is linked to patie nt care, but has only little connection to communi ty application	At least one training pro gram developed by the hospital, linked directly t o patient care, with com munity application	Level 3 plus we learn fro m good experience, an d base training in the co mmunity so others can le arn from the community	Every hospital program has so me form of training(to Level 3 & 4) and people want to join t he training from outside the ins titution, and are willing to pay f or it. Experienced based learning vi a SALT and faciliattion of transf er of knowledge are normal p arts of all training processes.

STRATEGIC AREA 4: HUMAN RESOURCES, PERSONNEL DEVELOPMENT TRAINING & RESOURCES

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PERSONNEL : ATTITUDE TO COMMUNITY				
1	2	3	4	5
Staff work well in hospital, do not go out to community	Some are willing to go out once in awhile	Some are willing to support, and regularly visit community	All staff has understanding of the purpose and process of community visits	All staff have some involvement out of hospital as well as in. Staff are strongly motivated for integrated mission

PERSONNEL : DEVELOPMENT				
1	2	3	4	5
Staff have commitment in their own departments for standard of work	Staff work well and seek professional development in their own areas of expertise	Professional and ethical standards discussed regularly. Good teamwork within departments and with administration	Staff seek development for overall health ministry. Teamwork between departments also. Learning transferred between departments and programmes	Teamwork within and between departments. Formal education integrated with participatory learning from experience(SALT) , for professional and skills development.

PERSONNEL : STANDARDS OF SERVICE AND CONDITIONS				
1	2	3	4	5
Salary scale not standardized. Protocols do not exist	Salary standardized. Protocols not adequate	Fair pay and adequate employment w/in economic framework of hospital. Appraisal system in place.	Respect for mission and economy, with fairness of salary and conditions. Guidelines and processes are implemented.	Job satisfaction. Protocols improved. Staff fulfilled, personally developed, and consistently seek the development of colleagues
PERSONNEL: INSERVICE TRAINING				
1	2	3	4	5
Each staff member is ex	Recognition of the need	Training programme pro	Staff are encourage to partici	An effective CPD (Continuous

pected to be up to dat e with their own technic al knowledge and skills. The hospital/clinic does not provide a training pr ogramme	to implement an in-hous e training/learning progr amme Administrator arranges S ALT visits (for community exposure)	vides for all staff. Few in centives for staff to parti cipate. Some staff undertake SA LT visits (community exp osure)	pate in training programmes (inclusive of technical, maint enance staff) SALT visits are made regularly	Professional Development) pr ogramme with a focus on on going improvement is planne d for the year and implement ed All staff undertake SALT visits a t least once every year and id eally every three months.

PERSONNEL : RELATIONSHIPS - to be developed				
1	2	3	4	5

STRATEGIC AREA 5: PRECINCT DEVELOPMENT – FACILITIES, ASSETS, EQUIPMENT & BUILDINGS,

EQUIPMENT (includes medical devices, power generators , ambulance and sterilizers etc)				
1	2	3	4	5
Equipment is old, mostly not functioning. Patient s ervices and diagnostic r esults are unreliable..	Equipment is old, but get ting repaired. Breakdow ns occur often and unreli able results sometimes o ccur.	Equipment is adequate, but needs upgrading. W e are learning to maintai n it. Equipment is operat ed in accordance with manufacturers instructio ns.. Equipment breakdo wn sometimes delays pa tient services. Diagnostic results are generally reli able.	Equipment is maintained , and is matched to the programme. Planned m aintenance(PM) schedul es are in place and som e planned maintenance completed. Purchases e nsure that products are available or altenatives are supplied. Incidents and hazards ar e documented and eval uated.	Equipment needs are planned and linked to other centres, if we do not have the equipmen t or technical skills. At least a five year capital equipment pl an with annual review at budg et time. We refer when need ed. Maintained, with a reserve pla n for replacement. PM is done on a regular schedule with ap propriate documentation and review. PM needs are match ed by the local skills and wher e necessary funds for external contractors budgeted. Design and planning is influenc

				ed by SALT visits of the team re sponsible for the work and pro curement.

BUILDINGS (includes electrical distribution, water and sanitation etc.)				
1	2	3	4	5
Buildings in poor conditi on. High infrastructure (over head) cost. Patients spread through out the buildings.	Not all parts of the hospi tal are used – some con solidation of wards and f acilities	Assessment conducted periodically on options f or rightsizing the hospital . Some policies in place for safety and risk minimi sation. Buildings are clea n, water and sanitation s upport a healthy and sa fe environment.	Consolidated space an d effective planned mai ntenance(PM) schedul es are attempted. Buildi ngs and services are ma naged to local regulatio ns. Performance indicat ors are used to improve and evaluate the buildin gs and utilities.	Hospital is the right size for the pr ogramme requirements of a co mmunity hospital Personnel and overhead require ments match hospital size Lab, x-ray, and other facilities ar e accessible to the wards, theat re, and outpatients dept. P M is done on a regular schedu le with
				appropriate documentation an d regular reviews. Design is influenced by SALT visit s done by the people involved i n decision making.

GUIDELINE FOR USE OF THE SELF-ASSESSMENT OF HOSPITALS/CLINICS/HEALTH FACILITIES

A self assessment has three steps:

1. **Where are we now,**
2. **Where do we want to be,** and
3. **How will we get from where we are, to where we want to be?**

First, form a working group.

A group of interested people meet together to answer these questions. The basic group includes people from the hospital administration, Church administration of the diocese, and as many staff members as possible, from all the departments of the hospital and community outreach. Additional participants should come from the division where the hospital is based, from the divisional leaders and the neighboring corps, both soldiers and officers. Also members of the surrounding community who have an ownership of the hospital should be included.

Step one: meet as a working group, divide into smaller groups of 5-6 to answer the questions. Hospital staff may be in some groups, hospital and administration in another, church participants in another, and community members in another. Each group answers the question to say how they see the hospital now.

For each category of the self-assessment, all the groups share their response aloud, and the responses are discussed, until an agreement is reached about the level of the hospital. By the end of the discussion, a combined self-assessment has been done, with the agreed levels noted down as **where we are**.

Step two, the whole group will look again at each category, and discuss where the hospital would like to be within the next year. So for example, if the group has already agreed that the hospital is at level one in equipment, they look again and agree together that it is realistic for the hospital to reach level two or level three within the next year. That level is noted down as **where we would like to be.**

EQUIPMENT				
1	2	3	4	5
Equipment is old, mostly not functioning **Where we are**	Equipment is old, but getting repaired	Equipment is adequate, but needs upgrading. We are learning to maintain it. **Where we would like to be**	Equipment is maintained, and is matched to the programme	Equipment needs are linked to other centres when needed, if we do not have the equipment or technical skills. We refer when needed. Maintained, with a reserve plan for replacement