Western Cape Government

Health

Strategic Plan
2015 - 2019

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FOREWORD BY THE MEC FOR HEALTH

I am singularly privileged to have the opportunity to lead the Health Department in the Western Cape. It is the Department with the largest budget within the Province, which in itself bears testimony to the priority accorded to Health by the Western Cape Government.

I inherit a Department that has a proud track record of having amongst the best health outcomes in the country, operates within its allocated budget and has received an unqualified audit for the last ten years. These achievements are the result of hard work, dedication and commitment of the staff and management of the Department.

I intend taking the Department to greater heights. I am fully supportive of Healthcare 2030, the long term vision of the Department that has been approved by the provincial cabinet. The challenge is to give effect to the laudable ideas contained in Healthcare 2030 – to convert the vision to reality.

The economic outlook in the short to medium term will not increase the allocation of resources in real terms to Health. The challenge may even be to do more within the current resource envelope. On the other hand, the burden of disease continues to escalate especially the burden of chronic diseases. There is no evidence of significant improvement in the trends of risk factors such as inadequate physical activity and obesity. The consequence of this tension between limited resources and escalating burden of disease is severe service pressures in many of the primary health care facilities and the acute hospitals. This situation results in amongst others long waiting times, more patient complaints and stressful working environments for staff.

We have to take urgent measures to alleviate the service pressures and bring relief in the interest of better quality of care for patients and care and greater support for staff. However, the sustainable long-term solution lies in a healthy population. Thus the Strategic Goal on improving Wellness and Safety and Reducing Social Ills is paramount. Notwithstanding the fact that many of the upstream prevention measures only have an impact in the long-term, as a Western Cape Government in partnership with all stakeholders and communities – as a whole of society- we need to strengthen our resolve to improve the wellness of our people in the province. Our interventions need to address the needs of all segments of the population from mothers and children, youth to adults and the elderly.

I wish to establish strong relationships with our partners. As I engage with staff in the Department and with our external partners, and learn more about the health service, I look forward to listening to your ideas and contributions on how we can take the health service in this province to the next level. Only together we can do better.

Dr Nomafrench Mbombo
Western Cape Minister of Health
February 2015

STATEMENT BY THE HEAD OF DEPARTMENT

The 2015-2019 five year plan is the first step toward the implementation of the Healthcare 2030 vision and strategic framework of the Department. It coincides with the appointment of Minister Nomafrench Mbombo on 1st January 2015 as well as the appointment of Dr Beth Engelbrecht as Head of Department with effect from 1st April 2015. For the first time since 1994, two women are at the helm of the Western Cape Department of Health, which is a major milestone in itself. This provides an opportunity to think afresh and bring in new perspectives but also maintain continuity and stability.

Given the economic climate the greatest challenge is to reprioritize resources internally and create opportunities within a budget that decreases in real terms over the next three years to give effect to the vision and strategic priorities of Healthcare 2030. This challenge is increased with an escalating burden of disease resulting in significant service pressures.

The Department must focus on efficiency, equity and quality. To get better value from the *health rand* the available resources must be targeted to the most cost-effective interventions with improved productivity and outputs. Healthcare 2030 modeling was based on directing the most resources to poorest communities and households where there is the greatest need. Healthcare 2030 aims to improve the patient experience, the clinical outcomes and the quality of care. To achieve this goal support and care for hard working and dedicated staff is essential. Further it is essential that within the provincial government efforts to address the upstream social determinants of health are increased.

A balance between being results-driven and being person–centric is necessary. The former requires detailed operational plans, indicators and targets focusing on implementation and close monitoring of progress. The latter requires attention to relationship building with our staff, patients and partners, improved communication and creating a learning environment within the department. Dr Engelbrecht and I are in agreement on this approach.

As the outgoing Head of Department I wish the department well for the future and I am sure that under the new leadership the Department will continue to improve the quality of health care for all in this province.

Prof Craig Household
HOD: Western Cape Department of Health
February 2015

OFFICIAL SIGN-OFF

It is hereby certified that this Strategic Plan:

- Was developed by the management of Western Cape Government: Health under the guidance of Minister Nomafrench Mbombo.
- Takes into account all the relevant policies, legislation and other mandates for which Western Cape Government: Health is responsible.
- Accurately reflects the strategic outcome oriented goals and objectives which Western Cape Government: Health will endeavour to achieve over the period 2015 to 2019.

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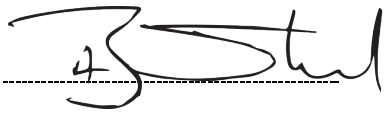
Chief Financial Officer **SIGNATURE:** 

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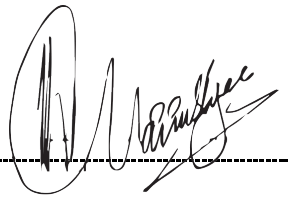
Chief Director: Strategy and Health Support **SIGNATURE:** 

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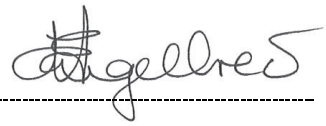
HoD Designate **SIGNATURE:** 

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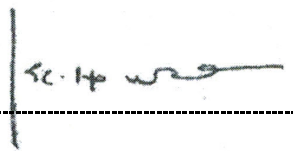
Accounting officer **SIGNATURE:** 

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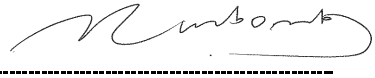
APPROVED BY:

Minister Nomafrench Mbombo
Executive Authority **SIGNATURE:** 

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PART A:
STRATEGIC OVERVIEW

PART A: STRATEGIC OVERVIEW

1. Vision

Access to person-centred quality care.

2. Mission

We undertake to provide equitable access to quality health services in partnership with the relevant stakeholders within a balanced and well managed health system to the people of the Western Cape and beyond.

3. Values

- Innovation
- Caring
- Competence
- Accountability
- Integrity
- Responsiveness
- Respect

4. Legislative & Other Mandates

The Department is directly responsible for implementing, managing or overseeing the issues emanating from the following legislative and policy mandates.

4.1. Constitutional Mandates

The rendering of health services is a legislative competency by virtue of Schedule 4, Part A of the Constitution of the Republic of South Africa, 1996. In addition the following obligates the Department to render certain services:

- Schedule 5, Part A of the Constitution empowers the Department with exclusive legislative competence on ambulance services.
- Section 27(1)(a) of the Constitution obligates the Department to provide basic health services, including reproductive health care.
- Section 27(3) provides that emergency medical treatment may not be refused.
- Section 28(c) prescribes that children have the right to basic health services.

4.2. Legislative Mandates

The following national and provincial legislation prescribes the specific services to be rendered by the Department. Some of the legislation has a very specific and direct impact on the Department whereas others have a more peripheral impact.

NATIONAL LEGISLATION

1. **Allied Health Professions Act, 63 of 1982 as amended**
   This Act sets out regulations of health practitioners like chiropractors, homeopaths and others, and for the establishment of the council to regulate these professions.

2. **Atmospheric Pollution Prevention Act, 45 of 1965**
   To provide for the prevention of the pollution of the atmosphere, for the establishment of a National Air Pollution Advisory Committee, and for matters incidental thereto.

3. **Basic Conditions of Employment Act, 75 of 1997 [BCEA]**
   The BCEA provides for the minimum conditions of employment that employers must comply with in their workplaces.

4. **Births and Deaths Registration Act, 51 of 1992**
   The Act regulates the registration of births and deaths and to provide for incidental matters.

5. **Broad Based Black Economic Empowerment Act, 53 of 2003**
   The piece of legislation deals with the promotion of black economic empowerment in the manner that the State awards contracts for the service to be rendered, and matters incidental thereto.

6. **Children's Act, 38 of 2005**
   The Act give effect to certain rights of children as contained in the Constitution; set out principles relating to the care and protection of children; defining parental responsibilities and rights; further; make provisions for regarding children's courts.

7. **Chiropractors, Homeopaths and Allied Health Service Professions Act, 63 of 1982**
   The Act abolishes Chiropractors, Homeopaths and Allied Health Service Professions Interim Council; establishes the Allied Health Professions Council of South Africa and further provides for establishment of the professional board; further, regulates the relationship between the new Council and professional boards.

8. **Choice on Termination of Pregnancy Act, 92 of 1996**
   The Act determines the circumstances and conditions under which the pregnancy of a woman may be terminated; and to provide for matters connected therewith.

9. **Compensation for Occupational Injuries and Diseases Act, 130 of 1993 [COIDA]**
   The Act provides for compensation for disablement caused by occupational injuries or diseases course of their employment, and for death resulting from such injuries or disease.

10. **Constitution of the Western Cape, 1 of 1998**
    This Constitution applies to the Western Cape. It is subject to the national Constitution, it is the highest law in the Western Cape.
    Section 78(2)(a) deals with protecting and promoting the interest of children in the Western Cape, insofar as health services.

Section 81 (h)(ii) places a duty on the Western Cape Government to adopt and implement policies to actively promote and maintain the welfare of its communities by ensuring proper realisation of the right of access to:
(a) Health care services;
(b) Basic health care services, which provides a healthy environment for all children, frail and elderly persons.

11. **Construction Industry Development Board Act, 38 of 2000**
To provide for the establishment of the Construction Industry Development Board to implement an integrated strategy for the reconstruction, growth and development of the construction industry and to provide for matters connected therewith.

12. **Correctional Services Act, 8 of 1959**
Section 12(1) places a duty on the Department of Health to provide, within its available resources, adequate health care services, based on the principles of primary health care. This is so, to allow every inmate to lead a healthy life.

13. **Council for the Built Environment Act, 43 of 2000**
To provide for the establishment of a juristic person to be known as the Council for the Built Environment; to provide for the composition, functions, powers, assets, rights, duties and financing of such a council; and to provide for matters connected therewith.

14. **Criminal Procedure Act, 51 of 1977**
The purpose of the Act is to regulate procedures and related matters in criminal proceedings:
It affects health insofar as:
(a) Mental health issues dealing with the criminal capacity of the accused and the witness;
(b) Examinations in terms of Sexual offences; and
(c) Drawing of blood samples by district surgeons/surgeons and medical practitioners.

15. **Dental Technicians Act, 19 of 1979**
The Act consolidates and amends laws relating to the profession of dental technician; regulates the profession of dental technologist and matters incidental thereof.

16. **Division of Revenue Act (Annually)**
Provides for the equitable sharing of nationally-raised revenue among the national, provincial and local spheres of government. The Division of Revenue Act is primarily directed at supporting the principles of co-operative government and strengthening inter-governmental relations, as stipulated in the Constitution.

17. **Domestic Violence Act, 116 of 1998**
The Act provides for the issuing of protection orders with regard to domestic violence and further provides remedies currently available to victims of domestic violence.

18. **Drugs and Drug Trafficking Act, 140 of 1992**
The Act provides for the prohibition of the use or possession of, or the dealing in, drugs and of certain acts relating to the manufacturer or supply of certain substances or the acquisition or conversion of the proceeds of certain crimes, for the obligation to report certain information to the police.

19. **Employment Equity Act, 55 of 1998 [EEA]**
The EEA sets out the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.

20. **Environment Conservation Act, 73 of 1998**
The Act provides for the effective protection and controlled utilization of the environment and for matters incidental thereto.

21. **Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972**
The Act provides for the control and safety standards of products for sale, manufacturing and importation of foodstuffs.

22. **Government Immovable Asset Management Act, 19 of 2007**
To provide for a uniform framework for the management of an immovable asset that is held or used by a national or provincial department, to ensure the coordination of the use of an immovable asset with the service delivery objective.

23. **Hazardous Substances Act, 15 of 1973**
The Act provides for the control of hazardous substances in particular those emitting radiation.

24. **Health Professions Act, 56 of 1974**
The Act provides for regulating health professions including medical practitioners, dentists, psychologists and related professions, further, guides the profession and protects the public.

25. **Higher Education Act, 101 of 1997**
To regulate higher education, provide for establishment, composition and functions of a Council on Higher Education, governance and funding of public higher education institutions.

26. **Human Tissue Act, 65 of 1983**
The Act provides for the administration of matters pertaining to human tissue and needs to be considered in conjunction with section 8 of the National Health Act, 2003 which regulates matters pertaining to decision making affecting personal health and treatment of a person, and section 68 of the same Act on the examination of the bodies of the deceased persons and removal of donated tissues or cells from persons and incidental matters.

27. **Inquests Act, 58 of 1959**
The Act provides for holding of inquests in cases of deaths or alleged deaths occurring from natural causes. The Act works in tandem with the application and administration of the Exhumation Ordinance 12 of 1980, in so far as application of exhumation and reburial through a court of law.

28. **Intergovernmental Relations Framework, Act 13 of 2005**
To establish a framework for national, provincial and local governments in order to promote and facilitate intergovernmental relations and provide for mechanisms and procedures and to facilitate settlement of intergovernmental disputes.

29. **Institution of Legal Proceedings against Certain Organs of State Act, 40 of 2002**
To regulate prescription and to harmonise periods of prescription of debts for which certain organs of state are liable; to make provision for notice requirements in connection with institutions of legal proceedings against certain organs of state in respect of recovery of debt.

30. **International Health Regulations Act, 28 of 1974**
Adopted by the World Health Organisation to provide for the protection of airports deemed to be sanitary and prescribe penalties for any contravention and failure to comply with related WHO prescripts and incidental matters thereto.

31. **Labour Relations Act, 66 of 1995 [LRA]**
To give effect to section 27 of the Constitution, regulate the organisational rights of trade unions, to promote and facilitate collecting bargaining at the workplace, to promote employee participation in decision-making process by establishing workplace forums; and to give effect to International law obligations of the Republic that relates to labour relations.

32. **Local Government: Municipal Demarcation Act, 27 of 1998**
Applicable to health department only in so far as the establishment of the district health councils in terms of section 31 of the Health Act, 2003 (Act No. 61 of 2003) read with the Western Cape District Health Councils Act, 2010 (Act No. 5 of 2010).

33. **Local Government: Municipal Systems Act, 32 of 2000**
Applicable to health department for the administration and the functioning of the Western Cape District Act, 2010 (Act No. 5 of 2010) in terms of section 31 of the National Health Act, 2003 (Act No. 61 of 2003).

34. **Medical Schemes Act, 131 of 1998**
To consolidate laws relating to registered medical schemes, further, provides for the establishment of the Council for Medical Schemes as a juristic person; further provides for the registration and control of certain activities of medical schemes and appointment of registrar.

35. **Council for Medical Schemes Levies Act, 58 of 2000**
This Act provides legal framework for the Council to charge medical schemes certain fees.

36. **Medicines and Related Substances Act, 101 of 1965**
This legislation provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy. The Act also provides for transparency in the pricing of medicines.

37. **Medicines and Related Substances Control Amendment Act, 90 of 1997**
The Act provides for the registration of medicines intended for human and animal use, registration of medical devices, establishment of a Medicines Control Council, scheduled substances and medical devices. Further, control of manufacturers, wholesalers and distributers.

38. **Mental Health Care Act, 17 of 2002**
The Act provides for care, treatment and rehabilitation of persons who are mentally ill, establish the Review Boards in respect of health establishment and set out different procedures to be followed.

39. **Municipal Finance Management Act, 56 of 2003**
The Act secures sound and sustainable management of the fiscal and financial affairs of municipalities and municipal entities. It establishes norms and standards, and ensuring accountability, responsibility and transparency in municipal affairs. It provides for budgetary and financial planning processes.

40. **National Building Regulations and Building Standards Act, 103 of 1977**
To provide for the promotion of uniformity in law relating to the erection of buildings in areas of jurisdiction of local authorities; for the prescribing of building standards; and for matters connected therewith.

41. **National Environmental Management Act, 1998**
To provide for cooperative, environmental governance by establishing principles for decision-making on matters affecting environment, institutions that will promote cooperative governance and procedures for environmental functions exercised by organs of state.

42. **National Health Act, 61 of 2003 [NHA]**
The Act provides for a structured uniform health system in the Republic and obligations imposed by the Constitution and other laws on the national, provincial and local governments on health services.

43. National Health Amendment Act, 2013
To amend the National Health Act, 2003 so as to provide for the establishment of the Office of Health Standards Compliance and, for the purpose of appointment of health officers and inspectors to be issued with certificates.

44. National Health Laboratories Service Act, 37 of 2000
Provides for a statutory body that offers laboratory services to the public health sector.

45. Non Profit Organisations Act, 71 of 1977
To establish an administrative and regulatory framework within which non-profit organisations can conduct their affairs by provisioning of Service Level Agreements by the Department to provide the specialised services on health matters.

46. Nuclear Energy Act, 46 of 1999
The inspector carrying on with inspection or investigation to ascertain the likelihood of danger or harmful effects to the health of persons.

47. Nursing Act, 33 of 2005
The Act regulates the nursing profession, promote the provision of nursing services to the inhabitants and serve and protect the public in matters involving health services.

48. Occupational Diseases in Mines and Works Act, 78 of 1973
Provides for medical examinations on persons suspected of having contracted occupational diseases especially in controlled mines and works and for compensation in respect of those diseases.

49. Occupational Health and Safety Act, 85 of 1993 [OHSA]
The Legislation set out the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

50. Older Persons Act, 13 of 2006
Deal effectively with the plight of older persons by establishing a framework aimed at empowerment and protection of older persons, maintenance of their status, rights, well-being, safety and security.

51. Pharmacy Act, 53 of 1974, as amended
The Act provides for the establishment of the South African Pharmacy Council, general powers to extend the control of council to the public sector, provides for pharmacy education and training, requirements for registration, provide for investigative and disciplinary powers of the council.

52. Preferential Procurement Policy Framework Act, 5 of 2000
The Act provides for the implantation of the policy on preferential procurement pertaining to historically disadvantages entrepreneurs.

53. Prevention and Combating of Corrupt Activities Act 12 of 2004
The Act provides for the strengthening of measures to prevent and combat corruption and corrupt activities. To provide for offence of corruption and offences relating to corrupt activities, to provide for investigative measures.

54. Prevention and Treatment of Drug Dependency Act, 20 of 1992
Provide for the establishment of a Drug Advisory Board, establishment of programmes for the prevention and treatment of drug dependency, establishment of treatment centres and hostels, registration of institutions as treatment centres and hostels and incidental matters.

55. **Promotion of Access to Information Act, 2 of 2000 [PAIA]**
PAIA amplifies the constitutional provisions pertaining to accessing information under the control of various bodies.

56. **Promotion of Administrative Justice Act, 3 of 2000**
PAJA amplifies the constitutional provisions pertaining to Administrative law by codifying it.

57. **Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000**
This Act provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

58. **Protected Disclosures Act, 26 of 2000**
This Act provides for the protection of "whistle-blowers" in the fight against corruption.

59. **Protection of Personal Information Act, 2013 (Act No. 4 of 2013) (POPI)**
To promote the protection of personal information processed by public and private bodies. To establish minimum requirements for processing of information, flow of personal information across boarders and to establish information Regulator. It affects health insofar as the processing and safekeeping of patient information and files.

60. **Public Audit Act, 25 of 2005**
The Act gives effect to the provisions of the Constitution in establishing and assigning functions to an Auditor-General. Provision is made for the auditing of institutions in the public sector; and for the accountability arrangements of the Auditor-General.

61. **Public Finance Management Act, 1 of 1999 [PFMA]**
The PFMA provides for the administration of State funds by functionaries, their responsibilities and incidental matters.

62. **Public Service Act, 1994**
The Act provides for the administration of public sector employees in its national and provincial spheres, provides for the powers of the Minister to employ and dismiss and incidental matters thereto.

63. **Road Accident Fund Act, 56 of 1996**
To provide victims of road accident with road accident benefit scheme and an Administrator to administer and implement the scheme, provide for a set of defined benefits on a "no –fault basis" to persons for bodily injury or death caused from road accidents, to exclude liability of certain persons liable for damages in terms of Common Law; and to provide for social security and provision of medical report by medical practitioners.

64. **Sexual Offences Act, 23 of 1957**
The Act provides for the consolidation and amending laws relating to brothels and unlawful carnal intercourse and other acts in relation thereto.

65. **Skills Development Act, 97 of 1998**
The Act provides measures employers are required to take to improve the level of skills of employees in workplaces.

66. **Skills Development Levies Act, 9 of 1999**
The Act provides measures employers are required to take to improve the level of skills of employees in workplaces.

67. **South African Medical Research Council Act, 58 of 1991**
The Act provides for the establishment of South African Medical Research Council and its role in relation to health research.

68. **South African Police Services Act, 68 of 1978**
The Act provides for the establishment, organisation, regulation and control of the South African Police Service.

69. **State Information Technology Agency Act, 88 of 1998**
This Act provides for the creation and administration of an institution responsible for the State's information technology system.

70. **Sterilisation Act, 44 of 1998**
The Act provides for the framework for sterilisation including persons with mental health conditions and challenges.

71. **Tobacco Products Control Act, 83 of 1993**
The Act provides for the control of tobacco products, prohibition of smoking in public places and advertisements of tobacco products, sponsoring of events by tobacco industry.

72. **Traditional Health Practitioners Act, 35 of 2004**
The Act provides for the establishment of Interim Traditional Health Practitioners Council of South Africa, provide for the regulatory framework for efficacy, safety and quality of traditional health care services; provide for management of control of registration, training and conduct of practitioners.

73. **University of Cape Town (Private) Act, 8 of 1999**
The Act provides anew for governance of the University of Cape Town and to bring it into line with Higher Education Act, 1997.

PROVINCIAL LEGISLATION

1. **Western Cape Ambulance Services Act, 3 of 2010**
The Act provides for the regulation of the delivery of ambulance services in the province. Further, establishes the Western Cape Ambulance Services Board and further provides for the accreditation, registration and licensing of ambulance services.

2. **Western Cape District Health Councils Act, 5 of 2010**
The Act provides for matters relating to district health councils so as to give effect to section 31 of the National Health Act, 2003 (Act 61 of 2003).Further, it establishes district health councils in consultation with the MEC responsible for local government in the province and municipal council of the relevant metropolitan or district municipality.

3. **Western Cape Health Care Waste Management Act, 7 of 2007**
The Act provides for the effective handling, storage, collection, transportation, treatment and disposal of health care waste. Further, provides for the prohibition of illegal dumping of health care waste and the co-disposal of health care waste with general household.

4. **Western Cape Health Facility Boards Act, 7 of 2001**
The Act provides for the establishment, functions, powers and procedures off health facility boards and incidental matters thereof.

5. **Western Cape Health Facility Boards Amendment Act, 2012(Act No. 7 of 2012)**
The Act provides for the amendment of the Western Cape Health Facility Boards Act, 2001 so as to regulate the manner in which the Provincial Department of Health monitors its financial affairs of health facility boards. Further, provides for procedure that will ensure sound financial governance of the boards and matters connected therewith.

6. **Western Cape Health Services Fees Act, 5 of 2008**
   The Act provides for a schedule of fees to be prescribed for health services rendered in the province by the department. Further, repeals the Hospital Ordinance, 1946, and provide for incidental matters.

7. **Western Cape Independent Health Complaints Committee Act, 2 of 2014**
   The Act provides that for the establishment of the Independent Health Complaints Committee; provide for a system for referral of complaints to the Committee for consideration and matters incidental thereto.

8. **Western Cape Land Administration Act, 6 of 1998**
   To provide for the acquisition of immovable property and the disposal of land which vests in it by the Western Cape Provincial Government and for matters incidental thereto.

9. **Exhumation Ordinance, 12 of 1980. Health Act, 63 of 1977**
   The Exhumation Ordinance deals with prohibiting desecration, destruction and damaging of graves in cemeteries and receptacles containing bodies; including matters that are incidental to Schedule 4 and 5 of the Constitution of the Republic of South Africa, 1996. It further regulates the exhumation, disturbance, removal and re-interment of bodies and remains of the deceased persons.

10. **Regulations Governing Private Health Establishments. Published in PN 187 of 2001**
    The Minister of Health, in terms of section 44 of the Health Act, 1977 (Act 63 of 1977), may grant a private health establishment exemption from all or any of the provisions of the Regulations, but only if good grounds exist for doing that subject to Regulation 27.

11. **Training of Nurses and Midwives Ordinance 4 of 1984**
    The Ordinance provides for training of nurses and midwives and empowers the Administrator to introduce diplomas and certificates that may be issued by the nursing colleges. Commencement of section 51 of the National Health Act, 2003 was determined and proclaimed by the President to come into effect on 27 February 2012 so that the Minister may, in consultation with the Minister of Education, establish academic complexes to educate and train health care personnel and conduct research in health services.

12. **Western Cape Health Facility Boards and Committees Bill, 2014 (Still being drafted)**
    The draft bill will provide for the establishment, functions, powers and procedures of hospital boards and primary health care facility committee.

13. **Regulations Governing the Financial Prescripts in terms of Western Cape Health Facility Boards Act, 2001**
    To regulate proper governance and financial control of health facility boards. (Drafting stage)

14. **Regulations Governing the submissions of nominations for membership of Health Facility Boards in terms of the Western Cape Health Facility Boards Act, 2001,**
    To provide for a procedure for inviting nominations for membership of board before appointment to the board in terms of section 6(1)(a) of the Act. Furthermore, to publish a notice in the Provincial Gazette for representatives of the community to serve on the boards. (Fully functional)

15. **Draft Regulations Relating to the Functioning of the District Health Councils in terms of the Western Cape District Health Councils Act, 2010**
    To provide proper functioning and administration of the district health councils. (Drafting stage)

16. **Draft Western Cape Independent Health Complaints Committee Regulations, 2014.**
    (Drafting stage – published for comment)

4.3. Policy Mandates

INTERNATIONAL POLICIES

1. **Millennium Development Goals**
   The goals that have relevance for the Health Sector are:
   - Reduce infant and under 5 child mortality rates;
   - Improve maternal health; and
   - Combat HIV and AIDS, malaria and other diseases

2. **UN Convention on the Rights of People with Disabilities, ratified 3rd November 2007**
   The Convention protects the rights and dignity of people with disabilities, Article 25 makes specific provision for the attainment of the highest standards of health without discrimination.

NATIONAL POLICIES

1. **Medium Term Strategic Framework (MTSF) 2014 – 2019**
   Social determinants of health addressed; health system strengthened; health information systems improved; prevent and reduce the disease burden and promote health; financing of universal health coverage achieved; human resource production, development and management improved; management positions and appointments reviewed and accountability mechanisms strengthened; improve quality through the use of evidence; and meaningful public-private partnerships.

2. **National Development Plan 2030**
   Address social determinants of health; reduce burden of disease to manageable levels; build human resources for the health sector of the future; strengthen the national health system; and implement national health insurance.

3. **Negotiated Service Delivery Agreement**
   Contribute to Government's vision of a long and healthy life for all South Africans by increasing life expectancy; decreasing maternal and child mortality; combating HIV and AIDS and decreasing the burden of disease from tuberculosis; and strengthening health system effectiveness.

4. **National Health Systems Priorities: The Ten Point Plan**
   Provision of strategic leadership and creation of a social compact for better health outcomes; implementation of National Health Insurance (NHI); improving the quality of health services; overhauling the health care system and improve its management; improving human resources management, planning and development; revitalisation of infrastructure; accelerated implementation of HIV and AIDS, and sexually transmitted infections' National Strategic Plan 2007-11 and increase focus on TB and other communicable diseases; mass mobilisation for better health for the population; review of the drug policy; and strengthening research and development.

5. **National Health Insurance**
   To provide improved access to quality health services for all South Africans irrespective of whether they are employed or not; to pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund; to procure services on behalf of the entire population and efficiently mobilise and control key financial resources; and to strengthen the under-resourced and strained public sector so as to improve health systems performance.

6. **Primary Health Care Re-engineering**
   Primary Health Care Re-engineering takes on a 3-stream approach, in the form of ward-based PHC outreach teams, school health and clinical specialist teams. The focus is on proactively engaging people on matters that affect their health and wellbeing, thus creating the capability for disease prevention; health promotion and wellness generation.

7. **Operation Phakisa – Ideal Clinic Initiative of South Africa**
   The Operation Phakisa approach to improving service delivery is based on the government of Malaysia's Big Fast Results methodology which has a track record of achieving impressive results in very short timeframes. Through this process 8 work streams have been identified to fast track delivery on Minister Motsoaledi's Ideal Clinic Initiative. The work streams cover Service delivery; Waiting times; Infrastructure (including maintenance and equipment); Human resources for health; Financial management; Supply chain management; Scale up and sustainability of the Ideal Clinics across the country; and lastly, Institutional arrangements. Priorities have been set for each of these stream.

8. **Human Resources for Health**
   Leadership, governance and accountability; health workforce information and health workforce planning; re-engineering of the workforce to meet service needs; scaling up and revitalising education, training and research; creating the infrastructure for workforce and service development (academic health complexes and nursing colleges); strengthening and professionalising the management of human resources and prioritise health workforce needs; ensuring professional quality care through oversight, regulation and continuing professional development; and improving access to health professionals and health care in rural and remote areas.

9. **National Environmental Health Policy (GN 951 in GG 37112 of 4 December 2013)**
   Strengthening capacity and development of environmental health personnel; training and improved learning; formulating an institutional framework; resource allocation for environmental health services (EHS); planning for proper implementation; planning for human settlements; protecting children; HIV and AIDS, TB, malaria and environmental health; environmental health information systems; EHS delivery within the framework of sustainable development; and climate change and health.

10. **National Health Act: Publication of Health Infrastructure Norms and Standards Guidelines (No R116 of 17 February 2014) and GN 512 of 30 June 2014**
    The guidelines are for public reference information and for application by Provincial Departments of Health in the planning and implementation of public sector health facilities. The approved guidelines will be applicable to the planning, design and implementation of all new building projects. Any deviations from the voluntary standards should be motivated during the Infrastructure Delivery Management Systems (IDMS) gateway approval process. The guidelines should not be seen as requirements necessitating the alteration and upgrading of all existing healthcare facilities

11. **National Health Act: Policy on Management of Public Hospitals (12 August 2011)**
    To ensure the management of hospitals is underpinned by the principles of effectiveness, efficiency and transparency. Specific objectives are to ensure implementation of applicable legislation and policies to improve functionality of hospitals; appointment of competent and skilled hospital managers; development of accountability frameworks; and training of managers in leadership, management and governance.

PROVINCIAL POLICIES

1. **Provincial Strategic Goals (PSG) 2014-2019**
   The Western Cape Government has identified the following 5 strategic goals for the Province over the next 5 years:

PSG 1: Creating Opportunities for growth and job.
PSG 2: Improve education outcomes and opportunities for youth development.
PSG 3: Increase wellness, safety and tackle social ills.
PSG 4: Build a quality living environment resilient to climate change.
PSG 5: Embed good governance and integrated service delivery through partnerships and spatial alignment.

The Department is the lead for PSG 3 and works in partnership with the Departments of Social Development and Community Safety and Culture and Sports.

2. **Western Cape Infrastructure Delivery Management System (IDMS)**
Aims to improve client ownership and oversight, package infrastructure projects in a manner which reduces programme management complexities, reduces costs and meets the objectives of client departments, proactively manage risks and ensure greater efficiency in service delivery.

3. **Healthcare 2030 – the Road to Wellness**
Healthcare 2030 – the Road to Wellness was endorsed by the provincial cabinet of the Western Cape Government in 2014, signalling the third wave of health care reform in the Province since 1994. The document outlines the Department's vision for the health system and provides a strategic framework to direct developments in the public health sector for the next 15 years. Healthcare 2030 is intended to enhance the health system's responsiveness to people's needs and expectations; with careful consideration given to person-centredness, integrated care provisioning, continuity of care and the life course approach.

4.4. Relevant Court Rulings

There are currently no specific court rulings that have a significant, ongoing impact on the operations or service delivery obligations of the Department.

4.5. Planned Policy Initiatives

THE RE-DESIGN OF PRIMARY HEALTH CARE SERVICES

The social dimensions of disease create the need for continuity, coupled with more comprehensive and person centred approaches to care. There is a need to strengthen the capability for early detection and treatment, the reduction of unhealthy lifestyles and the ability to address the underlying social determinants of disease. Healthcare 2030 proposes a set of service delivery reforms clearly intended to make the health system more people-centric. Primary Health Care (PHC) is recognised as having a pivotal role in enhancing the health system's responsiveness to people's needs and expectations; with careful consideration given to person-centredness, integrated care provisioning, continuity of care and the life course approach. Healthcare 2030 conceptualises Primary Health Care Services as spanning 3 distinct but complementary care settings, which collectively provide a comprehensive array of services. The 3 settings are:

- **Home and Community Based Care**
HCBC is embedded in the local context and is rendered in the living, learning, working, social and/or play spaces of the people we serve. It is innately designed to foster stable, long-term

personal relationships, with households, that builds understanding, empathy and trust; pivotal to continuity and person centredness of the health system. HCBC recognises people's capacity for self-help and involves a comprehensive array of context sensitive interventions that positively influences environmental and personal factors such as psychosocial abilities, coping abilities, lifestyle issues, behaviour patterns and habits. It is a collection of activities that supports the actions people take to maintain health and well-being; prevent illness and accidents; care for minor ailments and long-term conditions; and recover from periods of acute illness and hospitalisation. This is complimented by capacity for rehabilitative and palliative care being introduced into HCBC to further enhance the comprehensiveness of the care provided in this setting.

- **Intermediate Care**
  Intermediate Care refers to in-patient transitional care for children and adults, which facilitates optimal recovery from an acute illness or complications of a long-term condition; enabling users to regain skills and abilities in daily living, with the ultimate discharge destination being home or an alternate supported living environment. It involves post-acute, rehabilitative and end-of-life care, which includes comprehensive assessment, structured care planning, active therapy, treatment and/or an opportunity to recover. It allows for a seamless transition between acute care and the living environment; particularly where the person's ability to self-care is significantly compromised, a supported discharge thus becomes crucial to a successful recovery process. The focus of this service element is on improving people's functioning so that they can resume living at home and enjoy the best possible quality of life.

- **Primary Care**
  Primary Care services are ambulatory in nature, a comprehensive range of curative and preventative services are provided with a complementary capacity for rehabilitative and palliative care. There is sufficient evidence available to demonstrate the benefits of generalist ambulatory care in terms of the prevention of ill health and death; and improved health equity. It is particularly the case where services are organized in a dense network of close-to-patient service points.

The PHC service re-design initiatives over the next 5 years will be focused on enhancing the system's capability for prevention and health promotion; as well as giving effect to the National Departments' work stream priorities for Operation Phakisa. The intention is to take a more proactive approach to care provisioning by bring care closer to where people live, making quality, person-centred health services directly and permanently available.

THE VOICE OF THE PATIENT – TOWARDS PERSON-CENTRED, QUALITY HEALTH CARE

A people-centric health system that inspires public trust recognises people as partners in designing and managing their own health and that of the broader community. Re-orienting care around people's needs and expectations, making care more socially relevant to producing better health outcomes is fundamental to the notion of person-centredness. Over the next 5 years a number of patient feedback initiatives are likely to take effect in addition to the current complaints and compliments system. These include:

- The **SMS Complaints Hotline** which has now completed its piloting phase and will be rolled out across the provincial service platform
- The **Independent Health Complaints Committee** will be established, as the Act was promulgated this year and the Department is currently in the process of developing the regulations.
- The amendment to the **Western Cape Health Facility Boards and Committees Bill** is in the drafting phase and is intended to enhance peoples' involvement in the governance processes of hospitals and primary health care facilities. This is a significant milestone in strengthening community involvement in PHC services.

THE C²AIR² CLUB CHALLENGE

A person centred health system necessitates employees that are competent, engaged, caring and empowered; to this end, the Department has launched the C²AIR² Club Challenge at 38 of its facilities in August 2013. The C²AIR² Club Challenge is a unique and innovative change initiative to ensure a resilient health system with satisfied patients, through healthy, caring and committed employees who provide a quality healthcare service.

The programme:

- Is an innovative way of **changing organizational behaviour and culture**;
- Builds "**change fitness" and problem-solving capability**;
- **Gives staff enough support** in their everyday dealings with patients;
- **Recognises and rewards** committed employees for going the extra mile;
- Improves **staff morale and enables employees** to have fun;
- Focuses on team work, **shared vision and values**;
- Shifts mind-sets, **putting patient satisfaction at the forefront**.

Over the next 5 years the Department intends expanding the initiative significantly within the organisation.

OCCUPATIONAL HEALTH AND SAFETY (OHS)

Competent, engaged, caring and empowered employees are more likely to excel in a work environment that proactively addresses its inherent health and well-being risks. The next 5 years will see greater emphasis on the protection of healthcare workers through the following initiatives:

- The development of an OHS **management framework;**
- The Development of an OHS **service delivery model;**
- **Consolidation and strengthening** of OHS services to employees and patients;
- OHS **capacity building** within the Department;
- **Empower employees** to prevent and promote OHS;
- Surveillance system for OHS.

LEADERSHIP AND MANAGEMENT DEVELOPMENT STRATEGY

Healthcare 2030 calls for distributed leadership that is dynamic, inspires change, provides strategic direction, builds cohesion and motivates people. The Department will be focusing on building the leadership and management capabilities of its present and future mid-level leaders. A Leadership and Management Development Strategy is being formulated to enhance the cognitive, functional and social competencies of individual managers and teams at all levels:

- To **manage effectively** and to develop leaders who **embody the organisational values;**
- Enable **innovation;**
- Draw on the **inherent capabilities of employees;**
- Are not dependent on hierarchical forms of power but rather **interpersonal power**, and
- Are **visibly collaborative** in their relationships with employees and external stakeholders.

Mindful of a number of existing management capacity development initiatives, both inside and outside the Province, the Leadership and Management Development Strategy seeks to identify development needs, implement a relevant, sustainable and evidence-based model of intervention, and then to evaluate its effectiveness. The Department is partnering with a consortium of the Western Cape Higher

Education Institutions (HEIs), the universities of the Western Cape, Cape Town and Stellenbosch, to implement the following within a phased approach:

- Develop a **competency framework** and define capabilities of managers at all levels. This will draw on the work of existing projects;
- **Review of the current management competencies required** within each context; at district, facility and clinical management level etc;
- **Assess gaps in the competencies** and reasons for gaps;
- Develop and **implementing evidence-based interventions** that address the gaps aimed at the individuals and the systems surrounding the individuals;
- **Evaluation of the Leadership and Management Strategy** and review of the impact on strengthening the health systems.

INFORMATION COMMUNICATION TECHNOLOGY (ICT) STRATEGY

ICT has been identified as a "game changer" for the Province and the Department has identified the following principles to guide health information and information technology developments over the next 5 years:

- **Pragmatic choice** of solutions that can scale while minimising infrastructure dependencies;
- **Data centre** managed by the Department should be the hub that ensures interoperability, and shifts reporting to the centre for system independence;
- **Real-time or near-real time** updating of the data centre whenever possible;
- **HIS ever-greening**, to avoid large capital expenditure on a new HIS and build on the success of a uniform and widely implemented HIS;
- A new clinical-facing module that is easily accessed and extended, to drive **convergence of the primary health care and hospital care;**
- **Efficiency**, reliance on back-end systems and condensed targeted EMR interaction rather than trying to create paperless hospitals and PHC facilities within the medium term;
- Strengthening the capacity within the Department to **encourage and manage innovation** in ICT.

SG 3: INCREASING WELLNESS, SAFETY AND REDUCING SOCIAL ILLS

The lifestyle changes required to reduce all the components of the burden of disease and social ills are dependent partially on behaviour change, something that is not easy to achieve at a population level. For successful behaviour change the individual's responsibility for action needs to be supported by a conducive structural environment that makes living the desired behaviours the easy choice. For an example for chronic diseases to be prevented and reduced the environment should allow for affordable, easy access to healthy foods; opportunities and facilities for physical activity and structural and social disincentives for undesirable behaviour. The tobacco legislation is one such example of disincentives such as high cost due to high taxation, restrictions of smoking areas, banning of advertising etc.

The overall lack of wellness (physically, psychologically, financially, spiritually and socially) in the province results in increased pressure on services for health, social services, community safety and policing, education, and human settlements. In complex, socially challenging environments, there is no choice but to closely collaborate as a whole of government and whole of society. This requires most importantly the will to create enabling environments in order to influence individual behaviours and lifestyle choices as well as initiate broad system and community wide improvements to build sustainable human development and improve wellness and the quality of life through resilient communities and active citizenry.

The province has identified the following as potential 'game changers'[1] over the next 5 years, to improve wellness in communities through an integrated whole government approach:

1. Developing and piloting an **integrated service delivery model in the Drakenstein Municipality**, with a concentrated effort and pooling of resources by all departments to reduce social ills and increase wellness will increase. The pilot will identify the method, the costs, the success factors and the expected outcomes that can be achieved and provide a replicable model.
2. Addressing **alcohol and its impact on communities** has been identified and a joint game changer together with the City of Cape Town. A design lab approach will be used in 2015/16 to plan and deliver evidenced based interventions over the 5 year period.
3. **Parenting Programme** (first 1000 days), a focused programme on tracking every pregnant women (100 000 by year 5) from antenatal care – delivery – post natal care – ECD and schooling that can reduce alcohol and smoking in pregnancy, provide good prenatal and post natal care, improve breastfeeding rates, link children & parents to required health and social services, improve father involvement, parenting skills and bonding and readiness for ECD enrolment.

[1] Game changers are an intervention or service initiative that effects a significant shift in the current way of doing or thinking about service delivery, with substantial improvement in performance over a short timeframe.

5. Situational Analysis

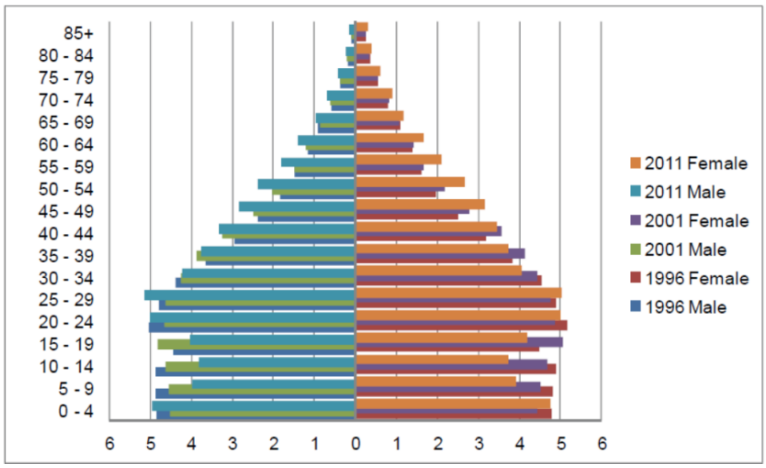
5.1. Performance Environment

The 2014 mid-year population estimates from Statistics South Africa (Stats SA), show that the population of the Western Cape Province was 6 116 324 or 11.3 per cent of the total South African population (Stats SA 2 Mid-Year Population Estimates, released July 2014). The Cape Town Metro District has the greatest proportion at 64.2 per cent and is the district with the smallest land surface area (2 502 km^2). Hence the Metro District has a higher population density which significantly impacts on the planning process. Significant urban sprawl or expansion of the population away from the central urban areas that occurred as a result of apartheid has been further aggravated by the location of informal settlements at the periphery since 1994. The consequences of this are higher cost of infrastructure, the lack of access to services, and the lack of mobility and social interaction for poor communities. The population distribution for the remainder of the Province is relatively sparse: 13.5 per cent Cape Winelands District, 9.9 per cent Eden District, 6.7 per cent West Coast District, 4.4 per cent Overberg District and 1.2 per cent Central Karoo District.

Population Structure, Growth & Migration

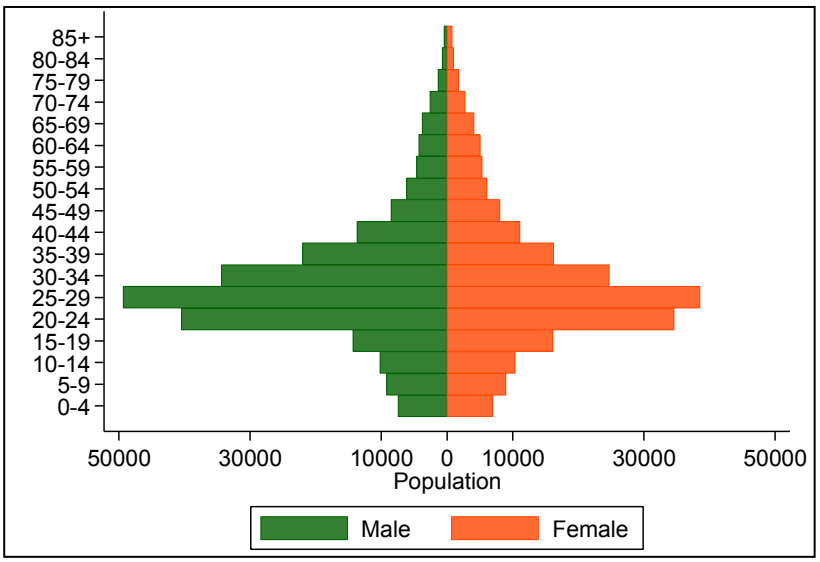
Overall projections show a steady increase in the total provincial population for both males and females. The population distribution shows a population that is ageing as noted by an increase in the population above the age of 50 years in both males and females between the 1996 and 2011 Census, with the increase being more substantial in females, see Figure A.1. The decrease in population between the ages of 5 and 19 years could be due to a decline in fertility in the province. Another reason could be that children of migrants are sent back to the parent's areas of origin, as soon as they reach school going age. The age distribution of in-migrants confirms that there is little in-migration at older ages and that the majority of migrants are young adults (20 to 35 years of age), and this may also account for the increase in children under 5 years of age as parents tend to migrate with their very young children. Overall, Statistics South Africa noted a net increase in migration to the Western Cape of about 3 per cent in the periods between 2001 and 2006 (n=299 055) and 2006 and 2011 (n=307 411). Approximately 40 per cent of the migrants are coming from the Eastern Cape, 26 per cent from outside the country and 17 per cent from Gauteng. Two thirds of the migrants settle within the Metro, and Eden (11 per cent) and Cape Winelands (10 per cent) are the two commonest rural districts for migrant settlements.

Figure A.1: Distribution of population by age and sex, Western Cape -1996, 2001 & 2011



Source: Census 2011 Municipal Report- Western Cape/Statistics South Africa. Pretoria: Statistics South Africa, 2012

Figure A.2: Age distribution of migrants in the Western Cape Province, Census 2011



SOCIO-ECONOMIC PROFILE

According to the South African Index of Multiple Deprivation (SAIMD), 72 per cent (18/25) of the municipalities in the Western Cape are in the highest quintile of multiple deprivations, and therefore defined as the least deprived municipalities in South Africa. Prince Albert and Laingsburg Municipalities are in third quintile and the most deprived of all municipalities in the Western Cape. The most deprived wards within the Western Cape are within the City of Cape Town Municipality, particularly the townships on the Cape Flats alongside the N2, and in the Karoo. More detailed analysis also suggests that approximately half of the fifty most deprived wards in the Province are most deprived in four or more of the following domains: income and material deprivation, employment deprivation, health deprivation, education deprivation, and living environment deprivation.

An alternate method to measuring poverty and deprivation is the multidimensional poverty index (MPI), which assesses the intensity of poverty in a specific area. Stats SA produced the South African MPI (SAMPI) in 2014 using 2001 and 2011 census data. Stats SA derived the SAMPI score from the proportion of households defined as multi-dimensionally poor using a poverty cut-off (the poverty headcount), and the average proportion of indicators in which poor households are deprived (the intensity of the poverty experienced). The Province had the lowest poverty headcount of all provinces in 2001 and 2011, with the headcount decreasing from 6.7 per cent in 2001 to 3.6 per cent in 2011. While it had the lowest headcount, the intensity of poverty in the Western Cape was second highest only to Gauteng in both Census years. Within the Province, Bitou Municipality had the highest poverty headcount at 6.3 per cent, followed closely by Knysna at 6.2 per cent in 2011.

Table A.1: Poverty measures for Census 2001 and Census 2011 for Municipalities in the Western Cape.

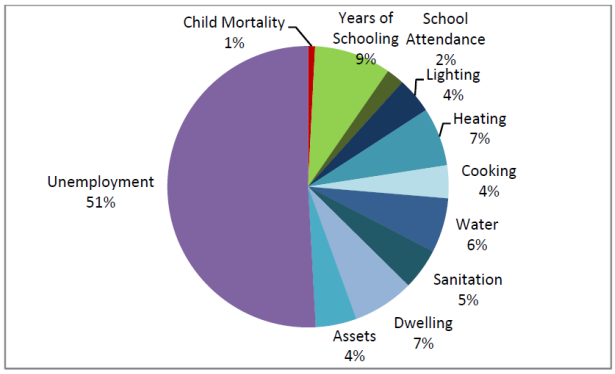
	CENSUS 2001			CENSUS 2011		
	Headcount	Intensity(A)	SAMPI(HxA)	Headcount	Intensity(A)	SAMPI(HxA)
BITOU	9.0%	43.8%	0.04	6.3%	41.8%	0.03
KNYSNA	10.1%	44.3%	0.04	6.2%	42.9%	0.03
OVERSTRAND	6.8%	44.6%	0.03	4.6%	42.8%	0.02
CITY OF CAPE TOWN	7.4%	45.6%	0.03	3.9%	42.8%	0.02
OUTSHOORN	7.0%	40.2%	0.03	3.9%	41.2%	0.02

STELLENBOSCH	4.0%	43.1%	0.02	3.8%	42.0%	0.02
THEEWATERSKLOOF	8.4%	46.0%	0.04	3.7%	41.9%	0.02
MATZIKAMA	4.8%	39.6%	0.02	3.4%	42.4%	0.01
GEORGE	7.8%	44.2%	0.03	3.3%	42.6%	0.01
MOSSELBAY	4.6%	42.5%	0.02	3.2%	43.6%	0.01
CEDERBERG	3.4%	39.3%	0.01	2.8%	42.9%	0.01
BREEDE VALLEY	4.7%	43.7%	0.02	2.8%	41.8%	0.01
PRINCE ALBERT	6.3%	41.5%	0.03	2.5%	42.4%	0.01
SWELLENDAM	3.5%	39.9%	0.01	2.5%	41.4%	0.01
BEAUFORT WEST	6.2%	40.8%	0.03	2.5%	40.5%	0.01
KANNALAND	5.0%	39.0%	0.02	2.5%	38.5%	0.01
SALDANHA BAY	5.6%	43.2%	0.02	2.2%	41.0%	0.01
DRAKENSTEIN	5.3%	45.2%	0.02	2.1%	42.5%	0.01
CAPE AGULHAS	3.4%	41.8%	0.01	2.1%	40.7%	0.01
LANGEBERG	4.1%	41.6%	0.02	1.7%	42.4%	0.01
WITZENBERG	5.8%	42.5%	0.02	1.7%	40.6%	0.01
HESSEQUA	3.4%	39.7%	0.01	1.5%	39.5%	0.01
LAINGSBURG	5.4%	38.0%	0.02	1.5%	37.3%	0.01
SWARTLAND	2.6%	39.8%	0.01	1.0%	40.6%	0.00
BERGRIVIER	1.4%	39.4%	0.01	1.0%	43.7%	0.00
WESTERN CAPE	**6.7%**	**44.9%**	**0.03**	**3.6%**	**42.6%**	**0.02**

Source: The South African MPI: Creating a multidimensional poverty index using Census data / Statistics South Africa. Pretoria: Statistics South Africa, 2014

Figure A.3 shows the contribution of the different indicators to poverty in the Western Cape. Economic activity, measured by unemployment, was the greatest contributor (51 per cent), whilst indices for the standard of living and education contributed less.

Figure A.3: Contribution of weighted indicators to poverty in Western Cape



Source: The South African MPI: Creating a multidimensional poverty index using Census data / Statistics South Africa. Pretoria: Statistics South Africa, 2014

EPIDEMIOLOGICAL PROFILE

Leading Causes of Premature Mortality

The leading cause of premature mortality (measured in years of life lost, YLL) in 2011 in all districts except West Coast was HIV and AIDS. This was followed by tuberculosis (TB) in all districts with the exception of Cape Metropole District, where interpersonal violence ranked second and TB third, and West Coast where HIV and AIDS ranked second and ischaemic heart disease third (Figure A.4).

Factors Contributing to the Major Causes of Mortality

Unsafe sex, alcohol abuse, smoking, diet/obesity and lack of physical activity accounts for over 60 per cent of the DALY (disability adjusted life years) burden in South Africa (Schneider et al 2007). DALYs are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences. One DALY can be thought of as one lost year of "healthy" life (World Health Organisation). These behaviours cause morbidity and disability and influencing these behaviours would have the most significant impact on health services.

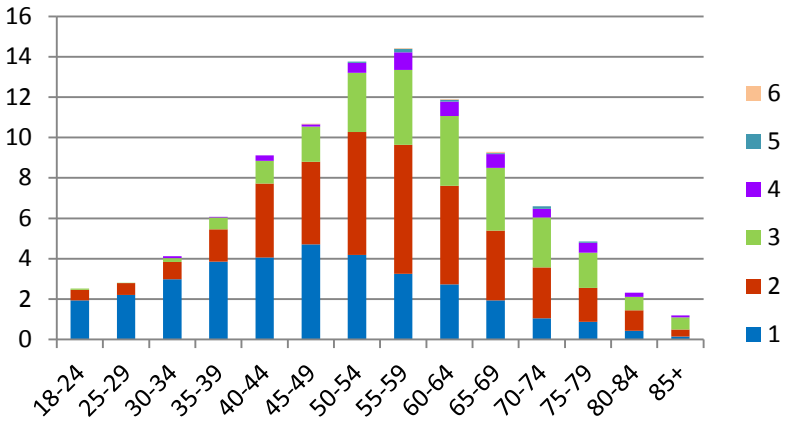
Figure A.4: League table of top 5 leading causes of premature mortality, Western Cape Districts 2011

Rank	CAPE WINELANDS	CENTRAL KAROO	CAPE TOWN	EDEN	OVERBERG	WEST COAST	WESTERN CAPE
1	HIV/AIDS (12.1%)	HIV/AIDS (14.9%)	HIV/AIDS (13.0%)	HIV/AIDS (12.3%)	HIV/AIDS (9.3%)	Tuberculosis (11.7%)	HIV/AIDS (12.4%)
2	Tuberculosis (9.8%)	Tuberculosis (11.4%)	Interpersonal violence (9.7%)	Tuberculosis (10.1%)	Tuberculosis (8.5%)	HIV/AIDS (8.7%)	Tuberculosis (8.6%)
3	Interpersonal violence (6.6%)	COPD (7.5%)	Tuberculosis (7.7%)	Ischaemic heart disease (7.0%)	Ischaemic heart disease (8.0%)	Ischaemic heart disease (8.3%)	Interpersonal violence (8.3%)
4	Cerebrovascular disease (6.0%)	Interpersonal violence (5.5%)	Ischaemic heart disease (6.7%)	Cerebrovascular disease (6.7%)	Interpersonal violence (6.5%)	Cerebrovascular disease (6.4%)	Ischaemic heart disease (6.6%)
5	COPD (5.6%)	Lower respiratory infections (5.3%)	Lower respiratory infections (4.7%)	Interpersonal violence (5.3%)	Cerebrovascular disease (6.1%)	Interpersonal violence (5.6%)	Cerebrovascular disease (5.1%)

Multi-morbidity

Multi-morbidity is the co-existence of more than one chronic condition in one person. In South Africa in particular, multi-morbidity due to co-morbid non-communicable and infectious diseases is a major challenge to the existing health model of healthcare delivery, which provides vertical services for chronic diseases such as HIV and TB (Tolu Oni et al. Chronic Diseases and multi-morbidity, BMC public Health, 2014). Although data on the burden of multi-morbidity in the Western Cape is limited, a cross sectional survey of chronic disease patients (n=184) across 10 PHC facilities in the Cape Metropole found that 53.9 per cent of patients had at least 1 co-morbidity, and over 20 per cent had 3 or more co-morbid conditions (Isaacs AA, A snapshot of non-communicable disease profiles and their prescription costs. S Afr Fam Pract 2014; 56(1)43-49), see Figure A.5.

Figure A.5: **Proportion of PHC Chronic Care Visits by Age Category and Number of Co-morbidities**



Priority Health Programmes

Based on the quadruple burden of disease, priority health programmes have been identified and key indicators relating to these are described in detail below.

TB, HIV & AIDS

The HSRC household survey conducted in 2012 showed that the proportion of respondents aged 15 years and older, who had used a condom at last sexual intercourse, had dropped in the Western Cape. The 2012 antenatal HIV and syphilis sentinel prevalence survey showed that the prevalence of HIV in 15 - 24 year old pregnant women had reduced from 11.6 per cent in 2011 to 10.4 per cent in 2012. Consistent with previous antenatal surveys, the Metro District accounted for approximately 70 per cent of the epidemic in the Western Cape, with nearly 50 per cent of the burden experienced by women between 25 and 34 years of age across the Province. The Western Cape has the third highest number of new TB infections in South Africa (746 cases per 100 000). Although a reduction in TB cases is observed, the proportion of new pulmonary tuberculosis (PTB) cases diagnosed with a high pre-treatment bacillary load is still 53 per cent.

Maternal & Child Health

Trends in infant and child mortality rates in the Western Cape from 2008 to 2011 are shown in Table A.2. Child mortality rates have dropped markedly in 2011 in the Western Cape and City of Cape Town. Year-on-year variations within the remaining districts are difficult to interpret due to the relatively small numbers represented in the data. In 2011, the leading cause of death in children under five years was neonatal, with prematurity being the leading cause. This was followed by pneumonia, diarrhoea and injuries. Prematurity also plays an important role in post neonatal deaths from pneumonia and diarrhoea. Other risk factors include the absence of breast feeding and increasing malnutrition. Morbidity and mortality may be significantly reduced if these high risk children are identified early and missed opportunities avoided through better use of the Road to Health Card and the promotion of Integrated Management of Childhood Illness (IMCI), when mothers and their children attend both preventive and curative health services.

Table A.2: **Infant and under-five mortality rate (per 1 000 live births)**

DISTRICT	Infant mortality rate				Under-five mortality rate			
	IMR (< 1yr)				U5MR (< 5yr)			
	2008	2009	2010	2011	2008	2009	2010	2011
CAPE WINELANDS	22.7	25.1	25.1	20.7	29.9	31.0	31.3	26.0
CENTRAL KAROO	44.0	40.5	33.4	34.4	58.4	51.5	43.6	41.0
CAPE TOWN METRO	21.0	21.7	22.2	17.1	25.9	26.2	27.4	21.6
EDEN	23.2	23.6	18.9	19.7	29.1	28.2	23.5	23.8
OVERBERG	27.9	28.5	32.4	30.4	34.9	33.5	45.5	38.4
WEST COAST	28.2	23.2	29.9	22.3	33.8	26.6	35.1	28.2
WESTERN CAPE	**22.3**	**22.7**	**23.1**	**19.1**	**27.7**	**27.5**	**28.6**	**24.1**

SOURCE: Groenewald P, Msemburi W, Morden E, Zinyakatira N, Neethling I, Daniels J, Evans J, Cornelius K, Berteler M, Martin LJ, Dempers J, Thompson V, Vismer M, Coetzee D, Bradshaw D. Western Cape Mortality Profile 2011. Cape Town: South African Medical Research Council, 2014. ISBN 978-1-920618-23-0

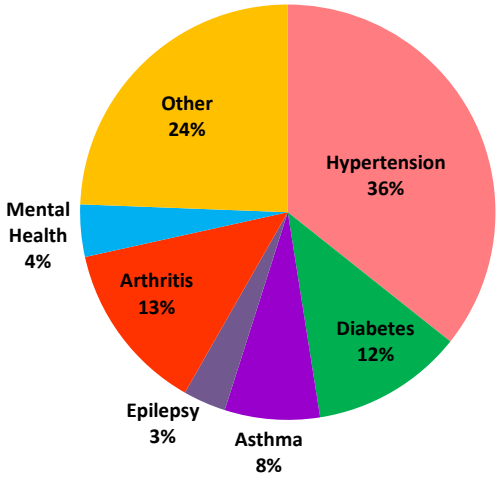
Interim findings from the most recent Confidential Enquiry Into Maternal Deaths (2011 to 2012) show the institutional maternal mortality rate (iMMR) in the Western Cape was 78.64 per 100 000 live births. Leading causes of maternal deaths in the Western Cape were non-pregnancy related infections (35 per cent), medical and surgical disorders (20 per cent), and complications of hypertension (14.4 per cent), pregnancy-related sepsis (9.6 per cent) and obstetric haemorrhage (8 per cent). The proportion of deaths due to medical and surgical disorders continue to increase (11 per cent in 2008 to 2010 compared to 20.0 per cent in 2011 and 2012), highlighting the need to improve obstetric services that manage pregnant women with pre-existing conditions.

Non-communicable Diseases

Based on findings from the South Africa National Health and Nutritional Examination Survey[2], self-reported prevalence of hypertension and diabetes in the Western Cape was 21.2 per cent (95 per cent confidence interval (CI) 17.8 - 25.0) and 6.7 per cent (95 per cent CI 5.2 - 8.6), respectively. Similarly, data from a study on chronic disease patients presenting at primary health care (PHC) facilities within the Cape Town Metro District (Western), showed that 36 per cent of patients were hypertensive, 12 per cent diabetic and 4 per cent were mental health patients, see Figure A.6. This study also demonstrated the high burden chronic diseases places on the services, as over 82 per cent of patients attending the ten PHC facilities surveyed were attending for chronic conditions[3]. The Chronic Disease Unit (CDU) provides scripts to stable chronic disease patients across the Province. On average, 260 000 scripts are issued monthly and 75 per cent of these are to clients residing within the Cape Town Metro District.

Mental health is included in the non-communicable disease burden, and for the Province in the 2013/14 financial year, there was a 7.6 per cent re-admission rate for psychiatric condition.

Figure A.6: Disease Profile of Patients at PHC Facilities mirrors population prevalence rates



SOURCE: Isaacs AA, Manga N, Le Grange C, Hellenberg DA, Titus V, Sayed R A snapshot of noncommunicable disease profiles and their prescription costs at ten primary healthcare facilities in the western half of the Cape Town Metropole. South African Family Practice 2014 56(1):43-39

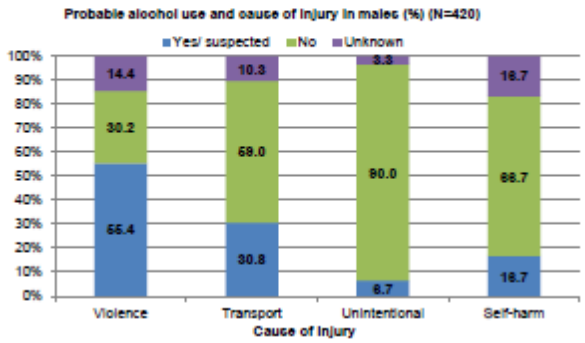
[2] Shisana O, Labadarios D, Rehle T, Simbayi L, Zuma K, Dhansay A, Reddy P, Parker W, Hoosain E, Naidoo P, Hongoro C, Mchiza Z, Steyn NP, Dwane N, Makoae M, Maluleke T, Ramlagan S, Zungu N, Evans MG, Jacobs L, Faber M, & the SANHANES-1 Team (2014) South African National Health and Nutrition Examination Survey (SANHANES-1): 2014 Edition. Cape Town. HSRC Press

[3] Isaacs AA, Manga N, Le Grange C, Hellenberg DA, Titus V, Sayed R A snapshot of noncommunicable disease profiles and their prescription costs at ten primary healthcare facilities in the western half of the Cape Town Metropole. South African Family Practice 2014 56(1):43-39

Injuries

In 2011, the greatest contributors to injury-related deaths were interpersonal violence and transport injuries. The Metro and Central Karoo had the highest mortality rates due to interpersonal violence at 41.6 and 41.1 deaths per 100 000 respectively. In the remaining districts, rates ranged from 27.6 to 33.5 deaths per 100 000. Transport injury mortality rates were highest in the Cape Winelands (30 per 100 000), Central Karoo (29.4 per 100 000) and West Coast (28.5 per 100 000) while Eden had the lowest (23 per 100 000). The Western Cape Provincial Government Injury Prevention Workgroup (IPWG) has identified 5 areas within the Cape Metro as high violence communities requiring injury prevention efforts. To determine high risk population sub-groups in these areas, rapid assessments (RA's) of injuries in emergency centres in Khayelitsha and Nyanga were conducted over a week in September 2012, September 2013 and February 2014. Results are similar across all 3 RA's, with approximately 40 per cent of cases reporting to the emergency centres (EC) being due to injuries. Of these injury cases, approximately 60 per cent were as a result of violence, 20 per cent unintentional injuries and 11 per cent were transport-related injuries[4]. Alcohol use was reported in almost half of all violent injuries (47- 53 per cent) and 20-25 per cent of transport related injuries. Amongst males, almost one third of transport related injuries were associated with alcohol (Figure A.7).

Figure A.7: Probable alcohol use and cause of injury among males[5]

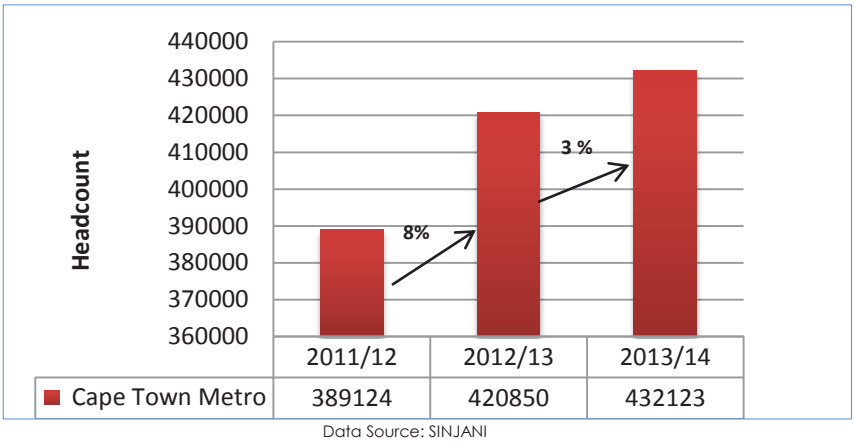


SERVICE PRESSURES

Emergency Centres

The emergency headcount in both urban and rural settings have continued to increase, with the exception of Central Karoo, over the last 3 financial years, see Figures A.8 and A.9

Figure A.8: Emergency Headcount - Metro

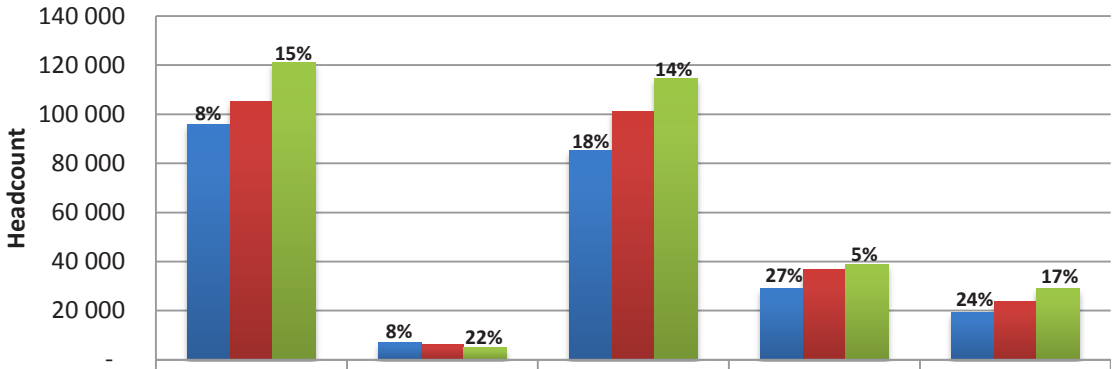


Data Source: SINJANI

[4] Mureithi L, Van Schaik N, Misra M, Naledi T, English R, Matzopoulos R Rapid Assessment of the Injury Morbidity Burden at Health Services in Three High Violence Communities in the Western Cape. 2013

[5] Mureithi L, Van Schaik N, Misra M, Naledi T, English R, Matzopoulos R Rapid Assessment of the Injury Morbidity Burden at Health Services in Three High Violence Communities in the Western Cape. 2013

Figure A.9: Emergency Headcount - Rural



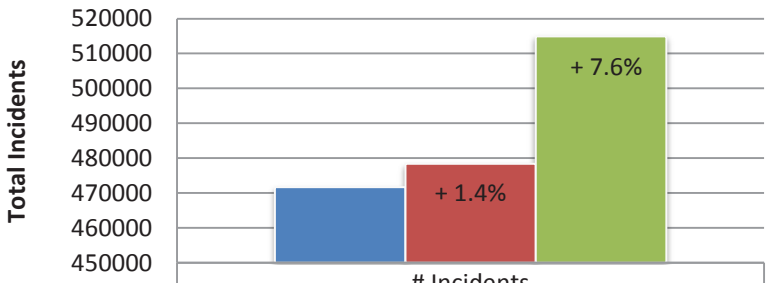
	Cape Winelands	Central Karoo	Eden	Overberg	West Coast
2011/12	95 986	6 864	85 270	28 988	19 306
2012/13	105319	6304	100905	36923	23881
2013/14	120856	4887	114661	38589	28865

Data Source: SINJANI

EMS

The EMS call volumes have increased by 7.6 per cent in the previous financial year, the Department had to respond to 36 536 more emergencies 2013/14.

Figure A.10: EMS Total Call Volume 2011/12 - 2013/14



	# Incidents
2011 - 2012	471652
2012 - 2013	478365
2013 - 2014	514901

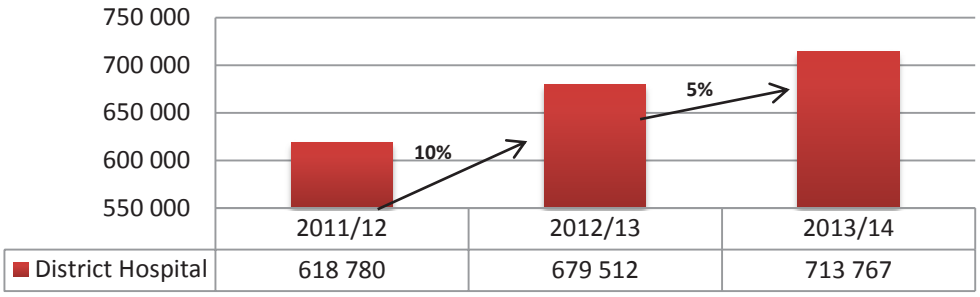
Source: EMS Efficiency Data

Urban Hospitals

Patient day Equivalent

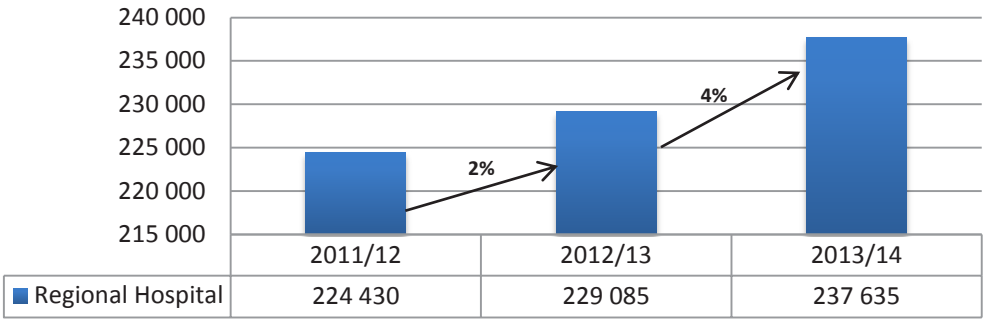
There has been a year on year increase in Patient Day Equivalents (PDE) for hospitals located in the Metro with the Regional hospital PDE doubling in growth 2013/14 and Central hospital growth holding steady at 3 per cent, see Figure A.11 – A.13 respectively.

Figure A.11: Patient day Equivalent for Urban District Hospitals



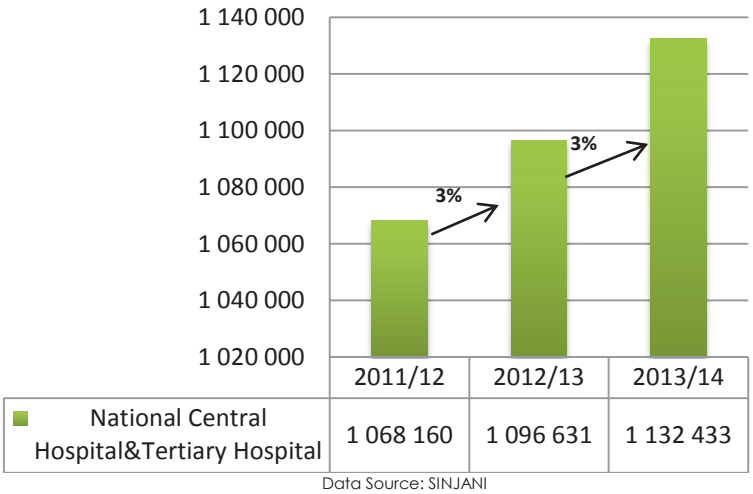
Data Source: SINJANI

Figure A.12: Patient day Equivalent for Urban Regional Hospitals



Data Source: SINJANI

Figure A.13: Patient day Equivalent for Central Hospitals



Data Source: SINJANI

Bed Occupancy Rate (BOR)

BOR is considered to be optimal at 85 per cent for acute hospitals as this level that the hospitals are considered to be most efficient. The BOR continues to increase in hospitals like Helderberg, Wesfleur, Tygerberg and Khayelitsha. 62 per cent of the hospitals have rates in excess of 90 per cent, while 31 per cent have rates in excess of 100 per cent; the hospital platform thus continues to take significant strain.

Table A.3: Bed Occupancy Rates 2011/12 - 2013/14

FACILITY	2011/2012	2012/2013	2013/14
Eerste River Hospital	120%	116%	103%
False Bay Hospital	65%	69%	69%
GF Jooste Hospital	103%	100%	90%
Groote Schuur Hospital	86%	84%	85%
Helderberg Hospital	94%	96%	104%
Karl Bremer Hospital	95%	93%	99%
Khayelitsha Hospital	94%	96%	120%
Mowbray Maternity Hospital	88%	83%	98%
New Somerset Hospital	95%	99%	93%
Red Cross War Memorial Children's Hospital	81%	78%	84%
Tygerberg Hospital	79%	81%	85%
Victoria Hospital	98%	99%	94%
Wesfleur Hospital	76%	84%	107%
Total	**87%**	**86%**	**91%**

Data Source: SINJANI

REVIEW OF THE PROGRESS TOWARDS THE HEALTH RELATED MILLENNIUM DEVELOPMENT GOALS (MDGs)

The table, below illustrates the progress made towards achieving the MDGs:

Table A.4: Progress towards the MDGs

MDG GOAL	TARGET	INDICATOR	SOURCE OF DATA	BASELINE (2009)	PROGRESS TO DATE (2014)	TARGET 2015/16[6]
Goal 1: Eradicate extreme poverty and hunger.	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Child under 5 years severe acute malnutrition case fatality rate	SINJANi	2.4%	4.1% (2014/15))	4.4%
Goal 4: Reduce child mortality.	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	Under-five mortality rate	Stats SA/ Mortality Surveillance	27.5 per 1 000	24.1 per 1 000 live births (2011)	22.5 per 1 000 live births
		Infant mortality rate	Stats SA/ Mortality Surveillance	22.7 per 1 000	19.1 per 1 000 live births (2011)	18 per 1 000 live births (MDG goal)
		Proportion of one-year-old children immunised against measles	SINJANI (APP 2012/13 and 2014/14)	99.29%	83.6% (2013/14)	99.5%
Goal 5: Improve maternal health.	Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate.	Maternal mortality ratio	Sixth Saving Mothers 2011-2013	84.87 per 100 000 live births	71.02 per 100 000 live births	66 per 100 000 (District health services – maternal deaths in facility)
		Proportion of births attended by skilled health personnel	South African Demographic and Health Survey (SADHS) 2003	89.6% (2003)	Not measured elsewhere since 2003	-
Goal 6: Combat HIV and AIDS, malaria and other diseases	Have halted by 2015, and begin to reverse the incidence of HIV and AIDS, malaria and other major diseases.	HIV prevalence among 15- to 49 year-old pregnant women	National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2009 National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2011	16.9%	18.2%	10.4%
		Couple year protection rate	SINJANI	40.7%	75.8%	76.4%

[6] Source is the 15/16 Annual Performance Plan

MDG GOAL	TARGET	INDICATOR	SOURCE OF DATA	BASELINE (2009)	PROGRESS TO DATE (2014)	TARGET 2015/16[6]
		Proportion of tuberculosis cases detected and cured under directly observed treatment, short-course (DOTS).	ETR.net (2012/13 APP and 2014/15 APP)	80.5% New smear positive PTB cure rate	80.4% (QPR projection at the 3rd quarter review)	82.9%

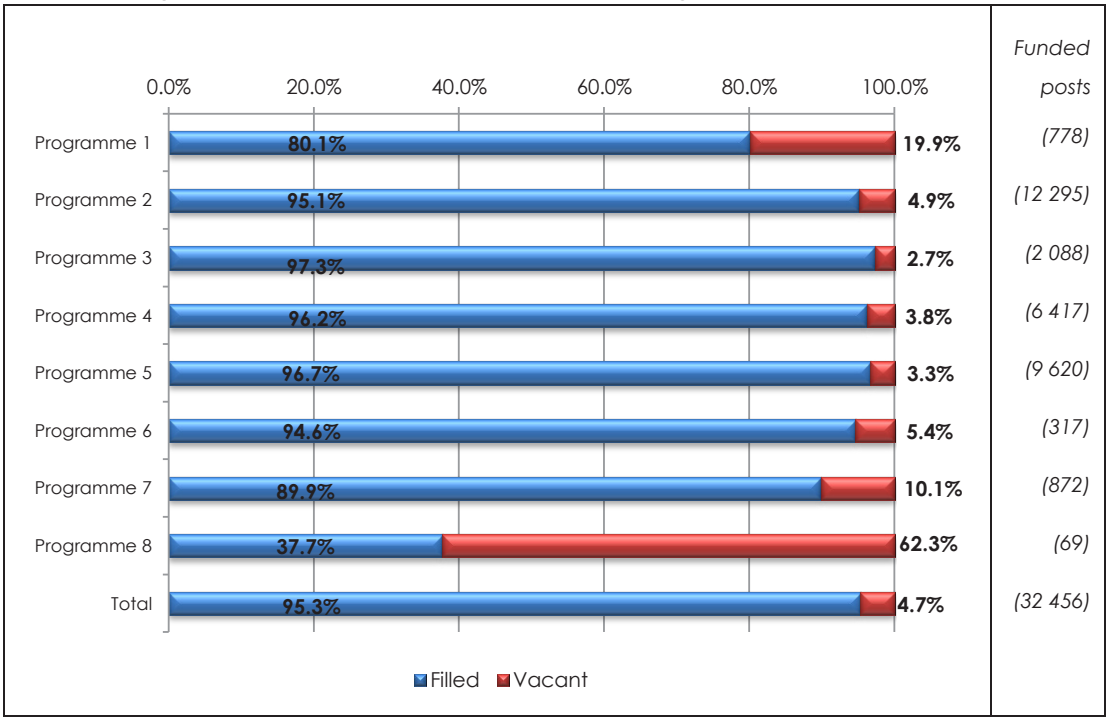
5.2. Organisational Environment

ORGANISATIONAL STRUCTURE

The current approved organisation and post structure of the Department is based on a combination of the Comprehensive Service Plan (CSP) establishment and amendments that have occurred to accommodate service delivery needs and a more integrated way of functioning. Further alignment may be required with the proposed Healthcare 2030 model. The establishment makes provision for the core and support functions required to achieve the strategic objectives of the Department. The alignment of employee functioning with the job purpose and functions of the current organisational design is being monitored. Priority projects are identified annually to address efficiency, based on service needs and operational requirements. The organisational structure (see organogram A) reflects the senior management service (SMS) members as at the 1st January 2015. It is important to note that the HoD designate has been appointed and is due to take office on the 1st April 2015 and organogram B reflects the structure as of the 1st April 2015.

ORGANISATIONAL CAPACITY

Figure A.14: Employment and vacancies by programme as at 31 March 2014



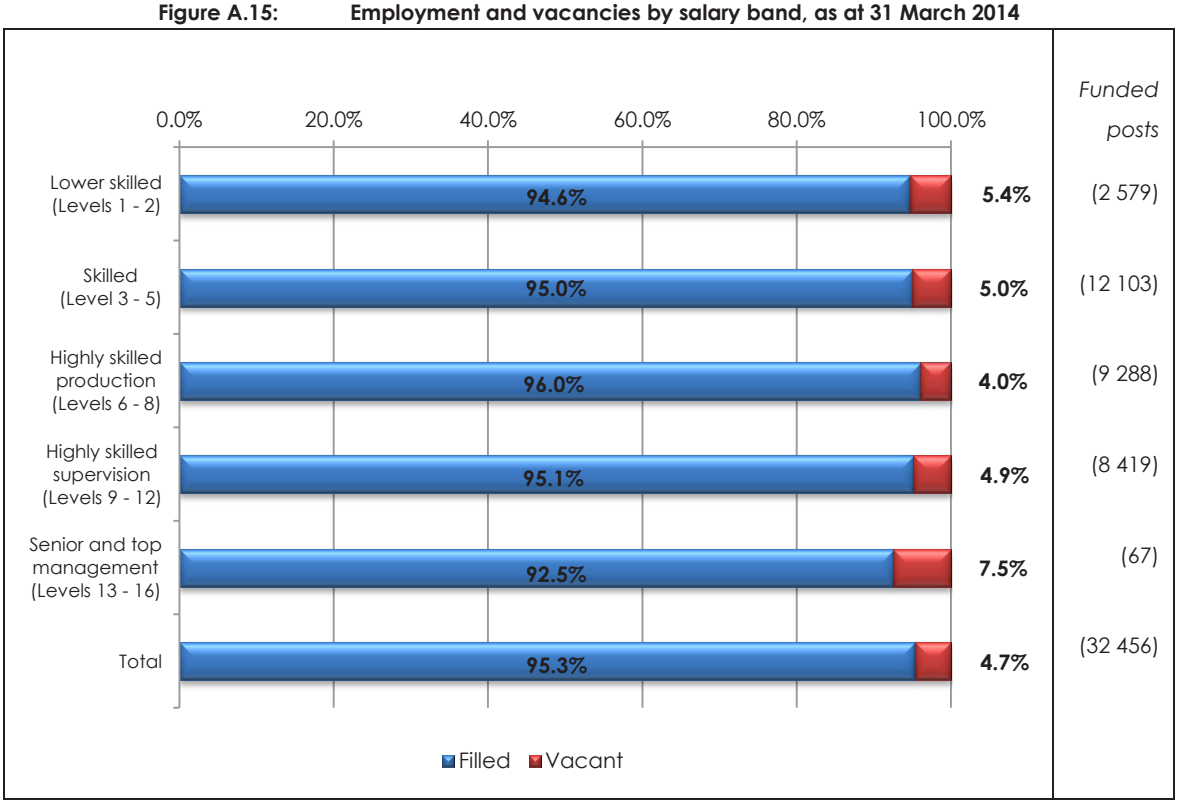
Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Vacancy rate is based on funded vacancies.

The above average vacancy rate of Programme 1 was a result of the implementation of various ODI interventions. The high vacancy rate for Programmes 7 and 8 amounts to 27 posts in the category: engineering which is a scarce skill and difficult to recruit, see Figure A.14. Although the Department has an overall vacancy rate of 4.7 per cent, it should be noted that 0.26 per cent of these posts are being used for staff appointed on short to medium term contracts and special projects, additional to the approved establishment, this translates into 4.44 per cent of the posts being vacant. The Department has an APL restriction of 95.5 per cent therefore vacancy rate of 4.44 per cent is acceptable and within target.

Figure A.15 provides the same statistical information as Figure A.14 but broken into salary bands.

Figure A.15: Employment and vacancies by salary band, as at 31 March 2014

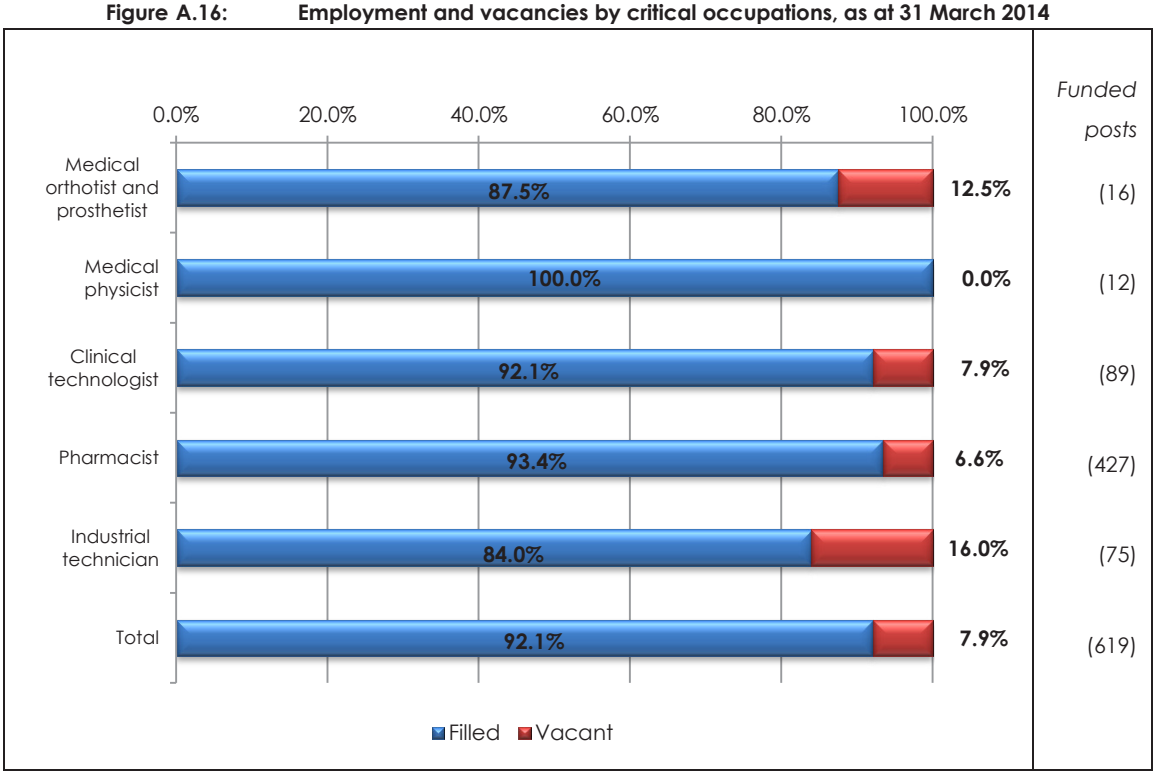


Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Vacancy rate is based on funded vacancies.

The figure below, refers to scarce skills in MTEF Period 2009/2014

Figure A.16: Employment and vacancies by critical occupations, as at 31 March 2014



Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.

An analysis of the core competencies of the current workforce of the Department indicates that availability of staff with the following competencies is limited:

- Nursing in specific specialty areas such as: emergency care, theatre and intensive care, advanced psychiatry, advanced midwifery and paediatric;
- Family physicians specifically speciality areas within the rural areas;
- Radiographers in specialty areas (ultrasound, oncology and nuclear medicine);
- Built environment professionals and clinical technicians
- Forensic pathology officers; and
- Emergency care technicians and paramedics.

Table A.5: Public health personnel as at 31 March 2014

PUBLIC HEALTH PERSONNEL							
Categories	**Number employed**	**% of total employed**	**Number per 1 000 people**	**Number per 1 000 uninsured people**	**Vacancy rate**	**% of total personnel budget**	**Annual cost per staff member**
Medical officers	1 984	6.4%	0.331	0.424	3.4%	16.0%	561 263
Medical specialists	661	2.1%	0.110	0.141	2.9%	9.4%	836 099
Dental specialists	6	0.0%	0.001	0.001	0.0%	0.1%	1 315 970
Dentists	87	0.3%	0.015	0.019	5.4%	0.8%	385 097
Professional nurse	5 978	19.3%	0.997	1.277	4.5%	23.2%	319 805
Staff nurses	2 483	8.0%	0.414	0.531	4.8%	5.5%	192 738
Nursing assistant	4 116	13.3%	0.686	0.880	2.6%	7.8%	163 025
Pharmacists	400	1.3%	0.067	0.085	6.3%	2.3%	436 681
Physiotherapists	137	0.4%	0.023	0.029	1.4%	0.5%	245 314
Occupational therapists	164	0.5%	0.027	0.035	5.8%	0.6%	260 412
Psychologists	79	0.3%	0.013	0.017	0.0%	0.4%	343 402
Radiographers	451	1.5%	0.075	0.096	2.6%	1.8%	303 995
Emergency medical staff	1 907	6.2%	0.318	0.408	2.4%	5.0%	231 968
Dieticians	88	0.3%	0.015	0.019	2.2%	0.3%	261 692
Other allied health professionals and technicians	1 461	4.7%	0.244	0.312	6.1%	4.4%	243 213
Other staff	11 015	35.5%	1.836	2.354	5.5%	22.1%	157 241
Grand total	**31 017**	**100.0%**	**5.171**	**6.628**	**4.4%**	**100.0%**	**257 480**

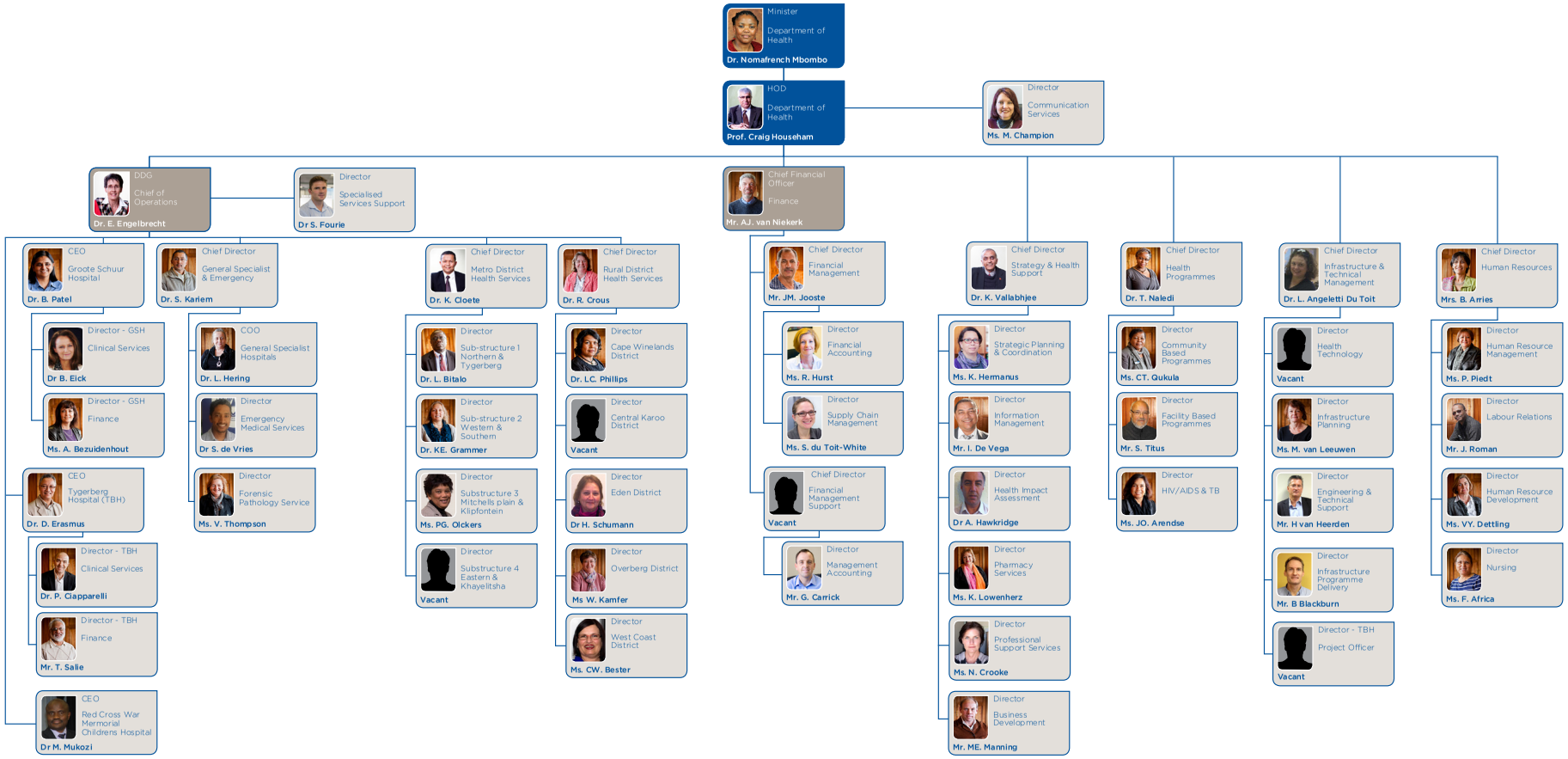
Competent health practitioners are required to deliver health care that is responsive to the needs, preferences and expectations of people accessing health services. Influencing the development of a comprehensive, harmonized medical, nursing and allied health curriculum that will improve patient-centred care and capacity for holistic and compassionate care is therefore an imperative. Health education has concentrated on disease aspects. The broader and important aspects of cultural context, psychosocial factors, medical ethics, and communication and relational skills, among others, have been neglected. There is a need to emphasize not only technical quality but also the experiential elements of care and the values of Western Cape Government Health. These will be developed and enhanced through a change management strategy.

Western Cape Government

BETTER TOGETHER.

Organisational Organogram

Structure as from 1 January 2015

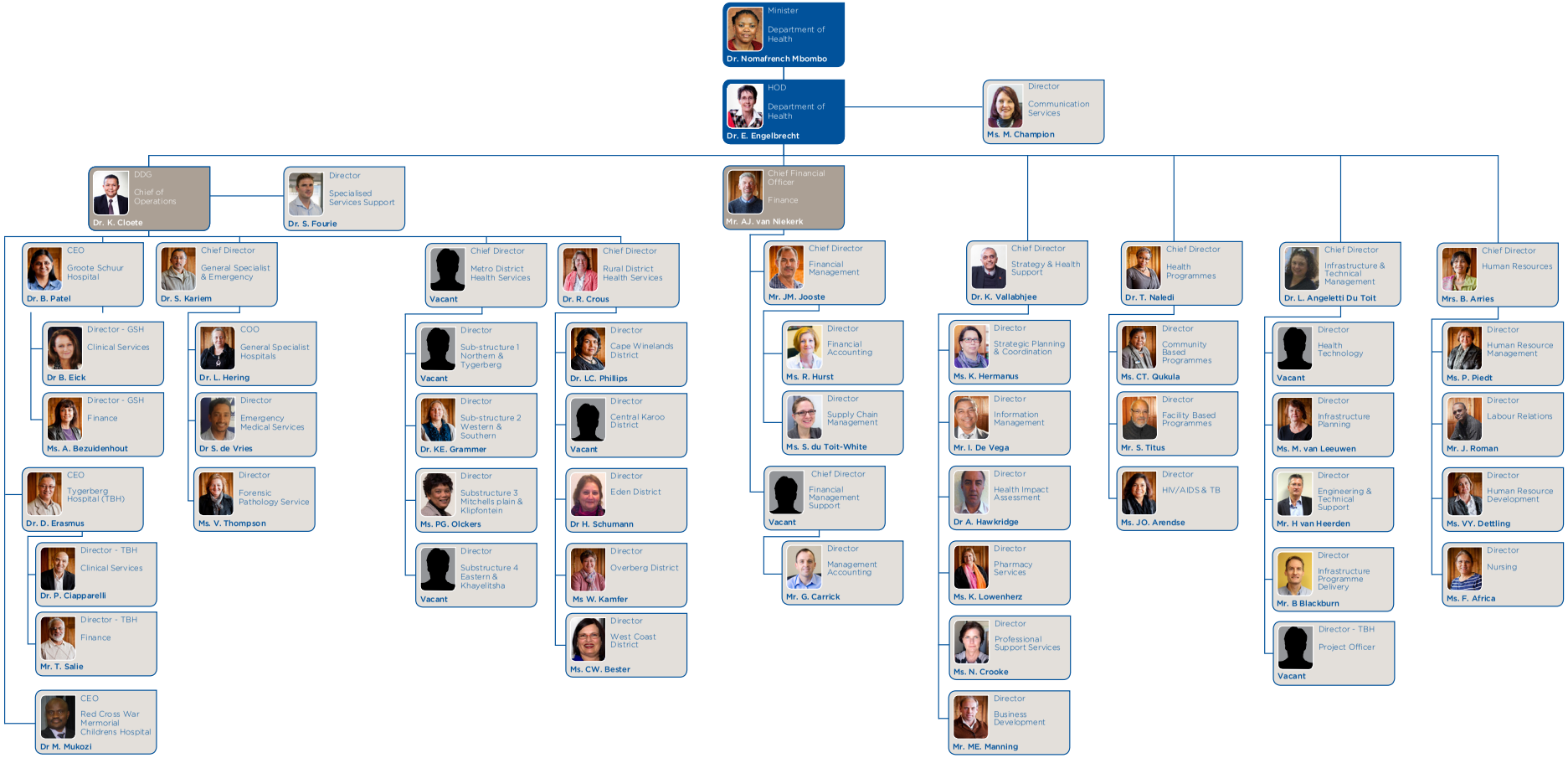


Western Cape Government

BETTER TOGETHER.

Organisational Organogram

Structure as from 1 April 2015

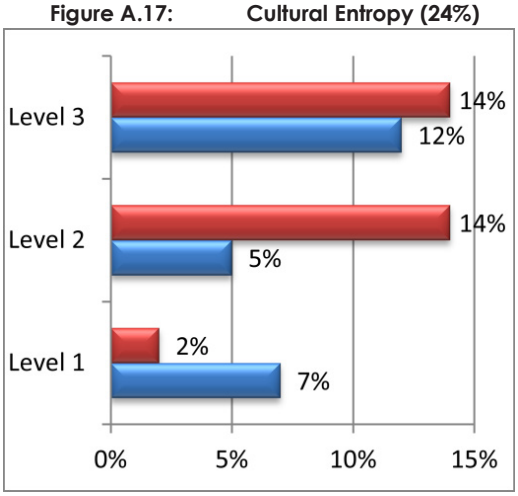


ORGANISATIONAL FACTORS THAT IMPACT ON SERVICE DELIVERY

Organisational Culture

The Barrett Survey was conducted in 2013 and found cultural entropy to be relatively high at 24 per cent in Western Cape Government: Health. Cultural entropy is a measure of the degree of dysfunction in a system and represents the proportion of votes for potentially limiting values (Blue bar, see Figure A.17). A cultural entropy level of 10 per cent or lower indicates a healthy organisation. The Department's cultural entropy score reflects significant issues requiring cultural and structural transformation and leadership coaching. It is spread across levels 1 (survival), 2 (relationships) and 3 (self-esteem); indicating problems affecting business viability, performance and how people work together. At level 1 the negative values (blue bar) outweigh the positive values (red bar, see Figure A.17) indicating that any good work here is being overwhelmed by problems.

Figure A.17: Cultural Entropy (24%)



There are five potentially limiting values in the top values of the current culture: red tape, control, hierarchy, cost reduction and confusion. Looking at these values the following issues can be identified:

- Unwieldy systems, processes and structures, along with restrictions on expenditure, frustrate people's efforts.
- There is a lack of clear and open communication.
- Internal divisions and power struggles impede group cooperation.
- People lack empowerment and are over-worked.
- Employees feel criticised and used.

In addition, when we look at matches between those values which are most important to employees and those they most experience at work, there is only one value match, '*accountability*'. In a highly aligned culture, one would expect to see three or four matching, personal and current culture values. This suggests that employees feel little personal connection in their working environment.

Employee Wellness

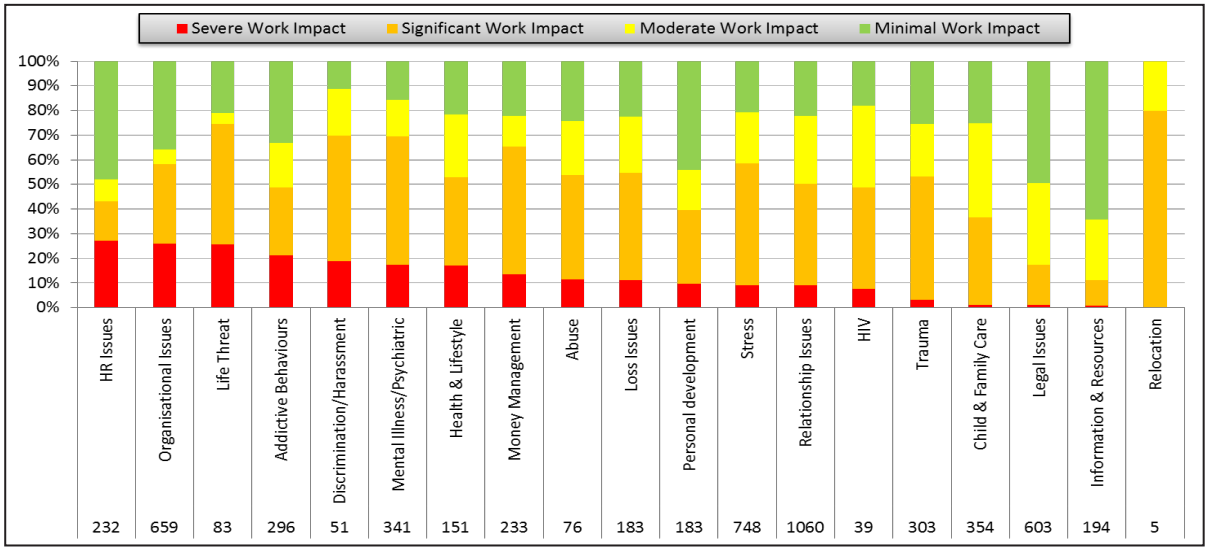
The impact of employee wellness on productivity levels is an ongoing challenge. In 2013/14 ICAS Report supervisors were most likely to refer employees for problems with absenteeism at 19.83 per cent and conflict amongst staff at 15.52 per cent, see Figure A.18. In 2013/14 6.6 per cent of employees had problems which had a severe impact on their work. This is comparable to the ICAS average of 5.6 per cent for the same period.

Figure A.18: Formal Referral Audit Results

A 'severe work impact' is characterised by a serious impairment in the occupational functioning of the individual and may include absenteeism, conflict, compromised performance and/or a disciplinary process. Figure A.19 illustrates work impact per problem cluster, where human resource issues and organisational issues were most likely to have a 'severe work impact'. Relocation related problems had a 'significant work impact', which involves occasional absences, presenteeism,

conflicts with colleagues and/or managers. The problem clusters for child and family care, and HIV most commonly had a 'moderate work impact'. This implies a slight difficulty with functioning, forgetting more often and possibly missing deadlines. Legal issues and the information and resource clusters were more likely to be associated with a 'minimal work impact', where employees were most likely to display proactive help seeking behaviour.

Figure A.19: Work Impact per Problem Cluster 2013/14



Information and Communications Technology (ICT) in Western Cape Government: Health

WCG Health has excellent ICT building blocks which are all currently maturing in order to support a new paradigm of using individual level patient data to support clinical care, routine reporting, and health intelligence. ICT progress to date includes:

- Only province in SA with a single Hospital Information System (HIS) across nearly all hospitals.
- Nearly all primary care clinics are on one of two platforms (PHCIS or PreHMIS).
- All core systems are linkable via the Clinicom number which is shared, thus we are the only department in the country with a functional unique patient identifier for each patient, allowing the patient care record to be viewed irrespective of the treatment centre.
- Electronic dispensing covers 43 per cent of all issues, and is expanding rapidly.
- All laboratory data are available electronically.
- PACS/RIS, EMS, ECM and other domains are potentially linkable.
- Data harmonisation project demonstrated the viability & utility of an individual-patient-level health data centre, which will create true intelligence and system independence.
- Complete electronic disease data for HIV, TB, and good progress being made on other chronic diseases, pregnancies and births.
- A single view that will include amongst others the demographic data, diagnosis, labs results and prescribed medicines of recent visits of the patient, is being developed.
- Unqualified performance information audits with reduced findings.

Infrastructure Development in Western Cape Government: Health

There have been considerable contextual changes in the planning and delivery of provincial government health infrastructure in the Western Cape: The Infrastructure Delivery Management System, or IDMS, with its relatively complex set of sub-systems and processes has begun implementation and institutionalisation in WCG: Health; national and provincial legislation has progressively imposed increased compliance obligations; there has been a change in focus from the delivery of new infrastructure to ensuring that the maintenance of existing infrastructure is appropriately carried out.

An important recent change, impacting on all provinces, during 2014 by National Treasury is the introduction of the Performance-Based Incentive (PBI) process for the HFRG. This process requires that provinces bid for HFRG allocations two years in advance and includes financial incentives for provinces that implement best practices in delivering infrastructure. This process is further elaborated in the paragraph dealing with resource considerations below.

The primary objective of the infrastructure programme is to promote and advance the health and well-being of health facility users in the Province in a sustainable responsible manner. This objective is being met through what has been termed the "5Ls Agenda":

- Long life (Sustainability).
- Loose fit (Flexibility and adaptability).
- Low impact (Reduction of carbon footprint).
- Luminous healing space (Enlightened healing environment).
- Lean Design and Construction (Collaborative and integrated).

Figure A.20: The 5Ls Agenda

The above 5Ls Agenda is implemented through a set of principles, which are embedded in the management of any infrastructure project embarked upon by WCG: Health through its implementing agent – these principles, are:

- Affordability: Avoid "state-of-the art" design and construction and rather aim for what is appropriate and easily maintainable.
- Green Building: Particularly in terms of energy and water, materials, land use and ecology, indoor environmental quality, transport, emissions.
- Flexibility: Facility design should take account of changing needs, workloads, healthcare policies, etc.
- Standardisation of design and construction: Health infrastructure projects will be based on standard designs, drawings and technical specifications, as well as on space planning norms and standards. At the planning stage, such standardisation eliminates or reduces the need for both conceptual development of a design and the need for detailed design work and thereby substantially reduces redundancy and the cost of professional fees. At procurement stage it facilitates the packaging of projects to improve procurement efficiencies; at construction stage, benefits would include reduced costs due to economies of scale for procurement of material and equipment, increased pace of construction due to contractor's knowledge of requirements and processes, etc. The pursuing of standardised unit layouts also assists in reducing healthcare team orientation to different facilities and in streamlining maintenance.
- Healing Environment: The building itself is part of the therapeutic setting and process (e.g. light, air quality, way finding, ergonomics).
- Innovation in Delivery, including new contracting arrangements and the use of new technology for construction.
- Life-cycle Costing, including:

- Estimation, at the planning stage, of all costs involved in the acquisition, operation including utilities, maintenance and disposal of an immovable asset.
- Building maintenance plan.
- Life-cycle plan and budget. (High-level plan include the analysis of what must be done with the healthcare buildings in a ten-year time frame namely maintenance, renovations, replacement, etc.)
- Balancing once-off capital expenditure against future on-going operational costs.
- Operational efficiency.

Dependencies / Partnerships

City of Cape Town

The Department has a service level agreement with the City of Cape Town Municipality (local government) for the provision of primary health care in the Cape Town Metro District. These services have been provincialised in the rural districts. The City of Cape Town is also a strategic partner for the provisioning of health facilities as well as integration with urban development.

Non-Profit Organisations (NPOs)

The Department has service level agreements with several NPOs for the rendering of intermediate care and home and community based care (HCBC).

South African Police Services (SAPS)

An MOU governs the relationship with SAPS in forensic pathology and emergency medical services

Western Cape Government Transport & Public Works

The Department has a Service Delivery Agreement (SDA)with the Western Cape Government (WCG) Transport and Public Works (TPW), as WCG TPW as the implementing agent for health infrastructure delivery. This SDA is fully aligned to the WC-IDMS. WCG TPW is also the Custodian of the provincial immovable assets in terms of the Government Immovable Asste Management Act (GIAMA).

Centre of E Innovation(CEI)

There is a dependence on CEI to ensure that the WCG Health has the necessary infrastructure to be able to communicate, transact and input meaningful day to day data through its information systems. In essence they are to ensure that that there is sufficient connectivity, proper data centre with sufficient server capacity to host WCG health systems and data, a full back up infrastructure in case of downtime that may be experienced. The department is also reliant on CEI to support its +-20 000 computer users on a day to day basis. CEI is equally charged to ensure that WCG benefits from a shared services offering by ensuring that software licences etc. are provided at a cost effective manner in order to reduce cost of ICT. Current an MOU with service schedules are used to manage this relationship.

Higher Education Institutions (HEIs)

The province has a multilevel agreement (MLA) with 4 HEIs for the training of health sciences students on its service platform. A separate bilateral agreement governs the relationship with each of the universities under the principles of the MLA. In 2009 there were 6,5m student hours on the service platform.

5.3. Description of the Strategic Planning Process

The Department has a clear planning and monitoring cycle with quarterly monitoring of the targets in the APP. A departmental monitoring and evaluation (M&E) session took place in June 2014 to reflect more meaningfully on the service trends, performance, achievements and challenges for each of the priority areas within the health service. The key areas of reflection included:

- Health outcome trends
- Women's health
- Child health
- Mental health
- Chronic diseases
- HIV and TB
- Emergency Medical Services
- Occupational Health
- Quality of care.

The support services of human resources, finance, infrastructure and information and communications technology (ICT) were also addressed. This provided a rich picture of the current reality faced by the Department.

Subsequently, two strategic planning sessions were held on 01 August 2014 (support services) and 11 August 2014 (clinical services), respectively. The main objective of the sessions was to identify the key priorities, strategic objectives and risks that need to be focussed on within the next five-year planning cycle. Clinicians, from a range of disciplines, participated in this process to provide valuable insights from the coalface.

A bilateral engagement between the WCG: Health and the National Department of Health took place on 14 August 2014. The purpose of this meeting was to discuss the planning process, framework and strategic health indicators to be included in the Strategic Plan 2015– 2019, the Annual Performance Plan 2015/16 and the District Health Plans 2015/16. Top Management spent a day consolidating the outputs and thinking from all of the above sessions and crystallised this into goals and strategic priorities for the next five years. The cumulative input from the above-mentioned engagements formed the basis for the technical work required to finalise the five-year plan.

6. Strategic Framework 2015-2019

6.1. Medium Term Strategic Framework

The National Development Plan 2030 was adopted by government as its vision. It will be implemented over three electoral cycles of government. The MTSF 2014-2019 therefore finds its mandate from National Development Plan 2030. The table below provides more details on the alignment between NDP 2030 goals, priority interventions proposed by NDP 2030 and sub-outcomes of MTSF 2014 – 2019.

Table A.6: Alignment between NDP Goals 2030, Priority interventions proposed by NDP 2030 and Sub-outcomes of MTSF 2014-2019

NDP GOALS 2030	NDP PRIORITIES 2030	SUB-OUTCOMES 2014-2019 (MTSF)
Average male and female life expectancy at birth increased to 70 years	A. Address the social determinants that affect health and diseases B. Prevent and reduce the disease burden and promote health	1. HIV & AIDS and Tuberculosis prevented and successfully managed 2. Maternal, infant and child mortality reduced
Tuberculosis (TB) prevention and cure progressively improved;		
Maternal, infant and child mortality reduced		
Prevalence of Non-Communicable Diseases reduced by 28%		
Injury, accidents and violence reduced by 50% from 2010 levels		
Health systems reforms completed	C. Strengthen the health system	3. Improved health facility planning and infrastructure delivery
		4. Health care costs reduced
	D. Improve health information systems	5. Efficient Health Management Information System for improved decision making
	E. Improve quality by using evidence	6. Improved quality of health care
Primary health care teams deployed to provide care to families and communities		7. Re-engineering of Primary Health Care
Universal health coverage achieved	F. Financing universal healthcare coverage	8. Universal Health coverage achieved through implementation of National Health Insurance
Posts filled with skilled, committed and competent individuals	G. Improve human resources in the health sector H. Review management positions and appointments and strengthen accountability mechanisms	9. Improved human resources for health
		10. Improved health management and leadership

The NDP 2030, together with the MTSF 2014-2019, forms the umbrella goals for the health sector.

Table A.7: Outcome Targets Committed by the Health Sector

IMPACT INDICATOR	BASELINE (2009[7])	BASELINE (2012[8])	2019 TARGETS (SOUTH AFRICA)	2012 BASELINE (PROVINCE)	2019 TARGET (PROVINCE)
Life expectancy at birth: Total	56.5 years	60.0 years (increase of 3.5 years)	63.0 years by March 2019 (increase of 3 years)	65.8 years (source: StatsSA)	67.5 years
Life expectancy at birth: Male	54.0 years	57.2 years (increase of 3.2 years)	60.2 years by March 2019 (increase of 3 years)	63.7 years (source: StatsSA)	65 years
Life expectancy at birth: Female	59.0 years	62.8 years (increase of 3.8 years)	65.8 years by March 2019 (increase of 3years)	67.9 years (source: StatsSA)	70 years
Under-5 Mortality Rate (U5MR)	56 per 1 000 live births	41 per 1 000 live births (25% decrease)	23 per 1 000 live births by March 2019 (20% decrease)	24.1 per 1 000 live births (source: StatsSA) (2011 Mortality Report)	20 per 1 000 live births
Neonatal Mortality Rate	-	14 per 1 000 live births	6 per 1 000 live births	8.2 per 1 000 live births (source: neonatal deaths from 2011 Mortality Report and StatsSA live births)	5 per 1 000 live births
Infant Mortality Rate (IMR)	39 per 1 000 Live births	27 per 1 000 live births (25% decrease)	18 per 1 000 live births	19.1 per 1 000 live births (source: StatsSA) (2011 Mortality Report)	18 per 1 000 live births
Child under 5 years diarrhoea case Fatality rate[9]	-	4.2%	<2%	0.37% in 2011/12 (Source: SINJANI)	0.2%
Child under 5 years severe acute malnutrition case fatality rate	-	9%	<5%	3.99% In 2011/12 (Source: SINJANI)	3.0%
Maternal Mortality Ratio	304 per 100 000 live births	269 per 100 000 live births	Downward trend <100 per 100 000live births by March 2019	78.64 per 100 000 live births (iMMR, from 10th interim report on confidential enquiries into Maternal Deaths in SA, 2011 and 2012)	65 per 100 000 live births

[7] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012
[8] Medical Research Council (2013): Rapid Mortality Surveillance (RMS) Report 2012
[9] Please note this was for diarrhoea with dehydration. Indicator changed in 2013/14 to include all diarrhoeal deaths)

6.2. Provincial Strategic Framework

STRATEGIC GOAL 3: INCREASE WELLNESS, SAFETY AND TACKLE SOCIAL ILLS

The priorities for PSG 3 for the next five years are healthy communities, families, youth children and workforce. In 2015/2016 there will be a planning process that includes community participation in Drakenstein Municipalitiy where this municipality will be used as a living lab to test the best way to deliver an eveidence based social package that would deliver on the five key priorities of PSG 3 listed below. It is anticipated that activities would start fully in 2016/17 with 2015/16 being a year of planning and small scale piloting of innovative interventions.

Healthy communities: This will be achieve through improving community safety, strengthening social services and the safety net for vulnerable groups, establishing robust community participatory platforms, greater participation in social and community life through sport, culture, libraries, museums, archives and heritage, increasing access to community workers (community health workers, community development workers, agricultural workers, etc.) that work collaboratively to serve priority communities, establishing Community Wellness Centres to promote strengthened personal agency for prevention and better self-management of NCDs, HIV and TB, and to facilitate access to services for psychological, social, financial and spiritual wellness and establishing community cafes

Healthy families: Through the promotion of positive parenting, increasing health literacy, personal agency and mental well-being. Promoting the positive role of fathers and men in integrated families. Promoting healthy lifestyles in families by building environments and personal capacity for behavior modification to improve citizen responsibility towards healthy lifestyles. Increasing the level of maternal education to promote financial wellness of women within the family unit

Healthy youth: In collaboration with PSG 2 providing appropriate and accessible sexual and reproductive health services for teenagers,educate and empower youth to develop and sustain safe and healthy lifestyle habits , strengthen mental well-being, self esteem and personal agency,facilitate opportunities for youth to be active and responsible citizens through training, internships and community involvement, consult with the youth to ensure effective intergenerational communication and contextually appropriate interventions, use appropriate technology for communication with youth that includes wellness-promoting resources (printed and electronic format), cell app promoting safe and healthy lifestyle choices, health literacy, and personal agency

Healthy children: Focus on the first 100 days of life from conception to 2 years, improve safety, water and sanitation at ECD centres (formal and informal),provide preventive health services (antenatal and postnatal care, immunisations, PMTCT, including mental wellbeing), encourage healthy eating (including breastfeeding) and health-related physical activity from an early age, ensure effective early childhood development and parenting

Healthy workforce: Pro-actively promote all domains of wellness amongst WCG employees, increase access to healthy foods in government buildings and events (meetings, workshops, vending machines, cafeterias etc), increase access to Employee Wellness and Assistance Programmes for WCG staff, engage major employers in the Western Cape to address wellness of their employees, ensure safety of employees in the workplace

'GAME CHANGERS'

The province has identified the following as potential 'game changers'[10] over the next 5 years, to improve wellness in communities through an integrated whole government approach:

1. Developing and piloting an **integrated service delivery model in the Drakenstein Municipality**, with a concentrated effort and pooling of resources by all departments to reduce social ills and increase wellness will increase. The pilot will identify the method, the costs, the success factors and the expected outcomes that can be achieved and provide a replicable model.
2. Addressing **alcohol and its impact on communities** has been identified and a joint game changer together with the City of Cape Town. A design lab approach will be used in 2015/16 to plan and deliver evidenced based interventions over the 5 year period.
3. **Parenting Programme** (first 1000 days), a focused programme on tracking every pregnant woman (100 000 by year 5) from antenatal care – delivery – post natal care – ECD and schooling that can reduce alcohol and smoking in pregnancy, provide good prenatal and post natal care, improve breastfeeding rates, link children & parents to required health and social services, improve father involvement, parenting skills and bonding and readiness for ECD enrolment.

6.3. Departmental Strategic Goals

Healthcare 2030 provides a powerful vision for the future of health care in the Province and its implementation success depends on well thought out incremental milestones over the next fifteen years. The budget realities over the next 5 years pose a significant challenge to the Department's service delivery reforms. The realisation of a people-centric, effective health system that inspires public trust, depends on significant allocative and technical efficiency gains in the next 15 years which will require tough decisions if the Department is to remain true to the tenets of 2030.

In moving forward towards the vision of 2030, three key leverage points have been identified as central to the trajectory of the Department over the next 5yrs:

- The re-orientation of the organisational culture to being person-centered;
- Integrated PHC Services;
- Information and Communication Technology (ICT) that enables integration and continuity within the health system.

Their effectiveness in taking the health system forward will depend heavily on the Department's capability to innovate, particularly with the severe resource constraints being forecast for the medium term. The strategic goals for the next 5 years are detailed in Table A.9 below.

[10] Game changers are an intervention or service initiative that effects a significant shift in the current way of doing or thinking about service delivery, with a substantial improvement in performance over a short timeframe.

Table A.9: 2015 - 2019 Strategic Goals of the Western Cape Government-HEALTH

STRATEGIC GOAL 1	**Promote health and wellness**
Goal Statement:	Promote health and wellness with the aim of increasing the life expectancy of citizens in the Western Cape.
Outcome 1.1.	**Comprehensive, efficient health services**
Priority Strategies	▪ Strengthen the continuum of care across the health system ▪ Person-centred approach to care provision ▪ Improving the waiting experience ▪ Comply with the National Core Standards ▪ Nurturing a culture of continuous quality improvement
Outcome 1.2.	**Effective PHC Services as part of a resilient, comprehensive health system**
Priority Strategies	▪ Service Re-design ▪ Strengthening Care Pathway Co-ordination ▪ Enhancing the health system's capability for prevention with a focus on wellness
STRATEGIC GOAL 2 :	**Embed good governance and values-driven leadership practices**
Goal Statement:	Embed good governance and values-driven leadership practices that enables integrated service delivery and person-centred care
Outcome 2.1.	**Competent, engaged, caring and empowered employees**
Priority Strategies	▪ Caring for the Carer Initiative ▪ Behaviour Change Programme
Outcome 2.2.	**Managers who Lead**
Priority Strategies	▪ Management and leadership capacity development initiative
Outcome 2.3.	**Basic Coverage of core ICT systems**
Priority Strategies	▪ Roll-out and operationalization of Clinicom, PHCIS & JAC ▪ Development of a data harmonising approach to integrate data from all systems ▪ Develop an approach to encourage and manage innovation in ICT
Outcome 2.4.	**Create an enabling built environment**
Priority Strategies	▪ Build health facilities that are conducive to healing and service excellence at the same time being sustainable, flexible, energy efficient, environmentally friendly and affordable
Outcome 2.5.	**Unqualified Audit**
Priority Strategies	▪ Continuously improve alignment of practice to policy in financial, human resources and information management. ▪ Establish systems to comply with the regularity framework, for example medical waste management

PART B:
STRATEGIC OBJECTIVES

PART B: STRATEGIC OBJECTIVES

7. Programme 1: ADMINISTRATION

7.1. Purpose

To conduct the strategic management and overall administration of the Department of Health

7.2. Structure

SUB-PROGRAMME 1.1: OFFICE OF THE MEC

Rendering of advisory, secretarial and office support services

SUB-PROGRAMME 1.2: MANAGEMENT

Policy formulation, overall management and administration support of the Department and the respective regions and institutions within the Department.

To make limited provision for maintenance and accommodation needs.

7.3. Key Components

OFFICE OF THE MEC AND THE OFFICE OF THE HEAD OF DEPARTMENT

The Provincial Cabinet and Minister of Health determine provincial policy. The Head of Department implements national and provincial policies ensuring that the Western Cape provincial health service is aligned with national, provincial and departmental strategy, policy and directives. The communication with stakeholders is managed and co-ordinated both via the Provincial Minister and the office of the Head of Department.

COMMUNICATION

The purposes of the Directorate is to facilitate and initiate two-way communication between the organisation and its internal and external stakeholders, which is aligned to the Departmental strategic objectives. It is responsible for informing and educating stakeholders and health consumers in the Province about the role of the Department and aims to build positive relationships. It also informs various stakeholders of campaigns and important health and wellness messages. This is done through various mediums: advertising, branding, social media, digital media, below-the –line advertising, media releases and one-on-one interactions and events. As part of person-centred-care, the Directorate manages the hotline for complaints, a Ministerial initiative, to fast-track complaints about health services received from citizens.

FINANCE

This division is headed by a chief financial officer and consists of two chief directorates (CDs), namely: Financial Management and Financial Management Support. The CD: Financial Management consists of two directorates:

1. Financial Accounting
2. Supply Chain Management

A key function of financial management is the annual compilation of the audited financial statements and ongoing interaction with the Auditor-General of South Africa. The management and support of this component enabled the Department to maintain an unqualified audit for the last ten financial years.
There is only one directorate in the CD: Financial Management Support, namely Management Accounting. This directorate is responsible for revenue generation and the budgeting process of the Department. This includes the financial control system, Financial Management Committee and the compilation of the required financial reports. This directorate is responsible for revenue generation, the budgeting process of the Department, the financial control system, and the compilation of the required financial reports.

HUMAN RESOURCES

The Chief Directorate: Human Resources consist of the following four directorates:

1. Human Resource Management (HRM)
2. Labour Relations
3. Nursing Services
4. Human Resource Development

The key functions are to provide workforce intelligence, a departmental framework for human resource policy and planning, implementation support and the monitoring and evaluation of human resource functions throughout the Department.

STRATEGY AND HEALTH SUPPORT

The Chief Directorate: Strategy and Health Support assists the Head of Department with the prescribed strategic planning and monitoring and evaluation functions as well as ensures alignment between the planning and reporting cycles. Departmental policy and planning also informs the budgetary processes and priorities. The range of other functions in this Chief Directorate include, amongst others, clinical support functions such as labs and blood, medicine management, as well as coordination of quality, research, managing public – private partnerships, coordination of security, medico-legal and other risks management, licencing of private establishments and ICT. The chief directorate consists of the following directorates:

1. Strategic Planning and Co-ordination.
2. Health Impact Assessment.
3. Information Management.
4. Professional Support Services.
5. Pharmacy Services.
6. Business Development

HEALTH PROGRAMMES

Health programmes focuses on priority health conditions such as child health, maternal health, mental health, HIV/TB and Chronic Diseases. It plays a key role in planning, policy development, implementation support and monitoring and evaluation. This Chief Directorate also plays the lead role in supporting the provincial strategic goal 3 of Wellness, Safety and Reducing Social Ills.

INFRASTRUCTURE MANAGEMENT

The Chief Directorate: Infrastructure and Technical Management plan and co-ordinate infrastructure management and development to ensure effective spending on infrastructure. The building and maintenance of infrastructure plays a pivotal role in the provision of accessible and quality health care to all residents of the Province. This chief directorate consists of the following directorates:

1. Health Technology
2. Infrastructure Planning
3. Engineering and Technical Support
4. Infrastructure Programme Delivery
5. Tygerberg Hospital re-development project officer

7.4. Strategic Objectives

GOAL: EMBED GOOD GOVERNANCE AND VALUES-DRIVEN LEADERSHIP PRACTICES

Table B.1: Strategic objectives and expected outcomes for Administration

Strategic objective (short title)	Strategic objective statement (SMART)	Indicator	Baseline (2013/14)	Target (2019/20)
1. Promote efficient use of financial resources.	1.1. Promote efficient use of financial resources to ensure the under/over spending of the annual equitable share is within 1% of the budget allocation.	1.1.1. Percentage of the annual equitable share budget allocation spent	99.8%	100%
		Numerator:	11 517 782 000	16 482 058 000
		Denominator:	11 544 801 000	16 482 058 000
2. Develop and implement a comprehensive Human Resource Plan.	2.1. Review and align the comprehensive Human Resource Plan with the goals and objectives of Healthcare 2030 by 2015.	2.1.1. Timeous submission of a Human Resource Plan for 2015 - 2019 to DPSA	Yes	Yes
3. Transform the organisational culture.	3.1. Reduce the level of cultural "entropy" within the organisation by 3% by 2019/20.	3.1.1. Cultural entropy level for WCG: Health	24%	21%
		Numerator	3 982	3 864
		Denominator	16 220	18 400
	3.2. To achieve two value matches in the Barrett's Survey by 2019/20	3.2.1. Number of value matches in the Barrett's Survey	1	2
4. Roll-out electronic patient administration systems to PHC facilities.	4.1. Roll-out the Primary Health Care Information System (PHCIS) software suite to 189 PHC facilities by 2019/20.	4.1.1. Percentage of PHC facilities where PHCIS software suite has been rolled-out	18.0%	100.0%
		Numerator	34	189
		Denominator	189	189

Note

Indicator 1.1.1 The estimated numerator and denominator targets for 2019/20 are subject to change based on the economic factors.

7.5. Resource Considerations

The past years have seen growth in real terms, the budgets allocated to the department for the MTEF period does however not enable further real growth. Any new priorities or initiatives, and growth in workload must be accommodated by reprioritization from lower value to higher value services. Total staff numbers will increase only marginally due to the filling of critical funded posts, but additional posts will not be made available.

EXPENDITURE TRENDS

The Programme 1 budget is based on staffing needs and the latest expenditure trends. The programme budget also includes expenditure related to the Chronic Dispensing Unit (a high volume, low cost dispensing process which alleviates workload at institutions), the cost of medico legal claims and other central costs such as audit fees, recruitment and advertising fees. In 2013/14 Programme 1 contributed 3.2 per cent to the overall departmental expenditure.

Figure B.1: Expenditure trends in Administration, 2009 to 2013

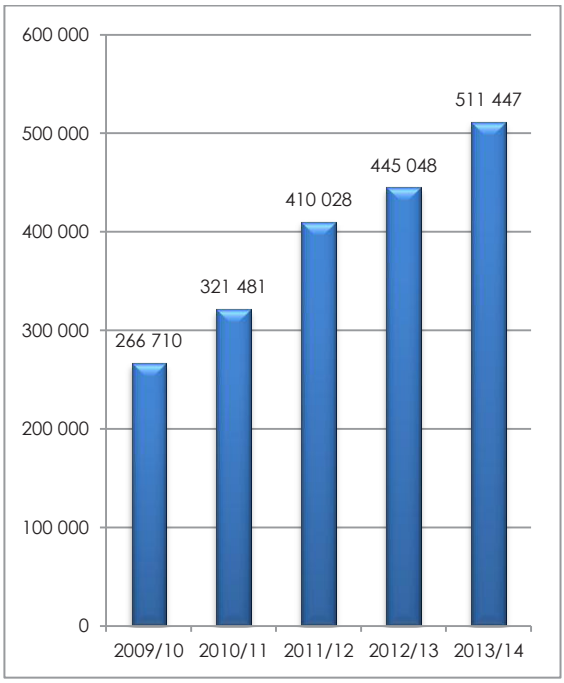


Figure B.2: Expenditure per sub-programme, 2013/14 (per R'000)

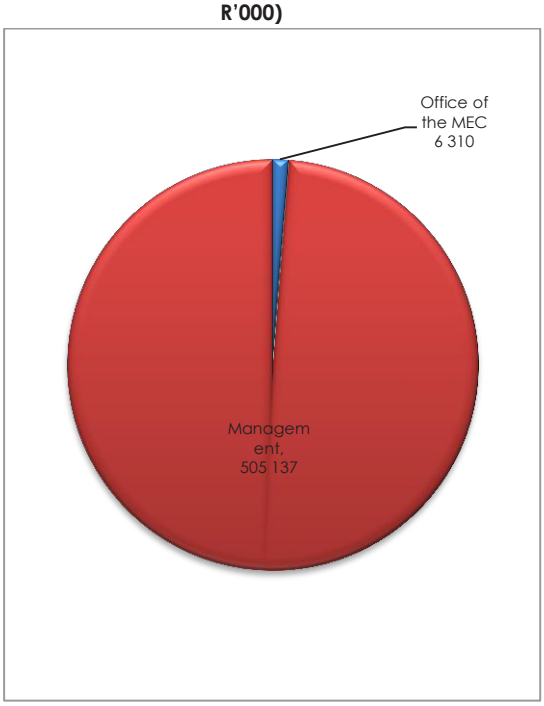


Figure B.3: Expenditure trends per economic classification in Administration, 2009 to 2013

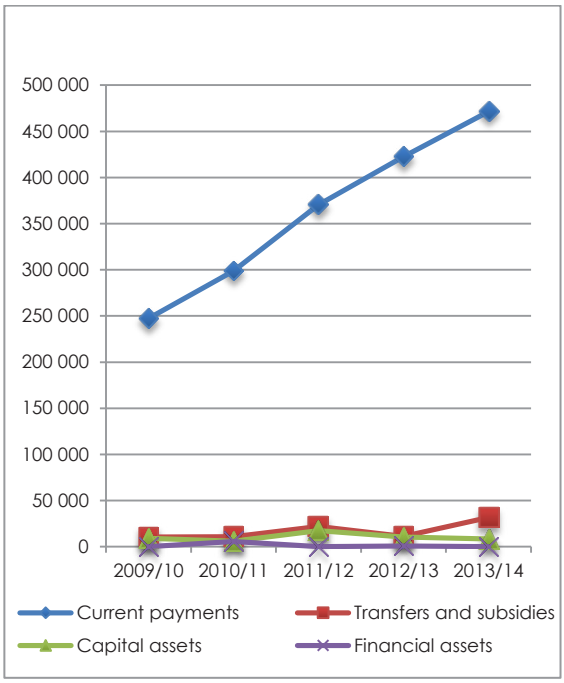
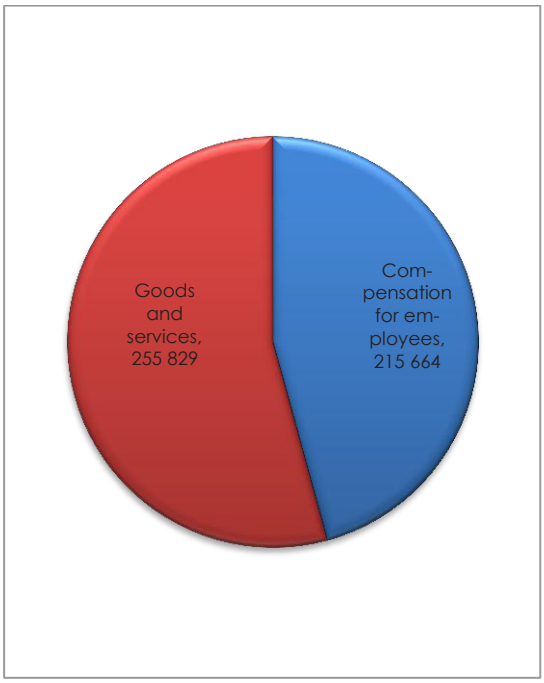


Figure B.4: Expenditure for current payments, 2013/14 (per R'000)



UNFUNDED PRIORITIES

- Expansion of the Chronic Dispensing Unit (CDU)
- Capacity building within Supply Chain Management (SCM), Internal Control and Quality Assurance

TRENDS IN THE SUPPLY OF KEY CATEGORIES OF HEALTH PERSONNEL

The recruitment and retention of key skilled staff remains a challenge within this programme. A contributing factor is the competition between government departments for skilled staff from a relatively limited pool. Categories of scarce and critical skills:

- Financial Accountants
- HR Practitioners
- Information Management Officers

7.6. Risk Management

RISK STATEMENT 1:	Shortage Of Skilled Staff
Risk	Inadequate competency levels
Root Cause	▪ Shortage of highly skilled professionals ▪ Inability to offer competitive remuneration packages
Measures to Mitigate Impact	▪ Allocation of bursaries per scarce-skilled profession as a recruitment strategy ▪ In the process of developing an on-line exit interview questionnaire to assist in identifying the reasons for exits and to inform future interventions ▪ Development and implementation of recruitment and retention policies ▪ Work in partnership with universities to recruit and retain highly skilled staff ▪ Strengthen organisational culture and staff wellbeing ▪ Succession planning ▪ Improve the working environment
RISK STATEMENT 2:	**Resource Constraints**
Risk	Inability to render comprehensive quality health services
Root Cause	▪ Allocative and technical inefficiencies ▪ Escalating burden of disease ▪ Escalating costs of labour, goods and services ▪ Fiscal envelope based on nominal growth ▪ Aging infrastructure
Impact	▪ Poor health outcomes ▪ Compromised ability to deliver on the department's mandate
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Priority setting ▪ Establish and embed mechanisms to enhance efficiencies ▪ Applying lean management principles to reduce waste in the system ▪ Rational prescribing ▪ Laboratory cost containment measures, e.g. Electronic Gatekeeping System ▪ Explore alternative financing options
RISK STATEMENT 3:	**ICT Systems Disruption**
Risk	Dysfunctional communication and information systems
Root Cause	▪ Inadequate and ageing technology infrastructure and resources ▪ Inadequate technical capacity within the Western Cape Government
Impact	▪ Compromised service delivery
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop a robust IT disaster recovery plan ▪ Monitor the responsiveness of the Helpdesk and support systems to IT system failures ▪ Constantly review and address out-dated infrastructure by conducting regular hardware and ICT audits
RISK STATEMENT 4:	**Fire Within Health Facilities**
Risk	Fire damage to state property and safety threat to building occupants
Root Cause	▪ Inadequate safety measures ▪ Constant trade-off between securing a building from a safety perspective versus maintaining the integrity of fire escapes etc. ▪ Building maintenance backlog and infrastructure budget constraints
Impact	▪ Service disruption ▪ Property damage ▪ Traumatised and/or injured staff and patients
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop and implement the Provincial Safety, Health, Environment, Risk, and Quality Management (SHERQ) Policy to support and guide facilities ▪ Ensure that design and construction of infrastructure is compliant through phased fire compliance ▪ Monitor and evaluate operational compliance with fire regulations ensuring that disaster plans and fire drills are in place ▪ Ensure compliance of the physical environment and physical entities such as fire detectors, fire extinguishers, alarms, sprinkler systems, fire doors, and fire exits are in order ▪ Establish Health and Safety committees, appoint and train emergency representatives (fire, first aid and floor marshals), in accordance with the National Core Standards

RISK STATEMENT 5:	Vandalism And Theft
Risk	Damage to and loss of state property
Impact	▪ Compromises the quality of care ▪ Property damage ▪ Escalates maintenance and repair expenditure
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Business continuity plans in place to minimise the impact on service delivery ▪ Installation of vandal-proof infrastructure including fixtures and fittings, as far as possible ▪ Improve security services and contract management at facility level
RISK STATEMENT 6:	**Fraud**
Risk	Unfair or unlawful access to public fund
Root Cause	▪ Inadequate (compliance with) internal controls ▪ Lack of commitment to values of the organisation
Impact	▪ Exacerbates resource constraints ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Monitor the implementation of the fraud prevention plan ▪ Ensure PERSAL is accurate to prevent ghost employees ▪ Embark upon change management initiative that emphasises the values of the organisation ▪ (Strengthening the DICU, ICU processes – IA, CA, etc.)
RISK STATEMENT 7:	**Labour Unrest**
Risk	Strike action
Root Cause	▪ Labour disputes
Impact	▪ Service disruption ▪ Compromises patient and staff safety ▪ Exacerbates resource constraints and staff shortages
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Maintaining good practices and relations with organised labour through robust structures of engagement ▪ In the event of a strike ensure contingency plans are in place to minimise service disruption
RISK STATEMENT 8:	**Load Shedding**
Risk	Disruption in the supply of electricity
Root Cause	▪ Eskom infrastructure ▪ Shortage in supply of diesel to support back-up power supply
Impact	▪ Service disruption ▪ Compromised quality of care ▪ Increased supply of and maintenance to alternative sources of power supply ▪ Increased diesel storage ▪ Cost of diesel supply ▪ Damage to electrical and electronic equipment (including medical) due to power surge
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Backup power supply in place for priority services ▪ Reduce dependency on Eskom by investing in alternative energy sources ▪ Business continuity plans in place to minimise the impact on service delivery ▪ Ensures adequate diesel supply and storage

8. Programme 2: DISTRICT HEALTH SERVICES

8.1. Purpose

To render facility-based district health services (at clinics, community health centres and district hospitals) and community-based district health services (CBS) to the population of the Western Cape Province

8.2. Structure

SUB-PROGRAMME 2.1: DISTRICT MANAGEMENT

Management of District Health Services, corporate governance, including financial, human resource management and professional support services e.g. infrastructure and technology planning and quality assurance (including clinical governance)

SUB-PROGRAMME 2.2: COMMUNITY HEALTH CLINICS

Rendering a nurse-driven primary health care service at clinic level including visiting points and mobile clinics

SUB-PROGRAMME 2.3: COMMUNITY HEALTH CENTRES

Rendering a primary health care service with full-time medical officers, offering services such as: mother and child health, health promotion, geriatrics, chronic disease management, occupational therapy, physiotherapy, psychiatry, speech therapy, communicable disease management, mental health and others

SUB-PROGRAMME 2.4: COMMUNITY BASED SERVICES

Rendering a community based health service at non–health facilities in respect of home-based care, community care workers, caring for victims of abuse, mental- and chronic care, school health, etc.

SUB-PROGRAMME 2.5: OTHER COMMUNITY SERVICES

Rendering environmental and port health services (port health services have moved to the National Department of Health)

SUB-PROGRAMME 2.6: HIV/AIDS

Rendering a primary health care service in respect of HIV/Aids campaigns

SUB-PROGRAMME 2.7: NUTRITION

Rendering a nutrition service aimed at specific target groups, combining direct and indirect nutrition interventions to address malnutrition

SUB-PROGRAMME 2.8: CORONER SERVICES

Rendering forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death; these services are reported in Sub-Programme 7.3: Forensic Pathology Services.

SUB-PROGRAMME 2.9: DISTRICT HOSPITALS

Rendering of a district hospital service at sub-district level

SUB-PROGRAMME 2.10: GLOBAL FUND

Strengthen and expand the HIV and AIDS prevention, care and treatment Programmes

NOTE: Tuberculosis (TB) hospitals are funded from Programme 4.2 but are managed as part of the district health system and are the responsibility of the district directors. The narrative and tables for TB hospitals is in Sub-Programme 4.2.

8.3. Key Components

DISTRICT HEALTH SYSTEM

Governance Structure of the DHS

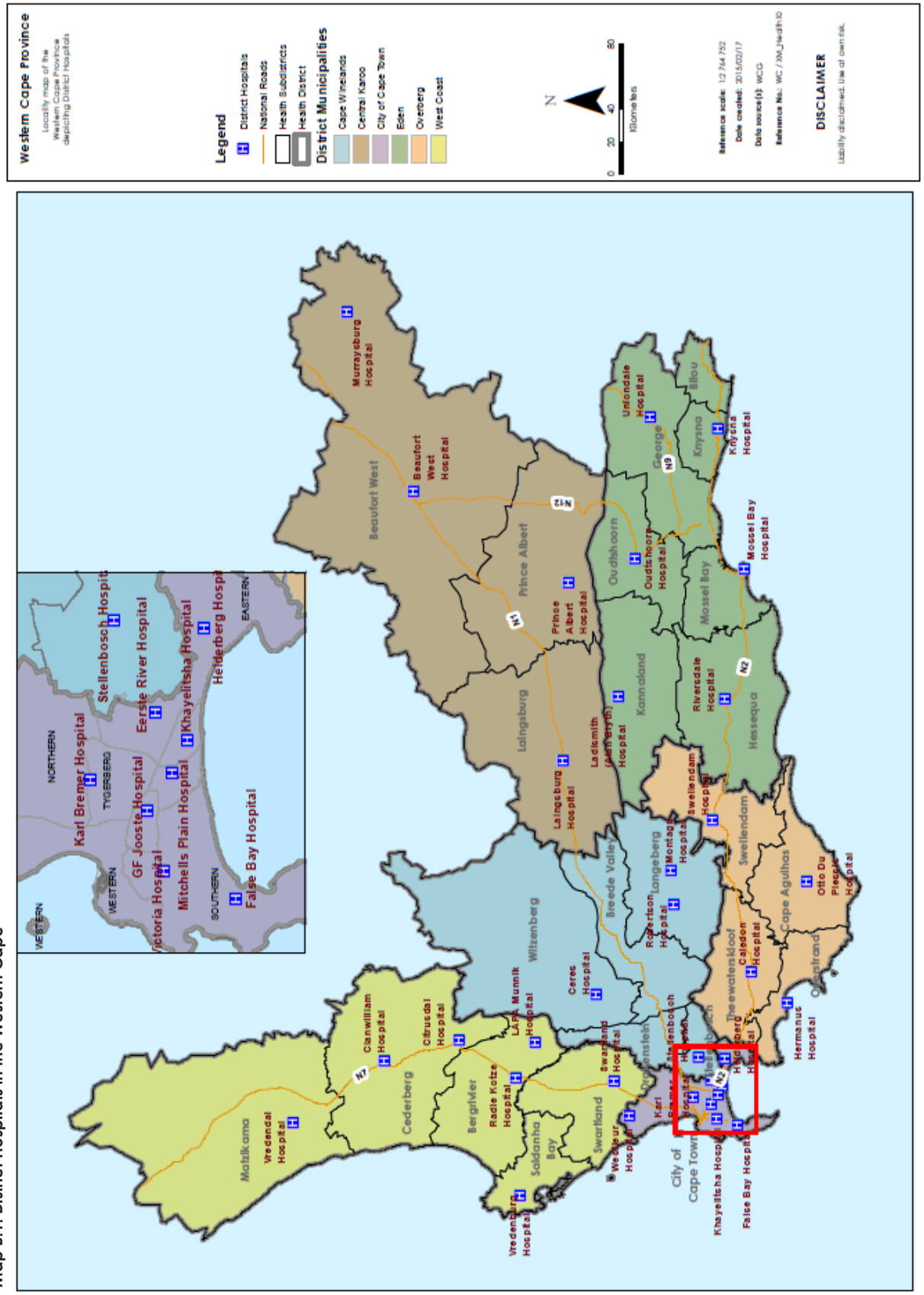
In line with the National Health Act (No. 61 of 2003), six district management structures were formalised during the 2008/09 financial year: one urban (the Cape Town Metro District) and five rural districts. The Cape Town Metro District has been further sub-divided into four sub-structures, each comprising of two sub-districts. This arrangement was necessitated by the population size and proportion of the burden of disease located within the geographical area. Each of the five rural districts and the four sub-structures in the Cape Town Metro District is managed by a director, who is responsible for ensuring that district health services are efficiently and effectively delivered. Each director in the Metro district reports to the Chief Director: MDHS and each rural director reports to the Chief Director: Rural DHS.

The districts and the location of the district offices are presented below:

1. City of Cape Town Cape Town Metro District — Cape Town City Centre
2. Cape Winelands District: — Worcester
3. Overberg District: — Caledon
4. West Coast District: — Malmesbury
5. Eden District: — George
6. Central Karoo District: — Beaufort West

The Department assumed responsibility for personal primary health care services (PPHC) in the rural districts in 2005. The Metro district has a dual authority; there is a service level agreement between the provincial government (Metro District Health Services) and the City of Cape Town Municipality regarding the delivery of personal primary health care services. Environmental health services in Cape Town are provided by the Municipality.

Since 2010 each district has a functional District Health Council, operating in accordance with the legislative framework.



Map B.1: District Hospitals in the Western Cape

Primary Health Care Services

Primary health care services consist of the following three care settings:

Home and Community Based Care (HCBC)

HCBC is rendered in the living, learning, working, and social and/or play spaces of the people we serve and involve an array of interventions that are largely preventative in nature. The service is outsourced to local Non-Profit Organisations (NPO) who employs a combination of lay-workers and health professionals to provide the much needed care.

Intermediate Care

This element refers to in-patient transitional care for children and adults, which facilitates optimal recovery from an acute illness or complications of a long-term condition; enabling users to regain skills and abilities in daily living, with the ultimate discharge destination being home or an alternate supported living environment. It involves post-acute, rehabilitative and end-of-life care, which includes comprehensive assessment, structured care planning, active therapy, treatment and/or an opportunity to recover. It allows for a seamless transition between acute care and the living environment; particularly where the person's ability to self-care is significantly compromised, a supported discharge thus becomes crucial to a successful recovery process. The focus of this service element is on improving people's functioning so that they can resume living at home and enjoy the best possible quality of life.

Primary Care

This service provides generalist ambulatory care with a comprehensive range of curative and preventative services on offer. These services are primarily provided in health facilities like clinics, Community Day Centres (CDC) and Community Health Centres (CHC).

District Hospitals (Acute services)

The package of care provided at a district hospital includes trauma and emergency care, in-patient care, outpatient visits and paediatric and obstetric care. A limited number of general specialist services are offered at the larger district hospitals to improve access and to facilitate easy referral to Level 2 general specialist facilities.

There are 34 district hospitals in the Province. Nine are located within the City of Cape Town Metro District. There are on average four district hospitals in each of the rural districts, with the exception of the West Coast where there are seven district hospitals. Since 2008/09, the six provincial TB hospitals form part of Programme 2 are managed by the respective district or sub-structure manager.

Environmental and Port Health Services

Surveillance at the three major harbours in the Western Cape, i.e. Cape Town, Saldanha and Mossel Bay, as well as at the Cape Town International Airport is reverting back to the National Department of Health (NDoH) in terms of the amended Health Act. The co-ordination of environmental services in the amended Act still remains a provincial function with the responsibility of surveillance of government premises reverting to being part of Municipal Environmental Health services. NDoH has been amending municipal health indicators and the Province has been ensuring that the Municipalities are up to date with these indicator amendments.

8.4. Strategic Objectives

GOAL: PROMOTE HEALTH AND WELLNESS

Table B.2: Strategic objectives and expected outcomes for District Health Services

Strategic objective (short title)	Strategic objective statement (SMART)	Indicator	Baseline (2013/14)	Target (2019/20)
1. Improve the proportion of ART clients who remain in care	1.1. 85% of people who initiate ART must remain in care after 12 months by 2019/20	1.1.1. ART retention in care after 12 month	74.8%	85.0%
		Numerator:	21 662	29 750
		Denominator:	28 960	35 000
	1.2. 70% of people who initiate ART must remain in care after 48 months	1.2.1. ART retention in care after 48 months	68.0%	70.0%
		Numerator:	4010	24 500
		Denominator:	5820	35 000
2. Improve the TB programme success rate	2.1. TB programme must have 85 % success rate in 2019/20.	2.1.1. TB programme success rate	81.5%	85.0%
		Numerator:	37 626	40 800
		Denominator:	46 187	48 000
3. Reduce mortality in children under 5 years	3.1. An under 5 years mortality rate of <18.0/1 000 children by 2019/20.	3.1.1. Under 5 mortality rate (Stats SA)	28.6/1 000	18/1000
		Numerator:	2 981	1 999
		Denominator:	104.102	99.347

8.5. Resource Considerations

The past years have seen growth in real terms, the budgets allocated to the department for the MTEF period does however not enable further real growth. Any new priorities or initiatives, and growth in work load must be accommodated by reprioritisation from lower value to higher value activities. Total staff numbers will increase marginally due to the filling of funded posts, but additional posts will not be made available unless the financial envelope for discretionary spending increases in real terms.

EXPENDITURE TRENDS

In 2013/14 Programme 2 contributed 37.9 per cent to the overall departmental expenditure. The new Khayelitsha Hospital has been largely funded through reprioritisation of existing services as well as the shift of services from existing facilities to the new hospital. The new Mitchells Plain Hospital has been funded through reprioritisation. The Heideveld Emergency Centre and the Carnation Ward would still run as entities supporting the immediate needs of the Klipfontein community until the GF Jooste Hospital is rebuilt in the next few years.

The Global Fund's Rolling Continuation Channel (RCC-I) funding enabled the Department to strengthen grant programme management; expand anti-retroviral treatment (ART) infrastructure and ART services;

strengthen the prevention of mother-to-child transmission (PMTCT) system, peer education and palliative care services. The RCC–II has been approved from 1 October 2013 to 31 March 2016 for grant programme funding. Peer education has been taken over by Western Cape Government: Education and is no longer part of the programme.

Figure B.5: **Expenditure trends in District Health Services, 2009 to 2013**

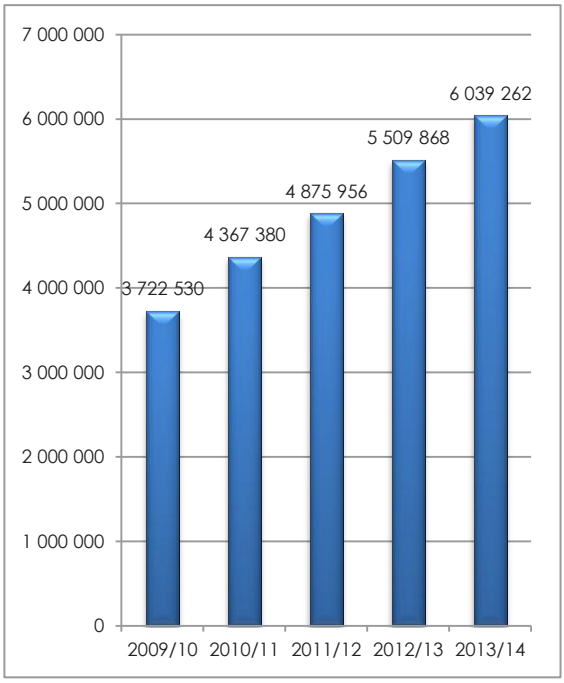


Figure B.6: **Expenditure per sub-programme in District Health Services, 2013/14 (per R'000)**

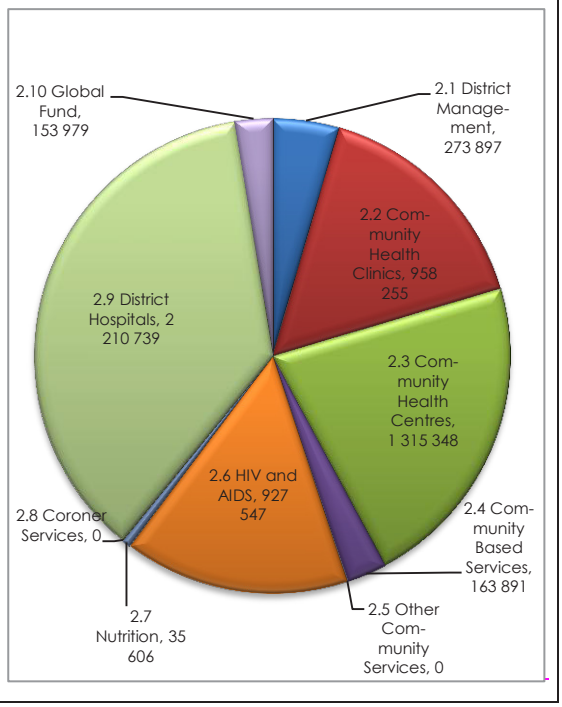


Figure B.7: Expenditure trends per economic classification in District Health Services, 2009 to 2013

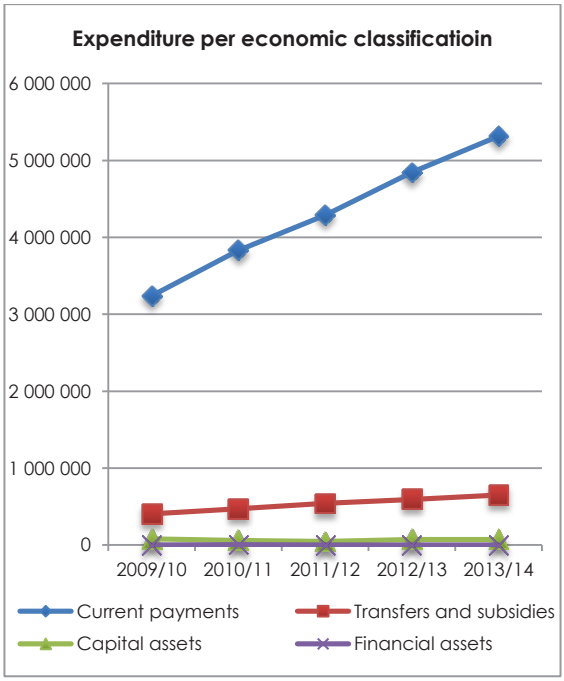
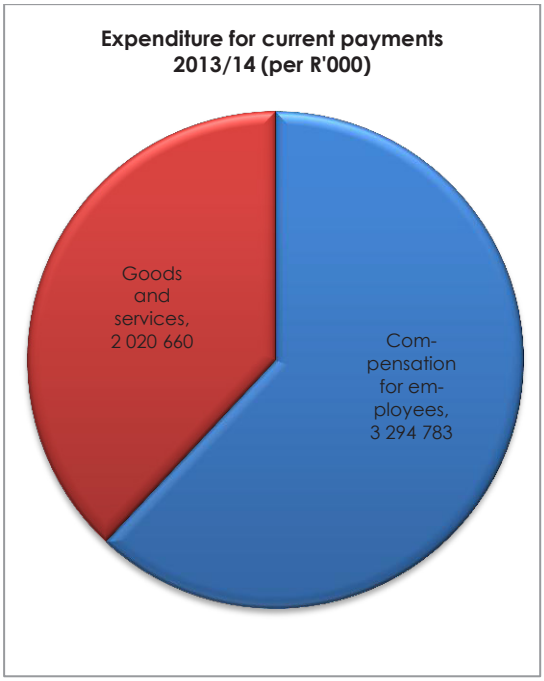


Figure B.8: Expenditure for current payments, 2013/14



UNFUNDED PRIORITIES

- Integration of the personal primary health care services in the City of Cape Town District (provincialisation)
- Commission of certain new facilities
- Reduction of the Conditional Grant for HIV/Aids

TRENDS IN THE SUPPLY OF KEY CATEGORIES OF HEALTH PERSONNEL

The recruitment and retention of key skilled staff remains a challenge within this programme. A contributing factor is the competition from the private sector as well as the overseas market, especially for nursing and medical doctors. Occupational groups that are mostly affected include:

- Professional Nurses in certain specialties, operating theatre, primary health care (rural areas), critical care, trauma and emergency, midwifery and orthopaedics.
- Medical specialists in Emergency Medicine, Family Medicine (rural),
- Radiographers, especially ultra-sonographers.

8.6. Risk Management

RISK STATEMENT 1:	**Shortage Of Skilled Staff**
Risk	Inadequate competency levels
Root Cause	▪ Shortage of highly skilled professionals ▪ Inability to offer competitive remuneration packages
Impact	▪ Compromised ability to deliver on the Department's mandate
Strategic Goal Impact	▪ Promote Health and Wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Allocation of bursaries per scarce-skilled profession as a recruitment strategy ▪ In the process of developing an on-line exit interview questionnaire to assist in identifying the reasons for exits and to inform future interventions ▪ Development and implementation of recruitment and retention policies ▪ Work in partnership with universities to recruit and retain highly skilled staff ▪ Strengthen organisational culture and staff wellbeing ▪ Succession planning ▪ Improve the working environment
RISK STATEMENT 2:	**Fragmented PHC Services**
Risk	Inefficient health service
Root Cause	▪ Dual authority in the City of Cape Town District ▪ Programmatic approach to priority diseases
Impact	▪ Poor health outcomes
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Integration of PHC services ▪ Health systems approach
RISK STATEMENT 3:	**Staff Safety**
Risk	Increased staff safety related, adverse incidents
Root Cause	▪ Volatility in the community e.g. gang violence, inter-personal violence ▪ High prevalence of infectious diseases e.g. HIV/AIDS and TB ▪ Inadequate Occupational Health and Safety measures ▪ Inadequate security measures
Impact	▪ Compromised employee wellness
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Safety guidelines and protocols that empower staff to make decisions around their own safety ▪ Raise employee awareness on safety in the workplace ▪ Ensuring optimal security measures are in place at health facilities ▪ Engage the SAPS and community safety stakeholders on ways in which closer collaboration and interagency partnerships could assist in securing the physical safety of staff ▪ Robust OHS measures in place
RISK STATEMENT 4:	**Resource Constraints**
Risk	Inability to render comprehensive quality health services
Root Cause	▪ Allocative and technical inefficiencies ▪ Escalating burden of disease ▪ Escalating costs of labour, goods and services ▪ Fiscal envelope based on nominal growth ▪ Aging infrastructure
Impact	▪ Poor health outcomes ▪ Compromised ability to deliver on the department's mandate
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Priority setting ▪ Establish and embed mechanisms to enhance efficiencies ▪ Applying lean management principles to reduce waste in the system ▪ Rational prescribing ▪ Laboratory cost containment measures, e.g. Electronic Gatekeeping System ▪ Explore alternative financing options

RISK STATEMENT 5:	Medico Legal Claims
Risk	Increasing litigation against the department as a result of malpractice and negligence
Root Cause	▪ Increasing service pressures ▪ Inadequate clinical governance mechanisms ▪ Technical inefficiencies
Impact	▪ Compromised quality of care ▪ Escalating expenditure ▪ Compromised public trust in the health system (reputational damage)
Strategic Goal Impact	▪ Promote Health and Wellness
Measures to Mitigate Impact	▪ Adverse incidence reporting system ▪ Strengthen clinical governance and antibiotic stewardship ▪ Contingency plans in place for service surges
RISK STATEMENT 6:	**Pharmaceutical Stock-outs**
Risk	Unavailability of essential pharmaceutical goods and services
Root Cause	▪ Supplier challenges e.g. global shortages of ingredients ▪ Lack of timeous and good contract management ▪ Inability to secure alternatives ▪ Late or inadequate awarding of national pharmaceutical contracts
Impact	▪ Compromises the quality of care ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Engage National Department of Health on timeous awarding of national tenders ▪ Monitor stocks out regularly ▪ Monitor vaccine supply ▪ Provide alternatives to the essential medicines, where possible ▪ Tight contract management with suppliers ▪ Create provincial contracts for items that have been excluded from the revised national tenders, where possible
RISK STATEMENT 7:	**ICT Systems Disruption**
Risk	Dysfunctional communication and information systems
Root Cause	▪ Inadequate and ageing technology infrastructure and resources ▪ Inadequate technical capacity within the Western Cape Government
Impact	▪ Compromised service delivery
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop a robust IT disaster recovery plan ▪ Monitor the responsiveness of the Helpdesk and support systems to IT system failures ▪ Constantly review and address out-dated infrastructure by conducting regular hardware and ICT audits
RISK STATEMENT 8:	**Fire Within Health Facilities**
Risk	Fire damage to state property and safety threat to building occupants
Root Cause	▪ Inadequate safety measures ▪ Constant trade-off between securing a building from a safety perspective versus maintaining the integrity of fire escapes etc. ▪ Building maintenance backlog and infrastructure budget constraints
Impact	▪ Service disruption ▪ Property damage ▪ Traumatised and/or injured staff and patients
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop and implement the Provincial Safety, Health, Environment, Risk, and Quality Management (SHERQ) Policy to support and guide facilities ▪ Ensure that design and construction of infrastructure is compliant through phased fire compliance ▪ Monitor and evaluate operational compliance with fire regulations ensuring that disaster plans and fire drills are in place ▪ Ensure compliance of the physical environment and physical entities such as fire detectors, fire extinguishers, alarms, sprinkler systems, fire doors, and fire exits are in order ▪ Establish Health and Safety committees, appoint and train emergency representatives (fire, first aid and floor marshals), in accordance with the National Core Standards

RISK STATEMENT 9:	Vandalism And Theft
Risk	Damage to and loss of state property
Root Cause	▪ Inadequate security measures ▪ Volatility in the community ▪ High crime prevalence
Impact	▪ Compromises the quality of care ▪ Property damage ▪ Escalates maintenance and repair expenditure
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Business continuity plans in place to minimise the impact on service delivery ▪ Installation of vandal-proof infrastructure including fixtures and fittings, as far as possible ▪ Improve security services and contract management at facility level
RISK STATEMENT 10:	**Fraud**
Risk	Unfair or unlawful access to public fund
Root Cause	▪ Inadequate (compliance with) internal controls ▪ Lack of commitment to values of the organisation
Impact	▪ Exacerbates resource constraints ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Monitor the implementation of the fraud prevention plan ▪ Ensure PERSAL is accurate to prevent ghost employees ▪ Embark upon change management initiative that emphasises the values of the organisation ▪ (Strengthening the DICU, ICU processes – IA, CA, etc.)
RISK STATEMENT 11:	**Labour Unrest**
Risk	Strike action
Root Cause	▪ Labour disputes
Impact	▪ Service disruption ▪ Compromises patient and staff safety ▪ Exacerbates resource constraints and staff shortages
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Maintaining good practices and relations with organised labour through robust structures of engagement ▪ In the event of a strike ensure contingency plans are in place to minimise service disruption
RISK STATEMENT 12:	**Load Shedding**
Risk	Disruption in the supply of electricity
Root Cause	▪ Eskom infrastructure ▪ Shortage in supply of diesel to support back-up power supply
Impact	▪ Service disruption ▪ Compromised quality of care ▪ Increased supply of and maintenance to alternative sources of power supply ▪ Increased diesel storage ▪ Cost of diesel supply ▪ Damage to electrical and electronic equipment (including medical) due to power surge
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Backup power supply in place for priority services ▪ Reduce dependency on Eskom by investing in alternative energy sources ▪ Business continuity plans in place to minimise the impact on service delivery ▪ Ensures adequate diesel supply and storage
RISK STATEMENT 13:	**Ebola**
Risk	Ebola Outbreak
Root Cause	▪ Failure in outbreak prevention strategies
Impact	▪ Fatalities ▪ Increased pressure on the health system
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Ebola outbreak preparedness plan in place ▪ Ebola surveillance strategies in place

RISK STATEMENT 14:	Affordability of the infrastructure requirements of Healthcare 2030
Risk	Affordability of delivering on required infrastructure in order to meet objectives of Healthcare 2030.
Root Cause	▪ Limited financial resources ▪ Inappropriate and over-designed infrastructure that is too complex and costly to construct and maintain. ▪ Current condition and functional limitations of existing health infrastructure portfolio
Impact	▪ Compromised healthcare services.
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices.
Measures to Mitigate Impact	▪ Develop standard health infrastructure designs which are appropriate to a developing economy ▪ Ensure compliance to standard designs, where appropriate and possible. ▪ Explore alternative finance options. ▪ Application of Prioritisation Tool for capital projects. ▪ Increase resources for maintenance of existing facilities.

9. Programme 3: EMERGENCY MEDICAL SERVICES

9.1. Purpose

To render pre-hospital emergency medical services including inter-hospital transfers, and planned patient transport; including clinical governance and co-ordination of emergency medicine within the Provincial Health Department

9.2. Structure

SUB-PROGRAMME 3.1: EMERGENCY TRANSPORT

To render emergency medical services including ambulance services, special operations, communications and air ambulance services

SUB-PROGRAMME 3.2: PLANNED PATIENT TRANSPORT

To render planned patient transport including local outpatient transport (within the boundaries of a given town or local area) and inter-city/town outpatient transport (into referral centres)

9.3. Key Components

EMERGENCY MEDICAL SERVICES (EMS)

Access to emergency care is established through the Constitution of South Africa and the National Health Act and is prioritised within the vision for Healthcare 2030. EMS is delivered through 49 ambulance stations in five rural districts and four Cape Town divisional EMS services with a fleet of 250 ambulances and 1 334 operational personnel and 122 supervisors (officers). Each district has an emergency contact centre which doubles as a disaster risk management centre in the rural districts.

In line with Healthcare 2030, a modernised software application will be implemented in the communication centre to enhance its operations by enabling better management reporting in real time and improving communication with emergency centres at hospitals. The bed bureau to monitor the availability of acute beds in all the major hospitals will be strengthened.
Aero-medical service will continue to play a vital role in the emergency transfer of complex patients. Non-acute patient transport service will be strengthened as a key component for access to services (especially for rural patients) and will improve efficiencies of acute hospitals by facilitating only those patients that have difficulty with transport out of these hospitals.

EMS includes the following components:

Communication Services

EMS receives and processes telephonic requests for assistance from the general public. Calls must be answered within three rings and take 120 seconds to process and dispatch. Calls are prioritised based on the information received from the caller at the scene, and vehicles are dispatched accordingly.

Ambulance services

EMS is the first point of medical contact to the injured or acutely ill. Patients will receive basic medical assistance on the scene of the incident and will then be transported to the nearest appropriate health care facility for definitive treatment. Currently 40 per cent of EMS acute transfers in Cape Town are between facilities and the Department will strive to reduce inappropriate inter-facility transfers.

Medical rescue services

Medical rescue services provide, in addition to patient care, the extraction of patients trapped in some physical environment, e.g. by using the "jaws of life". In addition Cape Town supports aquatic rescue through missions with the South African Airforce (SAAF) to provide air-sea-rescue of medical casualties recovered from ships at sea under the authority of the South African Maritime Safety Authority (SAMSA) and the Maritime Rescue Co-ordination Centre (MRCC), a diving rescue squad, swift water rescue, National Sea Rescue Institute (NSRI) rescue and in-shore rescue with the NSRI through the aero-medical programme. The EMS also has a hyperbaric service centre providing a decompression service for anybody with diving illness and governed by experts in the field.

Aero-medical services

The service, which is contracted out to an aviation medical services provider, includes acute primary scene responses for mainly traffic accidents and Wilderness Search and Rescue (WSAR) incidents, and acute inter-facility responses. The latter is provided by one fixed-wing aircraft for transfers from locations between 200km and 500km from Cape Town, and helicopters in Oudtshoorn and Cape Town that service a radius of 200km from the respective bases. Patients are transferred to the regional hospitals in George, Worcester and Paarl, and the central and tertiary hospitals in Cape Town, i.e. Groote Schuur, Tygerberg and Red Cross War Memorial Children's Hospital.

Disaster management

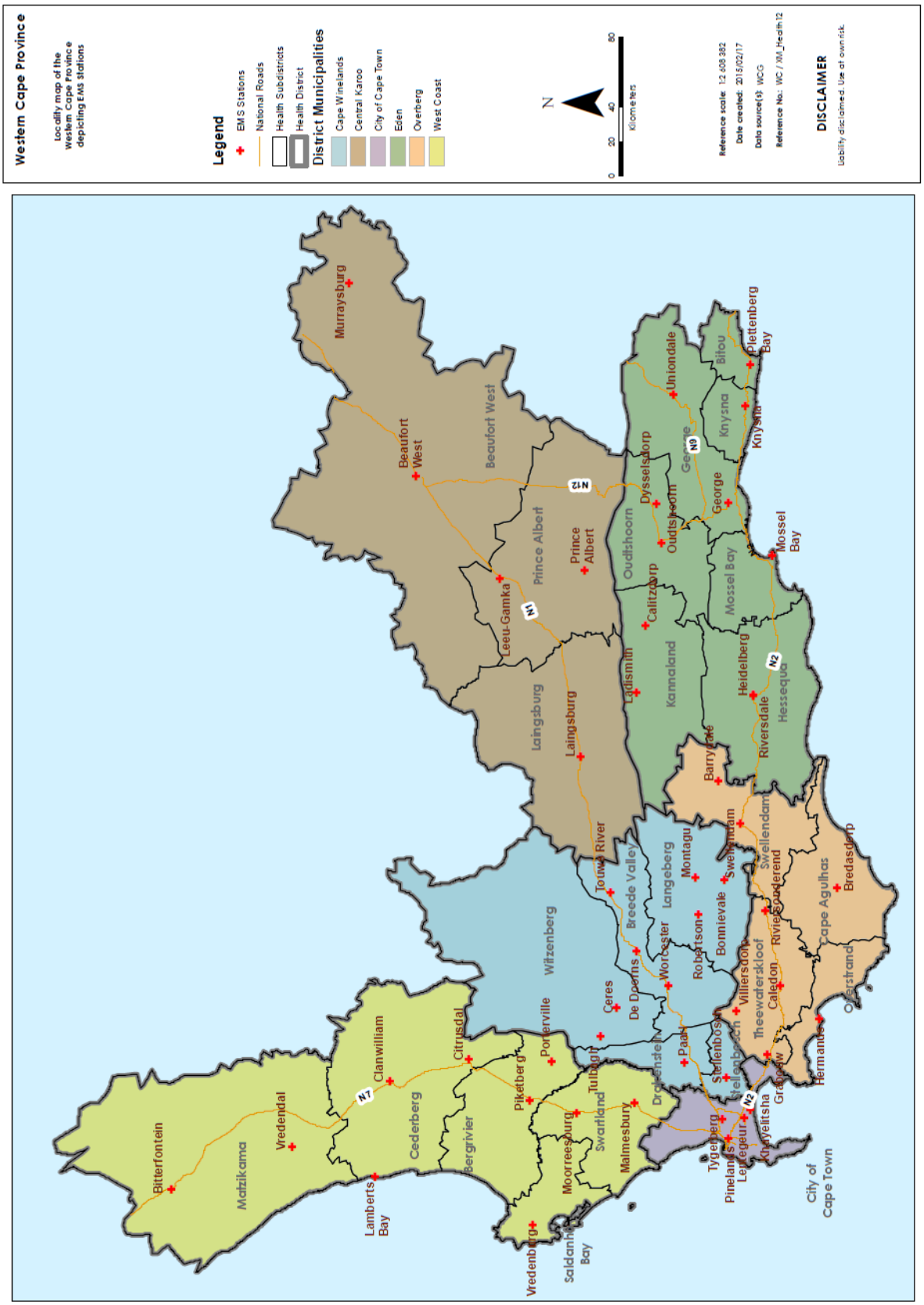
This component plays a key role in disaster preparedness from events such as terror or extreme weather, or any major incident such as Ebola, requiring very good collaboration with other stakeholders, departments and spheres of government. It is also responsible for the planning, provision and co-ordination of the EMS response to sporting and community events such as the Argus Cycle Tour and the Two Oceans Marathon.

Emergency medicine

Emergency medicine is a relatively new discipline in South Africa and plays a key role in connecting emergency services outside of health facilities with the emergency centres in hospitals.
Emergency centres have been identified as an important priority and the Department has been systematically strengthening the system through modernising the infrastructure and equipment, and appointing emergency medicine specialist in large district and regional hospitals.

Patient transport services

Outpatient transport is provided by HealthNET (health non-emergency transport) which operates five days a week for incoming referrals and seven days a week for outgoing transportations. Patient transport services are delivered with 82 vehicles and 90 drivers that drive specified transport routes to referral hospitals, transporting patients to ambulatory care appointments through hubs at district centres. Patients will only be transported to their personal residence if they are in a wheelchair, on a stretcher, on renal dialysis or over 60 years of age.



Map B.2: EMS Stations in the Western Cape

9.4. Strategic Objectives

GOAL: PROMOTE HEALTH AND WELLNESS

Table B.4: Strategic objectives and expected outcomes for Emergency Medical Services

Strategic objective (short title)	Strategic objective statement (SMART)	Indicator	Baseline (2013/14)	Target (2019/20)
1. Ensure registration and licensing of ambulances as per the statutory requirements*	1.1. Ensure at least 95% of all WCG: Health's rostered ambulances are registered and licensed in accordance with the statutory requirements* by 2019/20.	1.1.1. Percentage of WCG: Health rostered ambulances registered and licensed		
		Numerator:	0	181
		Denominator:	166	191

*The National Health Act: Regulations: Emergency Medical Services likely to take effect within the 2015 MTEF period.

9.5. Resource Considerations

The past years have seen growth in real terms, the budgets allocated to the department for the MTEF period does however not enable further real growth. Any new priorities or initiatives, and growth in work load must be accommodated by reprioritization from lower value to higher value activities. Total staff numbers will continue to increase marginally due to the filling of funded posts, but additional posts will not be made available unless the financial envelope for discretional spending increases in real terms.

EXPENDITURE TRENDS

The programme remains under pressure as is evident by the projected expenditure. In planning the budget process, funding streams have been geared towards achieving the strategic objectives within the next five years. Efficient co-ordination of EMS resources is dependent on an effective information communication technology solution which enables quick patient access and prompt ambulance dispatch.

In 2013/14 Programme 3 contributed 5.2 per cent to the overall departmental expenditure.

Figure B.9: **Expenditure trends in EMS, 2009 to 2013**

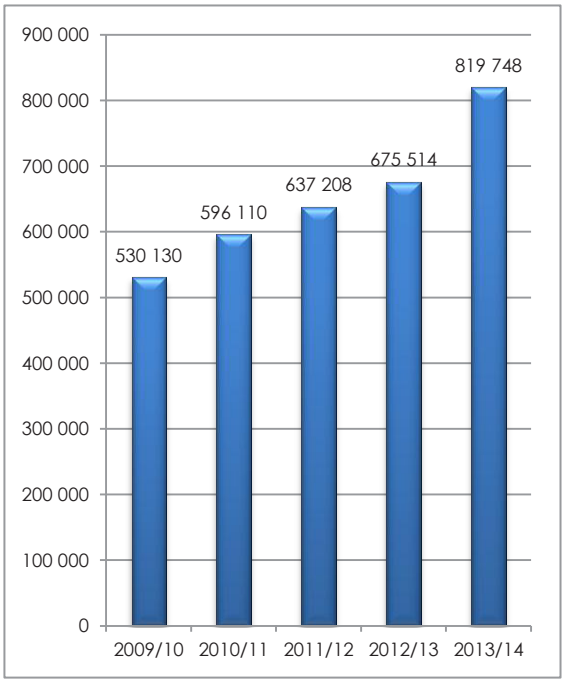


Figure B.10: **Expenditure per sub-programme in EMS, 2013/14 (per R'000)**

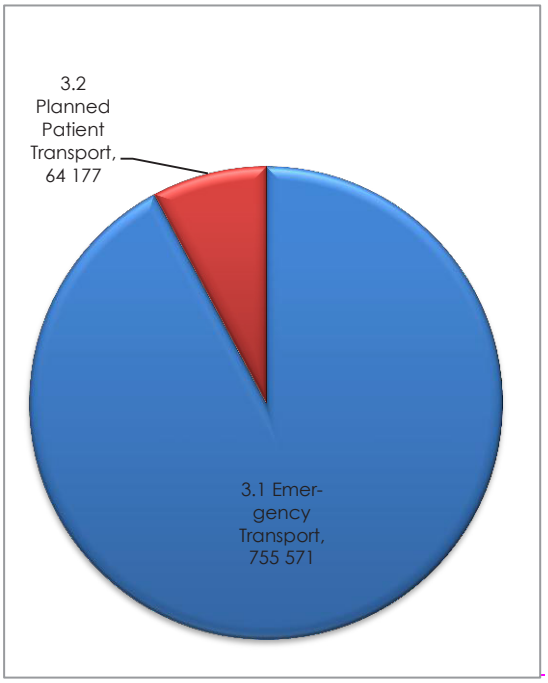


Figure B.11: **Expenditure trends per economic classification in Emergency Medical Services, 2009 to 2013**

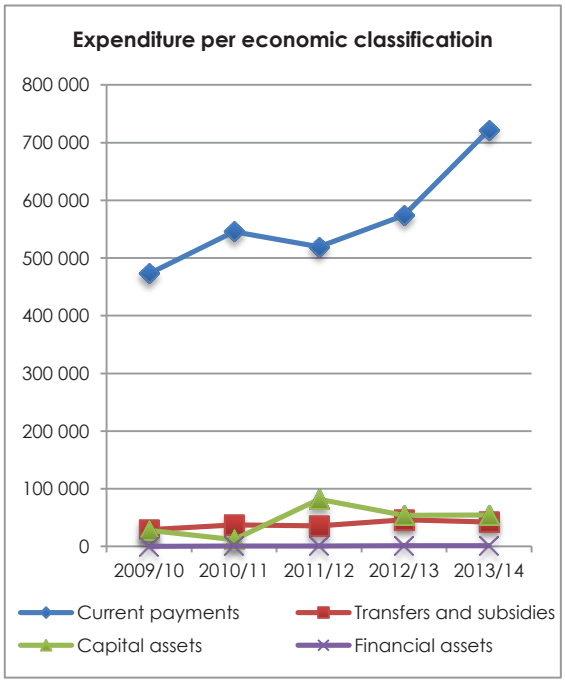
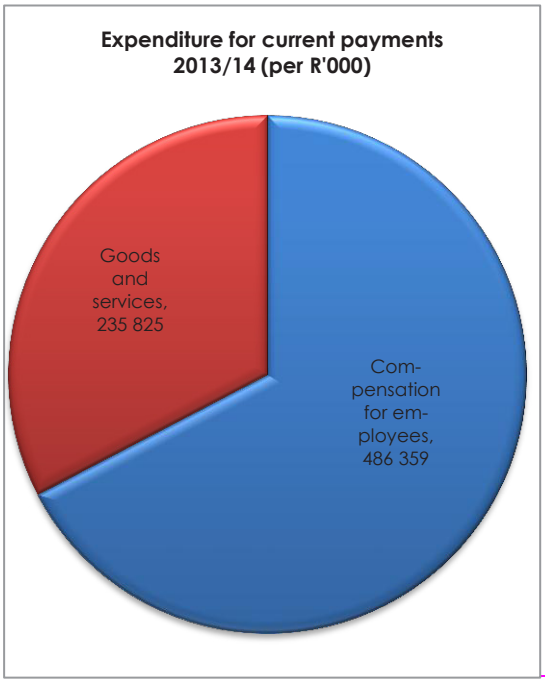


Figure B.12: **Expenditure for current payments, 2013/14**



UNFUNDED PRIORITIES

While none of the priorities for this budget programme are entirely unfunded, it is important to note that certain aspects are inadequately funded.

TRENDS IN THE SUPPLY OF KEY CATEGORIES OF HEALTH PERSONNEL

In terms of recruitment and retention of key skilled staff it remains a challenge to recruit and retain paramedics as the remuneration packages within the private sector are more lucrative.

9.6. Risk Management

RISK STATEMENT 1:	**Shortage Of Skilled Staff**
Risk	Inadequate competency levels
Root Cause	▪ Shortage of highly skilled professionals ▪ Inability to offer competitive remuneration packages
Impact	▪ Compromised ability to deliver on the Department's mandate
Strategic Goal Impact	▪ Promote Health and Wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Allocation of bursaries per scarce-skilled profession as a recruitment strategy ▪ In the process of developing an on-line exit interview questionnaire to assist in identifying the reasons for exits and to inform future interventions ▪ Development and implementation of recruitment and retention policies ▪ Work in partnership with universities to recruit and retain highly skilled staff ▪ Strengthen organisational culture and staff wellbeing ▪ Succession planning ▪ Improve the working environment
RISK STATEMENT 2:	**Staff Safety**
Risk	Increased staff safety related, adverse incidents
Root Cause	▪ Volatility in the community e.g. gang violence, inter-personal violence ▪ High prevalence of infectious diseases e.g. HIV/AIDS and TB ▪ Inadequate Occupational Health and Safety measures ▪ Inadequate security measures
Impact	▪ Compromised employee wellness
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Safety guidelines and protocols that empower staff to make decisions around their own safety ▪ Raise employee awareness on safety in the workplace ▪ Ensuring optimal security measures are in place at health facilities ▪ Engage the SAPS and community safety stakeholders on ways in which closer collaboration and interagency partnerships could assist in securing the physical safety of staff ▪ Robust OHS measures in place
RISK STATEMENT 3:	**Resource Constraints**
Risk	Inability to render comprehensive quality health services
Root Cause	▪ Allocative and technical inefficiencies ▪ Escalating burden of disease ▪ Escalating costs of labour, goods and services ▪ Fiscal envelope based on nominal growth ▪ Aging infrastructure
Impact	▪ Poor health outcomes ▪ Compromised ability to deliver on the department's mandate
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Priority setting ▪ Establish and embed mechanisms to enhance efficiencies ▪ Applying lean management principles to reduce waste in the system ▪ Rational prescribing ▪ Laboratory cost containment measures, e.g. Electronic Gatekeeping System ▪ Explore alternative financing options

RISK STATEMENT 4:	Medico Legal Claims
Risk	Increasing litigation against the department as a result of malpractice and negligence
Root Cause	▪ Increasing service pressures ▪ Inadequate clinical governance mechanisms ▪ Technical inefficiencies
Impact	▪ Compromised quality of care ▪ Escalating expenditure ▪ Compromised public trust in the health system (reputational damage)
Strategic Goal Impact	▪ Promote Health and Wellness
Measures to Mitigate Impact	▪ Adverse incidence reporting system ▪ Strengthen clinical governance and antibiotic stewardship ▪ Contingency plans in place for service surges
RISK STATEMENT 5:	**Pharmaceutical Stock-outs**
Risk	Unavailability of essential pharmaceutical goods and services
Root Cause	▪ Supplier challenges e.g. global shortages of ingredients ▪ Lack of timeous and good contract management ▪ Inability to secure alternatives ▪ Late or inadequate awarding of national pharmaceutical contracts
Impact	▪ Compromises the quality of care ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Engage National Department of Health on timeous awarding of national tenders ▪ Monitor stocks out regularly ▪ Monitor vaccine supply ▪ Provide alternatives to the essential medicines, where possible ▪ Tight contract management with suppliers ▪ Create provincial contracts for items that have been excluded from the revised national tenders, where possible
RISK STATEMENT 6:	**ICT Systems Disruption**
Risk	Dysfunctional communication and information systems
Root Cause	▪ Inadequate and ageing technology infrastructure and resources ▪ Inadequate technical capacity within the Western Cape Government
Impact	▪ Compromised service delivery
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop a robust IT disaster recovery plan ▪ Monitor the responsiveness of the Helpdesk and support systems to IT system failures ▪ Constantly review and address out-dated infrastructure by conducting regular hardware and ICT audits
RISK STATEMENT 7:	**Fire Within Health Facilities**
Risk	Fire damage to state property and safety threat to building occupants
Root Cause	▪ Inadequate safety measures ▪ Constant trade-off between securing a building from a safety perspective versus maintaining the integrity of fire escapes etc. ▪ Building maintenance backlog and infrastructure budget constraints
Impact	▪ Service disruption ▪ Property damage ▪ Traumatised and/or injured staff and patients
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop and implement the Provincial Safety, Health, Environment, Risk, and Quality Management (SHERQ) Policy to support and guide facilities ▪ Ensure that design and construction of infrastructure is compliant through phased fire compliance ▪ Monitor and evaluate operational compliance with fire regulations ensuring that disaster plans and fire drills are in place ▪ Ensure compliance of the physical environment and physical entities such as fire detectors, fire extinguishers, alarms, sprinkler systems, fire doors, and fire exits are in order ▪ Establish Health and Safety committees, appoint and train emergency representatives (fire, first aid and floor marshals), in accordance with the National Core Standards

RISK STATEMENT 8:	Vandalism And Theft
Risk	Damage to and loss of state property
Root Cause	▪ Inadequate security measures ▪ Volatility in the community ▪ High crime prevalence
Impact	▪ Compromises the quality of care ▪ Property damage ▪ Escalates maintenance and repair expenditure
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Business continuity plans in place to minimise the impact on service delivery ▪ Installation of vandal-proof infrastructure including fixtures and fittings, as far as possible ▪ Improve security services and contract management at facility level
RISK STATEMENT 9:	**Fraud**
Risk	Unfair or unlawful access to public fund
Root Cause	▪ Inadequate (compliance with) internal controls ▪ Lack of commitment to values of the organisation
Impact	▪ Exacerbates resource constraints ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Monitor the implementation of the fraud prevention plan ▪ Ensure PERSAL is accurate to prevent ghost employees ▪ Embark upon change management initiative that emphasises the values of the organisation ▪ (Strengthening the DICU, ICU processes – IA, CA, etc.)
RISK STATEMENT 10:	**Labour Unrest**
Risk	Strike action
Root Cause	▪ Labour disputes
Impact	▪ Service disruption ▪ Compromises patient and staff safety ▪ Exacerbates resource constraints and staff shortages
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Maintaining good practices and relations with organised labour through robust structures of engagement ▪ In the event of a strike ensure contingency plans are in place to minimise service disruption
RISK STATEMENT 11:	**Load Shedding**
Risk	Disruption in the supply of electricity
Root Cause	▪ Eskom infrastructure ▪ Shortage in supply of diesel to support back-up power supply
Impact	▪ Service disruption ▪ Compromised quality of care ▪ Increased supply of and maintenance to alternative sources of power supply ▪ Increased diesel storage ▪ Cost of diesel supply ▪ Damage to electrical and electronic equipment (including medical) due to power surge
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Backup power supply in place for priority services ▪ Reduce dependency on Eskom by investing in alternative energy sources ▪ Business continuity plans in place to minimise the impact on service delivery ▪ Ensures adequate diesel supply and storage
RISK STATEMENT 12:	**Ebola**
Risk	Ebola Outbreak
Root Cause	▪ Failure in outbreak prevention strategies
Impact	▪ Fatalities ▪ Increased pressure on the health system
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Ebola outbreak preparedness plan in place ▪ Ebola surveillance strategies in place

RISK STATEMENT 13:	Affordability of the infrastructure requirements of Healthcare 2030
Risk	Affordability of delivering on required infrastructure in order to meet objectives of Healthcare 2030.
Root Cause	▪ Limited financial resources ▪ Inappropriate and over-designed infrastructure that is too complex and costly to construct and maintain. ▪ Current condition and functional limitations of existing health infrastructure portfolio
Impact	▪ Compromised healthcare services.
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices.
Measures to Mitigate Impact	▪ Develop standard health infrastructure designs which are appropriate to a developing economy ▪ Ensure compliance to standard designs, where appropriate and possible. ▪ Explore alternative finance options. ▪ Application of Prioritisation Tool for capital projects. ▪ Increase resources for maintenance of existing facilities.

10. Programme 4: PROVINCIAL HOSPITAL SERVICES

10.1. Purpose

Delivery of hospital services, which are accessible, appropriate, effective and provide general specialist services, including a specialised rehabilitation service, dental service, psychiatric service, as well as providing a platform for training health professionals and conducting research.

10.2. Structure

SUB-PROGRAMME 4.1: GENERAL (REGIONAL) HOSPITALS

Rendering of hospital services at a general specialist level and providing a platform for the training of health workers and conducting research

SUB-PROGRAMME 4.2: TUBERCULOSIS HOSPITALS

To convert present Tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalisation under conditions, which allow for isolation during the intensive level of treatment, as well as the application of the standardized multi-drug and extreme drug-resistant protocols

SUB-PROGRAMME 4.3: PSYCHIATRIC/MENTAL HOSPITALS

Rendering a specialist psychiatric hospital service for people with mental illness and intellectual disability and providing a platform for the training of health workers and conducting research

SUB-PROGRAMME 4.4: SUB-ACUTE, STEP DOWN AND CHRONIC MEDICAL HOSPITALS

Rendering specialised rehabilitation services for persons with physical disabilities including the provision of orthotic and prosthetic services

SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

Rendering an affordable and comprehensive oral health service and providing a platform for the training of health workers and conducting research

10.3. Key Components

GENERAL (REGIONAL) HOSPITALS

These hospitals render a general specialist-driven acute hospital package of care. Regional hospitals are referral hospitals, but will render an acute district hospital service package to the population within the immediate geographic drainage area of the hospital if these services are not available locally. The

package of care includes health services in the fields of internal medicine, paediatrics, obstetrics and gynaecology, general surgery, trauma and emergency, orthopaedic surgery, psychiatry, anaesthetics and diagnostic radiology. Although Mowbray Maternity Hospital is classified as a regional hospital in the Western Cape, it is considered a "specialised hospital" in terms of the Regulations relating to categories of hospitals, published in terms of the National Health Act, 2003.

There are currently five regional hospitals in the Province, three in the rural areas and two in Cape Town. The number of beds in the regional hospitals varies from 200 to 350. The hospitals are:

1. George Hospital
2. Worcester Hospital
3. Paarl Hospital
4. New Somerset Hospital
5. Mowbray Maternity Hospital

TUBERCULOSIS (TB) HOSPITALS

South Africa remains one of the countries most affected by tuberculosis, with a high burden of drug-resistant TB and co-morbidity with HIV, which have led to a change in the profile of patients who are admitted to TB hospitals. The majority of the tuberculosis workload will be managed on the home community-based care and primary health care platforms and it is therefore important to strengthen these services to improve efficiencies within TB hospitals. The increase in drug-resistant TB cannot be sustainably managed through the admission of all patients to TB hospitals. A proportion of drug-resistant patients is clinically stable and can be managed on an ambulatory basis in a community-based treatment delivery system. There are six TB hospitals in the Province with the smaller ones having < 100 beds (i.e. Harry Comay, Sonstraal and Malmesbury ID Hospital). The number of beds in the bigger TB hospitals range from 200 to 350. The hospitals are:

1. Brooklyn Chest Hospital
2. DP Marais Hospital
3. Brewelskloof Hospital
4. Harry Comay Hospital
5. Sonstraal Hospital
6. Malmesbury Infectious Diseases Hospital

PSYCHIATRIC HOSPITALS

There is strong evidence that the burden on mental illness is increasing both globally and locally. The Mental Health Care Act, 17 of 2002, has created a statutory obligation for mainstreaming and integrating mental health service with general health services to improve access. Only those services requiring a more specialised level of intervention will the treated on the specialist hospital platform. Specialist psychiatric hospitals will provide the full range of treatment for the following: general adult psychiatric services, substance abuse and addiction treatment, child and adolescent services, neuropsychiatry, old-age psychiatry, and complications like challenging behaviour of people living with intellectual disabilities. There has also been a significant increase in the demand for forensic psychiatric services over the last fifteen years.

Hospital care for mental illness is currently primarily located in the Cape Town Metro District; however, these centres offer services for clients throughout the Province according to designated areas. There are four psychiatric hospitals, namely:

1. Alexandra Hospital
2. Lentegeur Hospital
3. Stikland Hospital
4. Valkenberg Hospital

The number of beds in these hospitals varies between 300 and 350 beds, except for Lentegeur Hospital, which has 740 beds. In addition, there are two intermediate care facilities that offer inpatient mental health step-down care, namely:

1. New Beginnings (supported by Stikland Hospital)
2. William Slater (supported by Valkenberg Hospital)

REHABILITATION SERVICES

There is one, 156-bed rehabilitation hospital in the Western Cape, namely the Western Cape Rehabilitation Centre (WCRC). Primary reasons for admission include acute rehabilitation management of people with long-term, permanent disabilities such as:

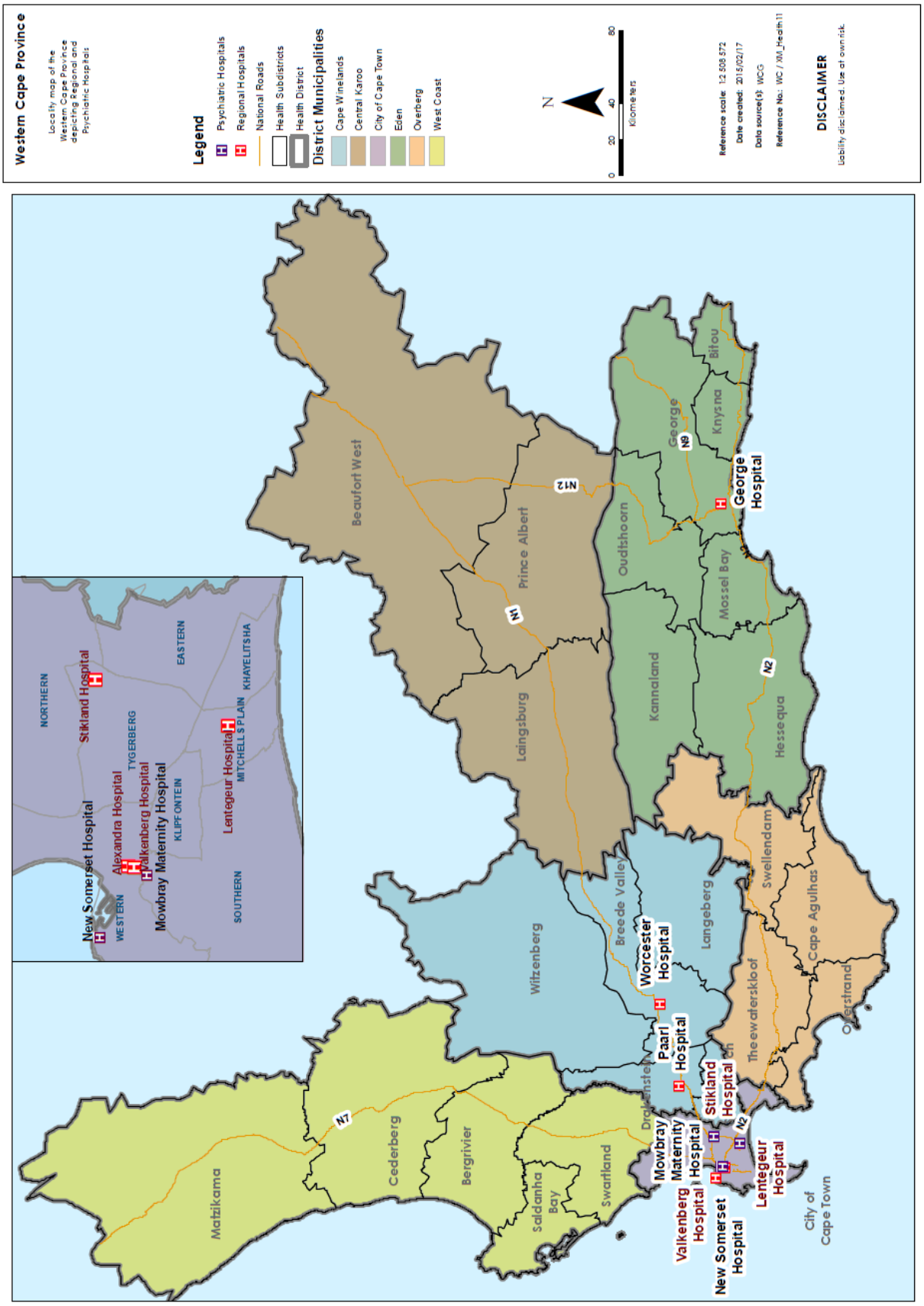
- Spinal cord afflictions (i.e. quadriplegia/paraplegia)
- Cerebrovascular accidents
- Traumatic brain injury
- Amputations
- Neurological conditions (e.g. Guillain-Barré syndrome, multiple sclerosis, motor neuron disease, Parkinson's disease, cerebral palsy etc.)

The provision of mobility- and other assistive devices, orthotic and/or prosthetics is an integral part rehabilitation services to facilitate the full re-integration of people with disabilities back into the community. The Orthotic and Prosthetic Centre (OPC) produces orthotic and prosthetic devices and is managed by the WCRC. The OPC services in Eden and Central Karoo districts are outsourced.

DENTAL TRAINING HOSPITALS

Oral health training centres (dental hospitals) have historically provided a high-end oral health service within the Province and in the main have been responsible for the training of dental professionals and research. Specialist oral health services include, amongst others, the management of complicated fractures, difficult impactions, oral oncology, forensic odontology, complicated periodontology, orthodontics and prosthodontics. There is close working relationship with maxilla-facial and ENT surgeons in complex surgical cases. The oral health professionals and specialists from oral health training centres will provide outreach and support to the primary care platform to strengthen the skills base and improve the quality of care at this level. At a district level oral health services form an integral part of the primary health care package and the department is systematically increasing the access to basic oral health care. There are two oral health training centres, namely:

1. Mitchells Plain Oral Health Centre
2. Tygerberg Oral Health Centre



Map B.3: Regional & Psychiatric Hospitals in the Western Cape

10.4. Strategic Objectives

GOAL: PROMOTE HEALTH AND WELLNESS

Table B.5: Strategic objectives and expected outcomes for Provincial Hospital Services

Strategic objective (short title)	Strategic objective statement (SMART)	Indicator	Baseline (2013/14)	Target (2019/20)
1. Provide quality general/regional hospital services	1.1. Provide access to the full package of regional hospital services by ensuring there are 1 389 regional hospital beds by 2019/20.	1.1.1. Actual (usable) beds in regional hospitals.	1 373	1 389
2. Provide quality tuberculosis hospital services	2.1. Provide access to the full package of tuberculosis hospital services by ensuring there are 1 026 tuberculosis hospital beds by 2019/20.	2.1.1. Actual (usable) beds in tuberculosis hospitals	1 026	1 026
3. Provide quality psychiatric hospital services	3.1. Provide access to the full package of psychiatric hospital services by ensuring there are 1 680 psychiatric hospital beds and 145 step-down psychiatric beds by 2019/20.	3.1.1. Actual (usable) beds in psychiatric hospitals	1 698	1 680
		3.1.2. Actual (usable) beds in step down facilities	145	145
4. Provide quality rehabilitation hospital services	4.1. Provide access to the full package of rehabilitation hospital services by ensuring there are 156 rehabilitation hospital beds by 2019/20.	4.1.1. Actual (usable) beds in rehabilitation hospitals	156	156
5. Provide quality dental training hospital services	5.1. Provide access to dental training hospital services by ensuring at least 115 598 oral health patients are treated per annum at dental training hospitals by 2019/20.	5.1.1. Oral health patient visits at dental training hospitals	114 848	115 598

10.5. Resource Considerations

The programme remains under pressure as is evident by the projected expenditure, yet the programme has implemented strict financial controls. In planning the budget process, funding streams have been geared towards achieving the strategic objectives within the next five years. The management structures created in the geographic service areas will improve service coordination and communication between institutions across levels of care.

EXPENDITURE TRENDS

Personnel

Personnel expenditure has increased significantly over time, despite the efforts made to remain within an affordable budget allocation for posts. Each institution has an approved post list, which is managed through the Establishment Control Committee of the Chief Directorate within the Programme.

Goods and Services

One of the main challenges is that the funding levels of the budget allocation do not match inflation over time, which is evident in the severe price increases for medical and surgical items. Certain cost drivers, for example blood and blood products, medical and surgical supplies and laboratory costs remain high and all efforts are made to implement saving mechanisms in these areas. There is a serious commitment to reduce the use of agencies in certain staff categories in a phased manner.

In 2013/14 Programme 4 contributed 15.7 per cent to the overall departmental expenditure.

Figure B.13: Expenditure trends in Provincial Hospital Services, 2009 to 2013

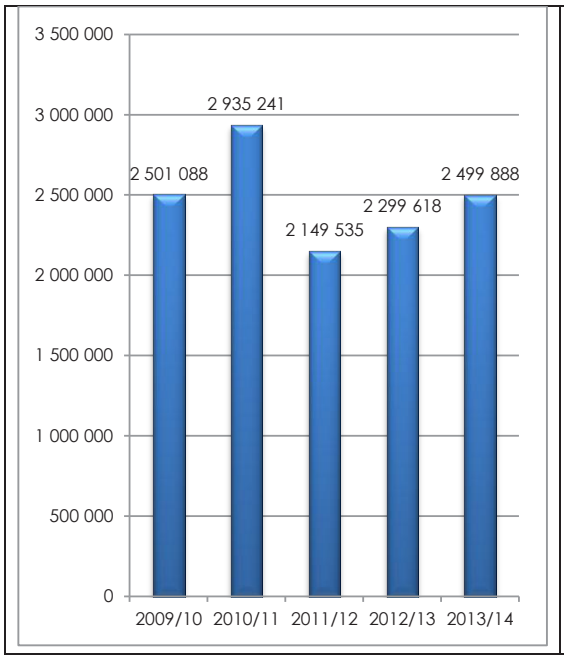


Figure B.14: Expenditure per sub-programme in Provincial Hospital Services, 2013/14 (R'000)

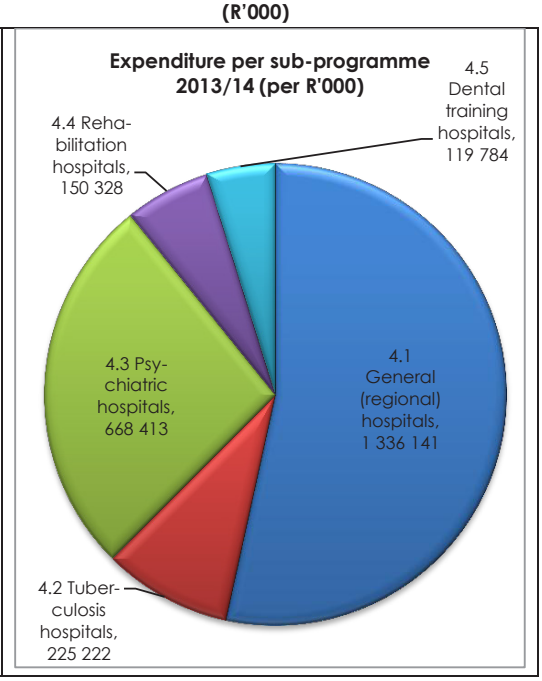


Figure B.15: Expenditure trends per economic classification in Provincial Hospital Services, 2009 to 2013

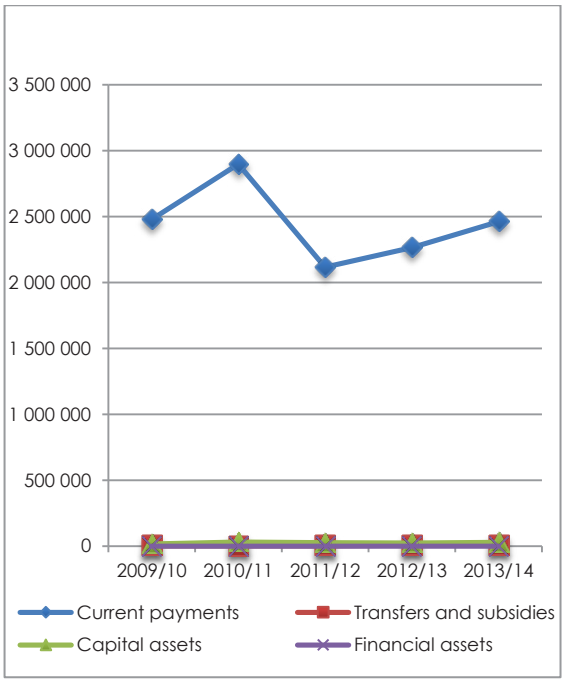
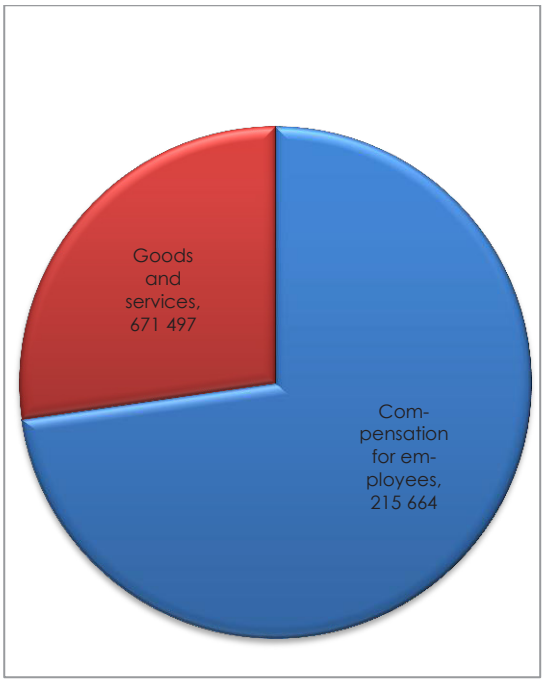


Figure B.16: Expenditure for current payments, 2013/14 (R'000)



UNFUNDED PRIORITIES

- Commissioning of new services, e.g. psychiatric services at Paarl, Worcester, George and New Somerset Hospital
- Commissioning of an additional 12 regional hospital beds for high care/ICU

TRENDS IN THE SUPPLY OF KEY CATEGORIES OF HEALTH PERSONNEL

The recruitment and retention of key skilled staff remains a challenge within this programme. A contributing factor is the competition from the private sector as well as the overseas market, especially for nursing and medical doctors. Occupational groups that are mostly affected include:

- Professional Nurses in certain specialties (operating theatre, trauma and emergency, and orthopaedics.
- Medical specialists in emergency medicine, orthopaedics, surgery and anaesthetics
- Radiographers, especially ultra-sonographers.

10.6. Risk Management

RISK STATEMENT 1:	**Shortage Of Skilled Staff**
Risk	Inadequate competency levels
Root Cause	▪ Shortage of highly skilled professionals ▪ Inability to offer competitive remuneration packages
Impact	▪ Compromised ability to deliver on the Department's mandate
Strategic Goal Impact	▪ Promote Health and Wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Allocation of bursaries per scarce-skilled profession as a recruitment strategy ▪ In the process of developing an on-line exit interview questionnaire to assist in identifying the reasons for exits and to inform future interventions ▪ Development and implementation of recruitment and retention policies ▪ Work in partnership with universities to recruit and retain highly skilled staff ▪ Strengthen organisational culture and staff wellbeing ▪ Succession planning ▪ Improve the working environment
RISK STATEMENT 2:	**Staff Safety**
Risk	Increased staff safety related, adverse incidents
Root Cause	▪ Volatility in the community e.g. gang violence, inter-personal violence ▪ High prevalence of infectious diseases e.g. HIV/AIDS and TB ▪ Inadequate Occupational Health and Safety measures ▪ Inadequate security measures
Impact	▪ Compromised employee wellness
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Safety guidelines and protocols that empower staff to make decisions around their own safety ▪ Raise employee awareness on safety in the workplace ▪ Ensuring optimal security measures are in place at health facilities ▪ Engage the SAPS and community safety stakeholders on ways in which closer collaboration and interagency partnerships could assist in securing the physical safety of staff ▪ Robust OHS measures in place
RISK STATEMENT 3:	**Resource Constraints**
Risk	Inability to render comprehensive quality health services
Root Cause	▪ Allocative and technical inefficiencies ▪ Escalating burden of disease ▪ Escalating costs of labour, goods and services ▪ Fiscal envelope based on nominal growth ▪ Aging infrastructure
Impact	▪ Poor health outcomes ▪ Compromised ability to deliver on the department's mandate
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Priority setting ▪ Establish and embed mechanisms to enhance efficiencies ▪ Applying lean management principles to reduce waste in the system ▪ Rational prescribing ▪ Laboratory cost containment measures, e.g. Electronic Gatekeeping System ▪ Explore alternative financing options
RISK STATEMENT 4:	**Medico Legal Claims**
Risk	Increasing litigation against the department as a result of malpractice and negligence
Root Cause	▪ Increasing service pressures ▪ Inadequate clinical governance mechanisms ▪ Technical inefficiencies
Impact	▪ Compromised quality of care ▪ Escalating expenditure ▪ Compromised public trust in the health system (reputational damage)
Strategic Goal Impact	▪ Promote Health and Wellness
Measures to Mitigate Impact	▪ Adverse incidence reporting system ▪ Strengthen clinical governance and antibiotic stewardship ▪ Contingency plans in place for service surges

RISK STATEMENT 5:	Pharmaceutical Stock-outs
Risk	Unavailability of essential pharmaceutical goods and services
Root Cause	▪ Supplier challenges e.g. global shortages of ingredients ▪ Lack of timeous and good contract management ▪ Inability to secure alternatives ▪ Late or inadequate awarding of national pharmaceutical contracts
Impact	▪ Compromises the quality of care ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Engage National Department of Health on timeous awarding of national tenders ▪ Monitor stocks out regularly ▪ Monitor vaccine supply ▪ Provide alternatives to the essential medicines, where possible ▪ Tight contract management with suppliers ▪ Create provincial contracts for items that have been excluded from the revised national tenders, where possible
RISK STATEMENT 6:	**ICT Systems Disruption**
Risk	Dysfunctional communication and information systems
Root Cause	▪ Inadequate and ageing technology infrastructure and resources ▪ Inadequate technical capacity within the Western Cape Government
Impact	▪ Compromised service delivery
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop a robust IT disaster recovery plan ▪ Monitor the responsiveness of the Helpdesk and support systems to IT system failures ▪ Constantly review and address out-dated infrastructure by conducting regular hardware and ICT audits
RISK STATEMENT 7:	**Fire Within Health Facilities**
Risk	Fire damage to state property and safety threat to building occupants
Root Cause	▪ Inadequate safety measures ▪ Constant trade-off between securing a building from a safety perspective versus maintaining the integrity of fire escapes etc. ▪ Building maintenance backlog and infrastructure budget constraints
Impact	▪ Service disruption ▪ Property damage ▪ Traumatised and/or injured staff and patients
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop and implement the Provincial Safety, Health, Environment, Risk, and Quality Management (SHERQ) Policy to support and guide facilities ▪ Ensure that design and construction of infrastructure is compliant through phased fire compliance ▪ Monitor and evaluate operational compliance with fire regulations ensuring that disaster plans and fire drills are in place ▪ Ensure compliance of the physical environment and physical entities such as fire detectors, fire extinguishers, alarms, sprinkler systems, fire doors, and fire exits are in order ▪ Establish Health and Safety committees, appoint and train emergency representatives (fire, first aid and floor marshals), in accordance with the National Core Standards
RISK STATEMENT 8:	**Vandalism And Theft**
Risk	Damage to and loss of state property
Root Cause	▪ Inadequate security measures ▪ Volatility in the community ▪ High crime prevalence
Impact	▪ Compromises the quality of care ▪ Property damage ▪ Escalates maintenance and repair expenditure
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Business continuity plans in place to minimise the impact on service delivery ▪ Installation of vandal-proof infrastructure including fixtures and fittings, as far as possible ▪ Improve security services and contract management at facility level

RISK STATEMENT 9:	Fraud
Risk	Unfair or unlawful access to public fund
Root Cause	▪ Inadequate (compliance with) internal controls ▪ Lack of commitment to values of the organisation
Impact	▪ Exacerbates resource constraints ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Monitor the implementation of the fraud prevention plan ▪ Ensure PERSAL is accurate to prevent ghost employees ▪ Embark upon change management initiative that emphasises the values of the organisation ▪ (Strengthening the DICU, ICU processes – IA, CA, etc.)
RISK STATEMENT 10:	**Labour Unrest**
Risk	Strike action
Root Cause	▪ Labour disputes
Impact	▪ Service disruption ▪ Compromises patient and staff safety ▪ Exacerbates resource constraints and staff shortages
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Maintaining good practices and relations with organised labour through robust structures of engagement ▪ In the event of a strike ensure contingency plans are in place to minimise service disruption
RISK STATEMENT 11:	**Load Shedding**
Risk	Disruption in the supply of electricity
Root Cause	▪ Eskom infrastructure ▪ Shortage in supply of diesel to support back-up power supply
Impact	▪ Service disruption ▪ Compromised quality of care ▪ Increased supply of and maintenance to alternative sources of power supply ▪ Increased diesel storage ▪ Cost of diesel supply ▪ Damage to electrical and electronic equipment (including medical) due to power surge
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Backup power supply in place for priority services ▪ Reduce dependency on Eskom by investing in alternative energy sources ▪ Business continuity plans in place to minimise the impact on service delivery ▪ Ensures adequate diesel supply and storage
RISK STATEMENT 12:	**Ebola**
Risk	Ebola Outbreak
Root Cause	▪ Failure in outbreak prevention strategies
Impact	▪ Fatalities ▪ Increased pressure on the health system
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Ebola outbreak preparedness plan in place ▪ Ebola surveillance strategies in place
RISK STATEMENT 13:	**Affordability of the infrastructure requirements of Healthcare 2030**
Risk	Affordability of delivering on required infrastructure in order to meet objectives of Healthcare 2030.
Root Cause	▪ Limited financial resources ▪ Inappropriate and over-designed infrastructure that is too complex and costly to construct and maintain. ▪ Current condition and functional limitations of existing health infrastructure portfolio
Impact	▪ Compromised healthcare services
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices.
Measures to Mitigate Impact	▪ Develop standard health infrastructure designs which are appropriate to a developing economy ▪ Ensure compliance to standard designs, where appropriate and possible. ▪ Explore alternative finance options. ▪ Application of Prioritisation Tool for capital projects. ▪ Increase resources for maintenance of existing facilities.

11. Programme 5: CENTRAL HOSPITAL SERVICES

11.1. Purpose

To provide tertiary and quaternary health services and to create a platform for the training of health workers and research

11.2. Structure

SUB-PROGRAMME 5.1: CENTRAL HOSPITAL SERVICES

Rendering of general and highly specialised medical health and quaternary services on a national basis and maintaining a platform for the training of health workers and research.

SUB-PROGRAMME 5.2: PROVINCIAL TERTIARY HOSPITAL SERVICES

Rendering of general specialist and tertiary health services on a national basis and maintaining a platform for the training of health workers and research.

11.3. Key Components

CENTRAL HOSPITALS

Central hospitals render a sub-specialist driven, level 3, acute hospital package of care, as well as a general specialist driven, level 2, acute hospital package of care to the population in the referral drainage area of the hospital. A central hospital provides tertiary hospital services, central referral services, and training of health care providers. It must conduct research, receive patients referred from other provinces, and must be attached to a medical school as the main teaching platform. It may also provide national referral services, i.e. extremely specialised and expensive services, e.g. heart and lung transplant, bone marrow transplant, liver transplant, cochlear implants, etc.

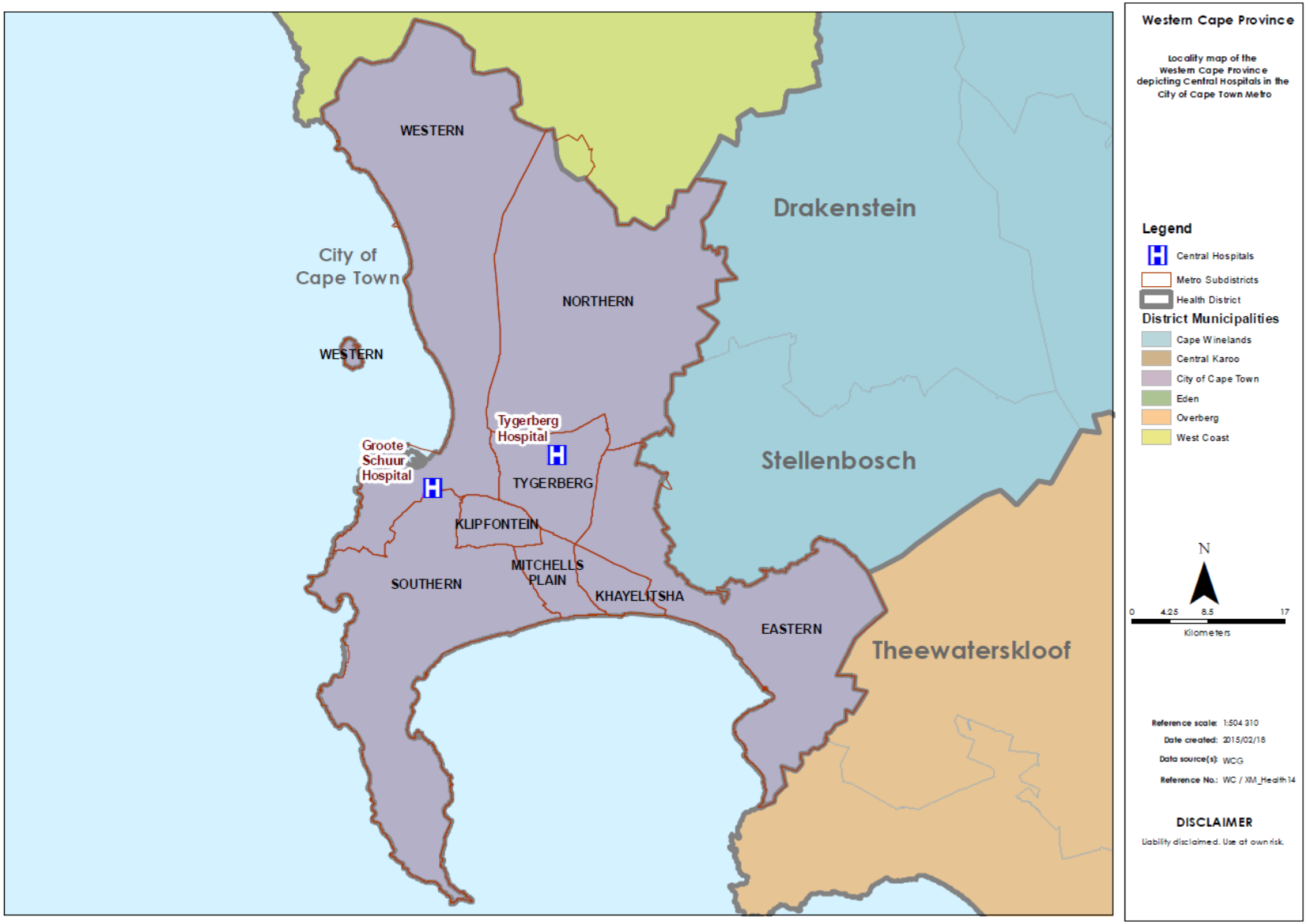
The Western Cape has two central hospitals, namely Tygerberg and Groote Schuur Hospitals, and one tertiary hospital namely Red Cross War Memorial Children's Hospital (RCWMCH). As from 2013/14 RCWMCH reported under Sub-programme 5.2: Provincial Tertiary Hospital Services.

Currently there are 2 359 beds in the central hospitals (975 and 1 384 in Groote Schuur and Tygerberg Hospitals respectively) and 272 beds in RCWMCH. The beds have been increased by 2 Intensive Care Unit beds in the 2014/15 financial year. Maitland Cottage Home is a provincially-aided health facility which operates as an extension of RCWMCH and provides for specialist orthopaedic surgery, post-operative care and rehabilitation for children with orthopaedic conditions. The facility has 85 beds and performs over 500 surgical procedures per annum.

Due to the central and tertiary hospitals providing a significant component of general specialist services and interaction with the general specialist platform of services, these hospitals are integral to the provincial health system, which it strengthens through outreach and support. Key success factors include a critical mass of scarce skills, with interdependency across disciplines. Medical specialists and

sub specialists, specialised nursing (especially intensive care and theatre scrub nurses), anaesthetists, clinical technologists, clinical engineering and a range of clinical support services such as occupational therapy, physiotherapy, speech and language therapy, audiology and radiography services render the services in multidisciplinary teams. The delivery of tertiary services also requires the availability of expensive equipment and related technology.

Map B.4:Central Hospitals in the Western Cape



11.4. Strategic Objectives

GOAL: PROMOTE HEALTH AND WELLNESS

Table B.6: Strategic objectives and expected outcomes for Central Hospital Services

Strategic objective (short title)	Strategic objective statement (SMART)	Indicator	Baseline (2013/14)	Target (2019/20)
1. Provide access to the full package of central hospital services.	1.1. Provide access to the full package of central hospital services by ensuring there are 2 359 central hospital beds by 2019/20.	1.1.1. Actual (usable) beds in central hospitals	2 359	2 359
2. Provide access to the full package of central hospital services at Groote Schuur Hospital.	2.1. Provide access to the full package of central hospital services by ensuring there are 975 central hospital beds at Groote Schuur Hospital by 2019/20.	2.1.1. Actual (usable) beds in Groote Schuur Hospital	975	975
3. Provide access to the full package of central hospital services at Tygerberg Hospital.	3.1. Provide access to the full package of central hospital services by ensuring there are 1 384 central hospital beds at Tygerberg Hospital by 2019/20.	3.1.1. Actual (usable) beds in Tygerberg Hospital	1 384	1 384
4. Provide access to the full package of central hospital services at RCWMCH.	4.1. Provide access to the full package of central hospital services by ensuring there are 272 central hospital beds at RCWMCH by 2019/20.	4.1.1. Actual (usable) beds in RCWMCH	270	272

11.5. Resource Considerations

The past years have seen growth in real terms, the budgets allocated to the department for the MTEF period does however not enable further real growth. Any new priorities or initiatives, and growth in workload must be accommodated by reprioritization from lower value to higher value activities. Total

staff numbers will increase marginally due to the filling of funded posts, but additional posts will not be made available unless there is a real increase in the discretionary fiunancial envelope. These facilities are highly dependent on two conditional grants, the National Tertiary Services Grant and the Health Professions training and Development Grant. Both these grants have been reduced in real terms over the MTEF.

EXPENDITURE TRENDS

In 2013/14 Programme 5 contributed 28.7 per cent to the overall departmental expenditure.

Figure B.17: Expenditure trends in Central Hospital Services, 2009 to 2013

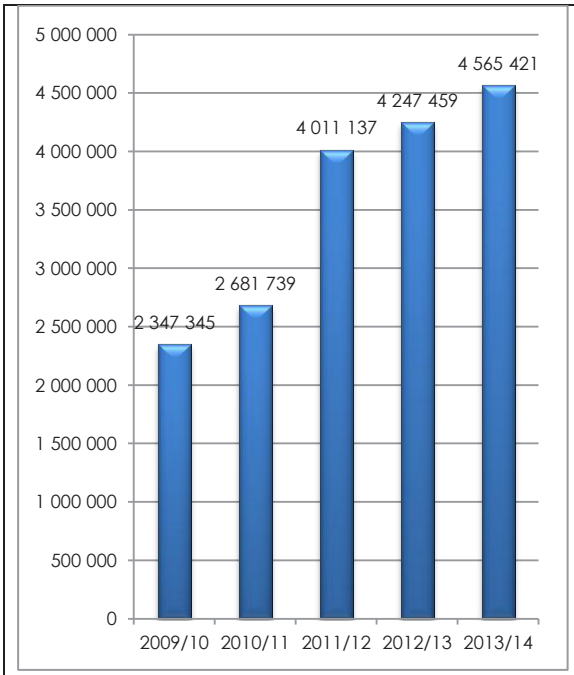


Figure B.18: Expenditure per sub-programme in Central Hospital Services, 2013/14 (R'000)

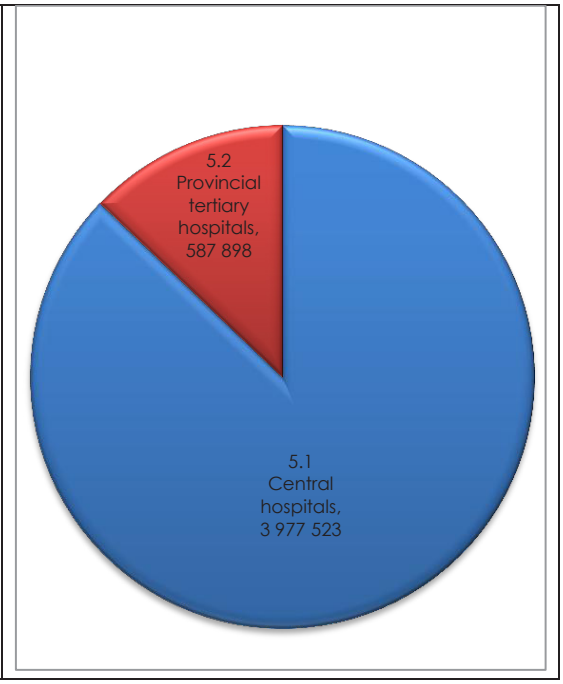


Figure B.19: Expenditure trends per economic classification in Central Hospital Services, 2009 to 2013

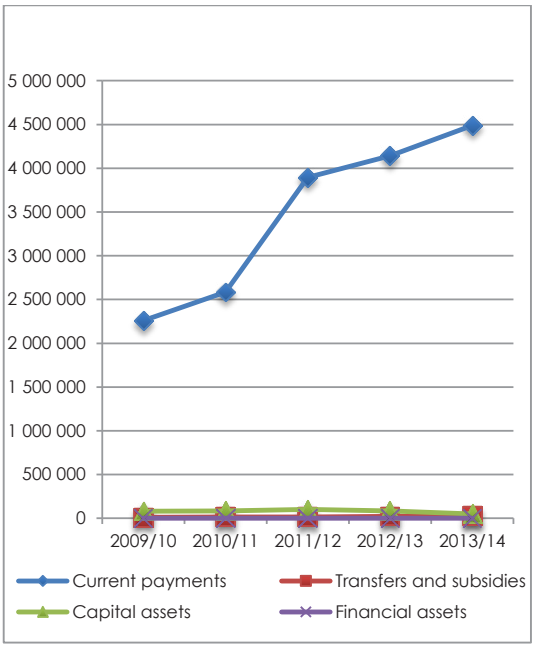
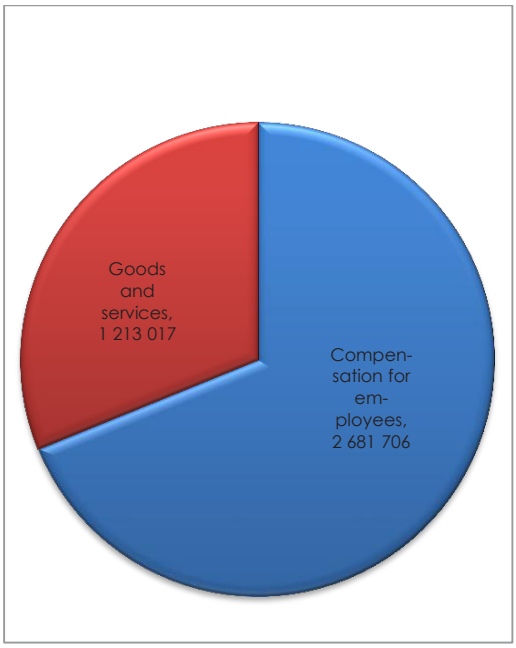


Figure B.20: Expenditure for current payments, 2013/14 (R'000)



National Tertiary Services Grant (NTSG)

The NTSG is a schedule 4 conditional grant that aims to compensate provinces for the supra-provincial nature of tertiary services provision and spill-over effects to enable provinces to plan, modernise, rationalise and render tertiary services in line with national policy objectives.
Challenges:

- The grant funding is inadequate for the current tertiary and quaternary services to be provided with an estimated shortfall exceeding R665 million.
- There is a lack of a comprehensive National Tertiary Health Plan, which would determine relative service distribution and access across the country and would guide more rational resource distribution.

The Western Cape Department of Health has made submissions to the National Department of Health in this regard.

Health Professions Training and Development Grant (HPTDG)

The purpose of the Health Professions Training and Development Grant is to support the funding of service costs associated with the training of health professionals in the services platform towards the national aim of expanding the number of health professionals. This platform accommodates students from four institutes of higher education, namely: University of Stellenbosch, University of Cape Town, University of Western Cape and Cape Peninsula University of Technology.
Challenge:

- The funding level of the grant has not kept pace with inflation, or the implications of the OSD. The funding deficit recorded in the 20134/2015 HPTDG business plan was R 190.7 million. This funding deficit is only considering the training of medical and dental under and post graduates only, whilst the grant is supposed to support the training of all priority categories of health trainees.

The Western Cape Department of Health has made submissions to the National Department of Health in this regard. The Province to continue to train health professionals to form part of a provincial and national pool of clinicians delivering health services to the citizens of South Africa and therefore the grant must therefore extend beyond the MTEF. The Department has identified the risk of medical

trainees from Cuba who might have to be accommodated for at least 18 months per exit group on the service platform of the Western Cape. Submissions will be made to the NDOH as required.

UNFUNDED PRIORITIES

- Radiology equipment for Red Cross Hospital
- Reduction in Conditional Grants NTSG and HPTDG

TRENDS IN THE SUPPLY OF KEY CATEGORIES OF HEALTH PERSONNEL

The recruitment and retention of key skilled staff remains a challenge within this programme. A contributing factor is the competition from the private sector as well as the overseas market, especially for nursing and medical doctors. Occupational groups that are mostly affected include:

- Professional Nurses in certain specialties (operating theatre, trauma and emergency, and orthopaedics.
- Medical specialists in emergency medicine, orthopaedics, surgery and anaesthetics
- Radiographers (ultra-sonographers, oncology and nuclear medicine).

11.6. Risk Management

RISK STATEMENT 1:	**Shortage Of Skilled Staff**
Risk	Inadequate competency levels
Root Cause	▪ Shortage of highly skilled professionals ▪ Inability to offer competitive remuneration packages
Impact	▪ Compromised ability to deliver on the Department's mandate
Strategic Goal Impact	▪ Promote Health and Wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Allocation of bursaries per scarce-skilled profession as a recruitment strategy ▪ In the process of developing an on-line exit interview questionnaire to assist in identifying the reasons for exits and to inform future interventions ▪ Development and implementation of recruitment and retention policies ▪ Work in partnership with universities to recruit and retain highly skilled staff ▪ Strengthen organisational culture and staff wellbeing ▪ Succession planning ▪ Improve the working environment
RISK STATEMENT 2:	**Staff Safety**
Risk	Increased staff safety related, adverse incidents
Root Cause	▪ Volatility in the community e.g. gang violence, inter-personal violence ▪ High prevalence of infectious diseases e.g. HIV/AIDS and TB ▪ Inadequate Occupational Health and Safety measures ▪ Inadequate security measures
Impact	▪ Compromised employee wellness
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Safety guidelines and protocols that empower staff to make decisions around their own safety ▪ Raise employee awareness on safety in the workplace ▪ Ensuring optimal security measures are in place at health facilities ▪ Engage the SAPS and community safety stakeholders on ways in which closer collaboration and interagency partnerships could assist in securing the physical safety of staff ▪ Robust OHS measures in place

RISK STATEMENT 3:	Resource Constraints
Risk	Inability to render comprehensive quality health services
Root Cause	▪ Allocative and technical inefficiencies ▪ Escalating burden of disease ▪ Escalating costs of labour, goods and services ▪ Fiscal envelope based on nominal growth ▪ Aging infrastructure
Impact	▪ Poor health outcomes ▪ Compromised ability to deliver on the department's mandate
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Priority setting ▪ Establish and embed mechanisms to enhance efficiencies ▪ Applying lean management principles to reduce waste in the system ▪ Rational prescribing ▪ Laboratory cost containment measures, e.g. Electronic Gatekeeping System ▪ Explore alternative financing options
RISK STATEMENT 4:	**Medico Legal Claims**
Risk	Increasing litigation against the department as a result of malpractice and negligence
Root Cause	▪ Increasing service pressures ▪ Inadequate clinical governance mechanisms ▪ Technical inefficiencies
Impact	▪ Compromised quality of care ▪ Escalating expenditure ▪ Compromised public trust in the health system (reputational damage)
Strategic Goal Impact	▪ Promote Health and Wellness
Measures to Mitigate Impact	▪ Adverse incidence reporting system ▪ Strengthen clinical governance and antibiotic stewardship ▪ Contingency plans in place for service surges
RISK STATEMENT 5:	**Pharmaceutical Stock-outs**
Risk	Unavailability of essential pharmaceutical goods and services
Root Cause	▪ Supplier challenges e.g. global shortages of ingredients ▪ Lack of timeous and good contract management ▪ Inability to secure alternatives ▪ Late or inadequate awarding of national pharmaceutical contracts
Impact	▪ Compromises the quality of care ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Engage National Department of Health on timeous awarding of national tenders ▪ Monitor stocks out regularly ▪ Monitor vaccine supply ▪ Provide alternatives to the essential medicines, where possible ▪ Tight contract management with suppliers ▪ Create provincial contracts for items that have been excluded from the revised national tenders, where possible
RISK STATEMENT 6:	**ICT Systems Disruption**
Risk	Dysfunctional communication and information systems
Root Cause	▪ Inadequate and ageing technology infrastructure and resources ▪ Inadequate technical capacity within the Western Cape Government
Impact	▪ Compromised service delivery
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop a robust IT disaster recovery plan ▪ Monitor the responsiveness of the Helpdesk and support systems to IT system failures ▪ Constantly review and address out-dated infrastructure by conducting regular hardware and ICT audits

RISK STATEMENT 7:	Fire Within Health Facilities
Risk	Fire damage to state property and safety threat to building occupants
Root Cause	▪ Inadequate safety measures ▪ Constant trade-off between securing a building from a safety perspective versus maintaining the integrity of fire escapes etc. ▪ Building maintenance backlog and infrastructure budget constraints
Impact	▪ Service disruption ▪ Property damage ▪ Traumatised and/or injured staff and patients
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop and implement the Provincial Safety, Health, Environment, Risk, and Quality Management (SHERQ) Policy to support and guide facilities ▪ Ensure that design and construction of infrastructure is compliant through phased fire compliance ▪ Monitor and evaluate operational compliance with fire regulations ensuring that disaster plans and fire drills are in place ▪ Ensure compliance of the physical environment and physical entities such as fire detectors, fire extinguishers, alarms, sprinkler systems, fire doors, and fire exits are in order ▪ Establish Health and Safety committees, appoint and train emergency representatives (fire, first aid and floor marshals), in accordance with the National Core Standards
RISK STATEMENT 8:	**Vandalism And Theft**
Risk	Damage to and loss of state property
Root Cause	▪ Inadequate security measures ▪ Volatility in the community ▪ High crime prevalence
Impact	▪ Compromises the quality of care ▪ Property damage ▪ Escalates maintenance and repair expenditure
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Business continuity plans in place to minimise the impact on service delivery ▪ Installation of vandal-proof infrastructure including fixtures and fittings, as far as possible ▪ Improve security services and contract management at facility level
RISK STATEMENT 9:	**Fraud**
Risk	Unfair or unlawful access to public fund
Root Cause	▪ Inadequate (compliance with) internal controls ▪ Lack of commitment to values of the organisation
Impact	▪ Exacerbates resource constraints ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Monitor the implementation of the fraud prevention plan ▪ Ensure PERSAL is accurate to prevent ghost employees ▪ Embark upon change management initiative that emphasises the values of the organisation ▪ (Strengthening the DICU, ICU processes – IA, CA, etc.)
RISK STATEMENT 10:	**Labour Unrest**
Risk	Strike action
Root Cause	▪ Labour disputes
Impact	▪ Service disruption ▪ Compromises patient and staff safety ▪ Exacerbates resource constraints and staff shortages
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Maintaining good practices and relations with organised labour through robust structures of engagement ▪ In the event of a strike ensure contingency plans are in place to minimise service disruption

RISK STATEMENT 11:	Load Shedding
Risk	Disruption in the supply of electricity
Impact	▪ Service disruption ▪ Compromised quality of care ▪ Increased supply of and maintenance to alternative sources of power supply ▪ Increased diesel storage ▪ Cost of diesel supply ▪ Damage to electrical and electronic equipment (including medical) due to power surge
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Backup power supply in place for priority services ▪ Reduce dependency on Eskom by investing in alternative energy sources ▪ Business continuity plans in place to minimise the impact on service delivery ▪ Ensures adequate diesel supply and storage
RISK STATEMENT 12:	**Ebola**
Risk	Ebola Outbreak
Root Cause	▪ Failure in outbreak prevention strategies
Impact	▪ Fatalities ▪ Increased pressure on the health system
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Ebola outbreak preparedness plan in place ▪ Ebola surveillance strategies in place
RISK STATEMENT 13:	**Affordability of the infrastructure requirements of Healthcare 2030**
Risk	Affordability of delivering on required infrastructure in order to meet objectives of Healthcare 2030.
Root Cause	▪ Limited financial resources ▪ Inappropriate and over-designed infrastructure that is too complex and costly to construct and maintain. ▪ Current condition and functional limitations of existing health infrastructure portfolio
Impact	▪ Compromised healthcare services.
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices.
Measures to Mitigate Impact	▪ Develop standard health infrastructure designs which are appropriate to a developing economy ▪ Ensure compliance to standard designs, where appropriate and possible. ▪ Explore alternative finance options. ▪ Application of Prioritisation Tool for capital projects. ▪ Increase resources for maintenance of existing facilities.

12. Programme 6: HEALTH SCIENCES & TRAINING

12.1. Purpose

To create training and development opportunities for actual and potential employees of the Department of Health

12.2. Structure

SUB-PROGRAMME 6.1: NURSE TRAINING COLLEGE

Training of nurses at undergraduate and post-basic level, target group includes actual and potential employees.

SUB-PROGRAMME 6.2: EMERGENCY MEDICAL SERVICES (EMS) TRAINING COLLEGE

Training of rescue and ambulance personnel, target group includes actual and potential employees.

SUB-PROGRAMME 6.3: BURSARIES

Provision of bursaries for health science training programmes at undergraduate and postgraduate levels, target group includes actual and potential employees.

SUB-PROGRAMME 6.4: PRIMARY HEALTH CARE (PHC) TRAINING

Provision of PHC related training for personnel, provided by the regions.

SUB-PROGRAMME 6.5: TRAINING (OTHER)

Provision of skills development interventions for all occupational categories in the Department, target group includes actual and potential employees.

12.3. Key Components

Human Resources Development (HRD) has a pivotal role to play to ensure the appropriate numbers and competencies of health and support professionals in line with the values of the organization.

NURSE TRAINING COLLEGE & EMERGENCY MEDICAL SERVICES COLLEGE

The objective of the Nurse Training College is to ensure a continuous supply of qualified undergraduate and post-basic specialty nurse professionals. Similarly the Emergency Medical Services College ensures an adequate supply of emergency medical care personnel to meet service delivery needs. The Nurse Training College is in the process of being transferred to the Cape Peninsular University of Technology.

BURSARIES

This is a funding mechanism to provide study opportunities for current and prospective employees in the fields of scarce and critical skills occupations.

PRIMARY HEALTH CARE TRAINING & TRAINING OTHER

Provides access to in-service training and the internal training capacity will be developed through the establishment of a Regional Training Centre (RTC). The Centre is intended to offer learning opportunities to enhance health care skills through training initiatives for all health workers, professionals and community level workers, in line with the HRD framework and training philosophy. The Expanded Public Works Programme (EPWP) is included under this component and creates work opportunities based on Departmental service delivery needs.

12.4. Strategic Objectives

GOAL: EMBED GOOD GOVERNANCE AND VALUES-DRIVEN LEADERSHIP PRACTICES

Table B.7: Strategic objectives and expected outcomes for Health Sciences and Training

Strategic objective (short title)	Strategic objective statement (SMART)	Indicator	Baseline (2013/14)	Target (2019/20)
1. Implement a Human Resource Development (HRD) strategy.	1.1. Implement a HRD strategy by providing study opportunities for categories of scarce and critical skills,by 2019/20.	1.1.1. Number of bursaries awarded for scarce and critical skills categories.	2915	2750

12.5. Resource Considerations

The past years have seen growth in real terms, the budgets allocated to the department for the MTEF period does however not enable further real growth. Any new priorities or initiatives, and growth in work load must be accommodated by reprioritization from lower value to higher value services. Total staff numbers will continue to increase marginally due to the filling of funded posts, but additional posts will not be made available

EXPENDITURE TRENDS

The cost of training and development is expected to increase per annum. If the funding envelope remains constant, the implication is that the education, training and development initiatives will decrease proportionately.

In 2013/14 Programme 6 contributed 1.7 per cent to the overall departmental expenditure.

Figure B.21: **Expenditure trends in Health Sciences and Training, 2009 to 2013**

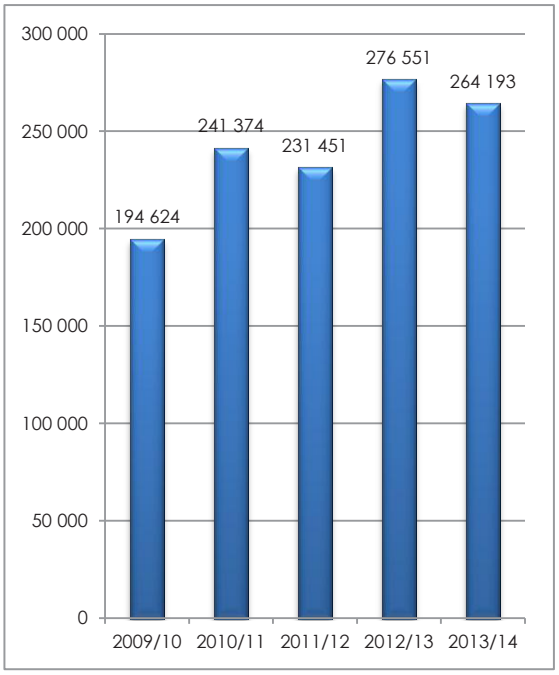


Figure B.22: **Expenditure per sub-programme in Health Sciences and Training, 2013/14 (per R'000)**

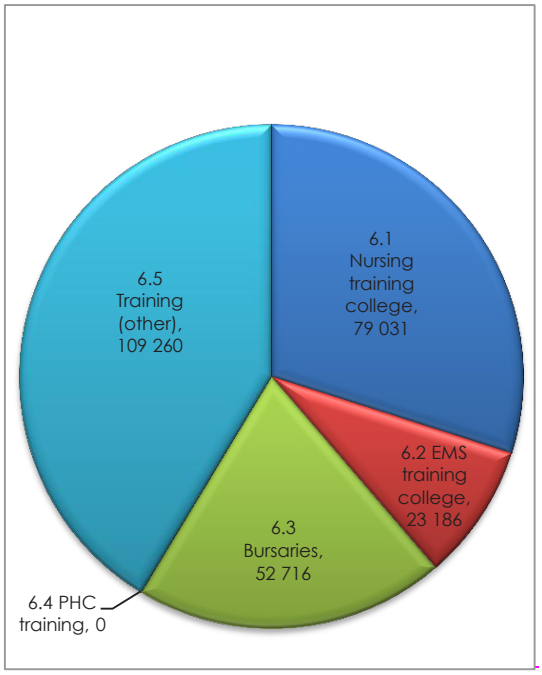


Figure B.23: **Expenditure trends per economic classification in Health Sciences and Training, 2009 to 2013**

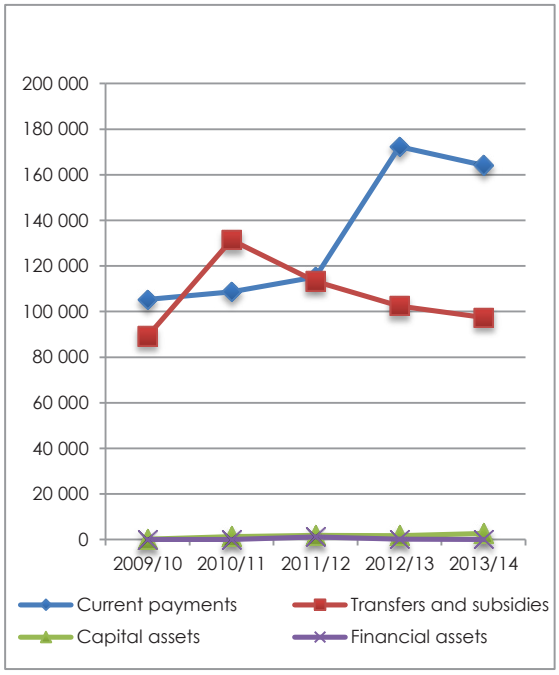
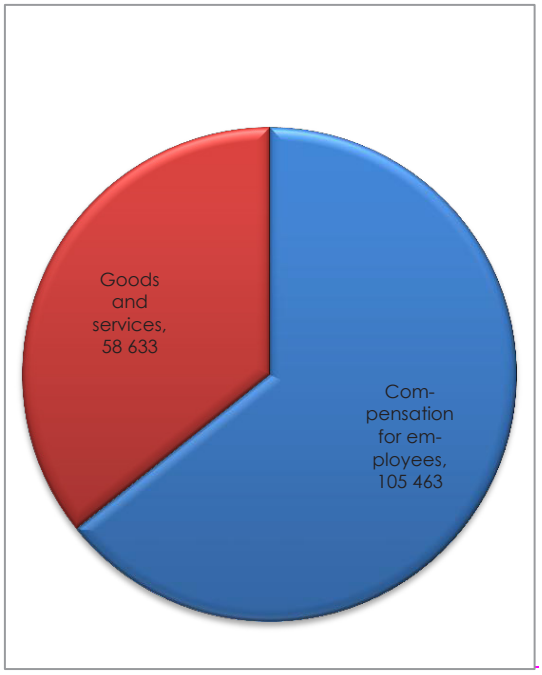


Figure B.24: **Expenditure for current payments, 2013/14 (per R'000)**



UNFUNDED PRIORITIES

While none of the priorities for this budget programme are entirely unfunded, it is important to note that certain aspects are inadequately funded.

TRENDS IN THE SUPPLY OF KEY CATEGORIES OF HEALTH PERSONNEL

Succession planning, ensuring that individual development performance plans are linked to individual, team and organisational growth, and providing developmental and experiential opportunities to capacitate personnel allied to a strong supply of HRD practitioners ensure that the programme is well resourced with the appropriate skills.

12.6. Risk Management

RISK STATEMENT 1:	**Shortage Of Skilled Staff**
Risk	Inadequate competency levels
Root Cause	▪ Shortage of highly skilled professionals ▪ Inability to offer competitive remuneration packages
Impact	▪ Compromised ability to deliver on the Department's mandate
Strategic Goal Impact	▪ Promote Health and Wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Allocation of bursaries per scarce-skilled profession as a recruitment strategy ▪ In the process of developing an on-line exit interview questionnaire to assist in identifying the reasons for exits and to inform future interventions ▪ Development and implementation of recruitment and retention policies ▪ Work in partnership with universities to recruit and retain highly skilled staff ▪ Strengthen organisational culture and staff wellbeing ▪ Succession planning ▪ Improve the working environment
RISK STATEMENT 2:	**Resource Constraints**
Risk	Inability to render comprehensive quality health services
Root Cause	▪ Allocative and technical inefficiencies ▪ Escalating burden of disease ▪ Escalating costs of labour, goods and services ▪ Fiscal envelope based on nominal growth ▪ Aging infrastructure
Impact	▪ Poor health outcomes ▪ Compromised ability to deliver on the department's mandate
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Priority setting ▪ Establish and embed mechanisms to enhance efficiencies ▪ Applying lean management principles to reduce waste in the system ▪ Rational prescribing ▪ Laboratory cost containment measures, e.g. Electronic Gatekeeping System ▪ Explore alternative financing options

RISK STATEMENT 3:	**ICT Systems Disruption**
Risk	Dysfunctional communication and information systems
Root Cause	▪ Inadequate and ageing technology infrastructure and resources ▪ Inadequate technical capacity within the Western Cape Government
Impact	▪ Compromised service delivery
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop a robust IT disaster recovery plan ▪ Monitor the responsiveness of the Helpdesk and support systems to IT system failures ▪ Constantly review and address out-dated infrastructure by conducting regular hardware and ICT audits
RISK STATEMENT 4:	**Fire Within Health Facilities**
Risk	Fire damage to state property and safety threat to building occupants
Root Cause	▪ Inadequate safety measures ▪ Constant trade-off between securing a building from a safety perspective versus maintaining the integrity of fire escapes etc. ▪ Building maintenance backlog and infrastructure budget constraints
Impact	▪ Service disruption ▪ Property damage ▪ Traumatised and/or injured staff and patients
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop and implement the Provincial Safety, Health, Environment, Risk, and Quality Management (SHERQ) Policy to support and guide facilities ▪ Ensure that design and construction of infrastructure is compliant through phased fire compliance ▪ Monitor and evaluate operational compliance with fire regulations ensuring that disaster plans and fire drills are in place ▪ Ensure compliance of the physical environment and physical entities such as fire detectors, fire extinguishers, alarms, sprinkler systems, fire doors, and fire exits are in order ▪ Establish Health and Safety committees, appoint and train emergency representatives (fire, first aid and floor marshals), in accordance with the National Core Standards
RISK STATEMENT 5:	**Vandalism And Theft**
Risk	Damage to and loss of state property
Root Cause	▪ Inadequate security measures ▪ Volatility in the community ▪ High crime prevalence
Impact	▪ Compromises the quality of care ▪ Property damage ▪ Escalates maintenance and repair expenditure
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Business continuity plans in place to minimise the impact on service delivery ▪ Installation of vandal-proof infrastructure including fixtures and fittings, as far as possible ▪ Improve security services and contract management at facility level
RISK STATEMENT 6:	**Fraud**
Risk	Unfair or unlawful access to public fund
Root Cause	▪ Inadequate (compliance with) internal controls ▪ Lack of commitment to values of the organisation
Impact	▪ Exacerbates resource constraints ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Monitor the implementation of the fraud prevention plan ▪ Ensure PERSAL is accurate to prevent ghost employees ▪ Embark upon change management initiative that emphasises the values of the organisation ▪ (Strengthening the DICU, ICU processes – IA, CA, etc.)

RISK STATEMENT 7:	Labour Unrest
Risk	Strike action
Root Cause	▪ Labour disputes
Impact	▪ Service disruption ▪ Compromises patient and staff safety ▪ Exacerbates resource constraints and staff shortages
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Maintaining good practices and relations with organised labour through robust structures of engagement ▪ In the event of a strike ensure contingency plans are in place to minimise service disruption

RISK STATEMENT 8:	Load Shedding
Risk	Disruption in the supply of electricity
Root Cause	▪ Eskom infrastructure ▪ Shortage in supply of diesel to support back-up power supply
Impact	▪ Service disruption ▪ Compromised quality of care ▪ Increased supply of and maintenance to alternative sources of power supply ▪ Increased diesel storage ▪ Cost of diesel supply ▪ Damage to electrical and electronic equipment (including medical) due to power surge
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Backup power supply in place for priority services ▪ Reduce dependency on Eskom by investing in alternative energy sources ▪ Business continuity plans in place to minimise the impact on service delivery ▪ Ensures adequate diesel supply and storage

13. Programme 7: HEALTH CARE SUPPORT SERVICES

13.1. Purpose

To render support services required by the Department to realise its aims.

13.2. Structure

SUB-PROGRAMME 7.1: LAUNDRY SERVICES

To render laundry and related technical support service to health facilities

SUB-PROGRAMME 7.2: ENGINEERING SERVICES

To render a routine, day-to-day and emergency maintenance service[11] to buildings, engineering installations and medical equipment[12].

SUB-PROGRAMME 7.3: FORENSIC SERVICES

(This function has been transferred from sub-programme 2.8)

To render specialised forensic pathology and medico-legal services in order to establish the circumstances and causes surrounding unnatural death. It includes the provision of the Inspector of Anatomy functions, in terms of Chapter 8 of the National Health Act and its Regulations.

SUB-PROGRAMME 7.4: ORTHOTIC AND PROSTHETIC SERVICES

To render specialised orthotic and prosthetic services; please note this service is reported in Sub-programme 4.4.

PROGRAMME 7.5: CAPE MEDICAL DEPOT

The management and supply of pharmaceuticals and medical supplies to health facilities

Please note, sub-programme 7.5 has been renamed since 2013, in line with the incorporation of the trading entity into the Department.

[11] Routine maintenance: regular on-going maintenance necessary to keep infrastructure operating safely and to prevent premature failure including repairs; Day-to-day maintenance: maintenance that takes place on an adhoc basis including minor repairs and replacements; Emergency maintenance: repairs which are unforeseen and require urgent attention due to the presence of, or the imminent risk of, an extreme or emergency situation arising from one or more of the following: human injury or death; human suffering or deprivation of human rights; serious damage to property or financial loss; livestock or animal injury, suffering or death; serious environmental damage or degradation; or interruption of essential services.

[12] Medical devices requiring calibration, maintenance, repair, user training, and decommissioning – activities usually managed by clinical engineers. This term typically excludes implantable, disposable or single-use medical devices.

13.3. Key Components

LAUNDRY SERVICES

Programme 7.1 is managed by the Chief Directorate: Infrastructure and Technical Management. Linen and laundry services are provided by two large regional laundries, namely Lentegeur Regional Laundry and Tygerberg Regional Laundry and several small on-premises laundries located and managed at some of the rural hospitals. In addition to this, an outsourced laundry service is provided by the private sector to various facilities. The outsourced laundry services are contracted, funded and managed by the respective facilities to which these services are rendered.
Although the health facilities are fully responsible for their own outsourcing and on-premises laundries, they are supported by the Directorate: Engineering and Technical Support with the preparation of outsourcing and equipment specifications, quality monitoring and *ad hoc* maintenance of on-premises laundry equipment.

ENGINEERING SERVICES

Sub-programme 7.2 is managed by the Chief Directorate: Infrastructure and Technical Management and is responsible for the routine, day-to-day and emergency maintenance of all health facilities. It should be noted that budget responsibility has been separated as follows:

- Day-to-day and emergency maintenance has been allocated to Sub-programme 7.2, and
- Routine maintenance[13] has been allocated to Programme 8.

In addition to the maintenance referred to above, Programme 7.2 is also responsible for the maintenance of medical equipment[14], which is managed by the Directorate: Health Technology, through the Goodwood Workshop. The mobile workshops, located at Bellville and Zwaanswyk (providing engineering and building maintenance support), while the Goodwood workshop specialises in the maintenance of medical equipment. These workshops also provide expertise and engineering support for maintenance work that is beyond the capability of the technical staff based at institutions other than the central hospitals. The Directorate: Health Technology provides technical advice in terms of incorporating maintenance requirements into respective tenders run by the various hospitals.

In order to improve efficiency and better utilisation of scarce skills in the delivery of infrastructure and health technology maintenance, a Maintenance Hub Organisation Development Study was commissioned. This work is currently reaching conclusion with the finalization of two separate documents being imminent, namely the Blueprint on the Organisation and Establishment for the Provision of Health Technology Services, and the Blueprint: Organisation and Establishment for the Provisioning of Day-to-day, Routine and Emergency Building Maintenance Services. Implementation plans for these Blueprints are being drafted with the view to a phased implementation approach. The preparation of these implementation plans will be completed shortly.

The Directorate: Engineering and Technical Support is also responsible for occupational health and safety compliance for machinery and engineering equipment as well as for the management and support of the health risk waste contracts in the Province. The latter is managed in partnership with WCG: Environmental Affairs and Development Planning.

FORENSIC PATHOLOGY SERVICE

The forensic pathology service is mandated to perform the medico-legal investigation of death in all cases where death are or appear to be, due to unnatural causes.

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[13] Routine maintenance: regular on-going maintenance necessary to keep infrastructure operating safely and to prevent premature failure including repairs; Day-to-day maintenance: maintenance that takes place on an adhoc basis including minor repairs and replacements; Emergency maintenance: repairs which are unforeseen and require urgent attention due to the presence of, or the imminent risk of, an extreme or emergency situation arising from one or more of the following: human injury or death; human suffering or deprivation of human rights; serious damage to property or financial loss; livestock or animal injury, suffering or death; serious environmental damage or degradation; or interruption of essential services.

[14] Medical devices requiring calibration, maintenance, repair, user training, and decommissioning – activities usually managed by clinical engineers. This term typically excludes implantable, disposable or single-use medical devices.

This includes:

- Investigation of scene of death.
- Collection of evidence.
- Assistance to the South African Police Service with the identification of deceased persons.
- Autopsy and post mortem examinations.
- Safe custody of all forms of evidence.
- Preparation of judicial reports and statements.
- Provide testimony in court proceedings.
- Training of doctors, registrars, undergraduate students, and forensic officers.
- Rendering FPS assistance to other provinces and countries.

Since the transfer of the service from the Police to Health in April 2006, the Provincial post-mortem rate per 1000 population has varied between 1.63 and 1.8 post-mortems per 1000 population, with a greater variance experienced at a district level. The post-mortem rate projected for 2020 is 1.74 per 1000 population. As a scarce resource the service is configured to ensure access, whilst at the same time ensuring the quality of the medico-legal investigation process.

The Forensic Pathology Service is a Specialised service rendered by Forensic Pathologists and Forensic Pathology Officers with a quantum of Level 1, 2, 3 and 4 activities being provided. This includes access to neuropathologists; histopathologists; paediatric pathologists; odontologists; toxicologists; molecular scientists; entomologists and anthropologists to ensure a comprehensive quality service. The Forensic Pathology facilities are classified according to the package of care (Level determinator) provided at such a facility as well as the caseload (M1 to M6).

The FPS operational geographical service is largely aligned with that of the SAPS and NPA as key strategic partners with an operational FPS manager responsible for each area, whilst Clinical Unit managers (specialist forensic pathologists) have the responsibility for clinical governance in each of their respective drainage areas. This service is rendered at eighteen forensic pathology facilities across the Province which includes two M6 academic forensic pathology laboratories in Cape Town, two academic departments of forensic medicine (one each associated with UCT and the other SU), three referral FPS laboratories (M3) and smaller FPS laboratories and holding centres (M1 and M2) in the West Coast, Cape Winelands, Overberg, Eden and Central Karoo Districts. This service will in future provide technical support to facilities delivering acute clinical forensic services.

Table B.8: Forensic Pathology Services facilities

PACKAGE OF CARE	FACILITIES IN THE PROVINCE IN THIS CATEGORY
L1	Laingsburg, Riversdale, Swellendam
L2	Beaufort West, Hermanus, Knysna, Malmesbury Mosselbay, Oudtshoorn, Stellenbosch, Vredenburg, Vredendal, Wolseley
L2 Referral Centres	Paarl, Worcester, George
L3/L4 Academic Centres	Salt River, Tygerberg

Skills development remains a priority and orientation as well as comprehensive basic training is required in order to ensure continued improved service delivery to the community. The Provincial incident response time will be maintained at a target of 78 per cent of cases being responded to within 40 minutes but with refined district specific targets. The Directorate will further continue to strengthen the Inspectorate of Anatomy functions to ensure compliance with Chapter 8 of the National Health Act and its Regulations.

CAPE MEDICAL DEPOT

The Cape Medical Depot (CMD) previously functioned as a trading entity but was incorporated into the Department on 1 April 2012. The operational functioning of the CMD remained unchanged. The CMD is responsible for the purchasing, warehousing and distribution of pharmaceuticals and medical sundries. Orders are supplied in bulk to larger hospitals and in smaller quantities to smaller institutions. The central hospitals procure pharmaceuticals and medical sundries directly from suppliers and use the CMD as a top-up service when required. The CMD is foreseen to play an increasing role in the provisioning, warehousing and distribution of non-pharmaceutical items.

The CMD provides a comprehensive pharmaceutical, medical and surgical supply service to health institutions and is licensed by the Pharmacy Act 53 of 1974, as amended, and is responsible for pharmaceutical quality control. Quality control is achieved by means of a quality control laboratory (QCL) situated at the Cape Peninsula University of Technology. The CMD also has a pre-pack unit responsible for the break-up of bulk stock into manageable quantities to be used at institutions.

13.4. Strategic Objectives

GOAL: PROMOTE HEALTH AND WELLNESS

Table B.9: Strategic objectives and expected outcomes for Health Care Support Services

Strategic objective (short title)	Strategic objective statement (SMART)	Indicator	Baseline (2013/14)	Target (2019/20)
1. Ensure access to Forensic Pathology Service.	1.1. Ensure access to Forensic Pathology Service by maintaining cases released within 5 days at 74.4% by 2019/20.	1.1.1. Percentage of FPS cases released within 5 days (excluding unidentified persons)	74.4%	74.4%
		Numerator:	7 266	9081
		Denominator:	9 340	12 204
2. Ensure optimum pharmaceutical stock levels to meet the demand.	2.1. Maintain stock levels to ensure 97% of pharmaceutical stock is available by 2019/20.	2.1.1. Percentage of pharmaceutical stock available	94.8%	97.0%
		Numerator:	746	735
		Denominator:	787	758

GOAL: EMBED GOOD GOVERNANCE AND VALUES-DRIVEN LEADERSHIP PRACTICES

Table B.10: Strategic objectives and expected outcomes for Health Care Support Services

Strategic objective (short title)	Strategic objective statement (SMART)	Indicator	Baseline (2013/14)	Target (2019/20)
1. Provide an efficient and effective laundry service.	1.1. Provide an efficient and effective laundry service by ensuring the average cost per item laundered in-house does not exceed R5.92 by 2019/20.	1.1.1. Average cost per item laundered in-house	R4.40	R5.92
		Numerator:	63 260 438	95 450 056
		Denominator:	14 376 272	16 123 320

Strategic objective (short title)	Strategic objective statement (SMART)	Indicator	Baseline (2013/14)	Target (2019/20)
2. Provide an efficient and effective maintenance service.	2.1. Provide an efficient and effective maintenance service by ensuring 100% of the maintenance budget is spent by 2019/20.	2.1.1. Percentage of maintenance budget spent	100.0%	100.0%
		Numerator:	107 356 000	140 102 393
		Denominator:	103 400 000	140 102 393

13.5. Resource Considerations

The past years have seen growth in real terms, the budgets allocated to the department for the MTEF period does however not enable further real growth. Any new priorities or initiatives, and growth in work load must be accommodated by reprioritisation from lower value to higher value activities. Total staff numbers will increase marginally due to the filling of funded posts, but additional posts will not be made available unless there is an increase in real terms of the discretionary funding envelope.

EXPENDITURE TRENDS

In 2013/14 Programme 7 contributed 2.1 per cent to the overall departmental expenditure.

Figure B.25: **Expenditure trends in Health Care Support Services, 2009 to 2013**

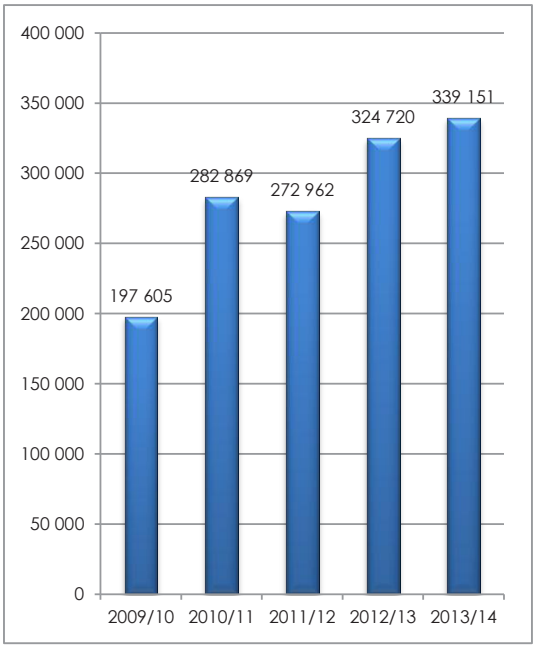


Figure B.26: **Expenditure per sub-programme in Health Care Support Services, 2013/14 (per R'000)**

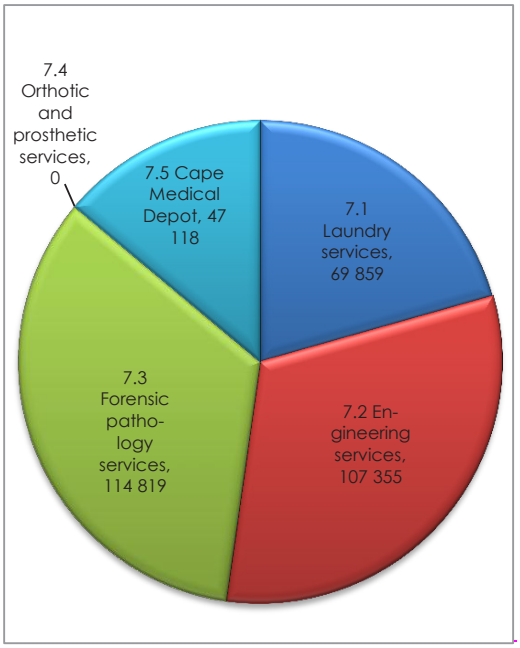


Figure B.27: **Expenditure trends per economic classification in Health Care Support Services, 2009 to 2013**

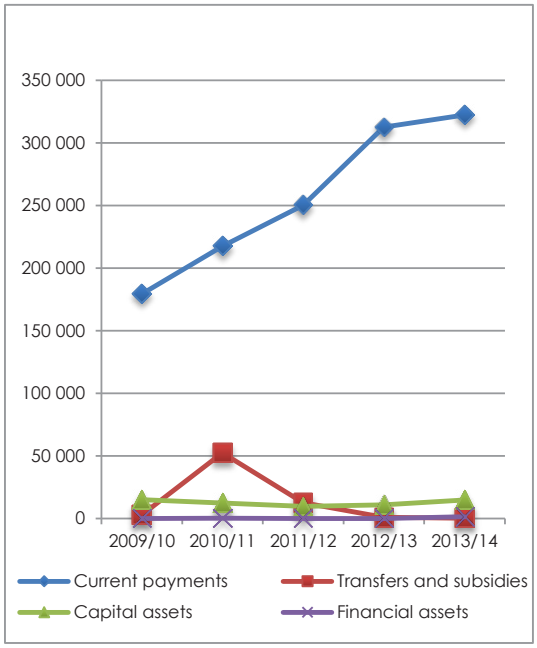
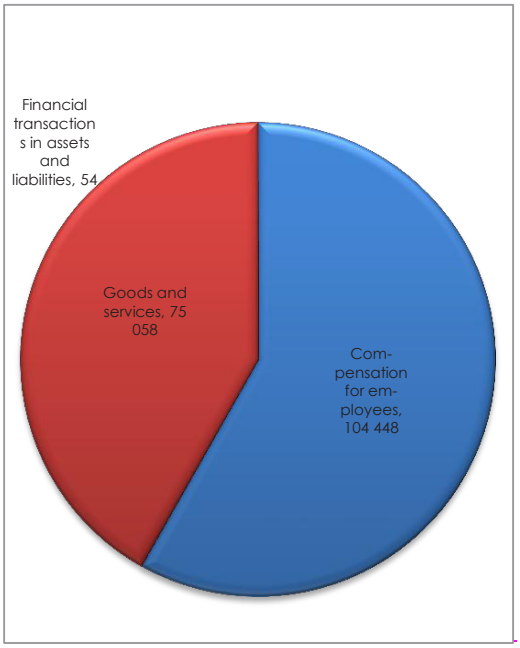


Figure B.28: **Expenditure for current payments, 2013/14 (per R'000)**



Laundry Services

The rendering of an efficient, effective, environmentally friendly and economical laundry service to all healthcare facilities is contingent upon uninterrupted access to utilities (electricity, water etc.) and an adequate provision of linen. Although increases in costs have been taken into consideration in the forward planning of the rendering of this service, aspects such as the potential significant increase in the cost of utilities (specifically electricity) and higher inflation could have a direct impact on the financial resources. In addition, the high rate of linen losses (primarily due to theft) experienced over the past few years will also impact on financial resources. The recent upgrading of the Lentegeur Regional Laundry, which included the installation of substantially more efficient equipment, has improved the efficiency of the service and made it more environmentally friendly. Compensation of employees negatively impacts on the cost to render the in-house laundry service. The future service model for the Tygerberg Laundry is being reviewed as part of the Tygerberg Central Hospital redevelopment, with the aim to improve resource efficiencies.

Engineering Services

It is anticipated that funding for engineering and clinical maintenance will not increase significantly over the next five years and that increases will largely be inflation linked. Fortunately, the upgrading, replacement and building of new facilities as well as medical equipment, utilising funding from the Health Facility Revitalisation Grant, assists in addressing the condition of facilities and equipment in general. The lack of adequate financial and human resources to address the maintenance need remains a challenge. The implementation of the Maintenance Hub for Building Maintenance and the Maintenance Hub for Health Technology is expected to improve the rendering of efficient, effective and economical engineering and clinical maintenance to health facilities. However, this implementation will need to follow a phased approach as both will require substantial budget increases due to increased resource requirements, particularly with respect to personnel.

Forensic Pathology Service

The increase in case load and case complexity and related stress on staff and the system continues to impact on the ability to recruit and retain personnel to the Forensic Pathology Service. This needs to be addressed by the implementation of an appropriate human resource plan which includes access to formal structured training programmes and career pathing opportunities. The commissioning of the Observatory Forensic Pathology Centre, to replace the current outdated and substandard Salt river mortuary, will enable the Forensic Pathology Service to deliver a more comprehensive package of services. This will result in an improvement in case management and conclusion of post-mortem findings. The forensic pathology academic training centres must be resourced and supported to enable the training of registrars; whilst continuing optimum, competent service delivery. The Inspectorate of Anatomy must be resourced to ensure compliance with Chapter 8 of the National Health Act and its Regulations.

Cape Medical Depot

The current depot has been significantly upgraded. The physical structure consists of a multi-story building with a central elevator. Due to the structural limitations of the current building a process is underway to find alternative premises to relocate the Depot in the long term to ensure the efficient management of inventory and to address the security of the contents of the CMD. Another factor that impacts on the CMD's ability to trade efficiently is the normal increase in the price of goods. Pharmaceuticals have increased in price on average by 8 per cent per annum. Certain items have shown an abnormally high price increase, which has been masked by the weighted averaging method used by the Cape Medical Depot to value the inventory in its control.

UNFUNDED PRIORITIES

While none of the priorities for this budget programme are entirely unfunded, it is important to note that certain aspects are inadequately funded.

TRENDS IN THE SUPPLY OF KEY CATEGORIES OF HEALTH PERSONNEL

The recruitment and retention of key skilled staff remains a challenge within this programme. A contributing factor is the competition from the private sector as well as the overseas market, especially for engineering staff. Occupational groups that are effected mostly are:

- Forensic Pathology Specialists
- Engineers (Electrical and Mechanical)
- Engineering Technicians
- Artisans

13.6. Risk Management

RISK STATEMENT 1:	Shortage Of Skilled Staff
Risk	Inadequate competency levels
Root Cause	▪ Shortage of highly skilled professionals ▪ Inability to offer competitive remuneration packages
Impact	▪ Compromised ability to deliver on the Department's mandate
Strategic Goal Impact	▪ Promote Health and Wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Allocation of bursaries per scarce-skilled profession as a recruitment strategy ▪ In the process of developing an on-line exit interview questionnaire to assist in identifying the reasons for exits and to inform future interventions ▪ Development and implementation of recruitment and retention policies ▪ Work in partnership with universities to recruit and retain highly skilled staff ▪ Strengthen organisational culture and staff wellbeing ▪ Succession planning ▪ Improve the working environment
RISK STATEMENT 2	**Resource Constraints**
Risk	Inability to render comprehensive quality health services
Root Cause	▪ Allocative and technical inefficiencies ▪ Escalating burden of disease ▪ Escalating costs of labour, goods and services ▪ Fiscal envelope based on nominal growth ▪ Aging infrastructure
Impact	▪ Poor health outcomes ▪ Compromised ability to deliver on the department's mandate
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Priority setting ▪ Establish and embed mechanisms to enhance efficiencies ▪ Applying lean management principles to reduce waste in the system ▪ Rational prescribing ▪ Laboratory cost containment measures, e.g. Electronic Gatekeeping System ▪ Explore alternative financing options
RISK STATEMENT 3:	**ICT Systems Disruption**
Risk	Dysfunctional communication and information systems
Root Cause	▪ Inadequate and ageing technology infrastructure and resources ▪ Inadequate technical capacity within the Western Cape Government
Impact	▪ Compromised service delivery
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop a robust IT disaster recovery plan ▪ Monitor the responsiveness of the Helpdesk and support systems to IT system failures ▪ Constantly review and address out-dated infrastructure by conducting regular hardware and ICT audits
RISK STATEMENT 4:	**Fire Within Health Facilities**
Risk	Fire damage to state property and safety threat to building occupants
Root Cause	▪ Inadequate safety measures ▪ Constant trade-off between securing a building from a safety perspective versus maintaining the integrity of fire escapes etc. ▪ Building maintenance backlog and infrastructure budget constraints
Impact	▪ Service disruption ▪ Property damage ▪ Traumatised and/or injured staff and patients
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop and implement the Provincial Safety, Health, Environment, Risk, and Quality Management (SHERQ) Policy to support and guide facilities ▪ Ensure that design and construction of infrastructure is compliant through phased fire compliance ▪ Monitor and evaluate operational compliance with fire regulations ensuring that disaster plans and fire drills are in place ▪ Ensure compliance of the physical environment and physical entities such as fire detectors, fire extinguishers, alarms, sprinkler systems, fire doors, and fire exits are in order ▪ Establish Health and Safety committees, appoint and train emergency representatives (fire, first aid and floor marshals), in accordance with the National Core Standards

RISK STATEMENT 5	**Vandalism And Theft**
Risk	Damage to and loss of state property
Root Cause	▪ Inadequate security measures ▪ Volatility in the community ▪ High crime prevalence
Impact	▪ Compromises the quality of care ▪ Property damage ▪ Escalates maintenance and repair expenditure
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Business continuity plans in place to minimise the impact on service delivery ▪ Installation of vandal-proof infrastructure including fixtures and fittings, as far as possible ▪ Improve security services and contract management at facility level
RISK STATEMENT 6:	**Fraud**
Risk	Unfair or unlawful access to public fund
Root Cause	▪ Inadequate (compliance with) internal controls ▪ Lack of commitment to values of the organisation
Impact	▪ Exacerbates resource constraints ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Monitor the implementation of the fraud prevention plan ▪ Ensure PERSAL is accurate to prevent ghost employees ▪ Embark upon change management initiative that emphasises the values of the organisation ▪ Strengthening the DICU, ICU processes – IA, CA, etc.
RISK STATEMENT 7:	**Labour Unrest**
Risk	Strike action
Root Cause	▪ Labour disputes
Impact	▪ Service disruption ▪ Compromises patient and staff safety ▪ Exacerbates resource constraints and staff shortages
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Maintaining good practices and relations with organised labour through robust structures of engagement ▪ In the event of a strike ensure contingency plans are in place to minimise service disruption
RISK STATEMENT 8:	**Load Shedding**
Risk	Disruption in the supply of electricity
Root Cause	▪ Eskom infrastructure ▪ Shortage in supply of diesel to support back-up power supply
Impact	▪ Service disruption ▪ Compromised quality of care ▪ Increased supply of and maintenance to alternative sources of power supply ▪ Increased diesel storage ▪ Cost of diesel supply ▪ Damage to electrical and electronic equipment (including medical) due to power surge
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Backup power supply in place for priority services ▪ Reduce dependency on Eskom by investing in alternative energy sources ▪ Business continuity plans in place to minimise the impact on service delivery ▪ Ensures adequate diesel supply and storage

RISK STATEMENT 9.	Disruption of the laundry service
Risk	Disruption of the laundry service
Root Cause	▪ Breakdown of equipment. ▪ Linen losses due to theft. ▪ Industrial action. ▪ Utility outages. ▪ Unavailability of products and / or services from suppliers.
Impact	▪ Inadequate supply of clean linen to institutions. ▪ Increased risk of infection. ▪ Compromised service delivery.
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices.
Measures to Mitigate Impact	▪ Maintenance contracts on new equipment. ▪ Apply lean management principles. ▪ Regular engagement between management and stakeholders. ▪ Continuous liaison with and monitoring of suppliers and service providers (outsource laundry providers). ▪ Increase utility redundancy. ▪ Implementation and monitoring of linen control policies and security measures.
RISK STATEMENT 10.	**Infrastructure and medical equipment maintenance backlog**
Risk	Continuously increasing infrastructure and medical equipment maintenance backlog.
Root Cause	▪ Fragmented maintenance budget and systems. ▪ Inadequate financial and human resources. ▪ Potential for fraud and corruption.
Impact	▪ Deteriorating health infrastructure and medical equipment. ▪ Compromised healthcare services. ▪ Compromised health and safety of staff and patients including fire protection. ▪ Shortened life-cycle of infrastructure and medical equipment.
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices.
Measures to Mitigate Impact	▪ Approval and implementation of 'Hub & Spoke' models[15]. ▪ Implement Maintenance Contract on major and life-support medical equipment. ▪ Implementation of improved contracting strategies in line with IDMS. ▪ Training specifically aimed at creating awareness, and combatting of, fraud and corruption. ▪ On-going Routine Maintenance budget allocation for new facilities.
RISK STATEMENT 11:	**Pharmaceutical Stock-outs**
Risk	Unavailability of essential pharmaceutical goods and services
Root Cause	▪ Supplier challenges e.g. global shortages of ingredients ▪ Lack of timeous and good contract management ▪ Inability to secure alternatives ▪ Late or inadequate awarding of national pharmaceutical contracts
Impact	▪ Compromises the quality of care ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Engage National Department of Health on timeous awarding of national tenders ▪ Monitor stocks out regularly ▪ Monitor vaccine supply ▪ Provide alternatives to the essential medicines, where possible ▪ Tight contract management with suppliers ▪ Create provincial contracts for items that have been excluded from the revised national tenders, where possible

[15] The 'Hub & Spoke model' implies that a central consolidator, referred to as the 'Hub', will provide a single face to Health Facilities while seamless extensions of the 'Hub' – referred to as 'Spoke' – are leveraged to provide the certain services across multiple health facility locations. The 'Hub' is responsible for management responsibilities which include customer relationship, regulatory compliance and uniform standards of delivery and management of human & financial resources. The 'Spoke' is a delivery centre that can be scaled up or down based on workload requirements.

14. Programme 8: HEALTH FACILITIES MANAGEMENT

14.1. Purpose

The provision of new health facilities and the refurbishment, upgrading and maintenance of existing facilities, including health technology

14.2. Structure

SUB-PROGRAMME 8.1: COMMUNITY HEALTH FACILITIES

Plan, design, construction, upgrade, refurbishment, additions and maintenance of community health centres, community day centres, and clinics

SUB-PROGRAMME 8.2: EMERGENCY MEDICAL RESCUE SERVICES

Plan, design, construction, upgrade, refurbishment, additions, and maintenance of emergency medical services facilities

SUB-PROGRAMME 8.3: DISTRICT HOSPITAL SERVICES

Plan, design, construction, upgrade, refurbishment, additions, and maintenance of district hospitals

SUB-PROGRAMME 8.4: PROVINCIAL HOSPITAL SERVICES

Plan, design, construction, upgrade, refurbishment, additions, and maintenance of provincial hospitals

SUB-PROGRAMME 8.5: CENTRAL HOSPITAL SERVICES

Plan, design, construction, upgrade, refurbishment, additions, and maintenance of central hospitals

SUB-PROGRAMME 8.6: OTHER FACILITIES

Plan, design, construction, upgrade, refurbishment, additions, and maintenance of other health facilities, including forensic pathology facilities and nursing colleges

14.3. Key Components

The Chief Directorate: Infrastructure and Technical Management plans and co-ordinates infrastructure management and development to ensure effective spending on infrastructure. The building and maintenance of infrastructure plays a pivotal role in the provision of accessible and quality health care to all residents of the Province. This chief directorate consists of the following directorates:

1. Infrastructure Planning
2. Infrastructure Programme Delivery
3. Engineering and Technical Support
4. Health Technology
5. Tygerberg Hospital re-development project officer

The Chief Directorate: Infrastructure and Technical Management is responsible for the management and implementation of Programme 8. This is done in partnership with the Western Cape Government: Transport and Public Works (WCG: TPW) as the preferred Implementing Agent. The relationship with WCG: TPW is managed through monitoring the alignment with the Western Cape Infrastructure Delivery Management System (WC IDMS) and the Service Delivery Agreement (SDA) – the SDA is reviewed and signed annually. The funding to implement the infrastructure programme emanates from both the Equitable Share and the Health Facility Revitalisation Grant (HFRG), the latter being a Schedule 5 Grant.

WCGH annually submits an Infrastructure Programme Management Plan IPMP) to WCGTPW on how it is proposed to execute, monitor and control its infrastructure programme over the MTEF period. Moreover, the IPMP informs the WCG: TPW of the scope, deliverables, targets and requirements of the portion of the programme for which they are responsible.

In addition to fulfilling the role of Implementing Agent on behalf of the WCG: Health, WCG: TPW is also the custodian of the Provincial Immovable Asset Portfolio, as described in the Government Immovable Asset Management Act, No.19 of 2007 (GIAMA). GIAMA prescribes the preparation of the document known as the User Asset Management Plan (U-AMP), which, inter alia, outlines the conditions and the suitability of each facility utilised by WCG: Health, as well as the requirement for new, upgrading, extension, and routine and scheduled maintenance for all health facilities (excluding Head Office, District and Sub-district office accommodation). Programme 8, through the Chief Directorate: Infrastructure and Technical Management, is responsible for the annual preparation and updating of the U-AMP (the latest version of this document is available at the following web address: *http://www.westerncape.gov.za/assets/departments/health/uamp2014_2015.pdf*
Although infrastructure planning and delivery comprise the largest component of the portfolio of the Chief Directorate, it is also responsible for the following supplementary components, which contribute to the provision of a comprehensive package of service:

- Health Technology comprising policy development, specification, procurement, installation, commissioning and maintenance of health technology services to WCG: Health and including the provisioning of apparatus, consumables, devices, equipment, instruments, systems, furniture etc. required to render a health facility operational.
- Organisational Development, which aims at strengthening institutional and operational efficiency of health facilities through improving their management systems, structures and processes.
- Quality Assurance, focusing on the modification of health facility systems in order to improve and sustain the quality of services that are provided whilst adhering to the national core standards.

The above initiatives are mainly implemented in conjunction with an infrastructure project (new and replacement; upgrading and additions; or rehabilitation, renovations and refurbishment),

The capacitation of the Chief Directorate is mainly funded through the Health Facility Revitalisation Grant.

14.4. Strategic Objectives

GOAL: EMBED GOOD GOVERNANCE AND VALUES-DRIVEN LEADERSHIP PRACTICES

Table B.11: Strategic objectives and expected outcomes for Health Care Support Services

Strategic objective (short title)	Strategic objective statement (SMART)	Indicator	Baseline (2013/14)	Target (2019/20)
1. Efficient and effective management of infrastructure.	1.1. Efficient and effective management of infrastructure by ensuring 100% of the annual allocated budgets are spent and 100% of projects planned for completion is achieved by 2019/20.	1.1.1. Percentage of Programme 8 capital infrastructure budget spent (excluding maintenance	82.6%	100%
		Numerator:	425 339 929	3 263 929 000
		Denominator:	514 935 000	3 263 929 000
		1.1.2. Percentage of Programme 8 capital infrastructure projects completed	16.7%	100%
		Numerator:	1	23
		Denominator:	6	23

14.5. Resource Considerations

The past years have seen marginal growth in real terms. The budgets allocated to the department for the MTEF period do, however, not enable further real growth. Any new priorities or initiatives, and growth in work load must be accommodated by reprioritization from lower value to higher value services. Total staff numbers will continue to increase to some extent and will be partially funded through the HFRG. However, access to appropriately skilled and experienced personnel in the built environment and engineering sector continues to remain a challenge.

EXPENDITURE TRENDS

In 2013/14 Programme 8 contributed 5.5 per cent to the overall departmental expenditure.

Figure B.29: **Expenditure trends in Health Facilities Management, 2009 to 2013**

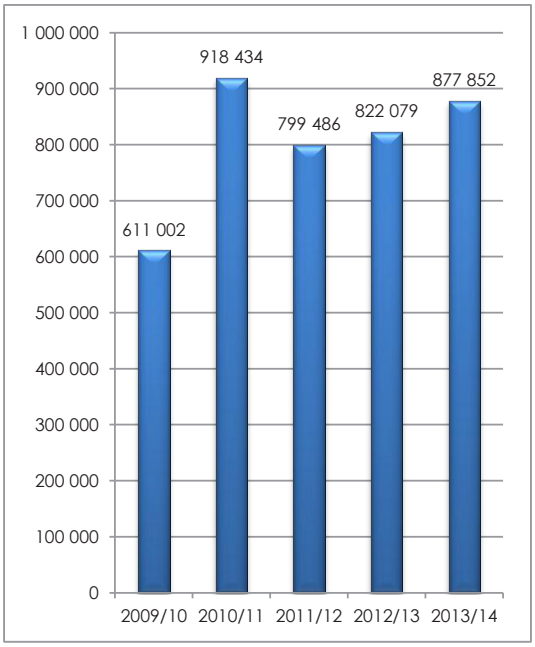


Figure B.30: **Expenditure per sub-programme, 2013/14 (per R'000)**

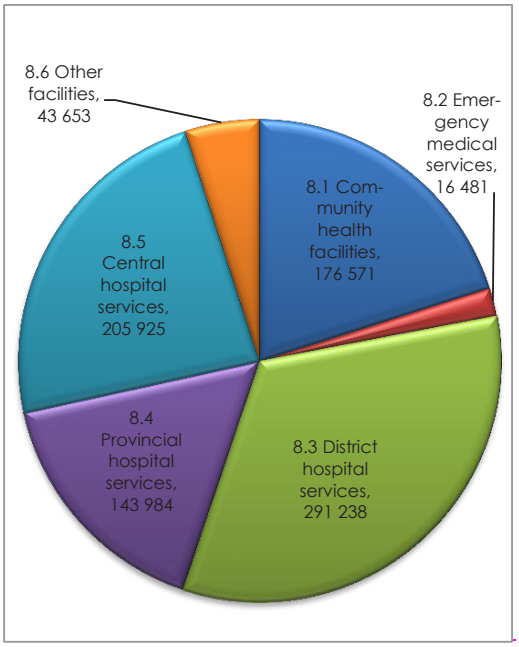


Figure B.31: **Expenditure trends per economic classification in Health Facilities Management, 2009 to 2013**

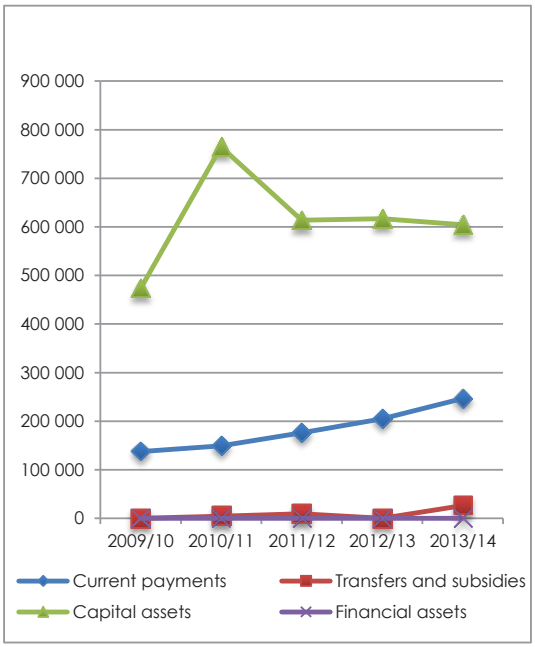
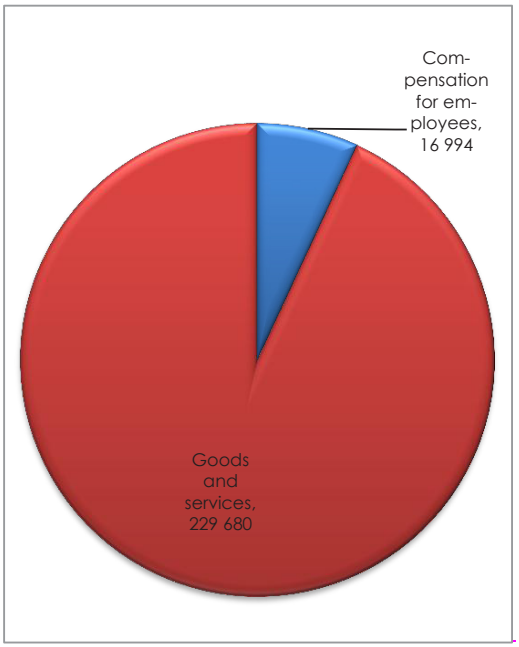


Figure B.32: **Expenditure for current payments, 2013/14 (per R'000)**



National Treasury introduced into the 2014 Division of Revenue Act (DoRA), the Performance-Based Incentive (PBI) process for the HFRG. The aim is to achieve better value for money from investment in provincial infrastructure by institutionalising rigorous planning within provinces. The PBI process requires that provinces bid for HFRG allocations two years in advance and includes financial incentives for provinces that implement best practices in delivering infrastructure. In terms of this process, provincial departments across the country are firstly, allocated what is referred to as a baseline budget; secondly, those departments which comply with the submission requirements of the current DoRA will be eligible to bid for unallocated funding from the following financial year, referred to as the PBI allocation. This bidding takes place through the following submissions:

- Project proposals for capital projects proposed to be in the planning phase in the forthcoming financial year.
- Concept reports for capital projects proposed to be in construction in the forthcoming financial year.

It is important to note that the portion of the budget allocated to salaries of relevant infrastructure personnel will continue to be provided to provinces through the HFRG and is therefore excluded from the PBI process.

In light of the above, it is anticipated that adequate funding will be made available annually to proceed with infrastructure projects planned for the Province and in line with Healthcare 2030 and related policy framework documents on service delivery models and health facility distribution plans.

UNFUNDED PRIORITIES

The backlog in terms of maintenance and infrastructure remain unfunded priorities. This is exacerbated by inadequate funding and capacity constraints within WCGH and WCGTPW (as its implementing agent).

TRENDS IN THE SUPPLY OF KEY CATEGORIES OF HEALTH PERSONNEL

The recruitment and retention of key skilled staff remains a challenge within this programme, with the following key categories posing a particular challenge:

- Mechanical engineers
- Electrical engineers
- Civil engineers
- Clinical technicians.

14.6. Risk Management

RISK STATEMENT 1.	**Affordability of the infrastructure requirements of Healthcare 2030**
Risk	Affordability of delivering on required infrastructure in order to meet objectives of Healthcare 2030.
Root Cause	• Limited financial resources • Inappropriate and over-designed infrastructure that is too complex and costly to construct and maintain. ▪ Current condition and functional limitations of existing health infrastructure portfolio
Impact	Compromised healthcare services.
Strategic Goal Impact	Embed good governance and values-driven leadership practices.
Measures to Mitigate Impact	• Develop standard health infrastructure designs which are appropriate to a developing economy • Ensure compliance to standard designs, where appropriate and possible. • Explore alternative finance options. • Application of Prioritisation Tool for capital projects. ▪ Increase resources for maintenance of existing facilities.
RISK STATEMENT 2.	**Ad hoc / urgent projects**
Risk	Prioritising projects not included in MTEF infrastructure planning cycle.
Root Cause	• Unforeseen operational response to service pressure • Changes in strategic objectives • Changes in burden of disease.
Impact	Delays on planned projects Cost escalation Compromised infrastructure service delivery
Strategic Goal Impact	Embed good governance and values-driven leadership practices.
Measures to Mitigate Impact	• Improved synergy with Directorate: Strategic Planning. Develop standard infrastructure response to deal with ad hoc / urgent projects. ▪ All projects to follow the IDMS prescripts as per the standard for infrastructure delivery in the Western Cape.

RISK STATEMENT 3.	**Lack of suitable sites**
Risk	Lack of suitable sites for construction of new facilities.
Root Cause	• Site procurement processes. • Increased legislative requirements. • Lack of inter-governmental co-operation.
Impact	Project delays. Uncertainty on planned deliverables. Compromised service delivery.
Strategic Goal Impact	Embed good governance and values-driven leadership practices.
Measures to Mitigate Impact	• Integrated planning with other government departments and local authorities. • Increase site request timeframe to ten years. • Flexibility in use of Capital Project Prioritisation Tool.
RISK STATEMENT 4.	**Under expenditure of DoRA Grant**
Risk	Under expenditure of DoRA Grant which will have detrimental effect on future infrastructure budget and ultimately ability to deliver required infrastructure.
Root Cause	• Compromised project implementation due to capacity and capability within WCGH as well as Implementing Department • Capacity, capability and commitment of professional service providers, contractors and suppliers to deliver projects within time, quality and budget. • Changes / additions to project scope. • Fluctuating currency exchange rate.
Impact	Delay of future projects. Increased infrastructure backlog. Cost escalation. Compromised service delivery Reduced future grant allocations.
Strategic Goal Impact	Embed good governance and values-driven leadership practices.
Measures to Mitigate Impact	• Rigorous Programme Management and monitoring of Implementing Department • Implementation of the IDMS • Assist WCGH user departments in developing Business Cases / Briefs. • Provide projected cash-flows aligned with deliverables / programme for each project. • Improve Strategic Briefs and Business Plan. • Ensure compliance to standardisation, where appropriate and possible. • Relevant training to up-skill existing staff. • Structured and formalised career- pathing. • Policy for recruitment and retention of scarce skills.
RISK STATEMENT 5:	**Shortage Of Skilled Staff**
Risk	Inadequate competency levels
Root Cause	▪ Shortage of highly skilled professionals
Impact	▪ Inability to offer competitive remuneration packages ▪ Compromised ability to deliver on the Department's mandate
Strategic Goal Impact	▪ Promote Health and Wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Allocation of bursaries per scarce-skilled profession as a recruitment strategy ▪ In the process of developing an on-line exit interview questionnaire to assist in identifying the reasons for exits and to inform future interventions ▪ Development and implementation of recruitment and retention policies ▪ Work in partnership with universities to recruit and retain highly skilled staff ▪ Strengthen organisational culture and staff wellbeing ▪ Succession planning ▪ Improve the working environment

RISK STATEMENT 6:	Resource Constraints
Risk	Inability to render comprehensive quality health services
Root Cause	▪ Allocative and technical inefficiencies ▪ Escalating burden of disease ▪ Escalating costs of labour, goods and services ▪ Fiscal envelope based on nominal growth ▪ Aging infrastructure
Impact	▪ Poor health outcomes ▪ Compromised ability to deliver on the department's mandate
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Priority setting ▪ Establish and embed mechanisms to enhance efficiencies ▪ Applying lean management principles to reduce waste in the system ▪ Rational prescribing ▪ Laboratory cost containment measures, e.g. Electronic Gatekeeping System ▪ Explore alternative financing options

RISK STATEMENT 7:	ICT Systems Disruption
Risk	Dysfunctional communication and information systems
Root Cause	▪ Inadequate and ageing technology infrastructure and resources ▪ Inadequate technical capacity within the Western Cape Government
Impact	▪ Compromised service delivery
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop a robust IT disaster recovery plan ▪ Monitor the responsiveness of the Helpdesk and support systems to IT system failures ▪ Constantly review and address out-dated infrastructure by conducting regular hardware and ICT audits

RISK STATEMENT 8:	Fire Within Health Facilities
Risk	Fire damage to state property and safety threat to building occupants
Root Cause	▪ Inadequate safety measures ▪ Constant trade-off between securing a building from a safety perspective versus maintaining the integrity of fire escapes etc. ▪ Building maintenance backlog and infrastructure budget constraints
Impact	▪ Service disruption ▪ Property damage ▪ Traumatised and/or injured staff and patients
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Develop and implement the Provincial Safety, Health, Environment, Risk, and Quality Management (SHERQ) Policy to support and guide facilities ▪ Ensure that design and construction of infrastructure is compliant through phased fire compliance ▪ Monitor and evaluate operational compliance with fire regulations ensuring that disaster plans and fire drills are in place ▪ Ensure compliance of the physical environment and physical entities such as fire detectors, fire extinguishers, alarms, sprinkler systems, fire doors, and fire exits are in order ▪ Establish Health and Safety committees, appoint and train emergency representatives (fire, first aid and floor marshals), in accordance with the National Core Standards

RISK STATEMENT 9:	Vandalism And Theft
Risk	Damage to and loss of state property
Root Cause	▪ Inadequate security measures ▪ Volatility in the community ▪ High crime prevalence
Impact	▪ Compromises the quality of care ▪ Property damage ▪ Escalates maintenance and repair expenditure
Strategic Goal Impact	▪ Promote health and wellness
Measures to Mitigate Impact	▪ Business continuity plans in place to minimise the impact on service delivery ▪ Installation of vandal-proof infrastructure including fixtures and fittings, as far as possible ▪ Improve security services and contract management at facility level
RISK STATEMENT 10:	**Fraud**
Risk	Unfair or unlawful access to public fund
Root Cause	▪ Inadequate (compliance with) internal controls ▪ Lack of commitment to values of the organisation
Impact	▪ Exacerbates resource constraints ▪ Compromises public trust in the health system
Strategic Goal Impact	▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Monitor the implementation of the fraud prevention plan ▪ Ensure PERSAL is accurate to prevent ghost employees ▪ Embark upon change management initiative that emphasises the values of the organisation ▪ (Strengthening the DICU, ICU processes – IA, CA, etc.)
RISK STATEMENT 11:	**Labour Unrest**
Risk	Strike action
Root Cause	▪ Labour disputes
Impact	▪ Service disruption ▪ Compromises patient and staff safety ▪ Exacerbates resource constraints and staff shortages
Strategic Goal Impact	▪ Promote health and wellness ▪ Embed good governance and values-driven leadership practices
Measures to Mitigate Impact	▪ Maintaining good practices and relations with organised labour through robust structures of engagement ▪ In the event of a strike ensure contingency plans are in place to minimise service disruption

PART C:
LINKS TO OTHER PLANS

PART C: LINKS TO OTHER PLANS

LINKS TO THE LONG-TERM INFRASTRUCTURE AND OTHER CAPITAL PLANS

Table C.1: New and replacement assets

NO	PROJECT NAME	SUB-PRO-GRAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
1	Athlone: Dr Abdurahman CDC	8.1	City of Cape Town	CDC Replacement	-	-	-	-	-	-	250	500	1 000
2	Beaufort West :Beaufort West Forensic Pathology Lab	8.6	Central Karoo	FPL Replacement	9 268	569	36	-	50	50	-	-	-
3	Beaufort West: Hill Side Clinic	8.1	Central Karoo	Clinic Replacement	-	33	2 000	500	1 000	1 000	13 000	6 300	1 000
4	Belhar: Tygerberg Regional Hospital	8.4	City of Cape Town	Replacement Hospital Phase 1	-	-	-	-	-	-	-	100	1 000
5	Ceres: Ceres Hospital	8.3	Cape Winelands	New Emergency Centre	10 539	1 894	4	-	-	-	-	-	-
6	De Doorns: De Doorns Ambulance Station	8.2	Cape Winelands	Ambulance Station Replacement	-	-	-	-	200	200	500	4 500	4 000
7	De Doorns: De Doorns Ambulance Station	8.2	Cape Winelands	Ambulance Station Replacement	-	-	500	-	-	-	-	-	-
8	Delft: Symphony Way CDC	8.1	City of Cape Town	New Community Day Centre	-	-	27 200	15 000	16 135	16 135	1 400	-	-
9	Delft: Symphony Way CDC	8.1	City of Cape Town	New Community Day Centre	1 142	5 483	-	-	-	-	-	-	-
10	District Six: District Six CDC	8.1	City of Cape Town	CDC Replacement	-	-	-	17 000	6 255	6 255	54 000	20 000	4 000
11	District Six: District Six CDC	8.1	City of Cape Town	CDC Replacement	1 581	2 200	8 500	-	-	-	-	-	-
12	Du Noon: Du Noon CHC	8.1	City of Cape Town	New Community Health Centre	-	-	49 500	6 400	14 601	14 601	2 000	-	-
13	Du Noon: Du Noon CHC	8.1	City of Cape Town	New Community Health Centre	3 107	10 949	-	-	-	-	-	-	-
14	Du Noon: Du Noon Temp Clinic	8.1	City of Cape Town	Clinic Replacement	-	7 841	420	-	-	-	-	-	-
15	Elsies River: Elsies River CHC	8.1	City of Cape Town	CHC Replacement	-	-	-	-	-	-	500	1 000	15 000
16	George: Centrum CDC	8.1	Eden	CDC Replacement	-	-	-	-	-	-	200	-	-

NO	PROJECT NAME	SUB-PRO-GRAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
17	George: Thembalethu CDC	8.1	Eden	CDC Replacement	-	-	500	-	100	100	500	1 000	4 000
18	Goodwood: Ruyterwacht CDC	8.1	City of Cape Town	CDC Replacement	-	-	-	14	71	71	-	-	-
19	Goodwood: Ruyterwacht CDC	8.1	City of Cape Town	CDC Replacement	46	4 023	7 500	-	-	-	-	-	-
20	Gouda: Gouda Clinic	8.1	Cape Winelands	Clinic Replacement	-	-	-	-	-	-	-	-	500
21	Grassy Park: Grassy Park Clinic	8.1	City of Cape Town	Clinic Replacement	10 431	89	-	-	-	-	-	-	-
22	Gugulethu: Gugulethu CHC	8.1	City of Cape Town	CHC Replacement	-	-	-	-	-	-	-	100	-
23	Hanover Park: Hanover Park CHC	8.1	City of Cape Town	CHC Replacement	-	-	-	-	-	-	500	1 000	9 000
24	Heidelberg: Heidelberg Ambulance Station	8.2	Eden	New Ambulance Station	636	106	-	2 000	2 000	2 000	400	-	-
25	Heidelberg: Heidelberg Ambulance Station	8.2	Eden	New Ambulance Station	-	-	5 000	-	-	-	-	-	-
26	Hermanus: Hermanus CDC	8.1	Overberg	CDC Replacement	-	-	-	13 800	17 171	17 171	2 100	-	-
27	Hermanus: Hermanus CDC	8.1	Overberg	CDC Replacement	-	-	28 000	-	-	-	-	-	-
28	Hout Bay: Hout Bay CDC	8.1	City of Cape Town	CDC Replacement	-	-	-	-	-	-	100	1 000	4 000
29	Khayelitsha: Khayelitsha Hospital	8.3	City of Cape Town	New Hospital and Ambulance Station	125 259	6 522	2 700	-	2 000	2 000	-	-	-
30	Khayelitsha: Khayelitsha Sub-District	8.6	City of Cape Town	Sub-district office accommodation	48	4 734	-	-	-	-	-	-	-
31	Klaarstroom: Klaarstroom Clinic	8.1	Central Karoo	Clinic Replacement	-	-	389	-	-	-	-	-	-
32	Knysna: Knysna CDC	8.1	Eden	CDC Replacement	1 525	24 698	600	-	600	600	-	-	-
33	Knysna: Knysna FPL	8.6	Eden	FPL Replacement	-	-	-	-	50	50	500	1 000	1 000
34	Knysna: Knysna FPL	8.6	Eden	FPL Replacement	-	-	1 318	-	-	-	-	-	-
35	Ladismith: Ladismith Clinic	8.1	Eden	Clinic Replacement	-	-	-	-	-	-	100	500	1 000
36	Laingsburg: Laingsburg FPL	8.6	Central Karoo	FPL Replacement	-	-	-	-	100	100	500	500	1 000
37	Laingsburg: Laingsburg FPL	8.6	Central Karoo	FPL Replacement	-	-	100	-	-	-	-	-	-
38	Maitland: Maitland Community Day Centre	8.1	City of Cape Town	CDC Replacement	-	-	-	-	-	-	-	100	1 000
39	Malmesbury: Abbotsdale Satellite Clinic	8.1	West Coast	Clinic Replacement	-	-	-	-	-	-	500	2 500	-

NO	PROJECT NAME	SUB-PRO-GRAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
40	Malmesbury: Chatsworth Clinic	8.1	West Coast	Clinic Replacement	-	-	-	-	-	-	-	1 000	2 000
41	Malmesbury: Malmesbury Ambulance Station	8.2	West Coast	Ambulance Station Replacement	3 566	10 073	1 900	-	-	-	-	-	-
42	Malmesbury: Wesbank CDC	8.1	West Coast	New Community Health Centre	16 048	2 134	1 000	300	300	300	300	-	-
43	Manenberg: New GF Jooste Hospital	8.3	City of Cape Town	Hospital Replacement phase 1	-	-	600	11 000	1 500	1 500	2 000	-	-
44	Manenberg: New GF Jooste Hospital	8.3	City of Cape Town	Hospital Replacement phase 1	-	-	-	-	-	-	-	12 194	10 000
45	Matjiesfontein: Matjiesfontein Satellite Clinic	8.1	Central Karoo	Clinic Replacement	-	-	-	-	-	-	1 000	2 000	-
46	Mfuleni: Mfuleni CDC	8.1	City of Cape Town	Temporary CDC Replacement	-	-	-	-	23 500	23 500	6 500	500	-
47	Mitchell's Plain: Mitchell's Plain Hospital	8.3	City of Cape Town	New Hospital	140 426	193 588	26 000	700	1 400	1 400	500	-	-
48	Mitchell's Plain: Mitchell's Plain Hospital	8.3	City of Cape Town	Psychiatric Evaluation Unit	-	-	18 000	23 000	27 481	27 481	200	-	-
49	Mitchell's Plain: Weltevreden CDC	8.1	City of Cape Town	New Community Day Centre	-	-	-	-	-	-	50	1 000	1 000
50	Mossel Bay: Mossel Bay New Hospital	8.3	Eden	Hospital Replacement	-	-	-	-	-	-	-	-	500
51	Napier: Napier Clinic	8.1	Overberg	Clinic Replacement	-	138	950	200	200	200	3 000	9 500	500
52	Observatory: Observatory Forensic Pathology Centre	8.6	City of Cape Town	FPL Replacement	-	-	1 000	4 856	500	500	8 000	5 000	10 000
53	Observatory: Valkenberg Hospital	8.4	City of Cape Town	Acute Precinct Redevelopment	-	-	1 250	-	-	-	4 500	-	-
54	Observatory: Valkenberg Hospital	8.4	City of Cape Town	Forensic Precinct Enabling Work	-	-	-	-	800	800	3 000	1 000	1 000
55	Observatory: Valkenberg Hospital	8.4	City of Cape Town	Forensic Precinct: Low Security, Chronic and OT	-	10 872	1 000	-	-	-	4 200	-	-
56	Observatory: Valkenberg Hospital	8.4	City of Cape Town	Pharmacy and OPD	-	-	1 000	-	-	-	-	-	-
57	Observatory: Valkenberg Hospital	8.4	City of Cape Town	Relocation of William Slater to Ward 15 and 16	-	-	-	-	-	-	100	100	1 000
58	Paarl: Paarl Hospital	8.4	Cape Winelands	Psychiatric Evaluation Unit	-	1 004	4 500	18 000	4 000	4 000	30 000	1 000	-
59	Parow: Cape Medical Depot	8.6	City of Cape Town	Cape Medical Depot replacement	-	-	-	-	-	-	500	1 000	10 000
60	Parow: Tygerberg Central Hospital	8.5	City of Cape Town	Hospital Replacement (PPP)	-	-	7 053	15 000	8 000	8 000	12 000	5 000	5 900

NO	PROJECT NAME	SUB-PRO-GRAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
61	Parow: Tygerberg Hospital	8.5	City of Cape Town	General Paediatric Outpatient Service Renovations	-	-	-	-	1 900	1 900	-	-	-
62	Parow: Tygerberg Hospital	8.5	City of Cape Town	Sunheart Trust	-	-	-	-	231	231	-	-	-
63	Parow: Tygerberg Hospital General Paediatric Outpatient Service Renovations	8.5	City of Cape Town	General Paediatric Outpatient Service Renovations	-	-	-	1 900	-	-	-	-	-
64	Piketberg: Piketberg Ambulance Station	8.2	West Coast	Ambulance Station Replacement	750	94	-	-	500	500	12 000	500	-
65	Prince Alfred Hamlet: Prince Alfred Hamlet Clinic	8.1	Cape Winelands	Clinic Replacement	-	256	1 000	200	500	500	6 000	12 000	500
66	Ravensmead: Ravensmead CDC	8.1	City of Cape Town	CDC Replacement	-	-	10	1 000	-	-	250	1 000	2 000
67	Rawsonville: Rawsonville Clinic	8.1	Cape Winelands	Clinic Replacement	95	606	-	10 000	11 488	11 488	500	-	-
68	Rawsonville: Rawsonville Clinic	8.1	Cape Winelands	Clinic Replacement	-	-	7 000	-	-	-	-	-	-
69	Riversdale: Riversdale FPS	8.6	Eden	FPL Replacement	107	-	600	-	90	90	-	-	-
70	Robertson: Robertson Ambulance Station	8.2	Cape Winelands	Ambulance Station Replacement	-	731	9 000	500	1 190	1 190	-	-	-
71	Robertson: Robertson Hospital	8.3	Cape Winelands	New Bulk Store	-	-	5 000	400	880	880	50	-	-
72	Saldanha: Diazville Clinic	8.1	West Coast	Clinic Replacement	-	-	-	-	-	-	-	-	500
73	Somerset West: Helderberg Hospital	8.4	City of Cape Town	Hospital Replacement	-	-	-	-	-	-	-	500	500
74	St Helena Bay: Sandy Point Clinic	8.1	West Coast	Clinic Replacement	-	-	-	-	-	-	500	2 500	-
75	Stellenbosch: Kayamandi CDC	8.1	Cape Winelands	CDC Replacement	-	-	-	-	-	-	-	500	5 000
76	Strand: Nomzamo Asanda Clinic	8.1	City of Cape Town	New clinic	-	-	-	21 500	16 000	16 000	8 000	1 000	-
77	Strand: Nomzamo Asanda Clinic	8.1	City of Cape Town	New clinic	297	1 432	3 400	-	-	-	-	-	-
78	Strand: Rusthof CDC	8.1	City of Cape Town	CDC Replacement	-	-	-	-	-	-	-	500	1 000
79	Tulbagh: Tulbagh Ambulance Station	8.2	Cape Winelands	New Ambulance Station	3 538	3 709	2	-	-	-	-	-	-
80	Villiersdorp: Villiersdorp Clinic	8.1	Overberg	Clinic Replacement	-	-	-	-	-	-	250	500	2 000
81	Vredenburg: Vredenburg CDC	8.1	West Coast	New Community Day Centre	-	-	-	-	-	-	-	500	2 000

NO	PROJECT NAME	SUB-PRO-GRAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
82	Vredendal: Vredendal Ambulance Station	8.2	West Coast	New Ambulance Station	5 718	194	-	-	-	-	-	-	-
83	Wolseley: Wolseley Clinic	8.1	Cape Winelands	Clinic Replacement	47	258	1 100	200	200	200	6 000	10 000	4 000
84	Worcester: Avian Park Clinic	8.1	Cape Winelands	New clinic	-	-	-	-	-	-	250	2 000	5 000
Total new and replacement assets					**334 174**	**294 230**	**225 632**	**163 470**	**160 993**	**160 993**	**186 700**	**110 894**	**111 900**

Table C.2: Maintenance and repairs

NO	PROJECT NAME	SUB-PRO-GRAMME	DISTRICT MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
Health Facilities Revitalisation Grant													
1	Community Health Facilities	8.1	Reported per sub-programme	Maintenance to various facilities to be identified	-	-	12 341	60 272	63 193	54 783	67 481	40 000	57 446
2	Emergency Medical Services	8.2		Maintenance to various facilities to be identified	-	-		-	-	1	7 800	4 000	9 223
	District Hospital Services	8.3		Maintenance (to various facilities to be identified)	-	-	18 579	51 276	53 761	46 925	57 500	42 000	64 000
	Provincial Hospital Services	8.4		Maintenance (to various facilities to be identified)	-	-	123	-	-	835	44 954	30 000	56 000
3	Central Hospital Services	8.5		Maintenance (to various facilities to be identified)	-	-	10 657	34 701	36 383	31 139	41 000	49 878	64 350
4	Other Facilities	8.6		Maintenance (to various facilities to be identified)	-	-	1 282	-	-	100	10 000	15 000	14 000
Expanded Public Works Programme Integrated Grant for Provinces													
1	Various Facilities		Various sub-programmes	Expanded Public Works Programme	-	-	3 000	-	-	-	-	-	-
Scheduled Maintenance													
1	Community Health Facilities	8.1	Reported per sub-programme	Maintain serviceability	23 395	29 173	8 215	7 992	8 763	8 708	-	18 585	26 456

NO	PROJECT NAME	SUB-PRO-GRAMME	DISTRICT MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
2	Emergency Medical Services	8.2		Maintain serviceability	1 040	1 753	269	4 350	4 770	4 227	-	-	-
3	District Hospital Services	8.3		Maintain serviceability	28 338	24 672	7 383	-	877	1 164	1 314	22 638	34 684
4	Provincial Hospital Services	8.4		Maintain serviceability	30 993	32 749	42 590	25 216	26 773	26 400	-	-	-
5	Central Hospital Services	8.5		Maintain serviceability	37 334	56 022	37 909	6 100	8 820	14 273	-	-	-
6	Other Facilities	8.6		Maintain serviceability	4 660	2 550	3 634	7 026	7 738	4 753	-	15 000	-
Preventative Maintenance													
1	Community Health Facilities	8.1	Reported per sub-programme	Maintain serviceability	-	512	933	1 935	1 755	1 755	-	4 281	4 516
2	Emergency Medical Services	8.2		Maintain serviceability	-	14	184	938	1 038	1 038	-	1 808	1 905
3	District Hospital Services	8.3		Maintain serviceability	-	3 104	5 181	7 221	7 271	7 271	-	13 081	12 944
4	Provincial Hospital Services	8.4		Maintain serviceability	-	4 210	5 671	8 421	8 421	8 421	-	8 903	8 478
5	Central Hospital Services	8.5		Maintain serviceability	-	2 004	7 851	9 307	9 307	9 307	-	6 779	7 138
6	Other Facilities	8.6		Maintain serviceability	-	441	644	2 000	2 030	2 030	-	1 158	1 223
Total maintenance and repairs								**226 755**	**240 900**	**223 130**	**230 049**	**273 111**	**362 363**

Table C.3: Upgrades and additions

NO	PROJECT NAME	SUB-PRO-GRAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
1	Athlone: Western Cape College of Nursing	8.6	City of Cape Town	Security upgrading	-	2 628	133	-	-	-	-	-	-
2	Atlantis: Westfleur Hospital	8.3	City of Cape Town	Emergency Centre and Paediatric Ward Additions	-	-	1 000	11 000	6 000	6 000	14 000	600	-
3	Bellville: Bellville engineering workshop	8.6	City of Cape Town	Hub and Spoke Implementation	-	-	-	-	-	-	4 546	8 000	10 000
4	Bellville: Karl Bremer Hospital	8.3	City of Cape Town	Emergency Centre Upgrade and Additions	3 170	22 270	32 200	500	4 514	4 514	800	-	-
5	Bellville: Karl Bremer Hospital	8.3	City of Cape Town	New Bulk Store	-	-	-	-	1 000	1 000	2 900	10 500	600
6	Brooklyn: Brooklyn Chest TB Hospital	8.4	City of Cape Town	New MDR & XDR wards	-	-	-	300	300	300	300	-	-
7	Brooklyn: Brooklyn Chest TB Hospital	8.4	City of Cape Town	New MDR & XDR wards	2 486	17 215	1 500	-	-	-	-	-	-
8	Caledon: Caledon Ambulance Station	8.2	Overberg	Communication Centre extension to Ambulance Station	-	-	-	-	200	200	500	1 000	100
9	Caledon: Caledon Ambulance Station	8.2	Overberg	Communication Centre extension to Ambulance Station	-	-	500	-	-	-	-	-	-
10	Caledon: Caledon Hospital	8.3	Overberg	Upgrade - Disa ward phase 2	760	6 508	-	150	150	150	-	-	-
11	Caledon: Caledon Hospital	8.3	Overberg	Upgrade - Disa ward phase 2	-	-	4 800	-	-	-	-	-	-
12	Ceres: Bella Vista Clinic	8.1	Cape Winelands	Clinic Upgrade and Additions	-	-	-	-	-	-	-	-	500
13	Ceres: Ceres Hospital	8.3	Cape Winelands	Entrance and security upgrade	-	-	-	-	-	-	-	500	500
14	Citrusdal: Citrusdal Clinic	8.1	West Coast	Upgrade and Additions	-	-	-	-	-	-	3 000	-	-
15	Citrusdal: Citrusdal Hospital	8.3	West Coast	Upgrade and additions of children ward	-	-	-	-	-	-	8 500	500	-
16	De Doorns: De Doorns CDC	8.1	Cape Winelands	CDC Upgrade and Additions	-	-	200	-	100	100	1 000	500	-
17	Delft: Delft CHC	8.1	City of Cape Town	ARV Consulting rooms and New Pharmacy	-	-	-	200	12 709	12 709	1 300	-	-

NO	PROJECT NAME	SUB-PRO-GRAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
18	Delft: Delft CHC	8.1	City of Cape Town	ARV Consulting rooms and New Pharmacy	-	-	10 500	-	-	-	-	-	-
19	Eerste River: Eerste River Hospital	8.3	City of Cape Town	Acute Psychiatric Unit	-	-	-	-	-	-	250	1 000	1 000
20	Eerste River: Kleinvlei CDC	8.1	City of Cape Town	CDC Upgrade and Additions	-	-	-	-	-	-	2 000	5 500	10 000
21	Elim Clinic	8.1	Overberg	Clinic Upgrade and Additions	-	-	-	-	-	-	-	-	1 500
22	Gansbaai: Gansbaai Clinic	8.1	Overberg	Clinic Upgrade and Additions	-	-	-	-	100	100	2 000	-	-
23	Gansbaai: Gansbaai Clinic	8.1	Overberg	Clinic Upgrade and Additions	-	-	500	-	-	-	-	-	-
24	Genadendal: Genadendal Clinic	8.1	Overberg	Clinic Upgrade and Additions	-	-	-	-	-	-	-	-	500
25	George: Harry Comay TB Hospital	8.4	Eden	Hospital upgrade Phase 1	4 289	683	-	-	-	-	-	-	-
26	Grabouw: Grabouw CDC	8.1	Overberg	CDC Upgrade and Additions	1 169	989	385	-	30	30	-	-	-
27	Green Point: Somerset Hospital	8.4	City of Cape Town	Acute Psychiatric Unit	-	-	130	-	200	200	500	5 000	5 000
28	Green Point: Somerset Hospital	8.4	City of Cape Town	Lift Upgrade	2 036	-	-	-	-	-	-	-	-
29	Heideveld: Heideveld CDC - Temporary EC at Klipfontein Hub	8.1	City of Cape Town	Enabling work for the GF Jooste Hospital Project: New Emergency Centre at Heideveld CHC	-	437	24 000	13 500	16 210	16 210	2 100	-	-
30	Hermanus: Hermanus Hospital	8.3	Overberg	EC, new wards, OPD and Administration	28 804	28 659	-	200	200	200	-	-	-
31	Hermanus: Hermanus Hospital	8.3	Overberg	EC, new wards, OPD and Administration	-	-	3 950	-	-	-	-	-	-
32	Khayelithsha: Michael Mapongwana CDC	8.1	City of Cape Town	CDC Upgrade and Additions	-	-	-	-	-	-	14 000	1 000	-
33	Khayelitsha: Khayelitsha Hospital	8.3	City of Cape Town	30 bed Acute Psychiatric Unit	-	-	-	-	100	100	1 000	2 000	5 000
34	Khayelitsha: Khayelitsha Hospital	8.3	City of Cape Town	CT Scan Infrastructure	-	-	-	-	100	100	250	2 250	-
35	Khayelitsha: Khayelitsha Hospital	8.3	City of Cape Town	EC Ventilation Upgrade	-	-	-	-	-	-	5 500	500	-
36	Khayelitsha: Khayelitsha Hospital	8.3	City of Cape Town	Ward completion	-	-	-	-	3 000	3 000	9 000	700	-

NO	PROJECT NAME	SUB-PRO-GRAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
37	Khayelitsha: Site B CHC	8.1	City of Cape Town	CHC Upgrade and Additions	-	-	-	-	-	-	250	1 000	1 000
38	Knysna: Knysna Hospital	8.3	Eden	New Emergency Centre and OPD	2 041	11 069	28 976	500	1 050	1 050	-	-	-
39	Laingsburg: Laingsburg Ambulance Station	8.2	Central Karoo	Ambulance station upgrade and additions	-	-	-	-	-	-	-	-	-
40	Laingsburg: Laingsburg Clinic	8.1	Central Karoo	Clinic Upgrade and Additions	-	-	100	-	100	100	600	5 800	3 000
41	Malmesbury: Swartland Hospital	8.3	West Coast	Emergency Centre Upgrade and Additions	-	3 967	720	-	-	-	-	-	-
42	Mamre: Mamre CDC	8.1	City of Cape Town	Clinic Extensions	-	-	-	-	-	-	250	2 750	-
43	Mitchell's Plain: Lentegeur Hospital	8.4	City of Cape Town	Conference Centre Upgrade	-	-	-	-	500	500	-	-	-
44	Mitchell's Plain: Lentegeur Hospital	8.4	City of Cape Town	Relocation of Lifecare Step Down Facility	-	5	-	-	-	-	-	-	-
45	Mitchell's Plain: Lentegeur Regional Laundry	8.6	City of Cape Town	Boiler House Upgrade including, supply, install, and commissionon one coal fired boiler	-	-	4 500	350	350	350	-	-	-
46	Mitchell's Plain: Lentegeur Regional Laundry	8.6	City of Cape Town	Regional Laundry Upgrade & Extension	929	44 107	9 500	100	100	100	-	-	-
47	Mitchell's Plain: Mitchell's Plain Hospital	8.3	City of Cape Town	EC Ventilation Upgrade	-	-	-	-	-	-	5 500	500	-
48	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	Emergency Centre Upgrade and Additions	-	141	-	-	-	-	-	-	-
49	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	Emergency Centre Upgrade and Additions	-	141	1 000	400	1 500	1 500	5 000	2 000	10 000
50	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	New Linear Accelerator Installation New Bunker	-	2 514	8 000	16 000	10 000	10 000	9 520	-	-
51	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	New Linear Accelerator Installation phase 1	-	2 514	700	-	-	-	-	-	-
52	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	NMB fire detection Phase 2	2 685	439	56	-	-	-	-	-	-
53	Paarl: Sonstraal TB Hospital	8.4	West Coast	UV Lights	1 596	24	-	-	-	-	-	-	-
54	Paarl: TC Newman CHC	8.1	Cape Winelands	CHC Upgrade and Additions	5 742	104	50	-	-	-	-	-	-
55	Phillipi: Inzame Zabantu Clinic	8.1	City of Cape Town	ARV Consulting rooms and New Pharmacy	-	-	-	100	4 690	4 690	700	-	-

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					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
56	Phillipi: Inzame Zabantu Clinic	8.1	City of Cape Town	ARV Consulting rooms and New Pharmacy	-	-	5 900	-	-	-	-	-	-
57	Plettenberg Bay: New Horizon Clinic	8.1	Eden	Clinic Upgrade and Additions	-	-	-	3 500	3 000	3 000	300	-	-
58	Plettenberg Bay: New Horizon Clinic	8.1	Eden	Clinic Upgrade and Additions	-	-	5 500	-	-	-	-	-	-
59	Prince Albert: Prince Albert Ambulance Station	8.2	Central Karoo	Ambulance station upgrade and additions	-	-	-	-	-	-	-	-	500
60	Riversdale: Riversdale Hospital	8.3	Eden	Hospital Upgrade Phase 3	7 867	913	67	-	-	-	-	-	-
61	Robertson: Robertson CDC	8.1	Cape Winelands	New Community Day Centre	-	-	-	-	-	-	-	-	500
62	Robertson: Robertson Hospital	8.3	Cape Winelands	New EC, Reception and Pharmacy Phase 1	-	-	-	-	-	-	-	-	500
63	Rondebosch: Red Cross Children's Hospital	8.5	City of Cape Town	Project in Partnership with CHT	-	-	-	-	-	-	10 000	10 000	10 000
64	Rondebosch: Red Cross Children's Hospital	8.5	City of Cape Town	Radiology upgrade & Extension (in partnership CHT)	-	-	25 320	-	-	-	-	-	-
65	Rondebosch: Red Cross Children's Hospital	8.5	City of Cape Town	Ward Upgrade	9 773	-	-	-	-	-	-	-	-
66	Somerset: Helderberg	8.3	City of Cape Town	Emergency Centre temporary accommodation	-	-	-	-	-	-	1 750	-	-
67	Stellenbosch: Stellenbosch Hospital	8.3	Cape Winelands	Emergency Centre Upgrade and Additions	-	-	200	50	650	650	1 000	3 000	-
68	Stikland: Stikland Nurse College	8.6	City of Cape Town	AC in Auditorium	-	364	20	-	-	-	-	-	-
69	Swellendam: Swellendam Ambulance Station	8.2	Overberg	Upgrade and Additions	-	-	-	-	-	-	1 500	1 000	500
70	Vredenburg: Vredenburg Hospital	8.3	West Coast	Acute Psychiatric Unit	-	-	-	-	-	-	-	-	1 000
71	Vredenburg: Vredenburg Hospital	8.3	West Coast	Hospital upgrade Phase 2A	4 198	315	422	-	-	-	-	-	-
72	Wellington: Wellington CDC	8.1	Cape Winelands	Pharmacy additions and alterations	-	-	-	-	200	200	1 000	3 500	-
73	Wellington: Wellington CDC	8.1	Cape Winelands	Pharmacy additions and alterations	-	-	500	-	-	-	-	-	-
74	Worcester: Boland Nurse College	8.6	Cape Winelands	Training facility at Keerom	-	-	360	-	500	500	1 000	9 500	11 000

NO	PROJECT NAME	SUB-PRO-GRAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
75	Worcester: Boland Nurse College	8.6	Cape Winelands	Nurses accommodation at the Erica hostel additions	-	685	2 950	8 000	4 300	4 300	5 800	600	1 300
76	Worcester: Worcester CDC	8.1	Cape Winelands	Dental suite additions and alterations	-	-	650	5 000	2 000	2 000	3 700	300	-
77	Wynberg: Victoria Hospital	8.3	City of Cape Town	New Emergency Centre	-	-	800	1 700	650	650	2 000	14 000	15 000
78	Wynberg: Victoria Hospital	8.3	City of Cape Town	Upgrade of Peads ward (in partnership with trust)	-	-	1 000	-	-	-	-	-	-
Total upgrades and additions					77 545	146 691	177 089	61 550	74 503	74 503	123 316	93 500	89 000

Table C.4: Rehabilitation, renovations and refurbishments

NO	PROJECT NAME	SUB-PRO-RAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED APPRO-PRIATION	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
1	Athlone: Western Cape College of Nursing	8.6	City of Cape Town	Convert garages into workshops	-	1 438	89	-	-	-	-	-	-
2	Atlantis: Westfleur Hospital	8.3	City of Cape Town	HT: EC	-	-	-	-	-	-	5 000	3 000	-
3	Atlantis: Westfleur Hospital	8.3	City of Cape Town	OD and QA	-	-	-	-	-	-	170	360	-
4	Beaufort West: Beaufort West Hospital	8.3	Central Karoo	Hospital rationalisation	-	-	-	-	-	-	-	500	1 000
5	Beaufort West: Beaufort West Hospital	8.3	Central Karoo	HT: Hospital Office accommodation: Extension to Nelspoort contract	-	-	-	-	-	-	-	800	-
6	Beaufort West: Beaufort West Hospital	8.3	Central Karoo	HT: Radiology	-	-	-	1 200	1 200	1 200	-	-	-
7	Beaufort West: Hill Side Clinic	8.1	Central Karoo	HT: Clinic	-	-	-	-	-	-	-	1 500	1 500
8	Beaufort West: Hill Side Clinic	8.1	Central Karoo	OD and QA	-	-	-	-	-	-	-	220	-
9	Bellville: Bellville Engineering Workshop	8.6	City of Cape Town	OD: Capacitation	-	-	-	-	2 224	2 224	2 767	2 919	3 065
10	Bellville: Bellville Engineering Workshop	8.6	City of Cape Town	OD: Infra Support	-	-	-	-	-	-	85	89	94
11	Bellville: Karl Bremer Hospital	8.3	City of Cape Town	HT: EC	-	-	20 000	2 000	6 500	6 500	-	-	-
12	Bellville: Karl Bremer Hospital	8.3	City of Cape Town	HT: Store	-	-	-	-	-	-	-	2 000	-
13	Bellville: Karl Bremer Hospital	8.3	City of Cape Town	Masterplan	-	-	-	-	-	-	500	-	-
14	Bellville: Stikland Hospital	8.4	City of Cape Town	HT: Hospital	-	-	-	-	-	-	2 000	-	-
15	Bellville: Stikland Hospital	8.4	City of Cape Town	HT: Ward	-	-	-	-	-	-	-	1 000	1 000
16	Bishop Lavis: Bishop Lavis CDC	8.1	City of Cape Town	HT: EC	-	-	-	-	-	-	-	1 000	1 000
17	Botrivier: Botrivier EMS	8.2	Overberg	HT: EMS	-	-	-	-	-	-	-	300	-
18	Bredasdorp: Otto du Plessis Hospital	8.3	Overberg	HT: EC	-	-	1 200	-	1 000	1 000	-	-	-

NO	PROJECT NAME	SUB-PRO-RAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED APPRO-PRIATION	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
19	Bredasdorp: Otto du Plessis Hospital	8.3	Overberg	HT: Ward	-	-	-	-	-	-	500	-	-
20	Brooklyn: Brooklyn Chest TB Hospital	8.4	City of Cape Town	HT: Hospital	-	-	-	-	500	500	-	-	-
21	Caledon: Caledon EMS	8.2	Overberg	HT: EMS	-	-	-	-	-	-	-	500	-
22	Caledon: Caledon Hospital	8.3	Overberg	HT: Hospital	-	-	1 500	-	-	-	-	-	-
23	Citrusdal: Clinic	8.1	West Coast	HT: Clinic	-	-	-	-	-	-	-	500	-
24	Citrusdal: Hospital	8.3	West Coast	HT: Hospital	-	-	-	-	-	-	316	1 684	-
25	Clanwilliam: Clanwilliam Clinic	8.1	West Coast	HT: Clinic	-	-	-	-	-	-	-	500	-
26	Clanwilliam: Clanwilliam Hospital	8.3	West Coast	HT: Hospital	-	-	-	-	-	-	500	500	-
27	De Doorns: De Doorns Ambulance Station	8.2	Cape Winelands	HT: Ambulance Station	-	-	-	-	-	-	-	-	1 200
28	De Doorns: De Doorns CDC	8.1	Cape Winelands	HT: CDC	-	-	-	-	-	-	-	-	1 500
29	Delft: Delft CHC	8.1	City of Cape Town	HT: CHC	-	-	2 500	-	1 148	1 148	-	-	-
30	Delft: Symphony Way CDC	8.1	City of Cape Town	HT: CDC	-	-	4 000	2 000	4 800	4 800	-	-	-
31	Delft: Symphony Way CDC	8.1	City of Cape Town	HT: ECM	-	-	385	-	-	-	-	-	-
32	Delft: Symphony Way CDC	8.1	City of Cape Town	OD and QA	-	-	-	145	340	340	-	-	-
33	District Six: District Six CDC	8.1	City of Cape Town	HT: CDC	-	-	-	-	-	-	-	7 000	4 000
34	District Six: District Six CDC	8.1	City of Cape Town	OD and QA	-	-	-	-	-	-	-	400	-
35	Du Noon: Du Noon CHC	8.1	City of Cape Town	HT: CHC	-	-	8 000	5 200	11 000	11 000	-	-	-
36	Du Noon: Du Noon CHC	8.1	City of Cape Town	HT: ECM	-	-	1 155	-	-	-	-	-	-
37	Du Noon: Du Noon CHC	8.1	City of Cape Town	OD and QA	-	-	-	350	155	155	-	-	-
38	Eerste River: Kleinvlei CDC	8.1	City of Cape Town	HT: CDC	-	-	-	-	-	-	-	-	2 500

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					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
39	False Bay Hospital	8.3	City of Cape Town	HT: General Upgrade	-	-	-	-	1 300	1 300	-	-	-
40	Fish Hoek: False Bay Hospital	8.3	City of Cape Town	HT: EC & Wards	-	-	-	-	-	-	1 500	1 500	-
41	Gansbaai: Gansbaai Clinic	8.1	Overberg	HT: Clinic	-	-	-	-	-	-	-	1 000	1 500
42	George: Eden Nurse College	8.6	Eden	HT: Nurse Hostel Upgrade (York Hostel)	-	-	400	-	-	-	-	-	-
43	George: Eden Nurse College	8.6	Eden	Nurse hostel upgrade (York Hostel)	-	-	-	200	500	500	5 000	11 000	4 300
44	George: Eden Nurse College	8.6	Eden	HT: Training College	-	-	-	-	-	-	1 000	-	-
45	George: George Kuyasa Clinic	8.1	Eden	HT: Clinic	-	-	1 200	-	-	-	-	-	-
46	George: George Regional Hospital	8.4	Eden	Hospital Upgrade Phase 3	29 179	9 260	100	-	900	900	-	-	-
47	George: George Regional Hospital	8.4	Eden	HT: ECM	-	-	5 985	-	2 600	2 600	-	-	-
48	George: George Regional Hospital	8.4	Eden	HT: Hospital	5 224	4 100	3 500	-	1 299	1 299	-	-	-
49	George: George Regional Hospital	8.4	Eden	HT: ICT	-	-	828	-	-	-	-	-	-
50	George: George Regional Hospital	8.4	Eden	HT: PACS-RIS	-	-	-	3 600	3 600	3 600	-	-	-
51	George: George Regional Hospital	8.4	Eden	HT: SCM Team 2	-	-	-	733	-	-	-	-	-
52	George: George Regional Hospital	8.4	Eden	OD and QA	1 772	674	731	-	-	-	-	-	-
53	George: George Regional Hospital	8.4	Eden	OD: SCM Support	-	-	-	-	241	241	636	671	704
54	George: George Regional Hospital	8.4	Eden	Psychiatric Evaluation Unit	-	1 143	14 000	4 000	5 700	5 700	1 200	-	-
55	George: Harry Comay TB Hospital	8.4	Eden	Hospital upgrade Phase 2	12	4 492	-	-	-	-	-	-	-
56	Goodwood: Dirkie Uys CDC	8.1	City of Cape Town	HT: CDC	-	-	-	-	-	-	-	300	-
57	Goodwood: Ruyterwacht CDC	8.1	City of Cape Town	HT: CDC	-	-	2 500	-	274	274	-	-	-
58	Green Point: Somerset Hospital	8.4	City of Cape Town	HT: Hospital	-	-	7 000	-	1 124	1 124	-	-	-

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					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
59	Green Point: Somerset Hospital	8.4	City of Cape Town	HT: Theatre Complex Upgrade	-	-	-	-	-	-	4 000	4 000	-
60	Green Point: Somerset Hospital	8.4	City of Cape Town	Upgrading of theatres and ventilation	-	-	-	-	-	-	1 000	4 000	12 000
61	Health Technology	8.6	City of Cape Town	OD: Capacitation	-	-	-	-	3 456	3 456	4 023	4 244	4 457
62	Health Technology	8.6	City of Cape Town	OD: Infra Support	-	-	-	-	553	553	1 369	1 444	1 516
63	Heideveld: Heideveld CDC - Temporary EC at Klipfontein Hub	8.1	City of Cape Town	HT: CDC	-	-	-	-	700	700	-	-	-
64	Hermanus: Hermanus CDC	8.1	Overberg	HT: CDC	-	-	3 500	1 000	1 600	1 600	-	-	-
65	Hermanus: Hermanus CDC	8.1	Overberg	OD and QA	-	-	-	-	-	-	155	-	-
66	Hermanus: Hermanus CDC(Bredasdrop)	8.1	Overberg	HT: ECM	-	-	855	-	-	-	-	-	-
67	Hermanus: Hermanus Hospital	8.3	Overberg	HT: Hospital	-	770	4 500	-	252	252	-	-	-
68	Infrastructure Management: CD	8.6	City of Cape Town	OD: Capacitation	-	-	-	-	2 508	2 508	2 694	2 842	2 984
69	Infrastructure Management: CD	8.6	City of Cape Town	OD: Infra Support	-	-	-	-	1 071	1 071	1 934	2 040	2 142
70	Infrastructure Planning	8.6	City of Cape Town	OD: Capacitation	-	-	-	-	5 997	5 997	7 374	7 780	8 168
71	Infrastructure Planning	8.6	City of Cape Town	OD: Infra Support	-	-	-	-	2 533	2 533	2 327	2 455	2 578
72	Infrastructure Unit	8.6	City of Cape Town	Capacitation of the Infrastructure Unit	-	6 116	16 000	30 000	-	-	-	-	-
73	Infrastructure Unit	8.6	City of Cape Town	Capacitation of the Infrastructure Unit	-	-	328	347	-	-	-	-	-
74	Khayelitsha: Khayelitsha Hospital	8.3	City of Cape Town	HT: Hospital	51 651	6 492	5 000	-	-	-	-	-	-
75	Khayelitsha: Khayelitsha Hospital	8.3	City of Cape Town	HT: Hospital	-	-	-	-	-	-	1 000	2 500	-
76	Khayelitsha: Khayelitsha Hospital	8.3	City of Cape Town	HT: Hospital (CT Scan)	-	-	-	-	-	-	-	6 000	-
77	Khayelitsha: Khayelitsha Hospital	8.3	City of Cape Town	HT: PACS-RIS	-	-	-	-	-	-	3 600	-	-

NO	PROJECT NAME	SUB-PRO-RAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED APPRO-PRIATION	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
78	Khayelitsha: Khayelitsha Hospital	8.3	City of Cape Town	OD and QA	3 523	110	-	-	-	-	-	-	-
79	Khayelitsha: Khayelitsha Hospital	8.3	City of Cape Town	HT: Waste Management	-	-	-	-	-	-	2 000	2 000	-
80	Klaarstroom: Klaarstroom Clinic	8.1	Central Karoo	HT: Clinic	-	-	600	-	-	-	-	-	-
81	Knysna: Knysna CDC	8.1	Eden	HT: ECM	-	-	855	-	-	-	-	-	-
82	Knysna: Knysna Hospital	8.3	Eden	Hospital and Ambulance Station Rehabilitation	-	-	-	2 000	7 500	7 500	500	-	-
83	Knysna: Knysna Hospital	8.3	Eden	Hospital and Ambulance Station Rehabilitation	-	-	7 200	-	-	-	-	-	-
84	Knysna: Knysna Hospital	8.3	Eden	HT: EC	-	-	10 000	2 000	3 500	3 500	-	-	-
85	Knysna: Knysna Hospital	8.3	Eden	HT: ECM	-	-	-	3 500	-	-	-	-	-
86	Knysna: Knysna Hospital	8.3	Eden	OD and QA	-	-	-	400	400	400	-	-	-
87	Laingsburg: Laingsburg FPL	8.6	Central Karoo	HT: FPL	-	-	-	-	-	-	-	-	400
88	Maitland: Alexandra Hospital	8.4	City of Cape Town	HT: Forensic wards	-	-	-	-	3 500	3 500	-	-	-
89	Malmesbury: Abbotsdale Satellite Clinic	8.1	West Coast	HT: Clinic	-	-	-	-	-	-	-	600	-
90	Malmesbury: Chatsworth Clinic	8.1	West Coast	HT: Clinic	-	-	-	-	-	-	-	-	400
91	Malmesbury: Malmesbury Ambulance Station	8.2	West Coast	HT: Ambulance Station	-	-	1 900	-	-	-	-	-	-
92	Malmesbury: Swartland Hospital	8.3	West Coast	HT: Hospital	-	-	2 500	-	95	95	-	-	-
93	Mamre: Mamre CDC	8.1	West Coast	HT: CDC	-	-	-	-	-	-	-	800	-
94	Manenberg: New GF Jooste Hospital	8.3	City of Cape Town	HT: Hospital	-	-	500	-	-	-	-	-	-
95	Matjiesfontein: Matjiesfontein Satellite Clinic	8.1	Central Karoo	HT: Clinic	-	-	-	-	-	-	-	600	-
96	Mfuleni: Mfuleni CDC	8.1	City of Cape Town	HT: CDC	-	-	-	-	1 800	1 800	-	-	-

NO	PROJECT NAME	SUB-PRO-RAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED APPRO-PRIATION	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
97	Mitchell's Plain: Lentegeur Hospital	8.4	City of Cape Town	HT: Conference Centre	-	-	-	-	-	-	500	-	-
98	Mitchell's Plain: Lentegeur Hospital	8.4	City of Cape Town	HT: Acute Psychiatric Unit	-	-	-	-	-	-	1 500	2 000	1 500
99	Mitchell's Plain: Lentegeur Regional Laundry	8.6	City of Cape Town	HT: Laundry	-	34 199	4 000	-	-	-	-	-	-
100	Mitchell's Plain: Lentegeur Regional Laundry	8.6	City of Cape Town	OD and QA	-	133	470	-	-	-	-	-	-
101	Mitchell's Plain: Mitchell's Plain Hospital	8.3	City of Cape Town	HT: ECM	-	-	4 795	-	-	-	-	-	-
102	Mitchell's Plain: Mitchell's Plain Hospital	8.3	City of Cape Town	HT: Hospital	-	51 986	25 000	2 000	6 500	6 500	-	-	-
103	Mitchell's Plain: Mitchell's Plain Hospital	8.3	City of Cape Town	HT: PACS-RIS	-	-	-	3 400	-	-	3 600	-	-
104	Mitchell's Plain: Mitchell's Plain Hospital	8.3	City of Cape Town	HT: SCM team 1	-	-	-	3 116	-	-	-	-	-
105	Mitchell's Plain: Mitchell's Plain Hospital	8.3	City of Cape Town	OD and QA	4 556	2 551	2 013	700	150	150	-	-	-
106	Mitchell's Plain: Mitchell's Plain Hospital	8.3	City of Cape Town	OD: SCM Support	-	-	-	-	3 395	3 395	4 329	4 567	4 796
107	Mitchell's Plain: Mitchell's Plain Hospital	8.3	City of Cape Town	HT: Acute Psychiatric Unit	-	-	-	2 500	2 500	2 500	-	-	-
108	Montagu: Montagu Hospital	8.3	Cape Winelands	Rehabilitation of hospital	-	-	-	-	-	-	-	-	100
109	Mossel Bay: Alma CDC	8.1	Eden	HT: CDC	-	-	-	300	-	-	-	-	-
110	Mossel Bay: Asla Park Clinic	8.1	Eden	HT: Clinic	-	-	-	-	-	-	500	1 000	-
111	Mossel Bay: D'Almeida Clinic	8.1	Eden	HT: Clinic	-	-	-	300	-	-	-	-	-
112	Mossel Bay: Eyethu Clinic	8.1	Eden	HT: Clinic	-	-	-	300	-	-	-	-	-
113	Mossel Bay: Sonskyn Vallei Clinic	8.1	Eden	HT: Clinic	-	-	600	-	-	-	-	-	-
114	Mossel Bay: Mossel Bay Hospital	8.3	Eden	HT: Kangaroo unit and Digital X-ray system	-	-	-	-	-	-	2 500	-	-
115	Napier: Napier Clinic	8.1	Overberg	HT: Clinic	-	-	-	-	-	-	-	1 000	1 000
116	Napier: Napier Clinic	8.1	Cape Winelands	OD and QA	-	-	-	-	-	-	-	-	230

NO	PROJECT NAME	SUB-PRO-RAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED APPRO-PRIATION	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
117	Nelspoort Hospital	8.1	Central Karoo	HT: Hospital	-	-	-	-	500	500	-	-	-
118	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	Central Kitchen: Floor Replacement	-	-	500	-	600	600	3 198	-	-
119	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	HT: CAT LAB	-	-	-	16 000	16 000	16 000	-	-	-
120	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	HT: Major equipment	-	-	-	12 300	42 900	42 900	-	-	-
121	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	HT: New LINAC	-	-	13 500	3 500	4 193	4 193	-	-	-
122	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	Hybrid theatre	-	-	2 000	100	500	500	13 544	40	-
123	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	Masterplan	-	-	500	-	-	-	-	-	-
124	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	Pharmacy additions and alterations	6 996	291	-	-	-	-	-	-	-
125	Observatory: Groote Schuur Hospital	8.5	City of Cape Town	HT: Radiotherapy Upgrade	-	-	-	-	-	-	10 000	2 000	-
126	Observatory: Observatory Forensic Pathology Centre	8.6	City of Cape Town	HT: FPL	-	-	-	-	5 300	5 300	-	-	10 000
127	Observatory: Valkenberg Hospital	8.4	City of Cape Town	Forensic Precinct: Admission, Assessment, High Security, Medium Security	-	-	-	-	-	-	4 000	1 000	1 000
128	Observatory: Valkenberg Hospital	8.4	City of Cape Town	HT: Hospital	-	-	-	-	-	-	6 200	-	-
129	Observatory: Valkenberg Hospital	8.4	City of Cape Town	Masterplan up to stage 3	-	-	4 638	-	1 000	1 000	-	-	-
130	Observatory: Valkenberg Hospital	8.4	City of Cape Town	OD and QA	-	-	413	1 250	645	645	250	353	1 340
131	Observatory: Valkenberg Hospital	8.4	City of Cape Town	OD: Commissioning Support	-	-	-	-	760	760	953	1 005	1 005
132	Observatory: Valkenberg Hospital	8.4	City of Cape Town	OD: Project Support	-	-	-	-	616	616	772	815	856
133	Observatory: Valkenberg Hospital	8.4	City of Cape Town	Renovations to the historical administration building (phase 1)	-	-	6 500	30 000	40 295	40 295	43 000	15 600	-
134	Observatory: Valkenberg Hospital	8.4	City of Cape Town	Renovations to the historical administration building (phase 2)	-	-	-	-	-	-	5 000	-	-

NO	PROJECT NAME	SUB-PRO-RAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED APPRO-PRIATION	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
135	Oudtshoorn: Dysselsdorp Clinic	8.1	Eden	HT: Clinic	-	-	1 000	-	-	-	-	-	-
136	Oudtshoorn: Oudtshoorn Hospital	8.3	Eden	HT: Digital x-ray system	-	-	-	-	-	-	2 000	-	-
137	Paarl: Paarl Hospital	8.4	Cape Winelands	Hospital revitalisation	34 525	4 245	6 000	-	2 500	2 500	-	-	-
138	Paarl: Paarl Hospital	8.4	Cape Winelands	HT: ECM	-	-	-	3 500	-	-	-	-	-
139	Paarl: Paarl Hospital	8.4	Cape Winelands	HT: Hospital	6 822	5 696	2 500	-	878	878	-	-	-
140	Paarl: Paarl Hospital	8.4	Cape Winelands	HT: PACS-RIS	-	-	-	-	3 400	3 400	-	-	-
141	Paarl: Paarl Hospital	8.4	Cape Winelands	OD and QA	2 491	1 642	766	-	-	-	280	-	-
142	Paarl: Paarl Hospital	8.4	Cape Winelands	HT: Acute Psychiatric Unit	-	-	-	-	-	-	-	3 000	1 000
143	Paarl: Sonstraal TB Hospital	8.4	West Coast	HT: Hospital	-	-	2 000	-	72	72	-	-	-
144	Parow: Tygerberg Hospital	8.5	City of Cape Town	CD WEST (EC phase 2)	-	-	-	-	500	500	1 300	12 400	700
145	Parow: Tygerberg Hospital	8.5	City of Cape Town	Emergency Centre Upgrade and Additions	-	-	-	600	771	771	-	-	-
146	Parow: Tygerberg Hospital	8.5	City of Cape Town	Emergency Centre Upgrade and Additions	680	6 225	6 600	-	-	-	-	-	-
147	Parow: Tygerberg Hospital	8.5	City of Cape Town	HT: Biplanar Angiography	-	-	-	10 500	10 500	10 500	-	-	-
148	Parow: Tygerberg Hospital	8.5	City of Cape Town	HT: CD West	-	-	-	-	-	-	-	6 000	-
149	Parow: Tygerberg Hospital	8.5	City of Cape Town	HT: CT Scan	-	-	-	8 500	8 500	8 500	-	-	-
150	Parow: Tygerberg Hospital	8.5	City of Cape Town	HT: EC	-	-	12 010	-	-	-	-	-	-
151	Parow: Tygerberg Hospital	8.5	City of Cape Town	HT: Major equipment	-	-	-	13 000	13 000	13 000	-	-	-
152	Parow: Tygerberg Hospital	8.5	City of Cape Town	HT: New LINAC	-	-	25 000	5 000	9 550	9 550	-	-	-
153	Parow: Tygerberg Hospital	8.5	City of Cape Town	OD and QA	172	1 164	3 099	2 605	-	-	-	-	-
154	Parow: Tygerberg Hospital	8.5	City of Cape Town	OD: Project Support	-	-	-	-	3 064	3 064	3 783	3 991	4 191

NO	PROJECT NAME	SUB-PRO-RAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED APPRO-PRIATION	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
155	Parow: Tygerberg Hospital	8.5	City of Cape Town	HT: Opthamology	-	-	-	-	-	-	8 550	-	-
156	Parow: Tygerberg Hospital	8.5	City of Cape Town	HT: Ward	-	-	-	-	-	-	2 000	2 000	2 000
157	Phillipi: Inzame Zabantu Clinic	8.1	City of Cape Town	HT: Clinic	-	-	1 500	-	174	174	-	-	-
158	Piketberg: Piketberg Ambulance Station	8.2	West Coast	HT: Ambulance Station	-	-	-	-	-	-	-	500	-
159	Piketberg: Radie Kotze hospital	8.3	West Coast	HT: Hospital	-	-	-	-	-	-	-	600	-
160	Plettenberg Bay: New Horizon Clinic	8.1	Eden	HT: Clinic	-	-	-	200	300	300	-	-	-
161	Porterville: Porterville clinic	8.1	West Coast	HT: Clinic	-	-	-	-	-	-	500	-	-
162	Prince Albert: Prince Albert Hospital	8.3	Central Karoo	HT: Hospital	-	-	-	300	300	300	-	-	-
163	Prince Alfred Hamlet: Prince Alfred Hamlet Clinic	8.1	Cape Winelands	HT: Clinic	-	-	-	-	-	-	-	-	2 000
164	Prince Alfred Hamlet: Prince Alfred Hamlet Clinic	8.1	Cape Winelands	OD and QA	-	-	-	-	-	-	-	195	-
165	Rawsonville: Rawsonville Clinic	8.1	Cape Winelands	HT: Clinic	-	-	-	2 000	1 500	1 500	-	-	-
166	Riviersonderend: Riviersonderend	8.1	Overberg	HT: Clinic	-	-	-	-	-	-	150	350	-
167	Robertson: Robertson Ambulance Station	8.2	Cape Winelands	HT: Ambulance Station	-	-	1 200	-	-	-	-	-	-
168	Robertson: Robertson Hospital	8.3	Cape Winelands	HT: Bulk Store	-	-	-	500	500	500	-	-	-
169	Rondebosch: Red Cross Children's Hospital	8.5	City of Cape Town	Masterplan	-	-	-	-	-	-	250	500	-
170	Saldanha: Diazville Clinic	8.1	West Coast	HT: Langebaan, Louwville and Velddrif	-	-	-	-	500	500	-	-	-
171	Saldanha: Diazville Clinic	8.1	West Coast	HT: Clinic	-	-	-	-	-	-	-	500	-
172	Somerset West: Helderberg Hospital	8.3	City of Cape Town	Emergency Centre Upgrade and Additions	-	-	500	1 000	1 000	1 000	5 000	18 000	3 000
173	Somerset West: Helderberg Hospital	8.3	City of Cape Town	HT: EC	-	-	-	-	-	-	-	3 000	5 000
174	Somerset West: Helderberg Hospital	8.4	City of Cape Town	OD and QA	-	-	-	-	-	-	-	-	430

NO	PROJECT NAME	SUB-PRO-RAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED APPRO-PRIATION	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
175	St Helena Bay: Laingville Clinic	8.1	West Coast	HT: Clinic	-	-	-	-	-	-	-	300	-
176	Stellenbosch: Stellenbosch Hospital	8.3	Cape Winelands	HT: EC	-	-	-	-	800	800	-	1 000	6 000
177	Stellenbosch: Stellenbosch Hospital	8.3	Cape Winelands	OD and QA	-	-	-	-	-	-	-	380	-
178	Stellenbosch: Victoria Street Clinic	8.1	Cape Winelands	Rehabilitation of clinic	-	-	-	-	-	-	3 000	5 000	1 000
179	Stikland: Stikland Hospital	8.4	City of Cape Town	Ex pharmacy to be coverted to archive	-	-	-	-	-	-	1 000	-	-
180	Stikland: Stikland Nurse College	8.6	City of Cape Town	College Renovations	-	174	950	-	-	-	-	-	-
181	Stikland: Stikland Nurse College	8.6	City of Cape Town	HT: College	-	-	-	-	1 900	1 900	-	-	-
182	Strand: Nomzamo Asanda Clinic	8.1	City of Cape Town	HT: Clinic	-	-	-	-	-	-	4 000	-	-
183	Strand: Nomzamo Asanda Clinic	8.1	City of Cape Town	OD and QA	-	-	-	-	-	-	155	-	-
184	Swellendam: Swellendam Hospital	8.3	Cape Winelands	HT: EC	-	-	1 500	-	-	-	-	-	-
185	Thornton: Western Cape Rehabilitation Centre	8.6	City of Cape Town	Orthotic & Prosthetic Centre upgrade	-	-	-	-	-	-	500	500	5 000
186	Van Rynsdorp : Van Rynsdorp Clinic	8.1	West Coast	HT: Clinic	-	-	-	-	-	-	-	300	-
187	Various CHS Facilities	8.5		HT: CHS	-	2 552	7 051	-	-	-	-	-	-
188	Various CHS Facilities	8.5		OD: Fire Compliance	-	-	-	-	-	-	200	-	-
189	Various DHS Facilities	8.3		HT: DHS	-	16 844	5 775	-	-	-	-	-	-
190	Various DHS Facilities	8.3		OD: Fire Compliance	-	-	-	-	-	-	400	-	-
191	Various Nurse Colleges	8.6		HT: Nursing College	-	-	5 000	-	-	-	-	-	-
192	Various OF Facilities	8.6		HT: ICT	-	-	-	1 000	-	-	-	-	-
193	Various OF Facilities	8.6		HT: OF	-	386	3 705	-	-	-	-	-	-
194	Various Pharmacies upgrade	8.1		Pharmacies rehabilitation	-	-	-	-	-	-	1 000	4 000	-

NO	PROJECT NAME	SUB-PRO-RAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED APPRO-PRIATION	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
195	Various Pharmacies upgrade	8.3		Pharmacy rehabilitation	-	-	-	-	-	-	1 000	4 000	-
196	Various PHS Facilities	8.1		HT: PHS	-	2 629	3 900	-	-	-	-	-	-
197	Various PHS Facilities	8.4		HT: PHS	-	311	2 569	-	-	-	-	-	-
198	Various PHS Facilites	8.4		OD: Fire Compliance	-	-	-	-	-	-	390	-	-
199	Veldrift: Veldrift clinic	8.1	West Coast	HT: Clinic	-	-	-	-	-	-	-	500	-
200	Vredenburg: Louwville clinic	8.1	West Coast	HT: Clinic	-	-	-	-	-	-	250	750	-
201	Vredenburg: Vredenburg Hospital	8.3	West Coast	Hospital upgrade Phase 2B	8 150	27 980	50 000	49 500	27 100	27 100	2 000	18 000	10 000
202	Vredenburg: Vredenburg Hospital	8.3	West Coast	HT: ECM	-	-	2 055	500	-	-	-	-	-
203	Vredenburg: Vredenburg Hospital	8.3	West Coast	HT: Hospital	2 184	1 169	2 000	7 000	2 000	2 000	500	-	-
204	Vredenburg: Vredenburg Hospital	8.3	West Coast	HT: SCM Team 3	-	-	-	733	-	-	-	-	-
205	Vredenburg: Vredenburg Hospital	8.3	West Coast	OD and QA	1 790	1 139	1 549	894	244	244	-	50	300
206	Vredenburg: Vredenburg Hospital	8.3	West Coast	OD: Project Support	-	-	-	-	600	600	753	794	833
207	Vredenburg: Vredenburg Hospital	8.3	West Coast	OD: SCM Support	-	-	-	-	638	638	832	878	922
208	Vredendal: FPL	8.6	West Coast	HT: FPL	-	-	-	-	-	-	500	-	-
209	Vredendal: Vredendal Hospital	8.3	West Coast	HT: Hospital	-	-	-	-	2 000	2 000	-	-	-
210	Vredendal: Vredendal Hospital	8.3	West Coast	HT: Hospital	-	-	-	-	-	-	800	-	-
211	Wolseley: Wolseley Clinic	8.1	Cape Winelands	HT: Clinic	-	-	-	-	-	-	-	-	2 000
212	Wolseley: Wolseley Clinic	8.1	Cape Winelands	OD and QA	-	-	-	-	-	-	-	197	-
213	Worcester: Boland Nurse College	8.6	Cape Winelands	Nurses accommodation at Erica Hostel, R & R	-	-	1 500	-	800	800	18 023	1 700	-

NO	PROJECT NAME	SUB-PRO-RAMME	DISTRICT / MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO-PRIATION	ADJUSTED APPRO-PRIATION	REVISED APPRO-PRIATION	MEDIUM TERM ESTIMATES		
					2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's			2015/16 R000's	2016/17 R000's	2017/18 R000's
214	Worcester: Boland Nurse College	8.6	Cape Winelands	HT: Additional Nurses accommodation: Erica Hostel	-	-	-	-	-	-	2 500	-	-
215	Worcester: Worcester CDC	8.1	Cape Winelands	HT: CDC	-	-	-	-	200	200	600	-	-
216	Worcester: Worcester Hospital	8.4	Cape Winelands	Fire compliance	-	-	-	-	-	-	500	5 500	-
217	Worcester: Worcester Hospital	8.4	Cape Winelands	Hospital Upgrade Phase 3	1 098	773	-	-	-	-	-	-	-
218	Worcester: Worcester Hospital	8.4	Cape Winelands	Hospital Upgrade Phase 4	8 656	15 295	420	-	500	500	-	-	-
219	Worcester: Worcester Hospital	8.4	Cape Winelands	Hospital Upgrade Phase 5	-	1 164	9 000	20 000	16 000	16 000	18 000	2 500	-
220	Worcester: Worcester Hospital	8.4	Cape Winelands	HT: ICT	-	-	1 530	500	-	-	-	-	-
221	Worcester: Worcester Hospital	8.4	Cape Winelands	HT: ECM	-	-	-	3 500	-	-	-	-	-
222	Worcester: Worcester Hospital	8.4	Cape Winelands	HT: Hospital	11 774	5 838	2 500	-	3 500	3 500	-	-	-
223	Worcester: Worcester Hospital	8.4	Cape Winelands	HT: PACS-RIS	-	-	-	3 600	3 600	3 600	-	-	-
224	Worcester: Worcester Hospital	8.4	Cape Winelands	OD and QA	1 923	900	760	1 391	741	741	-	-	-
225	Worcester: Worcester Hospital	8.4	Cape Winelands	OD: Project Support	-	-	-	-	735	735	904	953	1 001
226	Vredendal: Vredendal Clinics	8.1	West Coast	HT: Clinic	-	-	-	-	2 000	2 000	-	-	-
227	Engineering and Technical Services	8.6	City of Cape Town	OD: Capacitation	-	-	-	-	905	905	1 264	1 333	1 400
228	Engineering and Technical Services	8.6	City of Cape Town	OD: Infra Support	-	-	-	-	270	270	427	450	473
229	Infrastructure Programme Delivery	8.6	City of Cape Town	OD: Capacitation	-	-	-	-	7 407	7 407	10 164	10 723	11 259
230	Infrastructure Programme Delivery	8.6	City of Cape Town	OD: Infra Support	-	-	-	-	1 317	1 317	3 689	3 892	4 087
231	Various COMHC Facilities	8.1		OD: Fire Compliance	-	-	-	-	-	-	20	-	-
Total rehabilitation, renovations and refurbishments					183 178	219 881	357 679	270 764	337 990	337 990	250 180	224 664	142 431

CONDITIONAL GRANTS

(To be finalised upon confirmation of the conditional grant framework)

Table C.5: Conditional grants

Name of conditional grant	Purpose of the grant	Performance indicators	Baseline 2013/14	Continuation / discontinuation over the next 5 years	Motivation for continuation / discontinuation
2.1. Health Facility Revitalisation Grant (HFRG)	• To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including health technology, organisational design (OD) systems and quality assurance (QA). • Supplement expenditure on health infrastructure delivered through public-private partnerships. • To enhance capacity to deliver health infrastructure. • The Hospital Revitalisation component funds construction, upgrading or replacement of hospitals. • The Nursing Colleges and Schools component funds the upgrading of nursing colleges and schools. • The Health Infrastructure component funds improvements in all health facilities.	1. Number of health facilities planned (number of projects in identification / feasibility phase) 2. Number of health facilities designed (number of projects in design / tender phase) 3. Number of health facilities constructed (number of projects in construction / handover phase) 4. Number of facilities equipped 5. Number of health facilities operationalised 6. Number of work opportunities created	37 33 17 33 11 Reliable information is not available	According to the Health Facility Revitalisation Grant Framework, as published in Government Gazette No 37613 of 9 May 2014, '…the grant will remain in place until at least the end of the 2016/17 Medium Term Expenditure Framework'	According to the Health Facility Revitalisation Grant Framework, as published in Government Gazette No 37613 of 9 May 2014, 'Health is a key government priority and given the need to continually maintain health infrastructure and ensure that norms and standards are maintained, the grant will remain in place until at least the end of the 2016/17 Medium Term Expenditure Framework'
2.2. Expanded Public Works Programme (EPWP) Integrated Grant for	To incentivise provincial departments to expand work creation efforts through the use of labour intensive delivery methods in the following identified focus areas, in compliance with the EPWP guidelines: • Road maintenance and the maintenance of	1.) Increase number of people employed and receiving income through the EPWP 2.) Women 3.) Youth 4.) People with disabilities	339 222 (65%) 148 (44%) 0 (0%)	According to the Expanded Public Works Programme Integrated Grant for Provinces Framework, as published in	According to the Expanded Public Works Programme Integrated Grant for Provinces Framework, as published in Government Gazette No 37613 of 9 May 2014, the strategic goal for this grant is 'To provide Expanded Public Works

Name of conditional grant	Purpose of the grant	Performance indicators	Baseline 2013/14	Continuation / discontinuation over the next 5 years	Motivation for continuation / discontinuation
Provinces	buildings. • Low traffic volume roads and rural roads. • Other economic and social infrastructure. • Tourism and cultural industries. • Sustainable land based livelihoods.	5.) Increase income per EPWP beneficiary 6.) Increase average duration of work opportunities created	R75 6 months	Government Gazette No 37613 of 9 May 2014, the 'Grant continues until the end of 2018/19 financial year, subject to review'	Programme (EPWP) funding to expand job creation efforts in specific focus areas, where labour intensive delivery methods can be maximised'.
2.3. National Tertiary Services Grant (NTSG)	Ensure provision of tertiary health services for all South African citizens. To compensate tertiary facilities for the additional costs associated with provision of these services including cross border patients.	1.) Day patient separations - total 2.) Inpatient days - total 3.) Inpatient separations - total 4.) Outpatient first attendances 5.) Outpatient follow-up attendances - total	13 303 578 996 91 204 221 516 574 064		
2.4. Health Professions Training and Development Grant (HPTDG)	Support Provinces to fund service costs associated with training of health science trainees on the public health service platform.	1.) Number of enrolled medical undergraduate students 2.) Number a of enrolled dental undergraduate students 3.) Number of registrars 4.) Number of medical specialists	2 785 422 708 904		
2.5. Comprehensive HIV and AIDS Grant	To provide additional and targeted financial resources in order to accelerate the effective implementation of a programme that has been identified as a priority in the 10-point plan of the National Department of Health.	1.) ART: Number of facilities accredited as ART service points 2.) ART: Number of registered ART patients 3.) PMTCT: Number of antenatal clients tested for HIV 4.) PMTCT: Nevirapine dose to baby rate 5.) PMTCT: Transmission rate	236 156 703 90 348 99% 1.9%		

Name of conditional grant	Purpose of the grant	Performance indicators	Baseline 2013/14	Continuation / discontinuation over the next 5 years	Motivation for continuation / discontinuation
		6.) RTC: Number of monthly expenditure reports submitted in time	12		
		7.) RTC: Number of quarterly output reports submitted in time	4		
		8.) HCT: Number of lay counsellors receiving stipend	646		
		9.) HCT: Testing rate	98.6%		
		10.) MMC: Number of males > 15 years circumcised	16 596		
		11.) HCBC: Number of Home Based Carers receiving stipends	3 536		
		12.) Step-down care: Number of step-down care facilities funded	23		
2.6. National Health Insurance (NHI) Grant	• Contribute towards assessing the feasibility and affordability of innovative ways of engaging private sector resources for public purpose. • Test innovations in health service provision for implementing National Health Insurance, allowing for each district to interpret and design innovations relevant to its specific context. • Undertake health system strengthening initiatives. • Support selected pilot districts in implementing identified service delivery interventions.	1.) Appoint a project co-ordinator to manage the NHI projects	Project co-ordinator appointed.		
		2.) Conduct a workshop with provincial and Eden District health personnel on the outcomes of the 2012/13 NHI projects, and determine the way forward.	Workshop conducted and the way forward determined.		
		3.) Complete the 2012/13 investigation on the "Development and recommendation on the usage of an appropriate model for the strengthening of the current Governance and Critical Support functions of the District Health System", conduct a critical review of the findings, and develop and implement an appropriate action plan.	Investigation completed, findings reviewed, and appropriate action plan developed and implemented.		
		4.) Review the findings and recommendations of the policy framework of the contract management project of 2012/13, develop	Findings and recommendations reviewed. Appropriate		

Name of conditional grant	Purpose of the grant	Performance indicators	Baseline 2013/14	Continuation / discontinuation over the next 5 years	Motivation for continuation / discontinuation
		and implement an appropriate action plan.	action plan developed and implemented.		
		5.) Review 2012/13 consumables project that focused on bandages, dressings and sutures, with the development and implementation of an appropriate action plan. Execute an audit on remaining medical consumables at PHC facilities and all hospitals.	Project reviewed and an appropriate action plan was developed and implemented. Audit conducted. Database and report in advanced stage of completion.		
		6.) Continuation of the school health programme, utilising mobile health care units.	School health programme, utilising mobile health care units, implemented.		
		7.) Train CBS co-ordinators on chronic disease management, and roll-out to CCWs to create a long term sustainable training environment, with necessary monitoring and evaluation.	CBS co-ordinators and 376 CCWs trained on chronic disease management.		
		8.) Complete the 2012/13 review of the provincial policy on Home Community Based Care (HCBC), adherence support, and intellectual disability. Review findings and recommendations of report and develop and implement an appropriate action plan.	Review completed. Findings and recommendations reviewed and appropriate action plan developed and implemented.		
		9.) Review findings/recommendations of the 2012/13 situational analysis report on the referral processes at the George Regional Hospital specialist clinics; with the development and implementation of an appropriate action plan.	Findings / recommendations reviewed and appropriate action plan developed and implemented.		

Name of conditional grant	Purpose of the grant	Performance indicators	Baseline 2013/14	Continuation / discontinuation over the next 5 years	Motivation for continuation / discontinuation
		10.) Review of the findings/recommendations of the 2012/13 report on the evaluation study of the current patient folder management processes at PHC facilities, with development and implementation of an appropriate action plan.	Findings / recommendations reviewed and appropriate action plan developed and implemented.		
		11.) Complete the 2012/13 eye-care project and review the findings and recommendations of the rural eye-care model developed for the Eden District (which covers the four main causes of visual impairment or blindness) including the development and implementation of an appropriate phased action plan.	Project completed Findings / recommendations reviewed and appropriate action plan developed and implemented.		
		12.) Review the findings and recommendations of the audit on private health care providers in the Eden District (2012/13), which covers the main categories of service providers, and develop and implement an appropriate action plan.	Findings / recommendations reviewed and appropriate action plan developed and implemented.		
		13.) Conduct a situational analysis on women's health, focusing on the whole spectrum of services (including family planning and termination of pregnancies).	Situational analysis conducted. The project is in an advanced stage of completion.		
		14.) Conduct a situational analysis at the six district hospitals focusing on patient referral practices, in view of developing an integrated rational patient referral system.	Situational analysis conducted. The project is in an advanced stage of completion.		
		15.) Implement a patient folder management project at Knysna District Hospital.	System implemented at Ladismith and Knysna Hospitals.		

Name of conditional grant	Purpose of the grant	Performance indicators	Baseline 2013/14	Continuation / discontinuation over the next 5 years	Motivation for continuation / discontinuation
			Mossel Bay Hospital in progress.		
		16.) Conduct a situational analysis of existing audiology services rendered in the district and develop a sustainable model for rural districts.	Situational analysis conducted. A sustainable audiology model was developed for the rural districts.		
	To develop and implement innovative models for contracting general practitioners (GPs) within selected NHI pilot districts.	1.) Source and appoint GPs to provide for 240 sessions per week for six months	220 sessions were taken up		
		2.) Clinical package of care relevant to health facilities provided by GPs	All GPs complied with specified performance as per signed contracts.		
		3.) GPs trained to ensure compliance with national and provincial guidelines and adherence to the essential medicines list (EML)	No GP training conducted. Although GPs commenced with sessions, not enough time was left for centralised training sessions. At a local level, GPs were given the necessary information.		
		4.) GPs attend relevant meetings	Not all GPs attended meetings. Though GPs commenced with sessions, not enough time was left for the attendance of meetings.		
		5.) GPs complete administrative duties	All GPs fulfilled their administrative duties		

Name of conditional grant	Purpose of the grant	Performance indicators	Baseline 2013/14	Continuation / discontinuation over the next 5 years	Motivation for continuation / discontinuation
			by completing their monthly timesheets and travel claims.		
		6.) Relevant administration duties of project done by NHI admin clerk.	Administrative clerk appointed and on-the-job-training provided for capturing GP administrative data on a monthly basis. Filing system has been set up.		
2.7. Social Sector EPWP Incentive Grant	To increase work opportunities for home community based carers (HCBCs) engaged through non-profit organisations in the Metro district, and the training of the HCBCs on NQF levels 1 and 2 in ancillary health care and community health work.	1.) Improved quality of life of unemployed people through employment creation and increased income, and improved community health based services.	527 qualified HCBCs (552 full-time equivalents)		

PUBLIC ENTITIES

Table C.6: Public Entities

NAME OF PUBLIC ENTITY	MANDATE	OUTPUTS	CURRENT ANNUAL BUDGET (R'000)	DATE OF NEXT EVALUATION

Note:

The Western Cape Government Health does not have any public entities and therefore this table is not applicable.

PUBLIC-PRIVATE PARTNERSHIPS (PPPs)

Table C.7: Public-private partnerships [PPP]

Name of PPP	Purpose	Outputs	Current annual budget R' thousand	Date of termination	Measures to ensure smooth transfer of responsibilities
Western Cape Rehabilitation Centre (WCRC) Public Private Partnership	Provision of equipment, facilities management and all associated services at the Western Cape Rehabilitation Centre and the Lentegeur Hospital.	**Western Cape Rehabilitation Centre [WCRC]:** The private party ensures the provision of catering services, manning the Helpdesk, cleaning of all areas, provision of general estate management services, general grounds and garden maintenance, supply, maintenance and replacement of linen, control of pests and infestations, provision, management, calibration, repair, maintenance, cleaning and replacement of all medical devices, waste management, security services provision, utilities management and remedial works. **Lentegeur Hospital:** The private party ensures the provision of catering services, cleaning services, gardens and grounds maintenance, pest control services, security services and waste management.	52 894	28 February 2019	Partnership Management Plan Governance Structures PPP agreement Performance indicators Patients and other stakeholder satisfaction Knowledge management systems
Tygerberg Hospital Public Private Partnership		Replacement of the existing Tygerberg Hospital using a Public Private Partnership procurement approach. Note that this contract is in the process of being developed.	12 000	To be determined	Feasibility study in process

Conclusion

The Department is launching into a new period that will focus on implementing the first phase priorities of both the national development plan and Healthcare 2030. This is an exciting period with huge opportunities and many challenges. Implementing the identified leverages will put the health services on a firm path to person-centred care and achieving wellness of the broader population in the Province.

ANNEXURES

Annexure A: Technical indicator descriptions

PROGRAMME 1: ADMINISTRATION

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
GOAL 2: EMBED GOOD GOVERNANCE AND VALUES-DRIVEN LEADERSHIP PRACTICES														
1.1.1	Percentage of the annual equitable share budget allocation spent	Percentage of the allocated equitable share annual budget that was spent by the Department. For quarterly reporting the projected annual expenditure versus the annual budget should be used.	Ensure the under- / over-spending of the equitable share is within 1% of the budget allocation.	Numerator: Expenditure reports Denominator: Annual allocated budget	Numerator: BAS Denominator: BAS	Numerator: Annual expenditure on equitable share budget (Quarterly, use projected annual expenditure) Denominator: Total BAS annual equitable share budget allocation	100	Dependant on accurate expenditure information on the equitable share budget. (Quarterly dependant on realistic projected expenditure.)	Output	Percentage	Quarterly	No	The over- / under-spending of the annual equitable share do not exceed 1% of the budget allocation.	Chief Financial Officer (CFO)
2.1.1	Timeous submission of a Human Resource Plan for 2015 - 2019 to DPSA	The 2015 - 2019 Human Resource Plan is submitted to the Department of Public Service and Administration (DPSA) timeously.	Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan.	Submission of the 2015 - 2019 Human Resource Plan	Submission of the 2015 - 2019 Human Resource Plan	Revised Human Resource Plan for 2015 – 2019 submitted timeously to DPSA	Yes / No	Availability of documentation to proof submission of Plan.	Input	Compliance	Annually	Yes	Adherence to the due date for the submission of the plan to the Department of Public Service and Administration.	Director: Human Resource Management

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
3.1.1	Cultural entropy level for WCG: Health	Cultural entropy provides an indication of organisational culture and is the amount of energy in an organisation that is consumed in unproductive work. It is a measure of the conflict, friction and frustration that exists within an organisation. Cultural entropy is calculated as the proportion of votes for limiting values that participants in the Barrett values survey pick to describe the current culture of the organisation. Entropy risk bands: • Less than 10%: healthy functioning • 10% - 19%: problems requiring attention and careful monitoring • 20% - 29%: significant problems requiring immediate attention • 30% - 39%: crisis situation requiring immediate change • Above 40%: impending risk of implosion, bank-ruptcy, or failure.	Organisational culture has an influence on the overall performance of the organisation. Leadership plays a critical role in driving a values-driven culture with the organisation.	Numerator: Barrett values survey Denominator: Barrett values survey	Numerator: Cultural Values Assessment (CVA) report Denominator: Cultural Values Assessment (CVA) report	Numerator: Votes for potentially limiting values (PL) in current culture Denominator: Participants in the survey X 10 possible values	100	Respondents base their answers (votes for the values) on their personal perception of the organisation. Participation is limited to staff with access to computers and, therefore, the majority of staff who participate falls in the admin category.	Output	Percentage	Bi-annual	Yes	A reduction in cultural entropy enables a more optimal work environment that improves organisational performance, increases employee engagement as well as reduces employee turnover.	Director: Human Resource Management

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
3.2.1	Number of value matches in the Barrett survey	Cultural value matches highlight the relationship between personal values, current and desired organisational values. In a highly aligned culture, one would expect to see three or four positive values matches between personal, current, and desired values. These values indicate whole system change.	Matching values indicate alignment between personal, current and desired values - the individual and collective consciousness have grown to the same level and the collective exhibits the behaviours.	Barrett values survey	Cultural Values Assessment (CVA) report	Value matches in the Barrett values survey	1	Respondents base their answers (votes for the values) on their personal perception of the organisation. Participation is limited to staff with access to computers and, therefore, the majority of staff who participate falls in the admin category.	Output	Number	Bi-annual	Yes	Higher number of value matches indicates better alignment between personal, current and desired values.	Director: Human Resource Management
4.1.1	Percentage of PHC facilities where PHCIS software suite has been rolled-out	Proportion of PHC facilities on the Primary Health Care Information System (PHCIS) roll-out plan where the software suite has been rolled out. The software suite consists of the following modules: • PMI (Patient Master Index) • Appointment module • eRMR (electronic Routine Monthly Report-module)	Improve patient administration through a centralised database and establishing an unique identifier that will enable the department to track patients between facilities at different levels of care. Improve the patient experience and waiting times.	Numerator: PHCIS software suite project plan Denominator: PHCIS software suite project plan	Numerator: PHCIS software suite project plan Denominator: PHCIS software suite project plan	Numerator: PHC facilities where the roll-out of the PHCIS software suite has been completed Denominator: PHC facilities on the PHCIS software suite roll-out plan	100	Accuracy dependant on exact record keeping by roll-out team.	Input	Percentage	Annual	Yes	Higher percentage means more fixed PHC facilities have access to patient administration systems.	Director: Information Management

PROGRAMME 2: DISTRICT HEALTH SERVICES

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
GOAL 1: PROMOTE HEALTH AND WELLNESS														
1.1.1	ART retention in care after 12 months	The proportion of people who started ART treatment care 12 months previously and remained in care. Include 2nd and 3rd line treatment, transfers in (TFI) and clients who restarted their treatment. Retained in care excludes transfers out (TFO), lost to follow up (LTF) and deaths (RIP).	Treatment of HIV infection can be effective only if patients are retained in care over time.	Numerator: ART register Denominator: ART register	Numerator: Tier.net / iKapa Denominator: Tier.net / iKapa	Numerator: ART clients retained in care after 12 months Denominator: ART clients initiated on treatment (12 month cohort)	100	Accuracy dependent on quality of data from reporting facilities and ability to monitor the outcomes specific cohorts accurately.	Outcome	Percentage	Quarterly	Yes	Higher percentage indicates more patients are still on ART after 12 months.	Director: HIV/AIDS & TB
2.1.1	ART retention in care after 48 months	The proportion of people who started ART treatment care 48 months previously and remained in care. Include 2nd and 3rd line treatment, transfers in (TFI) and clients who restarted their treatment. Retained in care excludes transfers out (TFO), lost to follow up (LTF) and deaths (RIP).	Treatment of HIV infection can be effective only if patients are retained in care over time.	Numerator: ART register Denominator: ART register	Numerator: Tier.net / iKapa Denominator: Tier.net / iKapa	Numerator: ART clients retained in care after 48 months Denominator: ART clients initiated on treatment (48 month cohort)	100	Accuracy dependent on quality of data from reporting facilities and ability to monitor the outcomes specific cohorts accurately.	Outcome	Percentage	Annual	Yes	Higher percentage indicates more patients are still on ART after 12 months.	Director: HIV/AIDS & TB
3.1.1	TB programme success rate	All TB clients who successfully completed their TB treatment (i.e. cured + treatment completed) as a proportion of all TB clients who started on treatment. All TB patients include pulmonary and extra-pulmonary clients.	Monitors success of TB treatment for all types of TB.	Numerator: TB register Denominator: TB register	Numerator: ETR.net Denominator: ETR.net	Numerator: All TB cases treatment success (outcome cohort) Denominator: All TB cases (outcome cohort)	100	Accuracy dependent on quality of data from reporting facilities.	Outcome	Percentage	Quarterly	Yes	Higher percentage indicates more TB clients are treated successfully.	Director: HIV/AIDS & TB

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
4.1.1	Under 5 mortality rate (Stats SA)	The probability of a child born in a specific year dying before reaching the age of five if subject to current age-specific mortality rates. (Deaths under 5 years and live births, as reported from Stats SA, must be used.)	Measures the risk of dying in early childhood.	Numerator: Death notification form Denominator: Birth certificate	Numerator: Stats SA Statistical release (Mortality and caused of death in South Africa) Denominator: Stats SA Statistical release (Recorded live births)	Numerator: Children under 5 years who died (Stats SA) Denominator: Live births (Stats SA)	1 000	Reliant on accurate reporting by Stats SA. There is a 2 year delay in reporting (e.g. 2012 data is reported in 2014). Data for any specific year can change due to late registration of births and deaths.	Outcome	Rate per 1 000 live births	Annual	Yes	Lower rate means fewer children under-5 years died.	Director: Facility Based Programmes

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
GOAL 1: PROMOTE HEALTH AND WELLNESS														
1.1.1	Percentage of WCG: Health rostered ambulances registered and licensed	Monitors the proportion of ambulances within the service that comply with the National Ambulance Act	Ambulances are required to be licensed in order to be rostered / operational. Failure to license ambulances negatively affects the ability to service EMS incidents.	Numerator: License and registration papers Denominator: CAD system	Numerator: WCG Health EMS ambulance licensing database Denominator: CAD system	Numerator: WCG: Health rostered ambulances registered and licensed as per the National Ambulance Act Denominator: Rostered ambulances per hour	100	Delays in licensing documentation from the licensing authority may delay reporting. New ambulances added to fleet may not be licensed immediately.	Quality	Percentage	Annually	Yes	Higher proportion is better as this indicated the compliance with the National Ambulance Act.	EMS manager
	Rostered ambulances per hour	Rostered ambulances (i.e. staffed, equipped and ready to respond) available per hour in the Western Cape. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	Monitors resource availability in EMS in terms of equitable access and allows comparison with other ambulance services.	Numerator: CAD system Denominator: CAD system	Numerator: CAD system Denominator: CAD system	Numerator: Ambulance personnel hours worked for the reporting period Denominator: 2 x 24 hours per day for the reporting period	1	Accuracy dependant on the reliability of data recorded on the Efficiency Report at EMS stations.	Input	Cumulative	Quarterly	No	Higher number of rostered ambulances may lead to faster response time.	EMS manager

PROGRAMME 4: PROVINCIAL HOSPITALS

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
GOAL 1: PROMOTE HEALTH AND WELLNESS														
1.1.1	Actual (usable) beds in regional hospitals	Actual (usable) beds in regional hospitals are beds actually available for use within the regional hospital, regardless of whether they are occupied by a patient or a lodger. (This is a fixed value that does not fluctuate due to renovations or intermittent staff challenges.)	Monitors the availability of regional hospital beds to ensure accessibility of regional hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds (regional hospitals)	None (Nr)	Dependent on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease or greater reliance on the public health system.	Regional hospital programme manager
2.1.1	Actual (usable) beds in TB hospitals	Actual (usable) beds in TB hospitals are beds actually available for use within the TB hospital, regardless of whether they are occupied by a patient or a lodger. (This is a fixed value that does not fluctuate due to renovations or intermittent staff challenges.)	Monitors the availability of TB hospital beds to ensure accessibility of TB hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds (TB hospitals)	None (Nr)	Dependent on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease or greater reliance on the public health system.	Chief Director: Metro District Health Services (MDHS) and Chief Director: Rural District Health Services (RDHS)
3.1.1	Actual (usable) beds in psychiatric hospitals	Actual (usable) beds in psychiatric hospitals are beds actually available for use within the psychiatric hospital, regardless of whether they are occupied by a patient or a lodger. (This is a fixed value that does not fluctuate due to renovations or intermittent staff challenges.)	Monitors the availability of psychiatric hospital beds to ensure accessibility of psychiatric hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds (psychiatric hospitals)	None (Nr)	Dependent on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease or greater reliance on the public health system.	Psychiatric hospital programme manager

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
3.1.2	Actual (usable) beds in step-down facilities	Actual (usable) beds in step-down facilities are beds actually available for use within the psychiatric hospital, regardless of whether they are occupied by a patient or a lodger. (This is a fixed value that does not fluctuate due to renovations or intermittent staff challenges.)	Monitors the availability of psychiatric hospital beds to ensure accessibility of psychiatric hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds (step-down facilities)	None (Nr)	Dependent on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease or greater reliance on the public health system.	Psychiatric hospital programme manager
4.1.1	Actual (usable) beds in rehabilitation hospitals	Actual (usable) beds in rehabilitation hospitals are beds actually available for use within the rehabilitation hospital, regardless of whether they are occupied by a patient or a lodger. (This is a fixed value that does not fluctuate due to renovations or intermittent staff challenges.)	Monitors the availability of rehabilitation hospital beds to ensure accessibility of rehabilitation hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds (rehabilitation hospitals)	None (Nr)	Dependent on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease or greater reliance on the public health system.	Rehabilitation hospital programme manager
5.1.1	Oral health patient visits at dental training hospitals	Total number of patient visits for treatment recorded at the various clinics of the oral health centres.	Monitoring the service volumes at the oral health centres.	Dental Training Hospital Form	SINJANI	Sum of patient visits at Tygerberg and UWC Oral Health Centres + Other oral health clinics (outreach clinics)	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	Dean: Dental Faculty

PROGRAMME 5: CENTRAL AND TERTIARY HOSPITAL SERVICES

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
GOAL 1: PROMOTE HEALTH AND WELLNESS														
1.1.1	Actual (usable) beds in central hospitals	Actual (usable) beds in central hospitals are beds actually available for use within the central hospital, regardless of whether they are occupied by a patient or a lodger. (This is a fixed value that does not fluctuate due to renovations or intermittent staff challenges.)	Monitors the availability of central hospital beds to ensure accessibility of central hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds (central hospitals)	None (Nr)	Dependent on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease or greater reliance on the public health system.	Central hospital programme manager
2.1.1	Actual (usable) beds in Groote Schuur Hospital	Actual (usable) beds in Groote Schuur Hospital are beds actually available for use within the regional hospital, regardless of whether they are occupied by a patient or a lodger. (This is a fixed value that does not fluctuate due to renovations or intermittent staff challenges.)	Monitors the availability of Groote Schuur Hospital beds to ensure accessibility of Groote Schuur Hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds (Groote Schuur Hospital)	None (Nr)	Dependent on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease or greater reliance on the public health system.	CEO Groote Schuur Hospital
3.1.1	Actual (usable) beds in Tygerberg Hospital	Actual (usable) beds in Tygerberg Hospital are beds actually available for use within the regional hospital, regardless of whether they are occupied by a patient or a lodger. (This is a fixed value that does not fluctuate due to renovations or intermittent staff challenges.)	Monitors the availability of Tygerberg Hospital beds to ensure accessibility of Tygerberg Hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds (Tygerberg Hospital)	None (Nr)	Dependent on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease or greater reliance on the public health system.	CEO Tygerberg Hospital

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
4.1.1	Actual (usable) beds in Red Cross War Memorial Children's Hospital (RCWMCH)	Actual (usable) beds in RCWMCH are beds actually available for use within the regional hospital, regardless of whether they are occupied by a patient or a lodger. (This is a fixed value that does not fluctuate due to renovations or intermittent staff challenges.)	Monitors the availability of RCWMCH beds to ensure accessibility of RCWMCH services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds (RCWMCH)	None (Nr)	Dependent on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease or greater reliance on the public health system.	CEO RCWMCH

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
GOAL 2: EMBED GOOD GOVERNANCE AND VALUES-DRIVEN LEADERSHIP PRACTICES														
1.1.1	Number of bursaries awarded for scarce and critical skills categories	Bursaries awarded each year to students (prospective employees) for full-time study based on scarce skills and to current employees for part-time study, based on critical skills. This includes bursaries for each year of study, not only the first year. Scarce skills refer to staff shortages within an occupational category, e.g. radiographers, due to the department's inability to recruit and retain staff. Critical skill refer to skills shortages amongst existing staff, who, despite their formal qualifications, may require top up training or continuous clinical skills development, e.g. a doctor who may require basic life support training as an identified gap that exists within his/ her current competency level.	Tracks the number of bursaries allocated to students based on scarce and critical skills.	Bursary Information Management System	Bursary contracts signed	Bursaries awarded for scarce and critical skills categories	1	Accuracy dependant on good record keeping by the Provincial DoH, nursing colleges, HEIs and external accredited training providers	Input	Number	Annual	Yes	Higher number will lead to an increase in the number of scarce skills (prospective employees)and critical skills of current employees to improve service delivery	HRD programme manager

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
GOAL 1: PROMOTE HEALTH AND WELLNESS														
1.1.1	Percentage of FPS cases released within 5 days (excluding unidentified persons)	Percentage of FPS cases released within 5 days from admission – excluding unidentified deceased. The time is measured from when the deceased is admitted to FPS until the post-mortem body is released for burial.	Monitor turnaround times and therefore the efficiency as well as available resources in FPS, internal to the service. Also monitor equity to access across the province.	Numerator: Rural: FPS R003 Metro: FPS 013 Denominator: FPS 013	Numerator: Rural: FPS R003; Index Register Metro: Index Register Denominator: FPS R003 Metro: Index Register	Numerator: Cases released within 5 days after admission (EXCLUDE unidentified deceased) Denominator: Bodies released (EXCLUDE unidentified deceased)	100	Accuracy dependant on the reliability of data from FPS laboratories.	Quality	Percentage	Quarterly	No	Higher percentage indicates appropriate resource allocation and co-ordination in FPS.	FPS programme manager
2.1.1	Percentage of pharmaceutical stock available	Percentage of pharmaceutical stock that is available at the Cape Medical Depot (CMD) from the list of stock that should be available at all times.	To ensure optimum pharmaceutical stock levels to meet demand.	Numerator: Stock master Denominator: Stock master	Numerator: MEDSAS Denominator: MEDSAS	Numerator: Pharmaceutical items that are in stock at the CMD Denominator: Pharmaceutical items on the stock register	100	Accuracy dependant on the reliability of data on the MEDSAS system.	Efficiency	Percentage	Quarterly	No	Higher percentage indicate fewer items out of stock at the CMD.	Director: Pharmacy Services
GOAL 2: EMBED GOOD GOVERNANCE AND VALUES-DRIVEN LEADERSHIP PRACTICES														
1.1.1	Average cost per item laundered in-house	The average cost per linen item processed or laundered in-house at Tygerberg, Lentegeur and George Regional Laundries. The in-house laundry costs include the cost for electricity, water, coal, fuel, and salaries and wages. The expenditure on capital for buildings and equipment is excluded.	Monitor the cost per item laundered to ensure that in-house laundry services are cost effective.	Numerator: Financial records Denominator: Laundry linen count	Numerator: BAS Denominator: Laundry returns.xls	Numerator: Expenditure on in-house laundries excluding capital Denominator: Items laundered in-house	1	Accuracy dependant on the reliability of financial data and other records kept by in-house laundries.	Efficiency	Rate	Quarterly	No	Lower cost indicates efficient use of financial resources.	Laundry manager (Directorate: Engineering and Technical Support)

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
2.1.1	Percentage of maintenance budget spent	Programme 7.2's expenditure as a percentage of the Programme 7.2's budget.	Tracks expenditure on maintenance of health facilities.	Numerator: Financial records Denominator: Financial records	Numerator: BAS Denominator: BAS	Numerator: Sub-programme 7.2 expenditure Denominator: Sub-programme 7.2 budget	100	Accuracy dependant on the reliability of financial data on BAS and the costing of maintenance expenditure.	Input	Percentage	Quarterly	No	Higher percentage indicates efficient use of financial resources. Over-expenditure, if necessary funding is not available, however, is not desirable.	Director: Engineering and Technical Support

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
GOAL 2: EMBED GOOD GOVERNANCE AND VALUES-DRIVEN LEADERSHIP PRACTICES														
1.1.1	Percentage of Programme 8 capital infrastructure budget spent (excluding maintenance)	Capital expenditure expressed as a percentage of capital budget. (Excludes Programme 8 expenditure on scheduled maintenance, preventative maintenance, organisational development, quality assurance, health technology and EPWP.)	Tracks capital expenditure versus allocated capital budget.	Numerator: Financial data Denominator: Financial data	Numerator: BAS Denominator: BAS	Numerator: Programme 8 capital infrastructure expenditure (excluding maintenance) Denominator: Programme 8 capital infrastructure budget (excluding maintenance)	100	Accuracy dependant on financial data recorded on BAS.	Input	Percentage	Quarterly	Yes	Total budget allocated is spent in accordance with the cash flow. Higher percentage indicates efficient use of financial resources and improved health infrastructure and engineering equipment. Over-expenditure, if necessary funding is not available, however, is not desirable.	Director: Infrastructure Programme Delivery

No	Indicator title	Short definition	Purpose / Importance	Form (data collection)	Source	Method of Calculation	Factor	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1.1.2	Percentage of Programme 8 capital infrastructure projects completed	Capital projects that achieved practical completion as planned (practical completion certificate or relevant equivalent issued by professional team) expressed as a percentage of the number of projects planned to achieve practical completion.	Tracks the progress of capital projects against the project plan i.e. the period allocated in which the project should be completed.	Numerator: Practical completion certificate (or relevant equivalent) Denominator: Practical completion certificate (or relevant equivalent)	Numerator: Rational Portfolio Manager (RPM) Denominator: RPM	Numerator: Practical completion certificates (or relevant equivalent) issued for capital infrastructure projects Denominator: Practical completion certificates (or relevant equivalent) planned / scheduled for issue for capital infrastructure projects	100	Accuracy dependant on reliability of data recorded on RPM.	Output	Percentage	Quarterly	No	A higher percentage will reflect that projects have been completed ahead of schedule.	Director: Infrastructure Programme Delivery

Annexure B: List of facilities

1. Primary health care facilities

1.1 Cape Town District

Sub-district	Community Health Centres (CHCs)	Community Day Centres (CDCs)	Clinics	Specialised Clinics	Satellite Clinics	Mobiles
Eastern Sub-district	-	Gustrouw CDC Ikhwezi CDC* Kleinvlei CDC Macassar CDC Mfuleni CDC Strand CDC	Blue Downs Clinic* Dr Ivan Toms Clinic* Eerste River Clinic* Fagan Street Clinic* Gordon's Bay Clinic* Kuilsriver Clinic* Sarepta Clinic* Sir Lowry's Pass Clinic* Somerset West Clinic* Wesbank Clinic*	-	Driftsands Satellite Clinic* Hillcrest Satellite Clinic*	Eastern (Sub-district) Mobile Macassar Mobile* Living Hope (Mfuleni) Mobile* Masicendane (Somerset West) Mobile*
	0	**6**	**10**	**0**	**2**	**4**
Khayelitsha Sub-district	Khayelitsha (Site B) CHC	Kuyasa CDC* Luvuyo CDC* Matthew Goniwe CDC* Michael Mapongwana CDC Nolungile CDC Town 2 CDC*	Kuyasa Interchange Clinic* Mayenzeke Clinic* Nolungile Clinic* Site B Male Clinic* Site B Youth Clinic* Site C Youth Clinic* Zakhele Clinic*	-	-	Khayelitsha (Sub-district) Mobile
	1	**6**	**7**	**0**	**0**	**1**
Klipfontein Sub-district	Guguletu CHC Hanover Park CHC	Dr Abdurahman CDC Heideveld CDC Nyanga CDC	Guguletu Clinic* Hanover Park Clinic* Heideveld Clinic* Lansdowne Clinic* Manenberg Clinic* Masincedane Clinic* Nyanga Clinic* Silvertown Clinic* Vuyani Clinic*	Nyanga Junction Reproductive Health Service Eros Oral Health Service Silvertown Oral Health Service	Hazendal Satellite Clinic* Honeyside Satellite Clinic* Newfields Satellite Clinic*	-
	2	**3**	**9**	**3**	**3**	

Sub-district	Community Health Centres (CHCs)	Community Day Centres (CDCs)	Clinics	Specialised Clinics	Satellite Clinics	Mobiles
Mitchells Plain Sub-district	Mitchells Plain CHC	Crossroads CDC Brown's Farm (Inzame Zabantu) CDC Tafelsig CDC*	Crossroads 1 Clinic* Crossroads 2 Clinic* Eastridge Clinic* Lentegeur Clinic* Mzamomhle Clinic* Phumlani Clinic* Rocklands Clinic* Weltevreden Valley Clinic* Westridge Clinic*	Lentegeur Oral Health Service Westridge Oral Health Service Lentegeur Hospital Oral Health Service	Mandalay Satellite Clinic*	-
	1	**3**	**9**	**3**	**1**	**0**
Northern Sub-district	Kraaifontein CHC	Durbanville CDC Scottsdene CDC	Bloekombos Clinic* Bothasig Clinic* Brackenfell Clinic* Brighton Clinic* Durbanville Clinic* Fisantekraal Clinic* Harmonie Clinic* Northpine Clinic* Scottsdene Clinic* Wallacedene Clinic*	-	-	-
	1	**2**	**10**	**0**	**0**	**0**
Southern Sub-district	Retreat CHC	Grassy Park CDC Hout Bay Harbour CDC Lady Michaelis CDC Lotus River CDC Ocean View CDC*	Claremont Clinic* Diep River Clinic* Fish Hoek Clinic* Hout Bay Main Road Clinic* Klip Road Clinic* Lavender Hill Clinic* Lotus River Clinic* Masiphumelele Clinic* Muizenberg Clinic* Parkwood Clinic* Philippi Clinic* Retreat Clinic* Seawind Clinic* Strandfontein Clinic* Westlake Clinic* Wynberg Clinic*	-	Alphen Satellite Clinic* Pelican Park Satellite Clinic* Simon's Town Satellite Clinic*	Redhill Mobile*
	1	**5**	**16**	**0**	**3**	**1**

Sub-district	Community Health Centres (CHCs)	Community Day Centres (CDCs)	Clinics	Specialised Clinics	Satellite Clinics	Mobiles
Tygerberg Sub-district	Delft CHC Elsies River CHC	Bellville South CDC Bishop Lavis CDC Dirkie Uys CDC Parow CDC Ravensmead CDC Reed Street CDC Ruyterwacht CDC St Vincent CDC	Adriaanse Clinic* Bishop Lavis Clinic* Delft South Clinic* Dirkie Uys Clinic* Elsies River Clinic* Kasselsvlei Clinic* Netreg Clinic* Parow Clinic* Ravensmead Clinic* St Vincent Clinic* Tygerberg (TB/HIV) Health Education Clinic Uitsig Clinic* Valhalla Park Clinic*	Bellville Reproductive Health Service Tygerberg Community Dental Clinic	Chestnut Satellite Clinic* Groenvallei Satellite Clinic* Leonsdale Satellite Clinic* Men's Health Satellite Clinic*	-
	2	**8**	**13**	**2**	**4**	**0**
Western Sub-district	Vanguard CHC	Du Noon CDC Green Point CDC Kensington CDC Maitland CDC Mamre CDC Robbie Nurock CDC Woodstock CDC	Albow Gardens Clinic* Chapel Street Clinic* Factreton Clinic* Langa Clinic* Maitland Clinic* Melkbosstrand Clinic* Protea Park Clinic* Saxon Sea Clinic* Spencer Road Clinic* Table View Clinic	Atlantis Oral Health Service Hope Street Oral Health Service Maitland Oral Health Service Cape Town Reproductive Health Service Dorp Street Reproductive Health Service	Pella Satellite Clinic* Pinelands Satellite Clinic* Schotscheskloof Satellite Clinic*	Melkbosstrand Mobile Witsand Mobile*
	1	**7**	**10**	**5**	**3**	**2**
CAPE TOWN DISTRICT	**9**	**40**	**84**	**13**	**16**	**8**

Note: Facilities marked with an * fall under the authority of the City of Cape Town Municipality.

1.2 Cape Winelands District

Sub-district	Community Health Centres (CHCs)	Community Day Centres (CDCs)	Clinics	Specialised Clinics	Satellite Clinics	Mobiles
Breede Valley Local Municipality	-	Worcester CDC	De Doorns Clinic Empilisweni (Worcester) Clinic Orchard Clinic Rawsonville Clinic Sandhills Clinic Touws River Clinic	-	De Wet Satellite Clinic Maria Pieterse Satellite Clinic Overhex Satellite Clinic Somerset Street Satellite Clinic	Bossieveld Mobile Botha/Brandwacht Mobile De Wet Mobile Overhex Mobile Slanghoek Mobile
	0	**1**	**6**	**0**	**4**	**5**
Drakenstein Local Municipality	-	Mbekweni CDC TC Newman CDC Wellington CDC	Dalevale Clinic Gouda Clinic Huis McCrone Clinic JJ Du Pre Le Roux Clinic Klein Drakenstein Clinic Klein Nederburg Clinic Nieuwedrift Clinic Patriot Plein Clinic Phola Park Clinic Saron Clinic Simondium Clinic Soetendal/Hermon Clinic Windmeul Clinic	Wellington Reproductive Health Centre	-	Dal / E de Waal Mobile Gouda Mobile Hermon Mobile Hexberg Mobile Simondium Mobile Windmeul Mobile
	0	**3**	**13**	**1**	**0**	**6**
Langeberg Local Municipality	-	-	Bergsig Clinic Cogmanskloof Clinic Happy Valley Clinic McGregor Clinic Montagu Clinic Nkqubela Clinic Zolani Clinic	-	-	Bonnievale Mobile McGregor Mobile Montagu Mobile 1 Montagu Mobile 2 Robertson Mobile 1 Robertson Mobile 2
	0	**0**	**7**	**0**	**0**	**6**

Sub-district	Community Health Centres (CHCs)	Community Day Centres (CDCs)	Clinics	Specialised Clinics	Satellite Clinics	Mobiles
Stellenbosch Local Municipality	-	Cloetesville CDC	Aan-het-Pad Clinic Don and Pat Bilton Clinic Groendal Clinic Idas Valley Clinic Kayamandi Clinic Klapmuts Clinic Kylemore Clinic Victoria Street Clinic	-	Dirkie Uys Street Satellite Clinic Rhodes Fruit Farm Satellite Clinic	Devon Valley Mobile Franschhoek Mobile Groot Drakenstein Mobile Koelenhof Mobile Strand Road Mobile
	0	**1**	**8**	**0**	**2**	**5**
Witzenberg Local Municipality	-	Ceres CDC	Annie Brown Clinic Bella Vista Clinic Breerivier Clinic Nduli Clinic Op die Berg Clinic Prince Alfred Hamlet Clinic Tulbagh Clinic Wolseley Clinic	-	-	Koue Bokkeveld Mobile Prince Alfred Hamlet Mobile Skurweberg Mobile Tulbagh Mobile Warm Bokkeveld Mobile Wolseley Mobile
	0	**1**	**8**	**0**	**0**	**6**
CAPE WINELANDS DISTRICT	**0**	**6**	**42**	**1**	**6**	**28**

1.3 Central Karoo District

Sub-district	Community Health Centres (CHCs)	Community Day Centres (CDCs)	Clinics	Specialised Clinics	Satellite Clinics	Mobiles
Beaufort West Local Municipality	-	Beaufort West CDC	Beaufort West Constitution Street Clinic Kwamandlenkosi Clinic Murraysburg Clinic Nelspoort Clinic Nieuveldpark Clinic	-	Merweville Satellite Clinic	Beaufort West Mobile 1 Merweville Mobile Murraysburg Mobile Nelspoort Mobile
	0	**1**	**5**	**0**	**1**	**4**
Laingsburg Local Municipality	-	-	Laingsburg Clinic	-	Matjiesfontein Satellite Clinic	Laingsburg Mobile
	0	**0**	**1**	**0**	**1**	**1**
Prince Albert Local Municipality	-	-	Leeu-Gamka Clinic Prince Albert Clinic	-	Klaarstroom Satellite Clinic	Prince Albert Mobile
	0	**0**	**2**	**0**	**1**	**1**
CENTRAL KAROO DISTRICT	**0**	**1**	**8**	**0**	**3**	**6**

1.4 Eden District

Sub-district	Community Health Centres (CHCs)	Community Day Centres (CDCs)	Clinics	Specialised Clinics	Satellite Clinics	Mobiles
Bitou Local Municipality	-	Kwanokuthula CDC	Crags Clinic Kranshoek Clinic New Horizon Clinic Plettenberg Bay Clinic	-	Wittedrif Satellite Clinic	Plettenberg Bay Mobile
	0	**1**	**4**	**0**	**1**	**1**
George Local Municipality	-	Conville CDC George Central CDC Thembalethu CDC	Blanco Clinic Haarlem Clinic Kuyasa (George) Clinic Lawaaikamp Clinic Pacaltsdorp Clinic Parkdene Clinic Rosemoor Clinic Touwsranten Clinic Uniondale (Lyonsville) Clinic	George Oral Health Service	Avontuur Satellite Clinic Herold Satellite Clinic	George Mobile Herold Mobile Uniondale Mobile 1 Uniondale Mobile 2
	0	**3**	**9**	**1**	**2**	**4**
Hessequa Local Municipality	-	-	Albertinia Clinic Heidelberg Clinic Melkhoutfontein Clinic Riversdale Clinic	-	Slangrivier Satellite Clinic Still Bay Satellite Clinic	Albertinia Mobile Heidelberg Mobile Riversdale Mobile
	0	**0**	**4**	**0**	**2**	**3**
Kannaland Local Municipality	-	-	Amalienstein Clinic Calitzdorp (Bergsig) Clinic Ladismith (Nissenville) Clinic Zoar Clinic	-	Van Wyksdorp Satellite Clinic	Calitzdorp Mobile Ladismith Mobile Van Wyksdorp Mobile Zoar Mobile
	0	**0**	**4**	**0**	**1**	**4**
Knysna Local Municipality	-	Knysna CDC	Homlee Clinic Keurhoek Clinic Khayelethu Clinic Knysna Town Clinic Sedgefield Clinic	-	Karatara Satellite Clinic	Knysna Mobile Sedgefield Mobile
	0	**1**	**5**	**0**	**1**	**2**

Sub-district	Community Health Centres (CHCs)	Community Day Centres (CDCs)	Clinics	Specialised Clinics	Satellite Clinics	Mobiles
Mossel Bay Local Municipality	-	Alma CDC	D'Almeida Clinic Eyethu Clinic Great Brak River Clinic	-	Brandwacht Satellite Clinic Dana Bay Satellite Clinic Friemersheim Satellite Clinic George Road Satellite Clinic Hartenbos Satellite Clinic Herbertsdale Satellite Clinic Sonskynvallei Satellite Clinic	Mossel Bay Mobile 1 Mossel Bay Mobile 2 Mossel Bay Mobile 3 Mossel Bay Mobile 4
	0	**1**	**3**	**0**	**7**	**4**
Oudtshoorn Local Municipality	-	Bridgeton CDC	Bongolethu Clinic De Rust (Blommenek) Clinic Dysselsdorp Clinic Oudtshoorn Clinic Toekomsrus Clinic	Oudtshoorn Oral Health Service	-	De Rust Mobile Oudtshoorn Mobile 1 Oudtshoorn Mobile 3
	0	**1**	**5**	**1**	**0**	**3**
EDEN DISTRICT	**0**	**7**	**34**	**2**	**14**	**21**

1.5 Overberg District

Sub-district	Community Health Centres (CHCs)	Community Day Centres (CDCs)	Clinics	Specialised Clinics	Satellite Clinics	Mobiles
Cape Agulhas Local Municipality	-	-	Bredasdorp Clinic Napier Clinic Struisbaai Clinic	-	Elim Satellite Clinic Waenhuiskrans Satellite Clinic	Bredasdorp Mobile 1 Bredasdorp Mobile 2
	0	**0**	**3**	**0**	**2**	**2**
Overstrand Local Municipality	-	Hermanus CDC	Gansbaai Clinic Hawston Clinic Hermanus Clinic[16] Kleinmond Clinic Mount Pleasant Clinic[16] Stanford Clinic Zwelihle Clinic[16]	-	Baardskeerdersbos Satellite Clinic Betty's Bay Satellite Clinic Onrus Satellite Clinic Pearly Beach Satellite Clinic	Caledon/Hermanus/Stanford Mobile 4
	0	**1**	**7**	**0**	**4**	**1**
Sub-district	**Community Health Centres (CHCs)**	**Community Day Centres (CDCs)**	**Clinics**	**Specialised Clinics**	**Satellite Clinics**	**Mobiles**
Swellendam Local Municipality	-	-	Barrydale Clinic Buffeljagsrivier Clinic Railton Clinic Suurbraak Clinic Swellendam PHC Clinic	-		Barrydale Mobile 3 Ruens Mobile 5 Swellendam Mobile 4
	0	**0**	**5**	**0**	**0**	**3**
Theewaterskloof Local Municipality	-	Grabouw CDC	Botrivier Clinic Caledon Clinic Genadendal Clinic Riviersonderend Clinic Villiersdorp Clinic	-	Bereaville Satellite Clinic Greyton Satellite Clinic Voorstekraal Satellite Clinic	Caledon Mobile 1 Caledon Mobile 2 Caledon Mobile 3 Grabouw Mobile 1 Grabouw Mobile 2 Grabouw Mobile 3 Villiersdorp Mobile 1 Villiersdorp Mobile 2
	0	**1**	**5**	**0**	**3**	**8**
OVERBERG DISTRICT	**0**	**2**	**20**	**0**	**9**	**14**

[16] These clinics will be closed down in a phased approach as patients are transferred to the new Hermanus CDC.

1.6 West Coast District

Sub-district	Community Health Centres (CHCs)	Community Day Centres (CDCs)	Clinics	Specialised Clinics	Satellite Clinics	Mobiles
Bergrivier Local Municipality	-	-	Piketberg Clinic Porterville Clinic Velddrif Clinic	-	Aurora Satellite Clinic Eendekuil Satellite Clinic Goedverwacht Satellite Clinic Redelinghuys Satellite Clinic Wittewater Satellite Clinic	Piketberg Mobile 1 Piketberg Mobile 2 Piketberg Mobile 5 Porterville Mobile
	0	**0**	**3**	**0**	**5**	**4**
Cederberg Local Municipality	-	-	Citrusdal Clinic Clanwilliam Clinic Elandsbay Clinic Graafwater Clinic Lamberts Bay Clinic Wupperthal Clinic	-	-	Citrusdal Mobile 1 Clanwilliam Mobile Graafwater Mobile Leipoldtville Mobile
	0	**0**	**6**	**0**	**0**	**4**
Matzikama Local Municipality	-	-	Klawer Clinic Lutzville Clinic Van Rhynsdorp Clinic Vredendal Central Clinic Vredendal North Clinic	-	Bitterfontein Satellite Clinic Doringbaai Satellite Clinic Ebenhaezer Satellite Clinic Kliprand Satellite Clinic Koekenaap Satellite Clinic Molsvlei Satellite Clinic Nuwerus Satellite Clinic Rietpoort Satellite Clinic Stofkraal Satellite Clinic	Klawer Mobile Lutzville Mobile Van Rhynsdorp Mobile Vredendal Mobile
	0	**0**	**5**	**0**	**9**	**4**
Saldanha Bay Local Municipality	-	-	Diazville Clinic Hanna Coetzee Clinic Laingville Clinic Lalie Cleophas Clinic Langebaan Clinic Louwville Clinic Saldanha Clinic Vredenburg Clinic	-	Paternoster Satellite Clinic Sandy Point Satellite Clinic	Hopefield Mobile Vredenburg Mobile
	0	**0**	**8**	**0**	**2**	**2**
Swartland Local Municipality	-	Malmesbury CDC	Darling Clinic Moorreesburg Clinic Riebeeck Kasteel Clinic Riebeeck West Clinic	Darling Reproductive Health Service	Abbotsdale Satellite Clinic Chatsworth Satellite Clinic Kalbaskraal Satellite Clinic Koringberg Satellite Clinic Riverlands Satellite Clinic Yzerfontein Satellite Clinic	Darling Mobile Malmesbury Mobile 1 Malmesbury Mobile 2 Moorreesburg Mobile
	0	**1**	**4**	**1**	**6**	**4**
WEST COAST DISTRICT	**0**	**1**	**26**	**1**	**22**	**18**

2. Hospitals

Type of hospital	Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
District hospitals	Eerste River Hospital False Bay Hospital GF Jooste Hospital (Heideveld EC) Helderberg Hospital Karl Bremer Hospital Khayelitsha Hospital Mitchells Plain Hospital Victoria Hospital Wesfleur Hospital	Ceres Hospital Montagu Hospital Robertson Hospital Stellenbosch Hospital	Beaufort West Hospital Laingsburg Hospital Murraysburg Hospital Prince Albert Hospital	Knysna Hospital Ladismith (Alan Blyth) Hospital Mossel Bay Hospital Oudtshoorn Hospital Riversdale Hospital Uniondale Hospital	Caledon Hospital Hermanus Hospital Otto Du Plessis Hospital Swellendam Hospital	Citrusdal Hospital Clanwilliam Hospital LAPA Munnik Hospital Radie Kotze Hospital Swartland Hospital Vredenburg Hospital Vredendal Hospital	
	9	**4**	**4**	**6**	**4**	**7**	**34**
Regional hospitals	Mowbray Maternity Hospital New Somerset Hospital	Paarl Hospital Worcester Hospital	-	George Hospital	-	-	
	2	**2**	**0**	**1**	**0**	**0**	**5**
Tuberculosis hospitals	Brooklyn Chest Hospital DP Marais Hospital	Brewelskloof Hospital	-	Harry Comay Hospital	-	Malmesbury ID Hospital Sonstraal Hospital*	
	2	**1**	**0**	**1**	**0**	**2**	**6**
Psychiatric hospitals	Alexandra Hospital Lentegeur Hospital Stikland Hospital Valkenberg Hospital	-	-	-	-	-	
	4	**0**	**0**	**0**	**0**	**0**	**4**
Rehabilitation hospitals	Western Cape Rehab Centre (Including Orthotic and Prosthetic Centre)	-	-	-	-	-	
	1	**0**	**0**	**0**	**0**	**0**	**1**
National central hospitals	Groote Schuur Hospital Tygerberg Hospital	-	-	-	-	-	
	2	**0**	**0**	**0**	**0**	**0**	**2**
Tertiary hospitals	Red Cross War Memorial Children Hospital	-	-	-	-	-	
	1	**0**	**0**	**0**	**0**	**0**	**1**
HOSPITALS	**21**	**7**	**4**	**8**	**4**	**9**	**53**

Note:

* Sonstraal Hospital is physically located in the Cape Winelands District but is managed by the West Coast District with Malmesbury ID Hospital.

3. Intermediate care facilities

Type of facility	Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Intermediate care	Baphumelele Respite Care Centre Step Down Facility Booth Memorial Step Down Facility Conradie Care Centre Helderberg Step Down Facility Ithemba Labantu Care Centre Step Down Facility Lizonobanda Step Down Facility Living Hope Trust Step Down Facility Sarah Fox Step Down Facility St Joseph's Step Down Facility Stepping Stones Step Down Facility Tygerberg Trust Step Down Facility	Boland Step Down Facility Bram Care Step Down Facility Ceres Step Down Facility Drakenstein Intermediate Care Step Down Facility Franschhoek Hospice Stellenbosch Hospice	Cornerstone Step Down Facility Nelspoort Hospital Nelspoort Palliative Step Down Facility	@ Peace Palliative Step Down Facility Bethesda CMSR Step Down Facility Knysna Sedgefield Hospice Knysna Sub-acute Step Down Facility Oudtshoorn FAMSA Hospice	Overstrand Care Centre Step Down Facility Themba Care Step Down Facility	Goue Aar Intermediate Care Sederhof/ACVV Clanwilliam Intermediate Care Service LAPA Munnik Step Down Facility Siyabonga Step Down Facility Vredendal Old Age Home Convalescent Unit	
	11	**6**	**3**	**5**	**2**	**5**	**31**
Psychiatric intermediate care facilities	New Beginnings William Slater	-	-	-	-	-	
	2	**0**	**0**	**0**	**0**	**0**	**2**
Other specialised	Maitland Cottage	-	-	-	-	-	
	1	**0**	**0**	**0**	**0**	**0**	**1**
INTERMEDIATE CARE	**14**	**6**	**3**	**5**	**2**	**5**	**34**

4. Other facilities

Type of facility	Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Emergency Medical Services Ambulance Stations	Khayelitsha Eastern Lentegeur Southern Pinelands Western Tygerberg Northern	Bonnievale Ceres De Doorns Montagu Paarl Robertson Stellenbosch Touws River Tulbagh Worcester	Beaufort West Laingsburg Leeu-Gamka Murraysburg Prince Albert	Calitzdorp Dysselsdorp George Heidelberg Knysna Ladismith Mossel Bay Oudtshoorn Plettenberg Bay Riversdale Uniondale	Barrydale Bredasdorp Caledon Grabouw Hermanus Riviersonderend Swellendam Villiersdorp	Bitterfontein Citrusdal Clanwilliam Darling Lamberts Bay Malmesbury Moorreesburg Piketberg Porterville Vredenburg Vredendal	
TOTAL EMS	**4**	**10**	**5**	**11**	**8**	**11**	**49**
Forensic Pathology Laboratories (Mortuaries)	Salt River Tygerberg	Paarl Stellenbosch Wolseley Worcester	Beaufort West Laingsburg	George Knysna Mossel Bay Oudtshoorn Riversdale	Hermanus Swellendam	Malmesbury Vredenburg Vredendal	
TOTAL FPS	**2**	**4**	**2**	**5**	**2**	**3**	**18**

Annexure C: List of Sources

1. Census 2011 Municipal Report- Western Cape/Statistics South Africa. Pretoria: Statistics South Africa, 2012

2. Healthcare 2030 – The Road to Wellness

3. Data Source: SINJANI

4. EMS Efficiency Data

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6. HST Rapid Injury Study, 2013

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Annexure D: Abbreviations

AIDS	Acquired immune deficiency syndrome
APL	Approved post list
APP	Annual Performance Plan
ART	Anti-retroviral treatment
ARV	Anti-retroviral
BAS	Basic Accounting System
BCEA	Basic Conditions of Employment Act
BMC	BioMed Central
BOD	Burden of Disease
BOR	Bed Occupancy Rate
C^2AIR^2	Caring, Competence, Accountability, Integrity, Responsiveness, Respect
CBS	Community-based services
CD	Chief Directorate
CDC	Community Day Centre
CDU	Chronic Dispensing Unit
CEI	Centre of E Innovation
CEO	Chief executive officer
CFO	Chief Financial Officer
CHC	Community Health Centre
CHT	Children's Hospital Trust
CI	Confidence Interval
CMD	Cape Medical Depot
COIDA	Compensation for Occupational Injuries and Diseases Act
COPD	Chronic obstructive pulmonary disease
CQI	Continuous Quality Improvement
CSP	Comprehensive Service Plan
CT	Computerized axial tomography
DALY	Disability Adjusted Life Years
DHS	District Health Services
DICU	Devolved internal control unit
DoRA	Division of Revenue Act
DOTS	Directly Observed Treatment, short course
DPSA	Department of Public Service and Administration
Dr	Doctor
EC	Emergency centres
ECD	Early Child Development
ECM	Enterprise Content Management
EEA	Employment Equity Act

EHS	Environmental Health Services
EML	Essential medicines list
EMR	Electronic Medical Records
EMS	Emergency Medical Services
EPWP	Extended Public Works Programme
FPL	Forensic Pathology Lab
FPS	Forensic Pathology Services
GG	Government Gazette
GIAMA	Government Immovable Asset Management Act
GN	General Notice
GP	General practitioner
HCBC	Home and Community Based Care
HCT	HIV counselling and testing
HEALTHNET	Health non-emergency transport
HEI	Higher Education Institution
HFRG	Health Facility Revitalisation Grant
HIS	Hospital Information Systems
HIV	Human immunodeficiency virus
HOD	Head of Department
HPTDG	Health Professions Training and Development Grant
HR	Human Resources
HRD	Human Resources Development
HRM	Human Resource Management
HSRC	Human Sciences Research Council
HST	Health Sciences and Training
HT	Health Technology
IA	Internal assessment
ICAS	Independent Counselling and Advisory Services
ICT	Information Communication Technology
ICU	Information Compliance Unit
ICU	Intensive Care Unit
ID	Infectious Diseases
IDMS	Infrastructure Delivery Management System
IMCI	Integrated Management of Childhood Illness
iMMR	Institutional Maternal Mortality Rate
IMR	Infant Mortality Rate
IPMP	Infrastructure Programme Management Plan
IPWG	Injury Prevention Workgroup
ISBN	International Standard Book Number
IT	Information Technology
km	kilometre

km2	kilometre per square
L1	Level 1
L2	Level 2
L3	Level 3
L4	Level 4
LRA	Labour Relations Act
M&E	Monitoring and evaluation
MDG	Millennium Development Goals
MDHS	Metro District Health System
MDR	Multi-drug resistant
MEC	Member of Exexutive Council
MEDSAS	Medical Stores Administration System
MLA	Multilevel agreement
MOU	Midwife Obstetrics Unit
MPI	Multidimensional Poverty Index
Mr	Mister
MRCC	Maritime Rescue Co-ordination Centre
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
n	number of cases
N2	National Road
NCD	Non-communicable diseases
NDoH	National Department of Health
NDP	National Development Plan
NHA	National Health Act
NHI	National Health Insurance
No	Number
NPA	National Prosecuting Authority
NPO	Non-Profit Organisations
NSRI	National Sea Rescue Institute
NTSG	National Tertiary Services Grant
ODI	Organisational Development Intervention
OHS	Occupational Health and Safety
OHSA	Occupational Health and Satefy Act
OPC	Orthotic and Prosthetic Centre
OPD	Outpatient Department
OSD	Occupation Specific Dispensation
PACS/RIS	Picture Archive Communication System and Radiology Information System
PAIA	Promotion of Access to Information Act
PBI	Performance-Based Incentive
PDE	Patient Day Equivalents

PERSAL	Personnel and Salary Information System
PFMA	Public Finance Management Act
PHC	Primary Health Care
PHCIS	Primary Health Care Information System
PMTCT	Prevention of Mother to Child Transmission
PN	Provincial Notice
POPI	Protection of Personal Information Act
PPHC	Personal Primary Health Care
PPP	Public Private Partnerships
PPT	Planned Patient Transport
PreHMIS	Patient Record and Health Management System
PSG	Provincial Strategic Goal
PTB	Pulmonary Tuberculosis
QA	Quality Assurance
QCL	Quality control laboratory
QPR	Quarterly Performance Review
R	Rand
RA	Rapid Assessment
RCC	Rolling Continuation Channel
RCWMCH	Red Cross War Memorial Children's Hospital
RMS	Rapid Mortality Surveillance
RPM	Rational Portfolio Manager
RTC	Regional Training Centre
SA	South Africa
SAAF	South African Airforce
SADHS	South African Demographic and Health Survey
SAIMD	South African Index of Multiple Deprivation
SAMPI	South African Multidimensional Poverty Index
SAMSA	South African Maritime Safety Authority
SANHANES	South African National Health and Nutrition Examination Survey
SAPS	South African Police Service
SCM	Supply Chain Management
SDA	Service Delivery Agreement
SG	Strategic Goal
SHERQ	Safety, Health, Environment, Risk, and Quality
SINJANI	Standard Information Jointly Assembled by Networked Infrastructure
SMART	Specific, measurable, attainable, realistic, timely
SMS	Senior Management Service
Stats SA	Statistics South Africa
TB	Tuberculosis
TPW	Transport & Public Works

U5MR	Under-five Mortality Rate
U-AMP	User Asset Management Plan
UCT	University of Cape Town
UN	United Nations
UV	Ultraviolet
UWC	University of the Western Cape
VC	Victims of Crime
WC	Western Cape
WCCN	Western Cape College of Nursing
WCG	Western Cape Government
WCG TPW	Western Cape Government Transport and Public Works
WCGH	Western Cape Government: Health
WCRC	Western Cape Rehabilitation Centre
WHO	World Health Organisation
WSAR	Wilderness Search and Rescue
XDR	Extreme drug resistant
YLD	Years Lost due to Disability
YLL	Years of life lost

Western Cape Government

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Caring Competence Accountability Integrity Responsiveness Respect