Strategic Plan

2010/11 – 2014/15

FOREWORD BY THE MEC FOR HEALTH
FIVE-YEAR STRATEGIC PLAN AND ANNUAL PERFORMANCE PLAN

The Department of Health plays a leading role in the Provincial strategic objective of 'Maximising health outcomes'. The Department is responsible for the delivery of effective and efficient health services and for providing relevant information to assist the transversal government to target initiatives that will reduce the burden of disease in the province. This is within the broader context of achieving an Open Opportunity Society for All through:

1. Establishing lean and effective administration
2. Managing human capital and resources
3. Creating sustainable departmental income
4. Establishing strategic partnerships
5. Undertaking asset management
6. Creating centres of excellence
7. Enhancing customer care / service standards
8. Addressing the burden of disease
9. Ensuring constitutional responsibility
10. Ensuring accountability, transparency oversight and monitoring

In terms of the provincial objectives for the next 5 years, the Burden of Disease (no. 8), Strategic Partnerships and Income Streams (no. 4) and Skills and Training (no. 2), and Customer Care and Citizen Responsibility (no. 7) have been adopted as most important and will receive priority in this order.

In addressing the two major contributors to the Burden of Disease, the Department is in the process of finalizing comprehensive strategies and programmes to address substance abuse and alcohol. We are doing this in collaboration with international experts, international support, local universities as well as role players in the industry and the private sector.

In terms of customer care, two new hospitals are currently under construction and another three is in planning phase. Community Health Clinics will be commissioned this coming financial year and we're in the final stage of preparation to undertake a R800 million backlog in maintenance to be completed in 36 months. We are introducing programmes to reduce patient overflow at facilities and waiting times substantially.

The strategic objectives in this document offer a detailed framework to achieve the maximum health outcomes for the people of the Western Cape, within the available budget allocated to this Department. I endorse this Strategic Plan and commit to the implementation thereof.

Theuns Botha
Western Cape Minister of Health
February 2010

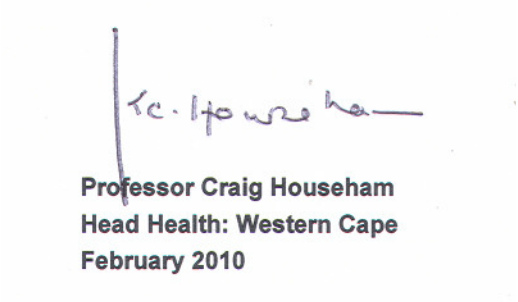
MESSAGE FROM THE HEAD OF DEPARTMENT
PROFESSOR KC HOUSEHAM

The Provincial Cabinet approved Healthcare 2010 in March 2003 and the Comprehensive Service Plan in May 2007. At that time the 2010 targets for reshaping the service were aspirational and seemed to be far-distant. Although many of these targets have not been fully realised, I am pleased that the Department has made significant progress towards implementing the principles of the CSP. The value of having a comprehensive plan that integrates the key elements of service delivery, human resources, infrastructure and finance cannot be underestimated as it provides a long-term framework that guides the annual planning and budget cycle; and provides a sound basis on which to motivate for the required resources. The benefits of this are evident in the budget allocated to the Department by Treasury in spite of the current financial constraints, but whilst this is appreciated, it remains insufficient to meet the demand for health services.

In crafting the Strategic Plan and Annual Performance Plans the 2010 CSP targets have been rolled out to 2014/15, based on anticipated population and utilization rates. In terms of service need the Department requires an additional 2 238 hospital beds by 2014/15. Currently there is neither the required funding, nor infrastructure, to accommodate this need. It is the Department's intention to update the Comprehensive Service Plan during the course of 2010 and to determine targets for 2020 that will facilitate the motivation for the development of future infrastructure and funding requirements in order to address these needs.

The value of these plans is to ensure that limited resources are optimally utilised to achieve the best return in health outcomes in relation to the investment made. The Annual Performance Plan sets the targets against which performance at all levels of care is monitored and evaluated.

I am therefore looking forward to this new phase of development and consolidation in the Department and from a personal perspective, barring unforeseen circumstances, I am committed to leading and facilitating the process to implement and institutionalize these plans prior to my anticipated retirement in 2013.



Professor Craig Household
Head Health: Western Cape
February 2010

OFFICIAL SIGN-OFF

It is hereby certified that this Strategic Plan:

- Was developed by the management of the Department of Health under the guidance of Minister Theuns Botha.
- Takes into account all the relevant policies, legislation and other mandates for which the Department of Health is responsible.
- Accurately reflects the strategic goals and objectives which the Department of Health will endeavour to achieve over the period 2010 - 2014.

Mr A Van Niekerk **Signature:** .....
Chief Financial Officer

Mr AR Cunninghame **Signature:** .....
Chief Director:
Strategy and Health Support

Professor KC Household **Signature:** .....
Accounting Officer

APPROVED BY:

Theuns Botha **Signature:** .....
Executive Authority

CONTENTS

PART A: STRATEGIC OVERVIEW

PART B: BUDGET PROGRAMME PLANS

PART C: LINKS TO OTHER PLANS

PART A:

Strategic Overview

PART A: STRATEGIC OVERVIEW

1. VISION

Quality health for all.

2. MISSION

We undertake to provide equitable access to health in partnership with the relevant stakeholders within a balanced and well managed health system.

3. VALUES

1) Integrity
2) Public accountability
3) Innovation
4) Openness and transparency
5) Commitment to high quality service
6) Respect for people
7) Excellence

4. LEGISLATIVE AND 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:

4.2.1 National legislation

Child Care Act, 74 of 1983

To provide for the establishment of children's courts and the appointment of commissioners of child welfare; for the protection and welfare of certain children; for the adoption of children; for the establishment of certain institutions for the reception of children and for the treatment of children after such reception; and for the contribution by certain persons towards the maintenance of certain children; and to provide for incidental matters.

Children's Act, 38 of 2005

To give effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children; to define parental responsibilities and rights; to make further provision regarding children's courts; to provide for the issuing of contribution orders; to make new provision for the adoption of children; to provide for inter-country adoption; to give effect to the Hague Convention on Inter-country Adoption; to prohibit child abduction and to give effect to the Hague Convention on International Child Abduction; to provide for surrogate motherhood; to create certain new offences relating to children; and to provide for matters connected therewith. Note that no all sections of this Act have came into operation.

Chiropractors, Homeopaths and Allied Health Service Professions Act, 63 of 1982

To provide for the control of the practice of the professions of chiropractor and homeopath and allied health professions, and for that purpose to establish a Chiropractors, Homeopaths and Allied Health Service Professions Interim Council and to determine its functions; and for matters connected therewith.

Choice on Termination of Pregnancy Act, 92 of 1996

To determine the circumstances in which and conditions under which the pregnancy of a woman may be terminated and to provide for matters connected therewith.

Dental Technicians Act, 19 of 1979

To consolidate and amend the laws relating to the profession of dental technician; to regulate the profession of dental technologist; and to provide for matters connected therewith.

Health Act, 63 of 1977

Parts of this Act were assigned to the provinces in 1994 and are therefore deemed to be provincial legislation. It provides for measures for the promotion of the health of the inhabitants of the Republic; the rendering of health services; defines the duties, powers and responsibilities of certain authorities which render health services to the Republic; provides for the co-ordination of such health services; and to provide for incidental matters. Parts of this Act will be repealed by the National Health Act of 2003 which has been assented to but has not yet commenced in full.

Health Professions Act, 56 of 1974

To establish the Health Professions Council of South Africa, to provide for control over the training of and for the registration of medical practitioners, dentists and practitioners of supplementary health service professions; to provide for the control over the training of and for the registration of psychologists; and to provide for matters incidental thereto.

Human Tissue Act, 65 of 1983

To provide for the donation or the making available of human bodies and tissue for the purposes of medical or dental training, research or therapy or the advancement of medicine or dentistry in general; for the post-mortem examination of certain human bodies; for the removal of tissue, blood and gametes from the bodies of living persons and the use thereof for medical or dental purposes; for the control of the artificial fertilisation of persons; and for the regulation of the import and export of human tissue, blood and gametes; and to provide for matters connected therewith. This Act will be repealed by the National Health Act of 2003 which has been assented to but has not yet commenced in full.

International Health Regulations Act, 28 of 1974

To apply the International Health Regulations, adopted by the World Health Assembly, in the Republic, and to provide for incidental matters.

Labour Relations Act, 66 of 1995

To change the law governing labour relations and, for that purpose –

- to give effect to section 27 of the Constitution;
- to regulate the organisational rights of trade unions;
- to promote and facilitate collective bargaining at the workplace and at sectoral level;
- to regulate the right to strike and the recourse to lock out in conformity with the Constitution;
- to promote employee participation in decision-making through the establishment of workplace forums;
- to provide simple procedures for the resolution of labour disputes through statutory conciliation, mediation and arbitration (for which purpose the Commission for Conciliation, Mediation and Arbitration is established), and through independent alternative dispute resolution services (sic) accredited for that purpose;

- to establish the Labour Court and Labour Appeal Court as superior courts, with exclusive jurisdiction to decide matters arising from the Act;
- to provide for a simplified procedure for the registration of trade unions and employers' organisations, and to provide for their regulation to ensure democratic practices and proper financial control;
- to give effect to the public international law obligations of the Republic relating to labour relations;
- to amend and repeal certain laws relating to labour relations; and
- to provide for incidental matters.

The Mental Health Care Act, 17 of 2002

To provide for the reception, detention and treatment of persons who are mentally ill and to provide for incidental matters.

National Health Act, 61 of 2003

This Act provides a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services and also provide for matters incidental thereto.

Nursing Act, 33 of 2005

To regulate the nursing profession; and to provide for matters connected therewith.

Sterilisation Act, 44 of 1998

To provide for the right to sterilisation; to determine the circumstances under which sterilisation may be performed and, in particular, the circumstances under which sterilisation may be performed on persons incapable of consenting or incompetent to consent due to mental disability; and to provide for matters connected therewith.

Traditional Health Practitioners Act, 35 of 2004

To establish the Interim Traditional Health Practitioners Council of South Africa; to provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services; to provide for the management and control over the registration, training and conduct of practitioners, students and specified categories in the traditional health practitioners profession; and to provide for matters connected therewith.

4.2.2 Provincial legislation

Western Cape Health Facility Boards Act, 7 of 2001

The aim of the Act is to provide for Boards at provincial facilities, which are comprised of members, which are representative of the community, which the facility serves as well as members of staff of

such a facility. The Boards have a prescribed set of powers and functions, which stipulates the scope of there authority.

Exhumation Ordinance, 1980

The ordinance stipulates the procedure, which must be complied with when applying for the exhumation of a body.

Regulations Governing Private Health Establishments, (P.N 187 of 2001)

These regulations govern the licensing and inspection of private health establishments in the province.

Training of Nurses and Midwives Ordinance, 4 of 1984

This Ordinance provides for the establishment and control of nursing colleges for the training of nurses and midwives, and for matters incidental thereto.

Communicable Diseases and Notification of Notifiable Medical Condition Regulations

Prescribes the obligations to be complied with in the event of the outbreak of a communicable disease.

Western Cape Health Care Waste Management Act, 7 of 2007

To provide for the effective handling, storage, collection, transportation, treatment and disposal of health care waste by all persons in the Province of the Western Cape; and to provide for matters incidental thereto.

Western Cape Health Services Fees Act, 5 of 2008

To provide for a schedule of fees to be prescribed for health services rendered in the Western Cape Province by the Department; and to provide for incidental matters.

Western Cape Health Amendment Act, 6 of 2002

To amend the Health Act, 1977, in so far as it applies in the province, to extend the powers of the Minister of Health to make regulations regarding private health establishments, and for matters incidental thereto.

4.2.3 Policy matters

The Comprehensive Service Plan [CSP]

The CSP was approved by Provincial Cabinet and signed by the provincial minister for implementation on 11 May 2007. The responsibility that it places on the Department is to reshape

the services to enable patients to be treated at the level of care that is most suited to their need, thereby optimising the return on the investment of limited health resources.

Human Resource Policies:

The Department of Health contributes to the transversal provincial human resource policies which are developed by the Department of the Premier. The Department of Health also develops specific policies for internal use.

There are policies on all facets of human resource management and development; and labour relations. The policies that are developed and implemented are monitored and their impact evaluated annually.

Financial management policies:

The Department generates financial management policies that are aligned with legislation and Treasury regulations.

Examples of key clinical policies includes:

To respond to the burden of HIV and AIDS, the province is guided by the National Strategic Plan of South Africa (NSP) for HIV and AIDS (2007 - 2011) and the Provincial Strategic Plan (PSP) for HIV and AIDS and STIs which require the province and sectors to:

1) Reduce the rate of new HIV infections by 50% by 2011.
2) Reduce the impact of HIV and AIDS on individuals, families and society by expanding access to an appropriate package of treatment, care and support to 80% of all HIV positive people and their families by 2011

In response to the TB epidemic, the provincial policy and strategy draws from the Draft National Tuberculosis Strategic Plan 2007 - 2011 to reduce morbidly and mortality due to TB. The strategic objectives to achieve TB control in the country are:

- To strengthen the implementation of the DOTS strategy;
- To address TB and HIV, MDR and XDR-TB;
- To contribute to health systems strengthening;
- To work collaboratively with all care providers; to empower people with TB as well as communities;
- To coordinate and implement TB research; and
- To strengthen infection control.

4.2.4 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.

4.2.5 **Planned policy initiatives**

- The Millennium Development Goals, specifically those related to health.
- The Medium Term Strategic Framework of national government
- The Health Sector Strategic Framework: Ten Point Plan for 2009 – 2014
- The Provincial Strategic Plan and specifically strategic objective 4: Maximising health outcomes.
- The Department is in the process of updating the Comprehensive Service Plan that will provide the long-term strategic direction for 2019/20.

With regards to specific issues the Department will develop appropriate policy initiatives as required, for example:

The province will continue to expand and upscale interventions that address HIV and AIDS, TB and STIs in the following areas:

1) Prevention
2) Treatment, care, and support
3) Monitoring, research and surveillance
4) Human rights and access to justice

The Department will continue to strengthen the implementation of the overall DOTS strategy through the implementation of the "Enhanced TB Response" and will roll out the revised Drug-Resistant TB Policy and strengthen the management of MDR-TB.

5. SITUATION ANALYSIS

5.1 SERVICE DELIVERY ENVIRONMENT

5.1.1 Socio-economic, demographic and epidemiological profiles

The Western Cape Province, located in the south west of the Republic of South Africa covers a land surface of 129 307 km^2 (Stats SA: 2006), which is 10.6% of the total surface area of the country and accommodates 10.9% of the total population (HSRC). The province contributed 14.3% to the national gross domestic product in 2008 (Stats SA: 2009).

The province is divided into five rural district municipalities, i.e. Eden, Cape Winelands, Central Karoo, Overberg and the West Coast, and one metropolitan district, the City of Cape Town. The Central Karoo covers the largest surface (38 873 km^2) whereas the City of Cape Town covers the smallest surface area (2 502 km^2).

Based on the outcome of the Community Survey 2007, the Western Cape has a population density of approximately 40.8 persons per square kilometre. The Cape Town Metro district accommodates approximately 66% of the population and display higher density ratios, which is significant for planning purposes. The remainder of the population is distributed more sparsely, in approximately equal proportions between the other rural districts, i.e. Cape Winelands, Overberg, Eden, and West Coast, with the exception of the Central Karoo, which is very sparsely populated.

Table 1 indicates the distribution of the population of South Africa across the respective provinces per year from 2001 to 2009. It is interesting to note that Gauteng and the Western Cape reflect an increase in the distribution profile since 2001.

All inclusive censuses were conducted by StatsSA in 1996 and 2001 and until recently the 2001 data was used to project population growth. However, the Cabinet resolved to move away from a five-year to a ten-year census with the result that the next census is scheduled in 2011, created a gap in information and resulted in the decision that StatsSA conduct the Community Survey 2007.

The outcome of the survey is particularly significant for the Western Cape as it reflected a 16.7% increase in the Western Cape population between 2001 and 2007, i.e. increasing from 4 524 332 to 5 278 634 which is double that of the average national increase from 44 819 778 in 2001 to 48 502 063 in 2007. The population projections up to 2015 are based on the 1996 and 2001 censuses and the 2007 Community Survey (Table 2).

Table 1: Distribution of population between provinces as a percentage of total population: 2001-2009

Province	2001	2002	2003	2004	2005	2006	2007	2008	2009	% Change in distribution profile since 2001
Eastern Cape	14.5	14.3	14.2	14.1	13.9	13.8	13.7	13.6	13.5	**-6.9%**
Free State	6.1	6.1	6.1	6.0	6.0	5.9	5.9	5.9	5.8	**-4.9%**
Gauteng	20.0	20.2	20.4	20.5	20.7	20.9	21.0	21.2	21.4	**7.0%**
KwaZulu-Natal	21.3	21.3	21.2	21.2	21.2	21.2	21.2	21.2	21.2	**-0.5%**
Limpopo	11.0	11.0	10.9	10.9	10.8	10.8	10.7	10.7	10.6	**-3.6%**
Mpumalanga	7.5	7.4	7.4	7.4	7.4	7.4	7.4	7.3	7.3	**-2.7%**
Northern Cape	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.3	2.3	**-4.2%**
North West	7.1	7.1	7.1	7.1	7.1	7.0	7.0	7.0	7.0	**-1.4%**
Western Cape	10.1	10.2	10.3	10.4	10.5	10.6	10.7	10.8	10.9	**7.9%**
RSA	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	

Source: StatsSA Statistical Release P0302


Western Cape District Municipalities
Legend
National Route
towns_points
District Municipalities
Cape Winelands
Central Karoo
City of Cape Town
Eden
Overberg
West Coast
Northern Cape
Eastern Cape
Western Cape
Atlantic Ocean
Indian Ocean
West Coast
Cape Winelands
Central Karoo
City of Cape Town
Eden
Overberg
Riet poort
Nuwerus
Lutzville
Vredendal
Klawer
Doringbaai
Lambert's Bay
Graafwater
Clanwilliam
Elandsbaai
Redelinghuys
Citrusdal
Dwarskersbos
Aurora
Eendekuil
St Helenabaai
Velddrif
Vredenburg
Piketberg
Koringberg
Porterville
Diazville
Langebaan
Hopefield
Saron
Moorreesburg
Gouda
Yzerfontein
Darling
Mamre
Atlantis
Abbotsdale
Wolseley
Ceres
De Doorns
Wellington
Worcester
Paarl
Franschhoek
Pniel
Paarl
Robertson
Ashton
Mc Gregor
Bonnievale
Barrydale
Suurbraak
Swellendam
Riversdale
Heidelberg
Albertinia
Mossel Bay
George
Herbertsdale
Groot Brakrivier
Wilderness
Sedgefield
Knysna
Nature's Valley
Plettenberg Bay
Uniondale
Haarlem
Oudtshoorn
Dysselsdorp
Ladismith Zoar
Calitzdorp
Matjiesfontein
Laingsburg
Prince Albert
Beaufort West
Murraysburg
Merweville
Leeu Gamka
Simons Town
Fish Hoek
Strand
Grabouw
Gordons Bay
Caledon
Botrivier
Kleinmond
Hawston
Betty's Bay
Stanford
Napier
Bredasdorp
Gansbaai
Witsand & Port Beaufort
Infanta
Stilbaai
Gouritzmond
Wagenhuiskrans & Arniston
Struisbaai
N
W
E
S

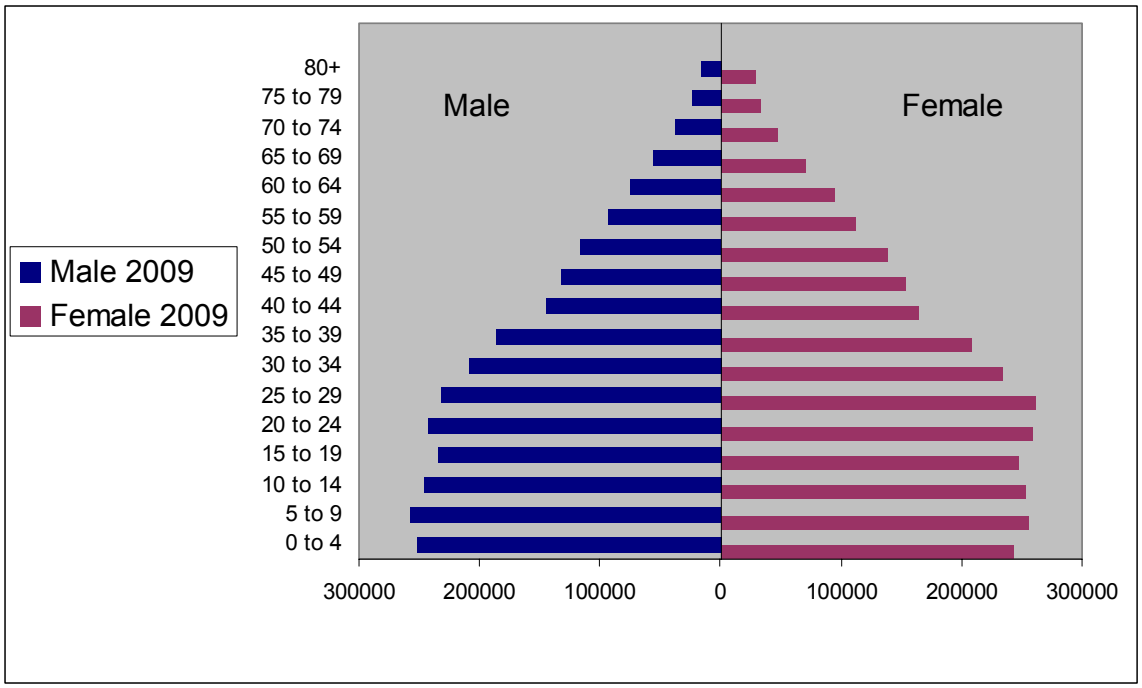
Figure 1: Cape Town Metro sub-districts

Table 2: Population estimates

District	Census 2001	Community Survey: 2007	2008	2009	2010	2011	2012	2013	2014	2015	% Uninsured
City of Cape Town	2 892 243	3 497 097	3 553 571	3 638 959	3 724 347	3 809 735	3 895 123	3 980 511	4 065 899	4 151 287	76%
Cape Winelands	630 492	712 413	726 687	740 556	754 426	768 295	782 165	796 034	809 903	823 773	77%
West Coast	282 672	286 750	299 888	304 901	309 914	314 926	319 939	324 952	329 965	334 978	83%
Overberg	203 519	212 836	223 706	228 499	233 292	238 086	242 879	247 673	252 466	257 259	83%
Eden	454 924	513 308	528 676	540 302	551 937	563 573	575 206	586 834	598 457	610 076	85%
Central Karoo	60 482	56 229	59 238	59 822	60 407	60 991	61 576	62 160	62 744	63 329	86%
Western Cape	**4 524 332**	**5 278 634**	**5 391 765**	**5 513 039**	**5 634 323**	**5 755 607**	**5 876 887**	**5 998 164**	**6 119 435**	**6 240 702**	78%
Uninsured											
City of Cape Town	2 209 674	2 671 782	2 714 928	2 780 164	2 845 401	2 910 637	2 975 874	3 041 110	3 106 346	3 171 583	
Cape Winelands	483 587	546 421	557 369	568 007	578 645	589 282	599 920	610 558	621 196	631 834	
West Coast	235 183	238 576	249 507	253 677	257 848	262 019	266 190	270 360	274 531	278 702	
Overberg	168 310	176 016	185 005	188 969	192 933	196 897	200 861	204 825	208 789	212 753	
Eden	387 140	436 825	449 903	459 797	469 699	479 601	489 500	499 396	509 287	519 175	
Central Karoo	51 833	48 188	50 767	51 268	51 769	52 269	52 770	53 271	53 772	54 273	
Western Cape	**3 535 728**	**4 117 808**	**4 207 479**	**4 301 882**	**4 396 294**	**4 490 706**	**4 585 115**	**4 679 521**	**4 773 922**	**4 868 319**	

Source: Circular H13/2010: Information Management

Figure 2: Western Cape population estimates by age and sex



Source: Mid year population estimates, 2009, StatsSA

The population pyramid above reflects the provincial 2009 mid-year population estimates by age and sex and resembles a country in transition. Just over a quarter of the population [28%] is under the age of 15 years whereas approximately 9% of the population is over 60 years of age. As more than 6% of the population is over the age of 75 years and those younger than 15 years comprise less than 30 years, the population can be considered to be an 'aging population'.

The larger number of men for the age categories 20-24 years and 30-34 years could be due to labour migration. This pattern diminishes after the age of 40 years. For the older age categories, the low number of men could be attributed to higher male mortality or male out-migration.

Total fertility rates

The total fertility rate (TFT) is defined as the average number of children a woman would bear during her lifetime, assuming her childbearing conforms to her age-specific fertility rate every year of her childbearing years (typically 14-44 years). The provincial average total fertility rates for 2001-2006 and 2006-2011 are estimated to be 2.19 and 2.11, respectively and are the lowest in the country. A population that maintains a TFT of 2 over a long period of time would decline in size unless immigration levels are high, which is the case for the Western Cape. However, the fertility rates in the Province may be expected to rise over time due to migration of the populations with higher fertility rates than the local populations.

Average Life Expectancy

The Western Cape is also estimated to have the highest life expectancy at birth for both males and females (59.38 years). For females, the life expectancy is estimated to be 66.5 years, compared to Kwa-Zulu Natal which has the lowest life expectancy, at 51 years. Females also tend to have a higher life expectancy than males. These age-specific patterns suggest early and late transition economies in the Province. According to StatsSA, the impact of the HIV and AIDS epidemic will result in a decline in life expectancy in the Western Cape with figures decreasing to below 60 years.

Migration

It is estimated that for the year 2001-2006 the Western Cape lost 117 060 of its population, but gained about 361 476 people, resulting in a net migration gain of 244 416 people. Approximately 33.3% of those leaving the province were lost to Gauteng with the majority (54.2%) gained from the Eastern Cape. It is estimated that between 2006 and 2011, the out-migration figures will be slightly lower (112 800) and the in-migration figure will be 249 800. The net migration gain will be 137 000 with the patterns being similar to those reported for the period 2001-2006. The impact of these observed demographic trends in the Western Cape might result in a smaller decline in the fertility rates, a drop in life expectancy as well as an increase in the levels of poverty. The migration patterns between the Western and Eastern Cape, however, are typical of a society in 'early and late transition' – characterized by increased industrialization.

5.1.1.1 Socioeconomic status

The Western Cape has relatively good access to basic amenities compared to the rest of the provinces, however, inequities still exist between and within districts.

The deprivation index measures the relative deprivation of populations across districts within South Africa and is derived from a set of demographic and socio-economic variables from the 2007 Community Survey and the 2005 and 2006 General Household Survey (District Health Barometer 2007/08). A high value for the deprivation index denotes higher levels of deprivation. Furthermore, districts that fall into socio-economic quintile 5 are the least deprived (best off), whereas those that fall into quintile 1 are most deprived (worst off). All the districts within the Western Cape are ranked amongst the least deprived in the country and fall into socio-economic quintile 5.

Province-specific deprivation indices (StatsSA) shows that 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. The Central Karoo comprises approximately 1% of the total population. More detailed analysis also suggests that approximately half of the 50 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.

The General Household Survey aims to determine the level of development in the country and has been undertaken on an annual basis since 2002. The following Table outlines that poverty and socio-demographic data obtained from the General Household Survey of 2008.

Table 3: Poverty and socio-demographic data

Indicator	2002	2003	2004	2005	2006	2007	2008	National 2008
Education Provincial distribution of the percentage of persons aged 7-15 years who were attending an educational institution	98.6%	97.7%	98.2%	98.3%	97.9%	98.3%	97.0%	97.7%
Housing Percentage of persons living in informal dwellings.	19.9%	21.7%	18.2%	17.7%	25.9%	21.4%	16.8%	13.4%
Source of energy Percentage of households connected to the mains electricity supply	87.7%	87.8%	90.1%	92.6%	92.9%	96.0%	94.0%	82.6%
Percentage of houses that use paraffin or wood for cooking	20.7%	20.1%	19.3%	9.7%	9.1%	6.4%	4.9%	23.6%
Sanitation Percentage of households that have no toilet facility or were using a bucket toilet	6.6%	9.7%	6.4%	5.6%	6.2%	4.1%	5.5%	7.7%
Refuse removal Percentage of households whose refuse is removed by the municipality	86.1%	85.8%	89.9%	91.4%	91.7%	90.7%	89.4%	60.5%
Water access and use Percentage of households with access to piped or tap water in the dwelling, off-site or on-site	98.9%	99.2%	99.5%	99.0%	99.6%	99.4%	99.2%	88.9%

Source: General Household Survey: 2008

5.1.2 Epidemiological profile

5.1.2.1 Mortality rates

The infant mortality rate (IMR) for the Western Cape was reported to be 45 per 1 000 live births compared to 43 per 1 000 live births nationally (2003 South African Demographic Health Survey) in 2003. However, prior to this, the 1998 South African Demographic and Household survey estimated the IMR to be 8.4 per 1 000 live births. Given the inconsistencies in the findings between the 2003 the 1998 survey results, the 2003 findings were considered implausible. The provincial mortality surveillance system of the Western Cape Burden of Disease project reports mortality data that accounts for 75% of the population in the province. Using this data the IMR for Cape Town is estimated to be 20.28. The ASSA 2003 model for IMR for 2003 also reports the estimate to be 26 per 1 000 live births compared to the national estimate of 48 per 1 000 live births.

Table 4: Trends in key provincial mortality indicators

Indicator	2000 (SAHR 2006: 386)		2006 ASSA 2003		National Target Health goals, objectives and indicators 2001 to 2005
	Western Cape	National	Western Cape	National	
Infant mortality (under 1)	31.7	59.1	26	48	45 per 1 000 live births by 2005
Child mortality (under 5)	46.3	94.7	39	73	59 per 1 000 live births by 2005
Maternal mortality ratio per 100,000 live births	**Source**: Saving Mothers: Third report on confidential enquiries into maternal deaths in South Africa 2002-2004, 2006: 34.				100 per 100 000 live births by 2005
	Western Cape				
	2000	**2002**	**2004**		
	62.4	74.7	98.8		

Table 5: Infant Mortality Rate (per 1 000 live births)

	2002[1]	2003	2004	2005	2006	2007	Source
South Africa	59	-	-	-	48		[1]South African Health Review 2005: 302 [2]South African Health Review 2006: 386
Western Cape	30	-	-	-	26		
Cape Town Metro district	**-**	**25.16**	**23.74**	**22.28**	**21.40**	20.28	City of Cape Town
Cape Town Metro Sub-districts	-						
Eastern	-	28.98	22.90	27.51	32.00	28.38	
Khayelitsha	-	42.11	36.61	34.72	31.33	30.16	
Klipfontein	-	28.65	28.79	27.41	24.65	24.74	
Mitchell's Plain	-	22.03	24.18	22.85	22.08	21.27	
Northern	-	24.55	20.80	22.88	20.62	21.08	
Southern	-	16.98	20.97	15.23	11.88	11.98	
Tygerberg	-	18.61	19.58	16.20	17.61	14.91	
Western	-	17.58	16.41	15.22	14.21	20.28	
Cape Winelands East				29	28		Groenewald et al. Cause of death and premature mortality in Boland Overberg Region, 2004-2006 (BOD Project)
Cape Winelands East Sub districts							
Breede River Winelands				28	24		
Breede Valley				21	23		
Witzenberg				42	45		
Overberg				35	26		
Overberg Subdistricts				29	28		
Cape Agulhas				35	23		
Overstrand				31	29		
Swellendam				11	23		
Theewaterskloof				31	26		

Note:
Cape Winelands East: Drakenstein and Stellenbosch data are not included in the infant mortality rates.

The 2000 Western Cape child (under 5 years) mortality rate was reported to be 46.3 per 100 000 live births compared to the national figure of 94.7 per 100 000 live births. (South African Health Review 2006:386). In 2003, the ASSA model reported a child mortality rate of 39 per 1000 live births compared to the national estimate of 73 per 1000 live births.

Over the past decade, the estimated Western Cape maternal mortality ratio has been 62.4 (2000), 74.7 (2002) and 98.9 (2004) per 100 000 live births. This indicates that despite being the lowest in the country, the provincial MMR has increased steadily over time and is attributed mainly to non-pregnancy related sepsis, primarily as a result of HIV and AIDS.

HIV and AIDS, social and health service related factors have the greatest impact on both the child and maternal mortality rates.

5.1.2.2 HIV prevalence

In 2008, the Western Cape provincial HIV prevalence amongst 15-49 year old antenatal women was 16.1% (95% CI: 12.6%-20.3%) (National Department of Health 2009). There was no statistically significant increase in the prevalence of HIV in the province when compared to that of 2007. Although the districts in the Western Cape have HIV prevalence estimates below the National average of 29.3% (95% CI: 28.5%-30.1%), the expanded provincial survey demonstrates the heterogeneity at sub-district level. Of the 32 sub-districts, 11 (34%) have a HIV prevalence estimate that exceeds the provincial prevalence of 16.1%. Since 2004, Khayelitsha sub-district in the Metro district has had a HIV prevalence estimate consistently higher than the National prevalence of 29.3%. The failure to observe a decline in prevalence in high HIV burden sub-districts may in part be due to the declining mortality as a result of access to antiretroviral therapy. Research studies in these specific sub-districts can inform the implementation of more targeted prevention strategies.

Table 6: HIV prevalence in antenatal clients in 2007 and 2008 in the Western Cape

DISTRICT	SUB-DISTRICT	n	2007 HIV Prevalence %	n	2008 HIV Prevalence %
Metropole	Eastern	753	18.3 (15.7-21.2)	829	18.9 (16.4-21.7)
	Khayelitsha	811	31.4 (28.3-34.7)	903	33.4 (30.4-36.6)
	Klipfontein	1140	23.2 (20.8-25.7)	719	23.4 (20.4-26.6)
	Mitchell's Plain	393	11.7 (8.9-15.3)	416	13.9 (10.9-17.6)
	Northern	573	22.7 (19.4-26.3)	392	21.4 (17.7-25.8)
	Southern	598	9.9 (7.7-12.5)	394	9.9 (7.3-13.2)
	Tygerberg	676	9.9 (7.9-12.4)	770	11.3 (9.3-13.7)
	Western	591	15.9 (13.2-19.1)	835	16.6 (14.3-19.3)
Metropole Total		**5 535**	**17.6 (16.6 -18.6)** [b]	**5258**	**18.3 (17.2 -19.3)** [b]
Overberg	Cape Agulhas	43	7.0 (2.4-18.6)	51	5.9 (2.0-15.9)
	Overstrand	182	25.3 (19.5-32.1)	165	21.8 (16.2-28.7)
	Swellendam	66	1.5 (0*-8.1)	69	14.5 (8.1-24.7)
	Theewaterskloof	229	21.8 (17.0-27.6)	248	14.9 (11.0-19.9)
Overberg Total		**520**	**19.0 (15.7 -22.4) b**	**533**	**16.3 (13.1 -19.4)** [b]
Cape Winelands	Breede Valley	211	8.5 (5.5-13.1)	249	12.4 (8.9-17.1)
	Breede river	133	13.5 (8.7-20.4)	201	5.0 (2.7-8.9)
	Drakenstein	312	12.2 (9.0-16.3)	582	10.7 (8.4-13.4)
	Stellenbosch	398	22.6 (18.8-27.0)	212	17.5 (12.9-23.1)
	Witzenberg	239	13.4 (9.6-18.3)	227	16.7 (12.4-22.1)
Cape Winelands Total		**1 293**	**13.6 (11.7 -15.5)** [b]**b**	**1471**	**12.3 (10.6 -14.1)** [b]

DISTRICT	SUB-DISTRICT	n	2007 HIV Prevalence %	n	2008 HIV Prevalence %
West Coast	Berg River	153	7.8 (4.5-13.2)	94	9.6 (5.1-17.2)
	Cederberg	87	9.2 (4.7-17.1)	94	10.6 (5.9-18.5)
	Matzikama/DMA[a]	156	3.8 (1.8-8.1)	129	7.8 (4.3-13.7)
	Saldanha	175	12.0 (8.0-17.6)	180	16.7 (11.9-22.8)
	Swartland	224	8.9 (5.9-13.4)	181	10.5 (6.8-15.8)
West Coast Total		**795**	**8.8 (6.7 -10.8)** [b]	**678**	**11.6 (9.2 -14.0)** [b]
Eden	Bitou	99	14.1 (8.6-22.3)	109	14.7 (9.2-22.5)
	George	490	15.9 (12.9-19.4)	417	16.8 (13.5-20.7)
	Hessequa	73	4.1 (1.4-11.4)	69	5.8 (2.3-14.0)
	Kannaland	13	0.0 (0.0 – 22.8)	50	6.0 (2.1-16.2)
	Knysna	232	19.0 (14.4-24.5)	175	14.9 (10.3-20.9)
	Mossel Bay	214	21.0 (16.1-27.0)	139	22.3 (16.2-29.9)
	Oudtshoorn/DMA[a]	118	3.4 (1.3-8.4)	226	8.0 (5.1-12.3)
Eden Total		**1 239**	**13.2 (11.3 -15.0)** [b]	**1185**	**14.4 (12.3 -16.4)** [b]
Central Karoo C	Beaufort West/DMA[a]	128	11.7 (7.2-18.4)	111	11.7 (7.0-19.0)
	Laingsburg/Prince Albert [a]	33	24.2 (12.8-41.0)	21	0.0 (0.0 – 15.5)
Central Karoo Total		**161**	**14.6 (9.1 -20.1)** [b]	**132**	**9.8 (4.6 -14.9)** [b]
Western Cape		**9 543**	**16.0 (15.3-16.8)** [b]	**9257**	**16.5 (15.7-17.3)** [b]

Notes:

* Lower-bound truncated at zero; CI – Confidence Interval
a Sub-districts combined due to low number of annual antenatal clients
b Sub-districts weighted to reflect annual antenatal booking data

5.1.2.3 **TB prevalence**

The Western Cape is reported to have the second highest incidence of new-smear positive cases of TB in the South Africa (518 per 100 000) and most patients with TB (up to 90%) fall into the economically active group. However, the TB cure rate for the Western Cape (2007) was 77.3%, which is just short of the national target of 78%. Over the past few years there has been an increase in the TB cure rate in the province. Urgent intervention and focus on high-burden areas, as is the case in the province, is required to halt the rise in prevalence.

5.1.2.4 **Mental illness**

Mental illness contributes to the burden of disease through morbidity rather than through mortality. Regardless of the paucity of data, substance abuse is a particular problem in the Western Cape and apart from a small number of suicides, which only constitute 2.3%, most people will not die from mental disorders. Nevertheless they present a significant burden on the health services and to communities at large. In general, prevalence data for mental illnesses in the country as a whole is very poor. In one national study it was stated that South African adults have a 30% lifetime prevalence for Mental Disease[1], which most likely constitutes a substantial burden. To date, there is no comparable estimate for the Western Cape

5.1.2.5 **The burden of disease strategy**

The role of the Department of Health is not only to manage disease; it is also to improve health status. However, the major determinants of health e.g. alcohol misuse are often beyond the reach of the health sector and include a range of socio-structural ('upstream') factors such as income

[1] Stein DJ, Seedat S, Herman A Lifetime prevalence of psychiatric disorders in South Africa *The British Journal of Psychiatry.*2008; 192: 112-11

inequality, poverty, access to basic services and social behavioural norms. This is very much in line with the concept of intersectoral action introduced at the Alma-Ata Conference on Primary Health Care (1978). This emphasises not only the need for health services but also takes into consideration economic conditions, socio-cultural and political determinants of health[2]. [WHO and UNICEF, 1978]

The Provincial Government of the Western Cape (PGWC) mandated the Western Cape Department of Health to lead an initiative to define the components of the burden of disease in the Province and to provide evidence-based recommendations as to how these can be reduced. In particular the aim is to focus on inter-sectoral collaboration that addresses the critical and especially upstream determinants of this burden in order to build and sustain health security.

To date mortality surveillance and injury surveillance has been institutionalised in the Department. Furthermore the Department participated extensively in the development of the Liquor Act, 2008 and in collaboration with Department of Social Development and Department of Community Safety in producing a documentary on alcohol use to challenge and undermine pervasive norms, attitudes and beliefs in order to promote a decrease in alcohol misuse in the Western Cape.

5.1.3 Review the progress towards the health related Millennium Development Goals (MDGs)

In September 2000 South Africa was one of the 189 countries to commit to the Millennium Development Goals to reduce global poverty at the United Nations Millennium Summit. The following table summarises the goals, targets and indicators of the Millennium Development Goals. The specific health-related Millennium Development Goals are numbers 4, 5, and 6.

[2] World Health Organisation and UNICEF. 1978. Declaration of Alma-Ata 1978. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 found at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

Table 7: Millennium development goals

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
1. Eradicate extreme poverty and hunger.	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children under 5 years of age.
		Proportion of the population below minimum level of dietary energy consumption.
2. Achieve universal primary education.	Ensure that by 2015, children everywhere, boys and girls alike, will able to complete a full course of primary schooling.	Net enrolment ratio in primary education.
		Literacy rate of 15 – 24 year-olds.
3. Promote gender equality and empower women.	Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.	Ratio of girls to boys in primary, secondary and tertiary education.
		Ratio of literate females to males of 15 – 24 year-olds.
4. Reduce child mortality.	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.	Under-5 mortality rate (U5MR).
		Infant mortality rate.
		Proportion of one-year old children immunised against measles.
5. Improve maternal health.	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	Maternal mortality ratio.
		Proportion of births attended by skilled health personnel.
6. Combat HIV and AIDS, malaria and other diseases.	Have halted, by 2015, and begun to reverse the spread of HIV and AIDS, malaria and other diseases.	HIV prevalence among 15 – 24 year old pregnant women.
		Condom use rate of the contraceptive prevalence rate.
		Number of children orphaned by HIV and AIDS.
		Proportion of the population in malaria risk areas using effective malaria prevention and treatment measures. (Prevention to measured by the % of under 5 year olds sleeping under insecticide treated bed-nets and treatment to be measured by % of under 5 year olds who are appropriately treated.
		Prevalence and death rates associated with TB.
		Proportion of TB cases detected and cured under DOTS.
7. Ensure environmental sustainability.	Halve, by 2015, the proportion of people without sustainable access to safe drinking water.	Proportion of people with sustainable access to an improved water source.
	By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers.	Proportion of urban population with access to improved sanitation.
8. Develop a global partnership for development.	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.	Official development assistance.
		Proportion of exports admitted free of duties and quotas.
	In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries.	Proportion of population with access to affordable essential drugs on an established basis.

Table 8: The Western Cape progress on health related Millennium Development Goals 2000-2006

Millennium Development Goal	MDG objective	Indicator	South Africa's progress 2004 - 2009	Western Cape										National Target	
				2000	2001	2002	2003	2004	2005	2006	2007	2008	2015 Target	2015	Source
Reduce Child Mortality.	Reduce <5 mortality by two thirds by 2015.	IMR/1000 live births	43 per 1 000	44 (1998)	-	-	43.5	-	-	26	25.3		15	14.3 or less per 1 000	SADHS 1998 and 2003 ASSA 2003
		Child (<5y) Mortality Rate/ 1000 live births	58 per 1 000	56.6 (1998)	-	-	56.3	-	-	39.0	38.8		19	19.7 or less per 1 000	SADHS 1998 and 2003 ASSA 2003
		Measles coverage under 1 year	85.8% in 2007	-	82.5	84.9	78.1	91.7	90.7	93.7	102.8	99.7	>90	100%	Departmental Annual Reports
Improve Maternal Health.	Reduce maternal mortality by 75% by 2015.	Maternal Mortality Ratio/100 000 live births	147 per 100 000	62.4	54.5	74.7	85.7	98.8	-	-			15	36.8 or less per 100 000	Saving mothers, Third report on confidential enquiries into maternal deaths in South Africa 2002-2004.
Combat HIV/AIDS and other diseases.	Halve new infections by 2015.	HIV Incidence		-	-	0.7% /y	-	0.9% /y	-	-			<0.35		SADH 1998 South African National HIV prevalence, incidence behavioural and communication survey 2005 (Empirical data)
		HIV Prevalence in age group <20years	5.4%	4.9	6.3	7.3	8.7	8.1	7.2	5.6	4.3	*	2.45		Departmental Annual Antenatal Survey reports
		HIV Prevalence in age group 20 -24years	13.6%	10.5	10.3	15.0	15.3	17.4	15.9	15.4	14.5	*	5.25		
		Condom distribution rate from public sector health facilities (per male >15years)	33.6%	-	5.9	9.1	10.3	15.6	20.1	25.7	41.1	36.9	-		Departmental Annual Reports.
		Number of maternal HIV and AIDS orphans under 15 years		1 876	3 097	4 871	7 325	10 572	14 682	19 648	25 334		-		Dorrington et al, 2003 HIV/AIDS profile in the provinces of South Africa
		New Smear Positive Cure Rate for TB	77.8%	-	72	68	72	68.3	69.3	71.9	77.6	79.7	-		Departmental Annual Reports.
		TB Incidence Rate per 100 000		797	933	960	993	967	1 041	1 038	1 004	947.8			Departmental Annual Reports.

Notes:
1. Acceptable sanitation is flush, chemical and VIP toilets.
2. Information is obtained from surveys and not routinely collected.

* Not yet released.
** Only Quarter 1 and 2 of 2008

5.1.4 Overview of the performance of the provincial Department of Health from 2004 to 2009

The table below highlights the key priorities that were identified by the National Department of Health in its Ten Point Plan for the period 2004 – 2009. This is followed by a brief overview of the progress made by the Western Cape.

Table 9: National Department of Health strategic priorities for 2004 - 2009

PRIORITY	ACTIVITY
1. Improve governance and management of the NHS.	• Review and strengthen communication within and between health departments. • Strengthen corporate identity, public relations and marketing of health policies and programmes. • Strengthen governance and maintenance structures and systems. • Strengthen oversight over public entities and other bodies. • Adopt Health Industry Charter.
2. Promotes healthy lifestyles.	• Initiate and maintain healthy lifestyles campaign. • Strengthen health promoting schools initiative. • Initiate and maintain diabetes movement. • Develop and implement strategies to reduce chronic diseases of lifestyle. • Implement activities and interventions to improve key family practices that impact on child health.
3. Contribute towards human dignity by improving quality of care.	• Strengthen community participation at all levels. • Improve clinical management of care at all levels of the health care delivery system. • Strengthen hospital accreditation system in each province in line with national norms and standards.
4. Improve management of communicable diseases and non-communicable illnesses.	• Scale up epidemic preparedness and response. • Improve immunisation coverage. • Improve the management of all children under the age of 5 years presenting with illnesses such as pneumonia, diarrhoea, malaria and HIV. • Updated malaria guidelines, integrate malaria control into comprehensive communicable disease control programme and ensure reduction of cases. • Implement TB programme and review recommendations. • Accelerate implementation of the Comprehensive Plan for HIV/AIDS. • Strengthen free health care for people with disabilities. • Strengthen programmes on women and maternal health. • Strengthen programmes for survivors of sexual abuse and victim empowerment. • Improve risk assessment of non-communicable illnesses. • Improve mental health services.
5. Strengthen primary health care, EMS and hospital service delivery systems.	• Strengthen primary health care. • Implement provincial EMS plans. • Strengthen hospital services.
6. Strengthen support services.	• Strengthen NHLS. • Ensure availability of blood through South African National Blood Service. • Transfer forensic labs including mortuaries to provinces. • Implement health technology management system. • Strengthen radiation control. • Quality and affordability of medicines. • Establish an integrated disease surveillance system. • Integrate non natural mortality surveillance into overall mortality surveillance system. • Establish an integrated food control system.

PRIORITY	ACTIVITY
7. Human resource planning, development and management.	• Implement plan to fast-track filling of posts. • Strengthen human resource management. • Implement national human resource plan.
	• Strengthen implementation of the CHW programme and expand mid level worker programme. • Strengthen programme of action to mainstream gender.
8. Planning, budgeting, monitoring and evaluation.	• Implement SHI proposals as adopted by Cabinet. • Strengthen health system planning and budgeting. • Strengthen use of health information system.
9. Prepare and implement legislation.	• Implement Mental Health Care Act. • Implement National Health Act. • Implement Provincial Health Acts. • Traditional healers, Nursing & Risk Equalisation Fund Bills implemented.
10. Strengthen international relations.	• Strengthen implementation of bi and multi-lateral agreements. • Strengthen donor co-ordination. • Strengthen implementation of NEPAD strategy and SADC.

5.1.4.1 Highlights of the Western Cape Department of Health's contribution to the National Department of Health's priorities

1) **Improve governance and management of the National Health System:**

- The Department developed, consulted and published its Service Transformation Plan, i.e. the Comprehensive Service Plan with the approval of the provincial minister in May 2007.
- Governance and management of the District Health System have been strengthened by the appointment of a district manager with appropriate administrative and clinical support staff in each of the rural districts and for each sub-structure in the Metro. A sub-structure consists of two sub-districts in the Metro.
- The Department assumed responsibility for Personal Primary Health Care from Local Government in the rural areas. The Department assumed financial responsibility for this function from 1 April 2005 and took over the operational control from 1 April 2006 and by July 2007 the staff and assets were transferred from Local Government to the Department of Health.
- The funding for the Works function for Health was transferred from the Department of Transport and Public Works to the Department of Health from 1 April 2005. A service level agreement has been signed between the two departments to provide guidelines on the respective roles and responsibilities.
- Five regional service areas, which cover the whole province and in which clinical governance structures have been established, have been identified A provincial co-ordinating committee is being established in each of the general clinical disciplines to focus on co-ordination, clinical governance, monitoring and evaluation of the discipline.

2) **Promote healthy lifestyles:**

- Chronic lifestyle disease programme: through clubs for diabetes, hypertension, asthma and epilepsy these programmes provide lifestyle information that enables individuals and groups to make informed choices regarding their health and well being.
- The Department has developed a documentary about alcohol which aims to empower young people to make responsible choices about drinking alcohol.
- The percentage of schools implementing the health promoting schools programme increased from 7% in 2004/05 to 15.8% [177 /1 118] in 2008/09.

3) **Contribute towards human dignity by improving quality of care:**

- Community participation has been facilitated by the appointment of facilities boards in all hospitals in terms of the Western Cape Health Facilities Boards Act, No 7 of 2001. The current term of office of these boards will soon expire and new boards are in the process of being appointed.
- Community participation is promoted through the Provincial Health Council, in line with the National Health Act.
- A provincial profile of complaints and compliments is compiled and reviewed on a quarterly basis.
- External client satisfaction surveys are conducted in accordance with a planned schedule.
- There is a structured system in place for reporting, investigating and resolving complaints.
- Generic and specific services standards have been developed.
- A provincial infection prevention and control policy has been developed and a provincial infection and control committee constituted to give strategic direction to the development of infection prevention and control strategies.
- Mortality and morbidity reviews are conducted at institutional level on a monthly basis.
- An adverse event incident reporting system with centralised data capture in order to create a provincial database of adverse clinical events which guide the proactive arm of the risk management programmes has been created.
- Staff satisfaction surveys are conducted.
- Waiting time surveys are conducted at selected sites, representative of Level 1, 2 and 3 services.
- A policy framework for clinical governance has been adopted, with implementation through family physicians and Heads of General Specialist Services.

4) **Improve management of communicable diseases and non-communicable illnesses:**

- HIV and AIDS: The Western Cape has implemented the national comprehensive plan for the management, treatment and care of people living with HIV and AIDS. The province has achieved significant increase in anti-retroviral treatment access and universal coverage for the PMTCT intervention, through successful partnerships and multi-sectoral efforts.

- The incidence of tuberculosis (TB) in the Western Cape continues to be amongst the highest in the world, exacerbated by the HIV and AIDS pandemic. The Department has made significant progress in the implementation of the WHO DOTS Strategy and is working towards the overall goal of achieving an 85% cure rate. However, the solution to this problem lies elsewhere in housing and socio-economic conditions.
- The TB hospitals were provincialised:
  - Harry Comay Hospital was provincialised from 1 June 2005
  - DP Marais Hospital was provincialised from 1 September 2006
  - Sonstraal Hospital in Paarl and the Infectious Diseases Hospital in Malmesbury were provincialised from July 2007.
- The Department has implemented the Chronic Dispensing Unit (CDU) which dispenses pre-packed chronic medications to over 70 000 stable chronic patients in the Metro each month, which are then delivered to the respective facilities and therefore decreasing waiting times for patients at the dispensary. Similarly the rural districts have alternative dispensing methods for chronic stable patients whose medication is pre-packed by pharmacists at the community health centres.
- The percentage of hospitals offering post exposure prophylaxis [PEP] to survivors of sexual abuse has increased from 73.6% in 2004/05 to 92.5% in 2008/09.

5) **Strengthen primary health care, Emergency Medical Services and hospital delivery systems:**

- The strengthening of Personal Primary Health Care includes the assumption of responsibility for the provision of these services in the rural districts, the establishment of facility management, the computerisation of PHC services and the development of an infrastructure plan for PHC. New CDC's were built in Montagu, Swellendam and Wellington. New clinics were built in Stanford and Simondium.
- The number of sub-districts offering the full package of PHC services has increased from 65% in 2004/05 to 100% [32/32] in 2008/09 and the percentage of facilities that are providing youth friendly services has improved from 2% in 2004/05 to 42% [160/372] in 2008/09.
- Emergency Medical Services have been strengthened with additional funding as well as restructuring of the service in line with the recommendations of an expert external review. Emergency services in hospitals are being enhanced by the appointment of emergency medicine specialists.
- New emergency centres (casualty departments) have been built at the Worcester, George, Vredenburg, Mossel Bay, Caledon and Riversdale Hospitals.
- New ambulance stations have been built at Beaufort West, Caledon, Riversdale, Hermanus and Worcester.
- Hospital services: The implementation of the CSP led to the shifting of hospital funding and management to the financial programme most appropriate to the level of care that they provide:
  - GF Jooste, Karl Bremer and Helderberg Hospitals were shifted from Sub-programme 4.1, regional hospitals to Sub-programme 2.9, district hospitals from 2007/08

- Victoria Hospital was shifted from Sub-programme 4.1 to Sub-programme 2.9 from 1 April 2009/10.
- The funding for the level two services that are provided in the central hospitals was shifted from Programme 5 to Sub-programme 4.1, regional hospitals, from 2008/09. Governance mechanisms and structured have been adjusted accordingly.

- The upgrading of the Paarl, Worcester and George Hospitals in terms of the Hospital Revitalisation Programme is nearing completion. The upgrading of the Vredenburg, Caledon and Riversdale Hospitals is in progress. The construction of new district hospitals for Khayelitsha and Mitchell's Plain has commenced.

6) **Strengthen support services**

- The Medico-Legal Mortuaries were transferred from the South African Police Services to a newly established Directorate: Forensic Pathology Services, in the Department of Health, from 1 April 2006.
- The National Health Laboratory Services [NHLS] has been strengthened by the establishment of the wwwdisa website which provides provisional laboratory results and which has reduced the turnaround time for laboratory results.
- Cellphone printers have been installed at TB clinics to enable TB laboratory results to be received by sms.
- A review of the provincial pharmaceutical code list was conducted using the packages of care and service configuration aligned with the CSP to optimise the availability of drugs at the relevant level of service delivery.

7) **Human resource planning, development and management**:

- The Department has a Provincial Human Resource Plan that is aligned with the National Human Resource Plan and the Comprehensive Service Plan.
- A provincial strategy has been developed to fast-track the filling of posts in terms of the Approved Post List. This includes the identification of vacant funded posts, placing of block advertisements for specific professional occupations which are valid for six months, engaging a response management agency to assist with screening and short listing of applicants.
- The Occupation Specific Dispensation [OSD] for nurses has been fully implemented. The ODS for other health professionals such as doctors, dentists, pharmacists and emergency medical service staff have been implemented.
- The Directorate: Nursing has been fully established with a staff complement of five members. The focus of the directorate is to provided guidance and direction, co-ordination and to strengthen support to nursing management in the province
- A strategy to strengthen the mid-level worker programme is fully implemented.
- Nurse training at various levels has been strengthened within the Department. The Department has also implemented a three-year nurse training programme with increased access in the rural areas.
- The Department has fully functional nursing schools at different hospitals linked to the Western Cape College of Nursing. There are the following satellite campuses:

- Boland Satellite Campus in Worcester, Cape Winelands district, offering the R425 programme.
- Associated Psychiatric Hospitals [APH] Satellited at Stikland, in the Metro East sub-district, offering the psychiatry programme.

- Training of additional categories of health workers will be extended through the Extended Public Works Programmes with learnerships in key areas.
- An Employment Equity Plan has been developed and implemented.
- An Affirmative Action Strategy has been implemented in consultation with the relevant stakeholders.

8) **Planning, budgeting, monitoring and evaluation:**

- The strategic planning of health services in the Western Cape is within the framework of the Comprehensive Service Plan.
- The Department participates in the quarterly reporting systems of the National Department of Health and Treasury in which non-financial performance is reported.
- Programme performance is monitored quarterly by an internal Monitoring and Evaluation Committee where Programme Managers report on the performance of the respective programmes against the set of indicators in the Annual Performance Plan. The Monitoring and Evaluation Committee is chaired by the Head of Department.
- Financial monitoring is done by means of the monthly in year monitoring and in addition quarterly evaluation in the Financial Monitoring Committee, chaired by the Head of Department.
- The Hospital Information System (HIS) has been implemented in the central hospitals and rolled out to several hospitals in the regions. Similarly the Primary Health Care Information System (PHCIS) is being implemented in the province. These initiatives are constrained by limited funding.

9) **Prepare and implement legislation:**

- Mental Health Act: The Mental Health Review Board has been is functioning well and has been a model for other provinces.
- National Health Act 61 of 2003: is being implemented and the governance requirements are being implemented with the Provincial Health Council which has been constituted in terms of the Act.
- The following redundant provincial legislation has been repealed as part of the provincial government's Law Review Project:
  1) Ambulance Personnel Transfer and Pensions Ordinance, 1955 (Ordinance 11 of 1955);
  2) Hospitals Ordinance, 1946 (Ordinance 18 of 1946) and its subordinate legislation namely:
     - Regulations relating to Honorary Medical Staff of Provincial Hospitals, 1953. (PN 553 of 1953);
     - Regulations for the procurement by Provincial Hospitals and Associated Institutions, 1953 (PN 761 of 1953);

- Regulations relating to the Payment of Transport Allowances to Members of Hospital Board, 1956 (PN 323 of 1956); and
- Regulations relating to Election, Powers and Functions of Medical Committees, 1960 (PN 307 of 1960).

- The Western Cape Fees Act 5 of 2008 was promulgated which regulates the fees to be paid by the public for health care services rendered by the Department and repeals the Hospital Ordinance 18 of 1946. The repeal of the Hospital Ordinance was a landmark as it removed the requirement that only certain medically qualified persons could be appointed as the head of a hospital. It means that the provincial Minister and the Department may now appoint a non-medically qualified manager as the head of hospital in terms of the Public Service Act.
- The Western Cape District Health Councils Bill which aims to regulate the functioning of district health councils has been drafted and is in the process of being further refined.

10) **Strengthen international relations:**

- The Department has a co-operation agreement with the Global Fund for TB and HIV and AIDS funding.

5.1.5 The Medium Term Strategic Framework [MTSF] for national government for the period 2009 – 2014:

The medium term strategic framework for national government has identified the following twelve key outcomes to be achieved in the period 2009 – 2014:

1) Quality basic education.
2) **A long and healthy life for all South Africans.**
3) All people in South Africa are and feel safe.
4) Decent employment through inclusive economic growth.
5) Skilled and capable workforce to support an inclusive growth path.
6) An efficient, competitive and responsive economic infrastructure network.
7) Vibrant, equitable, sustainable rural communities contributing towards food security for all.
8) Sustainable human settlements and improved quality of household life.
9) Responsive, accountable, effective and efficient Local Government.
10) Protect and enhance our environmental assets and natural resources.
11) Create a better South Africa, a better Africa and a better world.
12) An efficient, effective and development oriented public service and an empowered, fair and inclusive citizenship.

The following focus areas, outputs and proposed activities have been identified to achieve the outcome of “A long and healthy life for all South Africans” which is the outcome for which Health is the primary driver.

Table 10: Focus areas, key outputs and proposed activities identified to achieve the Health specific national MTSF outcome

FOCUS AREA	KEY OUTPUT	PROPOSED ACTIVITIES
1. INCREASE LIFE EXPECTANCY	1.1. Increased life expectancy at birth	1) Increase the number of new patients initiated on ART. 2) Initiate people with HIV and AIDS and TB co-morbidity at a CD4 count of 350 on ART. 3) Strengthen the integrated TB control programme. 4) Increase the national average TB cure rate. 5) Implement co-ordinated inetersectoral interventions to reduce intentional and unintentional injury. 6) Halt malaria transmission nationwide and prevent re-introduction of malaria in non-endemic areas. 7) Conduct ARV drug resistance baseline study. 8) Enhance the implementation of the National Epidemic Preparedness and Response Plan in line with International Health Regulations.
	1.2. Reduce child mortality	Reduce child mortality through diverse interventions including 1) Increasing the percentage of infants requiring dual therapy for PMTCT who actually receive it from 10% in 2009/10 to 60% in 2010/11. 2) Increasing the percentage of mothers and babies who receive post-natal care within 3 days of delivery from <5% in 2009/10 to 70% in 2010/11.. 3) Increasing the percentage of maternity care facilities which review maternal and perinatal deaths and address identified deficiencies from 45% in 2009/10 to 80% in 2010/11. 4) Ensuring that 90% of children under 1 year of age are vaccinated with pneumococcal and rotavirus vaccines during 2010/11. 5) Increasing the percentage of districts in which 90% of children are fully immunised at one year of age from 37% in 2009/10 to 60% in 2010/11. 6) Increasing the percentage of nurse training institutions who teach IMCI in pre-service curriculum from 70% in 2009/10 to 100% in 2010/11. 7) Increasing the proportion of schools which are visited by a school health nurse at least once a year from <5% to 20% in 2010/11. 8) Conducting health screening of learners in Grade 1 in Quality Improvement schools for eyes, ears and teeth. 9) Increase the percentage of children under the age of 1 year who are fully immunised against measles from 80% in 82% of the districts [43/52] in 2009/10 to 90% in 85% of the districts [44/52] in 2010. 10) Provide penicillin for prevention of rheumatic heart disease.
	1.3. Decrease the maternal mortality ratio	Decrease the maternal mortality ration through diverse interventions including: 1) Improve access to health care facilities. 2) Increasing the percentage of pregnant women who book for antenatal care before 20 weeks gestation from 27% in 2009/10 to 50% in 2010/11. 3) Increasing the percentage of mothers and babies who receive post-natal care within 3 days of delivery from <5% in 2009/10 to 70% in 2010/11.. 4) Increasing the percentage of maternity care facilities which review maternal and perinatal deaths and address identified deficiencies from 45% in 2009/10 to 80% in 2010/11. 5) Enhance the clinical skills of health workers. 6) Improve the use of clinical guidelines and protocols.
2. HIV AND AIDS	2.1. Managing HIV prevalence	Monitor and manage HIV prevalence 1) Implementing provider initiated VCT in 95% of health care facilities with special focus on STI, TB, antenatal, IMCI, family planning and general curative services. 2) Increase proportion of pregnant women tested through implementation of provider initiated VCT for all pregnant women to 90% by 2010/11. 3) Provide life skills education to youth.
	2.2. Reducing HIV incidence	Decrease HIV incidence amongst others through: 1) Implementing provider initiated HIV counselling in all health care facilities with special focus on STI, TB, antenatal, IMCI, family planning and general curative services 2) Provide life skills education to youth.
	2.3. Expanded PMTCT programme	Implementation of PMTCT and paediatric treatment guidelines and adult treatment guidelines 1) Improving access to health institutions 2) Integrate antenatal care and PMTCT services. 3) Ensuring a well co-ordinated roll out of ART and more effective roll-out of preventative measures for HIV mother to child transmission. 4) Increasing proportion of pregnant women tested for HIV during pregnancy. 5) Initiating eligible pregnant women on ART at a CD4 count of 350 or less

FOCUS AREA	KEY OUTPUT	PROPOSED ACTIVITIES
3. TB CASE LOAD	3.1. **Improved TB case finding**	Strengthen programmes against TB, MDR-TB and XDR-TB through 1) Increasing the number of community health workers trained as DOTS supporters. 2) Train at least 3 000 health professionals in TB management annually. 3) Reducing the TB defaulter rate annually. 4) Developing a research programme for new TB drugs. 5) Expanding the roll-out of the TB DOTS programme. 6) Integrate TB and HIV services 7) Improve access to health institutions especially primary care institutions 8) Place all HIV positive individuals on TB prophylaxis
	3.2. Improved TB outcomes	1) Increase the number community health workers trained as DOT supporters. 2) Train at least 3 000 health professionals in TB management annually. 3) Initiate TB-HIV infected patients at a CD4 count of 350 or less. 4) Accelerate contact tracing. 5) Enhance compliance with treatment guidelines. 6) Develop research programme for new TB drugs. 7) Expand roll-pit of the TB DOTS programme. 8) Integrate TB and HIV services. 9) Eliminate TB drug stock outs.
	3.3. Improved access to antiretroviral treatment for HIV-TB co-infected patients.	1) Increase the number of community health workers trained as DOT supporters. 2) Train at least 3 000 health professionals in TB management annually. 3) Initiate TB-HIV infected patients at a CD4 count of 350 or less. 4) Provide Isonaid Preventive Therapy [IPT] to HIV positive patients with no active TB. 5) Provide Co-Trimoxozole preventive therapy [CPT] to HIV-TB infected patients. 6) Integrate TB and HIV services including the provision of ART.
	3.4. Decreasing prevalence of MDR-TB	1) Ensure proper functioning and expanded TB DOTS programme. 2) Increase the number of MDR TB units. 3) Finalise guidelines for the treatment of MDR-TB. 4) Initiate all MDD patients who are HIV positive on ART irrespective of CD4 count. 5) Integrate TB and HIV services. 6) Develop and implement a model for decentralised management of MDR including at community and household levels.
4. HEALTH SYSTEM EFFECTIVENESS	4.1 Revitalisation of Primary Health Care	1) Finalise a PHC delivery model for South Africa. 2) Establish PHC teams in each district to improve access to health care. 3) Complete an audit of primary level services and infrastructure. 4) Establish governance structures for health facilities 5) Improve the resource allocation of primary level health services [per capita expenditure on PHC] 6) Finalise provincial legislation governing the functioning of the DHS. 7) Improve access to primary level services
	4.2 Improved physical infrastructure for healthcare delivery.	1) Improve access to primary level services. 2) Finalise and implement the National Infrastructure Plan to fast-track the delivery of health facilities. 3) Enhance the capacity of provinces to deliver and maintain health infrastructure. 4) Commission the audit of the Essential Equipment which will identify the proportion of functional and well maintained equipment.
	4.3 Improved patient care and satisfaction	1) Commission a national research study into average waiting times at public health facilities and design interventions to improve these. 2) Introduce the National Core Standards for improving quality across health facilities [public and private] and conduct initial baseline assessment in 25% of public facilities. 3) Establish a call centre to resolve complaints form users of the health service. 4) Conduct annual patient satisfaction surveys. 5) Ensure that 80% of health facilities are visited by a supervisor at least once per month. 6) Enhance telemedicine systems and connectivity. 7) Implement the National Adverse Events Management System to monitor patient safety.
	4.4 Accreditation of health facilities	1) Finalise national core standards for health establishments. 2) Establish an independent accreditation body. 3) Establish a ministerial advisory committee on quality. 4) Set up inspectorates or quality audit units to appraise health facilities. 5) Accredit health establishments.
	4.5 Enhanced operational management of health facilities.	1) Complete audit of the skills and qualifications of hospital CEOs. 2) Provide formal delegations to hospital CEOs.
	4.6 Improved access to human resources for health	1) Finalise policy on community health workers to ensure coherence and standardisation. 2) Re-introduce key PHC workers such as infection control officers.

FOCUS AREA	KEY OUTPUT	PROPOSED ACTIVITIES
		3) Produce human resources for health reflecting an appropriate balance between health professionals and administrative personnel. 4) Monitor vacancy rates in the public sector on a quarterly basis. 5) Verify professional registration and competencies of health professionals.
	4.7 Improved health care financing	1) Monitor resource allocation for access at all levels. 2) Support health districts to produce and implement good quality health plans. 3) Develop NHI policy and conduct public consultations. 4) Produce draft NHI legislation for submission to Cabinet.
	4.8 Strengthen Health Information Systems [HIS]	1) Develop and implement ICT strategy.
	4.9 Improved health services for the youth.	1) Provide life skills eduction to youth. 2) Increase availability of youth friendly services. 3) Enhance health promotion amongst youth at education institutions. 4) Implement interventions to reduce teenage pregnancy. 5) Reduce usage of illicit substances. 6) Implement programme to enhance healthy lifestyles. 7) Increase HIV testing amongst the youth. 8) Enhance mental health programmes.
	4.10 Expanded access to home based care and community health workers.	1) Policy on community health workers finalised. 2) Strategy for home and community-based care developed. 3) Training curriculum and conditions of service of community health workers standardised.

5.1.6 National Health Systems [NHS] priorities for 2009 – 2014

The National Department of Health has identified the following strategic priorities in its new Ten Point Plan for 2010 – 2014.

Table 11: Outline the strategic priorities for the new Ten Point Plan for 2010 - 2014

NHS PRIORITY]	KEY ACTIVITIES
1. Provision of strategic leadership and creation of a social compact for better health outcomes.	• Ensure unified action across the health sector in pursuit of common goals.
	• Mobilise leadership structures of society and communities
	• Communicate to promote policy and buy in to support government programmes.
	• Review of policies to achieve goals.
	• Impact assessment and programme evaluation.
	• Development of a social compact.
	• Grassroots mobilisation campaign.
2. Implementation of the National Health Insurance.	• Finalise the NHI policies and implementation plan.
	• Immediate implementation of steps to prepare for the introduction of the NHI, e.g. budgeting, initiation of the drafting of legislation.
3. Improve the quality if health services	• Focus on 18 health districts.
	• Refine and up scale the detailed plan on the improvement of quality of services and direct its immediate implementation.
	• Consolidate and expand the implementation of the Health Facilities Improvement Plans.
	• Establish a National Quality Management and Accreditation body.
4. Overhauling the health care system and improve its management.	• Identify existing constitutional and legal provisions to unify the public health service.
	• Draft proposals fro legal and constitutional reform.
	• Develop a decentralised operational model, including new governance arrangements.
	• Train managers in leadership, management and governance.
	• Decentralisation of management.
	• Develop an accountability framework for the public and private sectors.
5. Improve human resources	• Refine the human resource plan for Health.
	• Re-open nursing schools and colleges.
	• Recruit and retain professionals including urgent collaboration with countries that have an excess of these professionals.

NHS PRIORITY]	KEY ACTIVITIES
	• Specify staff shortages and training targets for the next five years.
	• Assess and review the role of the Health Professions Training and Development Grant [HPTDG] and the National Tertiary Services Grant [NTSG].
	• Manage the coherent integration and standardisation of all categories of community health workers.
6. Revitalisation of infrastructure	• Urgent implementation of refurbishment and preventative maintenance of all health facilities.
	• Submit a progress report on revitalisation.
	• Assess progress on revitalisation.
	• Review the funding of the revitalisation programme and submit proposals to get the participation of the private sector to speed up this programme.
7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases.	• Implementation of PMTCT and paediatric treatment guidelines.
	• Implementation of adult treatment guideline.
	• Urgently strengthen programmes against TB, MDR-TB and XDR-TB.
8. Mass mobilisation for the better health of the population.	• Intensify health promotion programmes.
	• Strengthen programmes focussing on maternal, child and women's health.
	• Place more focus on the programmes to attain the Millennium Development Goals [MDGs].
	• Place more focus on non-communicable diseases and patients' rights, quality and provide accountability.
9. Review of drug policy.	• Complete and submit proposals and a strategy, with the involvement of various stakeholders.
	• Draft plans for the establishment of a state-owned drug manufacturing entity.
10. Research and development.	• Commission research to accurately quantify Infant mortality.
	• Commission research into the impact of social determinants on health and nutrition.
	• Support research studies to promote indigenous knowledge system and the use of appropriate traditional medicines.

The following table reflects more detailed activities, indicators and targets of the draft National Department of Health for 2014.

Table 12: National Department of Health Ten Point Plan for 2010 to 2014

NHS PRIORITY]	KEY ACTIVITIES	NATIONAL DEPARTMENT OF HEALTH		
		Indicators	**Baseline 2009**	**Target 2009 - 2014**
1. Provision of strategic leadership and creation of a social compact for better health outcomes.	Ensure unified action across the health sector in pursuit of common goals.	Ten Point Plan for 2009 - 2014 adopted and implemented as a common vision of the health sector.	NDOH and all provinces strategic and annual performance plans based on the Ten Point Plan.	National DOH strategic plan and provincial APPs for 2011 – 2014 reflect the strategies required to achieve the priorities outlined in the Ten Point Plan [TPP].
		Annual National Health Plan [ANHP] produced and adopted by the National Health Council.	ANHP produced annually since the promulgation of the National Health Act of 2003. ANHP for 2009 produced based on the TPP for 2009 – 2014.	ANHP produced annually by May each year for 2009 – 2014.
		Number of provincial DOHs producing Service Transformatin Plans [STPs] aligned to the TPP for 2009 – 2014.	9/9 provinces produced long term plans during 2006 – 2008 [8 draft and 1 Comprehensive Service Plan (CSP) approved and published]	9/9 provincial STPs produced and approved by provincial MECs in 2010
	Primary Health Care (PHC) approach affirmed as the fundamental approach to service delivery in South Africa.	Comprehensive PHC package for South Africa revised and updated.	Comprehensive PHC package for South Africa for 2000 – 2005 produced in 2000.	Comprehensive PHC package for South Africa for 2000 – 2005 revised and updated in 2010.
		Model for the delivery of PHC services in RSA developed.	Technical work conducted focusing on achieving the Millennium Development Goals in SA through the revitalisation of Primary Health Care and a strengthened District Health System [DHS].	PHC service delivery model developed by December 2010.
		Expenditure on PHC improved.	41% of health budgets spent on PHC services in 2009 including district hospitals.	50% of health budgets spent on PHC services including district hospitals.
			22% of budgets spent on regional hospital services.	16.6% of budgets spent on regional hospital services.
			13% spent on tertiary hospital services.	10% spent on tertiary hospital services.
	Mobilise leadership structures of society and communities	Percentage of National Health Council [NHC] meetings attended by all 9 provincial MECs.	60%	90%
		Percentage of Technical Committee meetings attended by all 9 provincial HODs.	60%	90%
		Percentage of hospital boards trained	None. Manual for training hospital boards is being developed.	100% [386/386]
		Percentage of PHC Facility Committees established.	63% of existing PHC facilities.	100% in 2013
		Percentage of PHC Facility Committees trained.	63% of existing PHC facilities.	100% in 2013
	Communicate to promote policy and buy in to support government programmes.	National Health Consultative Forum [NHCF] convened in terms of the National Health Act of 2003.	NCHF convened annually since 2006.	NCHF convened in 2010 and the social compact with the people outlining health outcomes to be achieved by 2014 is adopted by the leadership of the health sector and all stakeholders. NCHF convened annually from 2011 – 2014 and progress with the implementation of the social compact is monitored.
		Number of provinces convening Provincial Consultative Fora [PHCF] in terms of the National Health Act of 2003.	5/9 provinces convened PHCF in 2007.	9/9 provinces convening annually by March 2015.
		Number of provinces with communication strategies.		9/9 March 2009. All South Africans are fully informed of the policies, plans and progress of the health sector on a weekly basis through an effective communication strategy.

NHS PRIORITY]	KEY ACTIVITIES	NATIONAL DEPARTMENT OF HEALTH		
		Indicators	**Baseline 2009**	**Target 2009 - 2014**
	Review of policies to achieve goals.	Number of formal progress reports submitted to the Minister and the NHC on the implementation of the NHS priorities for 2009 – 2014.	Two bi-annual reports on the 2004 – 22009 NHS priorities produced.	3 reports annually.
	Impact assessment and programme evaluation.	Number of provinces that commission a mid-term evaluation of their performance.	No baseline	9/9 by March 2012
		Number of provinces commissioning a five-year evaluation of their performance.	No baseline	9/9 by March 2015
2. Implementation of the National Health Insurance.	Finalise the NHI policies and implementation plan.	NHI policy document released for public comment.	NHI policy document submitted to Cabinet by December 2009.	NHI policy document released for public comment by March 2010.
				Revised NHI policy document incorporating public comments produced and presented to Cabinet by July 2010.
	Immediate implementation of steps to prepare for the introduction of the NHI, e.g. budgeting, initiation of the drafting of legislation.	Draft NHI legislation presented to Cabinet.	NHI policy unit established at National DOH Ministerial Advisory Committee gazetted on 11 September 2009.	National Health Insurance Bill submitted to Cabinet for approval in September 2010.
				NHI Bill tabled before Parliament early in 2011.
	Conduct accreditation of health facilities based on the quality of care provided.	Percentage of health facilities accredited annually.	None.	Ministerial Advisory Committee for Quality to be established in 2010.
				National Health Act to be amended during 2010 to provide for the establishment of an independent accreditation body.
				Inspectorates or Quality Audit Units established to appraise health establishments.
				Accredit 25% of health establishments annually.
	Conduct an audit of Health ICT at all levels of the National Health System for the public sector only.	Final Health ICT Audit Report adopted by the NHC.	ICT Audit Report completed.	ICT Audit Report approved by the National Health Council.
	Draft the National ICT Strategy for Health.	Draft National ICT Strategy for Health produced and presented to the NHC.	ICT Strategy to be produced in November 2010.	ICT Strategy adopted by the NHC by March 2010.
				ICT Strategy approved and implemented in all provinces.
3. Improve the quality if health services	Implement quality improvement plans for the 18 identified health districts.	A report on the improvement of services in the 18 identified health districts.	Written analysis of the District Health Plans [DHPS] of all 18 priority districts produced.	Written analysis of the District Health Plans [DHPS] of all 18 priority districts annually during 2010/11 – 2014/15.
			DHPs of 18 districts reflect an average data quality and completeness score of 36.7% - 93.2%	DHPs of 18 districts reflect an average data quality and completeness score of 85 - 90%
			Adverse performance of 18 priority districts on the following **coverage** indicators: • Immunisation coverage under 1 year [range 61.5% - 129%] • ANC coverage [46.6% - 109%] • ANC visits before 20 weeks rate [range: 20 – 30%] • Male condom distribution rate [5.8% - 17.3]	Improved performance of all 18 districts on the following **key service delivery** indicators: • Immunisation coverage under 1 • Antenatal coverage rate [Annualised] • • Male condom distribution rate [annualised]
			Adverse performance of 18 priority districts on the following **health systems performance** indicators:	Improved performance of all 18 districts on the following key **service delivery** indicators:
			• Nurse clinical workload [Range: 28.8 – 68 patients per day]	• Nurse clinical workload

NHS PRIORITY]	KEY ACTIVITIES	NATIONAL DEPARTMENT OF HEALTH		
		Indicators	**Baseline 2009**	**Target 2009 - 2014**
			• PHC utilisation rate [1.5 – 3.5 visits per patient per annum]	• PHC utilisation
			• PHC utilisation under 5 [Range: 2.8 – 6.1 visits per patient per annum]	• PHC utilisation under 5
			• Utilisation rate under 5 years [annualised]	• Utilisation rate under 5 years [annualised]
			• District Hospital: BUR [Range: 58.1% - 78.7%]	• District Hospital: BUR
			• District Hospital ALOS [Range 2.7 – 7.8 days]	• District Hospital ALOS
			Adverse performance of 18 priority districts on the following health systems **outcome** indicators:	Improved performance of all 18 districts on the following key service delivery indicators:
			• TB cure rate	• TB cure rate
			• HIV prevalence	• HIV prevalence
			• Maternal mortality rate	• Maternal mortality rate
			• Infant mortality rate	• Infant mortality rate
			• Child mortality rate	• Child mortality rate
	Refine and up scale the detailed plan on the improvement of quality of services and direct its immediate implementation.	Revised National Core Standards for Quality completed and adopted by the NHC.	• Revised National Core Standards for Quality produced in 2009.	Revised National Core Standards for Quality adopted by the NHC in 2010..
				All 4 000 public health facilities with Quality Improvement Plans [QIPs] by 2015.
		Adoption and implementation of quality improvement plans covering patient safety, infection prevention and control; availability of medicines, waiting times and positive and caring attitudes.	• National implementation plan produced to facilitate the development of QIPs.	1 500 public health facilities producing, implementing and reporting on QIPS in 2011.
				National Core Standards implemented in all 4 000 public sector facilities by 2013.
	Improved patient waiting times.	Average patient waiting times.	• No baseline	Commission a national research study into the average waiting time at public health facilities and design an intervention to improve these.
	Improved patient satisfaction.	Levels of patient satisfaction with health services.	• 87.6%	• 90% • Annual patient satisfaction surveys conducted. • Call centre established to resolve complaints from users of health services.
4. Overhauling the health care system and improve its management.	Identify existing constitutional and legal provisions to unify the public health service and draft proposals for constitutional and legal reform.	Draft proposals for legal reforms presented to the NHC.	• National Health Act of 2003 promulgated	• National Health Amendment Bill developed to review powers and functions of both the National and Provincial DOHs and submitted to Cabinet for approval in 2010.
				• National Health Amendment Bill passed by Parliament in 2011.
	Development of a decentralised operational model including new governance arrangements.	Proposal for a decentralised operational model approved by the NHC.	• Draft delegations for District Health managers produced.	• Delegations for District Health managers approved by the NHC in 2010.
				• Delegations implemented by all 9 provinces by 2013.
			• Draft regulations that will govern the establishment of hospital boards were produced in 2009.	• Regulations for the establishment and functioning of hospital boards adopted by the National Health Council.
				• Hospital Boards in district, regional and tertiary hospitals functioning in a standardised approach.

NHS PRIORITY]	KEY ACTIVITIES	NATIONAL DEPARTMENT OF HEALTH		
		Indicators	Baseline 2009	Target 2009 - 2014
			• Guidelines for the functioning of hospitals boards were also finalised.	• Guidelines for the establishment and functioning of hospital boards adopted by the NHC and implemented.
	Train managers in leadership, management and governance.	Hospital CEOs enrolled for a Masters degree	• 226 Hospital CEOs enrolled for a Masters Degree in Hospital Management at the Universities of the Witwatersrand and KwaZulu-Natal.	• 226 CEOs complete the courses successfully, 160 additional CEOs enrolled on the course.
				• All 336 hospitals to be managed by skilled competent and appropriately qualified CEOs.
	Assess skills, competencies and qualifications of hospital managers.	Conduct a skills audit.	• Audit of the skills and qualifications of hospital CEOs being conducted.	• Skills audit completed by April 2010 which reflects the capacity needs of hospital CEOs.
				• Eligible CEOs provided with formal delegations.
	Decentralisation of management.	Hospital CEOs delegations approved by the NHC.	• Draft frameworks were produced for providing hospital CEOs with human resource, finance and procurement delegations.	• Framework delegations of hospital managers approved by the NHC and implemented across 9 provinces.
	Develop an accountability framework for the public and private sectors.	Draft accountability framework approved for the start of a wider consultative process.	• Due to its complex nature and the capacity required this activity has not commenced.	
	Improve financial audit outcomes.	Financial management improvement project.	• Project Plan accepted by the NHC Technical Committee.	• 5/9 provinces with unqualified financial audit reports by the end of 2011/12.
			• Memorandum of understanding for the provision of technical support to provinces on the improvement of financial management was entered into between National Treasury, Accountant-General's Office and NDOH.	• 9/9 provinces with unqualified financial audit reports by the end of 2013/14.
5. Improve human resources planning, development and management	Refine the human resource plan for Health.	A report on the review of he Human Resources for Health Plan submitted to the Minster.	• Framework for the development of the revised National HRH plan was produced.	• Ministerial Committee or working group to be established by March 2010 to guide the development of a new HRH Plan for South Africa.
				• Revised HRH Plan to be produced by December 2010 which will quantify the country's needs for health care workers, and specify training targets for the next 5 years.
				• Revised HRH for Health will reflect comprehensive strategies for the recruitment and retention of health professionals; including urgent collaboration with countries that have excess of these professionals, as well as strategies to strengthen the training platform.
				• Norms and standards for human resources for all levels of the health system to be produced by 2010?
	Make an assessment of and review the role of the Health Professions Training and Development Grant [HPTDG] and the National Tertiary Services Grant [NTSG].	Review the HPTDG and the NTSG.	• Health Sciences Review Committee established by the DOH and Department of Higher Education examined the utility of the HPTDG and	• New policy and funding mechanisms for the development of health professionals and delivery of tertiary hospital services

NHS PRIORITY]	KEY ACTIVITIES	NATIONAL DEPARTMENT OF HEALTH		
		Indicators	Baseline 2009	Target 2009 - 2014
			completed a series of investigations into the costs of maintaining the current trends in the system along with scenarios and costs of enrolment growth, using medicine as a tracer profession. Preliminary results of the study were released.	adopted by the NHC and implemented across provinces.
	Manage the coherent integration and standardisation of all categories of community health workers.	Plans and progress reports on the expansion of the scope and numbers of CHWs submitted to the Minister	• Draft CHW Policy produced in collaboration with the National Departments of Social Development and Treasury.	• CHW policy to be finalised by December 2010.
			• 27 000 CHWs received stipends in 2009.	• Training curriculum and conditions of 60 000 CHWs standardised across the 9 provinces by December 2013.
				• 60 CCGs receiving stipends by end Marc h2014.
6. Revitalisation of infrastructure	Urgent implementation of refurbishment and preventative maintenance of all health facilities.	Monitor refurbishment and preventive maintenance based on the resolution that 3 – 5% of budgets be used for the purpose, is implemented in health facilities.	• Data collection in process to determine health facilities maintenance baseline.	• 3-5% expenditure on preventive health maintenance achieved
	Asses progress on revitalisation and submit progress reports.	Number of revitalised hospitals against the total in need of revitalisation	• 17 of 386 hospitals revitalised since 2005.	• National Infrastructure Plan fast-tracked and implemented to fast track the delivery of health facilities.
			• All 386 hospitals will require revitalisation over the next 20 years.	• 18 additional projects to be initiate annually through Public Private Partnerships [PPPs]
		Percentage of population within 30 minutes access to Primary Health Care facilities	• 95% in 2005	• 100%
	Review the funding of the revitalisation programme and submit proposals to get the participation of the private sector to speed up this programme.	Funding of the Hospital Revitalisation Programme reviewed and proposals on the participation of the private sector submitted to Cabinet for consideration.	• Development of the National Infrastructure Plan commenced.	•
	Commission an audit of essential equipment audit to assess percentage [%] of equipment that is fully functional and maintained.	Essential Equipment Audit completed and report produced.	• Zero	• Essential Equipment Audit competed in all 9 provinces and Audit Report produced.
7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases.	Decrease HIV incidence amongst others through:	HIV incidence	• 1.3%	• 0.6%
	Implementing provider initiated HIV counselling in all health care facilities with special focus on STI, TB, antenatal, IMCI, family planning and general curative services.			
	Monitor and manage HIV prevalence	HIV prevalence	• 29.3% amongst antenatal attendees.	• Key objective is to reduce HIV incidence [new cases] and to improve the quality of life and life expectancy of people living with AIDS. • Prevalence will be monitored but there are no specific targets set.
	• Implementing provider initiated VCT in 95% of health care facilities with special focus on STI, TB, antenatal, IMCI, family planning and general curative services. • Increase proportion of pregnant women tested through implementation of provider initiated VCT for all pregnant women.			
	Implementation of PMTCT and paediatric treatment guidelines and adult treatment guidelines, through:	% of eligible HIV exposed infants initiated on ART paediatric treatment, viz. dual therapy.	• 10%	• 90%
	Improving access to health institutions integrate antenatal care and PMTCT services.	% of eligible women initiated on PMTCT dual therapy	• No baseline	• 100%
	Increasing proportion of pregnant women tested for HIV during pregnancy. Ensuring a well co-ordinated roll out of ART and more effective roll-out of preventative measures for HIV	% of eligible HIV positive pregnant women initiated on ART at a CD4 count of 350	• No baseline	• 100%

NHS PRIORITY]	KEY ACTIVITIES	NATIONAL DEPARTMENT OF HEALTH		
		Indicators	Baseline 2009	Target 2009 - 2014
	mother to child transmission. Initiating eligible pregnant women on ART at a CD4 count of 350 or less.			
	Expand access to ART for people living with HIV and AIDS.	Number of adult patients initiated on ART.	• 856 268	• 2 926 268
		Number of child patients initiated on ART.	• 83 454	• 263 454
	Urgently strengthen programmes against TB, MDR-TB and XDR-TB through: Expanding the roll-out of the TB DOTS programme. Increasing the number of community health workers trained as DOTS supporters. Increasing the number of health professionals trained in TB management annually. Reducing the TB defaulter rate annually. Developing a research programme for new TB drugs.	TB incidence	• 341 165	• 175 000
		TB cure rate	• 64%	• 85%
		Defaulter rate	• 7%	• <5%
		Number of TB-HIV co-infected patients initiated on ART	• No baseline	• 100%
		Percentage of TB patients with MDR-TB	• 2% (2006)	• To be determined
	Urgently strengthen programmes against TB, MDR-TB and XDR-TB	Number of health professionals trained in the management of TB.	• 3 000	• 3 000 annually
		Number of non-professionals [Community Health Workers] trained in the management of DOTS support.	• 2 253	• 2 500 annually
8. Mass mobilisation for the better health of the population.	Increase the **life expectancy** of all South Africans through diverse interventions including: Increasing the number of new patients initiated on antiretroviral therapy [ART].	Life expectancy [The average number of additional years a person could expect to live if current mortality trends were to continue for the rest of that person's life]	• 47 – 51 years	• 58 – 60 years
	Initiating people with HIV and AIDS and Tuberculosis [TB] co-morbidity at a CD4 count of 350 on ART.			
	Strengthening the integrated TB control programme.			
	Increasing the national average TB cure rate			
	Co-ordinated inter-sectoral interventions to reduce intentional and unintentional injury cure rate.			
	Implementing co-ordinated intersectoral interventions to reduce intentional and unintentional injury.			
	Halt malaria transmission nation wide and prevent re-introduction of malaria in non-endemic areas.			
	Reduce child mortality through diverse interventions including:	Child mortality [Number of deaths of children under 5 years of age per 1 000 live births].		
	Increasing the percentage of mothers and babies who receive post-natal care within 3 days of delivery.			
	Increasing the percentage of infants requiring dual therapy for PMTCT who actually receive it.			
	Increasing the percentage of maternity care facilities which review maternal and perinatal deaths and address identified deficiencies.			
	Ensuring that 90% of children under 1 year of age are vaccinated with pneumococcal and rotavirus vaccines annually.			
	Increasing the percentage of districts in which 90% of children are fully immunised at one year of age.			
	Increasing the percentage of nurse training institutions who teach IMCI in pre-service curriculum.			
	Increasing the proportion of schools which are visited by a school health nurse at least once a year.			
	Conducting health screening of learners in Grade 1 in Q1 schools for eyes, ears and teeth.			
	Implement Household and community component of the IMCI in all districts.			
	Implement Perinatal Problem Identification Programme [PPIP] in all districts.			
	Decrease the maternal mortality ration through diverse interventions including:	Number of maternal deaths per 100 000 live births.	• 400 – 625 per 100 000 live births	• 100 or less per 100 000 live births
	Increasing the percentage of pregnant women who book for antenatal care before 20 weeks gestation.			
	Increasing the percentage of mothers and babies who receive post-natal care within 3 days of delivery.			
	Increasing the percentage of maternity care facilities which review maternal and perinatal deaths and address identified deficiencies.			

NHS PRIORITY]	KEY ACTIVITIES	NATIONAL DEPARTMENT OF HEALTH		
		Indicators	Baseline 2009	Target 2009 - 2014
	Intensify health promotion programmes.	Health promotion strategy finalised and incorporated into provincial health promotion plans.	• Draft National Integrated Health Promotion strategy produced, which aims to identify priorities for health promotion in the country and to provide a mechanism for enhancing existing health promotion strategies and initiatives.	• Health Promotion Strategy incorporated into all 9 provincial health strategies. • Health promotion strategy implemented in all 52 districts.
	Place more focus on the programmes to attain the Millennium Development Goals [MDGs].	Diabetes Declaration and the strategy on unintentional injuries fully implemented by all 18 priority health districts.	• Second draft of the South African Plan of Action for Diabetes was produced. • Plan of Action will guide health districts to reduce morbidity, disability and mortality resulting from diabetes and to measure outcomes in these areas.	• South African Plan of Action for Diabetes finalised and implemented in all 52 districts.
9. Review of drug policy.	Complete and submit proposals and a strategy, with the involvement of various stakeholders.	Approved proposal and strategy signed off by the Minister.	• Drug policy review completed and report produced.	• Monitoring system • Zero stock out rate maintained for TB and ARV medicines.
	Draft plans for the establishment of a state-owned drug manufacturing entity.	Approved proposal and strategy for the establishment of a state-owned drug manufacturing entity.	• Department of Trade and Industry embarked on a feasibility study on the production of ARVs locally.	• Report on the feasibility study on the production of ARVs locally completed and submitted to Cabinet.
	Secure all essential drug supplies.		• Joint investigation between DOH, DTI and the Department of Science and Technology [DST] was conducted to consider the feasibility of purchasing the patent rights for the new ARV.	• Report on the Joint investigation between DOH, DTI and DST completed and submitted to Cabinet.
			• Further funding for BIOVAC Public Private Partnership was provided through Cape Biotech Trust to increase the ability to manufacture vaccines locally.	
10. Research and development.	Commission research to accurately quantify Infant mortality.	South African Demographic and Health Survey 2008 published.	• Sampling frame of the SADHS 2008 was produced; all survey questionnaires were revised and finalised and cost estimates for the survey done.	• SADHS 2008 completed in 2010 and report produced. • SADHS 2013 completed and report produced.
	Commission research into the impact of social determinants on health and nutrition.	Research into the impact of the social determinants of health and nutrition commissioned.	• No research studies were commissioned. • Departments of Health and Agriculture met in June 2009 to revitalise the Integrated Food Security and Nutrition Task team and to develop a road map.	• Research studies into the impact of social determinants of health and nutrition commissioned and conducted by external research organisations [MRC, HSRC, HST, etc].
	Support research studies to promote indigenous knowledge system and the use of appropriate traditional medicines.	Enhanced support for research studies on indigenous knowledge systems and the use of appropriate traditional medicines.	• Final draft of the African Traditional Medicine [ATM] Policy was produced and endorsed by the National DOH	• ATM policy finalised and adopted by the National Health Council.

5.1.7 **Provincial Government of the Western Cape's ten strategic objectives for 2010 – 2014:**

1) Maximising economic and employment growth.
2) Improving school education outcomes.
3) Increasing access to efficient and safe transport.
4) **Maximising health outcomes**.
5) Reducing crime.
6) Optimising human settlement integration.
7) Maximising sustainable resource management.
8) Increasing social cohesion.
9) Alleviating poverty.
10) Clean, value-driven, efficient, effective and responsive government.

5.1.7.1 **Maximising Health outcomes**

The Western Cape Government will improve the health of its citizens by maximizing health outcomes. This will be achieved through the provision of comprehensive quality health care services from primary health care to highly specialized services; and by co-ordinating measures to address the upstream factors that contribute to the burden of disease.

The approach to maximizing health outcomes in the Western Cape is two-pronged.

Firstly, there is the core business of the Department of Health which is the provision of a comprehensive package of health services which includes promotion of health, prevention of disease, curative care and rehabilitation, training and education across all levels of care. The need for these services outweighs the available resources and therefore the primary focus of the Department of Health is to deliver a quality service as effectively and efficiently as possible.

Secondly, there is a need to address transversal issues that contribute to the burden of disease that the Department of Health has to manage but over which it has no control, by addressing issues at provincial government level. For example, addressing issues related to availability and use of alcohol in order to reduce alcohol related injuries that burden the health services. There is therefore a need to establish a high-level inter-sectoral structure to identify, manage and co-ordinate such initiatives.

5.1.7.1.1 **Problem statement**

1) **Core function: provision of health services**:

   The Department of Health struggles to meet the increasing demand for services, as a result of the increasing burden of disease and in-migration to the province, in the face of limited financial and human resources.

   Highly specialized tertiary services, which are very expensive services to render, are funded by national conditional grants. However, these grants are insufficient to cover the current need for these services and are therefore substantially subsidized from the equitable share. The Department has not been successful in securing additional funding for these grants in spite of extensive motivations to national government.

   The recruitment and retention of highly skilled and experienced health care personnel is a challenge.

The development of the required infrastructure in appropriate locations to meet the service requirements is a challenge in terms of securing appropriate funding levels for building and maintenance and in terms of the relationship with the Department of Transport and Public Works.

2) **Upstream factors that impact on health services:**

The Department deals with the outcomes of many socio-economic problems and bears the burden of government's failure to address socio-economic issues impacting on health, for example:

- The highest incidence of TB, due to poverty, overcrowding, poor nutrition.
  The Western Cape is reported to have the second highest incidence of new-smear positive cases of TB in the South Africa (518 per 100 000) and most (90%) patients with TB fall into the economically active group and the TB cure rate for the Western Cape (2007) was 77.3%, which is just short of the national target of 78%. Over the past few years there has been an increase in the TB cure rate in the province. Urgent intervention and focus on high-burdened areas is required to halt the rise in prevalence.
- The increasing prevalence of HIV and AIDS. In 2008, the Western Cape provincial HIV prevalence amongst 15-49 year old antenatal women was 16.1% (95% CI: 12.6%-20.3%) (National Health Department 2009). There has been a steady increase in the prevalence between 1990 and 2008. However, all the districts in the Western Cape have prevalences that are below the national average of 29.3% (95% CI: 28.5%-30.1%). The prevalence is beginning to stabilise, however, the Khayelitsha sub-district has the highest burden of 32%. The Province is putting plans in place to upscale the necessary prevention measures to reduce new HIV infections while increasing access to treatment, care and support.
- Seasonal diarrhoeal disease in children as the result of poor housing and sanitation and without interventions, the prevalence will continue to rise.
- Injuries are the second largest contributor to the burden of disease in the Western Cape after HIV and AIDS, and Tuberculosis. Injuries occur as a result of motor vehicle accidents and interpersonal violence which is fuelled by substance abuse, particularly alcohol. The Department of Health does not have a mandate to regulate factors such as the availability and abuse of alcohol that contribute significantly to violence and injury.
- The increased burden of trauma on the health service means that elective procedures are crowded out by emergency interventions for trauma patients.

5.1.7.1.2 Plans to achieve outcomes

The strategic goals of the Department, addressed in the following table, are crafted to focus the Department's endeavours on maximising health outcomes within its sphere of influence.

Table 13: Strategic goals for the Western Cape Department of Health for 2010 – 2014 to maximise health outcomes

STRATEGIC GOAL	GOAL STATEMENT	JUSTIFICATION	LINKS
1. Burden of disease	1.1. Manage the burden of disease.	This strategic goal relates to the core business of the department, i.e. delivering a health service. All the related strategic objectives are focussed on effective and efficient service delivery in order to maximise health outcomes.	Millennium Development Goals No4, 5 and 6 National Government MTSF: A long and healthy life for all South Africans.: • Focus area: o Increase life expectancy o HIV and AIDS o TB caseload National Department of Health: Ten Point Plan: • Provision of strategic leadership and creation of a social compact for better health outcomes. • Improving the quality of health services. • Overhaul the health system and improve its management. • Accelerated implementation of HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases. • Mass mobilisation for the better health for the population. • Strengthening research and development. Draft provincial strategic plan, strategic objective No.4: Maximising health outcomes
2. Strategic management capacity and synergy.	2.1 Ensure and maintain organizational strategic management capacity and synergy.	This goal aims to ensure that: • The department has a clear plan and targets against which to measure its performance • Management systems are in place to optimally utilise available resources in a co-ordinated manner.	National Government MTSF: A long and healthy life for all South Africans.: • Focus area; o Health system effectiveness National Department of Health: Ten Point Plan: • Provision of strategic leadership and creation of a social compact for better health outcomes. • Improvement of human resources Draft provincial strategic plan, strategic objective No.4: Maximising health outcomes
3. A capacitated workforce.	3.1 Develop and maintain a capacitated workforce to deliver the required health services.	The purpose of this goal is to ensure that staff is appropriately trained and skilled to perform the functions for which they are employed.	National Government MTSF: A long and healthy life for all South Africans.: • Focus area; o Health system effectiveness National Department of Health: Ten Point Plan Draft provincial strategic plan, strategic objective No.4: Maximising health outcomes
4. Health technology and infrastructure.	4.1 Provide and maintain appropriate health technology and Infrastructure.	This goal addresses the provision of the appropriate infrastructure to delivery the required service in the most cost effective and efficient manner. It address buildings, equipment and information communication technology.	National Government MTSF: A long and healthy life for all South Africans.: • Focus area; o Health system effectiveness National Department of Health: Ten Point Plan: • Revitalisation of infrastructure Draft provincial strategic plan, strategic objective No.4: Maximising health outcomes
5. Sustainable income.	5.1 Ensure a sustainable income to provide the required health services according to the needs.	Given that the need for health services outstrips the available funding the purpose of this goal is to focus attention on: • The importance of appropriate budgeting and financial control. • The need to explore all appropriate avenues of revenue generation to supplement the budget.	National Government MTSF: A long and healthy life for all South Africans.: • Focus area; o Health system effectiveness National Department of Health: Ten Point Plan Draft provincial strategic plan, strategic objective No.4: Maximising health outcomes
6. Quality of health services.	6.1 Improve the quality of health services.	The purpose of this goal is to focus on the importance of delivering a quality service in all spheres of the department to enable the department to deliver quality health care.	National Government MTSF: A long and healthy life for all South Africans.: • Focus area; o Health system effectiveness National Department of Health: Ten Point Plan: • Improving the quality of health services. Draft provincial strategic plan, strategic objective No.4: Maximising health outcomes

In striving to meet these goals the Department will address the following:

1) **Access to health services**:

The Department of Health through implementing the Comprehensive Service [CSP] will provide access to quality health care in all districts of the province. The current CSP targets will be rolled out to 2020 to facilitate planning of services, personnel, infrastructure and budget requirements.

Steps are being taken to ensure that appropriate facilities are built in areas of need and measures are being implemented to address issues such as waiting times.

2) **Response times:**

The response times of Emergency Medical Services will be improved by means of ongoing development of EMS and its support systems, such as the dispatch of ambulances. The turnaround time of ambulances at facilities will be improved, making ambulances available for the next mission as soon as possible, by means of improving the interface between the EMS and health facility personnel. These criteria will be measured and benchmarked.

The effectiveness of the Planned Patient System will be further enhanced to ensure that ambulances are used for emergency cases and not to transport ambulatory out-patients to and between facilities.

3) **Funding envelope and promoting strategic partnerships:**

The Department will use its planning tools to provide credible motivations for the appropriate levels of funding from both National and Provincial Treasury. In addition it will strive to implement efficiency gains in all processes without compromising the quality of care and stringent measures will be implemented to ensure that there is no frivolous expenditure.

The Department will explore alternative means of revenue generation in order to supplement the funding envelope by mechanisms such as a bed levy, sponsorships, promoting strategic partnerships and maximizing current revenue generation and collection.

4) **Human resources:**

The implementation of the occupation specific dispensation will improve the ability to recruit and retain health care professionals.

Initiatives to address service volumes and appropriate staffing levels and skill mix of staff will lead to improved staff morale.

The Department will ensure that appropriate training opportunities are provided in relation to the service requirements.

5) **Management and leadership:**

The Department of Health will continue to provide management and leadership training.

All managers will conclude performance agreements with their supervisors, and their staff, that are directly linked to the implementation of the strategic objectives and targets reflected in the strategic and annual performance plans. These will be monitored on a quarterly basis.

6) **Infrastructure:**

Two long awaited new district hospitals are being built in Khayelitsha and Mitchells Plain and are due for completion by 2012/13. These hospitals will provide district hospital services in

previously disadvantaged areas will alleviate service pressure on neighbouring facilities. A number of the existing district hospitals with a focus on the emergency centres, community health centres and clinics will be built in under serviced areas.

Progress will be made in the planning and construction of a replacement hospital for Tygerberg by means of a public private partnership.

In addition the Department is prioritizing the allocation of funding to maintenance to ensure that expensive assets are well maintained and maintain an acceptable standard for the clients of the department.

7) **Technology:**

The Department is committed to remaining abreast of technological advances that enhance clinical diagnosis and treatment. The Department will improve the information systems which will contribute directly to improved patient care and indirectly enhance planning initiatives.

8) **Quality of care:**

The Department will carefully monitor the quality of care provided to patients and undertakes to impartially investigate and report on every complaint received within thirty days of receipt.

5.1.7.1.3 **Plans to address upstream factors contributing to the burden of disease:**

The Provincial Government will co-ordinate transversal initiatives to address the following issues, the details of which are still being finalised:

1) **Traffic-related injury and trauma**

Effective traffic management: including safety of minibus taxis and buses; speed law enforcement; monitoring of drunk driving or driving under the influence of other substances (drugs); cooperation and coordination between the different spheres of government regarding law enforcement/road blocks; utilization of spatial information on the most important areas of “trauma”.

Determine the potential impact of a well-functioning public transport system on ‘relieving’ the current demand on the Planned Patient Transport system.

Departments that are key stakeholders in this respect are the Department of Transport and Public Works, the Department of Community Safety, as well as municipal law enforcement agencies.

2) **Effective policing as a preventative measure**

Explore a mechanism through which to influence effective policing as it relates to the enforcement of the provincial Liquor Act (E.g.: closing down illegal access to alcohol).

Coordinate /influence the location and frequency of road blocks / effective prevention of drink-related accidents.

Key stakeholders: Department of Community Safety; Department of Economic Development and Tourism.

3) **International cooperation on injury prevention**

Explore the option of collaborating with the WHO Violence and Injury Prevention team, who are leading a project supported by the Scottish Government that aims to enable the development and implementation of multi-sectoral violence and prevention policy by sharing technical expertise on building enhanced collaboration. The project would act as a catalyst for the implementation of cross-cutting upstream violence prevention policies and programmes.

4) **Effective public education on alcohol and substance abuse**

- Effective public education at schools around the dangers of alcohol abuse and the personal and public benefit of not abusing substances.
- Appropriate allocation of resources for public education campaigns to ensure that they are appropriately sustainable.

The relevant stakeholder departments are: Health, Education, Social Development

5) **Human settlements (Provincial Strategic objective: No.:6)**

The following issues impact on health, e.g. diarrhoeal disease, TB, etc. and must be addressed:

- Water and sanitation
- Air quality
- Waste management

6) **Poverty reduction (Provincial strategic objective: No.: 9)**

A critical aspect of poverty that impacts on the health of the population is poor nutrition.

7) **Chronic diseases:**

- Chronic diseases as a result of lifestyle choices such as poor diet, lack of exercise, cigarette smoking, etc.
- Similar steps could be adopted to address the issues as for education regarding alcohol and substance abuse:
    - Effective public education messaging at school around the dangers of alcohol abuse/public benefit of not abusing
    - Ensuring effective public education campaigns that have dedicated resources so that there is sustainability/longevity.

5.1.7.1.4 **Effective cooperation**

Inter-sectoral collaboration needs to be effectively planned, implemented, monitored and evaluated by a high-level structure that has the mandate to ensure that appropriate strategies are implemented. The role of the Department of Health is to provide information on the health outcomes that can be used to target upstream interventions and assess the impact of inter-sectoral interventions.

5.1.7.1.5 **Interdepartmental information management**

The availability and reliability of information relating to crime, traffic accidents and the effects on the provincial health services (admissions, trauma, mortality etc.) are crucial to effective responses. Obtaining valid, reliable and recent mortality information is a challenge – the official source is the Department of Home Affairs (death certificates). This must be an inter-sectoral priority, and will be contained in a strategic directive that outlines and commits different departments to effective collaboration.

The following example illustrates the role that is played directly by the Department of Health, in addressing the provincial priority of preventing injury. However, the transversal management of initiatives to address the priority needs to be centrally driven:

The Provincial Injury Mortality Surveillance System (PIMSS) is a focal point of the Provincial Government's Burden of Disease Project. This mortuary-based surveillance collates information from three sources:

- Post mortem reports completed by forensic pathologists
- Police crime incident reports
- Chemical pathology laboratory results.

The system provides a robust and simple surveillance system for directing, monitoring and evaluating interventions to reduce the provincial burden of disease resulting from injury.

The Provincial Mortality Surveillance System and an Injury Surveillance Registry is being piloted in the province, and will be institutionalized to provide the necessary data on which to base upstream interventions.

5.1.8 **Outline of the resource envelope and unfunded priorities**

The demand for health services in the Western Cape continue to outweigh the available resources and this is reflected in the modelling outlined below that was done to determine the number of beds that will be required by the public health sector by 2014/15.

5.1.8.1 **Methodology applied to calculate the bed need by 2014/15**

The calculation of the need for hospital beds in 2014/15 is based on the projected 2014/15 uninsured population, the expected admissions per 1 000 uninsured people per level of care and assumptions regarding the average length of stay and bed occupancy rate. These assumptions are outlined in Table 14.

Table 14: Assumptions applied in the calculation of bed need

Variable	Applied
L1 admissions /1000 uninsured	67
L2 admissions /1000 uninsured	54
L3 admissions /1000 uninsured	20
Average length of stay (ALOS) L1	3
Average length of stay (ALOS) L2	4
Average length of stay (ALOS) L3	6
Bed Utilisation L1	0.85
Bed Utilisation L2	0.85
Bed Utilisation L3	0.85

To make provision for factors that may influence the bed utilisation and length of stay in hospitals in rural areas, e.g. population density, road infrastructure and socio-economic conditions, the rural beds were weighted accordingly:

Table 15: Weighting factor relating bed utilisation rate and average length of stay to population density

Calculation of L1 Beds	Average length of stat [ALOS]	Bed Utilisation	Weighting
Urban	3.00	0.85	1.0000
Rural High Density	3.20	0.85	1.0667
Rural 1	3.40	0.80	1.1833
Rural 2	3.60	0.75	1.3000
Deep Rural	3.90	0.70	1.4500

In Healthcare 2010 and the Comprehensive Service Plan the rural Level 2 beds were also weighted because of the dependency of the rural regional hospitals on the regional and central hospitals in the Cape Town Metro. A result of the restructuring process to implement the Comprehensive Service Plan is the provision of adequate resources to rural regional hospitals to render the full package of regional hospital services without dependency on support from hospitals in Cape Town. No weighting was therefore applied for Level 2 beds in rural areas in the 2014/15 bed plan. The number of Level 3 beds will eventually be determined by the NTSG funding envelope which is currently insufficient to fund the need based model.

5.1.8.2 Trends in population growth: 2001 - 2007

From 2001 to 2007 the total population of the Western Cape increased by 16.7%. The focal point of the growth was the Cape Town Metro district where the population increased by 20.9%. Significant increases also occurred in the Cape Winelands and Eden districts.

The growth per district is depicted in the following table.

Table 16: Population growth from 2001 to 2007 per district

District	Growth: 2001-2007
City of Cape Town	20.9%
Cape Winelands	13.0%
West Coast	1.4%
Overberg	4.6%
Eden	12.8%
Central Karoo	-7.0%
Western Cape	**16.7%**

Due to possible inaccuracies regarding the population distribution between districts, the decrease of population in the Central Karoo was not applied in the allocation of beds for this district. Also, the PHC utilisation rate is the highest in this district and the bed utilisation rate is equal to the average for the province (Annual Performance Plan 2009/10: 85-86).

Note that the population projection in the CSP for 2010 was based on census 1996 and 2001 and mid-year estimates for the period 2002 - 2005. The projected population based on the 1996 and 2001 census and 2007 Community Survey is 22.6% more than the projection in the CSP. This explains the large gap between the 2010 CSP bed need and the projected 2014/15 bed need.

Table 17: Population base bed need by 2014/15

Level 1 Bed need					
District	**2010 CSP**	**2015**	**2020**	**2010 - 2015 Additional beds required**	**2015 - 2020 Additional beds required**
Cape Town Metro	1 246	2 055	2 266	809	211
Cape Winelands	332	437	473	105	37
Overberg	137	166	181	29	15
Central Karoo	102	56	58	See note 1	See note 1
Eden	300	405	444	105	39
West Coast	250	254	273	4	19
Western Cape	**2 367**	**3 371**	**3 695**	**1 051**	**321**
Level 2 Bed need					
Cape Town Metro	1 514	2 208	2 435	694	227
Cape Winelands	562	440	477	-122	37
Overberg	30	148	162	118	14
Central Karoo	10	38	40	28	2
Eden	348	361	396	13	34
West Coast	85	200	215	115	15
Western Cape	**2 549**	**3 396**	**3 725**	**847**	**329**
Level 3 Bed need					
Western Cape	**1 460**	**1 886**	**2 069**	**426**	**183**
Grand Total	**6 376**	**8 654**	**9 489**	**2 324**	**833**

* The bed numbers in this column are aligned with the *hospital infrastructure* in each district. The bed numbers in the 2015 and 2020 columns show the *bed need based on the population* in each district. Once the population based bed need is aligned with the future infrastructure in each district a more meaningful comparison can be made with the 2010 CSP column.

** As explained in the text above the beds in Central Karoo will not decrease.

5.1.8.3 **Hospital infrastructure**

The current infrastructure cannot accommodate the ideal 2010 bed configuration in the Metro district. The new Khayelitsha and Mitchell's Plain Hospitals are under construction and will be commissioned in 2013/14 and GF Jooste Hospital is scheduled to be refurbished. Most of the beds in the new hospitals are already commissioned as temporary hubs in Lentegeur and Tygerberg Hospitals.

Even with this new infrastructure the infrastructure capacity will be insufficient to accommodate the projected bed need by 2014/15. The bed configuration for 2014/15 will therefore be the same as reflected in the CSP for 2010. The only change is that the bed capacity of Khayelitsha and Mitchells Plain Hospitals will increase from the '2010' target of 210 beds each to 230 beds each. However, the completion and commissioning of new PHC facilities in areas such as Du Noon, Delft Symphony, Asanda Village, and Weltevreden Valley will relieve the pressure on hospitals.

It appears that the rural infrastructure will be able to accommodate the additional 288 required beds up to 2014/15 but thereafter additional infrastructure may be required in the Stellenbosch, Drakenstein and George sub-districts.

Therefore projected service need indicates that the Department will require an additional 2 238 hospital beds by 2014/15.

Apart from the infrastructure constraints, the MTEF budget does not allow for increases in district and regional hospital beds. This is also true for central hospital beds where the extent of under-funding is reflected in the amount of the equitable share currently allocated to sustain tertiary services.

Table 18: Bed need based on available infrastructure and MTEF budget allocation

Acute hospitals in the Cape Town Metro	Type of hospital	Ideal Configuration: 2014/15			
		L1	L2	L3	Total
Eerste River Hospital	District	90			90
False Bay Hospital	District	40			40
GF Jooste Hospital	District	180	60		240
Helderberg Hospital	District	90	30		120
Karl Bremer Hospital	District	210			210
Somerset Hospital	Regional	95	152		247
Victoria Hospital	District	90	82		172
Wesfleur Hospital	District	31			31
Khayelitsha Hospital *	District	230			230
Mitchells Plain Hospital *	District	230			230
Mowbray Maternity Hospital	Regional		155		155
Groote Schuur Regional Hospital	Regional		301		301
Groote Schuur Central Hospital	Central			607	607
Red Cross Regional Hospital	Regional		50		50
Red Cross Central Hospital	Central			260	260
Tygerberg Regional Hospital	Regional		684		684
Tygerberg Central Hospital	Central			593	593
Total: Metro Infrastructure		**1 286**	**1 514**	**1 460**	**4 260**
Total: Rural Infrastructure		**1 121**	**1 035**	**-**	**2 156**
Grand Total Infrastructure		**2 407**	**2 549**	**1 460**	**6 416**
Total Bed need in the Western Cape by 2014/15		**3 371**	**3 396**	**1 886**	**8 654**
Additional beds required by 2014 based on need		**964**	**847**	**426**	**2 238**

5.1.9 Overview of the funding envelope

The following table provides an overview of the funding envelope of the Department of Health for the MTEF period

Table 19: Summary of payments and estimates

Programme R'000	Outcome						Medium-term estimate			
	Audited 2006/07	Audited 2007/08	Audited 2008/09	Main appro-priation 2009/10	Adjusted appro-priation 2009/10	Revised estimate 2009/10	2010/11	% Change from Revised estimate 2009/10	2011/12	2012/13
1. Administration [a]	162 125	205 333	249 104	313 813	306 934	305 833	**397 522**	29.98	404 265	430 865
2. District Health Services [c,d,g]	1 922 792	2 707 578	3 139 800	3 503 630	3 713 233	3 776 720	**4 223 003**	11.82	4 640 909	4 953 181
3. Emergency Medical Services	277 844	341 877	403 118	488 136	534 298	525 905	**560 578**	6.59	580 791	614 550
4. Provincial Hospital Services [c]	1 397 635	1 306 027	2 260 650	2 621 311	2 506 979	2 544 912	**2 876 231**	13.02	3 084 286	3 253 649
5. Central Hospital Services [b,c]	2 123 000	2 349 884	1 970 686	1 911 422	2 270 500	2 369 550	**2 595 971**	9.56	2 799 434	2 953 284
6. Health Sciences and Training h	98 858	133 706	136 629	191 334	192 280	193 471	**216 966**	12.14	230 715	244 508
7. Health Care Support Services [g]	92 906	81 785	96 150	177 978	199 393	200 668	**215 944**	7.61	230 912	244 330
8. Health Facilities Management [e,f]	344 355	371 678	399 708	685 174	740 099	639 043	**876 648**	37.18	818 720	865 346
Total payments and estimates	6 419 515	7 497 868	8 655 845	9 892 798	10 463 716	10 556 102	**11 962 863**	13.33	12 790 032	13 559 713

[a] MEC total remuneration package: R1 420 489 with effect from 1 April 2009.

[b] National Conditional grant: Comprehensive HIV and Aids - R554 054 000 (2010/11) , R648 314 000 (2011/12) and R738 098 000 (2012/13).

[c] National Conditional grant: Health Professions Training and Development - R384 711 000 (2010/11), R407 794 000 2011/12) and R428 120 000 (2012/13).

[d] National Conditional grant: National Tertiary Services - R1 763 234 000 (2010/11), R1 894 680 000 (2011/12) and R1 989 415 000 (2012/13).

[e] National Conditional grant: Hospital Revitalisation - R580 554 000 (2010/11), R485 501 000 (2011/12) and R506 363 000 (2012/13).

[f] National Conditional grant: Infrastructure Grant to Provinces - R131 529 000 (2010/11), R160 540 000 (2011/12) and R178 539 000 (2012/13).

[g] National Conditional grant: Forensic Pathology Services - R66 251 000 (2010/11), R70 226 000 (2011/12) and R73 737 000 (2012/13).

Table 20: Summary of provincial payments and estimates by economic classification

Economic classification R'000	Outcome						Medium-term estimate			
	Audited 2006/07	Audited 2007/08	Audited 2008/09	Main appro-priation 2009/10	Adjusted appro-priation 2009/10	Revised estimate 2009/10	2010/11	% Change from Revised estimate 2009/10	2011/12	2012/13
Current payments	5 625 806	6 609 562	7 756 666	8 638 307	9 061 668	9 239 454	**10 436 523**	12.96	11 288 338	11 965 179
Compensation of employees	3 419 042	4 138 765	4 876 271	5 364 971	5 748 979	5 830 387	**6 609 793**	13.37	7 076 153	7 423 095
Goods and services	2 206 764	2 470 797	2 879 999	3 273 336	3 312 689	3 409 067	**3 826 730**	12.25	4 212 185	4 542 084
Interest and rent on land			396							
Transfers and subsidies to	378 356	410 989	427 489	505 285	560 780	562 686	**619 653**	10.12	649 192	691 065
Provinces and municipalities	141 475	150 924	165 186	191 557	229 551	229 551	**240 191**	4.64	253 141	268 952
Departmental agencies and accounts	6 089	3 580	4 368	4 712	4 712	4 712	**5 014**	6.41	5 259	5 559
Universities and technikons	1 275	1 400		1 708	1 708	1 708	**1 817**	6.38	1 906	2 015
Non-profit institutions	164 525	191 404	211 455	217 889	241 990	241 990	**271 514**	12.20	282 157	300 227
Households	64 992	63 681	46 480	89 419	82 819	84 725	**101 117**	19.35	106 729	114 312
Payments for capital assets	413 938	474 224	469 518	749 206	841 268	751 561	**906 687**	20.64	852 502	903 469
Buildings and other fixed structures	234 589	297 470	328 119	509 319	607 091	505 039	**657 752**	30.24	597 116	576 451
Machinery and equipment	179 116	176 704	141 302	239 887	233 950	246 042	**248 935**	1.18	255 386	327 018
Software and other intangible assets	233	50	97		227	480		(100.00)		
Of which: "Capitalised Goods and services" included in Payments for capital assets			326 951	509 319	599 014	500 328	**667 007**	33.31	606 826	586 717
Payments for financial assets	1 415	3 093	2 172			2 401		(100.00)		
Total economic classification	6 419 515	7 497 868	8 655 845	9 892 798	10 463 716	10 556 102	**11 962 863**	13.33	12 790 032	13 559 713

5.2 ORGANISATIONAL ENVIRONMENT

5.2.1 Structure and capacity of the Department

The organisation and post structure of the Department is based on the Strategic Plan of the Department and reflects the core and support functions to be executed in achieving the strategic objectives of the Department.

During the past six years the Departmental strategic plan, Healthcare 2010, and specifically the Comprehensive Service Plan, guided the development and amendment of new and current organisation and post structures of the Department. This contributed to the development of new structures for the District Health Services. New organisation and post structures were developed for the five rural health districts, which included the amendment of the district offices structures and district hospital structures. The focus of the development of the new organisational structures was the efficient rendering of primary health care services at district level.

With respect to District Health Services the staff has been aligned with the new structures which have been implemented on PERSAL and the matching and placement of staff against the new post establishment has been finalised. The focus during 2010/11 will be the implementation of the new organisation and post structures of the institutions within the Metro Health District. The hospitals that will be addressed in this regard will be Karl Bremer, Victoria, Helderberg, GF Jooste, Eerste Rivier, False Bay and Wesfleur Hospitals.

The CSP specifically addressed the split in the rendering of level two and level three health services at Groote Schuur and Tygerberg Hospitals. The development of new organisation and post structures for these two institutions commenced during 2009 and will be finalised during 2010. The implementation of these structures will contribute to the physical separation of the rendering of the level two and three services within these institutions. This exercise will also address the placement of about 9 000 current staff members in accordance with the new structures. It is anticipated that this exercise will be conducted during the course of the 2010/11 and 2011/12 financial years.

Following an organisational development investigation it has been decided to strengthen Professional Support Services. The current Chief Directorate will has been split into two Chief Directorates with the following components:

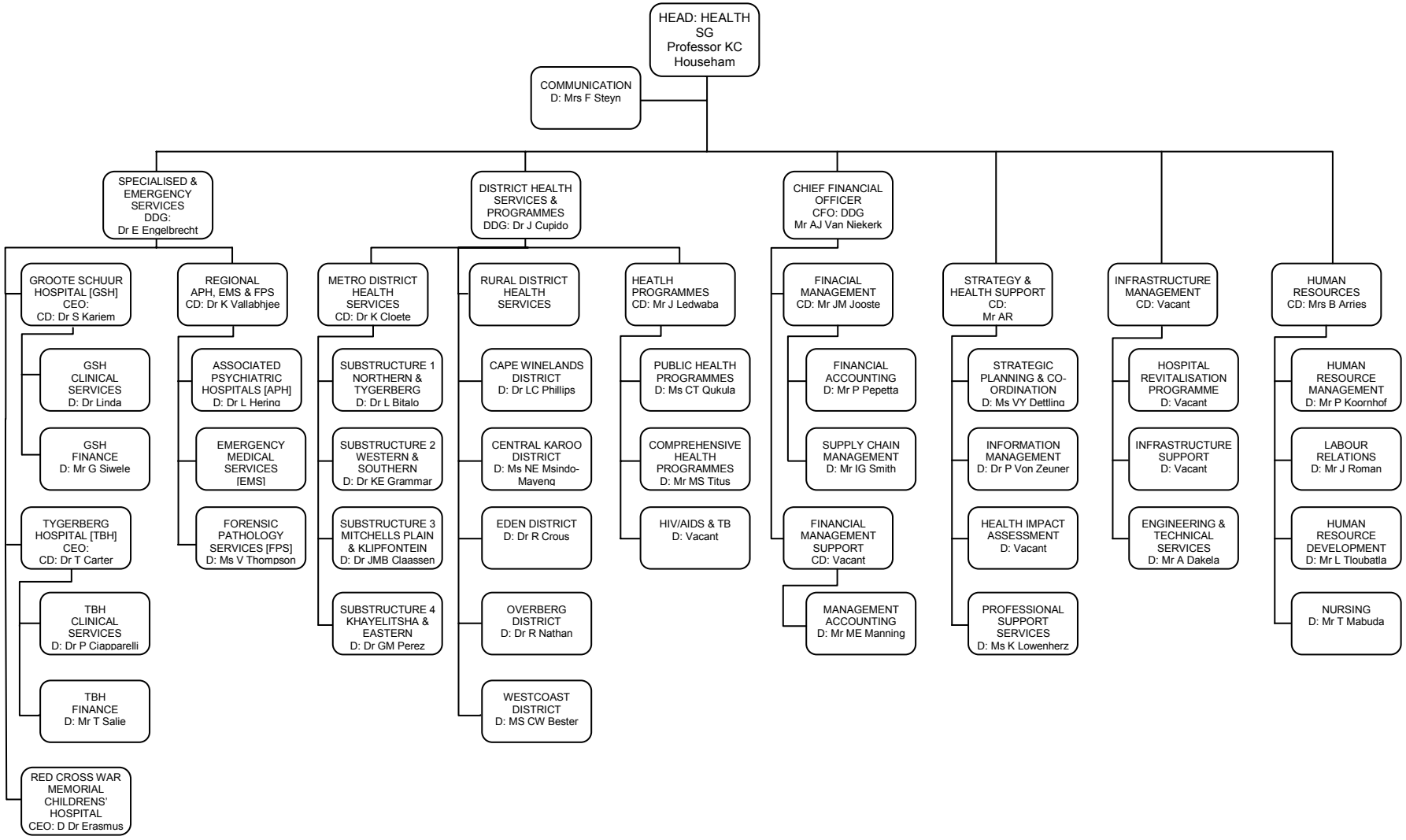
- Chief Directorate Infrastructure Management with the following directorates: Infrastructure Management, Hospital Revitalisation Programme; and Engineering and Technical Support.
- Chief Directorate: Strategy and Health Support with the following directorates: Strategic Planning and Co-ordination; Information Management, Health Impact Assessment and Professional Support Services.

The implementation of the Occupation Specific Dispensation (OSD) has resulted in specific occupational streams within occupations having new job titles and remuneration packages and a new mix of posts regarding scope of practice providing health services at ward/unit/clinic level. As a result the entire organisation and post structure of the Department will be aligned in terms of the new approved OSDs. Over the past two years the implementation of the OSDs has resulted in significantly higher personnel costs which have not been matched by appropriately increased funding allocations to the Department.

A significant risk that has been identified in the approved Human Resource Plan is that 5 100 employees of the Department are between the age of 51 and 65 and in view of the provisions available within the Public Service the it is possible that a large percentage of these staff could leave

the service within the next five years. A total of 500 employees will leave the service due to retirement during the next two years. The importance of efficient human resource planning and the implementation of systems and processes to ensure the timeous recruitment and retention of the required work force to render an efficient health service has become one of the most important challenges of the Department.

Figure 3: Organogram of the senior management of the Department



5.3 DESCRIPTION OF THE STRATEGIC PLANNING PROCESS

Prior to commencing the planning for 2010 to 2014 the senior management of the Department, led by the Head of Department, reviewed the actual performance of each financial programme and sub-programme against their pre-determined performance targets for 2008/09, in a two-day workshop. Valuable lessons were learned, for example the importance of setting appropriate and realistic targets.

This was followed by a strategic planning meeting in July 2009, attended by all members of senior management, representatives of the respective health faculties and community representatives. The provincial Minister of Health attended the meeting and outlined his vision and priorities for the Department.

Through group work and plenary sessions the vision, mission, strategic goals and strategic objectives of the Department were revised in line with the priorities of the Provincial Government of the Western Cape.

The Department has subsequently submitted the two drafts and final version of the respective documents in August and December 2009 and February 2010. In the preparation of each version of the documents performance measures and targets have been reviewed in an iterative process between the programme managers, the strategic planning team and the Head of Department. There has also been extensive collaboration with Treasury and the National Department of Health.

It is noted that the preparation of the required documents has been a challenge for the following reasons:

1) Departments are required to produce two planning documents this year, i.e. the five-year Strategic Plan and the Annual Performance Plan.

2) The generic formats for strategic and annual performance plans provided by National Treasury were significantly changed and were only made available relatively late in the budget process. These still needed to be customised by the respective sectors. In effect this meant that the Department was liaising with the National Department of Health providing input on the alignment of the requirements of the formats, whilst trying to compile the first draft.

3) There has been ongoing interaction with the various stakeholders to finalise the nationally prescribed indicators and the subset required for the Quarterly Performance Reports.

4) The requirements of the performance information environment are understandably becoming more rigorous, however, this does place an additional burden on the existing staff and systems. The fact that final budgets are only made available to the Department within a few days of submitting the documents to Treasury compounds the issue.

5) An important factor that has influenced the planning process in this cycle is that it is the first year of the election cycle and that new strategies have been developed at different levels of government, e.g. National Government, National Department of Health and the Provincial Government all of which need to find expression in the documents. The fact that these are developed in parallel with the planning process and do not precede it is not ideal.

This being said, the strategic plan and annual performance plan of the Western Cape Department of Health is aligned with the strategies of all the above stakeholders, including the health related Millennium Development Goals.

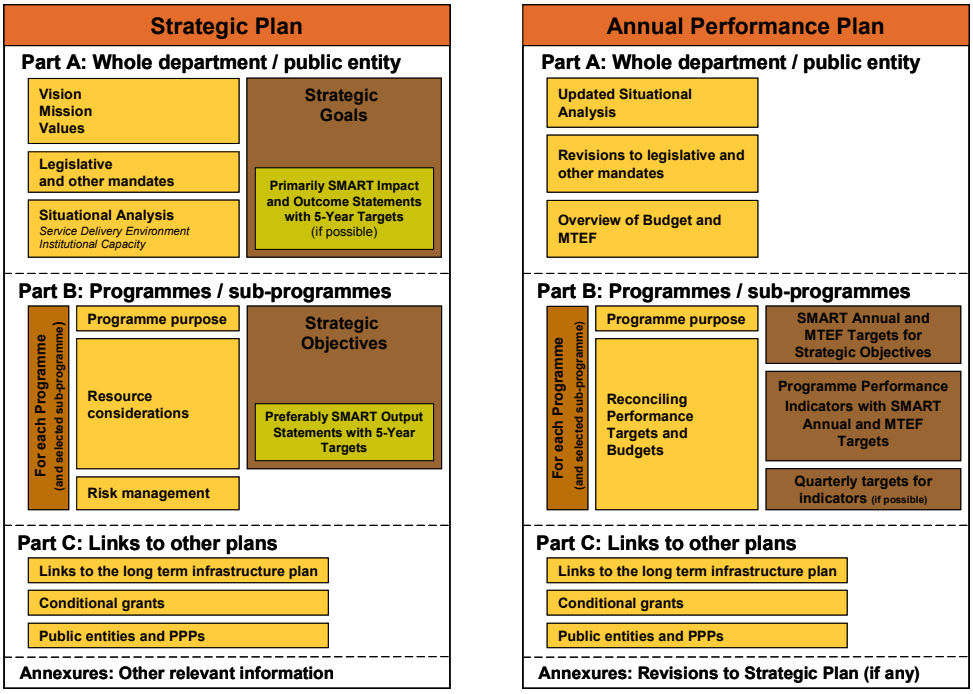
The Department has embarked upon a process of revisiting the Comprehensive Service Plan to develop a long-term strategic plan for 2020.

5.3.1 Technical notes

1) The format in which the Strategic and Annual Performance Plans is written is determined by National Treasury. This format is then customised by sector specific national departments, such as the National Department of Health, in order to address the specific sector issues.

2) The framework used by National Treasury is outlined in Figure 4 below.

Figure 4: Structure and content of Strategic Plans and Annual Performance Plans



Source: Framework for Strategic Plans and Annual Performance Plans, National Treasury, May 2009

3) In customising the format for Health, the National Department of Health prescribes a number of indicators per financial programme. A limited sub-set of these indicators are selected by the National Department of Health and National Treasury and are reported on in the Quarterly Performance Reports [QPR] to both national departments.

4) The provincial departments have the scope to add province specific indicators per financial programme. The Western Cape Department of Health monitors performance against all the performance indicators on a quarterly basis, the culmination of which is captured in the Annual Report.

5) The format of the five-year Strategic Plan requires each programme to present a table of its strategic goals and strategic objectives with the baseline level of performance for each strategic objective.

6) The strategic objectives are carried forward into the Annual Performance Plan where annual targets are provided for each strategic objective,

7) The format requires that there should be a separate table for performance indicators, with annual targets and another table where all the indicators are repeated with the annual target for 2010/11 and the targets for each quarter of 2010/11.

8) Treasury requested that the 'nationally prescribed' indicators be listed prior to the 'provincial' indicators in the respective tables in order to facilitate checking of the documents.

9) However, having separate tables for strategic objectives and performance indicators made the flow of information cumbersome as in some instances 'nationally prescribed' indicators were used as baselines for strategic objectives. Therefore the Department has developed a single table for the annual targets for strategic objectives and indicators but has accommodated the Treasury requirements by:

- Highlighting the strategic objective baseline measures in yellow and also labelling each as "baseline measure'
- Adding a column to reflect the 2014/15 baseline target.
- The performance targets of the nationally prescribed indictors are highlighted in blue
- The table references to the National Department of Health Format for Annual Performance Plans of Provincial Health Departments are reflected in square brackets after each table heading.

10) A separate table is provided for the quarterly performance targets.

11) A set of definitions for each performance indicator is provided. Note that the definition of the strategic objective baseline measures serve as the definition of the strategic objectives.

12) The following three tables illustrate the application of the above.

EXAMPLE: Table x: Strategic objectives and expected outcomes for 2010 – 2015

Strategic Goal	Strategic Objective: Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
1. This column is not 'required' but is provided to illustrate the logical flow.	1.1 Provides a title for the strategic objective.	1.1.1. States the strategic objective and should be SMART.	1) The measure by which the strategic objective is measured	Current performance	Target performance in 2014/15	Statement of why this is an important strategic objective	Links to the strategic goals of national and provincial government

EXAMPLE: Table x: Strategic objectives, performance indicators and annual targets for Programme Y [NDOH table reference] in the Annual Performance Plan

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Type	Baseline target 2014	Audited/ actual performance			Estimate	Medium term target		
						2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
1. .Carried forward from the strategic plan.	1.1 Carried forward from strategic plan	1.1.1. Carried forward from the strategic plan	**Strategic Objective [SO] Baseline measure:** **1)**	Whether the indicator is e.g. a number, % or rand value	Carried forward from strategic plan							
			2)		Blue shading indicates a nationally prescribed performance indicator							
		1.1.2.	**SO Baseline measure:** 3)									

EXAMPLE: Table x: Quarterly targets for Programme Y for 2010/11 [NDOH table reference] in the Annual Performance Plan

Strategic al goal	Strategic objective: Title	Strategic objective	Performance indicator	Reporting period	Annual target	Quarterly Targets			
					2010/11	Q1	Q2	Q3	Q4
1.	1.1	1.1.1	SO Baseline measure: **1)**	E.g.: Quarterly or annually	Carried forward from table above				
			2)						
		1.1.1	**SO Baseline measure:** **3)**	**Blue shading = national indicator**					

PART B:

Strategic Objectives

PROGRAMME 1: ADMINISTRATION

1. PURPOSE

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

2. PROGRAMME STRUCTURE

2.2 SUB-PROGRAMME 1.1: OFFICE OF THE MEC

Rendering of advisory, secretarial and office support services.

2.3 SUB-PROGRAMME 1.2: MANAGEMENT

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

2.3.1 Sub-programme 1.2.1: Central management

Policy formulation by the Provincial Minister and other members of management, implementing policy and organizing the Health Department, managing personnel and financial administration, determining working methods and procedures and exercising central control.

2.3.2 Sub-programme 1.2.2: Decentralised management

Implementing policy and organising health regions, managing personnel and financial administration, determining work methods and procedures and exercising regional control.

3. KEY COMPONENTS OF THE PROGRAMME:

Key management components of the Department of Health that provide strategic leadership and support include the following:

3.1 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 coordinated both via the provincial Minister and the office of the Head of Department.

3.2 FINANCE:

This division is headed by the Chief Financial Officer with a Chief Directorate of Financial Management and a Chief Directorate of Budget Administration.

Financial Management has two directorates, responsible for financial management and 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. The management and

support of this component enabled the Department to maintain an unqualified audit for the 2008/09 financial year. Other key issues addressed by this Chief Directorate include:

- Supply chain management
- Transport management
- The Cape Medical Depot, which procures medical and surgical sundries in bulk for the pharmaceuticals Department.
- Salary administration

The Management Accounting Directorate within the Chief Directorate: Budget Administration 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.

3.3 STRATEGY AND HEALTH SUPPORT AND INFRASTRUCTURE MANAGEMENT:

Currently there is one Chief Directorate: Professional Support Services which is being divided into two chief directorates, i.e. Strategy and Health Support; and Infrastructure Management in order to strengthen these vital support functions. The posts are in the process of being filled.

The key focus of the Chief Directorate: Strategy and Health Support is to assist the Head of Department with the prescribed strategic planning framework to ensure alignment with planning and reporting cycles and procedures and to ensure that policy and planning inform the budgetary processes. The chief directorate consists of the following directorates:

- Information Management
- Professional Support Services
- Strategic Planning and Coordination
- Health Impact Assessment

The key function of the Chief Directorate: Infrastructure Management is to plan and coordinate 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:

- Engineering and Technical Services (Programme 7)
- Hospital Revitalisation Programme (Programme 8)
- Infrastructure Support

3.4 HUMAN RESOURCE MANAGEMENT

The Chief Directorate: Human Resources consist of the following four directorates and a transformation unit. The key function is to develop an appropriate human resource plan that will meet the current and future need of the department. The four directorates are:

- Human Resource Management
- Labour Relations
- Human Resource Development

- Nursing

The Modernisation Programme of the Department of the Premier, which is in an advanced stage, proposes the shift of the Human Resources (excluding the Departments of Health and Education), Internal Audit and Enterprise Risk Management functions to a shared Corporate Services within the Department of the Premier from 1 April 2010. Therefore the strategic objectives and performance indicators relating to these functions are only reflected in the Strategic and Annual Performance Plans of the Department of the Premier. The financial implications of the function shift will be finalised during the 2010/11 Adjusted Estimates process once all of the HR and other related issues have been finalised.

4. STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2014

Table 1.1: Strategic objectives and expected outcomes for Administration for 2010 - 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Strategic Objective Baseline Measure	2009/10	2014/15		
1. Ensure a sustainable income to provide the required health services.	1.1. Promote efficient financial resource use.	1.1.1. The development and maintenance of a financial efficiency programme to ensure under/over spending is within 1% of the annual allocated budget throughout the reporting periods.	1) Percentage under /over spending of the annual allocated budget	1% 10. 556 bn/ 10. 463 bn	1% 13. 424bn/ 13. 559 bn	To ensure sound financial management by aligning the annual allocated budget with the department's strategic objectives.	PFMA Provincial Treasury Instructions National Treasury Regulations Department of Revenue Act
2. Develop and maintain a capacitated workforce.	2.1. Develop and maintain a comprehensive human resource plan for the department.	2.1.1. To determine the educational qualifications and experience of 98% of the current staff by conducting a skills analysis by 2014/15.	2) Percentage of occupational skills analysis completed for all staff.	31% 8 883/ 28 656	98% 28 082/ 28 656	The assessment of whether staff are in possession of the necessary skills and competencies to successfully perform the functions linked to their post and for managers to have a common understanding of the set of competencies and skills that are core to the department.	DPSA - HR Plan Ten Point Plan: • Improve Human Resources Maximising health outcomes Comprehensive Service Plan
	2.2. Ensure optimal staffing levels within the finance components at Head Office.	2.2.1. Ensure a 97% filled post rate within the finance components at Head Office throughout the reporting periods.	3) Percentage of filled finance posts at head office.	88 %	97 %	To increase capacity within the finance components to support sound financial management practices.	
3. Ensure organisational strategic management capacity and synergy.	3.1. To implement and maintain the organisational post structures of the CSP.	3.1.1. Ensure the implementation and maintenance of 147 organisational and post structures aligned to the CSP by 2014/15.	4) Number of organisational and post structures implemented by 2014/15.	65	147	To ensure greater accountability, organisational and managerial effectiveness.	Ten Point Plan: • Provision of strategic leadership; • Overhauling the health system Guidelines of the Medical Control Council PFMA National Treasury Regulations Provincial Treasury Instructions Preferential Procurement Policy Framework Act Comprehensive Service Plan
	3.2. An effective and viable departmental website.	3.2.1. Revitalisation and maintenance of the official website to increase optimal usage of site by 2014/15.	5) Number of Chief Directorates' policies and practices posted on the department's official website.	0	8	To ensure an effective and viable departmental website to serve as the primary source of communication and departmental information, policies and practices.	
	3.3. Provide an effective financial compliance reporting tool.	3.3.1. Ensure that 63 institutions report monthly on the financial compliance to the departmental predetermined list which addresses the shortcomings identified by the Auditor-General.	6) Number of institutions submitting monthly finance compliance reports.	40	63	To ensure adherence to the legislative requirement imposed on the department.	
	3.4. Ensure optimum pharmaceutical stock levels.	3.4.1. Maintain a 93% stock availability rate at Cape Medical Depot {CMD] during each reporting period.	7) Percentage of pharmaceutical stock availability at the CMD.	93%	93%	To ensure pharmaceutical stock levels meet demand.	

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Strategic Objective Baseline Measure	2009/10	2014/15		
	3.5. Raise Supply Chain Management to a level 3 compliance.	3.5.1. Ensure the policy maintenance of the Accounting Officers System (AOS) by end April of each reporting period.	8) Provision of the Accounting Officers System policy.	1	1	To ensure all institutions are in possession of the departmental procurement and provisioning policy	
		3.5.2. Development and maintenance of a Procurement Plan for minor and major assets by end April of each reporting period.	9) Provision of a Procurement Plan.	1	1	To align the procurement of minor and major assets to the budget and programme deliverables.	
		3.5.3. Ensure that the 59 sites registered on the LOGIS or SYSPRO system account for all assets by performing monthly reconciliation reports throughout the reporting periods.	10) Number of registered sites performing asset reconciliation reports.	59	59	To ensure all sites are in possession of an up-to-date asset register and all expenditure on assets is recorded.	
	3.6. Co-ordinate, integrate and provide health information to the department.	3.6.1. Improve the integrity of performance data by ensuring a 99% submission rate of prioritised data by 2014/15.	11) Data submission rate of prioritised data used.	85% (11 760/ 13 836)	99% (13 698/ 13 836)	Optimal use of information and information technology to effectively support the strategic objectives of the department.	Ten Point Plan: • Overhaul the health system and improve its management
4. Ensure the provision of infrastructure that meets the needs of current and future development.	4.1. Infrastructure to support workforce development.	4.1.1. 98% implementation of the Health Information System (HIS) at all contracted hospitals by 2014/15.	12) Percentage of hospitals where the HIS has been implemented.	68% (28/41)	98% (40/41)		
5. To improve the quality of health services.	5.1. The institutionalisation and integration of Quality Improvement (QI) at all levels of care in line with National and Provincial Departmental objectives and initiatives.	5.1.1. The institutionalisation and integration of QI across all levels of care reflected by the timeous submission of composite reports on consumer and technical quality.	13) Number of organisational structures (APH, central hospitals, districts, CD: Regional Hospitals and EMS) submitting composite QI reports.	6	12	To ensure an improved quality of service at health facilities.	Ten Point Plan: • Improve the quality of health services

5. RESOURCE CONSIDERATIONS

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 work load at institutions), the cost of medico legal claims and other central costs such as audit fees, recruitment and advertising fees.

The central pharmaceutical depot carries stock to the value of R100m and although this is the managerial responsibility of Finance management in Programme 1, the funding is reflected in Sub-programme 7.3: Medicine Trading Account.

Trends in the availability 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. At the same time the competing interest between direct and support service delivery in battling for additional funding remains a challenge within the programme.

6. RISK MANAGEMENT

Given the financial pressures that the Department continues to experience in the face of increasing demand for services, the management and leadership of the Department must continue to address the following risks:

1) Securing an appropriate funding envelope to deliver the services required in line with national and provincial policy and the guidelines of the Comprehensive Service Plan is a significant risk. In order mitigate against this the Department develops credible budgets and motivations for appropriate funding that are based on logical and credible strategic plans for service delivery, human resources and infrastructure.

2) A significant risk for the Department is the quality of its performance data. Not only is this important in terms of prescribed planning and reporting frameworks but it forms the basis of all planning and therefore budget allocations. Various steps are being taken to address the quality of the Department's data, e.g. the creation of a single repository of valid and reliable data.

3) The ability to deliver health services is dependent on the availability of the appropriately skilled and experienced health professionals and other staff. The ability to train, recruit and retain sufficient numbers of skilled personnel is therefore a risk for the Department.

4) The shortage of nurses in the Department hampers service delivery in some service areas. The Department has developed a nursing strategy. The remuneration of health professionals remains a challenge although the Occupation Specific Dispensation (OSD) for different categories of health staff has been developed and implemented.

PROGRAMME 2: DISTRICT HEALTH SERVICES

1. PROGRAMME PURPOSE

The purpose of the Division of District Health Services and Health Programmes (Programme 2) is 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.

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 2.1 DISTRICT MANAGEMENT

Management of District Health Services (including Facility and Community Based Services), Corporate Governance (including financial, human resource management and professional support services e.g. infrastructure and technology planning) and Quality Assurance (including Clinical Governance).

2.2 SUB-PROGRAMME 2.2 COMMUNITY HEALTH CLINICS

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

2.3 SUB-PROGRAMME 2.3 COMMUNITY HEALTH CENTRES

Rendering a primary health care service with full-time medical officers in respect of mother and child, health promotion, geriatrics, occupational therapy, physiotherapy, psychiatry, speech therapy, communicable diseases, mental health, etc.

2.4 SUB-PROGRAMME 2.4 COMMUNITY BASED SERVICES

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

2.5 SUB-PROGRAMME 2.5 OTHER COMMUNITY SERVICES

Rendering environmental and port health services.

2.6 SUB-PROGRAMME 2.6 HIV AND AIDS

Rendering a primary health care service in respect of HIV and AIDS.

2.7 SUB-PROGRAMME 2.7 NUTRITION

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

2.8 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 7.4: Forensic Pathology Services.

2.9 SUB-PROGRAMME 2.9 DISTRICT HOSPITALS

Rendering of a district hospital service at sub-district level.

2.10 SUB-PROGRAMME 2.10 GLOBAL FUND

Strengthen and expand the HIV and AIDS care, prevention and treatment programmes.

3. OVERVIEW

Programme 2 has confirmed six key strategic goals which it will pursue during this MTEF period (in line with the Departmental strategic goals). These are:

1) Managing the burden of disease.

2) Ensuring a sustainable income to provide the required health services.

3) Developing and maintaining a capacitated workforce.

4) Ensuring organizational strategic management capacity and synergy.

5) Provision and maintenance of appropriate health technology and infrastructure.

6) Improving the quality of health services

Programme 2 has identified clear priorities aimed at reducing the burden of disease and ensuring the delivery of equitable and efficient health care services at all levels within the District Health System (DHS). To ensure the achievement of these priorities and other relevant international, national and provincial priorities, three focus areas have been identified that serve as the framework through which the health system will be strengthened and service delivery will be improved.

These focus areas are:

- Service provision
    - District Health Services which focus on Ambulatory Care and De-hospitalized (CBS) Care

- District Hospitals whose primary focus is on Acute Services
- Infectious diseases with a strong emphasis on HIV/AIDS, Tuberculosis and Sexually Transmitted Illnesses
- Women's and Child Health
- Disease prevention with an emphasis on Environmental Health

- Corporate governance
  - Financial administration
  - Workforce/human resources management
  - Management capacity enhancement
  - Infrastructure and technology improvement
- Quality assurance and Clinical governance.

The Division is committed to managing the above-mentioned areas through the institutionalisation of a comprehensive monitoring and evaluation (M and E) framework. Performance is reviewed on a monthly and quarterly basis in alignment with the key Departmental Performance Areas, namely:

1) Acute services (including EMS)

2) Ambulatory care (including chronic disease management and outreach and support)

3) Infectious disease management (HIV and AIDS and TB control).

4) De-hospitalised care (community-based services)

5) Women's and child health

3.1 DISTRICT HEALTH SYSTEM AND MANAGEMENT

3.1.1 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 City of Cape Town District) and five rural districts. The City of Cape Town District, which is the largest district, has been further sub-divided into four sub-structures, each comprising of two sub-districts. Each of the five rural districts and the four sub-structures in the City of Cape Town District is managed by a Director, who is responsible for ensuring that district health services are efficiently and effectively delivered and that the CSP is fully implemented within the structure of the DHS.

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

- City of Cape Town: Cape Town
  - Southern and Western sub-districts: Retreat
  - Northern and Tygerberg sub-districts: Parow
  - Mitchell's Plain and Klipfontein sub-districts: Mitchell's Plain

- Khayelitsha and Eastern sub-districts: Khayelitsha

- Cape Winelands District : Worcester
- Overberg District: Caledon
- West Coast District: Malmesbury
- Eden District: George
- Central Karoo District: Beaufort West

The Department assumed responsibility for personal primary health care services (PPHC) in the rural districts in 2005. This resulted in the transfer of PPHC services from the local municipalities to the Provincial Government of the Western Cape in the five rural districts between 2005 and 2007. Subsequently, 545 Local Government staff members were successfully transferred onto the provincial establishment.

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, therefore these services are provided jointly by both spheres of government. Environmental health care in Cape Town is provided by the City of Cape Town Municipality. The establishment of the District Health Councils should be concluded in 2010.

3.1.2 **Primary Health Care Services**

Community Health Clinics (Sub-programmes 2.2) and Community Health Centres (Sub-programme 2.3) are considered to be the first port of call for patients who enter the public health system. These facilities also serve as referral points for patients who require care at other levels in the health system.

Community Health Clinics are primarily nurse-run (with Clinical Nurse practitioners), and include fixed, satellite and mobile clinics, as well as visiting points. The package of services provided at clinics comprise of: all curative, promotive and preventative services; antenatal, postnatal, family planning and other specialised services; mental health; TB and HIV and AIDS; chronic disease management and walk-through services (in accordance with the National Package of services). Termination of pregnancy services are not provided at clinic level in the Province. There are 404 clinics in the province, of which 57% are fixed facilities, and 172 are non-fixed (satellite and mobile clinics). The latter are primarily concentrated in rural areas where access to health services is constrained by geographical and other infrastructural challenges.

At Community Day Care Centres (CDCs) and Community Health Centres (CHCs) services are provided by clinical nurse practitioners, who are supported by full-time medical officers and pharmacists. Patients at these services have access to radiology services. Community day centres and community health centres provide a comprehensive package of services, which includes: antenatal care; termination of pregnancy; reproductive health; chronic disease care including tuberculosis; HIV and AIDS; other curative care; mental health; oral health, rehabilitation and disability services; occupational health; casualty and maternity services (in accordance with the National Package of services). Community health centres provide 24-hour accident and emergency services and the South African Triage System (SATS) has been implemented to ensure appropriate

care and prompt referral. In addition, ten Cape Metropole CDCs/ CHCs provide a nurse-based package of services between the hours of 16h00 and 21h00 on weekdays and between 08h00 and 13h00 over weekends. Furthermore, eleven CDCs/CHCs also provide 24-hour midwife obstetric services.

Key personnel who work within provincial government PHC facilities are professional nurses (1 165), medical officers (173) and pharmacists (110). In the City of Cape Town Municipality, there are 465 professional nurses, 32 medical officers, and 12 pharmacists. Family physicians and family medicine registrars have been appointed to provide leadership and capacity building, and to ensure a high quality of care for clients.

3.1.3 **Community-based Services**

The Community-Based Services (CBS) sub-programme renders a full package of services at related institutions (namely, chronic, sub-acute and palliative care facilities) and at non-health facilities such as homes, mental health institutions, early child development (ECD) centres, prisons, old aged homes and schools. Effective functioning of community-based services is designed to reduce pressure on facility-based care, and to strengthen facility-based services by providing healthcare directly to the community, and through actively empowering the community to participate in preventive and adherence health programmes.

Community-based services focus on:

- Disease prevention and health promotion
- Adherence support
- De-hospitalised care

Through a process of formal contractual agreements, Non-Profit Organisations (NPOs) are primarily responsible for service delivery and for appointing caregivers. De-hospitalised care is provided to clients who have been discharged from acute hospitals, but require ongoing personal clinical care.

Community-based care services that are provided for de-hospitalised clients are:

- Sub-acute/step-down services – these are for clients who are ill but who do not necessarily need to be in an acute hospital.
- Respite centres – for terminal/chronic clients in care of families where a short period of respite is needed.
- Chronic or life-long care – for lifelong/long-term clients (e.g. greater than six months) (offered in one consolidated facility (Life Esidimeni).
- Home-based care – integrated community home-based care (three service delivery stream): home-based care; community adherence support and prevention/health promotion.
- Community-Mental Health centres – to assist mental health clients to live more independently in the community, and to provide services to de-hospitalised mental health clients in order to prevent hospitalisation or placement in a more restful environment.

The Department contracts 155 NPOs who employ 2 245 caregivers. The carers are required to consult a minimum of five client visits per day during their 4.5 hour working day. Palliative care

services provide care to terminally and chronically ill clients. Chronic disease management entails the dispensing of chronic medication to clients. Pre-packaging medication decreases waiting times at the Pharmacy. Furthermore, pre-packaged medications are delivered to clients through alternative supply routes in that the medication is supplied either at the health facility, or to an old age home, or registered NPO which runs community-based support groups.

3.2 DISTRICT HOSPITALS (ACUTE SERVICES)

Sub-programme 2.9 is responsible for rendering District Hospital services in the Province. The package of care provided at a district hospital includes trauma and emergency care, in-patient care, outpatient visits and paediatric and obstetric care. According to the CSP, a limited number of Level 2 services are offered at the larger district hospitals to improve access and to facilitate easy referral to Level 2 facilities. These beds are primarily for non-acute cases.

There are 34 district hospitals in the province. Nine are located within the City of Cape Town District, including the Khayelitsha and Mitchell's Plain hubs based at Tygerberg and Lentegeur hospitals, respectively. Khayelitsha and Mitchell's Plain Hospitals are currently under construction. Four previously classified regional hospitals have been re-classified as district hospitals over the last three years. 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 the 2008/09, the six provincial TB hospitals form part of Programme 2.

3.3 MATERNAL, CHILD AND WOMEN'S HEALTH (INCLUDING NUTRITION)

Nutrition is located within the budget Sub-programme 2.7. No dedicated budgets exist for MCWH as various sub programmes fund the activities. The MCWH and Nutrition programme renders services at all facilities within the province, including secondary, tertiary, specialised hospitals and within communities, including community outreach programmes.

Malnutrition is a major contributing factor to morbidity and mortality and thus the Integrated Nutrition Programme is implemented as one of the key strategies within the health programmes to decrease these rates. It focuses on the specific health needs of individuals through the stages of the human life cycle, namely: maternal; neonatal; infant and early childhood; late childhood; adolescence; adulthood and old age (geriatric). The programme links with cross cutting issues including HIV, AIDS, TB and other chronic debilitating conditions. Liaison and cooperation with other departments and programmes (e.g. Education, Social Development, Local Government) assists with prevention, implementation of health programmes; and prevention and management of women and children in order to provide holistic care.

The MCWH and Nutrition aims to:

- Prevent and reduce morbidity and mortality during pregnancy, birth, post-delivery, infancy and early childhood.
- Prevent infectious diseases through immunisation.
- Render high quality health services for maternal and child survival.

- Contribute to the institutional care of clients through access to high quality health care.
- Contribute to the improvement of nutritional status and food security.

Maternal, Child and Women's health, and Nutrition services are rendered through existing human resources at all levels of care (i.e. by doctors, nurses, dieticians, pharmacists and other healthcare workers). Improving MCWH services is a key factor in achieving MDGs 4 and 5. These include access to antenatal services, intra-partum care, postnatal care, neonatal care and child health services at all levels. Staff members are continuously up-skilled through programmes such as IMCI, infant feeding, BANC (Basic Antenatal Care) and ESMOE (Essential Steps in Management of Obstetric and Neonatal Emergencies).

3.4 HIV AND AIDS AND TUBERCULOSIS

Sub-programme 2.6 aims to render health services in respect of HIV, AIDS, STI and TB care. The Province has committed itself to a comprehensive HIV and AIDS, and TB programme that, via all relevant departments of the provincial government and all sectors of society, addresses the various aspects of the HIV and AIDS and TB dual epidemics. The provincial Cabinet has endorsed the Provincial Strategic Plan 2007–2011, which is aligned with the National Strategic Plan and provides a roadmap for increased effort and commitment to contain the spread of HIV, with ambitious targets,

The primary aims of the HIV and TB programme in the Department of Health are to:

1) Reduce the number of new HIV infections by 50%, by 2015.
2) Provide an appropriate package of treatment, care and support to 80% of all people diagnosed with HIV.
3) Implement care and support programmes for people living with HIV and AIDS.
4) Strengthen the implementation of the DOTS Strategy through the expansion and enhancement of high quality DOTS in high TB burden sub-districts and health facilities.
5) Address MDR-TB and XDR-TB to ensure the adequate treatment and management of these patients.
6) Ensure functional integration of TB and HIV activities at facility level.

The Department is committed to integrating the HIV and AIDS programme into the general health services in a manner whereby additional resources enhance the general health system as opposed to further insitutionalising the vertical HAST service delivery model. First contact ambulatory care for HIV infected clients and TB patients are provided at all community health centres and clinics, including appropriate counselling, specimen collection for laboratory testing and initiation of appropriate treatment for TB and/or opportunistic infections. Voluntary counselling and testing (VCT), male and female condoms and treatment for STI are also available at all PHC facilities in the province. Prevention of mother-to-child transmission (PMTCT) services are offered at all facilities which provide antenatal care and maternity services. Services and starter-packs for PEP are available at PHC level for those who sustain needle-stick injuries, and follow-up care and support is available at designated hospitals throughout the province.

HIV and TB services are also available at all district, regional and central hospitals for clients with complex HIV or TB disease and/or co-morbidity. Furthermore, HIV services are available at the six dedicated TB hospitals in the province. Clients who are eligible for anti-retroviral therapy (ART) are referred to specific ART sites where they undergo a readiness assessment prior to initiation of therapy. Currently, there are 66 registered ART service sites. Thirty-two multi-sectoral action teams (MSATs) ensure community mobilisation by bringing together relevant role-players (government departments, civil society organisations, local government and non-profit organisations) at a sub-district level in order to initiate local responses to the HIV epidemic. Life skills and peer education is important for ensuring 'an HIV-free generation".

Decanting of stable ART patients from Level 3 and Level 2 to PHC level is in progress. The implementation of the nurse-led, doctor supported service is monitored to ensure that the services of trained clinical nurse practitioners are retained and quality of service is maintained.

3.5 DISEASE PREVENTION INCLUDING ENVIRONMENTAL HEALTH SERVICES

Environmental Health Services (EHS), which relate to disease prevention, are primarily a Local Government function. The provincial government is responsible for providing a limited range of EHS. The responsibility of monitoring the delivery of EHS resides with the provincial government.

The monitoring of the provision of clean water and basic hygiene and sanitation services is an essential task. This function is vital for maintaining environmental health and for preventing water-related diseases such as diarrhoeal disease outbreaks, particularly in the densely populated informal settlements in the City of Cape Town District.

An Eye Care Plan has been developed to ensure that eye care screening is integrated into the DHS. District Eye Care services, which includes a high volume cataract surgery site, refraction services, low vision and community-based services provide services within the districts. In addition, to the central hospitals, Eerste River District Hospital has been identified as a high volume cataract surgery site.

4. SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2015.

1) Improving access to PHC Services in the DHS will entail increasing the number of primary health contacts by managing clients at the appropriate level, including within the community. The community-based services will be strengthened to meet the challenges of health prevention and promotion, while simultaneously providing adequate access to community-based curative and palliative interventions. The management of chronic illnesses will be optimised by improving the delivery of chronic medicines to communities whose main complaints have centered on long waiting times at facilities. In the rural areas the construction of the Hermanus, Kwanakothula and Witlokasie Community Health Centres will greatly improve access to ambulatory care. It is also envisaged that services in the Metropole will be strengthened by the construction of the Du Noon, Delft Symphony, Weltevreden Valley, Grassy Park, Asanda Village and District Six Community Day Centres.

2) Emergency services are the constitutional right of every person in South Africa. The gap in the provision of these services on the Cape Flats will be addressed in this five-year cycle with the opening of the two acute hospitals in Mitchell's Plain and Khayelitsha. This period will also see the expansion of emergency centres at Karl Bremer and Eerste River Hospitals. The emergency centres at the 24-hour community health centres will be converted to extended hours facilities when the two new hospitals are opened.

3) Key strategies have been developed to reduce both the incidence of new cases and the impact of existing cases of HIV and TB. The next five years will see an intensification of the efforts to prevent further spread of both diseases and to halve the incidence of new cases.

4) Several factors continue to impact negatively on health outcomes for young children. Poverty and deprivation are key "upstream" factors which continue to make children vulnerable to imminently preventable diseases like lower respiratory tract infections, diarrhoea and malnutrition. Despite success with the Expanded Programme of Immunization, much still needs to be done for the children of the Province. In this regard the Province will continue to strengthen the annual diarrhoeal season campaign, with a view to institutionalising the system-wide response to address all child health challenges. The PMTCT programme has contributed enormously to a systematic decline in the under-1 mortality, but efforts will be made to eradicate mother-to-child transmission of HIV. Collaborative efforts with sister provincial government departments will be strengthened to promote improved outcomes for children, particularly through the strengthening of the Early Child Development programmes of departments such as Social Development and Education.

5) Maternal morbidity and mortality have improved over the past decade as a consequence of the introduction of ARV treatment and the PMTCT programme. The recently released Confidential Report on Saving Mothers and Children, however, continues to paint a bleak picture. In this regard the Province has identified the provision of access to basic antenatal services to 80% of pregnant mothers before 20 weeks gestation as a key priority. Cervical and breast cancer programmes, and the provision of termination of pregnancy services will form the other core elements to reduce both mortality and morbidity. The Department will, in conjunction with the South African Police Services and the Department of Justice, continue to strengthen forensic clinical services with the aim of protecting women and bringing to justice those who violate women's rights through violence.

6) The funding of primary health care and district hospitals remains a challenge for the Department. The opening of acute hospitals in Mitchell's Plain and Khayelitsha will require careful allocation strategies if the Department is to remain within budget. The need to access additional funding streams has also been identified and until now has been located mainly with the area of HIV care through strategic partnerships with entities such as the Global Fund. Continuous dependence on such funding streams leaves the Department vulnerable in the longer term.

Table 2.1: Specification of strategic objectives and expected outcomes for 2010 - 2014

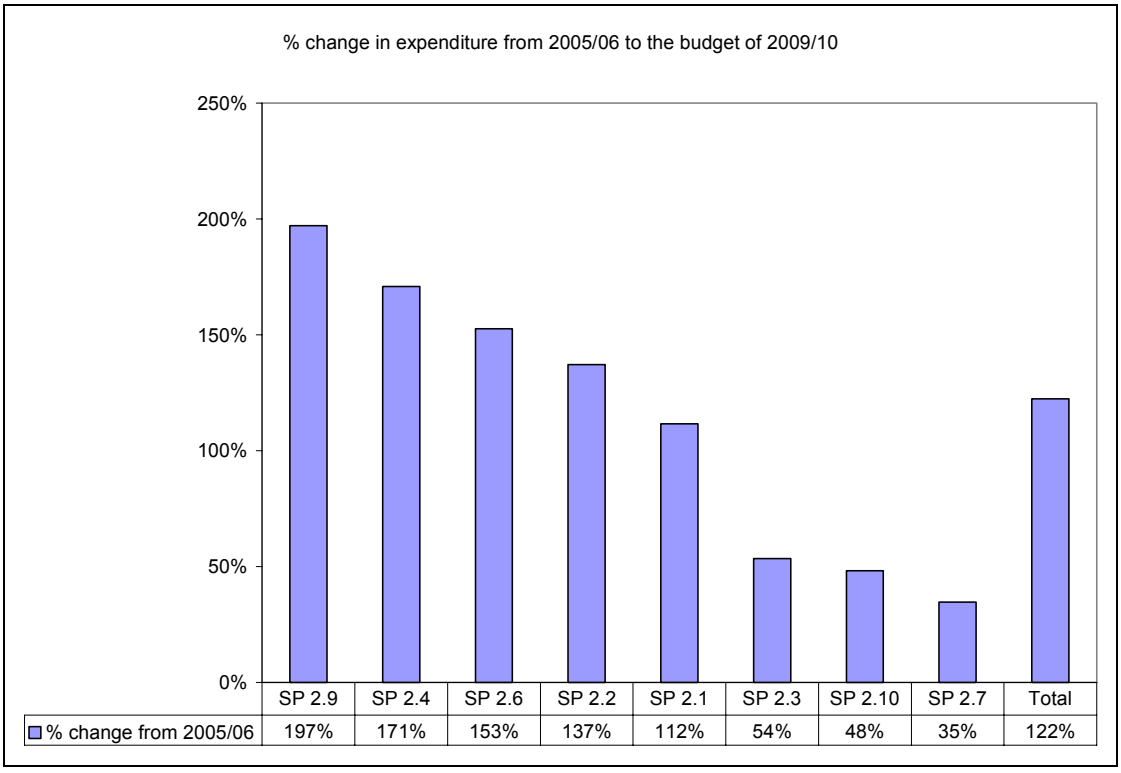
Strategic Goal	Strategic Objective	Strategic Objective Statement	Baseline	Target 2014	Justification	Links
			2009/10	2014/15		
1. Manage the burden of disease	1.1 Increase access to PHC services in the DHS in the Western Cape	1.1.1 Achieve a PHC utilisation rate of 3.84 visits per person per annum by 2014/15.	2.96 headcounts per person per annum	3.84 headcounts per person per annum	This is in line with the Comprehensive Service Plan to ensure that 90% of all first contacts are seen in the District Health System	MTSF Focus area: • Increase life expectancy • HIV and AIDS • TB caseload NDOH Ten Point Plan: • Improve quality of health services • Mass mobilistation for the better health of the people. Provincial priority: • Maximise health outcomes.
	1.2 Ensure access to acute services/district hospitals	1.2.1 Establish 2 673 acute district hospital beds in district hospitals in the DHS by 2014/15.	2 452 beds in district Hospitals	2673 beds in district hospitals the DHS	This is in line with the Service Plan to ensure that 90% of all first contacts are seen in the District Health System	
	1.3 MDG Goal 6: Have halted and begun to reverse the spread of HIV and AIDS and TB by 2015	1.3.1 Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15-24 years to 8% in 2015.	15% in 2004 (peak)	8%	This will reduce the prevalence of HIV. This is in line with the Millennium Development Goal to combat HIV and AIDS, malaria and other diseases and the National Strategic Objective to Accelerate implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases.	MDG 6 MTSF Focus area: • HIV and AIDS • TB caseload NDOH Ten Point Plan: 7: • Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases. Provincial priority: • Maximise health outcomes.
	1.4 MDG goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	1.4.1 Reduce the mortality in children under the age of 5 years to 30 per 1 000 live births by 2015.	38.8 per 1000 live births (2007)	30 per 1000 live births (1990 baseline to verified)	Children and youth are priority vulnerable groups.	MDG to reduce child mortality MTSF Focus area: • Reduce child mortality NDOH Ten Point Plan: 7: • Mass mobilisation for better health of the population. Provincial priority: Maximise health outcomes
	1.5 MDG goal 5: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	1.5.1 Reduce the maternal mortality ratio to 90 per 100 000 live births by 2015.	98 per 100 000 live births	90 per 100 000 live births (1990 baseline to verified)	Women are s priority vulnerable group	MDG to improve maternal health MTSF Focus area: • Decrease the maternal mortality ratio. NDOH Ten Point Plan: 7: • Mass mobilisation for better health of the population. Provincial priority: Maximise health outcomes

Strategic Goal	Strategic Objective	Strategic Objective Statement	Baseline 2009/10	Target 2014 2014/15	Justification	Links
2. Ensure a sustainable income to provide the required District Health Services	2.1 Allocate sufficient funds to ensure access to and the sustained delivery of the full package of quality PHC Services by 2014.	2.1.1 Achieve a primary health care (PHC) expenditure of R950 per uninsured person by 2015 (in 2008/09 rands).	R850	R950	Allocation of sufficient funds is required to ensure the delivery of the full package of PHC services.	MTSF Focus area: • Health system effectiveness Provincial priority: • Maximising health outcomes. Department: • Aligned with the CSP.
	2.2 Allocate sufficient funds to ensure access to and the sustained delivery of the full package of quality District Hospital Services by 2014	2.2.1 Achieve a provincial district hospital expenditure of R365 per uninsured person by 2015 (in 2008/09 rands).	R271	R365	Allocation of sufficient funds is required to ensure the delivery of the full package of DH services.	
3. Ensure quality assurance	3.1 Improve clinical governance in all six districts by employing Family Medicine Specialists and Family Medicine Registrars.	3.1.1 Employ 37 Family Medicine Specialists and 80 Family Medicine Registrars to work within the district health system.	16 Family Physicians and 50 Registrars	37 Family Physicians and 80 Registrars	Continuous improvement in the quality of care provided on the DHS platform.	MTSF Focus area: • Health system effectiveness NDOH Ten Point Plan, 3: • Improve the quality of health services Provincial priority: • Maximising health outcomes. Department: Aligned with the CSP.

5. RESOURCE CONSIDERATIONS

5.1 EXPENDITURE TRENDS IN THE DHS PROGRAMME DURING THE MTEF PERIOD 2007/08-2009/10

Figure 2.1: Expenditure trends in the DHS programme during the MTEF period 2007/08 - 2009/10



In summary, the total nominal budget for Programme 2, excluding coroner services and nutrition, has increased by 115%. Coroner services have been moved to Sub Programme 7.4 and nutrition funding has been mainstreamed into primary health care funding in Sub-programme 2.2 and 2.3.

The largest increase in funding in Programme 2 has been in district hospitals with an increase of almost 200%. This is due to an increase in district hospital beds as a result of a change in the status of previous regional hospitals (GF Jooste, Helderberg and Karl Bremer Hospitals) to district hospitals in the financial year 2007/08 and Victoria Hospital in financial year 2009/10. This has resulted in an increase in district hospital beds from 1 546 in 2005/06 to 2 312 in 2008/09.

5.2 UNFUNDED PRIORITIES

5.2.1 Service delivery expansion

- The funding for the full commissioning of Khayelitsha and Mitchells Plain hospitals in 2012 will challenge the equitable share allocation in year 3 of the current MTEF cycle.
- The funding for the commissioning of new PHC facilities in Du Noon, Delft Symphony and Weltevreden Valley over the MTEF period will need to be secured.

5.2.2 **De-hospitalised care**

- An additional ninety beds for sub-acute care for the city of Cape Town District is estimated to cost about R12 million per year.
- Existing DHS community mental health services need to be maintained but an increase in the NPO subsidy is required.

5.2.3 **HIV and AIDS, and Tuberculosis**

- Dependant on the national policy that determines which patients, and at what CD4 count level they commence treatment, there is a potentially a significant shortfall in funding.
- The enhanced TB programme is to be expanded to beyond eleven sub-districts to all thirty-two sub-districts to ensure a cure rate of 85% and to minimize the incidence of MDR/XDR TB that is estimated to cost R42 million additional per year.
- Ninety beds are required for the provincial implementation of capacity building initiatives for Brooklyn Chest Hospital and rural TB hospitals:
  - R16 million is required for the commissioning of an additional 90 beds
  - Systematic implementation towards the Comprehensive Service Plan's organisational development structure requires about R12 million.
  - Community-based MDR TB pilot in Khayelitsha sub-district needs to be consolidated, with a view of roll-out to other sub-districts.
  - Implementation of infection control measures to cover all hospitals in the province.

6. RISK MANAGEMENT

6.1 Financial constraints and unfunded mandates, as discussed above, are major risks. The Department is in the process of submitting a proposal to the Global Fund for continued funding for the HIV programme. If successful, funding for an additional six years will be secured. PEPFAR funded agencies have also given an undertaking to continue providing donations in kind to alleviate pressures in the ART and TB services. In addition a Global Fund round 10 submission for TB in 2010, is being prepared.

6.2 Funding for the full commissioning of Khayelitsha and Mitchells Plain district hospitals at the completion of the construction of these facilities remain uncertain.

6.3 PHC Infrastructure requiring upgrade and maintenance is another risk. Many of the PHC facilities taken over from rural municipalities during the PHC assumption of responsibility process were poorly maintained. The current Global Fund grant has enabled the province to undertake substantial renovation at PHC facilities for the provision of ART services. In many instances, the renovation has also included a general up-grade and improvement of the facility as a whole. If the Global Fund grant application is successful, further renovations will be undertaken at PHC level. Other more general risks include under-spending on capital assets, theft, misuse and loss of assets.

6.4 The availability of sufficient and competent clinical, support and management staff is a risk at all levels in the district health system. Training plans in human resource development, clinical governance and peer review processes are in the process of being developed. The province has contracted the services of the Knowledge Translation Unit (KTU) at the University of Cape Town to train nurses to take over the management of stable HIV and AIDS clients on ART, using the

Streamlining Tasks and Roles to Expand Treatment and Care for HIV (STRETCH) model, which builds on PALSA Plus training - a flip-chart guide plus a package of training focusing on lung health (TB and asthma) and HIV/ART. Other risks are inadequate occupational health services to staff and abuse of sick leave.

6.5 Other service-specific risks are missed opportunities for cervical cancer detection, inadequate management of medical supplies and drugs from suppliers to end users, the acquisition of appropriate equipment in accordance with standardized list (e.g. information technology and office equipment), inconsistent maintenance of cold chain management, and inadequate infection control at health facilities.

6.6 The outbreak of infectious diseases (e.g. H1N1) and the prevention and management thereof has been identified as another major risk.

7. CONCLUSION

District Health Services and Programmes aims to strengthen the District Health System and act as a vehicle to provide Primary Health Care services. It provides a range of services in the community and within health facilities to ensure that pressure on acute services is alleviated and that patients have services closest to their homes. In addition, access to acute inpatient services in district hospitals will also be strengthened such that they can oversee clinical governance and provide outreach and support to the PHC platform in a “hub and spoke” type configuration (the district hospital being a hub and the surrounding PHC facilities being the spokes). These structures will be supported by a District Management Team with the aim of supporting the improvement of the quality of care on the DHS platform. In addition to strengthening the system, as mentioned above, there will be the strengthening of programmes to ensure that maternal, woman and child mortality and morbidity is reduced; and that the burdens of HIV/AIDS and TB and other chronic diseases are also reduced.

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

1. PROGRAMME PURPOSE

The rendering of pre-hospital Emergency Medical Services including inter-hospital transfers, and Planned Patient Transport.

The clinical governance and co-ordination of Emergency Medicine within the Provincial Health Department.

The co-ordination for the Department of Health of preparation for the FIFA 2010 World Cup Soccer Tournament.

1.1. EMERGENCY MEDICAL SERVICES' VISION FOR 2009-2014

"To be the leading Emergency Medical Service through quality patient care"

1.2. EMERGENCY MEDICAL SERVICES MISSION STATEMENT FOR 2009 - 2014

"Our Mission is to respond to the Constitutional imperative of the universal individual right of:

- Access to emergency care, through the delivery of a comprehensive well co-ordinated EMS system consisting of:
  - Communication Services
  - Ambulance Services
  - Rescue Services
  - Aeromedical Services
  - Patient Transport Services and
  - Emergency Centers
- Staffed by passionate, performance focused, proficient personnel using cutting edge technology solutions in a culture of:
  - Compassion
  - Diligence
  - Integrity
  - Honesty
  - Accountability
  - Respect And Dignity
- With the best possible patient outcomes.

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 3.1: EMERGENCY MEDICAL SERVICES

Rendering Emergency Medical Services including ambulance services, special operations, communications and air ambulance services.

Emergency Medicine and the FIFA 2010 World Cup are reflected as two separate objectives within Sub-programme 3.1: Emergency Medical Services

2.2 SUB-PROGRAMME 3.2: PLANNED PATIENT TRANSPORT (PPT) - HEALTHNET

Rendering 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).

2.3 OVERVIEW OF EMERGENCY MEDICAL SERVICES

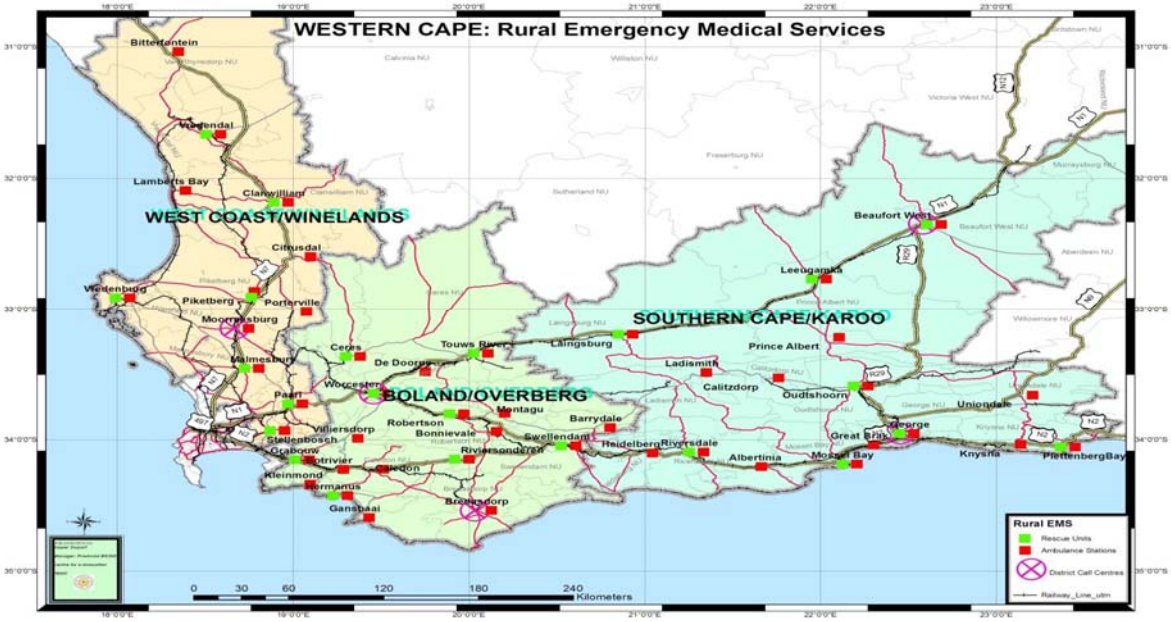
Emergency Medical Services in the Western Cape is managed transversally across the Province as a single institution with its own financial and human resource administration and with services delivered through three arms of EMS Operations, EMS Support Services and Emergency Medicine.

Emergency Medical Services Operations delivers ambulance, rescue and patient transport services from fifty stations in five rural district EMS services and four Cape Town divisional EMS services with a fleet of 250 ambulances and 1 334 operational personnel and 122 supervisors (officers).

Emergency Medical Services Support Services include the Air Mercy Service which provides for the transfer of acutely ill or injured patients into referral hospitals, the Fleet Management Services which ensures the provision of an operational vehicle fleet, the Information Communication Technology Services which provides contact centre access to public patients and the communication systems necessary to communicate with mobile and fixed EMS resources and deliver management information on service performance, the Special Event Services which provide cover to thousands of community events every year and the Facility Management Services which coordinate the delivery and maintenance of EMS buildings throughout the Province.

Emergency Medicine provides for the clinical governance and co-ordination of Emergency Medicine within Emergency Centres and EMS across the Province. Emergency Medicine also supports the undergraduate and post graduate training in Emergency Medicine at the Universities of Cape Town and Stellenbosch.

Figure 3.1: Map illustrating the location of rural EMS services



2.4 OVERVIEW OF PLANNED PATIENT TRANSPORT (PPT) - HEALTHNET

Patient Transport Services are delivered with 82 vehicles and 90 drivers that drive specified transport routes into referral hospitals. Patients are transported both to and from ambulatory care appointments passing through hubs at District Centres and in the Cape Town where patients transition to designated routes and vehicles.

3. SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010 - 2014

Table 3.1: Specification of strategic objectives and expected outcomes for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
1. Manage the burden of disease	1.1 Integration of quality assurance into all levels of care	1.1.1 To improve quality and decrease adverse patient incidents to 10 per annum by the institution of staff surveys, patient surveys, adverse incident reporting and a quality management structure by 2014.	1) Number of adverse incidents per annum	>20	10	Quality patient care is a fundamental outcome of the service and quality improvement can only be effected if quality measurement is in place.	**NDOH Ten Point Plan** • Improving the Quality of Health Services
	1.2 Fully implement the Comprehensive Service Plan model by 2014.	1.1.2 To complete the implementation of the Comprehensive Service Plan by operationalizing the EMRS resources (542 vehicles, 54 bases and 2366 personnel) necessary to the specified service levels of 156 rostered ambulances per hour in the CSP by 2014.	2) Number of rostered ambulances	126	156	Service levels specified in the CSP can only be met by the implementation of the full resource complement.	**NDOH Ten Point Plan** • Overhauling the Healthcare System and improve its management
	1.3 Manage all patients at the appropriate level of care within the appropriate packages of care	1.1.3 To meet the patient response, transport and inter hospital referral needs of the Department in line with the 90:10 CSP Model by realigning the configuration (proportion of emergency versus non emergency resources) of the EMRS Service by 2014.	3) Percentage of ambulance patients transfer facilities	34%	10%	In order to support service levels of the CSP patients must be managed at the appropriate level of care and have access to required levels of care.	**NDOH Ten Point Plan** • Overhauling the Healthcare System and improve its management
	1.4 Efficiently and effectively manage chronic diseases.	1.1.4 To meet the APPROPRIATE outpatient transfer needs of 10 000 patients through the intra-district and trans-district HealthNET Transport System ensuring that patients are managed at the appropriate level of care by 2014.	4) Number of patients transferred to tertiary level hospitals per annum.	36000	10000	All clients must have access to appropriate levels of care and be assured of access in appropriate time frames.	**NDOH Ten Point Plan** • Overhauling the Healthcare System and improve its management
	1.5 Provide roadside to bedside definitive emergency care within defined emergency time frames within and across geographic and clinical service platforms.	1.1.5 To meet the response time performance for urban (90% P1 Within 15 Min) and rural (90% P1 within 40 min) clients and ensure the shortest time to definitive care by integrated management of pre-hospital and hospital emergency care resources by 2014.	5) Percentage of urban Priority 1 responses within 15 minutes	45%	90%	Emergency Care is a Constitutional and legal imperative.	**Millenium Development Goals** • Reduce Child Mortality • Improve Maternal Health • Emergency Care is a Constitutional and legal imperative **Provincial priority:** • Maximise health outcomes
			6) Percentage of rural Priority 1 responses within 40 minutes	80%	90%		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
	1.6 Institute Trauma and Violence Prevention Programs	1.1.6 To initiate a trauma and violence prevention program in Cape Town and each of the five rural Districts by 2014.	7) Number of prevention programs initiated.	0	6	Trauma and violence is the greatest proportion of disease burden and cost in the Western Cape	
2. Ensure and maintain organizational strategic management capacity and synergy	2.1 Develop integrated support and management structures to render effective clinical service.	2.1.1 To ensure the integrated management of emergency clients through competent EMRS and Support Managers and the institution of 5 geographic cooperative emergency care management structures by 2014.	8) Number of Emergency Medicine Specialist led cooperative geographic structures operational out of 5 geographic areas	2	5	Competent and effective management is fundamental to effective and efficient delivery of services	**NDOH Ten Point Plan** • Overhauling the Healthcare System and improve its management • Improvement of Human Resources • Provision of Strategic Leadership and the creation of Social Compact for better Health outcomes
		2.1.2 To achieve a qualification of Certificate in Management for 100 shift and station managers by 2014.	9) Number of supervisors with a certificate in management.	0	100	Management and Supervisory Capacity is fundamental to the coordination of the dispersed EMS resources	
		2.1.3 To achieve an HRM Clerk, Finance Clerk, Reception Clerk, Information Clerk and Admin clerk in each of 9 District/Divisional structures by 2014.	10) Number of support clerks appointed out of 36.	9	36	Administrative support of EMS structures is fundamental to administrative process.	
	2.3 Ensure efficient and cost effective procurement	2.1.4 To complete the institution of EMRS Supply Chain Management structures and systems (LOGIS, personnel, administration, training) necessary to the continuous supply and maintenance of EMRS equipment by 2014.	11) Number of districts that can electronically requisition goods and services.	0	6	An efficient Supply Chain in support of clinical services is essential. Audit and control is facilitated by SCM Systems.	
3. Develop and maintain a capacitated workforce to deliver the required health services.	3.1 Implement the Human Resource Plan	3.1.1 To recruit, train and deploy all 2366 staff necessary to achieving service levels in the CSP by 2014.	12) The percentage of CSP personnel out of 2366 Appointed	73%	100%	People make up 68% of expenditure in EMRS and quality of care depends on motivated personnel. Performance targets can only be achieved by appropriate staffing levels.	**NDOH Ten Point Plan** • Improvement of Human Resources
	3.2 Become the employer of choice in the health sector by creating an environment for a satisfied workforce.	3.1.2 To develop a positive attitude and motivation in 80% of operational staff by instituting the good quality facilities, squad system, providing squad leadership, quality uniforms, training and development, quality equipment and vehicles, acknowledgement and rewards by 2014.	13) Percentage of personnel surveyed with a positive attitude and motivation.	0	80%	Salaries and the working environment are important to the retention of staff.	**NDOH Ten Point Plan** • Improvement of Human Resources
		3.1.3 To imbed an Occupational Health and Safety Structure in EMS with a dedicated OHS Officer in each of the 9 Districts/Divisions by 2014.	14) Number of OHS Officers appointed	0	9	Safety is the First Rule of Emergency Response	

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
4. Provide and maintain appropriate health technology and infrastructure.	4.1 To provide responsive and appropriate information technology for the Department	4.1.1 To institute a comprehensive Information Communication Technology Solution for EMRS in Cape Town and the Five Rural Districts integrated with Hospital Emergency Centers to provide reliable, real time and accurate data in order to meet target emergency care outcomes (response times) by 2014.	15) Number of districts out of six with fully functional ICT solution.	0	6	Management information is essential to inform changes to improve efficiency and effectiveness	**NDOH Ten Point Plan** • Research and Development
5. Ensure a sustainable income to provide the required health services according to the needs	5.1 Augment the funding streams for health services	5.1.1 To institute 6 sponsorship, branding and business relationships that provide additional funding streams for EMRS in order to achieve quality service levels by 2014.	16) Number of projects delivering sponsorship.	0	6	Current levels of equitable share funding do not meet the needs of the CSP and therefore collateral income streams are required.	**NDOH Ten Point Plan** • Improving the Quality of Health Services.

4. RESOURCE CONSIDERATIONS

The MTEF funding for EMS is not projected to expand beyond inflation and the realization of the EMRS CSP Service levels cannot be achieved without additional funding. Inflation for specific elements of EMS (Air Mercy Service) occurs at a rate of 35-40% because costs are Euro linked in respect of maintenance of aircraft costs.

Emergency Medical Services currently has 40% of the managers and 73% of the personnel required in terms of the Comprehensive Service Plan of which 9% are advanced life support [ALS], 39% intermediate life support [ILS] and 52% basic life support [BLS]. There is clearly a large supervisory gap in EMS. The CSP is not fully funded and therefore service targets are not possible without augmented funding. At current Rand values EMS is R173 million short in terms of a personnel budget relative to the CSP establishment.

Efficient co-ordination of EMS resources is dependent on an effective Information Communication Technology solution which enables quick patent access and prompt ambulance dispatch. The cost of the complete EMS ICT solution is yet to be determined and specific funding for this purpose is not allocated in the MTEF.

Emergency Medical Services is unlikely to realize five year strategic goals without funding first for the ICT solution and secondly to expand its personnel complement.

5. RISK MANAGEMENT

Table 3.2: Risks and mitigating steps

Risk	Description	Mitigation
1. Information Communication Technology Solution	The efficiency and effectiveness of EMS depends on its ability to receive and locate emergency calls and dispatch and control resources in response. The failure to realize this system will prevent EMS from achieving service targets.	A definitive costing of the necessary system is unavailable at this time and funds have not been specifically earmarked for this function. A business process description and user specification is currently being developed in order to scope the total system requirement and costs for EMS. The ICT Solution is a key enabler for EMS performance and it is anticipated that costs will be beyond affordability within the current budget. Cooperation with National, Provincial and Local Government agencies to derive collaborative and cooperative efficiency will continue.
2. Personnel Migration	There is a real threat that the current proposed OSD for EMS personnel will cause the migration of trained staff at higher skilled levels into the private sector and global market. College based training will also be threatened by the implementation of the OSD. The stressful emergency response environment is also a threat to retaining personnel.	EMS will try to create a flexible staff retention strategy by allowing periods of unpaid leave for personnel to sample the private or global EMS experience while being able to return easily into the public service. Efforts will be made to improve the working environment.
3. Vehicle Costs	Vehicle capital costs and running costs are accelerating at a greater rate than inflation. Varying fuel costs create uncertainty. The high rate of vehicle accidents adds to the cost burden.	EMS has through GMT instituted a vehicle tracking and monitoring system which will be used to dynamically monitor the fleet in real time and positively influence driver behaviour to reduce accidents and damage to the vehicle and engine.
4. Service Demand	Service demand is increasing at a rate of 10% and more because of migration into the Western Cape.	Greater emphasis will be placed on injury and illness prevention in order to reduce the burden of disease and service demand. Cooperation with the private sector will be expanded. Efficiency gains will be driven by improvements in Information Communication Technology.

PROGRAMME 4: PROVINCIAL HOSPITALS

1. PROGRAMME PURPOSE

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

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 4.1: GENERAL (REGIONAL) HOSPITALS

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

2.2 SUB-PROGRAMME 4.2: TUBERCULOSIS HOSPITALS

To provide for the hospitalisation of acutely ill and complex TB patients (including MDR and XDR TB.)

2.3 SUB-PROGRAMME 4.3: PSYCHIATRIC 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 research.

2.4 SUB-PROGRAMME 4.4: REHABILITATION SERVICES

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

2.5 SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

Rendering an affordable and comprehensive oral health service for complicated dental patients and provide a platform for training and research.

3. STRATEGIC DIRECTION OF THE PROGRAMME

Programme 4 remains focused on developing and maintaining a high quality, efficient and equitable health system that is accessible to the population of the Western Cape.

Access to services and service delivery excellence are the key components of the broader goal of the Department to ensure quality health for all.

This programme is committed to reducing the impact of the burden of disease.

3.1 INSTITUTIONS RESPONSIBLE FOR SERVICE DELIVERY:

3.1.1 Sub-Programme 4.1 (Regional Hospitals)

1) George Hospital
2) Worcester Hospital
3) Paarl Hospital
4) New Somerset Hospital
5) Mowbray Maternity Hospital
6) Groote Schuur Hospital (Level 2)
7) Tygerberg Hospital (Level 2)
8) Red Cross War Memorial Children's Hospital (Level 2)

3.1.2 Sub-Programme 4.2 (TB Hospitals)

1) Brooklyn Chest Hospital
2) DP Marais Hospital
3) Malmesbury TB Hospital
4) Paarl TB Hospital
5) Brewelskloof Hospital
6) Harry Comay Hospital

3.1.3 Sub-Programme 4.3 (Psychiatric Hospitals)

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

3.1.4 Sub-programme 4.4 (Rehabilitation Services)

1) Western Cape Rehabilitation Centre
2) Orthotic and Prosthetic Centre

3.1.5 Sub-Programme 4.5 (Dental training hospitals)

1) Dental Schools

3.2 STRATEGIC GOALS FOR SERVICE DELIVERY

The priorities for the next five years are addressed in an integrated approach to service delivery across the health platform. The Programme 4 strategies are categorized in terms of the strategic goals of the Department:

1) Manage the burden of disease
2) Ensure and maintain organizational strategic management capacity and synergy
3) Develop and maintain a capacitated workforce to deliver the required health services
4) Provide and maintain appropriate health technology and infrastructure
5) Ensure a sustainable income to provide the required health services according to the needs

4. SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2014.

Table 4.1: Strategic objectives and expected outcomes for regional hospitals for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline Measure	2009/10	2014/15	Justification	Links
1. M**anage the burden of disease**.	1.1 Ensure access to general specialist hospital services.	1.1.1 Ensure access to regional hospital services by providing 2 384 regional hospital beds by 2014. [Sub-programme 4.1]	1) Number of regional hospital beds.	2 362	2 384	• Escalating burden of disease and the increased acuity of patients caused by HIV and TB. • Improve the Western Cape's population health status. Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care. • Ensure progress is made towards providing the complete package of care within regional hospitals, thus increasing access to services. • Provision of outreach and support to District Health Services, especially district hospitals.	National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Maximising health outcomes Departmental priority: Comprehensive Service Plan
		1.1.2 Ensure access to the full package of TB hospital services by providing 1 284 TB hospital beds by 2014. [Sub-programme 4.2]	2) Number of TB hospital beds.	1 020	1 284	• Increase access to TB beds in view of XDR/MDR fuelled by HIV causing acuity of TB patients to increase. • Improve the Western Cape's population health status. • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care, • Ensure that the complete package of care within hospitals are provided, thus increasing access to services. • Provision of outreach and support.	
		1.1.3 Ensure access to the full package of psychiatric hospital services by providing 1 528 psychiatric hospital beds by 2014. [Sub-programme 4.3]	3) Number of psychiatric hospital beds.	1 745	1 528	• Increase in mental illness globally and locally especially with co morbidity of substances. Pressure on access to acute beds to be increased. • Improve the Western Cape's population health status. • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care. • Ensure that the complete package of care within hospitals are provided, thus increasing access to services. • Provision of outreach and support. • Continue the de-institutionalisation of chronic patients. • Sub-acute beds to be shifted away from Programme 4 during the MTEF period.	

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline Measure	2009/10	2014/15	Justification	Links
		1.1.4 Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014. [Sub-programme 4.4]	4) Number of rehabilitation hospital beds.	156	156	• Prevalence of disability has increased with a need to find innovative ways to increase access at general services • Improve the Western Cape's population health status • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care • Ensure that the complete package of care within hospitals are provided • Provision of outreach and support	
		1.1.5 Ensure access to an integrated oral health service and training platform by providing for 185 454 patient visits per annum by 2014. [Sub-programme 4.5]	5) Number of oral health patient visits per annum.	179 120	185 454	• Increase patient access to dental services. • Improve the Western Cape's population health status. • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care.	
	1.2 Reduce maternal mortality	1.2.1 Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies.	6) Caesareans section rate for regional hospitals (Number of Caesarean sections/ Deliveries)	35%	35%	• Ensure an improved health outcome for mothers and babies.	Millennium development goal 5 (MDG): Improve maternal health National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Maximising health outcomes
	1.3 Provide roadside to bedside definitive emergency care	1.3.1 Improve access to emergency services and improving the quality of care and the interface between the emergency services and the admitting hospital	7) Casualty/ Emergency Trauma headcount	296 716	312 332	• Ensure compliance with the Acute Emergency Case Load Management Policy (AECLM) with specific focus on bed management improving the throughput in the emergency centres to definite care. • Emergency care is a national constitutional provision and therefore has to be prioritised.	National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Maximising health outcomes

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline Measure	2009/10	2014/15	Justification	Links
	1.4 Improve quality of care at all levels of care	1.4.1 Implement and maintain quality assurance measures in regional and specialist hospitals to minimize patient risk by performing monthly mortality and morbidity meetings to monitor the quality of hospital services as reflected in the acuity of diseases, adverse events and proportion of deaths for the reporting period.	8) Case fatality rate in regional hospitals for surgery separations (Number of surgical separations/ Number of surgical deaths)	3.9%	3.5%	Ensure the maintenance and constant improvement of the quality of health services by: • The appropriate care and treatment to patients. • Correct clinical outcomes are achieved, complications are minimized and protocols are enhanced for preventable events. • Treatment of patients with dignity and respect. • Creating an environment conducive to patient safety. • Assess how our patients experience the health services and improve on complaints/ consider their suggestions.	National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Maximising health outcomes
		1.4.2 Perform and analyze one standardized patient satisfaction survey per annum to measure patient satisfaction in the General, TB, Psychiatric, Specialized Rehabilitation and Dental Hospitals.	9) Percentage of regional hospitals with patient satisfaction survey using DOH template.	100%	100% (8/8)	Systematically assess patient risk through an institutionalised process of regular mortality and morbidity meetings	National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Maximising health outcomes
			10) Percentage of TB hospitals with patient satisfaction survey using DOH template.	100%	100% (6/6)		
			11) Percentage of Psychiatric hospitals with patient satisfaction survey using DOH template.	100%	100% (4/4)		
			12) Percentage of Rehabilitation hospitals with patient satisfaction survey using DOH template.	100%	100% (1/1)		
		1.4.3 Implement quality assurance measures to minimize patients risk in the Regional, TB, Psychiatric, Specialized Rehabilitation and Dental Hospitals by monthly mortality and morbidity meetings.	13) Percentage of regional hospitals with mortality and morbidity meetings every month.	100%	100% (8/8)		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline Measure	2009/10	2014/15	Justification	Links
			14) Percentage of TB hospitals with mortality and morbidity meetings every month.	100%	100% (6/6)		
			15) Percentage of psychiatric hospitals with mortality and morbidity meetings every month	100%	100% (4/4)		
			16) Percentage of rehabilitation hospitals with mortality and morbidity meetings every month.	100%	100% (1/1)		
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1 Allocate sufficient funds to ensure the sustained delivery of quality general specialist hospital services.	2.1.1 Allocate sufficient funds to ensure the effective and efficient delivery of regional hospital services at a rate of R2 629 per PDE [Constant 2008/09 rand]	17) Expenditure per PDE in regional hospitals.	R1 653	R2 629	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Maximising health outcomes
		2.1.2 Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R750 per PDE. [Constant 2008/09 rand]	18) Expenditure per PDE in TB hospitals.	R 509	R 750	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	
		2.1.3 Allocate sufficient funds to ensure the effective and efficient delivery of the full package of psychiatric hospital services at a rate of R977 per PDE. [Constant 2008/09 rand]	19) Expenditure per PDE in psychiatry hospitals.	R 667	R 977	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	
		2.1.4 Allocate sufficient funds to ensure the effective and efficient delivery of the full package of rehabilitation hospital services at a rate of R1 667 per PDE. [Constant 2008/09 rand]	20) Expenditure per PDE in rehabilitation hospitals.	R1 193	R1 667	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	
		2.1.5 Allocate sufficient funds to ensure the effective and efficient delivery of integrated oral health services at a rate of R23.64 per uninsured person. [Constant 2008/09 rands]	21) Allocation per capita.[uninsured]	R19.79	R23.64	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Maximising health outcomes

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline Measure	2009/10	2014/15	Justification	Links
3. Develop and maintain a capacitated workforce to deliver the required health services.	3.1 Become the employer of choice in the health sector by creating an environment for a satisfied workforce	3.1.1 Perform and analyze one annual standardized staff satisfaction survey to measure workforce satisfaction in the General, TB, Psychiatric, Specialized Rehabilitation and Dental Hospitals.	22) Percentage of regional hospitals with annual staff satisfaction survey completed.	100%	100% (8/8)	• Ensure workforce capacity across the platform to provide the planned services as reflected in the package of care • A satisfied and motivated staff compliment at all facilities will enhance quality of patient care	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. • Improve human resources Provincial priority: Maximising health outcomes
			23) Percentage of TB hospitals with annual staff satisfaction survey completed.	100%	100% (6/6)		
			24) Percentage of psychiatric hospitals with annual staff satisfaction survey completed.	100%	100% (4/4)		
			25) Percentage of rehabilitation hospitals with annual staff satisfaction survey completed.	100%	100% (1/1)		
		3.1.2 Ensure optimum staffing levels for all facilities by ensuring that 97.5% of affordable staff establishment remains filled.	26) The percentage of regional hospitals that have 97.5% of affordable staff establishment filled.		100% (8/8)		
			27) The percentage of TB hospitals that have 97.5% of affordable staff establishment filled.	Not reported	100% (6/6)		
			28) The percentage of psychiatric hospitals that have 97.5% of affordable staff establishment filled.	Not reported	100% (4/4)		
			29) The percentage of rehabilitation hospitals that have 97.5% of affordable staff establishment filled.	Not reported	100% (1/1)		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline Measure	2009/10	2014/15	Justification	Links
4. Ensure and maintain organisational strategic management capacity and synergy.	4.1 Ensure that management provides sustained support and strategic direction in the delivery of health services: - • By the development of annual performance plans that align and integrates the Departmental objectives • With well defined efficiency targets. • Create structures across levels of care to ensure organizational synergy.	4.1.1 Efficiently manage the allocated resources of regional hospitals to achieve a target bed utilisation rate of 85% and an average length of stay of 4 days.	30) Bed utilisation rate in regional hospitals.	85%	85%	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence. • Minimize patient transfers between institutions.	
			31) Average length of stay in regional hospitals.	4 days	4 days	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Maximising health outcomes
		4.1.2 Establish functional business units within provincial hospitals as a key supportive structure in ensuring that resources are adequately utilised within cost centres.	32) Number of hospitals with fully Functional Business Units.	Not reported	5	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Maximising health outcomes Departmental policy
		4.1.3 Efficiently manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 85 days.	33) Bed utilisation rate in TB hospitals.	78%	90%	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence • Minimize patient transfers between institutions	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Maximising health outcomes
			34) Average length of stay in TB hospitals.	86 days	85 days	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline Measure	2009/10	2014/15	Justification	Links
		4.1.4 Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 85% and an average length of stay of 110 days.	35) Bed utilisation rate in psychiatric hospitals.	86%	85%	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence • Minimize patient transfers between institutions	
			36) Average length of stay in psychiatric hospitals.	115 days	90 days	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	
		4.1.5 Efficiently manage the allocated resources of rehabilitation hospitals to achieve a bed utilisation rate of 85% and an average length of stay of 50 days.	37) Bed utilisation rate in rehabilitation hospitals.	85%	85%	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence • Minimize patient transfers between institutions	
			38) Average length of stay in rehabilitation hospitals.	52 days	50 days	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	
5. Provide and maintain appropriate health technology and infrastructure	5.1 Ensure the provision of infrastructure that meets the needs of current and future development	5.1.1 Ensure the establishment of PCU's at all institutions	39) Percentage of hospitals with PCU's 4.1 (5/5); 4.2 (6/6); 4.3 (4/4); 4.4 (1/1)	Not reported	100%	Ensure that health infrastructure is appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Maximising health outcomes~~;~~
		5.1.2 Ensure 5 year plan per institution	40) Percentage of hospitals with 5 year infrastructure plan 4.1 (5/5); 4.2 (6/6); 4.3 (4/4); 4.4 (1/1)	Not reported	100%	Ensure that health infrastructure is appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	

5. RESOURCE CONSIDERATIONS

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.

Strengthening the hospital information systems is vital, as reliable information will assist managers in setting priorities and ensuring effective and efficient service delivery.

5.1 EXPENDITURE TRENDS:

5.1.1 Personnel

Personnel expenditure has increased significantly and the impact of OSD for nurses, clinicians and other categories of staff is evident in the budget shortfall. It is envisaged that the impact of OSD will ensure staff retention and a reduction in agency staff.

Each institution has an approved post list, which is managed through the Establishment Control Committee of the Chief Directorate within the Programme.

5.1.2 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.

Agency expenditure remains high and all efforts are made to appoint staff permanently. There is a serious commitment to reduce the use of agencies in certain staff categories in a phased manner.

Table 4.2: Budget 2009/10 including Level 2 services in central hospitals

Sub-Program	Percentage of total budget	Personnel	Non-personnel
4.1	70.3%	64%	36%
4.2	6%	59%	41%
4.3	16.4%	84%	16%
4.4	4.3%	48%	52%
4.5	3%	79%	21%
Total	**100%**	**67%**	**33%**

5.1.3 Future considerations

The following objectives have not been taken into account in the budget resource allocations:

- Relocation/ upgrading the current Orthotic and Prosthetic Centre/ Investigate the possible outsourcing of certain areas within the service
- Service expansions
- Aligning staff establishments towards the Comprehensive Service Plan
- Maintenance funding for revitalization hospitals

6. RISK MANAGEMENT

6.1 FINANCIAL MANAGEMENT

The Program will face a tight financial future. Implementation of key priorities will be confined to the funding envelope. The service demands continue to grow with the increasing population, escalating burden of disease and challenging socio-economic conditions. The cost of service provision is also escalating as the cost of labour, utilities and basic goods and service inputs required to provide an adequate health service increases. Inadequate increases in funding will constrain the ability of the Department to meet the objectives in the Strategic Plan as well as the Annual Performance Plan.

The increasing financial reporting frameworks have placed an administrative burden on the current staff with an increasing risk of errors and data inaccuracies.

The Department will continue to campaign for increased allocations at national and provincial levels to enable it to provide an adequate health service. A more rigorous process to set priorities will be embarked upon. Cost containment strategies need to be institutionalised as the demand for health services is always greater than the available resources. Expenditure reports must be tabled frequently with a clear analysis, understanding and monitoring of the cost drivers.

The Department will strengthen the financial, supply chain and human resource components within the institutions to better manage the administration of resources.

Contract management will be improved to ensure that the output specifications are adhered to by service providers

Asset management will be strengthened to prevent the loss of assets.

6.2 HUMAN RESOURCE MANAGEMENT

Maintenance of an approved post list per institution and filling of posts must be fast tracked, thus decreasing the impact of the current staff turnover. Improving the work environment especially with modernised infrastructure and the acquisition of newly developed medical equipment will help to retain clinical staff.

Improving human resource management and focussing on decreasing the staff absenteeism, especially in areas that are directly patient related.

Training and development programmes must be geared towards strengthening the workforce in areas that are understaffed. The unavailability of special skills will be addressed through the numbers trained and it is envisaged that the occupation specific dispensations will impact positively in retaining special skills.

6.3 IMPROVING QUALITY OF CARE

The escalating workload within a resource constrained environment increases the risk of compromised quality of care. This could lead to an increase in adverse incidents, nosocomial infections, morbidity and mortality.

Hospitals will ensure that full-time or part-time staff adequately covers the functions of Quality Assurance and Infection Control. The recently endorsed clinical governance policy of the

Department will be implemented. Clinical audit and mortality and morbidity meetings will be institutionalised.

There will be an increased focus on monitoring quality of care and addressing the challenges raised through patient and staff satisfaction surveys as well as patient complaints. There will be a heightened awareness and stronger measures around patient and staff safety.

6.4 INFORMATION MANAGEMENT

The slowness of information systems along with the increasing downtimes poses the risk to timeously process orders and payments. Institutions must ensure that adequate servers and data lines address this challenge.

The completeness, quality and validity of data need to be improved at institutional level. The capacity and systems need to be strengthened to enable better and timeous information for managers to make better decisions.

PROGRAMME 5: CENTRAL HOSPITAL SERVICES (HIGHLY SPECIALIZED)

1. PROGRAMME PURPOSE

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

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 5.1. CENTRAL HOSPITAL SERVICES

Rendering of highly specialized tertiary and quaternary services on a national basis, and a platform for the training of health workers, and research.

2.2 PROGRAMME OVERVIEW

The three central hospitals, Tygerberg Hospital, Groote Schuur Hospital and Red Cross War Memorial Children's Hospital, provide highly specialized health services to the people of the Western Cape, as well as patients from beyond provincial boundaries.

These three hospitals form the Unitary/Integrated Western Cape Tertiary Service (UWCTS) having a total of 1 460 tertiary beds various outpatient clinics.

The UWCTS interacts with the level two (general specialist) platform of services, and through outreach, support and participation in clinical governance structures, the service plays an important role in the comprehensive service delivery of the Western Cape Province.

Highly specialised tertiary and quaternary services are positioned at the end of the referral chain and provide definitive specialized care to patients. Key success factors include a critical mass of scare skills and competence, with interdependency across disciplines. Key categories of staff required to render these services include medical specialists and sub specialists, specialized nursing (especially intensive care and theatre scrub nurses), anaesthetists, clinical technologists and clinical engineering. The delivery of tertiary services is also dependant on the availability of expensive equipment and related technology.

3. SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2015.

Table 5.1: Strategic objectives and expected outcomes for central hospitals for 2010 - 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
1. Manage the burden of disease	1.1. Reduce maternal mortality due to complications during delivery	1.1.1. Perform appropriate 44% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in central hospitals[1]	44% (5 058/ 11 527)	44% (6 055/ 13 690)	Ensure an improved health outcome for mothers and babies.	MDG 5:Improve maternal health. MTSF Focus area: • Increase life expectancy: Decrease the maternal mortality ratio NDOH Ten Point Plan, 8: • Mass mobilisation for the better health of the population. Provincial priority: • Maximising health outcomes.
	1.2. Ensure the delivery of tertiary services to manage the burden of disease at the appropriate level of care.	1.2.1. Ensure acces to tertiary services by providing 1460 tertiary beds.	2) Number of designated tertiary beds in central hospitals.	1 460	1 460	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	MTSF Focus area: • Health system effectiveness NDOH Ten Point Plan: • Overhauling the health care system and improving its management. Provincial priority: • Maximising health outcomes.
	1.3. Ensure optimal access to highly specialised services to manage the burden of disease.	1.3.1. Manage bed utilisation to achieve a bed utilsation rate of 85% in Central Hospitals by 2014/2015.	3) Bed utilisation rate (based on usable beds) in central hospitals	84% (450 000/ 1 460/ 365)	85% (460 836/ 1 460/365)	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	
	1.4. Integration of quality assurance into all levels of care.	1.4.1. Implement quality assurance measures to minimise patient risk in the 3 Central Hospitals by performing monthly morbidity and mortality meetings to monitor the quality of hospital services by 2014/15.	4) Number of central hospitals conducting monthly morbidity and mortality reviews	3	3	Ensure the maintenance and constant improvement of the quality of health services.	MTSF Focus area: • Health system effectiveness NDOH Ten Point Plan: • Improve quality of health services. Provincial priority: • Maximising health outcomes.
		1.4.2. Perform and analyse one annual survey to measure patient satisfaction in each of the Central Hospitals by 2014/15.	5) Number of central hospitals that performed and annual patient satisfaction survey	3	3	Ensure the maintenance and constant improvement of the quality of health services.	
		1.4.3. Implement quality assurance measures to minimise patients risk in the Central Hospitals by monthly monitoring of the surgical deaths (mortality)	6) Case fatality rate in central hospitals for surgery separations	3.8% (806/ 21 182)	4.0% (920/23 100)	Ensure the maintenance and constant improvement of the quality of health services.	MTSF Focus area: • Health system effectiveness NDOH Ten Point Plan:

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
		for the reporting period and maintaining a mortality rate of less than 4.0% for Tertiary surgical services by 2014/15.					• Improve quality of health services. Provincial priority: • Maximising health outcomes
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, highly specialised services.	2.1.1. Increase the ICD coding of inpatient activities to 80% in central hospitals by 2014/15.	**SO Baseline measure:** 7) ICD 10 coding rate of 80% for inpatient activities in central hospitals by 2014/15.	Not reported on	80% 61 445/ 76 805	Ensure a generation of income to fund sustainable health services.	MTSF Focus area: • Health system effectiveness Provincial Cabinet Programmes and Priorities nr. 2
		2.1.2. Ensure the cost effective management of central hospitals at a target cost of R5 534 per patient day equivalent by 2014/15. [Constant 2008/09 rands]	8) Expenditure per patient day equivalent in central hospitals	R3 392	R5 534	Ensure the efficient application of resources in rendering health services.	NDOH Ten Point Plan: • Provision of strategic leadership and creation of a social compact for better health outcomes. Provincial priority: • Maximising health outcomes
3. Develop and maintain a capacitated workforce to deliver the required health services.	3.1. Have a human resource development plan in place to deliver the required package of care and manage its resources.	3.1.1. Ensure each central hospital has a skills development plan to develop and maintain key skills to render effective and quality health services and manage its resources by 2014/15.	9) Number of central hospitals with an approved annual skills development plan.	3	3	Develop and maintain a capacitated workforce adequately skilled to deliver the required health services	NDOH Ten Point Plan: • Improve human resources Provincial priority: • Maximising health outcomes
	3.2. Become the employer of choice in the health sector by creating an environment for a satisfied workforce.	3.2.1. Perform, analyse and respond to the findings of one annual standardised staff satisfaction survey to measure workforce satisfaction in the each of the central hospitals by 2014/15.	10) Number of central hospitals that performed a staff satisfaction survey.	3	3	Ensure that an appropriately skilled and capacitated workforce is sustained as a key success factor for delivering health services.	NDOH: Ten Point Plan,.5: • Improve human resources Provincial priority: Maximising health outcomes
4. Ensure and maintain organisational strategic management capacity and synergy.	4.1. Establish a Drug and Therapeutic committee to ensure compliance with Provincial Drug policies and participate in the review of drug policy	4.1.1. Ensure that a drug and therapeutic committee is established at each central hospital by 2014/15.	11) Number of central hospitals with an appointed Drug and Therapeutic committee.	3	3	Ensure the review, uniform implementation and compliance with Provincial drug policy	NDOH: Ten Point Plan 9: • Review of the drug policy. Provincial priority: • Maximising health outcomes
	4.2. Establish a health facility board as a key supportive governance structure.	4.2.1. An appointed, functional health facility board serves as a key interface with the community at each central hospital by 2014/15.	12) Number of central hospitals with an appointed health facility board	3	3	Improve the nation's health status and ensure cohesive and sustainable communities.	NDOH:Ten Point Plan 1; • Provision of strategic leadership and creation of a social compact for better health outcomes.

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
							Provincial priority: • Maximising health outcomes
	4.3. Management provides sustained strategic direction in the delivery of sustained health services with well defined efficiency targets for Tertiary services.	4.3.1. Effectively mange allocated resources to achieve the Comprehensive Service Plan target average length of stay of 6 days for central hospitals by 2014/15.	13) Average length of stay in central hospitals.	6.6 days (450 000/ 69 000)	6 days 460 836/ 76 806	Ensure the optimal utilisation of hospital resources.	NDOH Ten Point Plan: • Overhauling the health care system and improving its management.. Provincial priority: • Maximising health outcomes
5. Provide and maintain appropriate health technology and infrastructure	5.1. Ensure the provision of infrastructure that meets the needs of current and future development	5.1.1. Ensure that a functional planning and commissioning unit is appointed at each central hospital to perform key planning and monitoring activities to ensure that current and future infrastructure needs are met by 2014/15.	14) Number of hospitals with an appointed and functioning planning and commissioning unit.	3	3	Ensure the adequate provision and maintenance of infrastructure in geographical regions suitable to house the provision of quality services.	NDOH Ten Point Plan: • Revitalisation of infrastructure.

Note:

Indicator 1: The ceasarian section rate indicated is for the central hospital services. The ceasarian section rate would change once the Comprehensive Service Plan service shifts and differentiation between Level 2 and Level 3 services in terms of ceasarian sections has been completed.

4. RESOURCE CONSIDERATIONS

4.1 FUNDING TRENDS:

Programme 5.1 is primarily funded from the National Tertiary Services Grant [NTSG] and the Health Professions Training and Development Grant [HPTDG], which are conditional grants. These funds are insufficient to provide the required services and therefore Programme 5.1 is supplemented with equitable share funding.

Table 5.2 Total budget allocations for Programme 5.1

(Rands)	Audited 2006/07	Audited 2007/08	Audited 2008/09	Revised estimate 2009/10	2010/11	2011/12	2012/13
Total Programme 5	2 123 000	2 349 884	1 970 686	2 369 550	2 595 971	2 799 434	2 953 284

Note:

From 2008/09 the central hospital services were differentiated in Programme 4.1 and Programme 5.1. services. The funding allocation for the Programme 4.1. services in the central hospitals, is reflected in Programme 4.1. from 2008/2009.

4.2 CONDITIONAL GRANTS

4.2.1 National Tertiary Service Grant (NTSG)

The NTSG aims to compensate provinces for the supra-provincial nature of tertiary services provision and spill over effects to enable provinces to plan, modernize, rationalize and render tertiary services in line with national policy objectives.

Challenges:

- The grant funding is inadequate for the tertiary and quaternary services to be provided with an estimated shortfall exceeding R800 million.
- There is a lack of a comprehensive National Tertiary Health Plan, which would determine relative service distribution and access across the country.

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

4.2.2 Health Professional Training and Development Grant (HPTDG)

The purpose of the Health Professional 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 Educations (University of Stellenbosch, University of Cape Town, University of Western Cape, Cape Peninsula University of Technology).

Challenge:

- The funding levels of the grant have not matched inflation over time, or OSD implications. A costing study concluded in 2007 reiterated the grant under funding for that year amounting to be R468.4 million required to provide a service platform for teaching and training for students. This situation makes it difficult to continue to have the same number of students training on the service platform.

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

The Western Cape needs 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.

4.3 RELATING EXPENDITURE TRENDS TO STRATEGIC GOALS

4.3.1 Personnel

Personnel expenditure has increased over the MTEF period with the main cost drivers improved conditions of service (ICS) and Occupational Specific Dispensation (OSD) for nurses, doctors, pharmacists, social workers, and engineers.

4.3.2 Goods and services

The expenditure in goods and services remains a challenge for the Central Hospitals as medical inflation exceeds general inflation. The same basket of goods and services cost up to 18% more in 2009/2010 compared to 2008/2009. Tertiary services also represent the end of the referral chain and depend heavily on advanced health technology. Control measures for the purchasing of goods and services are in place to ensure decisions based on the best value for money is made.

5. RISK MANAGEMENT

Risk description	Risk description and effects	Risk mitigation
1) **Funding cannot sustain services**	▪ Unable to meet APP objectives and inability to meet current service demand. ▪ Deterioration in working conditions affecting staff morale.	▪ Motivations for supplementary funding to be submitted to Treasury and NDoH. ▪ Prioritize resource allocation in key identified areas using the Accountability for Reasonableness (A4R) framework. ▪ Ensure ICD coding of cases for billing purposes to ensure that revenue targets are met.
2) **Unavailability of special skills due to numbers trained and exodus to private sector and abroad.**	▪ Inability to deliver highly specialized services. ▪ Increase in workload for remaining skilled employees. ▪ Inability to execute the necessary transactions and non-compliance with policies and regulations leading to adverse audit findings.	▪ Bolster training of staff in scarce skills categories. ▪ Hospitals to have specific skills development plans in place to address skill shortcomings. ▪ Perform staff satisfaction survey to measure staff satisfaction and implement measures to improve staff satisfaction to promote staff retention. ▪ Incentive mechanisms to recruit and retain key staff. ▪ Positioning the WCDOH as an employer of choice to recruit skilled staff. ▪ Employment Assistance Programme to support staff in the service.
3) **Increase in case load & acuity**	▪ Increase on demand of service. Affecting access and quality of care and increase morbidity and mortality and a loss of reputation due to negative publicity. Staff morale decreases due to high workload. Potential for overspending, negatively affecting cash flow.	▪ Effective bed management through implementation of AECLMP policy. ▪ Integrated quality assurance mechanisms to ensure continuous quality of services ▪ Active participation and engagement with District Health Services to identify and promote interventions that would reduce the burden of disease by promoting healthy lifestyles.

Risk description	Risk description and effects	Risk mitigation
4) **Major adverse clinical incidents**	▪ Major clinical adverse events causing costly medico legal action against the Department, and negative publicity resulting in lower staff morale.	▪ Ensure compliance with standardized policy and procedures in the management of patients. ▪ Ensure adequate staff capacity and mix to provide safe and quality services. ▪ Ensure integrated quality assurance mechanisms such as the adverse event reporting system. ▪ Embed a culture of meticulous medical record keeping. ▪ Perform monthly morbidity and mortality meetings to review minor and major adverse clinical evens with corrective actions.
5) **Information technology system failures.**	▪ Loss of valuable information ▪ Inability to transact (BAS) or communicate vie e-mail. ▪ Lack of information and the quality thereof, ▪ Audit trail of activities and transactions lost. ▪ Payments not possible ▪ Reporting not possible	▪ Agreement with Ce-I and SITA ▪ Prioritise bandwith to perform key operational functions and transactions ▪ Improved IT support & systems management ▪ Improved stability of new systems and system enhancement through ICT strategies. ▪ Regular backup of critical data is performed ▪ JIMI process to ensure the uniform and accurate capturing of information. ▪ Provincial Treasury and Premier office support

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

1. PROGRAMME PURPOSE

Rendering of training and development opportunities for actual and potential employees of the Department of Health.

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 6.1: NURSE TRAINING COLLEGE

Training of nurses at undergraduate and post-graduate level. Target group includes actual and potential employees.

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

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

2.3 SUB-PROGRAMME 6.3: BURSARIES

Provision of bursaries for health science training programmes at undergraduate and post graduate levels. Target group includes actual and potential employees.

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

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

2.5 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.

3. OVERVIEW

The Department needs to recruit, train and retain the appropriate numbers of personnel with the appropriate competencies to address current and future service requirements across the levels of care. The number of various categories of staff required at each of the levels of care is reflected in the CSP.

Programme 6 resources provide education; training and development opportunities for serving and prospective employees and for community members engaged in governance of or service delivery for the Department of Health.

Interventions to address the scarce and critical skills and the evaluation to examine the impact and effectiveness thereof on health indicators are required to drive the following interdivisional key performance areas for 2010/11

- Acute Services
- Ambulatory Care
- Infectious Diseases
- De - hospitalised Care
- Emergency Health Care
- Child and Women's health
- Chronic disease management

A comprehensive Human Resource Development Strategy (HRDS) and an annual implementation plan will flow from the Human Resource Plan (HRP).

A competency profile assessment of fourteen targeted occupational categories, which will support the HRD strategy and the HR Plan, is due for completion by May 2010.

In addition a skills audit on SMS and facilities management will be conducted from November 2009 to September 2010 to ensure managers are fit for purpose.

To increase the numbers of competent nurses the Department invests substantially in nursing education, training and development, marketing, recruitment and retention strategies.

The Expanded Public Works Programme (EPWP) is a short to medium term government initiative aimed at the provision of work opportunities coupled with training, with particular focus on communities with high levels of unemployment. The EPWP strengthens the sustainability of community-based services at primary care level through the training of Home Community Based Carers toward formal qualifications in ancillary health care and community health work. It contributes to creating employment opportunities and alleviating poverty through stipendiary work opportunities and training of relief workers who are recruited from the community.

Learnership programmes for unemployed persons within nursing and the pharmaceutical services are also provided. Internship opportunities are offered through the National Department of Health EPWP funded 3 535 Data Capturer programme and the Assistant to Artisan (ATA) programme will be implemented in 2010.

As an exit strategy the learners and interns may be absorbed by the Department on completion of their learning and internship programmes.

Ongoing analysis of education, training and development requirements for specific priority occupational groups will be informed by the annual Workplace Skills Plan and the HWSETA and the PSETA Sector Skills Plans. These analyses are done in collaboration with relevant service personnel and higher education institutions. Information will be supplemented by the outcomes of the competency profile assessment.

Education, training and development needs of health and support professionals in the Department are indicated through the continued engagement with all the appropriate Higher Education Institutions (HEIs) in South Africa.

Current relationships with professional bodies in relation to the following require strengthening:

- Formal training of professionals (health and support)
- Exit strategies for community-based workers
- Mid-level categories within professions.

The improvement and maintenance of competencies (iMOCOMP) of health professionals in the district health services strives to strengthen effective and efficient service delivery to the public through the continual improved capacity of healthcare professionals of evidence-based interventions. The iMOCOMP project is based on an internal partnership with District Health Services and an external partnership between the Department and all four Western Cape HEIs.

The Provincial Government of the Western Cape College of Emergency Care was re-established in 2008. It received accreditation from HPCSA to restart short course training for EMS personnel from January 2009. The college currently trains Emergency Care Practitioners through short course certificate programmes. They also provide Rescue and Communication modular training.

Short course training is being phased out by HPCSA and from 2010/11 the Western Cape College of Emergency Care will apply for and run the Emergency Care Technician Certificate which is a two-year programme.

Emergency Medical Services (EMS) will address the shortfall of Emergency Care Personnel being trained in order to meet current and future EMS patient care requirements, promote formal career pathing to previously informal categories of personnel within the Emergency Medical Services by:

- Formalising emergency communications training
- Formalising medical rescue training
- Building management/ leadership capacity in support services crucial to the provision of Emergency Medical Care within the Western Cape
- Continual Medical Education of EMC staff.

4. SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010 – 2014

Table 6.1: Strategic objectives and expected outcomes for 2010 - 2015

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
1. Develop and maintain a capacitated workforce to deliver the required health services.	1.1 Develop, implement, monitor and evaluate a comprehensive Training Plan guided by the HRP (BP: 1) for health & support professionals (BP 2, 3, 4 & 5) in line with the packages of care within the Comprehensive Service Plan (CSP).	1.1.1 Increase the availability of health science students to address scarce skills.	1) Total number of health science students graduating.	542	900	Increase the critical mass of health science students to address scarce skills.	MTSF: Focus area: • Health system effectiveness NDOH Ten Point Plan for 2009 - 2014, priority 5: • Improve human resources Provincial strategic plan: • Maximising health outcomes
		1.1.2 Ensure optimum competency levels of health and support professionals through education, training and development to render optimum accessible packages of care in line with CSP by 2014.	2) Total number of health and support professionals trained and developed through formal and informal training.	2 520	2 970	Integrated health professional and health support professional including EMS training to address the CSP needs and current health and support professional shortages by maximizing the training opportunities and available resources.	
2. Ensure and organisational strategic management capacity and synergy.	2.1 Develop, maintain and implement a training plan for managers based on the result of a skills audit of senior management and facilities management.	2.1.1 Ensure senior management and facilities' management have the required management competencies to deliver quality health services	3) Number of bursaries awarded to managers for formal Leadership & Management training toward a qualification	48	86	The predominant profile of managers in the health care sector is that of a healthcare professional that has migrated into management with no formal management qualification. This intervention is based on the needs and experiences of managers which will train them to provide leadership and which will lead to a sustainable improvement in the quality of health care.	MTSF: Focus area: • Health system effectiveness NDOH Ten Point Plan for 2009 - 2014, priority 1&4: • Provision of Strategic leadership and creation of social compact for better health outcomes. • Overhauling the health care system and improving its management. Provincial strategic plan: • Maximising health outcomes
3. Improve the quality of health services	3.1 Develop and implement an iMOCOMP training plan in alignment with the Clinical Governance Framework (CGF) to support quality assurance through the provision of training	3.1.1 Ensure optimum improvement and maintenance of competencies (iMOCOMP) of health and support professionals to address integrated health care including DHS burden of disease priorities	4) Number of health and support professionals receiving clinical training at the various levels of care on interdivisional burden of disease priorities	2 200	2 400	The improvement and maintenance of competence of health professionals strives to strengthen primary health care level service delivery through the continual improved capacity of healthcare professionals. Support quality assurance through the provision of training	MTSF: Focus area: • Health system effectiveness NDOH Ten Point Plan for 2009 - 2014, priority 3, 4,5 & 8: • Improving quality health services. • Overhauling the health care system and improving its management. • Improved human resource planning, development and management. • Mass mobilisation for better health of the population. Provincial strategic plan: • Maximising health outcomes
		3.1.2 Ensure the integration of quality assurance into all levels of care	5) Number of front line personnel on salary level 1 - 6 trained on Batho Pele principles	600	998		
4. Manage the burden of disease	4.1 Efficiently and effectively manage the dehospitalisation of patients and health promotion and prevention in the home and community.	4.1.1 Expand community-based care services through the optimum training and development of Home based Carers as part of Expanded Public Works Programme (EPWP).	6) Number of Home community- Based Carers trained.	2 000	2 800	To create additional community-based services capacity for step-down de-hospitalised care to service patients in the communities where they live and to facilitate access to employment for unemployed persons.	

5. RESOURCE CONSIDERATIONS

5.1 EXPENDITURE TRENDS IN PROGRAMMES AND HOW THESE ARE EXPECTED TO EVOLVE OVER THE NEXT FIVE YEARS

Expenditure is expected to increase in a range of 9 -10% per annum. The implication is that the education, training and development initiatives to manage the burden of disease as per the divisional priorities, to ensure a competent workforce and capacitate management in line with the Comprehensive Service Plan and the integration of quality assurance as per the clinical governance framework, will increase proportionately to the level of funding.

5.2 TRENDS IN NUMBERS AND SUPPLY OF KEY STAFF

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.

6. RISK MANAGEMENT

Key risks for the Health Sciences and Training programme include:

1) **Fragmented nature of nurse training programmes**

Nursing schools, established as satellites of the college, will ensure the coordination of nurse training at all levels.

2) **Management/ leadership capacity in Emergency Medical Care**

The continued provision of formal management training through an accredited Higher Education Institution, and specialized skills training such as infection control, human resource management, labour relations, financial management and information technology will build leadership capacity.

3) **Inadequate programme budget increase**

The increase allows for inflation only and therefore sustains only the existing levels of training. The expansion of programmes to address the critical and scarce skills as per CSP is compromised. Education, training and development initiatives will increase proportionately to the level of funding.

4) **Divergent nature of iMOCOMP training**

The iMOCOMP training in its current guise is too divergent and is not addressing the focus areas within the service delivery model and therefore it is imperative to attune iMOCOMP to the burden of disease. iMOCOMP must be linked to the four interdivisional focus areas

- Acute Services ;
- Ambulatory Care ;
- Infectious Diseases ;
- De - hospitalised Care

The focus for 2010/ 11 will be acute services and ambulatory services and thereafter as a guide infectious diseases and de-hospitalised care.

5) **Lack of effective HRD information system**

The Programme has engaged the Department of Transport Public Works and contractors who have developed the Umsebenzi portal to design an effective HRD information system.

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

1. PROGRAMME PURPOSE

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

2. PROGRAMME STRUCTURE

2.1 PROGRAMME 7.1: LAUNDRY SERVICES

Rendering a laundry service to hospitals, care and rehabilitation centres and certain local authorities.

2.2 PROGRAMME 7.2: ENGINEERING SERVICES

Rendering a maintenance service to equipment and engineering installations, and minor maintenance to buildings.

2.3 PROGRAMME 7.3: FORENSIC SERVICES

Rendering specialised forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death.

This service is now transferred from programme 2.

2.4 PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

Rendering specialised orthotic and prosthetic services.

This service is transferred to Sub-programme 4.4.

2.5 PROGRAMME 7.5 MEDICINE TRADING ACCOUNT

Managing the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities.

3. SUB-PROGRAMME 7.1: LAUNDRY SERVICES

3.1 SUB-PROGRAMME OVERVIEW

Linen and laundry services are provided by large central laundries located at Tygerberg, Lentegeur and George Hospital and several rural hospitals have small in-house laundries. A large portion of the service is outsourced which has proved cost effective and ensured availability of linen. In addition outsourcing has resulted in a reduction in overtime worked at in-house laundries.

- Twenty million linen items are processed annually of which in-house laundries process fourteen million pieces per annum and out-sourced private sector laundries process six million pieces per annum.
- Tygerberg Laundry is processing eight million pieces per annum; George and Lentegeur Laundries combined process a further six million pieces per annum.
- Tygerberg Laundry has 170 staff, Lentegeur Laundry has 72 staff and George Laundry has 36 staff.
- All laundry personnel are multi-skilled.

In order to provide a cost effective service with minimum risk, there is a combination of in-house and outsourced laundry services. The priority has been to increase the efficiency of in-house services. Large volumes of work are imperative for the strategic laundries to be cost-competitive with the private sector. Recent productivity gains have led to a shift of work from the private sector to the in-house laundries. This was necessary to ensure that personnel resources are fully utilised.

3.2 SPECIFICATION OF STRATEGIC OBJECTIVES AND OUTCOMES FOR 2010 - 2014

3.2.1 Alignment with the Strategic Goals of the Department

Programme 7.1 supports the Strategic Goals of the Department by providing a reliable supply of clean disinfected linen:

- An uninterrupted supply of linen is essential for the provision of healthcare to manage the burden of disease
- The cost effective delivery of laundry services reduces the drain on financial resources and promotes the sustainability of the service delivery platform.
- Promotes quality of healthcare by ensuring that patients have clean disinfected linen at all times.

3.2.2 Focus Areas

The focus for the five year period will be increasing operational efficiency by:

- Training of personnel – particularly Laundry Managers.
- Achieving the optimum balance between in-house and outsourced work.
- Replacing older inefficient equipment with new equipment designed to reduce the consumption of water, electricity and chemicals.

Table 7.1: Strategic objective and outcomes fo Laundry Services for 2010 - 2014

Strategic goal	Strategic objective title	Strategic objective statement	Baseline			Justification	Links
			Baseline measure	2009/10	2014/15		
1. Provide and maintain appropriate health technology and infrastructure.	1.1 Provide an effective and efficient laundry service to all hospitals	1.1.1. Provide all health facilities with the quantity of clean disinfected linen required to deliver quality healthcare	1) Total number of pieces laundered:	20.05m	20.5m	An uninterrupted supply of clean, disinfected linen is essential for the delivery of healthcare. Clean linen stocks at most hospitals will be depleted in 3 days if the laundry service were to fail.	**MTSF: Focus area** • **Health system effectiveness.** **National Ten Point Plan Priority 6:** Improve the quality of health services **Departmental Strategic Goals:** • Reduce and effectively manage the burden of disease. • Ensure and maintain organisational strategic management capacity and synergy. • Provide and maintain appropriate health technology and Infrastructure.
		1.1.2. Provide a laundry service using in-house laundries	2) Total number of pieces laundered: In-house	15m	15m	In-house laundries are provided in areas where private sector laundries are unable to supply a service. In addition in-house laundries are maintained to ensure that the State is not wholly dependent on the private sector.	
		1.1.3. Provide a laundry service using outsourced laundries in the private sector	3) Total number of pieces laundered: Outsourced	5.5m	5.5m	Linen can be processed by the private sector at a lower cost than the in-house laundries. In many instances there is a considerable saving by out-sourcing laundry services to the private sector	
		1.1.4. Provide cost effective in-house laundry service	4) Average cost per item laundered: In-house	R1.90	R4,90	The average cost per piece of in-house laundry services is monitored to ensure that the service is not unduly expensive when compared to the private sector.	
		1.1.5. Provide cost effective outsourced laundry service	5) Average cost per item laundered: Outsourced	R1.70	R5,20	The average cost per piece of out-sourced laundry services is monitored to ensure that utilising the private sector leads to a real saving in laundry costs.	
		1.1.6. Ensure effective and efficient utilisation of the linen stock: In-house laundries	6) Turnaround time for laundered linen: In-house	24 hour weekday 72 hour weekend	24 hour weekday 72 hour weekend	A quick turnaround is essential to ensure the availability of clean linen and to keep the linen stock to a minimum.	
		1.1.7. Ensure effective and efficient: out-sourced laundries utilisation of the linen stock	7) Turnaround time for laundered linen: Outsourced	24 hour weekday 72 hour weekend	24 hour weekday 72 hour weekend	A quick turnaround is essential to ensure the availability of clean linen and to keep the linen stock to a minimum.	

3.3 RESOURCE CONSIDERATIONS

It is anticipated that funding for laundry services will not increase significantly over the next five years and that increases will be largely inflation linked. An important exception is the upgrading of the Lentegeur Laundry as part of the Hospital Revitalisation Programme. This upgrading will result in the replacement of major high cost equipment.

The funding for both linen replacement and linen losses often poses a problem as institutions often do not have the budget to purchase adequate quantities on new linen. In order to keep the linen service operational it has, in the past, been necessary for new linen to be purchased by Programme 7.1. This situation may be regarded as an unfunded priority

The availability of qualified and experienced laundry managers is of concern and training of laundry managers is on-going.

3.4 RISK MANAGEMENT

The availability of large private commercial laundries capable of processing hospital linen is very limited. Unless the volume of linen processed by the private sector increases there is little opportunity for reducing the cost of laundry services. A procurement strategy to strengthen the private sector laundries is in place.

The cost of utilities is expected to increase at a pace well above inflation over the next 5 years. With this in mind new equipment is being purchased that will reduce the consumption of water, electricity and chemicals.

4. SUB-PROGRAMME 7.2 ENGINEERING SERVICES

4.1 SUB-PROGRAMME OVERVIEW

The Directorate: Engineering and Technical Support Services is responsible for hospital equipment repairs and maintenance, clinical engineering, engineering services repairs and maintenance, operation of plant and machinery, in-house building repairs and maintenance, in-house minor building projects, and continuous refinement of systems and processes.

Responsibility for day-to-day maintenance of health facilities, including hospitals, primary healthcare facilities, ambulance stations and forensic mortuaries, lies with the individual institutions. Capital repair and rehabilitation requirements are identified by the facility and the Directorate: Engineering and Technical Support and is normally undertaken by the Department of Transport and Public Works.

There is an acceptance by Health management that there is an urgent need to prioritise maintenance. The prioritisation of maintenance work is acknowledged in Healthcare 2010, the long-term strategic plan of the Department. There is acknowledgement that the maintenance backlog must be addressed as a matter of urgency.

4.2 SPECIFICATION OF STRATEGIC OBJECTIVES AND OUTCOMES FOR 2010 - 2014

4.2.1 Alignment with the Strategic Goals of the Department

Programme 7.2 supports the strategic goals of the Department by providing well maintained infrastructure and equipment in order to facilitate:

- The management of the burden of disease
- The maintenance of appropriate healthcare technology and infrastructure.
- Improving the quality of health services.

4.2.2 Focus Areas

A successful maintenance programme requires the following six key interlinking needs which are:

- A clear, unambiguous and structured approach – including policies and procedures – to maintenance and immovable asset management;
- A management information system to enable effective maintenance planning, budgeting and decision making;
- Current, quality information on existing assets;
- Sufficient funding;
- Sufficient capacity at all levels, and
- Clearly defined processes and allocated responsibilities for maintenance related functions.

In the 5 year period the Department will strive to meet all of these needs.

Table 7.2: Strategic objectives and outcomes for Engineering Services 2010 - 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
1. Provide and maintain appropriate health technology and infrastructure.	1.1 Provide an effective and efficient maintenance service to all health facilities	1.1.1 Provide effective maintenance on facilities, plant and equipment	1) Number of maintenance jobs completed	13 000	13 500	The Department has physical assets with a replacement value estimated at R20 billion. Effective maintenance will maximise the lifespan of these assets, reduce breakdowns and ensure safety.	**MTSF: Focus area** • **Health system effectiveness.** **National Ten Point Plan Priority 6:** • Improve the quality of health services • Revitalisation of infrastructure **Departmental Strategic Goals:** • Manage the burden of disease. • Provide and maintain appropriate health technology and Infrastructure. • Improve the quality of health services.
		1.1.2 Provide preventative maintenance to critical equipment	2) Number of preventative maintenance jobs completed	2 000	2 100	Effective preventative maintenance will reduce breakdowns, promote safety and lengthen the lifespan of equipment.	
		1.1.3 Provide repairs and renovation to DoH infrastructure	3) Number of repairs completed	10 800	10 800	An effective repair service will reduce the impact of breakdowns and deterioration of assets through age.	
		1.1.4 Provide a service to deal with all infrastructure emergencies at institutions	4) Number of emergencies handled	200	300	In the healthcare sector a rapid response to infrastructure emergencies is essential to ensure patient safety and prevent disruption of clinical care.	
		1.1.5 Provide efficient engineering installations	5) Average cost of utilities per bed	7 300	R10 800	With the rapidly rising cost of electricity, fuel, water, gas, etc. it is essential to monitor utilities cost and be proactive in increasing efficiency to reduce expenditure.	
		1.1.6 Ensure compliance with the Occupational Health and Safety [OHS] Act	6) Number of reportable incidents	160	95	Compliance with the OHS Act promotes safety in the workplace and protects personnel, patients and the public.	

4.3 RESOURCE CONSIDERATIONS

Based on the present cost of construction the replacement value of the buildings is estimated at R13.5 billion. Assuming a norm of 4% of replacement cost as an appropriate annual maintenance budget, the estimated expenditure on the maintenance of buildings should be in the region of R540 million per annum. The 2009/2010 Programme 7 budget for allocated Engineering Services was R58m and 2010/11 budget is R64m. The 2009/10 Programme 8 maintenance budget for buildings was R113 million. The 2010/11 Programme 8 maintenance budget is R134 million showing an increase of 19%. However, there is still a significant backlog of maintenance, repair and rehabilitation work that is estimated to be in the region of R800 million. Despite a decision by the Provincial Treasury to "ring-fence" maintenance funding the reality is that in the absence of increases in real terms in the health budget an increase in maintenance funding would require a commensurate reduction in the operating budget for the line services of the department.

It is anticipated that funding for engineering maintenance will not increase significantly over the next five years and that increases will be largely inflation linked. Fortunately the upgrading and replacement of facilities using funding from both the Infrastructure Grant to Provinces (IGP) and the Hospital Revitalisation Programme (HRP) will significantly reduce the maintenance backlog over the next five years. Without this conditional grant funding no noteworthy inroads could be made to reduce the backlog.

The shortage of qualified and experienced technical and professional personnel will be addressed through additional training and bursaries.

4.4 RISK MANAGEMENT

In 2007 the Department of Health appointed the CSIR to carry out a situational analysis and make recommendations to substantially improve the maintenance of both buildings and equipment. Their major findings can be summarised as follows:

- At present, and as it has been for many years, maintenance relies on the expertise and dedication of a relatively very small number of technical personnel who are doing an outstanding job of keeping services and equipment operational.
- There is no clear, unambiguous and structured approach, including policies and procedures, to maintenance and immovable asset management.
- Processes are not clearly defined and responsibilities are not clearly allocated for maintenance related functions.
- There is no management information system to enable effective maintenance planning and decision making.
- No formal assessment of all immovable assets has been done since 1998. There is no current, quality information on existing assets.
- Funding is insufficient. As a result of the absence of information systems and a formal condition assessment it is not possible to provide a substantiated motivation for additional funding.
- There is inadequate capacity. This is particularly evident by the shortage of technically qualified maintenance managers, technicians and artisans.
- Lack of compliance with legislation places the Department at risk.

A start on the implementation of measures to address these deficiencies has commenced and the process will continue over the next 5 years.

An issue that was not addressed in the CSIR Report is a maintenance burden that results from poorly designed and executed capital projects. Capital projects must be designed with due regard to future maintenance. The Department has engaged the Department of Transport and Public Works on this issue but lack of capacity in Public Works is a problem.

The Department of Health is participating in the implementation of the Infrastructure Development Improvement Programme (IDIP). Implementation of the IDIP complements the work of the CSIR and has lead to the creation of an Infrastructure Management component in the Department. IDIP will also address relationships with the Department of Transport and Public Works that was a problem identified by the CSIR.

Another significant initiative that commenced in 2007 is the implementation of a comprehensive maintenance management system at the George Hospital as part of the Hospital Revitalisation Programme. The system is being rolled out to other Revitalisation Programme Hospitals with the aim of including all hospitals when funding permits.

5. SUB-PROGRAMME 7.3 FORENSIC PATHOLOGY SERVICES

5.1 PROGRAMME OVERVIEW

After the transfer of the "Medico-legal Mortuaries'" from the South African Police Service to Provincial Departments of Health on 1 April 2006 the Department of Health, Provincial Government Western Cape established a new Forensic Pathology Service (FPS) in the Province. This service is rendered via 18 Forensic Pathology Facilities across the province which includes two M6 Academic Forensic Pathology Laboratories in the Metro, 2 Departments of Forensic Medicine, 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.

Figure 7.1: Map of Forensic Pathology Services

Forensic Pathology facilities are classified according to the number of cases that are managed at the facility.

Table 7.3: Forensic Pathology Services facilities

Grading of Forensic Pathology Facilities		
FPL Grade	**Number of Post Mortems**	**Facilities in the Province in this Category**
M1	0 - 249	Vredendal, Vredenburg, Malmesbury, Swellendam, Riversdale, Beaufort West, Laingsburg
M2	250 – 499	Hermanus, Mosselbay, Knysna
M3	500 - 999	Regional Referral Centres: Paarl, Worcester, George, Stellenbosch, Oudtshoorn
M4	1000 - 1499	None
M5	1500 - 1999	None
M6 (Academic)	> 2000	Salt River, Tygerberg

The Department is required to provide a Forensic Pathology Service in the Province in accordance with the provisions of the following Acts: Inquest Act, National Health Act, Human Tissue Act, Births and Death Registration Act, Prisons Act, and the Medical, Health Professions Act as well as the Forensic Pathology Services Regulations and Code.

The Forensic Pathology Service is responsible for the medico-legal investigation of unnatural deaths. 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**.**

To expedite full implementation, the Forensic Pathology academic training centres must be resourced and supported in the short to medium term, to enable the training of Registrars; whilst continuing optimum, competent service delivery.

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 Human Resource plan for the service will be implemented with maintenance of personnel numbers at 267 filled posts out of an establishment of 306 in 2009/10 financial year as the establishment of 306 is not fully funded. The Infrastructure plan will be revised to accommodate the funding shortfall in the Conditional Grant allocation.

Incident response time will be maintained below an average of 40 minutes across the Province by ensuring sixty-six vehicles in active service on the road.

5.2 SPECIFICATION OF STRATEGIC OBJECTIVES AND OUTCOMES FOR 2010 – 2014

5.2.1 Alignment with the Strategic Goals of the Department

Programme 7.3 (Forensic Pathology Service) supports the Strategic Goals of the Department by providing an accessible and professional scientific medico-legal investigation of death service in order to facilitate:

- Reduction and effective management of the burden of disease. This will be achieved through ensuring access to the service and by integrating quality assurance into all aspects of the service.
- Organisational strategic management capacity and synergy by continued interaction with all relevant Stakeholders including SAPS, Home Affairs, National Prosecuting authority and others
- The development and maintenance of a capacitated workforce by the implementation of the Human Resource Plan and through continued structured employee assistance programmes.
- Provision and maintenance of appropriate health technology and Infrastructure needs
- Ensuring sustainable income by achieving the set revenue targets.

5.2.2 Focus Areas

The focus areas for programme 7.3 for the next 5 years are:

- Manage the burden of disease by ensuring access to the Forensic Pathology Service.
- Integration of quality assurance into all aspects of the service through the implementation of standard operating procedures and quality improvement initiatives.
- Financial management including compliance with financial prescripts.
- Recruitment, retention, development and support of personnel.
- Infrastructure and equipment that meets the service needs.
- Adequate and responsive information technology through the implementation of enhancements to the Forensic Pathology business solution and expansion of electronic content management.
- Continued interaction with stakeholders to ensure synergy and optimal service delivery.
- Preparedness to deal with major incidents as well as surges in service demands.

Table 7.4: Strategic objectives and outcomes for Forensic Pathology Services for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
1. **Manage the burden of disease**	1.1 Ensure access to Forensic Pathology services.	1.1.1 Provide an efficient Forensic Pathology Service through maintenance of average response times ≤ 40 minutes	1) Average response time from dispatch to arrival of FPS on scene	≤ 40 minutes	≤ 40 minutes	Management of response times is an indicator of the quality of service being rendered. This also measure equity, access and efficiency.	**MTSF: Focus area** • Health system effectiveness. **National Ten Point Plan Priority 6:** • Improve the quality of health services **Provincial Strategic Plan:** • **Maximising health outcomes.** **Departmental Strategic Goals:** • Manage the burden of disease. Batho Pele Principles
		1.1.2 Provide an efficient Forensic Pathology Service through maintenance of turnaround time from admission to examination done ≤ 3,5 days)	2) Average turnaround time from admission to examination done.	≤ 3.5 days	≤ 3.5 days	The Forensic Pathology Service contributes to the development of a just society through the medico-legal investigation of death	
		1.1.3 Ensure an efficient Forensic Pathology Service through maintenance of turnaround from admission to release of deceased to ≤ 5,5 days (excluding unidentified persons).	3) Average turnaround time from admission to release of deceased (Excluding unidentified persons).	≤ 5.5 days	≤ 55 days	Management of the turnaround time from admission to release is an indicator of the quality of service being rendered. This also measure equity, access and efficiency as well as the contribution to the medico-legal investigation of death.	
	1.2 Integration of quality assurance into all levels of care	1.2.1 Implement and maintain standard operating procedures across all 20 Forensic pathology facilities.	4) The percentage of Standard operating procedures implemented across all facilities	70%	100%	Ensure the maintenance and constant improvement of the quality of forensic pathology service by: • The appropriate management of each FPS case • Treatment of FPS cases and next of kin with dignity and respect. • Creating an environment conducive to staff safety.	
2. Ensure and maintain organisational strategic management capacity and synergy	2.1 Develop integrated support and management structures to render effective FPS service	2.1.1 Improve the management of unknowns by reducing the number of unknowns ≥ 90 days	5) Number of unknown persons exceeding 90 days	150	125	The Forensic Pathology Service contributes to the development of a just society through the medico-legal investigation of death Endeavour to protect the rights of all persons	
3. Develop and maintain a capacitated workforce.	3.1 Implement the Human Resource Plan	3.1.1 Maintain the percentage of filled posts at 97.5% of the funded establishment.	6) % of funded posts filled	90	97.5	Ensure adequate skilled capacity to deliver on the mandate and contribute to the development of a just society through the medico-legal investigation of death	**MTSF: Focus area** • Health system effectiveness. **National Ten Point Plan Priority 5:** • **Improve human resources** **Departmental Strategic Goals:** • Manage the burden of disease. Batho Pele Principles;
	3.2 Become the employer of choice in the health sector by creating and environment for a satisfied workforce.	3.2.1 Pilot, implement and analyze one annual standardized staff satisfaction surveys to measure workforce satisfaction in all FPS facilities by 2014	7) Annual staff satisfaction survey completed.	None	Yes	Ensure adequate skilled capacity to deliver on the mandate and contribute to the development of a just society through the medico-legal investigation of death	

5.3 RESOURCE CONSIDERATIONS

5.3.1 Infrastructure

Improvement to the physical infrastructure remains a priority. The implementation of the Infrastructure plan has been severely impacted on by delays in construction projects as well as the increase experienced in building costs. Three new Forensic Pathology Laboratories (Worcester, Paarl and Malmesbury) will reach practical completion during the 2010/11 financial year, following on from the two facilities (George and Hermanus) that were completed during the 2008/09 financial year. This implies that twelve of the eighteen Forensic Pathology Laboratories still require either relocation or upgrading. Currently services are rendered via private undertaker premises in Riversdale, Swelendam and Vredenburg. Investigation is underway in securing property in Swellendam, Riversdale and Wolseley.

Planning has commenced for four new projects, i.e.:

- The relocation of the Salt River (M6 academic) facility onto the Groote Schuur Hospital premises and construction of a new facility to deal with a caseload exceeding 3 000 cases per annum.
- The expansion of the Tygerberg (M6 academic) facility to adequately deal with the caseload and also to act as the Provincial disaster response centre.
- The construction of a new facility in Beaufort West (M1) to ensure adequate facilities to deal with the caseload and also to act as disaster response centre for the Karoo district.
- The construction of a new facility to replace the current facility in Stellenbosch (M3), which is inadequate to deal with the caseload.

These construction projects can only proceed if additional funding is secured. Building and infrastructure can only be upgraded as per the infrastructure plan if additional funding is secured. Infrastructure funding to implement the infrastructure plan is limited and business cases were submitted to secure funding for the construction of a new M6 Academic facility in the Metro, as well as the upgrading of Tygerberg FPL to accommodate the caseload and to ensure disaster preparedness.

5.3.2 Human resources

The proposed human resource plan can not be fully implemented as it is not fully funded. The high workload and related stress 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 occupation specific dispensation for the Forensic officer categories. This should ensure adequate grading of Forensic Pathology Support post. The institutionalisation of structured and dedicated employee wellness programmes within the Forensic Pathology Service remains a priority. The National Strategic Plan for FPS, (linked to that the Healthcare 2010 Plan) proposes 123 forensic pathologists (FP's) for South Africa (SA). There are approximately thirty registered and practising forensic pathologists in SA at present. There are eight university training centres in South Africa, of which only six train post-graduate students. The average output of these centres is not even one qualified student (forensic pathologist) per year.

The Human Resource plan for the service will be implemented with the maintenance of personnel at 267 filled posts out of an establishment of 306 in 2010/11 financial year. Incident response time will be maintained below an average of 40 minutes across the Province by ensuring sixty-six vehicles in active service on the road.

5.4 RISK MANAGEMENT

- The reliance on stakeholders to deliver on the Forensic Pathology Service mandate remains a risk. Aspects of service delivery that are impacted on is the following:
    - Identification of deceased.
    - Processing of toxicology and blood alcohol samples to inform the post-mortem findings.
    - Response and adequate management of Major incidents.

  The risk is being mitigated through the implementation of a Memorandum of Understanding and regular interaction with the relevant stakeholders
- Continued ring-fenced funding is required. The current position is that the Conditional Grant allocation will be phased out at the end of the 2011/2012 financial year. It is the view of the Department that this service should be continued to be funded through conditional grant allocation. The current allocation is not sufficient to implement the service as per the original business plan as approved by Cabinet. Increase in infrastructure costs as well as the fact that the allocation does not address inflationary pressures as well as increases in staff salaries had an impact.
- The implementation of the infrastructure plan is limited by the funding availability. Business cases will be submitted to obtain funding to proceed with prioritized projects.
- The ability to respond to major incidents is being mitigated through the implementation of Local, District and Provincial Major Incident Response Plans.

6. SUB-PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

Funding and managerial responsibility for Orthotic and Prosthetic Services has been transferred to Sub-programme 4.4.

7. SUB-PROGRAMME 7.5 MEDICINE TRADING ACCOUNT

7.1 SUB-PROGRAMME OVERVIEW

The Cape Medical Depot (CMD), operating on a trading account, 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 academic hospitals procure pharmaceuticals and medical sundries directly from suppliers and use the CMD as a top-up service when required.

The CMD is responsible for pharmaceutical quality control. This is achieved by means of a Quality Control Laboratory (QCL) situated at the Cape Peninsula University of Technology. The Pre-pack Unit is responsible for the break up of bulk stock into manageable quantities to be used at institutions.

The Cape Medical Depot provides a comprehensive pharmaceutical and medical and surgical supply service to health institutions. The Family Planning unit was incorporated as part of the Cape Medical Depot during the 2008/09 financial year. The Medical Depot was significantly upgraded and as a result the depot has been licensed as required by the Pharmacy Act. The Cape Medical Depot is awaiting the successful implementation of a new computerised system at the pilot site in Gauteng before it is rolled out locally. The aim of the system is to ensure that all purchases and warehouse functions and issues to institutions are properly accounted for

7.2 SPECIFICATION OF STRATEGIC OBJECTIVES FOR 2010 - 2014

7.2.1 Alignment with the Strategic Goals of the Department

Programme 7.5 supports the Strategic Goals of the Department by providing pharmaceuticals and medical sundries in order to facilitate:

- Reduce and effectively manage the burden of disease.
- Improve the quality of health services.

7.2.2 Focus Areas

The focus areas for programme 7.5 for the next 5 years are:

- Augmenting the working capital in the medicine trading account.
- Relocating the Cape Medical Depot to a purpose built premises.

Table 7.5: Strategic objectives and outcomes for the Medicine Trading Account for 2010 – 2014

Strategic Goal	Strategic Goal Title	Strategic Objective Statement	Baseline			Justification (Rationale)	Links (Expected Outcomes)
			Baseline Measure	2009/10	2014/15		
Ensure and maintain organizational strategic management capacity and synergy	To ensure adequate working capital to allow for efficient stockholding of pharmaceuticals and non-pharmaceuticals at the Cape Medical Depot	Increase working capital annually in line with projected inflator	Working capital in the medicine trading account	R58,3 m	R84 m	Maintain adequate stock to ensure service delivery.	**MTSF: Focus area** • Health system effectiveness. **National Ten Point Plan Priority 6:** • Improve the quality of health services **Departmental Strategic Goals:** • Manage the burden of disease.

7.3 RESOURCE CONSIDERATIONS

The current depot has been significantly upgraded. The physical structure consists of a multi-storey 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 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.

7.4 RISK MANAGEMENT

Inadequate working capital is an on-going problem. Motivations have been made annually to augment the working capital in line with the inflationary price increase percentage for pharmaceuticals and other stock, taking into account the annual turnover of the CMD.

The current depot is inadequate to service demands effectively even though the current physical infrastructure has been upgraded. A process is underway to find alternative premises to relocate the depot in the long term.

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

1. PROGRAMME PURPOSE:

To provide for new health facilities, upgrading and maintenance of existing facilities, including the Hospital Revitalisation Programme and the Provincial Infrastructure Grant.

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 8.1: COMMUNITY HEALTH FACILITIES

Construction of new community health facilities and the upgrading and maintenance of existing facilities.

2.2 SUB-PROGRAMME 8.2: EMERGENCY MEDICAL RESCUE

Construction of new medical rescue facilities and the upgrading and maintenance of existing facilities.

2.3 SUB-PROGRAMME 8.3: DISTRICT HOSPITAL SERVICES

Construction of new district hospitals and the upgrading and maintenance of existing hospitals.

2.4 SUB-PROGRAMME 8.4: PROVINCIAL HOSPITAL SERVICES

Construction of new provincial hospitals and the upgrading and maintenance of existing hospitals.

2.5 SUB-PROGRAMME 8.5: CENTRAL HOSPITAL SERVICES

Construction of new central hospitals and the upgrading and maintenance of existing hospitals.

2.6 SUB-PROGRAMME 8.6: OTHER FACILITIES

Construction of other new health facilities and the upgrading and maintenance of existing facilities.

2.7 PROGRAMME OVERVIEW

Although the programme is officially structured in accordance with the above-mentioned sub-programmes, in reality the programme is structured around the funding sources, i.e. Equitable share capital, Provincial Infrastructure Grant [IPG] Hospital Revitalisation Programme [HRP] and equitable share maintenance. The reason for this is the need to spend in accordance with the allocated budgets and conditions applicable to the funding sources.

Delivery of the programme is undertaken jointly by the Department of Health as the client and the Department of Transport and Public Works as implementing agent.

The absence of programme management capacity in Health coupled with capacity (largely expertise) deficiencies in the Department of Transport and Public Works continues to hamper infrastructure delivery. This problem will be addressed both as part of the Infrastructure Delivery Improvement Plan [IDIP] process and in terms of the modernisation exercise of the Provincial Government.

The creation of a new Chief Directorate: Infrastructure Management has been approved and will become operational in 2010/11. The Chief Directorate will incorporate the existing Directorates of Engineering and Technical Support and the Hospital Revitalisation Programme. A new Directorate: Infrastructure Support will be part of this Chief Directorate.

The new Chief Directorate: Infrastructure Management will manage both the infrastructure work undertaken by Implementing Agents and the in-house work undertaken by the engineering workshops at hospitals and the central workshops at Bellville, Vrijzee and Retreat.

3. SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010 - 2014

3.1 ALIGNMENT WITH THE STRATEGIC GOALS OF THE DEPARTMENT

Programme 8 directly supports the Strategic Goals of the Department by providing infrastructure that is:

- Located as indicated in the Comprehensive Service Plan (CSP) to ensure accessibility of healthcare.
- Planned to facilitate the level and quantum of healthcare defined in the CSP.
- Designed to ensure the efficient and effective utilisation of both human and material resources.
- Constructed for ease of maintenance to promote long-term sustainability.

The long-term vision of the Department, Healthcare 2010, requires an incremental approach to the restructuring of health services to align with the CSP. Programme 8 will ensure infrastructure alignment with the implementation of the CSP by providing infrastructure in synchronisation with the re-alignment of health services in the Province.

3.2 FOCUS AREAS

A major infrastructure initiative is to strengthen the rural regional hospitals. The rural regional hospitals at George, Worcester and Paarl are part of the national Hospital Revitalisation Programme. The final phases of these three projects will be completed during the MTEF period.

The need for clinics and community health centres (CHC's) in under-serviced areas is an ongoing focus area for infrastructure delivery. During the MTEF period new CHC's are planned for Malmesbury, Plettenberg Bay, Delft and Knysna. A clinic is planned for Grassy Park.

The upgrading and extending of district hospitals in growth areas and the improvement of district hospitals in other towns is an on-going focus area. The upgrading of the Caledon and Riversdale Hospitals is nearing completion. The upgrading and extension of the Hermanus and Karl Bremer Hospitals will commence in the MTEF period. The final phase of the revitalisation project at Vredenburg Hospital will also commence in the MTEF period.

The increasing of level one beds in the Metropole has long been a priority. The construction of the Khayelitsha and Mitchell's Plain District Hospitals has commenced. These two hospitals will greatly alleviate the level one bed shortage in the Cape Metropole once completed and commissioned.

The upgrading of the Red Cross Children's War Memorial Hospital, in co-operation with the Children's Hospital Trust, continues. In the past three years the Trust has undertaken a number of major projects including the construction of a new operating theatre complex and the upgrading of wards. The ward upgrades will continue in the MTEF period.

The construction of appropriate facilities for the Emergency Medical Services and the upgrading of casualty units at hospitals is a focus area. During the MTEF period new ambulance stations are planned for Khayelitsha, Kwanokuthula, Ceres, Vredendal, Leeu Gamka and Malmesbury. Upgraded casualty units are planned for Knysna, Hermanus, Ceres, Eerste River and Tygerberg Hospitals.

The campaign to prevent the spread of TB and to provide adequate treatment for those infected requires a major improvement of the physical infrastructure. A major concern is infection control to prevent cross infection between patients and to protect the hospital personnel. Interim measures are being applied using maintenance funding. An additional earmarked sum of R10 million was provided in 2008/09 and 2009/10, and a similar amount will be provided in 2010/11. There is an urgent need for new purpose-built facilities. Brooklyn Chest Hospital has been accepted into the Hospital Revitalisation Programme but funding has as yet to be approved.

Table 8.1: Strategic objectives and outcomes for 2010 - 2014

The following are the strategic objectives and outcomes to be achieved using the Programme 8 capital budget.
The programme 8 capital budget includes funding from the following sources:

- Equitable share capital
- Infrastructure Grant to Provinces
- The Hospital Revitalisation Grant
- Donor funding

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
1. Provide and maintain appropriate health technology and infrastructure.	1.1 Construct and commission new health care facilities and upgrade facilities to ensure access to the integrated comprehensive health care platform.	1.1.1. Allocate sufficient capital funding to ensure the infrastructure backlog is significantly reduced between 2010/11 and 2014/15.	1) Programme 8 capital funding as a percentage of total health expenditure	0.6% R599m/ R9,893	0.6% R800/ R13,200	The Programme 8 capital budget provides funding to construct new facilities and to substantially upgrade existing facilities. Quality healthcare requires facilities that are fit for purpose and many of the existing facilities do not meet this criterium.	**MTSF: Focus: Health system effectiveness:** • Improved physical infrastructure **for healthcare delivery,** **National Ten Point Plan Priority 6:** • Revitalisation of Infrastructure **Provincial priority:** • Maximising health outcomes **Departmental Strategic Goals:** • Manage the burden of disease. • Provide and maintain appropriate health technology and Infrastructure
		1.1.2. Complete the 10 PHC projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	2) Number of capital projects completed in PHC facilities that are funded by the Programme 8 capital budget. [Sub-programme 8.1]	New indicator	10	The Clinics and Community healthcare facilities are the first point of contact for ± 90% of patients. Providing appropriate treatment at this level is the most cost effective way to provide an accessible health service. Most of the existing facilities are not suited for purpose and require upgrading or replacement.	
		1.1.3. Complete the 9 ambulance station projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	3) Number of ambulance stations projects completed funded by the Programme 8 capital budget. [Sub-programme 8.2]	0	9	An efficient and effective emergency medical service plays a pivotal role in appropriate access to health services. Many of the existing ambulance stations are not fit for purpose which impacts negatively on personnel morale and the ability to render an effective and efficient service.	

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
		1.1.4. Complete the 14 district hospital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	4) Number of capital projects completed in district hospitals funded by the Programme 8 capital budget. [Sub-programme 8.3]	0	14	Appropriate district hospital infrastructure is essential for the implementation of the CSP. Currently many of the district hospitals require upgrading	
		1.1.5. Complete the 9 provincial hospital capital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	5) Number of capital projects completed in provincial hospitals funded by the Programme 8 capital budget. [Sub-programme 8.4]	0	9	Appropriate provincial hospital infrastructure is essential for the implementation of the CSP. Currently many of the provincial hospitals require upgrading.	
		1.1.6. Complete the 8 central hospital capital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	6) Number of Capital projects completed in central hospitals funded by the Programme 8 capital budget. [Sub-programme 8.5]	0	8	Appropriate central hospital infrastructure is essential for the implementation of the CSP. Currently central hospitals require upgrading.	
		1.1.7. Complete the 6 forensic mortuary and other projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	7) Number of projects completed in forensic mortuaries and other projects funded by the Programme 8 capital budget. [Sub-programme 8.6]	0	6	The Forensic Service was taken over from the SAPS. Much of the infrastructure is deficient and is in need of replacement	

3.3 RESOURCE CONSIDERATIONS

The following have been taken into consideration when determining the strategic objectives:

- It is anticipated that there will be an increase in the budget at least equal to inflation beyond the MTEF period.
- It is assumed that there will be no unfunded priorities.
- It is assumed that the availability and expertise of key personnel will be augmented with the establishment of the proposed Chief Directorate: Infrastructure Management.

Table 8.2 shows the historic and projected expenditure in Health Facilities Management.

Table 8.2: Historical and planned capital expenditure by type

R'000s	2007/08 (actual)	2008/09 (actual)	2009/10 (estimate)	2010/11 (MTEF projection)	2011/12 (MTEF projection)	2012/13 (MTEF projection)	2013/14 (MTEF projection	2014/15 (MTEF projection
Major capital (Health)	16,434	21,000	68,000	30,000	31,000	33,000	33,000	33,000
Major capital (HRP)	192,159	238,992	388,845	580,554	485,501	506,363	506,363	506,363
Major capital (IPG)	79,429	94,643	114,924	131,529	160,540	178,539	178,539	178,539
Major capital (Other)	43,456	34,291	27,050	-	-	-	-	-
Major capital (Donor RCCH)	25,000	25,000	-	-	-	-	-	-
Maintenance and minor capital	84,155	85,197	113,405	134,565	141,679	147,444	147,444	147,444
Total capital	**440,633**	**499,123**	**712,224**	**876,648**	**818,720**	**865,346**	**865,346**	**865,346**

Notes on table HFM 1

1. "Maintenance and minor capital" is the "maintenance" expenditure by Public Works.
2. "Major Capital (Other)" refers to the upgrade of the forensic ~~and~~ pathology service ?

4. RISK MANAGEMENT

4.1 MANAGEMENT OF THE PROGRAMME

The management of this programme poses a challenge, and in particular that which relates to financial administration and accountability. The programme budget is with the Department of Health whereas the actual expenditure occurs within the Department of Transport and Public Works. The present arrangement makes the accounting officer of Health accountable for all expenditure and the programme performance, while having no direct jurisdiction over the actions that lead to such expenditure. Thus the Department of Health is accountable for the budget for the capital projects for the Department, however, it currently makes use of the Department of Transport and Public Works as the implementing agent to implement and manage the respective projects.

The programme has under-spent its budget in the past three years as a result of inadequate managerial control over the implementation of projects.

The management of the Programme is being addressed as part of the IDIP process. In line with the IDIP Business Plan a new organisational structure is being created to manage the programme as

required in terms of the Division of Revenue Act (DORA). The new structure will also provide capacity to fulfil the requirements of the Government Immovable Assets Management Act (GIAMA). It was the intention to commence the filling of posts in the new structure during 2008. However, final approval for the creation of the new structure is subject to the approval of the Department of Public Administration and the filling of posts is only likely to commence in 2010. The plan provides for the establishing of programme management capacity in Health.

4.2 CAPACITY CONSTRAINTS

The lack of infrastructure planning and programme management capacity in Health, coupled with capacity deficiencies, largely specialist healthcare engineering expertise, in the Department of Transport and Public Works, continues to hamper infrastructure delivery. The result is long planning lead times and ineffective programme management on the one hand, and inappropriate designs, excessively high consultant's fees and inordinate time delays on the other. Ultimately, projects are delayed and annual budget allocations are under-spent.

However, it is important to note that, in conjunction with the IDIP initiative, capacity constraints are being addressed. Specifically:

- The Department of Health has recently approved a new Chief Directorate: Infrastructure Management and the posts are currently being filled.
- The Western Cape Department of Transport and Public Works has recently been designated the provinces preferred Implementing Agent and as a result, specific energies within the province are being focussed on ensuring that it has the necessary capacity to deliver on this mandate
- The technical and professional personnel of both Health and of Public Works are together working on an initiative to produce standard drawings and technical specifications, design guidelines, and space planning norms and standards. This will go a long way in improving the turn-around time of the planning and design processes.

4.3 FUNDING MECHANISMS

The estimated backlog in infrastructure is estimated to be in the order of R5.8 billion. It is clear that the existing funding streams will not address this backlog in a reasonable time frame. The Department has identified the sale of surplus property as a viable means of supplementing infrastructure funding. Whilst vacant land is limited, the rationalisation of facilities could release significant parcels of valuable land to fund new infrastructure. Examples are the construction of replacement facilities for the existing Somerset and Stikland Hospitals on small portions of their existing sites thereby creating surplus land for re-development. The Provincial Treasury has indicated support for this initiative.

The CSIR has completed a report on the condition and suitability of the physical infrastructure at Tygerberg Hospital. The recommendation is that it will be more economical to construct a new hospital than to upgrade and renovate the existing hospital. Tygerberg Hospital has been accepted into to the Hospital Revitalisation Programme but has yet to be funded. The Department has registered the project as a Mega Project with National Treasury. There is great potential to fund the project through a public private partnership (PPP) with the bonus of an income stream from the redevelopment of the existing hospital building by the private partner.

5. CAPITAL INFRASTRUCTURE PROGRAMME

5.1 Deliverables

The tables that follow indicate the deliverables in the capital infrastructure programme.

5.2 Definitions

Inception:	Health is detailing the need and is drafting a brief for Public Works
Planning:	Public Works have received the brief from Health and are proceeding with the design.
Tender:	Public Works have completed the documentation to tender readiness.
Construction:	Project is under construction.
Start date:	Date of letter of acceptance of tender
Completion date:	Date of practical completion
Duration:	Time from Start to Completion.

Schedule 1: Capital Projects Funding

No	Sub Program.	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2008/09 R'000	2009/10 R'000	2010/11 R'000	2011/12 R'000	2012/13 R'000	2013/14 R'000	2014/15 R'000
1	8.1	Bonnievale New clinic	Clinic	Inception	12	2013	2014	9 600			100	500	5 200	4 000	
2	8.2	De Doorns ambulance station	Ambulance station	Inception	6	2012	2013	5 000				200	4 700	100	
3	8.2	Heidelberg ambulance station	Ambulance station	Inception	12	2015	2016	4 000				100	584	1 416	4 100
4	8.2	Piketberg Ambulance Station	Ambulance station	Inception	12	2011	2012	8 700			100	6 484	2 116		
5	8.5	Red Cross Hospital	Radiology & Paed. ward	Inception	12	2013	2014	23 500						7 000	16 500
6	8.2	Robertson Hospital	Ambulance station	Inception	12	2013	2014	8 000					400	6 300	1 500
7	8.2	Tulbach Ambulance Station	Ambulance station	Inception	12	2013	2014	5 184			100			4 184	900
8	8.2	Leeu Gamka Ambulance Station	Ambulance station	Planning	15	2010	2011	10 400	120	364	6 600	3 316			
9	8.5	Red Cross Hospital	Ward upgrades		12					7 000	7 000	8 000	10 000		
10	8.1	Simondium	New CHC	Complete	16	2006	2007	11 000		720					
11	8.2	Swellendam Ambulance station	Property to be acquired		6	2010	2010	800			800				
12	8.5	Tygerberg	Kitchen					7 500			5 100	2 400			
13	8.2	Vredendal Hospital	Ambulance station	Tender	12	2009	2010	10 000	500	997					
14	8.1	Wellington	New CHC	Complete	22	2006	2008	21 500	10 249	1 998					
	TOTALS									**11 079**	19 800	21 000	23 000	23 000	23 000
	BUDGET								**11 000**	**18 000**	19 800	21 000	23 000	23 000	23 000

Schedule 2: Capital Projects Funding (Earmarked TB allocation)

No	Sub Prog.	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2008/09 R'000	2009/10 R'000	2010/11 R'000	2011/12 R'000	2012/13 R'000	2013/14 R'000	2014/15 R'000
1	8.4	Bewelskloof TB Hospital	Fire Escape	Complete	3	2008	2008	450	450						
2	8.4	Brooklyn Chest TB hospital	Repair & renovations	Complete	10	2009	2009	5 800	350	5 935					
3	8.4	Brooklyn Chest TB hospital	New MDR & XDR wards		Inception	48	2011	2015			2 000	8 000	10 000	10 000	10 000
4	8.4	George Harry Comay TB Hospital	Repair & renovations	Complete	8	2008	2009	1 600	650	868					
5	8.4	Malmesbury TB Hospital	Repair & renovations	Complete	12	2008	2009	3 700	400	3 185					
6	8.4	Paarl Sonstraal TB hospital	Repair & renovations	Complete	9	2009	2009	6 600	900	5 700					
7	8.4	Paarl Sonstraal TB hospital		Inception	12	2010	2011				4 000	2 000			
8	8.4	Paarl Sonstraal TB hospital	UV lights & extraction	Inception	12	2010	2011				4 000				
	TOTAL								**2 750**	15 688	10 000	10 000	10 000	10 000	10 000
	BUDGET								**10 000**	10 000	10 000	10 000	10 000	10 000	10 000

Schedule 3: Infrastructure Grant to Provinces

No	Sub Program.	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2007/08 R'000	2008/09 R'000	2009/10 R'000	2010/11 R'000	2011/12 R'000	2012/13 R'000	2013/14 R'000	2014/15 R'000
1	8.1	Asanda Clinic	New clinic	Inception	12	2013	2015	24 000				**800**			10000	13 200
2	8.1	Beaufort West	New clinic	Inception	12	2014	2015	15 000							1 500	10 000
3	8.1	Delft Symphony Way	New CHC	Inception	18	2011	2013	35 000				**1 940**	21 060	12 000		
4	8.1	District 6	New CHC	Inception	18	2013	2015	35 000				**911**	100	8 000	24 000	1 989
5	8.1	Du Noon CHC	New CHC	Inception	24	2011	2014	80 000				**2 000**	18 000	45 000	15 000	
6	8.1	Hermanus	New CHC	Inception	18	2013	2015	35 000				**800**		21 925	10 000	
7	8.1	Rawsonville	New clinic	Inception	12	2013	2014	8 300				**300**			8 000	
8	8.1	Weltevedren Valley	New CHC	Inception	14	2013	2015	36 000				**500**			1 000	12 000
9	8.2	Malmesbury EMS	Ambulance station	Inception	12	2011	2012	10 000				**1 200**	8 000	800		
10	8.2	Pinelands EMS	New Ambulance Station	Inception	18	2014	2016	20 000							5 314	7 914
11	8.3	Karl Bremer Hosp	Emergence Centre	Inception	20	2012	2104	50 000				**1 200**	10 000	25 000	12 800	1 000
12	8.3	Knysna Hospital	Emergence Centre	Inception	18	2013	2015	25 000				**2000**	100	100	20 000	2 800
13	8.3	Robertson Hospital	EC and new wards	Inception	24	2014	2016	60 000						1 000	20 000	23 436
14	8.3	Robertson Hospital	Maternity ward	Inception	9	2011	2012	3 000				**500**	2 500			
15	8.3	Swellendam Hospital	EC and offices	Inception	12	2016	2018	12 500								700
16	8.5	Groote Schuur Hospital	Interim improvements	Inception				36 425						500	15 925	20 000
17	8.5	Groote Schuur Hospital	Master Plan	Inception	24	2010	2011	1 500				**500**	1 000			
18	8.5	Tygerberg Hospital	Interim improvements	Inception				35 500						3 000	13 500	19 000
19	8.6	Dept of Health	CD:IM offices	Inception	10	2010	2011	3 000				**3 000**				
20	8.6	Riversdale Hospital	Forensic mortuary	Inception	12	2013	2014	8 200				**1 000**			5 000	2 500
21	8.6	Salt River	Forensic mortuary	Inception	24	2014	2016	120 000				**1 420**		6 509	9 912	60 000
22	8.1	Knysna - Witlokasie	New CHC	Planning	18	2011	2013	35 000			200	**2000**	11 800	21 000		
23	8.3	Caledon Hospital	Upgrade - phase 2	Planning	12	2010	2011	8 000			660	**6 000**	1 340			
24	8.3	Ceres Hospital	Emergence Centre	Planning	12	2010	2012	8 000			90	**5 910**	2 000			
25	8.3	Hermanus Hospital	EC and new wards	Planning	30	2010	2013	68 000			2 000	**16 000**	27 926	24 412	2 588	
26	8.3	Malmesbury Hospital	Casualty extension	Planning	12	2010	2011	3 000				**3 000**				
27	8.3	Riversdale Hospital	Phase 3 upgrade	Planning	9	2010	2011	7 500				**6 000**	1 500			
28	8.4	Somerset Hospital	Lift Upgrade	Planning	15	2010	2011	6 000			348	**920**	4 500			

No	Sub Program.	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2007/08 R'000	2008/09 R'000	2009/10 R'000	2010/11 R'000	2011/12 R'000	2012/13 R'000	2013/14 R'000	2014/15 R'000
29	8.5	Groote Schuur Hospital	Alt TB patient areas	Planning	8	2010	2010	900			150	**750**				
30	8.5	Groote Schuur Hospital	NMB fire detection ph 2	Planning	12	2010	2011	3 500				**1 500**	1 950			
31	8.5	Tygerberg Hospital	EC Upgrade	Planning	12	2010	2011	13 200			500	**3 000**	7 700	2 000		
32	8.6	4 Dorp Street	15th and 16th floor	Planning	4	2009	2010	150			250					
33	8.6	Beaufort West Hospital	Forensic mortuary	Planning	12	2011	2013	8 000				**6 000**	2 000			
34	8.6	Central Karoo	Office accommodation	Planning	5	2009	2010	1 800			200	**1 600**				
35	8.1	Grassy Park	New clinic	Tender	14	2010	2011	18 100		34	859	**16 643**	523			
36	8.1	Malmesbury - Wesbank	New CHC	Tender	18	2010	2011	33 000		238	1 337	**12 000**	19 039	100		
37	8.2	Lamberts Bay	Ambulance station	Tender	4	2010	2010	1 622		5	659	**847**				
38	8.2	Vredendal Hospital	Ambulance Station	Tender				10 000				**7 285**	1 550			
39	8.5	Groote Schuur Hospital	Relocation of Engineering Workshop	Tender	8	2010	2011	8 400			1 616	**6 000**	1 200			
40	8.5	Groote Schuur Hospital	Upgrade pharmacy	Tender	15	2010	2011	16 500		12	1878	**7 295**	4 000	3 193		
41	8.1	Bonnievale/Happy Valley Clinic	Extend clinic	Construction	6	2009	2010	1 500			840	**500**				
42	8.1	Kwanokuthula	New CDC	Construction	18	2010	2011	30 000			2 200	**24 000**	6 000			
43	8.1	Mitchell's Plain CHC	EC & Pharmacy	Construction	12	2009	2010	33 700				**10 200**				
44	8.2	Ceres	Ambulance Station	Construction	12	2010	2011	10 500		148	1 018	**8 000**	1 352			
45	8.2	Kwanokuthula	New ambulance station	Construction	12	2010	2011	9 000		110	495	**7 000**	1 400			
46	8.3	Eerste River Hospital	New casualty	Construction	16	2008	2010	30 139	438	7 400	17 828	**3 115**				
47	8.3	Riversdale Hospital	Phase 2 upgrade.	Construction	22	2008	2010	17 000		8 450	7 214	**1 271**				
48	8.3	Vredendal Hospital	New Chiller	Construction	2	2009	2010	150			150					
49	8.4	Somerset Hospital	2010 Enabling Work	Construction	10	2009	2010	32 131				**2 000**				
50	8.5	Groote Schuur Hospital	Security upgrade Ph 1	Construction	8	2009	2010	12 500		373	7 226	**1 727**				
51	8.5	Tygerberg Hospital	Electric fence	Construction	9	2009	2010	2 400			2 979	**100**				
52	8.5	Tygerberg Hospital	Lift upgrading	Construction	14	2008	2010	7 956		200	7 656	**100**				
53	8.4	Somerset Hospital	Shipley building renovation	Complete		2009	2009					**500**				
54	8.5	Groote Schuur Hospital	Fire detection Ph 1	Complete	36	2006	2009	14 000	8 100	3 300	1 930	**570**				
55	8.5	Groote Schuur Hospital	Lift upgrading	Complete	11	2007	2007	2 264	1 926	277	61					

No	Sub Program.	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2007/08 R'000	2008/09 R'000	2009/10 R'000	2010/11 R'000	2011/12 R'000	2012/13 R'000	2013/14 R'000	2014/15 R'000
56	8.5	Groote Schuur Hospital	Pharmacy store a/c	Complete	2	2009	2009	146			146					
57	8.5	Groote Schuur Hospital	Topographical survey	Complete	4	2009	2009	534			534					
58	8.5	Groote Schuur Hospital	Ugrade D23 department anaesthesia	Complete	5	2009	2009	2 150		193	2 142	87				
59	8.5	Tygerberg Hospital	Helipad	Complete	4	2009	2009	1 470			1 242					
60	8.5	Tygerberg Hospital	Security fence - East Side	Complete	4	2009	2009	6 100		745	4 919	55				
61	8.1	Mitchell's Plain CHC	Site acquistion	In progress		2010	2010	2 500				2 500				
62	8.3	Beaufort West Hospital	New store	Complete	7	2008	2009	3 852		1 752	2 267					
63	8.3	Bredasdorp Hospital	Upgrade entrance & store	Complete	3	2008	2008	827		801	26					
64	8.3	Caledon hospital	Upgrading of electrical supply	Complete	5	2008	2008	1 822		1 447	544					
65	8.3	Caledon Hospital	New wards & EMS	Complete	8	2007	2009	26 500	8 200	12 500	3 522					
66	8.3	Eerste River Hospital	Pre-Fab	Complete	6	2009	2009	4 500		4 000	500					
67	8.3	Helderberg Hospital	New OPD & wards	Complete	14	2007	2008	18 400	2 630	12 800	1 058					
68	8.3	Riversdale Hospital	Phase 1	Complete	12	2007	2008	5 000			155					
69	8.3	Riversdale Hospital	Resurface roads	Complete	6	2009	2009	2 018		33	1 925	60				
70	8.3	Vredendal Hospital	CSSD and X-Ray	Complete	30	2006	2008	9 000	4 485	1250	1164					
71	8.4	Western Cape Rehab	Road maintenance								1 000					
72	8.5	Groote Schuur Hospital	Survey for place utilisation	In progress	12	2008	2009	2 972			2 972					
73	8.5	Tygerberg Hospital	Fire door upgrade phase 2	Retention	15	2008	2009	4 433		1 263	2 703	194				
74	8.6	4 Dorp Street	video conference								200					
75	8.6	Dept of Health	Technical capacity	In progress				1 000			1 000	3 000	4 000	4 000	4 000	4 000
76	8.6	George Harry Comay	Office accomodation								3 000					
		TOTAL	**Expenditure**						25 779	57 331	91 363	185 800	160 540	178 539	178 539	178 539
								BUDGET	80 262	94 643	114 924	131 529	160 540	178 539	178 539	178 539
								Roll over			30 710	54 271				
								Adjust Budget			145 634	185 800	160 540	178 539	178 539	178 539
								Under/ over expenditure		54 271						

Schedule 4: Hospital Revitalisation

No.	Sub Prog	Project name	Project Description/ Type of Infrastructure	Project duration		Total project cost		Estimated expenditure to date from previous years	Professional Fees Budget	Construction/ Maintenance Budget	Total available	MTEF Forward Estimates				
				Date: Start	Date: Finish	At start	At completion		MTEF 2009/10			MTEF 2010/11	MTEF 2011/12	MTEF 2012/13	MTEF 2013/14	MTEF 2014/15
								R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
1	8.3	Helderberg	Replacement Hospital	1-Apr-14	31-Mar-17	300 000	350 000							3 500	40 000	80 000
2	8.3	Mitchell's Plain hospital	Regional laundry upgrade	1-Apr-13	31-Mar-13	30 000	40 000							2 501	35 000	
3	8.3	Mossel Bay	New hospital	1-Oct-13	31-Mar-16	300 000	350 000							2 000	25 500	80 500
4	8.3	Victoria	Replacement Hospital	1-Oct-14	31-Mar-17	540,000	600,000							2 000	25 500	25 862
5	8.4	Brooklyn Chest	Extensions & Upgrades	1-Apr-13	31-Mar-13	350,000	400,000							2 000	80 000	134 500
6	8.4	Worcester Hospital phase 5	Hospital upgrade phase 5	1-Apr-12	30-Jun-13	30 000	32 000						2 500	25 000	4 500	
7	8.5	Tygerberg	Replacement Hospital									2 000	7 200	29 000	25 000	25 000
8	8.3	Vredenburg hospital	Upgrading phase 2B	1-Oct-10	30-Sep-12	90,000	138,000	3 000	2 257		2 257	8 000	47 000	70 000	2 804	
9	8.4	Paarl Hospital	New Administration Block	1-Apr-13	31-Mar-14	18 000	25 000					2 000	23 000			
10	8.4	Valkenberg hospital	Hospital upgrading	1-Apr-12	31-Mar-17	1 000 000		1 200	240		240	6 500	5 000	66 677	187 558	80 000
11	8.1	Paarl TC Newman CHC	Community health center upgrade (co-funded GF)	15-May-09	14-May-11	10 000	10 000					16 000				
12	8.3	Khayelitsha hospital	New hospital and ambulance station	5-Jan-09	4-Jan-12	480 000	540 000	52 000	11 000	104 594	115 594	193 924	115 600	7 962		
13	8.3	Mitchell's Plain hospital	New hospital	22-Sep-09	21-Oct-12	480 000	520 000	32 000	5 319	6 391	11 710	120 500	212 076	168 224		
14	8.3	Vredenburg hospital	Upgrading phase 1B- Varous internal work	29-Oct-08	31-Mar-09	3,700	5,600	1 800	356	2 964	3 320	20				
15	8.3	Vredenburg hospital	Upgrading phase 2A	28-Jan-09	29-Jul-10	30,000	35,000	1 200	2 045	14 641	16 686	11 000				
16	8.4	George hospital	Hospital upgrade phase 3	1-Apr-09	31-Mar-11	56 000	59 000	2 500	5 160	14 249	19 409	28 750	5 000			

No.	Sub Prog	Project name	Project Description/ Type of Infrastructure	Project duration		Total project cost		Estimated expenditure to date from previous years	Professional Fees Budget	Construction/ Maintenance Budget	Total available	MTEF Forward Estimates				
				Date: Start	Date: Finish	At start	At completion		MTEF 2009/10			MTEF 2010/11	MTEF 2011/12	MTEF 2012/13	MTEF 2013/14	MTEF 2014/15
								R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
17	8.4	Paarl hospital	Hospital upgrade	10-Apr-06	1-Dec-10	332 000	430 000	228 861	9 278	105 569	114 847	90 000	6 100			
18	8.4	Valkenberg hospital	Emergency repairs to admin building	17-Apr-09	31-Mar-10	5,000	7,800	1 750	1 109	4 801	5 910	1 500				
19	8.4	Worcester hospital phase 4	Hospital upgrade phase 4	2-Nov-09	1-Nov-10	20 000	45 000		3 991	3 621	7 612	30 000	1 300			
20	8.2	Worcester DMC & ambulance station	New DMC and ambulance station	14-Nov-06	9-Apr-09	10 900	16,400	11 500	759	7 962	8 721					
21	8.3	Khayelitsha hospital	Infrastructure Installation	8-Aug-08	23-Mar-09	14 000	15 020	9 700	400	5 397	5 797					
22	8.4	Worcester hospital phase 3	Hospital upgrade phase 3	26-Jun-03	31-Dec-08	170 000	260 540	255 000	2 626	3 053	5 679					
									Infrastructure		317 782	510 194	424 776	378 864	425 862	425 862
									OD and QA		89 500	81 923	67 925	127 499	80 501	80 501
									TOTAL		407 282	592 117	492 701	506 363	506 363	506 363
									Roll-over		30 000	11 563				
									BUDGET		388 845	580 554	492 701	506 363	506 363	506 363
									Adjustment Budget		418 845	592 117	492 701	506 363	506 363	506 363
									Surplus / (Shortfall)		11 563					

Schedule 5: Recurrent Maintenance

Name of the project/Programme	Type of infrastructure	Brief need/ proposed outcome	2008/09 R'000	2009/10 R'000	2010/11 R'000	2011/12 R'000	2012/13 R'000	2013/14 R'000	2014/15 R'000
Vote 6 : Health	Community Health facilities	Maintain Serviceability	9 678	9 678	14 651	15 426	16 053	16 053	16 053
	District Hospitals	Maintain Serviceability	11 000	12 000	18 158	19 118	19 896	19 896	19 896
	Provincial Hospitals	Maintain Serviceability	21 725	22 533	34 075	35 876	37 336	37 336	37 336
	Central Hospitals	Maintain Serviceability	37 794	38 716	58 602	61 700	64 211	64 211	64 211
	Other Facilities	Maintain Serviceability	5 000	6 000	9 079	9 559	9 948	9 948	9 948
TOTAL			85 197	88 927	134 565	141 679	147 444	147 444	147 ,444

PART C:

Links to other plans

PART C: LINKS TO OTHER PLANS

1. LINKS TO THE LONG-TERM INFRASTRUCTURE AND OTHER CAPITAL PLANS

Table C1: Links to the long-term infrastructure plan

No	Project Name	Prog	Municipality	Outputs	Out come			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimate		
					2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
1	**New and replacement assets** (R 'thousand)												
	Bonnievale New clinic	8.1	Cape Winelands	Clinic				100			500	4 800	3 800
	De Doorns ambulance station	8.2	Cape Winelands	Ambulance station							200	4 700	100
	Heidelberg ambulance station	8.2	Eden	Ambulance station							100		
	Leeu Gamka Ambulance Station	8.2	Central Karoo	Ambulance station		120	364	6 600			3 316		
	Piketberg Ambulance Station	8.2	West Coast	Ambulance station				100			6 868	1 732	
	Red Cross Hospital	8.5	Cape Town	Ward upgrades			7 000	7 000			8 000	9 952	
	Robertson Hospital	8.2	Cape Winelands	Ambulance station								200	6 300
	Simondium	8.1	Cape Winelands	New CHC			720						
	Swellendam Ambulance station	8.2	Overberg	Property to be acquired				800					
	Tulbach Ambulance Station	8.2	Cape Winelands	Ambulance station				100					4 184
	Vredendal Hospital	8.2	West Coast	Ambulance station		500	997						
	Wellington	8.1	Cape Winelands	New CHC		10 249	1 998						
	Helderberg	8.3	Cape Town	Replacement Hospital								3,500	40,000
	Khayelitsha hospital	8.3	Cape Town	Infrastructure Installation				5,797					
	Khayelitsha hospital	8.3	Cape Town	New hospital and ambulance station			115,594	196,021			115,600	7,962	
	Mitchell's Plain hospital	8.3	Cape Town	New hospital			11,710	120,500			238,000	142,300	
	Mossel Bay	8.3	Eden	New hospital								2,000	25,500
	Tygerberg	8.5	Cape Town	Replacement Hospital				2,000			7,200	29,000	25,000
	Victoria	8.3	Cape Town	Replacement Hospital								2,000	5,058
	Worcester DMC & ambulance station	8.2	Cape Winelands	New DMC and ambulance station			8,721						
	Asanda Clinic	8.1	Cape Town	New clinic				800					10000
	Beaufort West	8.1	Central Karoo	New clinic									1 500

No	Project Name	Prog	Municipality	Outputs	Out come			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimate		
					2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
	Beaufort West Hospital	8.6	Central Karoo	Forensic mortuary				6 000			2 000		
	Central Karoo	8.6	Central Karoo	Office accommodation			200	1 600					
	Ceres	8.2	Cape Winelands	Ambulance Station		148	1 018	8 000			1 352		
	Delft Symphony Way	8.1	Cape Town	New CHC				1 940			21 060	12 000	
	District 6	8.1	Cape Town	New CHC				911			100	8 000	24 000
	Du Noon CHC	8.1	Cape Town	New CHC				2 000			18 000	45 000	15 000
	George Harry Comay	8.6	Eden	Office accommodation			3 000						
	Grassy Park	8.1	Cape Town	New clinic		34	859	16 643			523		
	Hermanus	8.1	Overberg	New CHC				800				21 925	10 000
	Knysna - Witlokasie	8.1	Eden	New CHC			200	2000			11 800	21 000	
	Kwanokuthula	8.2	Eden	New ambulance station		110	495	7 000			1 400		
	Kwanokuthula	8.1	Eden	New CDC			2 200	24 000			6 000		
	Malmesbury - Wesbank	8.1	West Coast	New CHC		238	1 337	12 000			19 039	100	
	Malmesbury EMS	8.2	West Coast	Ambulance station				1 200			8 000	800	
	Pinelands EMS	8.2	Cape Town	New Ambulance Station									5 314
	Rawsonville	8.1	Cape Winelands	New clinic				300					8 000
	Riversdale Hospital	8.6	Eden	Forensic mortuary				1 000					5 000
	Salt River	8.6	Cape Town	Forensic mortuary				1 420				6 509	9 912
	Vredendal Hospital	8.2	West Coast	Ambulance Station				7 285			1 550		
	Weltevedren Valley	8.1	Cape Town	New CHC				500					1 000
Total new and replacement assets						**20 120**	**155 489**	**426 620**			**470 608**	**323 480**	**199 668**

No	Project Name	Prog	Municipality	Outputs	Out come			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimate		
					2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
2	**Maintenance and repairs**												
	(R thousand)												
	Community Health facilities	8.1		Maintain Serviceability		9,678	9,678	14 651			15 426	16 053	16 053
	District Hospitals	8.3		Maintain Serviceability		11,000	12,000	18 158			19 118	19 896	19 896
	Provincial Hospitals	8.4		Maintain Serviceability		21,725	22,533	34 075			35 876	37 336	37 336
	Central Hospitals	8.5		Maintain Serviceability		37,794	38,716	58 602			61 700	64 211	64 211
	Other Facilities	8.6		Maintain Serviceability		5,000	6,000	9 079			9 559	9 948	9 948
Total maintenance and repairs						**85 197**	**88 927**	**134 565**			**141 679**	**147 444**	**147 444**
3	**Upgrades and additions**												
	(R thousand)												
	Brewelskloof TB Hospital	8.4	Cape Winelands	Fire Escape		450							
	Brooklyn Chest TB hospital	8.4	Cape Town	Repair & renovations		350	5 935						
	Brooklyn Chest TB hospital	8.4	Cape Town	New MDR & XDR wards				2 000			8 000	10 000	10 000
	George Harry Comay TB Hospital	8.4	Eden	Repair & renovations		650	868						
	Malmesbury TB Hospital	8.4	West Coast	Repair & renovations		400	3 185						
	Paarl Sonstraal TB hospital	8.4	Cape Winelands	Repair & renovations		900	5 700						
	Paarl Sonstraal TB hospital	8.4	Cape Winelands	Interim improvements				3 500			2 000		
	Paarl Sonstraal TB hospital	8.4	Cape Winelands	UV lights & extraction				4 000					
	Red Cross Hospital	8.5	Cape Town	Radiology & Paediatric. ward									7 000
	Tygerberg	8.5	Cape Town	Kitchen				5 100			2 400		
	4 Dorp Street	8.6	Cape Town	15th and 16th floor			250						
	4 Dorp Street	8.6	Cape Town	Video conference			200						
	Beaufort West Hospital	8.3	Central Karoo	New store		1 752	2 267						
	Bonnievale/Happy Valley Clinic	8.1	Cape Winelands	Extend clinic			840	500					
	Bredasdorp Hospital	8.3	Overberg	Upgrade entrance & store		801	26						
	Caledon hospital	8.3	Overberg	Upgrading of electrical supply		1 447	544						
	Caledon Hospital	8.3	Overberg	New wards & EMS		12 500	3 522						
	Caledon Hospital	8.3	Overberg	Upgrade - phase 2			660	6 000			1 340		

No	Project Name	Prog	Municipality	Outputs	Out come			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimate		
					2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
	Ceres Hospital	8.3	Cape Winelands	Emergence Centre			90	5 910			2 000		
	Dept of Health	8.6	Cape Town	CD:IM offices				3 000					
	Dept of Health	8.6	Cape Town	Technical capacity			1 000	3 000			4 000	4 000	4 000
	Eerste River Hospital	8.3	Cape Town	New casualty		7 400	17 828	3 115					
	Eerste River Hospital	8.3	Cape Town	Pre-Fab		4 000	500						
	Groote Schuur Hospital	8.5	Cape Town	Alt TB patient areas			150	750					
	Groote Schuur Hospital	8.5	Cape Town	Fire detection Ph 1		3 300	1 930	570					
	Groote Schuur Hospital	8.5	Cape Town	Interim improvements								500	15 925
	Groote Schuur Hospital	8.5	Cape Town	Lift upgrading		277	61						
	Groote Schuur Hospital	8.5	Cape Town	Master Plan				500			1 000		
	Groote Schuur Hospital	8.5	Cape Town	NMB fire detection ph 2				1 500			1 950		
	Groote Schuur Hospital	8.5	Cape Town	Pharmacy store a/c			146						
	Groote Schuur Hospital	8.5	Cape Town	Relocation of Engineering Workshop			1 616	6 000			1 200		
	Groote Schuur Hospital	8.5	Cape Town	Security upgrade Ph 1		373	7 226	1 727					
	Groote Schuur Hospital	8.5	Cape Town	Survey for place utilisation			2 972						
	Groote Schuur Hospital	8.5	Cape Town	Topographical survey			534						
	Groote Schuur Hospital	8.5	Cape Town	Upgrade D23 department anaesthesia		193	2 142	87					
	Groote Schuur Hospital	8.5	Cape Town	Upgrade pharmacy		12	1878	7 295			4 000	3 193	
	Helderberg Hospital	8.3	Cape Town	New OPD & wards		12 800	1 058						
	Hermanus Hospital	8.3	Overberg	EC and new wards			2 000	16 000			27 926	24 412	2 588
	Karl Bremer Hosp	8.3	Cape Town	Emergence Centre				1 200			10 000	25 000	12 800
	Knysna Hospital	8.3	Eden	Emergence Centre				2000			100	100	20 000
	Lamberts Bay	8.2	West Coast	Ambulance station		5	659	847					
	Malmesbury Hospital	8.4	Eden	Casualty extension				3 000					
	Mitchell's Plain CHC	8.1	Cape Town	Emergency Centre & Pharmacy				10 200					
	Mitchell's Plain CHC	8.1	Cape Town	Site acquisition				2 500					
	Riversdale Hospital	8.3	Eden	Phase 1			155						
	Riversdale Hospital	8.3	Eden	Phase 2 upgrade.		8 450	7 214	1 271					

No	Project Name	Prog	Municipality	Outputs	Out come			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimate		
					2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
	Riversdale Hospital	8.3	Eden	Phase 3 upgrade				6 000			1 500		
	Riversdale Hospital	8.3	Eden	Resurface roads		33	1 925	60					
	Robertson Hospital	8.3	Cape Winelands	EC and new wards								1 000	20 000
	Robertson Hospital	8.3	Cape Winelands	Maternity ward				500			2 500		
	Somerset Hospital	8.4	Cape Town	2010 Enabling Work				2 000					
	Somerset Hospital	8.4	Cape Town	Lift Upgrade			348	920			4 500		
	Somerset Hospital	8.4	Cape Town	Shipley building renovation				500					
	Swellendam Hospital	8.3	Overberg	EC and offices									
	Tygerberg Hospital	8.5	Cape Town	EC Upgrade			500	3 000			7 700	2 000	
	Tygerberg Hospital	8.5	Cape Town	Electric fence			2 979	100					
	Tygerberg Hospital	8.5	Cape Town	Helipad			1 242						
	Tygerberg Hospital	8.5	Cape Town	Interim improvements								3 000	13 500
	Tygerberg Hospital	8.5	Cape Town	Lift upgrading		200	7 656	100					
	Tygerberg Hospital	8.5	Cape Town	Security fence - East Side		745	4 919	55					
	Tygerberg Hospital	8.5	Cape Town	Fire door upgrade phase 2		1 263	2 703	194					
	Vredendal Hospital	8.3	West Coast	CSSD and X-Ray		1250	1164						
	Vredendal Hospital	8.3	West Coast	New Chiller			150						
	Western Cape Rehab	8.4	Cape Town	Road maintenance			1 000						
Total upgrades and additions						**59 551**	**97 742**	**105 001**			**82 116**	**73 205**	**105 815**
4	**Rehabilitation, renovations and refurbishments (R thousand)**												
	Brooklyn Chest	8.4	Cape Town	Extensions & Upgrades								2,000	80,000
	George hospital	8.4	Eden	Hospital upgrade phase 3			19,409	28,750			5,000		
	Mitchell's Plain hospital	8.3	Cape Town	Regional laundry upgrade								2,501	35,000
	Paarl Hospital	8.4	Cape Winelands	New Administration Block								2,000	23,000
	Paarl hospital	8.4	Cape Winelands	Hospital upgrade			114,847	90,000			6,100		
	Paarl TC Newman CHC	8.1	Cape Winelands	Community health center upgrade (co-funded GF)			-	16,000					

No	Project Name	Prog	Municipality	Outputs	Out come			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium Term Estimate		
					2007/08	2008/09	2009/10	2010/11			2011/12	2012/13	2013/14
	Valkenberg hospital	8.4	Cape Town	Hospital upgrading			240	2,285			2,076	90,601	185,000
	Valkenberg hospital	8.4	Cape Town	Emergency repairs to admin building			5,910	1,500					
	Vredenburg hospital	8.3	West Coast	Upgrading phase 2B			2,257	8,000			47,000	70,000	2,804
	Vredenburg hospital	8.3	West Coast	Upgrading phase 1B- Various internal work			3,320	20					
	Vredenburg hospital	8.3	West Coast	Upgrading phase 2A			16,686	11,000					
	Worcester hospital phase 3	8.4	Cape Winelands	Hospital upgrade phase 3			5,679	-					
	Worcester hospital phase 4	8.4	Cape Winelands	Hospital upgrade phase 4			7,612	30,000			1,300		
	Worcester Hospital phase 5	8.4	Cape Winelands	Hospital upgrade phase 5							2,500	25,000	4,500
	HT, OD and QA			HT, OD and QA			89 500	86 041			67 925	127 499	80 501
Total rehabilitation, renovations and refurbishments							**265 460**	**273 596**			**131 901**	**319 601**	**410 805**

2. CONDITIONAL GRANTS

Table C2: Conditional grants

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Outputs	Continuation / discontinuation over the next five years	Motivation for continuation / discontinuation
Infrastructure Grant to Provinces	To help accelerate construction maintenance upgrading and rehabilitation of new and existing infrastructure in education health roads and agriculture; to enhance the application of labour intensive methods in order to maximise job creation and skills development as encapsulated in the EPWP guidlines; and to enhance capacity to deliver infrastructure.	Delivery of infrastructure in accordance with the Schedules in Programme 8. Targets in terms of cost, commencement, completion and cash flow are given in the schedules.	Infrastructure delivery, job creation and skills development.	Continuation	The Western Cape has a backlog of infrastructure estimated at 5,6 billion. The continuation of this grant is essential if the province is to make an impact on reducing this backlog.
Hospital Revitalisation Grant [HRP]	To provide funding to enable provinces to plan, manage, modernise, rationalise and transform the infrastructure, health technology, monitoring and evaluation of hospitals; and to transform hospital management and improve quality of care in line with national policy objectives.	Delivery of infrastructure in accordance with the Schedules in Programme 8. Targets in terms of cost, commencement, completion and cash flow are given in the schedules.	Hospitals with modernised infrastructure, equipment and management systems.	Continuation	The Western Cape has a backlog of infrastructure estimated at 5,6 billion. The continuation of this grant is essential if the province is to make an impact on reducing this backlog in respect of hospitals. The grant is also essential to ensure that operational efficiency and quality of care is improved at hospitals.
National Tertiary Services Grant [NTSG]	The purpose of the NTSG is to compensate provinces for the supra-provincial nature of tertiary services provision and spill over effects and to provide strategic funding to enable provinces to plan, modernize, rationalize and transform the tertiary hospital service delivery platform in line with national policy objectives including improving access and equity.	Number of designated tertiary beds operated	1 460	Continuation	Continue to provide highly specialised clinical services and fulfil provincial and national policy objectives. The grant must therefore extend beyond the MTEF.
Health Professions Training and Development Grant [HPTDG]	The Health Professional Training and Development Grant had been established to support the funding of service costs associated with the training of health professionals in the services platform towards the outcome of expanding the bulk of Health Professionals Nationally.	Number of Health Science Institutes of Higher Education (HEI) accommodated on the health service platform	4	Continuation	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. The grant must therefore extend beyond the MTEF.
Comprehensive HIV and AIDS	To provide 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. The grant is utilised in line with the National Operational Plan for HIV and AIDS Care, Management and Treatment in South Africa, the National HIV/AIDS/STI Strategic Plan 2007-2011 and Healthcare 2010.	Number of facilities accredited as Antiretroviral treatment (ART) service points	76	Continuation	
		Number of registered ART patients	68 236	Continuation	
		Number of High Transmission Areas sites in the province	42	Continuation	
		Percentage of hospitals offering Post exposure Prophylaxis services	100%	Continuation	
		Prevention of Mother to Child Transmission rate	4%	Continuation	

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Outputs	Continuation / discontinuation over the next five years	Motivation for continuation / discontinuation
		Programme Management: Number of quarterly output reports submitted in time	4	Continuation	
		Regional Training Centre: Number of quarterly output reports submitted in time	4	Continuation	
		Number of usable beds at Step Down Units	269	Continuation	
		Percentage of the population over the age of 15years tested for HIV	12.5%	Continuation	Revised targets for the future MTEF years would take into account the Presidential call to scale testing the entire population.
Forensic Pathology services Grant	To establish a Forensic Pathology Service that is effective, efficient and rendered in accordance with the statutory requirements by implementing a new Forensic Pathology Service as per policy and legal requirements (Code and Regulations).	Percentage of autopsies performed	80%	Current indication that grant will cease after 2011/12 Financial year	Continuation of the grant is critical to the full implementation of the Forensic Pathology Service
		Average Turn-around time from receipt of body to hand-over in days	5,00		
		Average response time (From receipt of call to arrival on scene in minutes)	38		
		Number of response vehicles	43		
		Number of facilities upgraded, under construction or built	5		
		Percentage of posts filled according to Human Resource Plan	90%		

Note:

1. The numbers of students indicated in the projections as the final number of students trained in terms of the HPTDG can only be verified once the selection and registration processes of the HEIs have been concluded.

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3. PUBLIC PRIVATE PARTNERSHIPS

Table C3: 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 Help Desk, 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.	43 587	28 February 2019	Partnership Management Plan; Governance Structures; PPP agreement; Performance indicators; Patients and other stakeholder satisfaction; Knowledge management systems

Annexures

PROGRAMME 1: ADMINISTRATION

ADMINISTRATION : TABLE ADMIN 2

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Percentage under /over spending of the annual allocated budget	Percentage of the allocated annual budget the department has under- or overspent.	Promote efficient use of financial resources to ensure that the annual allocated budget is utilised and aligned to the department's strategic objectives.	Numerator: Expenditure reports Denominator: Annual allocated budget	Numerator: BAS Denominator: BAS	Numerator: Actual expenditure MINUS Annual allocated budget (In-year monitoring uses Projected annual expenditure MINUS Annual allocated budget) Denominator: Annual allocated budget	100 (%)	Dependant on accuracy of expenditure information recorded on BAS.	Output	Percentage	Quarterly	Yes	Positive percentage indicates over-expenditure and negative percentage under-expenditure.	Chief Financial Officer
2) Percentage of occupational skills analysis completed for all staff	Percentage of completed occupational skills analysis completed for all categories of staff: • Allied health workers • Dental staff • Medical staff • Emergency medical staff • Engineering and related staff • Nursing staff • Pharmacist and related staff • Social worker staff • Administrative staff	To ensure all staff possess the necessary qualification, experience and competencies to perform the job requirements.	Numerator: Personnel records and completed questionnaires Denominator: PERSAL	Numerator: PERSAL Denominator: PERSAL	Numerator: Competency assessments completed and recorded for all staff categories Denominator: Funded posts on staff establishment (filled and vacant) as per the Approved Post List at 1 April of the reporting period	100 (%)	Dependant on accuracy of PERSAL data and completed questionnaires.	Input	Percentage	Quarterly	Yes	Higher percentage indicates an increase in the number of occupational skills analysis completed and recorded to determine the competency gap.	Director: Human Resource Management
3) Percentage of filled finance posts	Percentage of filled posts within the finance components at head office.	To increase capacity within the finance components to support sound financial management practices.	Numerator: Personnel records Denominator: Personnel records	Numerator: PERSAL Denominator: PERSAL	Numerator: Filled finance posts Denominator: Funded vacant posts on the finance staff establishment at Head Office	100 (%)	Dependant on accuracy of PERSAL system.	Input	Percentage	Quarterly	Yes	Higher percentage indicates increase in the number of posts filled.	Chief Financial Officer
4) Number of organisational and post structures implemented	The number of organisational and post structures, aligned to the Comprehensive Service Plan (CSP), that have been implemented by 2014/15.	To ensure the organisational and post structures are implemented and maintained in accordance with the recommended CSP structures to improve service delivery.	Organisational and post structures	OrgPlus software	Organisational and post structures implemented	None (No)	Dependant on accuracy of OrgPlus data.	Input	Cumulative	Quarterly	Yes	Higher number indicates an increase in the organisational and post structures that are aligned with the CSP.	Director: Human Resource Management

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Number of chief directorates with policies and practices posted and maintained on the departmental website	The number of chief directorates with policies and practice notes that have been upload onto the department's official website.	To ensure an informed and well-equipped workforce by utilising the department's official website as the primary source of communication for internal stakeholders.	Policies and practice notes	Departmental website	Chief Directorates with policies and practice notes uploaded on website	None (No)	Dependant on submission of all policies and practice notes by the respective chief directorates.	Efficiency	Cumulative	Quarterly	Yes	Higher number indicates more policies and practice notes are available on the website and should lead to a better-informed and equipped workforce.	Director: Communication
6) Number of institutions submitting monthly financial reports	Number of institutions that report monthly on financial compliance with regard to the predetermined list of requirements.	To ensure adherence to the legislative requirement imposed on the department.	Monthly financial reports	Financial Reporting Tool (FRT)	Institutions submitting monthly	None (No)	Dependant on accuracy of data input by reporting institutions.	Input	Number	Quarterly	Yes	Higher number will contribute to achieving an unqualified audit report with regard to financial compliance management.	Chief Director Financial Administration
7) Percentage of pharmaceutical stock availability	The percentage of pharmaceutical stock that has to be available at all times at the Cape Medical Depot (CMD).	To ensure optimum pharmaceutical stock levels to meet demand.	Numerator: Stock master Denominator: Stock master	Numerator: MEDSAS Denominator: MEDSAS	Numerator: Pharmaceutical items on the Essential Drug List that are in stock at the CMD Denominator: Pharmaceutical items on the Essential Drug List	100(%)	Dependant on accuracy of data recorded on MEDSAS.	Efficiency	Percentage	Quarterly	Yes	Higher percentage indicate fewer items out of stock at the CMD.	Director: Supply Chain Management
8) Provision of the Accounting Officers System policy	An Accounting Officers System policy is maintained and provided to institutions on an annual basis.	To ensure level 3 compliance for Supply Chain Management.	AOS policy document	AOS policy document	AOS policy provided	None (Yes/No)	None.	Output	Yes/No	Annually	Yes	Compliance will contribute to achieving a level 3 financial compliance for Supply Chain Management.	Director: Supply Chain Management
9) Provision of a procurement plan	A Procurement Plan for minor and major assets is developed and maintained on an annual basis.	To ensure level 3 compliance for Supply Chain Management.	Procurement Plan	Procurement Plan	Procurement Plan provided	None (Yes/No)	Dependant on accuracy and completeness of asset register.	Output	Yes/No	Annually	Yes	Compliance will ensure assets are aligned to the budget and programme deliverables for the department.	Chief Director: Metro Districts
10) Number of registered sites compiling asset reconciliation reports	The number of registered sites that compile asset reconciliation reports on a monthly basis. Reconciliation reports are manually compiled based on capital asset expenditure reflected on BAS and capital asset additions reflected on the LOGIS and SYSPRO systems (the 3 central hospitals use SYSPRO and all other hospitals use LOGIS).	To ensure level 3 compliance for Supply Chain Management	Monthly asset reconciliation reports	Monthly asset reconciliation reports	Registered sites performing asset reconciliations	None (no)	Dependant on accuracy of data input by reporting sites.	Output	Number	Quarterly	Yes	Higher number will indicate that all expenditure on assets is being recorded by institutions.	Director: Supply Chain Management

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
11) Data submission rate of prioritised datasets	Percentage of Routine Monthly Reports (RMR), Hospital Throughput Forms and HIV Counselling and Testing Register Reports that have been submitted to the provincial office according to the Western Cape Department of Health Data Flow Policy.	To ensure a complete health information dataset that is available for monitoring and reporting purposes.	Numerator: Missing Data Report Denominator: Facility list	Numerator: SINJANI Denominator: Facility list	Numerator: Sum of: • PHC forms submitted • Hospital forms submitted • VCT forms submitted Denominator: Sum of: • Expected PHC forms • Expected hospital forms • Expected VCT forms	100 (%)	Dependant on reporting facilities submitting data.	Efficiency	Percentage	Quarterly	No	Higher percentage indicates a more complete dataset is available for monitoring and reporting purposes.	Director: Information Management
12) Percentage of hospitals where the HIS has been implemented	Percentage of provincial health hospitals where the HIS (Hospital Information System) has been implemented.	Co-ordinate, integrate and provide health information to the department.	Numerator: HIS Roll-out Project Plan Denominator: Contract with Health Systems Technology (HST)T	Numerator: HIS Roll-out Project Plan Denominator: Contract with HST	Numerator: Hospitals where the HIS has been implemented Denominator: Hospitals on the HIS contract	100 (%)	Dependant on availability and accuracy of HIS Roll-out Project Plan.	Efficiency	Percentage	Quarterly	No	Higher percentage indicates an increase in the number of facilities with access to the HIS.	Director: Information Management
13) Number of organisational structures (APH, central hospitals, districts, CD: Regional Hospitals and EMS) submitting composite QI reports	Composite Quality Improvement (QI) reports relating to consumer and technical quality that have been submitted by the Associated Psychiatric Hospitals (APH), central hospitals, districts, and the Chief Directorate: Regional hospitals and Emergency Medical Services (EMS). This include reports on complaints and compliments, safety and security, hospital improvement plans, morbidity and mortality, staff and patient satisfaction surveys, staff attitudes, adverse incident s, infection, prevention and control.	Tracks the number of composite QI reports submitted across the levels of care by organisational structures within the Department.	Numerator Facility and District QA Return Denominator: Quality Assurance organisational structures	Denominator Quarterly Return.xls Denominator: Quality Assurance organisational structures	Numerator Composite QI reports submitted Denominator Number of Quality Assurance organisational structures	100 (%)	Accuracy dependant on quality of data from reporting structures.	Quality	Number	Quarterly	Yes	Higher percentage indicates an increase in the number of QI related activities that are integrated and institutionalised into service delivery and quality of care.	Quality Assurance Programme Manager

PROGRAMME 2: DISTRICT HEALTH SERVICES

DISTRICT HEALTH SERVICES: TABLES DHS3 & DHS 5

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Utilisation rate - PHC	Rate at which services are utilised by the target population, represented as the average number of visits per person per period in the target population.	Tracks the uptake of PHC services at PHC facilities for the purposes of allocating staff and other resources.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI / DHIS Denominator: StatsSA	Numerator: PHC total headcount Denominator: Total population	None (no)	Dependant on the accuracy of estimated total population from StatsSA	Output	Rate (annualised)	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	District Health Services (DHS) Programme Manager
2) Provincial expenditure per PHC headcount	Expenditure on primary health care (PHC) by the provincial DoH, per PHC headcount at provincial PHC facilities.	Tracks the cost to provincial DoH for every headcount seen at provincial PHC facilities.	Numerator: Financial data Denominator: Routine Monthly Report	Numerator: BAS Denominator: SINJANI / DHIS	Numerator: Expenditure on PHC by provincial DoH at PHC facilities (Sub-programmes 2.1, 2.2 and 2.3) Denominator: PHC total headcount	None (no)	Accuracy of Expenditure depends on the correct expenditure allocation. Accuracy of headcount depends on the reliability of PHC record management at facility level.	Efficiency	Rate	Quarterly	No	Lower expenditure could indicate efficient use of financial resources, or incomplete provision of the comprehensive PHC package.	DHS Programme Manager

DISTRICT HOSPITALS: TABLES DHS8 AND DHS10

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of district hospital beds	Useable beds in district hospitals are beds actually available for use within the district hospital, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of district hospital beds to ensure accessibility of district hospital services.	Hospital Throughput form	SINJANI / DHIS	Usable beds in district hospitals	None (no)	Accuracy is dependent on the quality of data from reporting facility.	Input	Cumulative	Quarterly	No	Adequate bed numbers ensure the availability of services to reduce the burden of disease.	District Health Services (DHS) Programme Manager
2) Provincial district hospital expenditure per uninsured person.	Total expenditure by the DOH on district hospital services per uninsured person.	To monitor the adequacy of funding levels for district hospitals services.	Numerator: Financial data Denominator: Population data	Numerator: BAS Denominator: StatsSA	Numerator Total expenditure of the province on district hospital services (sub-programme 2.9 Denominator Uninsured population	None (no)	Accuracy is dependent on the adequate recording of finances and accurate estimation of the population data by StatsSA.	Input	Rate (annualised)	Quarterly	Yes	Higher levels of expenditure reflect prioritisation of services.	DHS Programme Manager

Note:
Blue shading denotes indicators prescribed by the National Department of Health.
Yellow shading denotes Strategic Objective Baselines

HIV AND AIDS, TB AND STI CONTROL: TABLES HIV1 AND HIV3

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) HIV prevalence in women aged 15 – 24 years	The percentage of HIV positive antenatal women aged 15 - 24 years in the province tested during the national component of the annual antenatal HIV and syphilis survey.	To determine the HIV prevalence and the success of prevention programmes at halting and/or reversing the number of new cases.	Numerator: Annual Antenatal HIV and Syphilis Survey Denominator: Annual Antenatal HIV and Syphilis Survey	Numerator: Annual Antenatal HIV and Syphilis Survey results Denominator: Annual Antenatal HIV and Syphilis Survey results	Numerator: HIV positive women aged 15 - 24 years Denominator: Women aged 15-24 years tested for HIV	100 (%)	Insufficient specimen collection from 15-24 age group, incomplete data completion of forms, analysis of results.	Outcome	Percentage	Annual	Yes	Used to monitor and evaluate impact of prevention programmes.	HIV and AIDS Programme Manager

MATERNAL, CHILD AND WOMAN HEALTH: TABLES MCWH3 & MCHW4

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Under-5 mortality rate	The number of children who have died between birth and their fifth birthday, expressed per thousand live births as determined by the South African Demographic and Health Survey (SADHS).	Monitoring of children deaths on a routine basis is very important to monitor progress towards MDG.	Numerator: SADHS Denominator: SADHS	Numerator: SADHS Denominator: SADHS	Numerator: Children less than 5 year old who die in one year Denominator Live births during that year	1 000	Empirical data is provided by the SADHS every 5 years.	Outcome	Rate	Annual	Yes	Lower infant mortality rates are desired.	MCWH Programme Manager
2) Maternal mortality rate	Number of women who die as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy in one year, per 100,000 live births during that year as determined by the South African Demographic and Health Survey (SADHS).	Monitors trends in maternal mortality.	Numerator: SADHS Denominator: SADHS	Numerator: SADHS Denominator: SADHS	Numerator Women who die as a result of child-bearing, during pregnancy or within 42 days of delivery or termination of pregnancy in one year Denominator Live births during that year	100 000	Empirical data are provided by the SADHS every 5 years	Outcome	Rate	Annual	Yes	Lower maternal mortality rates are desired.	MCWH Programme Manager

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

EMERGENCY MEDICAL AND PATIENT TRANSPORT SERVICES: TABLES EMS1 - 4

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of adverse incidents per annum	The number of reported patient adverse incidents or complaints with regard to emergency medical services (EMS).	Monitors quality of care delivered by EMS.	Quality Management Report Form	Quality Management Data Base	Adverse incidents and complaints reported for EMS	None (no)	Accuracy dependant on quality of data from reporting EMS stations.	Quality	Sum for period under review	Quarterly	Yes	Lower number of incidents indicates better quality of care.	Emergency Medical Services (EMS) Manager
2) Number of rostered ambulances	The total number of road ambulances in the emergency medical services (EMS) fleet. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	Monitors resource availability in EMS.	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: The total ambulance personnel hours worked for the reporting period Denominator: 2 and 24 hours for the reporting period	None (no)	Accuracy dependant on quality of data received from Efficiency Report	Input	Cumulative	Quarterly	No	Higher number of rostered ambulances may lead to faster response time.	EMS Manager
3) Percentage of ambulance patients transferred between facilities	The percentage of ambulance patients transferred between health facilities.	Monitor the compliance with the Comprehensive Service Plan (CSP) in terms of patients treated at the appropriate level of care.	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Patients transferred between health facilities Denominator: Total number of patients transferred	100 (%)	Accuracy dependant on quality of data from reporting EMS stations and communication centres.	Output	Percentage	Quarterly	No	Lower percentage suggests that ambulances are being used appropriately to transfer patients to the appropriate level of care.	EMS Manager
4) Number of patients transferred to tertiary level hospitals per annum	Number of outpatients transferred to tertiary level hospitals per annum.	Monitors the appropriate consultation of patients at tertiary hospitals with regard to the Comprehensive Service Plan (CSP).	Efficiency Report	Efficiency Report	OPD patients transferred to tertiary hospitals	None (no)	Accuracy dependant on quality of data from reporting EMS stations	Output	Sum for period under review	Quarterly	Yes	Only 2% of patients should consult at tertiary hospitals.	EMS Manager
5) Percentage of urban priority 1 responses within 15 minutes	Percentage of urban (built up area) responses classified as a Priority 1 or emergency by the Emergency Call Centre Agent where the response time is 15 minutes or less.	Monitors response times to emergencies within national urban target.	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Priority 1 ambulance responses under 15 minutes - urban Denominator: Priority 1 ambulance responses - urban	100 (%)	Accuracy dependant on quality of data from reporting EMS stations	Quality	Percentage	Quarterly	No	Higher percentage indicates appropriate resource allocation and coordination of the EMS system.	EMS Manager
6) Percentage of rural priority 1 responses within 40 minutes	Percentage of rural (farming areas outside of a town or built up area) responses classified as Priority 1 or emergencies by the Emergency Call Centre Agent where the response time is 40 minutes or less.	Monitor response times to emergencies within national rural target.	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Priority 1 ambulance responses under 40 minutes - rural Denominator: Priority 1 ambulance responses - rural	100 (%)	Accuracy dependant on quality of data from reporting EMS stations	Quality	Percentage	Quarterly	No	Higher percentage indicates appropriate resource allocation and coordination of the EMS system.	EMS Manager

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
7) Number of prevention programs initiated	The number of trauma and violence prevention projects initiated by emergency medical services (EMS) in the Province.	Monitors the implementation of programmes to prevent trauma and violence.	Quality Management Report	Quality Management Data Base	Trauma and violence prevention programs initiated	None (no)	Accuracy dependant on quality of data from reporting EMS stations.	Input	Cumulative	Quarterly	Yes	Higher levels indicate more prevention projects have been initiated which will decrease the burden of trauma and violence.	EMS Manager
8) Number of emergency medicine specialist led cooperative geographic structures operational out of 5 regional service areas	The number of emergency medicine geographic structures established under the supervision of an emergency medicine specialist.	Monitors the coordination of management of emergency medicine across geographic areas.	Quality Management Report	Quality Management Data Base	Geographic EMS structures established	None (no)	Accuracy dependant on quality of data from reporting EMS stations.	Quality	Cumulative	Quarterly	Yes	Higher levels imply improved coordination which in turn improves quality of emergency care.	EMS Manager
9) Number of supervisors with a certificate in management	The number of EMS supervisors with a formal qualification in management.	Improving management capacity will improve the quality of service delivered.	Personnel records	PERSAL	Supervisors with a certificate / qualification in management	None (no)	Accuracy dependant on quality of data from PERSAL.	Quality	Cumulative	Quarterly	Yes	Higher levels indicate improved management which in turn improves the quality of service.	EMS Manager
10) Number of support clerks appointed out of 36	The number of support clerks appointed.	Monitors the implementation of support structures in an effort to reduce administrative burden on operational staff.	Personnel records	PERSAL	Filled support clerk posts	None (no)	Accuracy dependant on quality of data from PERSAL.	Quality	Cumulative	Quarterly	Yes	Higher levels indicate improved support and improved service quality.	EMS Manager
11) Number of districts that can electronically requisition goods and services	The number of EMS districts that have access to LOGIS and can electronically requisition goods.	Monitors the access to Supply Chain.	LOGIS	LOGIS	Districts with access to LOGIS	None (no)	Dependant on accurate reporting of districts with access to LOGIS.	Input	Cumulative	Quarterly	Yes	Higher levels indicate improved electronic requisitioning and access to goods, and supports service quality.	EMS Manager
12) Percentage of CSP personnel out of 2 366 appointed	The percentage of the planned Comprehensive Service Plan (CSP) staff establishment that has been appointed.	Monitors the implementation of the CSP for emergency medical services (EMS) as the minimum capacity necessary to deliver services in 2010.	Numerator: Personnel records Denominator: Comprehensive Service Plan	Numerator: PERSAL Denominator: Comprehensive Service Plan	Numerator: Filled EMS posts Denominator: EMS staff establishment in the CSP	100 (%)	Dependant on accuracy of PERSAL system.	Input	Percentage	Annually	Yes	Higher percentage indicates movement towards completed implementation of the CSP.	EMS Manager
13) Percentage of personnel surveyed with a positive attitude and motivation	The percentage of EMS personnel surveyed who reflect a positive attitude and motivation.	To monitor the reflection of EMS as employer of choice.	Numerator: Personnel Survey Form Denominator: Staff Survey Form	Numerator: Personnel Survey Database Denominator: Staff Survey Database	Numerator: EMS personnel surveyed reflecting a positive attitude and motivation Denominator: EMS staff telephonically surveyed	100 (%)	Accuracy dependant on quality of survey data from reporting EMS stations.	Quality	Percentage	Annual	Yes	Higher levels indicate positive attitude and motivation of staff which lead to improved quality of care.	EMS Manager

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
14) Number of OHS officers appointed	The number of Occupational Health and Safety (OHS) officers appointed in Emergency Medical Services.	To monitor the appointment of OHS officers as a reflection of focus on safety.	Personnel records	PERSAL	Filled OHS officer posts in EMS	None (no)	Accuracy dependant on quality of data from PERSAL.	Quality	Cumulative	Quarterly	Yes	Appointment of more OHS officers will improve safety and therefore quality of care.	EMS Manager
15) Number of districts out of six with fully functional ICT Solution	The number of EMS districts that have a fully functional Information and Communication Technology (ICT) system as determined by audit against the Business Process Mapping and User Specification.	Monitors the roll out of ICT solutions in EMS.	Systems audit	Audit Report	Districts with a fully functional ICT solution	None (no)	Dependant on accurate reporting of districts with a fully functional ICT solution.	Input	Cumulative	Quarterly	Yes	Higher number will lead to more efficient emergency medical services rendered in the Province.	EMS Manager
16) Number of projects delivering a sponsorship	The number of projects delivering sponsorship.	Monitors additional funding streams to Emergency Medical Services (EMS).	Efficiency Report	Efficiency Report	Projects delivering sponsorship	None (no)	Accuracy dependant on quality of data from reporting EMS stations.	Input	Cumulative	Quarterly	Yes	A higher number of sponsorship generating projects will add to EMS resources and improve services.	EMS Manager

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

REGIONAL HOSPITALS: TABLE PHS 1 - 3

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of regional hospital beds	Useable 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.	Tracks the availability of regional hospital beds to ensure accessibility of regional hospital services.	Hospital Throughput form	SINJANI / DHIS	Usable beds in regional hospitals	None (no)	Accuracy is dependent on quality of data from reporting facility	Input	Cumulative	Quarterly	No	Usable beds fully utilised may indicate a greater reliance on the public health system	Provincial Hospital Services Programme Manager
~~2)~~ Emergency headcount in regional hospitals	Headcount of all patients attending an emergency unit in a regional hospital.	Monitoring the service volumes in regional hospitals.	Hospital Throughput form	SINJANI / DHIS	Emergency headcount in regional hospitals	None (no)	Accuracy dependant on quality of data from reporting facility.	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.	Provincial Hospital Services Programme Manager
3) Caesarean section rate for regional hospitals	Caesarean section deliveries in regional hospitals expressed as a percentage of all deliveries in regional hospitals.	Track the performance of obstetric care of the regional hospitals.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: Caesarean section in regional hospitals Denominator: Deliveries in regional hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Output	Percentage	Quarterly	No	Higher percentage of caesarean section indicates higher burden of disease, and/or poorer quality of antenatal care.	Provincial Hospital Services Programme Manager
4) Percentage of regional hospitals with patient satisfaction survey using DOH template	Percentage of regional hospitals with a published nationally mandated patient satisfaction survey in the last 12 months.	To measure the degree of patient's satisfaction with the service delivered to the patient.	Numerator: Client Satisfaction Survey Report Denominator: Facility list	Numerator: QA Initiatives-Facility.xls Denominator: Facility list	Numerator: Regional hospitals with a published nationally mandated patient satisfaction survey in the last 12 months Denominator: Number of regional hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative percentage	Quarterly	No	Higher percentage should lead to improved quality of care.	Quality Assurance (QA) Programme Manager
5) Regional hospitals with mortality and morbidity (M&M) meetings every month	Percentage of regional hospitals having morbidity and mortality (M&M) meetings every month (12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases (morbidity) adverse events; and proportion of deaths (mortality).	Numerator: Minutes of M & M meetings Denominator: Facility list	Numerator: QA Initiatives-Facility.xls Denominator: Facility list	Numerator: Number of regional hospitals having M&M meetings every month Denominator: Number of regional hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Percentage	Quarterly	No	Higher percentage suggests better clinical governance.	Quality Assurance (QA) Programme Manager
6) Case fatality rate for regional hospitals for surgery separations	Percentage of surgery separations in regional hospitals and designated level 2 wards in central hospitals that died.	To measure the quality of care by means of health outcomes for surgical separations.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: Inpatient death – surgery in regional hospitals Denominator: Separation – surgery in regional hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Percentage	Quarterly	No	Lower percentage indicates improved quality of care.	Provincial Hospital Services Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
7) Expenditure per patient day equivalent (PDE) in regional hospitals	Average cost per patient day equivalent in regional hospitals. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in regional hospitals.	Numerator: Financial data Denominator: Hospital Throughput form	Numerator: BAS Denominator: SINJANI / DHIS	Numerator: Total expenditure in regional hospitals (sub-programme 4.1) Denominator: Patient day equivalent (PDE) in regional hospitals	None (no)	Accuracy of expenditure depends on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facility.	Efficiency	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	Provincial Hospital Services Programme Manager
8) Percentage of regional hospitals with annual staff satisfaction survey completed	Percentage of regional hospitals that performed a staff satisfaction survey using the official provincial survey template.	To monitor staff satisfaction in the regional hospitals.	Numerator: Staff satisfaction survey reports Denominator: Facility list	Numerator: QA Initiatives-Facility.xls Denominator: Facility list	Numerator: Regional hospitals with a published staff satisfaction survey in the last 12 months Denominator: Number of regional hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative	Quarterly	Yes	Higher number should lead to improved staff satisfaction.	Quality Assurance (QA) Programme Manager
9) Bed utilisation rate (based on usable beds) in regional hospitals	Patient days in regional hospitals during the reporting period, expressed as a percentage of the sum of the daily number of usable beds in regional hospitals.	Track the over/under utilisation of regional hospital beds.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in regional hospitals Denominator: Number of usable bed days (Usable beds x number of days in the reporting period)	100 (%)	Accuracy dependant on quality of data from reporting facility.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	Provincial Hospital Services Programme Manager

TB HOSPITALS: TABLE PHS 1 - 3

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of TB hospital beds	Useable 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.	Tracks the availability of TB hospital beds to ensure accessibility of TB hospital services.	Hospital Throughput form	SINJANI / DHIS	Usable beds in TB hospitals	None (no)	Accuracy is dependent on quality of data from reporting facility.	Input	Cumulative	Quarterly	No	Usable beds fully utilised may indicate a greater reliance on the public health system	TB Hospital Services Programme Manager
2) Percentage of TB hospitals with patient satisfaction survey using DOH template	Percentage of TB hospitals with a published nationally mandated patient satisfaction survey in the last 12 months.	To measure the degree of patient's satisfaction with the service delivered to the patient.	Numerator: Client Satisfaction Survey Report Denominator: Facility list	Numerator: QA Initiatives-Facility.xls Denominator: Facility list	Numerator: TB hospitals with a published nationally mandated patient satisfaction survey in the last 12 months Denominator: Number of TB hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative percentage	Quarterly	No	Higher percentage should lead to improved quality of care.	Quality Assurance (QA) Programme Manager
3) TB hospitals with mortality and morbidity (M&M) meetings every month	Percentage of TB hospitals having M&M meetings every month (12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases (morbidity) adverse events; and proportion of deaths (mortality).	Numerator: Minutes of M & M meetings Denominator: Facility list	Numerator: QA Initiatives-Facility.xls Denominator: Facility list	Numerator: Number of TB hospitals having M&M meetings every month Denominator: Number of TB hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Percentage	Quarterly	No	Higher percentage suggests better clinical governance.	Quality Assurance (QA) Programme Manager
4) Expenditure per patient day equivalent (PDE) in TB hospitals	Average cost per patient day equivalent in TB hospitals. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in TB hospitals.	Numerator: Financial data Denominator: Hospital Throughput form	Numerator: BAS Denominator: SINJANI / DHIS	Numerator: Total expenditure in TB hospitals (sub-programme 4.2) Denominator: Patient day equivalent (PDE) in TB hospitals	None (no)	Accuracy of expenditure depends on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facilities.	Efficiency	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	TB Hospital Services Programme Manager
5) Percentage of TB hospitals with annual staff satisfaction survey completed	Percentage of TB hospitals that performed a staff satisfaction survey using the official provincial survey template.	To monitor staff satisfaction in the TB hospitals.	Numerator: Staff Satisfaction Survey Report Denominator: Facility list	Numerator: QA Initiatives-Facility.xls Denominator: Facility list	Numerator: TB hospitals with a published staff satisfaction survey in the last 12 months Denominator: Number of TB hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative	Quarterly	Yes	Higher number should lead to improved staff satisfaction.	Quality Assurance (QA) Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
6) Average length of stay in TB hospitals	Average number of patient days that an admitted patient spends in the TB hospital before separation.	To monitor the efficiency of TB hospitals.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in TB hospitals Denominator: Total separations in TB hospitals	None (no)	High levels of efficiency could hide poor quality.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care.	TB Hospital Services Programme Manager

PSYCHIATRIC HOSPITALS: TABLE PHS1 - 3

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of beds in psychiatric hospitals	Useable 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.	Tracks the availability of psychiatric hospital beds to ensure accessibility of psychiatric hospital services.	Hospital Throughput form	SINJANI / DHIS	Usable beds in psychiatric hospitals	None (no)	Accuracy is dependant on quality of data from reporting facility.	Input	Cumulative	Quarterly	No	Usable beds fully utilised may indicate a greater reliance on the public health system	Associated Psychiatric Hospitals (APH) Programme Manager
2) Number of step down beds	Useable beds in step down psychiatric facilities are beds actually available for use within the step down psychiatric facility, regardless of whether they are occupied by a patient or a lodger. These facilities are New Beginnings, William Slater, Lentegeur 103 and Stikland 12 beds.	Tracks the availability of step down psychiatric beds to ensure accessibility of step downl services.	Hospital Throughput form	SINJANI / DHIS	Usable beds in step down psychiatric facilities	None (no)	Accuracy is dependant on quality of data from reporting facility.	Input	Cumulative	Quarterly	No	Usable beds fully utilised may indicate a greater reliance on step down services.	APH Programme Manager
3) Psychiatric hospitals with mortality and morbidity (M&M) meetings every month	Percentage of psychiatric hospitals having M&M meetings every month (12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases (morbidity) adverse events; and proportion of deaths (mortality).	Numerator: Minutes of M & M meetings Denominator: Facility list	Numerator: QA Initiatives-Facility.xls Denominator: Facility list	Numerator: Number of psychiatric hospitals having M&M meetings every month Denominator: Number of psychiatric hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Percentage	Quarterly	No	Higher percentage suggests better clinical governance.	Quality Assurance (QA) Programme Manager
4) Percentage of psychiatric hospitals with patient satisfaction survey using DOH template	Percentage of psychiatric hospitals with a published nationally mandated patient satisfaction survey in the last 12 months.	To measure the degree of patient's satisfaction with the service delivered to the patient.	Numerator: Client Satisfaction Survey Report Denominator: Facility list	Numerator: QA Initiatives-Facility.xls Denominator: Facility list	Numerator: Psychiatric hospitals with a published nationally mandated patient satisfaction survey in the last 12 months Denominator: Number of psychiatric hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative percentage	Quarterly	No	Higher percentage should lead to improved quality of care.	Quality Assurance (QA) Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Expenditure per patient day equivalent (PDE) in psychiatric hospitals	Average cost per patient day equivalent in psychiatric hospitals. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in psychiatric hospitals.	Numerator: Financial data Denominator: Hospital Throughput form	Numerator: BAS Denominator: SINJANI / DHIS	Numerator: Total expenditure in psychiatric hospitals (sub-programme 4.3) Denominator: Patient day equivalent (PDE) in psychiatric hospitals	None (no)	Accuracy of expenditure depends on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facilities.	Efficiency	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	APH Programme Manager
6) Percentage of psychiatric hospitals with staff satisfaction surveys conducted every second year completed	Percentage of psychiatric hospitals that perform a staff satisfaction survey every second year using the official provincial survey template.	To monitor staff satisfaction in psychiatric hospitals.	Numerator: Staff satisfaction survey reports Denominator: Facility list	Numerator: QA Initiatives-Facility.xls Denominator: Facility list	Numerator: Psychiatric hospitals with a published staff satisfaction survey every second year Denominator: Number of psychiatric hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative	Quarterly	Yes	Higher number should lead to improved staff satisfaction.	Quality Assurance (QA) Programme Manager

SPECIALISED REHABILITATION SERVICES: TABLE PHS2

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of beds in rehabilitation hospitals	Useable 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.	Tracks the availability of rehabilitation hospital beds to ensure accessibility of rehabilitation hospital services.	Hospital Throughput form	SINJANI / DHIS	Usable beds in rehabilitation hospitals	None (no)	Accuracy is dependant on quality of data from reporting facility.	Input	Cumulative	Quarterly	No	Usable beds fully utilised may indicate a greater reliance on the public health system.	Rehabilitation Programme Manager
2) Rehabilitation hospitals with mortality and morbidity (M&M) meetings every month	Percentage of rehabilitation hospitals having M&M meetings every month (12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases (morbidity) adverse events; and proportion of deaths (mortality).	Numerator: Minutes of M & M meetings Denominator: Facility list	Numerator: QA Initiatives-Facility.xls Denominator: Facility list	Numerator: Number of rehabilitation hospitals having M&M meetings every month Denominator: Number of rehabilitation hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Percentage	Quarterly	No	Higher percentage suggests better clinical governance.	Quality Assurance (QA) Programme Manager
3) Average length of stay in rehabilitation hospitals	Average number of patient days that an admitted patient spends in the rehabilitation hospital before separation.	To monitor the efficiency of rehabilitation hospitals.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in rehabilitation hospitals Denominator: Total separations in rehabilitation hospitals	None (no)	High levels of efficiency could hide poor quality.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care.	Rehabilitation Programme Manager
4) Bed utilisation rate (based on usable beds) in rehabilitation hospitals	Patient days in rehabilitation hospitals during the reporting period, expressed as a percentage of the sum of the daily number of usable beds in rehabilitation hospitals.	Track the over/under utilisation of rehabilitation hospital beds.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in rehabilitation hospitals Denominator: Number of usable bed days (Usable beds x number of days in the reporting period)	100 (%)	Accuracy dependant on quality of data from reporting facility.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	Rehabilitation Programme Manager
5) Expenditure per patient day equivalent (PDE) in rehabilitation hospitals	Average cost per patient day equivalent in rehabilitation hospitals. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in rehabilitation hospitals.	Numerator: Financial data Denominator: Hospital Throughput form	Numerator: BAS Denominator: SINJANI / DHIS	Numerator: Total expenditure in rehabilitation hospitals (sub-programme 4.4) Denominator: Patient day equivalent (PDE) in rehabilitation hospitals	None (no)	Accuracy of Expenditure depends on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facilities.	Efficiency	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	Rehabilitation Programme Manager

DENTAL TRAINING HOSPITALS: TABLE PHS2

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of patient visits per annum	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.	Oral Health Centre Tygerberg / UWC Patient Visit Form	Clinicom for Tygerberg and UWC Oral Health Centres Patient record card for other oral health clinics (out-reach clinics)	Sum of patient visits at: • Tygerberg and UWC Oral Health Centres • Other oral health clinics (outreach clinics)	None (no)	Accuracy dependant on quality of data from reporting facility.	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 HOSPITAL SERVICES

CENTRAL/TERTIARY HOSPITALS: TABLE CHS4 - 6

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Caesarean section rate for central hospitals	Caesarean section deliveries in central hospitals expressed as a percentage of all deliveries in central hospitals.	Track the performance of obstetric care of the central hospitals.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: Caesarean section in central hospitals Denominator: Deliveries in central hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Output	Percentage	Quarterly	No	Higher percentage of caesarean section indicates higher burden of disease, and/or poorer quality of antenatal care.	Central Hospital Services Programme Manager
2) Provide a total of 1 460 tertiary beds in central hospitals	Useable 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.	Tracks the availability of central hospital beds to ensure accessibility of central hospital services.	Hospital Throughput form	SINJANI / DHIS	Usable beds in central hospitals	None (no)	Accuracy is dependent on quality of data from reporting facility	Input	Cumulative	Quarterly	No	Usable beds fully utilised may indicate a greater reliance on the public health system.	Central Hospital Services Programme Manager
3) Bed utilisation rate (based on usable beds) in central hospitals	Patient days in central hospitals during the reporting period, expressed as a percentage of the sum of the daily number of usable beds in central hospitals.	Track the over/under utilisation of central hospital beds.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in central hospitals Denominator: Number of usable bed days (Usable beds x number of days in the reporting period)	100 (%)	Accuracy dependant on quality of data from reporting facility.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	Central Hospital Services Programme Manager
4) Number of central hospitals conducting monthly morbidity and mortality reviews	Number of central hospitals having morbidity and mortality (M&M) meetings every month (12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases (morbidity) adverse events; and proportion of deaths (mortality).	Minutes of M & M meetings	QA Initiatives-Facility.xls	Number of central hospitals having M&M meetings every month	None (no)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative	Quarterly	No	Higher number suggests better clinical governance.	Quality Assurance (QA) Programme Manager
5) Number of central hospitals with patient satisfaction survey using DOH template	Number of central hospitals with a published nationally mandated patient satisfaction survey in the last 12 months.	To measure the degree of patient's satisfaction with the service delivered to the patient.	Client Satisfaction Survey Report	QA Initiatives-Facility.xls	Central hospitals with a published nationally mandated patient satisfaction survey in the last 12 months	None (no)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative	Quarterly	No	Higher number should lead to improved quality of care.	Quality Assurance (QA) Programme Manager
6) Case fatality rate in central hospitals for surgery separations	Percentage of surgery separations in central hospitals that died.	To measure the quality of care by means of health outcomes for surgical separations.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: Inpatient death – surgery in central hospitals Denominator: Separation – surgery in central hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Percentage	Quarterly	No	Lower percentage indicates improved quality of care.	Central Hospital Services Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
7) Expenditure per patient day equivalent (PDE) in central hospitals	Average cost per patient day equivalent in central hospitals. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in central hospitals.	Numerator: Financial data Denominator: Hospital Throughput form	Numerator: BAS Denominator: SINJANI / DHIS	Numerator: Total expenditure in central hospitals (sub-programme 5.1) Denominator: Patient day equivalent (PDE) in central hospitals	None (no)	Accuracy of expenditure depends on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facility.	Efficiency	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	Central Hospital Services Programme Manager
8) The ICD 10 coding rate of 75% is reached for inpatient activities	The percentage of separations with an ICD-10 code discharge diagnoses recorded on the Hospital Information System (HIS).	To ensure that requirements for billing purposes are met by recording an ICD 10 code for all patient episodes.	Numerator: Electronic patient record on Clinicom Denominator: Electronic patient record on Clinicom	Numerator: Clinicom (HIS) Denominator: Clinicom (HIS)	Numerator: Inpatient separations with an ICD 10 discharge diagnosis Denominator: Inpatient separations in central hospitals	100 (%)	Accuracy dependant on quality of data from reporting facility.	Output	Percentage	Quarterly	Yes	Higher rate indicate improved performance and ability to comply with prescripts for billing purposes.	Central Hospital Services Programme Manager
9) Number of central hospitals with an approved skills development plan in place	All central hospitals submitted an approved skills development plan for the financial year.	To ensure that skills development takes place to ensure and maintain a capacitated workforce to deliver the required health services.	Hospital semi permanent data report	SINJANI	Central hospitals with an approved skills development plan in place	None (no)	Dependant on hospital to finalise the plan in consultation with various stakeholders.	Input	Cumulative	Quarterly	Yes	Higher number should lead to improved staff satisfaction.	Central Hospital Services Programme Manager
10) Average length of stay in central hospitals	Average number of patient days that an admitted patient spends in the central hospital before separation.	To monitor the efficiency of central hospitals.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in central hospitals Denominator: Total separations in central hospitals	None (no)	High levels of efficiency could hide poor quality.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care.	Central Hospital Services Programme Manager
11) Number of central hospitals with an appointed health facility board	The number of central hospitals with an appointed health facility board.	Plays an integral part in the monitoring of governance of the hospital as well as being an important liaison forum between the community and hospital management.	Hospital semi permanent data report	SINJANI	Central hospitals with an appointed health facility board	None (no)	Dependant on the availability of members to serve on the board.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better governance of hospitals as well as improved liaison between the community and hospital management.	Central Hospital Services Programme Manager
12) Number of institutions with an appointed drug and therapeutic committee	The number of central hospitals with an appointed drug and therapeutic committee.	To assist with the review and implementation of drug policy at an institutional and provincial level.	Hospital semi permanent data report	SINJANI	Central hospitals with an appointed drug and therapeutic committee	None (no)	Dependant on the availability of members to serve on the committee.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better review and implementation of drug policies.	Central Hospital Services Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
13) Number of hospitals with an appointed and functioning planning and commissioning unit	The number of central hospitals with an appointed Planning and Commissioning Unit (PCU).	The planning and commissioning unit will assist with key planning and monitoring functions to ensure and maintain appropriate health technology and infrastructure.	Hospital semi permanent data report	SINJANI	Central hospitals with an appointed Planning and Commissioning Unit	None (no)	Dependant on the availability of members to serve on the committee and to attend meetings.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better and more appropriate health technology and infrastructure provision and planning	Central Hospital Services Programme Manager

GROOTE SCHUUR HOSPITAL: TABLE CHS4 - 6

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Caesarean section rate for Groote Schuur Hospital	Caesarean section deliveries in Groote Schuur Hospital expressed as a percentage of all deliveries Groote Schuur Hospital.	Track the performance of obstetric care of the central hospitals.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: Caesarean section in Groote Schuur Hospital Denominator: Deliveries in Groote Schuur Hospital	100 (%)	Accuracy dependant on quality of data from reporting facility.	Output	Percentage	Quarterly	No	Higher percentage of caesarean section indicates higher burden of disease, and/or poorer quality of antenatal care.	CEO Groote Schuur Hospital
2) Provide a total of 617 tertiary beds in Groote Schuur Hospital	Useable beds in Groote Schuur Hospital are beds actually available for use within Groote Schuur Hospital, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of central hospital beds to ensure accessibility of central hospital services.	Hospital Throughput form	SINJANI / DHIS	Usable beds in Groote Schuur Hospital	None (no)	Accuracy is dependent on quality of data from reporting facility	Input	Cumulative	Quarterly	No	Usable beds fully utilised may indicate a greater reliance on the public health system.	CEO Groote Schuur Hospital
3) Bed utilisation rate (based on usable beds) in Groote Schuur Hospital	Patient days in Groote Schuur Hospital during the reporting period, expressed as a percentage of the sum of the daily number of usable beds in Groote Schuur Hospital.	Track the over/under utilisation of central hospital beds.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in Groote Schuur Hospital Denominator: Number of usable bed days (Usable beds x number of days in the reporting period)	100 (%)	Accuracy dependant on quality of data from reporting facility.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	CEO Groote Schuur Hospital
4) Groote Schuur Hospital conducts monthly mortality and morbidity (M&M) meetings	Groote Schuur Hospital conducts morbidity and mortality (M&M) meetings every month (12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases (morbidity) adverse events; and proportion of deaths (mortality).	Minutes of M & M meetings	QA Initiatives-Facility.xls	Groote Schuur Hospital has M&M meetings every month	None (no)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative	Quarterly	No	Higher number suggests better clinical governance.	CEO Groote Schuur Hospital

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Groote Schuur Hospital performed an annual patient satisfaction survey using DOH template	Groote Schuur Hospital published a nationally mandated patient satisfaction survey in the last 12 months.	To measure the degree of patient's satisfaction with the service delivered to the patient.	Client Satisfaction Survey Report	QA Initiatives-Facility.xls	Groote Schuur Hospital has a published nationally mandated patient satisfaction survey in the last 12 months	None (no)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative	Quarterly	No	Higher number should lead to improved quality of care.	CEO Groote Schuur Hospital
6) Case fatality rate in Groote Schuur Hospital for surgery separations	Percentage of surgery separations in Groote Schuur Hospital that died.	To measure the quality of care by means of health outcomes for surgical separations.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: Inpatient death – surgery in Groote Schuur Hospital Denominator: Separation – surgery in Groote Schuur Hospital	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Percentage	Quarterly	No	Lower percentage indicates improved quality of care.	CEO Groote Schuur Hospital
7) Expenditure per patient day equivalent (PDE) in Groote Schuur Hospital	Average cost per patient day equivalent in Groote Schuur Hospital. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in central hospitals.	Numerator: Financial data Denominator: Hospital Throughput form	Numerator: BAS Denominator: SINJANI / DHIS	Numerator: Total expenditure in Groote Schuur Hospital (sub-programme 5.1) Denominator: Patient day equivalent (PDE) in Groote Schuur Hospital	None (no)	Accuracy of expenditure depends on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facility.	Efficiency	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	CEO Groote Schuur Hospital
8) The ICD 10 coding rate of 75% is reached for inpatient activities	The percentage of separations in Groote Schuur Hospital with an ICD-10 code discharge diagnoses recorded on the Hospital Information System (HIS).	To ensure that requirements for billing purposes are met by recording an ICD 10 code for all patient episodes.	Numerator: Electronic patient record on Clinicom Denominator: Electronic patient record on Clinicom	Numerator: Clinicom (HIS) Denominator: Clinicom (HIS)	Numerator: Inpatient separations with an ICD 10 discharge diagnosis in Groote Schuur Hospital Denominator: Inpatient separations in Groote Schuur Hospital I	100 (%)	Accuracy dependant on quality of data from reporting facility.	Output	Percentage	Quarterly	Yes	Higher rate indicate improved performance and ability to comply with prescripts for billing purposes.	CEO Groote Schuur Hospital
9) Groote Schuur Hospital has an approved skills development plan in place	Groote Schuur Hospital submitted an approved skills development plan for the financial year.	To ensure that skills development takes place to ensure and maintain a capacitated workforce to deliver the required health services.	Hospital semi permanent data report	SINJANI	Groote Schuur Hospital has an approved skills development plan in place	None (no)	Dependant on hospital to finalise the plan in consultation with various stakeholders.	Input	Cumulative	Quarterly	Yes	Higher number should lead to improved staff satisfaction.	CEO Groote Schuur Hospital
10) Average length of stay in Groote Schuur Hospital	Average number of patient days that an admitted patient spends in Groote Schuur Hospital before separation.	To monitor the efficiency of central hospitals.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in Groote Schuur Hospital Denominator: Total separations in Groote Schuur Hospital	None (no)	High levels of efficiency could hide poor quality.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care.	CEO Groote Schuur Hospital

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
11) Groote Schuur Hospital has an appointed hospital board in place	Groote Schuur Hospital has an officially appointed health facility board in place.	Plays an integral part in the monitoring of governance of the hospital as well as being an important liaison forum between the community and hospital management.	Hospital semi permanent data report	SINJANI	Groote Schuur Hospital has an appointed health facility board	None (no)	Dependant on the availability of members to serve on the board.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better governance of hospitals as well as improved liaison between the community and hospital management.	CEO Groote Schuur Hospital
12) Groote Schuur Hospital has an appointed Drug and Therapeutic committee in place	Groote Schuur Hospital has an officially appointed drug and therapeutic committee in place.	To assist with the review and implementation of drug policy at an institutional and provincial level.	Hospital semi permanent data report	SINJANI	Groote Schuur Hospital has an appointed drug and therapeutic committee	None (no)	Dependant on the availability of members to serve on the committee.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better review and implementation of drug policies.	CEO Groote Schuur Hospital
13) Groote Schuur Hospital has an appointed and functioning planning and commissioning unit.	Groote Schuur Hospital has an officially appointed Planning and Commissioning Unit (PCU) in place.	The planning and commissioning unit will assist with key planning and monitoring functions to ensure and maintain appropriate health technology and infrastructure.	Hospital semi permanent data report	SINJANI	Groote Schuur Hospital has an appointed Planning and Commissioning Unit	None (no)	Dependant on the availability of members to serve on the committee and to attend meetings.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better and more appropriate health technology and infrastructure provision and planning	CEO Groote Schuur Hospital

TYGERBERG HOSPITAL: TABLE CHS4 - 6

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Caesarean section rate for Tygerberg Hospital	Caesarean section deliveries in Tygerberg Hospital expressed as a percentage of all deliveries in Tygerberg Hospital.	Track the performance of obstetric care of the central hospitals.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: Caesarean section in Tygerberg Hospital Denominator: Deliveries in Tygerberg Hospital	100 (%)	Accuracy dependant on quality of data from reporting facility.	Output	Percentage	Quarterly	No	Higher percentage of caesarean section indicates higher burden of disease, and/or poorer quality of antenatal care.	CEO Tygerberg Hospital
2) Provide a total of 608 tertiary beds in Tygerberg Hospital	Useable beds in Tygerberg Hospital are beds actually available for use within Tygerberg Hospital, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of central hospital beds to ensure accessibility of central hospital services.	Hospital Throughput form	SINJANI / DHIS	Usable beds in Tygerberg Hospital	None (no)	Accuracy is dependent on quality of data from reporting facility	Input	Cumulative	Quarterly	No	Usable beds fully utilised may indicate a greater reliance on the public health system.	CEO Tygerberg Hospital
3) Bed utilisation rate (based on usable beds) in Tygerberg Hospital	Patient days in Tygerberg Hospital during the reporting period, expressed as a percentage of the sum of the daily number of usable beds in Tygerberg Hospital.	Track the over/under utilisation of central hospital beds.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in Tygerberg Hospital Denominator: Number of usable bed days (Usable beds x number of days in the reporting period)	100 (%)	Accuracy dependant on quality of data from reporting facility.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	CEO Tygerberg Hospital
4) Tygerberg Hospital conducts monthly mortality and morbidity (M&M) meetings	Tygerberg Hospital conducts morbidity and mortality (M&M) meetings every month (12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases (morbidity) adverse events; and proportion of deaths (mortality).	Minutes of M & M meetings	QA Initiatives-Facility.xls	Tygerberg Hospital has M&M meetings every month	None (no)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative	Quarterly	No	Higher number suggests better clinical governance.	CEO Tygerberg Hospital
5) Tygerberg Hospital conducted an annual patient satisfaction survey using DOH template	Tygerberg Hospital published a nationally mandated patient satisfaction survey in the last 12 months.	To measure the degree of patient's satisfaction with the service delivered to the patient.	Client Satisfaction Survey Report	QA Initiatives-Facility.xls	Tygerberg Hospital has a published nationally mandated patient satisfaction survey in the last 12 months	None (no)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative	Quarterly	No	Higher number should lead to improved quality of care.	CEO Tygerberg Hospital
6) Case fatality rate jn Tygerberg Hospital for surgery separations	Percentage of surgery separations in Tygerberg Hospital that died.	To measure the quality of care by means of health outcomes for surgical separations.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: Inpatient death – surgery in Tygerberg Hospital Denominator: Separation – surgery in Tygerberg Hospital	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Percentage	Quarterly	No	Lower percentage indicates improved quality of care.	CEO Tygerberg Hospital

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
7) Expenditure per patient day equivalent (PDE) in Tygerberg Hospital	Average cost per patient day equivalent in Tygerberg Hospital. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in central hospitals.	Numerator: Financial data Denominator: Hospital Throughput form	Numerator: BAS Denominator: SINJANI / DHIS	Numerator: Total expenditure in Tygerberg Hospital (sub-programme 5.1) Denominator: Patient day equivalent (PDE) in Tygerberg Hospital	None (no)	Accuracy of expenditure depends on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facility.	Efficiency	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	CEO Tygerberg Hospital
8) The ICD 10 coding rate of 75% is reached for inpatient activities	The percentage of separations in Tygerberg Hospital with an ICD-10 code discharge diagnoses recorded on the Hospital Information System (HIS).	To ensure that requirements for billing purposes are met by recording an ICD 10 code for all patient episodes.	Numerator: Electronic patient record on Clinicom Denominator: Electronic patient record on Clinicom	Numerator: Clinicom (HIS) Denominator: Clinicom (HIS)	Numerator: Inpatient separations with an ICD 10 discharge diagnosis in Tygerberg Hospital Denominator: Inpatient separations in Tygerberg Hospital	100 (%)	Accuracy dependant on quality of data from reporting facility.	Output	Percentage	Quarterly	Yes	Higher rate indicate improved performance and ability to comply with prescripts for billing purposes.	CEO Tygerberg Hospital
9) Tygerberg Hospital has an approved skills development plan in place	Tygerberg Hospital submitted an approved skills development plan for the financial year.	To ensure that skills development takes place to ensure and maintain a capacitated workforce to deliver the required health services.	Hospital semi permanent data report	SINJANI	Tygerberg Hospital has an approved skills development plan in place	None (no)	Dependant on hospital to finalise the plan in consultation with various stakeholders.	Input	Cumulative	Quarterly	Yes	Higher number should lead to improved staff satisfaction.	CEO Tygerberg Hospital
10) Average length of stay in Tygerberg Hospital	Average number of patient days that an admitted patient spends in Tygerberg Hospital before separation.	To monitor the efficiency of central hospitals.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in Tygerberg Hospital Denominator: Total separations in Tygerberg Hospital	None (no)	High levels of efficiency could hide poor quality.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care.	CEO Tygerberg Hospital
11) Tygerberg Hospital has an appointed hospital board in place	Tygerberg Hospital has an officially appointed health facility board in place.	Plays an integral part in the monitoring of governance of the hospital as well as being an important liaison forum between the community and hospital management.	Hospital semi permanent data report	SINJANI	Tygerberg Hospital has an appointed health facility board	None (no)	Dependant on the availability of members to serve on the board.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better governance of hospitals as well as improved liaison between the community and hospital management.	CEO Tygerberg Hospital
12) Tygerberg Hospital has an appointed Drug and Therapeutic committee in place	Tygerberg Hospital has an officially appointed drug and therapeutic committee in place.	To assist with the review and implementation of drug policy at an institutional and provincial level.	Hospital semi permanent data report	SINJANI	Tygerberg Hospital has an appointed drug and therapeutic committee	None (no)	Dependant on the availability of members to serve on the committee.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better review and implementation of drug policies.	CEO Tygerberg Hospital

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
13) Tygerberg Hospital has an appointed and functioning planning and commissioning unit.	Tygerberg Hospital has an officially appointed Planning and Commissioning Unit (PCU) in place.	The planning and commissioning unit will assist with key planning and monitoring functions to ensure and maintain appropriate health technology and infrastructure.	Hospital semi permanent data report	SINJANI	Tygerberg Hospital has an appointed Planning and Commissioning Unit	None (no)	Dependant on the availability of members to serve on the committee and to attend meetings.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better and more appropriate health technology and infrastructure provision and planning	CEO Tygerberg Hospital

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL: TABLE CHS4 - 6

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Caesarean section rate for Red Cross War Memorial Children's Hospital	Caesarean section deliveries are not done at Red Cross War Memorial Children's Hospital.	Not applicable (N/A).	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2) Provide a total of 235 tertiary beds in Red Cross War Memorial Children's Hospital	Useable beds in Red Cross War Memorial Children's Hospital are beds actually available for use within Red Cross War Memorial Children's Hospital, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of central hospital beds to ensure accessibility of central hospital services.	Hospital Throughput form	SINJANI / DHIS	Usable beds in Red Cross War Memorial Children's Hospital	None (no)	Accuracy is dependent on quality of data from reporting facility	Input	Cumulative	Quarterly	No	Usable beds fully utilised may indicate a greater reliance on the public health system.	CEO Red Cross War Memorial Children's Hospital
3) Bed utilisation rate (based on usable beds) in Red Cross War Memorial Children's Hospital	Patient days in Red Cross War Memorial Children's Hospital during the reporting period, expressed as a percentage of the sum of the daily number of usable beds in Red Cross War Memorial Children's Hospital.	Track the over/under utilisation of central hospital beds.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in Red Cross War Memorial Children's Hospital Denominator: Number of usable bed days (Usable beds x number of days in the reporting period)	100 (%)	Accuracy dependant on quality of data from reporting facility.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	CEO Red Cross War Memorial Children's Hospital
4) Red Cross War Memorial Children's Hospital conducts monthly mortality and morbidity (M&M) meetings	Red Cross War Memorial Children's Hospital conducts morbidity and mortality (M&M) meetings every month (12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases (morbidity) adverse events; and proportion of deaths (mortality).	Minutes of M & M meetings	QA Initiatives-Facility.xls	Red Cross War Memorial Children's Hospital has M&M meetings every month	None (no)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative	Quarterly	No	Higher number suggests better clinical governance.	CEO Red Cross War Memorial Children's Hospital
5) Red Cross War Memorial Children's Hospital conducted an annual patient satisfaction survey using DOH template	Red Cross War Memorial Children's Hospital published a nationally mandated patient satisfaction survey in the last 12 months.	To measure the degree of patient's satisfaction with the service delivered to the patient.	Client Satisfaction Survey Report	QA Initiatives-Facility.xls	Red Cross War Memorial Children's Hospital has a published nationally mandated patient satisfaction survey in the last 12 months	None (no)	Accuracy dependant on quality of data from reporting facility.	Quality	Cumulative	Quarterly	No	Higher number should lead to improved quality of care.	CEO Red Cross War Memorial Children's Hospital

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
6) Case fatality rate jn Red Cross War Memorial Children's Hospital for surgery separations	Percentage of surgery separations in Red Cross War Memorial Children's Hospital that died.	To measure the quality of care by means of health outcomes for surgical separations.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: Inpatient death – surgery in Red Cross War Memorial Children's Hospital Denominator: Separation – surgery in Red Cross War Memorial Children's Hospital	100 (%)	Accuracy dependant on quality of data from reporting facility.	Quality	Percentage	Quarterly	No	Lower percentage indicates improved quality of care.	CEO Red Cross War Memorial Children's Hospital
7) Expenditure per patient day equivalent (PDE) in Red Cross War Memorial Children's Hospital	Average cost per patient day equivalent in Red Cross War Memorial Children's Hospital. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in central hospitals.	Numerator: Financial data Denominator: Hospital Throughput form	Numerator: BAS Denominator: SINJANI / DHIS	Numerator: Total expenditure in Red Cross War Memorial Children's Hospital (sub-programme 5.1) Denominator: Patient day equivalent (PDE) in central hospitals	None (no)	Accuracy of expenditure depends on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facility.	Efficiency	Rate	Quarterly	No	Lower rate indicating efficient use of financial resources.	CEO Red Cross War Memorial Children's Hospital
8) ed Cross War Memorial Children's Hospital has an approved skills development plan in place	Red Cross War Memorial Children's Hospital submitted an approved skills development plan for the financial year.	To ensure that skills development takes place to ensure and maintain a capacitated workforce to deliver the required health services.	Hospital semi permanent data report	SINJANI	Red Cross War Memorial Children's Hospital has an approved skills development plan in place	None (no)	Dependant on hospital to finalise the plan in consultation with various stakeholders.	Input	Cumulative	Quarterly	Yes	Higher number should lead to improved staff satisfaction.	CEO Red Cross War Memorial Children's Hospital
9) Average length of stay in Red Cross War Memorial Children's Hospital	Average number of patient days that an admitted patient spends in Red Cross War Memorial Children's Hospital before separation.	To monitor the efficiency of central hospitals.	Numerator: Hospital Throughput form Denominator: Hospital Throughput form	Numerator: SINJANI / DHIS Denominator: SINJANI / DHIS	Numerator: • Inpatient days • 1/2 day patients in Red Cross War Memorial Children's Hospital Denominator: Total separations in Red Cross War Memorial Children's Hospital	None (no)	High levels of efficiency could hide poor quality.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care.	CEO Red Cross War Memorial Children's Hospital
10) Red Cross War Memorial Children's Hospital has an appointed hospital board in place	Red Cross War Memorial Children's Hospital has an officially appointed health facility board in place.	Plays an integral part in the monitoring of governance of the hospital as well as being an important liaison forum between the community and hospital management.	Hospital semi permanent data report	SINJANI	Red Cross War Memorial Children's Hospital has an appointed health facility board	None (no)	Dependant on the availability of members to serve on the board.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better governance of hospitals as well as improved liaison between the community and hospital management.	CEO Red Cross War Memorial Children's Hospital

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
11) Red Cross War Memorial Children's Hospital has an appointed Drug and Therapeutic committee in place	Red Cross War Memorial Children's Hospital has an officially appointed drug and therapeutic committee in place.	To assist with the review and implementation of drug policy at an institutional and provincial level.	Hospital semi permanent data report	SINJANI	Red Cross War Memorial Children's Hospital has an appointed drug and therapeutic committee	None (no)	Dependant on the availability of members to serve on the committee.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better review and implementation of drug policies.	CEO Red Cross War Memorial Children's Hospital
12) Red Cross War Memorial Children's Hospital has an appointed and functioning planning and commissioning unit	Red Cross War Memorial Children's Hospital has an officially appointed Planning and Commissioning Unit (PCU) in place.	The planning and commissioning unit will assist with key planning and monitoring functions to ensure and maintain appropriate health technology and infrastructure.	Hospital semi permanent data report	SINJANI	Red Cross War Memorial Children's Hospital has an appointed Planning and Commissioning Unit	None (no)	Dependant on the availability of members to serve on the committee and to attend meetings.	Output	Cumulative	Quarterly	Yes	Higher numbers implies better and more appropriate health technology and infrastructure provision and planning	CEO Red Cross War Memorial Children's Hospital

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

HEALTH SCIENCES AND TRAINING: TABLE HST 2

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Total number of health science students graduating	Sum of health science students who graduate from the basic nursing course, post-graduate training (medical registrars) and post basic nursing qualifications (professional nurses).	Tracks the production of nurses with a basic nursing registration, medical specialists and nurses with a post basic nursing qualification.	Registration list for: • Basic student nurses • Medical registrars • Post basic nurses	HEI survey.xls	Sum of: • Basic student nurses graduating • Medical registrars graduating • Advanced student nurses graduating	None (no)	Data quality depends on good record keeping by both the Provincial DoH and nursing colleges and training institutions.	Output	Cumulative	Quarterly	No	Higher number indicates that more nurses, medical registrars and/or professional nurses with a post basic nursing qualification are graduating.	HRD Programme Manager
2) Total number of health and support professionals trained and developed through formal and informal training	Sum of health and support professionals trained and developed through formal and informal training programmes.	Tracks the number of health and support professionals who receive formal and informal training.	Service provider attendance records	HRD database.xls	Health and support professionals trained and developed through formal and informal training	None (no)	Data quality depends on good record keeping by the Provincial DoH and service providers.	Output	Cumulative	Quarterly	No	Higher number will lead to an increase in the availability of skilled and competent health and support professionals to render optimum accessible packages of care.	HRD Programme Manager
3) Number of bursaries awarded to managers for formal Leadership & Management training	Bursaries awarded to personnel for formal Leadership & Management training.	Tracks the number of bursaries awarded to personnel for formal Leadership & Management training.	Signed bursary contracts	HRD database.xls Management training	Bursaries awarded to personnel for formal Leadership & Management training	None (no)	Data quality depends on good record keeping by the Provincial DoH and external service providers.	Output	Cumulative	Quarterly	No	Higher number will lead to an increase in personnel attending the course which will improve corporate governance and quality of service delivery.	HRD Programme Manager
4) Number of health and support professionals receiving clinical training at the various levels of care on interdivisional burden of disease priorities	Health professionals trained through iMOCOMP (Improvement and Maintenance of Competencies) within the district health system.	Tracks the number of health professionals trained through iMOCOMP.	Quarterly Training Report from external service providers	HRD Combined QTR.xls	Health professionals trained through iMOCOMP	None (no)	Data quality depends on good record keeping by both the Provincial DoH and external service provider/s.	Output	Sum for period under review	Quarterly	No	Higher number will improve clinical governance, quality of care and service delivery when addressing the key district health system priorities.	HRD Programme Manager
5) Number of front line personnel on salary level 1 - 6 trained on Batho Pele principles	Personnel on salary level 1 – 6, who explicitly interacts with members of the public or community, who received training on the Batho Pele principles.	Tracks the number of front line personnel on salary level 1 - 6 trained on Batho Pele principles.	Service provider attendance records	HRD database.xls	Front line personnel on salary level 1 - 6 trained on Batho Pele	None (no)	Data quality depends on good record keeping by the Provincial DoH and external service providers.	Output	Cumulative	Quarterly	No	Higher number will result in improved customer care.	HRD Programme Manager

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
6) Number of Home Community Based Carers (HCBCs)	Home Community Based Carer (HCBC) learners receiving training on SAQA accredited qualifications in ancillary health care and community care as part of the Expanded Public Works Programme (EPWP).	Tracks the number of Home Community Based Carers (HCBCs) registered on the four levels of qualifications.	Registration form	HRD: EPWP Learners on Quarterly Basis.xls	Home based care learners registered	None (no)	Data quality depends on good record keeping by both the Provincial DoH and external service provider/s.	Output	Sum for period under review	Quarterly	No	Higher number of HCBCs will improve health promotion and prevention within the home and community and is pivotal in ensuring quality of de-hospitalised care.	HRD Programme Manager

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

LAUNDRY SERVICES

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1. Total number of pieces laundered:	The actual number of linen pieces processed or laundered by both in-house and outsourced laundries.	To ensure that clean and disinfected linen is supplied to all provincial hospitals.	• Laundry linen count • Private contractor accounts	Linen counting spreadsheet.xls	Sum of: • Items laundered in-house • Items laundered outsourced	None (no)	Dependant on the submission of information and accuracy of records kept by in-house laundries and private contractors.	Output	Sum for period under review	Quarterly	No	Higher workload indicates greater demand on the service.	Laundry manager (Directorate: Engineering and Technical Support)
2. Total number of pieces laundered: in-house	The actual number of linen pieces processed or laundered by large central in-house laundries located at Tygerberg, Lentegeur and George Hospitals.	To ensure that in-house laundries are providing clean and disinfected linen in areas where private sector laundries are unable to provide a service.	Laundry linen count	Linen counting spreadsheet.xls	Items laundered in-house	None (no)	Dependant on the accuracy of records kept by in-house laundries.	Output	Sum for period under review	Quarterly	No	Higher workload indicates greater demand on the service.	Laundry manager (Directorate: Engineering and Technical Support)
3. Total number of pieces laundered: outsourced	The actual number of linen pieces processed or laundered by outsourced laundries in the private sector	To ensure that private laundries are providing clean and disinfected linen as per the agreed contract.	Private contractor accounts	Linen counting spreadsheet.xls	Items laundered outsourced	None (no)	Dependant on the submission of information and the reliability of records kept at private laundries.	Output	Sum for period under review	Quarterly	No	Higher workload indicates greater demand on the service.	Laundry manager (Directorate: Engineering and Technical Support)
4. Average cost per item laundered: in-house	The average cost per linen item processed or laundered in-house at Tygerberg, Lentegeur and George Hospitals. 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: Linen counting spreadsheet.xls	Numerator: Expenditure on in-house laundries excluding capital Denominator: Items laundered in-house	None (no)	Dependant on the accuracy of financial data and reliability of 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)
5. Average cost per item laundered: outsourced	The average cost per linen item processed or laundered by outsourced laundries. The outsourced laundry costs include the cost of capital, profit and VAT (all of which are not included in the in-house cost).	Monitor the cost per item laundered to ensure that outsourced laundry services are cost effective.	Numerator: Financial records Denominator: Private contractor accounts	Numerator: BAS Denominator: Linen counting spreadsheet.xls	Numerator: Expenditure on outsourced laundry services Denominator: Items laundered outsourced	None (no)	Dependant on the accuracy of financial data. Dependant on the submission of information and the reliability of records kept at private laundries.	Efficiency	Rate	Quarterly	No	Lower cost indicates efficient use of financial resources.	Laundry manager (Directorate: Engineering and Technical Support)

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
6. Turnaround time for laundered linen: in-house	The time taken by in-house laundries to process dirty linen. The time from receipt of soiled linen until the linen is dispatched, is measured. All linen should be returned within 24 hours except linen that require re-wash and mending. Linen is dispatched on an even exchange basis – one soiled for one clean.	Monitor turnaround time for in-house laundry services to ensure that clean linen is available at all times.	Numerator: Ward/theatre list linen register Denominator: Ward/theatre list linen register	Numerator: Linen dispatching Register Denominator: Ward/theatre list linen register	Numerator: Turnaround time for in-house laundry items Turnaround time per item = Date/time of dispatch – Date/time of receipt Denominator: Linen items laundered in-house	None (no)	Dependant on the accuracy of records kept by in-house laundries.	Quality	Average	Quarterly	Yes	Lower response times could indicate more efficient service delivery.	Laundry manager (Directorate: Engineering and Technical Support)
7. Turnaround time for laundered linen: outsourced	The time taken by outsourced laundries to process dirty linen. The time from dispatch of soiled linen until the linen is returned, is measured. All linen should be returned within 24 hours except linen that require re-wash and mending.	Monitor turnaround time for outsourced laundry services to ensure that clean linen is available at all times.	Numerator: Ward/theatre list linen register Denominator: Ward/theatre list linen register	Numerator: Linen dispatching Register Denominator: Ward/theatre list linen register	Numerator: Turnaround time for outsourced laundry items Turnaround time per item = Date/time of receipt – Date/time of dispatch Denominator: Linen items laundered outsourced	None (no)	Dependant on the submission of information and the reliability of records kept at private laundries.	Quality	Average	Quarterly	Yes	Lower response times could indicate more efficient service delivery.	Laundry manager (Directorate: Engineering and Technical Support)

ENGINEERING SERVICES

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1. Number of maintenance jobs completed	The number of jobs completed by clinical engineering or hospital engineering workshops as well as outside contractors. Jobs include repairs, renovations, upgrades, etc.	Monitor maintenance done by the Department to maximise the lifespan of equipment, reduce breakdowns and ensure safety.	Engineering workshop requisitions	Job card system.xls	Maintenance jobs completed	None (no)	Dependant on accurate record keeping from reporting facility.	Output	Sum for period under review	Quarterly	No	Higher numbers indicate more maintenance of assets resulting in improved condition of health facilities and equipment.	Director: Engineering and Technical Support
2. Number of preventative maintenance jobs completed	Number of preventative maintenance jobs to critical equipment that has been completed.	Monitor preventative maintenance done by the Department to reduce breakdowns, promote safety and lengthen the lifespan of equipment.	Engineering workshop requisitions	Job card system.xls	Preventative maintenance jobs completed	None (no)	Dependant on accurate record keeping at engineering workshops.	Output	Sum for period under review	Quarterly	Yes	Higher numbers indicate more preventative maintenance done which should lead to improved condition and lifespan of equipment.	Director: Engineering and Technical Support
3. Number of repairs completed	Number of repairs and renovations to buildings, plant and equipment that has been completed.	Monitor repairs done by the Department to reduce the impact of breakdowns and deterioration of assets through age.	Engineering workshop requisitions	Job card system.xls	Repairs completed	None (no)	Dependant on accurate record keeping at engineering workshops.	Output	Sum for period under review	Quarterly	Yes	Higher numbers indicate more repairs completed and should result in improved condition of health facilities and equipment. However, it may also indicate poor condition of facilities and equipment, i.e. greater need for preventative maintenance.	Director: Engineering and Technical Support
4. Number of emergencies handled	Number of emergency repairs to health facilities that has been completed.	Monitor emergency repairs done by the Department to increase patient safety and prevent disruption of clinical services.	Request for emergency repair work form	Job card system.xls	Emergency jobs completed	None (no)	Dependant on accurate record keeping at health facilities.	Output	Sum for period under review	Quarterly	Yes	Higher numbers indicate more repairs completed and should result in improved condition of health facilities and equipment. However, it may also indicate poor condition of health facilities, i.e. greater need for preventative maintenance and renovations.	Director: Engineering and Technical Support
5. Average cost of utilities per bed	The average expenditure on utilities per useable bed in provincial health hospitals. Utilities include expenditure on electricity and water as based on municipal and Eskom accounts.	Monitor the cost of utilities.	Numerator: Municipal and Eskom accounts Denominator: Hospital Throughput Form	Numerator: LOGIS Denominator: SINJANI	Numerator: Expenditure on utilities Denominator: Useable beds in provincial health hospitals	None (no)	Dependant on submission and accuracy of information (utility accounts) from health facilities.	Output	Rate	Quarterly	No	Lower cost indicates reduction in expenditure required for utilities (e.g. electricity and water)	Director: Engineering and Technical Support
6. Number of reportable incidents	The number of reportable incidents related to safe working environments in terms of the Occupational Health and Safety Act. These incidents require an incident investigation and prevention plan.	Monitor compliance with the OHS Act and promote safety in the workplace.	Health and Safety Incident Reports	HR incident report system.xls	Health and Safety incidents reported	None (no)	Dependant on accurate record keeping at the reporting facility.	Output	Sum for period under review	Quarterly	No	Lower number of reportable incidents indicates safer working environment or greater compliance with OHS Act.	Director: Engineering and Technical Support

FORENSIC PATHOLOGY SERVICES

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Average response time from dispatch to arrival of FPS on scene	Average Forensic Pathology Service response time from receipt of call to arrival on scene.	Monitor response times and therefore the efficiency of the Forensic Pathology Services.	Numerator: Index Register Denominator: Index Register	Numerator: FPS software Denominator: FPS software	Numerator: Forensic Pathology Service response time per case Denominator: Total number of forensic pathology cases	None (no)	Accuracy dependent on quality of data from reporting facilities.	Quality	Average	Quarterly	No	Lower response times indicate greater efficiency.	Forensic Pathology Services (FPS) Programme Manager
2) Average turnaround time from admission to examination done	Average Forensic Pathology Service turnaround time from the admission of a deceased until the post-mortem examination is done.	Monitor turnaround times and therefore the efficiency as well as resourcing of Forensic Pathology Services.	Numerator: Index Register Denominator: Index Register	Numerator: FPS software Denominator: FPS software	Numerator: Forensic Pathology Service turnaround time from admission to post-mortem per case Denominator: Total number of forensic pathology cases	None (no)	Accuracy dependent on quality of data from reporting facilities.	Quality	Average	Quarterly	Yes	Lower turnaround times indicate greater efficiency and improved resource allocation.	FPS Programme Manager
3) Average turnaround time from admission to release of deceased (excluding unidentified persons)	Average Forensic Pathology Service turnaround time from the admission of a deceased until the time that the deceased is released for burial – excluding unidentified persons.	Monitor turnaround times and therefore the efficiency as well as resourcing of Forensic Pathology Services, internal to the service.	Numerator: Index Register Denominator: Index Register	Numerator: FPS software Denominator: FPS software	Numerator: Forensic Pathology Service turnaround time from admission to release of all identified persons per case Denominator: Forensic pathology cases which have been identified	None (no)	Accuracy dependent on quality of data from reporting facilities.	Quality	Average	Quarterly	Yes	Lower turnaround times indicate greater efficiency and improved resource allocation.	FPS Programme Manager
4) The percentage of standard operating procedures implemented across all facilities	The percentage of standard operating procedures (SOPs) implemented across all Forensic Pathology Services (FPS) facilities.	Monitor the implementation of standards across all facilities.	Numerator: Monthly statistical returns Denominator: Monthly statistical returns	Numerator: Monthly statistical returns Denominator: Monthly statistical returns	Numerator: SOPs implemented at all facilities Denominator: Total number of SOPs finalised for implementation	100 (%)	Accuracy dependent on quality of data from reporting facilities.	Quality	Percentage	Quarterly	Yes	Higher percentage indicates improved compliance to the code of guidelines and standardisation of practice across Forensic Pathology Services.	FPS Programme Manager
5) Number of unknown persons exceeding 90 days	Number of deceased within the Forensic Pathology Service who has not yet been positively identified after 90 days from admission. All unidentified deceased for which the 90 day period has elapsed during the reporting period should be included.	Monitor the efficiency within the Forensic Pathology Service as well as within external stakeholders such as the SAPS and Home Affairs.	Index Register	FPS software	Cases still unidentified after 90 days have elapsed	None (no)	Accuracy dependent on quality of data from reporting facilities.	Quality	Cumulative	Quarterly	Yes	Lower number indicates improved efficiency and/or better cooperation between various agencies responsible for the identification process.	FPS Programme Manager

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
6) % of funded posts filled	Percentage of funded Forensic Pathology Services (FPS) posts on the staff establishment that has been filled.	Monitor the ability to attract and retain Forensic Pathology service personnel.	Numerator: Personnel records Denominator: Personnel records	Numerator: PERSAL Denominator: PERSAL	Numerator: Filled FPS posts Denominator: Funded FPS posts on the staff establishment	100%	Dependant on accuracy of PERSAL system.	Input	Percentage	Quarterly	Yes	Higher percentage indicates increased ability to attract and retain FPS personnel.	FPS Programme Manager
7) Annual staff satisfaction survey completed	Annual staff satisfaction survey conducted and completed (at each Forensic Pathology Service facility).	Implement a tool to monitor and improve staff satisfaction	Staff satisfaction surveys form	Staff satisfaction surveys	Staff satisfaction survey conducted	None	None	Quality / Process	Compliance	Annual	Yes	Compliance indicates that systems are implemented to measure and address staff satisfaction levels.	FPS Programme Manager

MEDICINE TRADING ACCOUNT

Indicator title	Short definition	Purpose/ Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
Working capital in the medicine trading account	The working capital available to support adequate stock-holding at the Cape Medical Depot.	Monitor that the working capital for the Cape Medical Depot is sufficient to support adequate stock holding.	Cape Medical Depot Capital Account	MEDSAS	Working capital for CMD	None (no)	Dependant on accuracy of MEDSAS system.	Input	Cumulative	Annual	No	Higher capital indicates ability to increase stock holding and avoid supply delays.	Director: Supply Chain Management

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

HEALTH FACILITIES MANAGEMENT: TABLE HFM 1 - 3

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of Indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Programme 8 capital funding as a percentage of total health expenditure	Capital expenditure on buildings, including conditional grants, as a percentage of total provincial health expenditure.	Tracks total expenditure on health infrastructure.	Numerator: Financial data Denominator: Financial data	Numerator: BAS Denominator: BAS	Numerator: Capital expenditure on buildings upgrade renovation and construction Denominator Total expenditure by provincial DoH	100 (%)	Accuracy of financial data on BAS.	Input	Percentage	Annual	Yes	Higher percentage shows additional funding allocated but is also a reflection of the poor condition of health facilities and infrastructure backlog.	Health Facilities Management Programme Manager
2) Number of capital projects completed in PHC facilities that are funded by the Programme 8 capital budget [Sub-programme 8.1]	Number of capital projects completed in primary health care (PHC) facilities that are funded by the Programme 8 capital budget (sub-programme 8.1).	Tracks the progress in implementing the capital works programme for PHC facilities.	Electronic record	Public Works RPM	Capital projects for PHC facilities completed	None (no)	Accuracy dependent on RPM being kept up to date.	Outcome	Cumulative	Quarterly	Yes	Alignment with the APP schedules to ensure that capital funding is utilised effectively.	Health Facilities Management Programme Manager
3) Number of ambulance stations projects completed funded by the Programme 8 capital budget [Sub-programme 8.2]	Number of ambulance stations projects completed funded by the Programme 8 capital budget (sub-programme 8.2).	Tracks the progress in implementing the capital works programme for ambulance stations (emergency medical rescue).	Electronic record	Public Works RPM	Capital projects for ambulance stations completed	None (no)	Accuracy dependent on RPM being kept up to date.	Outcome	Cumulative	Quarterly	Yes	Alignment with the APP schedules to ensure that capital funding is utilised effectively.	Health Facilities Management Programme Manager
4) Number of capital projects completed in district hospitals funded by the Programme 8 capital budget [Sub-programme 8.3]	Number of capital projects completed in district hospitals funded by the Programme 8 capital budget (sub-programme 8.3).	Tracks the progress in implementing the capital works programme for district hospitals.	Electronic record	Public Works RPM	Capital projects for district hospitals completed	None (no)	Accuracy dependent on RPM being kept up to date.	Outcome	Cumulative	Quarterly	Yes	Alignment with the APP schedules to ensure that capital funding is utilised effectively.	Health Facilities Management Programme Manager
5) Number of capital projects completed in provincial hospitals funded by the Programme 8 capital budget Sub-programme 8.4]	Number of capital projects completed in provincial hospitals funded by the Programme 8 capital budget (sub-programme 8.4).	Tracks the progress in implementing the capital works programme for provincial hospitals.	Electronic record	Public Works RPM	Capital projects for provincial hospitals completed	None (no)	Accuracy dependent on RPM being kept up to date.	Outcome	Cumulative	Quarterly	Yes	Alignment with the APP schedules to ensure that capital funding is utilised effectively.	Health Facilities Management Programme Manager
6) Number of capital projects completed in central hospitals funded by the Programme 8 capital budget. [Sub-programme 8.5]	Number of Capital projects completed in central hospitals funded by the Programme 8 capital budget (sub-programme 8.5).	Tracks the progress in implementing the capital works programme for central hospitals.	Electronic record	Public Works RPM	Capital projects for central hospitals completed	None (no)	Accuracy dependent on RPM being kept up to date.	Outcome	Cumulative	Quarterly	Yes	Alignment with the APP schedules to ensure that capital funding is utilised effectively.	Health Facilities Management Programme Manager
7) Number of projects completed in forensic mortuaries and other projects funded by the Programme 8 capital budget.[Sub-programme 8.6]	Number of projects completed in forensic mortuaries and other projects funded by the Programme 8 capital budget (sub-programme 8.6).	Tracks the progress in implementing the capital works programme for forensic mortuaries and other projects.	Electronic record	Public Works RPM	Capital projects for forensic mortuaries and other projects completed	None (no)	Accuracy dependent on RPM being kept up to date.	Outcome	Cumulative	Quarterly	Yes	Alignment with the APP schedules to ensure that capital funding is utilised effectively.	Health Facilities Management Programme Manager

LIST OF FIXED FACILITIES AS AT FEBRUARY 2010

1. PRIMARY HEALTH CARE FACILITIES

1.1 Cape Town **District**

1.1.1 Eastern and Khayelitsha Sub-districts

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres (CHCs) Khayelitsha (Site B) CHC Mfuleni CHC Michael Mapongwana CHC **Community Day Centres (CDCs)** Gustrouw CDC Kleinvlei CDC Macassar CDC Strand CDC Nolungile CDC **Midwife Obstetric Unit** Khayelitsha (Site B) MOU Macassar MOU Michael Mapongwana MOU	Blue Downs Clinic Dr Ivan Toms Clinic Gordon's Bay Clinic Ikwezi Clinic Khayelitsha (Site B) Clinic Kleinvlei Clinic Kuilsriver (Carinus Street) Clinic Kuyasa Clinic Luvuyo Clinic Macassar Clinic Male (Site C) Clinic Matthew Goniwe Clinic Mayenzeke Clinic Nolungile Clinic Russel's Rest Clinic Sarepta Clinic Sir Lowry's Pass Clinic Site B Youth Clinic Site C Youth Clinic Somerset West Clinic Town 2 Clinic Wesbank (Oostenberg) Clinic Zakhele Clinic	Driftsands Satellite Clinic Fagan Street Satellite Clinic Hillcrest (Kuils River) Satellite Clinic	Macassar Mobile
3 + 5 + 3	**23**	**3**	**1**

1.1.2 Klipfontein and Mitchells Plain Sub-districts

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres (CHCs) Crossroads CHC Guguletu CHC Hanover Park CHC Mitchells Plain CHC **Community Day Centres (CDCs)** Dr Abdurahman CDC Heideveld CDC Inzame Zabantu (Brown's Farm) CDC Nyanga CDC **Midwife Obstetric Unit** Guguletu MOU Hanover Park MOU Mitchells Plain MOU	Crossroads 1 Clinic Crossroads 2 Clinic Eastridge Clinic Guguletu Clinic Hanover Park Clinic Heideveld Clinic Lansdowne Clinic Lentegeur Clinic Manenberg Clinic Masincedane Clinic Mzamomhle Clinic Nyanga Clinic Phumlani Clinic Rocklands Clinic Silvertown Clinic Tafelsig Clinic Vuyani Clinic Weltevreden Valley Clinic Westridge Clinic	Hazendal Satellite Clinic Honeyside Satellite Clinic Mandalay Satellite Clinic Newfields Satellite Clinic	None
4 + 4 + 3	**19**	**4**	**0**

1.1.3 Northern and Tygerberg Sub-districts

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres (CHCs) Delft CHC Elsies River CHC Kraaifontein CHC **Community Day Centres (CDCs)** Bellville South CDC Bishop Lavis CDC Dirkie Uys CDC Durbanville CDC Parow CDC Ravensmead CDC Reed Street CDC Ruyterwacht CDC St Vincent CDC **Midwife Obstetric Unit** Bishop Lavis MOU Elsies River MOU Kraaifontein MOU	Adriaanse Clinic Bishop Lavis Clinic Bloekombos Clinic Bothasig Clinic Brackenfell Clinic Brighton Clinic Delft South Clinic Dirkie Uys Clinic Durbanville Clinic Elsies River Clinic Harmonie Clinic Kasselsvlei Clinic Netreg Clinic Northpine Clinic Parow Clinic Ravensmead Clinic Scottsdene CHC Scottsdene Clinic St Vincent Clinic Uitsig Clinic Valhalla Park Clinic Wallacedene Clinic	Chestnut Satellite Clinic Fisantekraal Satellite Clinic Groenvlei Satellite Clinic Leonsdale Satellite Clinic Matroosfontein Satellite Clinic Volks Centre RHC Satellite Clinic	Oosternberg Mobile
3 + 9 + 3	**22**	**6**	**1**

1.1.4 Southern and Western Sub-districts

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres (CHCs) Grassy Park CHC Green Point CHC Hout Bay Harbour CHC Kensington CHC Lady Michaelis CHC Langa CHC Lotus River CHC Mamre CHC Ocean View CHC Retreat CHC Robbie Nurock CHC Woodstock CHC **Community Day Centres (CDCs)** Albow Gardens/Good Hope CDC Vanguard CDC **Midwife Obstetric Unit** Retreat MOU Vanguard MOU	Albow Gardens Clinic Chapel Street Clinic Civic Centre Clinic Claremont Clinic Diep River Clinic Du Noon Clinic Factreton Clinic Fish Hoek Clinic Grassy Park Civic Centre Clinic Hout Bay Main Road Clinic Klip Road Clinic Langa Clinic Lavender Hill Clinic Lotus River Clinic Maitland Clinic Masiphumelele Clinic Melkbosstrand Clinic Muizenberg Clinic Ocean View Clinic Parkwood Clinic Philippi Clinic Protea Park Clinic Retreat Clinic Saxon Sea Clinic Seawind Clinic Spencer Road Clinic Strandfontein Clinic Westlake Clinic Wynberg Clinic	Alphen Satellite Clinic Kommetjie Satellite Clinic Milnerton Satellite Clinic Pelican Park Satellite Clinic Pella Satellite Clinic Pinelands Satellite Clinic Schotscheskloof Satellite Clinic Sea Point Satellite Clinic Simon's Town Satellite Clinic Sun Valley Satellite Clinic Table View Satellite Clinic	Blaauwberg Mobile Melkbosstrand Mobile Redhill Mobile Witsand Mobile
12 + 2 + 2	**29**	**11**	**4**

1.2 Cape Winelands District

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres (CHCs) None **Community Day Centres (CDCs)** Ceres CDC Cloetesville CDC TC Newman CDC Wellington CDC Worcester CDC	Aan-het-Pad Clinic Annie Brown Clinic Bella Vista Clinic Bergsig Clinic Bird Street Clinic Bonnievale Main Street Clinic Breerivier Clinic Cogmanskloof Clinic Dalvale Clinic De Doorns Clinic Dirkie Uys Street Clinic Don and Pat Bilton Clinic Empilisweni (Worcester) Clinic Groendal Clinic Happy Valley Clinic Huis McCrone Clinic Idas Valley Clinic JJ Du Pre Le Roux Clinic Kayamandi Clinic Klapmuts Clinic Klein Drakenstein Clinic Klein Nederburg Clinic Kylemore Clinic Mbekweni Clinic McGregor Clinic Montagu Clinic Nduli Clinic Nieuwedrift Clinic Nkqubela Clinic Op die Berg Clinic Orchard Clinic Patriot Plein Clinic Phola Park Clinic Prince Alfred Hamlet Clinic Rawsonville Clinic Sandhills Clinic Saron Clinic Simondium Clinic Soetendal/Hermon Clinic Touws River Clinic Tulbagh Clinic Victoria Street Clinic Windmeul Clinic Wolseley Clinic Wolseley Medical Centre Clinic Zolani Clinic	De Wet Satellite Clinic Gouda Satellite Clinic Hexberg Satellite Clinic Maria Pieterse Satellite Clinic Newton Satellite Clinic Overhex Satellite Clinic Rhodes Fruit Farm Satellite Clinic Somerset Street Satellite Clinic	Bonnievale Mobile Bossieveld Mobile Botha/Brandwacht Mobile Dal / E de Waal Mobile Devon Valley Mobile Franschhoek Mobile Groot Drakenstein Mobile Karoo Mobile Koelenhof Mobile Koue Bokkeveld Mobile Montagu Mobile 1 Montagu Mobile 2 Robertson Mobile 1 Robertson Mobile 2 Skurweberg Mobile Slanghoek Mobile Strand Road Mobile Tulbagh Mobile Warm Bokkeveld Mobile Wolseley Mobile
0 + 5	**46**	**8**	**20**

1.3 Central Karoo District

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres (CHCs) None **Community Day Centres (CDCs)** Beaufort West CDC	Beaufort West Constitution Street Kwamandlenkosi Clinic Laingsburg Clinic Leeu-Gamka Clinic Murraysburg Clinic Nelspoort Clinic Nieuveldpark Clinic Prince Albert Clinic	Klaarstroom Satellite Clinic Matjiesfontein Satellite Clinic Merweville Satellite Clinic	Beaufort West Mobile 1 Beaufort West Mobile 2 Laingsburg Mobile Leeu-Gamka Mobile Merweville Mobile Murraysburg Mobile Nelspoort Mobile Prince Albert Mobile
0 + 1	**8**	**3**	**8**

1.4 Eden District

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres (CHCs) None **Community Day Centres (CDCs)** Bridgeton CDC Conville CDC Plettenberg Bay CDC Thembalethu CDC	Albertinia Clinic Alma Clinic Blanco Clinic Bongolethu Clinic Calitzdorp (Bergsig) Clinic Crags Clinic D'Almeida Clinic De Rust (Blommenek) Clinic Dysselsdorp Clinic Eyethu Clinic George Civic Centre Clinic George Road Clinic Great Brak River Clinic Haarlem Clinic Heidelberg Clinic Herold Clinic Hornlee Clinic Keurhoek Clinic Khayelethu Clinic Knysna Town Clinic Kranshoek Clinic Kwanokathula Clinic Ladismith (Nissenville) Clinic Lawaaikamp Clinic New Horizon Clinic Oudtshoorn Clinic Pacaltsdorp Clinic Parkdene Clinic Riversdale Clinic Rosemoor Clinic Sedgefield Clinic Still Bay Clinic Toekomsrus Clinic Uniondale (Lyonville) Clinic Wit Lokasie Clinic Zoar Clinic	Avontuur Satellite Clinic Brandwacht Satellite Clinic Friemersheim Satellite Clinic Hartenbos Satellite Clinic Herbertsdale Satellite Clinic Karatara Satellite Clinic Melkhoutfontein Satellite Clinic Slangrivier Satellite Clinic Touwsranten Satellite Clinic Van Wyksdorp Satellite Clinic Wittedrif Satellite Clinic	Albertinia Mobile Calitzdorp Mobile Dana Bay Mobile De Rust Mobile Diepkloof and Geelhoutboom Mobile Haarlem Mobile Heidelberg Mobile Herold Mobile Keurhoek Mobile Knysna Mobile Kraaibos Mobile Ladismith Mobile Mossel Bay Mobile 1 Mossel Bay Mobile 2 Mossel Bay Mobile 3 Mossel Bay Mobile 4 Oudtshoorn Mobile 1 Oudtshoorn Mobile 3 Plettenberg Bay Mobile Riversdale Mobile Sedgefield Mobile Uniondale Mobile Van Wyksdorp Mobile Wilderness Mobile
0 + 4	**36**	**11**	**24**

1.5 Overberg District

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres (CHCs) None **Community Day Centres (CDCs)** Grabouw CDC	Barrydale Clinic Botrivier Clinic Bredasdorp Clinic Buffeljagsrivier Clinic Caledon Clinic Gansbaai Clinic Genadendal Clinic Greyton Clinic Hawston Clinic Hermanus Clinic Hermanus Hospital PHC Clinic Kleinmond Clinic Mount Pleasant Clinic Napier Clinic Railton Clinic Riviersonderend Clinic Stanford Clinic Suurbraak Clinic Swellendam Hospital PHC Clinic Villiersdorp Medical Centre Clinic Willa Clinic	Baardskeerdersbos Satellite Clinic Bereaville Satellite Clinic Betty's Bay Satellite Clinic Elim Satellite Clinic Malgas Satellite Clinic Onrus Satellite Clinic Pearly Beach Satellite Clinic Protem Satellite Clinic Struisbaai Satellite Clinic Voorstekraal Satellite Clinic Waenhuiskrans Satellite Clinic	Barrydale Mobile 3 Bredasdorp Mobile 1 Bredasdorp Mobile 2 Caledon Mobile 1 Caledon Mobile 2 Caledon Mobile 3 Caledon/Hermanus/Stanford Mobile 4 Grabouw Mobile 1 Grabouw Mobile 2 Grabouw Mobile 3 Ruens Mobile 5 Swellendam Mobile 4 Villiersdorp Mobile 1 Villiersdorp Mobile 2

	Zwelihle Clinic		
0 + 1	**22**	**11**	**14**

1.6 West Coast District

Community Health Centres (CHCs); Community Day Centres (CDCs)	**Clinics**	**Satellite Clinics**	**Mobiles**
Community Health Centres (CHCs) None **Community Day Centres (CDCs)** None	Citrusdal Clinic Clanwilliam Clinic Darling Clinic Diazville Clinic Elandsbaai Clinic Graafwater Clinic Hanna Coetzee Clinic Klawer Clinic Laingville Clinic Lalie Cleophas Clinic Lamberts Bay Clinic Langebaan Clinic Louwville Clinic Lutzville Clinic Moorreesburg Clinic Piketberg Clinic Porterville Clinic Riebeeck Kasteel Clinic Riebeeck West Clinic Saldanha Clinic Van Rhynsdorp Clinic Velddrif Clinic Vredenburg Clinic Vredendal Central Clinic Vredendal North Clinic Wesbank Clinic Wupperthal Clinic	Abbotsdale Satellite Clinic Aurora Satellite Clinic Bitterfontein Satellite Clinic Chatsworth Satellite Clinic Chempos Satellite Clinic Doringbaai Satellite Clinic Ebenhaezer Satellite Clinic Eendekuil Satellite Clinic Goedverwacht Satellite Clinic Kalbaskraal Satellite Clinic Kliprand Satellite Clinic Koekenaap Satellite Clinic Koringberg Satellite Clinic Malmesbury Satellite Clinic Molsvlei Satellite Clinic Nuwerus Satellite Clinic Paternoster Satellite Clinic Redelinghuys Satellite Clinic Rietpoort Satellite Clinic Riverlands Satellite Clinic Sandy Point Satellite Clinic Stofkraal Satellite Clinic Wittewater Satellite Clinic Yzerfontein Satellite Clinic	Citrusdal Mobile 1 Clanwilliam Mobile Darling Mobile Graafwater Mobile Hopefield Mobile Klawer Mobile Leipoldtville Mobile Lutzville Mobile Malmesbury Mobile 1 Malmesbury Mobile 2 Moorreesburg Mobile Piketberg Mobile 1 Piketberg Mobile 2 Piketberg Mobile 5 Porterville Mobile Van Rhynsdorp Mobile Vredenburg Mobile Vredendal Mobile Wupperthal Mobile
0 + 0	**27**	**24**	**19**

2. HOSPITALS

2.1 Acute hospitals

2.1.1 District hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Eerste Rivier False Bay GF Jooste Helderberg Karl Bremer Khayelitsha Mitchells Plain Victoria Wesfleur	Ceres Montagu Robertson Stellenbosch	Beaufort West Laingsburg Murraysburg Prince Albert	Knysna Ladismith (Alan Blyth) Mossel Bay Oudtshoorn Riversdale Uniondale	Caledon Hermanus Otto du Plessis Swellendam	Citrusdal Clanwilliam LAPA Munnik Swartland Vredenburg Vredendal Radie Kotze (PAH)	
9	**4**	**4**	**6**	**4**	**6 + 1**	**34**

2.1.2 Regional hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Mowbray Maternity Somerset Groote Schuur L2 Red Cross War Memorial ChildrenL2 Tygerberg L2	Paarl Worcester	None	George	None	None	
2 + 3	**2**	**0**	**1**	**0**	**0**	**8**

2.1.3 Tuberculosis hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Brooklyn Chest DP Marais	Brewelskloof Sonstraal	None	Harry Comay	None	Malmesbury ID	
2	**2**	**0**	**1**	**0**	**1**	**6**

2.1.4 Psychiatric hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Alexanddra Lentegeur Stikland Valkenberg	None	None	None	None	None	
4	**0**	**0**	**0**	**0**	**0**	**4**

2.1.5 Rehabilitation hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Western Cape Rehab Centre	None	None	None	None	None	
1	**0**	**0**	**0**	**0**	**0**	1

2.1.6 Central hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Groote Schuur L3 Red Cross War Memorial Children L3 Tygerberg L3	None	None	None	None	None	
3	**0**	**0**	**0**	**0**	**0**	**3**

2.2 Palliative, sub-acute and chronic care inpatient facilities

2.2.1 Palliative

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
St Luke's Hospice Bapumelele Eagle's Rest Special Lifecare Helderberg Hospice Ithemba Labantu Living Hope Temba Care	Boland Hospice Bram Care Luthando Stellenbosch Hospice Ceres Step Down	Beaufort West Hospice	Bethesda Knysna Hospice	Themba Care	Siyabonga	
8	5	1	2	**1**	1	18

2.2.2 Sub-acute

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Booth Memorial Sarah Fox	None	None	None	None	None	
2	**0**	**0**	**0**	**0**	**0**	2

2.2.3 Chronic

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
St Joseph's Home Conradie Care Centre	None	Nelspoort	None	None	None	
2	**0**	1	**0**	**0**	**0**	3

2.2.4 Other specialised

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Maitland Cottage	None	None	None	None	None	
1	**0**	**0**	**0**	**0**	**0**	1

3. OTHER FACILITIES

3.1 Emergency Medical Services Ambulance Stations

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Emergency Services Centre Karl Bremer Hospital Pinelands Station Ndabeni Khayelithsa Lentegeur U2 Tygerberg Hospital Atlantis	Ceres Hospital Worcester Hospital Robertson Hospital Montague Hospital Touws River Clinic De Doorns Traffic Office Bonnievale Clinic Tulbagh Municipal Offices Stellenbosch Hospital Paarl	Beaufort West Weigh Bridge Prince Albert Leeu Gamka School Laingsburg Multipurpose Centre Murraysburg	George Hospital Mossel Bay Hospital Knysna Hospital Riversdale Hospital Oudtshoorn Hospital Calitzdorp Ladismith Uniondale Dysselsdorp Plettenberg Bay Heidelberg	Grabouw CHC Caledon Hospital Villiersdorp Municipal Office Hermanus Hospital Bredasdorp Barrydale Riviersonderend Swellendam Hospital	Bitterfontein Van Rhynsdorp Lamberts Bay Clanwilliam Citrusdal Piketberg Mooreesburg Vredenburg Porterville Malmesbury	
6	**10**	**5**	**11**	**8**	**10**	**50**

3.2 Forensic Pathology Laboratories (Mortuaries)

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Salt River Tygerberg	Paarl Stellenbosch Wolseley Worcester	Beaufort West Laingsburg	George Knysna Mossel Bay Oudtshoorn Riversdale	Hermanus Swellendam	Malmesbury Vredenburg Vredendal	
2	**4**	**2**	**5**	**2**	**3**	**18**

ABBREVIATIONS

ACT	Assertive community teams
AECL(M)P	Acute emergency case load (management) policy
AIDS	Acquired immune deficiency syndrome
AOS	Accounting Officers System
APH	Associated psychiatric hospitals
ART	Antiretroviral treatment
ARV	Antiretroviral
ASSA	Actuarial Society of South Africa
ATA	Assistant to artisan
AZT	Azidothymidine/Zidovudine
BP	Budget programme
CBR	Community based rehabilitation
CBS	Community-based services
CD4	Cluster of Differentiation 4 (lymphocyte)
CDC	Community day centre
CDU	Chronic dispensing unit
CGF	Clinical governance framework
CHC	Community health centre
CMD	Cape medical depot / Central Medicine Depot
CME	Continuous medical training
CPIX	Consumer price index
CSP	Comprehensive Service Plan
DDG	Deputy Director General
DH	District hospital
DHIS	District health information system
DPO	Diabled persons organisation
EMC	Emergency medical care
EMS	Emergency medical services
EMRS	Emergency medical rescue service
EPI	Expanded programme on immunisation
FBU	Financial business unit
FIFA	Fédération Internationale de Football
FPS	Forensic pathology services
H1N1	Subtype of Influenza Type A category virus (H1N1 – Haemagglutinin 1 Neuraminidase 1)
HBC	Home-based care
HCBC	Home community based services
HEI	Institutes of higher education
HIV	Human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
HPTDG / HPT & D grant	Health professions training and development grant
HRDS	Human resource development strategy
HWSETA	Health and Welfare Sector Education and Training Authority
ICD10	International classification of disease coding
ICS	Improved conditions of service
ICT	Information communications technology
iMOCOMP	Improvement and maintenance of competence project
IMR	Infant mortality rate

LG	Local Government
LOGIS	Logistic Information Management System
MCWH & N	Maternal, Child, Women's Health and Nutrition
MDG	Millennium development goal
MDR	Multi-drug resistant
MEC	Member of the Executive Committee (Minister)
MIP	Massified induction programme
MMR	Maternal mortality rate
MOUs	Midwife obstetric units
MTEF	Medium-term expenditure framework
MTSF	Medium Term Strategic Framework
NDOH	National Department of Health
NHI	National Health Insurance
NPO	Non-profit organisation
NTSG	National tertiary services grant
NVP	Nevirapine
ODI	Organisational development investigation
OHS	Occupational health and safety
OPC	Orthotic and Prosthetic Centre
OPD	Out-patient department
OSD	Occupational specific dispensation
P1	Priority 1
PCU	Planning and commissioning unit
PCV	Pneumococcal vaccine
PDE	Patient day equivalent
PEPFAR	(United States) Presidents emergency plan for aids relief
PGWC	Provincial Government Western Cape
PHC	Primary health care
PMTCT	Prevention of mother-to-child transmission
PPP	Public-private partnership
PSETA	Public Service Education and Training Authority
PTB	Pulmonary tuberculosis
QPR	Quarterly performance reports
QI	Quality improvement
SADHS	South African Demographic and Health Survey
SCM	Supply chain management
SMART	Strategic, measurable, achievable, realistic, time-bound
SO	Strategic objective
SP	Strategic plan
STI	Sexually transmitted infections
SYSPRO	Supply chain management system
TB	Tuberculosis
UWCTS	Unitary/integrated Western Cape Tertiary Service
VIP (latrine)	Ventilated improved pit latrine
WCRC	Western Cape Rehabilitation Centre
WHO	World Health Organisation
XDR	Extreme drug resistant

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