DEPARTMENT OF HEALTH
VOTE 6
ANNUAL REPORT 2010/11

Contents

4. HUMAN RESOURCE MANAGEMENT

5. OTHER INFORMATION

1. GENERAL INFORMATION

1.1 Submission of the Annual Report to the executive authority

DEPARTMENT of HEALTH
Provincial Government of the Western Cape

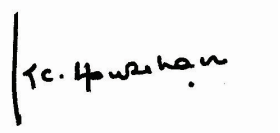
HEAD OF DEPARTMENT
Keith.Household@pgwc.gov.za
tel: +27 21 483 4473: +27 21 483 5677
7 Wale Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: 13/3/1
ENQUIRIES: Professor KC Household

Minister TL Botha
Minister of Health

In accordance with section 40(1)(d) of the Public Finance Management Act, 1999; the Public Service Act, 1994 (as amended), the National Treasury Regulations (NTR) and Treasury Circular 37/2004 (Supplementary 1 of 2011), I hereby submit the Western Cape Department of Health's Annual Report on performance indicators and departmental activities for the 2010/11 financial year.

Please note in terms of section 65(1)(a) of the Public Finance Management Act, 1999 the MEC is required to table the report in the Provincial Legislature by 30 September 2011.



PROFESSOR KC HOUSEHAM
HEAD HEALTH: WESTERN CAPE

Date: 16 August 2011

1.2 Vision, Mission and Values

The Western Cape Department of Health's vision statement is "Quality health for all".

The Department's mission is to provide equitable access to health in partnership with the relevant stakeholders within a balanced and well managed health system.

The overarching values identified by the Provincial Government of the Western Cape are:

(1) Caring;
(2) Competence;
(3) Accountability;
(4) Integrity; and
(5) Responsiveness.

The core values that will be reflected in the way in which the vision and mission are achieved are:

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

1.3 Organisational Structure

Minister: Mr Theuns Botha

Superintendent General: Head of Department: Professor KC Household

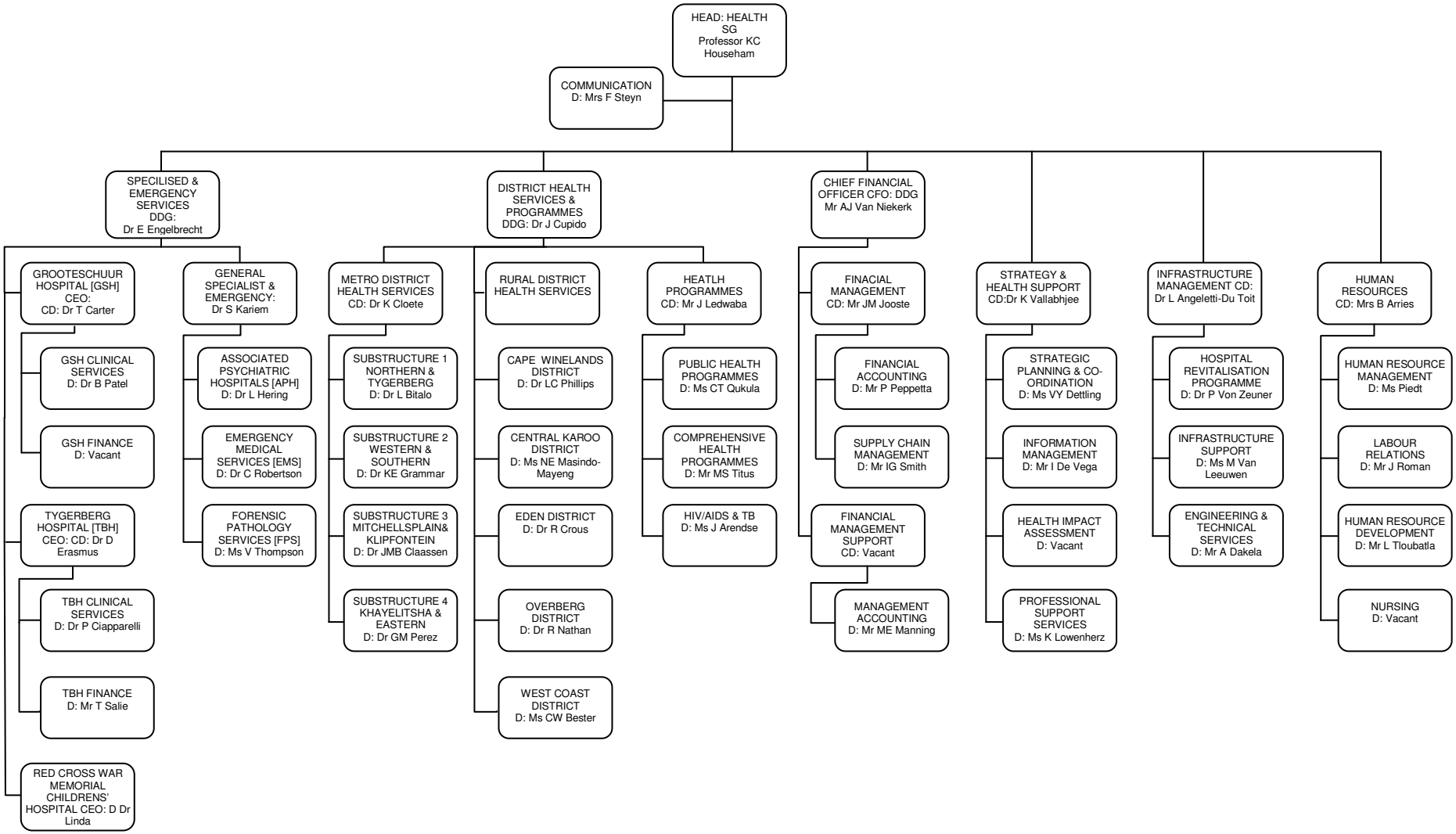
Deputy Director-Generals:

(1) Specialised and Emergency Services: Dr E Engelbrecht.
(2) District Health Services and Programmes: Dr J Cupido.
(3) Chief Financial Officer (CFO): Mr AJ van Niekerk.

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

An organogram of senior management in the Department is attached.

ORGANOGRAM OF SENIOR MANAGEMENT IN THE WESTERN CAPE DEPARTMENT OF HEALTH



1.4 Legislative Mandate

National Legislation

(1) Aged Persons Act, 81 of 1967
(2) Allied Health Professions Act, 63 if 1982
(3) Atmospheric Pollution Prevention Act, 45 of 1965
(4) Basic Conditions of Employment Act, 75 of 1997
(5) Births and Deaths Registration Act, 51 of 1992
(6) Broad Based Black Economic Empowerment Act, 53 of 2003
(7) Child Care Act, 74 of 1983
(8) Children's Act, 30 of 2005
(9) Chiropractors, Homeopaths and Allied Health Service Professions Act, 63 of 1982
(10) Choice on Termination of Pregnancy Act, 92 of 1996
(11) Compensation for Occupational Injuries and Diseases Act, 130 of 1993
(12) Constitution of the Republic of South Africa, 1996
(13) Constitution of the Western Cape, 1 of 1998
(14) Correctional Services Act, 8 of 1959
(15) Criminal Procedure Act, 51 of 1977
(16) Dental Technicians Act, 19 of 1979
(17) Division of Revenue Act (Annually)
(18) Domestic Violence Act, 116 of 1998
(19) Drugs and Drug Trafficking Act, 140 of 1992
(20) Employment Equity Act, 55 of 1998
(21) Environment Conservation Act, 73 of 1998
(22) Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972
(23) Government Immovable Asset Management Act, 19 of 2007
(24) Hazardous Substances Act, 15 of 1973
(25) Health Act, 63 of 1977
(26) Health Professions Act, 56 of 1974
(27) Higher Education Act, 101 of 1997
(28) Inquests Act, 58 of 1959
(29) Intergovernmental Relations Framework, Act 13 of 2005
(30) Institution of Legal Proceedings Against Certain Organs of State Act, 40 of 2002
(31) International Health Regulations Act, 28 of 1974
(32) Labour Relations Act, 66 of 1995
(33) Local Government: Municipal Demarcation Act, 27 of 1998
(34) Local Government: Municipal Systems Act, 32 of 2000
(35) Medical Schemes Act, 131 of 1997
(36) Medicines and Related Substances Control Amendment Act, 90 of 1997
(37) Mental Health Care Act, 17 of 2002
(38) Municipal Finance Management Act, 56 of 2003
(39) National Health Act, 61 of 2003
(40) National Health Laboratories Service Act, 37 of 2000
(41) Non Profit Organisations Act, 71 of 1977
(42) Nuclear Energy Act, 46 of 1999

(43) Nursing Act, 33 of 2005
(44) Occupational Health and Safety Act, 85 of 1993
(45) Pharmacy Act, 53 of 1974
(46) Preferential Procurement Policy Framework Act, 5 of 2000
(47) Promotion of Access to Information Act, 2 of 2000
(48) Promotion of Administrative Justice Act, 3 of 2000
(49) Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000
(50) Protected Disclosures Act, 26 of 2000
(51) Prevention and Treatment of Drug Dependency Act, 20 of 1992
(52) Public Finance Management Act, 1of 1999
(53) Public Service Act, 1994
(54) Road Accident Fund Act, 56 of 1996
(55) Sexual Offences Act, 23 of 1957
(56) State Information Technology Agency Act, 88 of 1998
(57) Skills Development Act, 97 of 1998
(58) Skills Development Levies Act, 9 of 1999
(59) South African Medical Research Council Act, 58 of 1991
(60) South African Police Services Act, 68 of 1978
(61) Sterilisation Act, 44 of 1998
(62) Tobacco Products Control Act, 83 of 1993
(63) Traditional Health Practitioners Act, 34 of 2004
(64) University of Cape Town (Private) Act, 8 of 1999

Provincial Legislation

(1) Communicable Diseases and Notification of Notifiable Medical Condition Regulations. Published in Proclamation R158 of 1987
(2) Exhumation Ordinance, 12 of 1980. Health Act, Act 63 of 1977
(3) Regulations Governing Private Health Establishments. Published in PN 187 of 2001
(4) Training of Nurses and Midwives Ordinance 4 of 1984
(5) Western Cape Health Facility Boards Act 7 of 2001 and its regulations
(6) Western Cape Land Administration Act, 6 of 1998
(7) Western Cape Health Care Waste Management Act, 7 of 2007
(8) Western Cape Direct Charges Act, 6 of 2000
(9) Western Cape Health Services Fees Act, 5 of 2008 and its regulations
(10) Western Cape Ambulance Services Act, 3 of 2010
(11) Western Cape District Health Councils Act, 5 of 2010

Bills submitted to the Legislature

The Premier assented to the following Acts during the 2010/11 financial year:

(1) Western Cape Ambulance Services Act, 3 of 2010
(2) Western Cape District Health Councils Act, 5 of 2010

1.5 Entities Reporting to the Minister

Trading entities

(1) Cape Medical Depot

Governing legislation:	Established in terms of the Public Finance Management Act, 1 of 1999 (PFMA).
Functions/objectives:	Manage the supply of pharmaceuticals and medical sundries to hospitals, community health centres and local authorities.
Accountability:	The Head of Department is the accounting officer of this trading entity.

1.6 Minister's Statement

2010/11 has been a significant year for the Department. South Africa hosted the World Cup – an event of unprecedented proportions. The Emergency Medical Services (EMS) and staff within our health facilities made the Department proud in the manner in which they addressed the health needs of the large number of visitors and the local population at the same time. An important legacy has been the strengthening of the EMS.

Significant preparatory work was undertaken during 2010 developing the cabinet priority on "Increasing Wellness" which provides an important strategic framework for the planning of 2020. A provincial summit will be convened during 2011 by the Premier to launch the whole of society approach to improving wellness. The key focus for the next few years will be to improve the patient experience within our health service. The national core standards on quality assurance will be used to develop a baseline and plan the way forward for quality improvement in greater detail.

The relationship with the private sector has been strengthened through regular engagements. A public–private health forum facilitates this process. A range of proposals are being explored to give meaningful effect to this partnership in practice.

I am proud of the public health services in the Western Cape. The provision of a quality health service is made possible through the daily commitment and dedication of thousands of health workers and support staff within the Department. Let me use this opportunity to thank each one of you for your efforts. You make us proud.

THEUNS BOTHA
WESTERN CAPE MINISTER OF HEALTH
AUGUST 2011

1.7 Accounting Officer's Overview

2010 was an important year for the Department as this was the end point of the Healthcare 2010 strategic vision. During July 2010, the Department assessed the achievements against the goals identified in the Comprehensive Service Plan (CSP) and Healthcare 2010. There was a general consensus after this evaluation that the foundations of the health service as envisaged by the CSP had been laid.

The planning process for the next decade has commenced in earnest. The patient experience will lie at the heart of the 2020 vision. A booklet capturing the vision, values and principles will be produced to form the basis for dialogue and organisational renewal within the Department towards 2020.

The Provincial Government of the Western Cape (PGWC) is developing a values based approach across departments. A values survey was conducted in the Department of Health sampling approximately six hundred staff members including doctors, nurses, other health professionals and administrative staff. The outcome was discussed by senior management and the results communicated through a series of workshops. Building a consciousness around values will require on-going leadership and effort at all levels of the organisation, but is essential to improving the quality of health services in the Western Cape.

The provincial cabinet approved a draft provincial strategic plan in which the objective of the Department of Health is "Increasing Wellness ". This shifts the focus from disease and ill health to the positive concept of wellness. More importantly there is recognition that achieving good health is not the sole responsibility of the Department of Health, but rather requires the continued efforts of other departments, spheres of government and civil society.

The strategic objective "Increasing Wellness" speaks to the provision of quality health services by the Department of Health and also addresses the upstream risk factors that cause disease and ill health. This approach is welcomed by the Department. The Burden of Disease Report, developed by the Department, in large measure guides the interventions, based on evidence, to address the upstream factors in Health. The PGWC launched the Provincial Transversal Management System (PTMS) to give structural and organisational effect to this approach. The Department has identified four focus areas in line with the Millennium Development Goals – reducing injuries, healthy lifestyles, women and child health and HIV/TB.

The National Minister formalised his service delivery agreement with clearly identified national strategic goals and outcomes towards "a long and healthy life for all South Africans". The priorities within the provincial department are in line with this national framework.

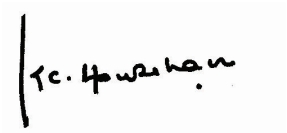
In May 2010, a senior management reshuffle was undertaken to better address the needs of the organisation by matching the skills and experience of individual managers to the respective posts in senior management. Two new chief directorates were created to give a greater focus to infrastructure development and strategic planning.

The hosting of the World Cup in June/July 2010 provided an unprecedented challenge but also an opportunity in events management. The Emergency Medical Services were strengthened by employing three hundred additional staff, training one thousand staff in major incident management, purchasing thirty new ambulances and other vehicles and R 6 million worth of medical equipment. The staff are to be commended on the excellent service they provided at the World Cup events.

Approximately 16.2 million patient contacts were seen at primary health care clinics, of which 2.4 million were children under five years. The ambulance services transported almost 446 500 patients to health facilities, while the general acute hospitals saw approximately 1.68 million patients in outpatient departments and admitted more than 480 000 patients in 2010/11. Over 6 600 cataract operations were performed in 2010/11 and 29 728 new patients were started on anti-retroviral treatment (ART). The Western Cape now has a total of 96 011 patients on anti-retroviral therapy. There were approximately 4.6 million patient contacts at people's homes through the community-based carer programme in 2010/11 compared to 2.7 million in 2009/10. More than 1.7 million scripts were processed through the central dispensing unit which is a 27% increase over the previous year. This has made a significant difference in reducing the waiting times for patients at pharmacies. All of this bears testimony to the increasing service load experienced by the Department in 2010.

A major achievement was of the prevention of mother-to-child transmission (PMTCT) programme in the province with only 3.2% babies born to HIV positive mothers testing positive for the HI virus. The TB cure rate, peaking at 80.5% by the end of 2010/11, is the highest in the country. The HIV counselling and testing (HCT) campaign was launched in 2010 with a target of 1.1 million people to be tested by June 2011. At the end of the financial year approximately 840 000 people had been routinely tested for HIV.

My thanks to the staff of the Department at all levels whose on-going commitment to service delivery and hard work enables the Western Cape Department of Health to make a difference in the lives of people of this province and the country.



PROFESSOR KC HOUSEHAM
HEAD HEALTH: WESTERN CAPE
DATE: 16 August 2011

2. INFORMATION ON PREDETERMINED OBJECTIVES

2.1 Overall Performance

2.1.1 Voted funds

Appropriation	Main appropriation R'000	Adjusted appropriation R'000	Actual amount spent R'000	(Over)/Under expenditure R'000
Vote 6	11 962 863	12 408 383	12 344 628	63 755
Responsible Minister/ MEC	Provincial Minister of Health			
Administering Department	Department of Health			
Accounting Officer	Head of Department, Department of Health			

2.1.2 Aim of vote

The core function and responsibility of the Western Cape Department of Health is to deliver a comprehensive package of health service to the people of the province. This includes preventive, promotive, emergency and curative services, rehabilitation, and chronic care.

Effective interventions are implemented to reduce morbidity and mortality particularly in the high priority areas of HIV and AIDS, tuberculosis (TB), trauma and chronic diseases. In addition, highly specialised tertiary health care services are rendered to the people of the Western Cape and neighbouring provinces which are largely funded from the National Tertiary Services Grant.

The Department provides training facilities for health care workers and professionals in conjunction with higher education institutions. The Department is also responsible for the licensing and regulation of private hospitals within the province and the rendering of a forensic pathology service.

Finally, the Department is responsible for the development and maintenance of appropriate enabling support services and infrastructure, and the procurement of appropriate technology, in order to deliver the above-mentioned services.

2.1.3 Summary of programmes

The Department of Health consists of the following eight budget programmes:

Programme 1: Administration

The purpose of the Administration programme is to conduct the strategic management and overall administration of the Department of Health.

Programme 2: District Health Services

The purpose of the District Health Services programme is to render primary health care and district hospital services.

Programme 3: Emergency Medical Services

The purpose of the Emergency Medical Services programme is the rendering of pre-hospital emergency medical services including inter-hospital transfers and planned patient transport.

Programme 4: Provincial Hospital Services

The purpose of the Provincial Hospital Services programme is the delivery of hospital services, which are accessible, appropriate, effective and to provide general specialist services, including a specialised rehabilitation service, as well as a platform for training health professionals and research.

Programme 5: Central Hospital Services

The purpose of the Central Hospital Services programme is to provide tertiary health services and create a platform for the training of health workers.

Programme 6: Health Sciences and Training

The purpose of the Health Sciences and Training programmes is the rendering of training and development opportunities for actual and potential employees of the Department of Health.

Programme 7: Health Care Support Services

The purpose of the Health Care Support Services programmes is to render support services required by the Department to realise its aims.

Programme 8: Health Facilities Management

The purpose of the Health Facilities Management programmes is to provide for new health facilities, upgrading and maintenance of existing facilities, including the hospital revitalisation and provincial infrastructure grants.

More detail is provided on the sub-programmes within each budget programme in the section on "Programme performance" (Section 2.2) later on in this Report.

2.1.4 Key strategic objective achievements

The 2010/11 financial year was the first year of the five year strategic planning cycle covering the period from 2010 – 2014. One of the ten strategic objectives identified by the Provincial Government of the Western Cape covering the same period is to maximise health outcomes. The strategic goals of the Department of Health were developed to focus the Department's endeavours on improving this objective, namely:

(1) Manage the burden of disease.
(2) Ensure and maintain organisational 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.
(6) Improve the quality of health services.

Some of the significant achievements in terms of the progress made in achieving the above-mentioned goals, as highlighted in the 2011/12 Budget Statement, are:

Manage the burden of disease

Primary health care

In 2010/11 there was a total primary health care (PHC) headcount of 16 206 552. Although this is 7.2% below the target of 17 466 401 this must be offset against the increase in the headcount for community-based services and the number of prescriptions for patients with chronic diseases that are being delivered via the chronic dispensing unit, and thus not reflected in the total PHC headcount.

HIV and AIDS

Since 1 July 2010 the Western Cape Department of Health has conducted an HIV counselling and testing (HCT) campaign which aimed to reach 1.1 million people within fifteen months. As of the 31st March 2011, 840 288 clients were tested.

Prevention of mother-to-child transmission (PMTCT) services are offered at all facilities which provide antenatal care, maternity services and baby clinics. Services and starter-pack post exposure prophylaxis (PEP) are available at PHC level for those who sustain needle-stick injuries. Follow-up care and support is available at designated hospitals throughout the province.

HIV and TB services are also available at all district, secondary and central hospitals for clients with HIV or TB disease and/or co-morbidity. In addition, 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 132 fully functional ART service points. 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 are important for ensuring "an HIV-free generation".

Maternal, child and women's health

These services 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 the Integrated Management of Childhood Illness (IMCI), infant feeding, Basic Antenatal Care (BANC) and Essential Steps in Management of Obstetric and Neonatal Emergencies (ESMOE). Regional and central hospitals provide access to specialist and critical care, and perform outreach and support to district health services. Ambulance services have established a rapid response system prioritising pregnant women and children.

Disease prevention and control

Chronic disease is a major burden on the health service. One of the reduction strategies is to aggressively implement health system interventions ranging from health promotion to secondary prevention.

The Department continued to implement promotion/prevention interventions for purposes of:

- Promoting healthy lifestyles;
- Improving community participation; and
- Strengthening of primary health care services through collaboration with chronic disease management and nutrition programmes.

Emergency Medical Services

Emergency Medical Services (EMS) in the Western Cape provides a comprehensive emergency medical system which delivers ambulance, rescue and patient transport services from fifty stations in five rural districts and four Cape Town divisional EMS services with a fleet of 250 ambulances, 1 264 operational personnel and 84 supervisors. Six communication centres, one in each health district, receive over 500 000 public calls for emergency assistance and dispatch 519 228 responses with ambulances and rescue vehicles.

Patient transport or HealthNET performs outpatient transfers between levels of care within districts and across districts to regional and tertiary hospitals. Approximately 6 640 patients are transported every month by HealthNET. Approximately three thousand of these patients are transported to Cape Town hospitals from rural areas.

Improving response times remains a priority and detailed operational plans have been developed to facilitate the achievement of the targets within the resources provided.

Forensic Pathology Service

The medico-legal investigation of unnatural deaths is delivered through eighteen forensic pathology laboratories across the province. This is achieved with a staff component of 254 personnel and a fleet of 44 body transportation vehicles. Ensuring access remains a priority and this is being measured through response times to death scenes, turn-around times from admission to post-mortem and admission to release of the deceased.

Provincial hospitals

Services in regional hospitals are in the process of being reconfigured and strengthened, particularly in the rural districts where the focus is on the provision of general specialist services, with continued outreach and support to district hospitals. Heads of general specialist services have been appointed to facilitate the process.

Designated multi-drug resistant TB (MDR-TB) units have been established at Brewelskloof, Harry Comay and Brooklyn Chest Hospitals. Brooklyn Chest and DP Marais Hospitals have been amalgamated into the Metro TB Complex with the appointment of a single management structure. A pilot infectious disease palliative centre has been established at Nelspoort Hospital in the Central Karoo District to manage patients with extreme drug resistant TB (XDR-TB) treatment failure.

Psychiatric hospitals remain under pressure, particularly as a result of the high rate of substance abuse. Therefore it is important that the Department continue to focus on the de-institutionalisation of chronic clients and build capacity for acute admissions.

The Western Cape Rehabilitation Centre continued to provide a specialised, comprehensive, multi-disciplinary inpatient and outpatient rehabilitation service to persons with physical disabilities. This service includes the provision of mobility and other assistive devices such as orthotics and prosthetics. An outcome-based approach is followed, which demonstrates the positive impact of the service on re-integrating disabled clients back to their homes, communities and where appropriate, a return to productive activity.

Central hospitals

There are three central hospitals in the Western Cape namely Groote Schuur, Tygerberg and Red Cross War Memorial Children's Hospital. These hospitals provide highly specialised services to the people of the Western Cape and beyond the provincial boundaries. They also provide the major platform for the training of health sciences students and research.

Ensure and maintain organisational strategic management capacity and synergy.

The Department is implementing the Human Resource Plan for 2009 – 2014, which includes a skills audit and action plans, to address the identified human resource priorities.

An important focus area during 2010/11 has been the reduction of the turnaround time in the filling of vacancies.

The strategic management capacity has been strengthened by the creation of the Chief Directorate: Infrastructure and the Chief Directorate: Health Strategy and Support. However, many of the posts in these components still need to be filled.

Develop and maintain a capacitated workforce to deliver the required health services

The occupational specific dispensations for various categories of staff have been implemented to facilitate the recruitment and retention of staff.

There is a joint initiative between Human Resources and Finance to facilitate the filling of all funded posts using the Approved Post List.

The higher education institutions continue to facilitate the training of various categories of health professionals.

Provide and maintain appropriate health technology and infrastructure

The following infrastructure projects were completed during 2010/11:

- Ceres Ambulance Station
- Eerste River Hospital new emergency centre
- Groote Schuur Hospital workshop relocation
- Western Cape Procurement (Business Interests of Employees) Act, 2010 (Act 8 of 2010)
- Malmesbury Forensic Pathology Laboratory
- Mitchell's Plain CHC new emergency centre and pharmacy
- Paarl TC Newman CHC new ARV clinic, pharmacy and general upgrade
- Paarl Forensic Pathology Laboratory

- Kwanokuthula Ambulance Station in Plettenberg Bay
- Red Cross War Memorial Children's Hospital ward D1 upgrade (in partnership with the Red Cross Children's Hospital Trust)
- Worcester Forensic Pathology Laboratory

The Modernisation of Tertiary Services (MTS) Grant was used to implement the Picture Archive Communication System and Radiological Imaging System (PACS/RIS) at Tygerberg Hospital and to commence the roll out at Groote Schuur Hospital. The MTS Grant was also used to fund scarce clinical engineers, responsible for the maintenance of medical equipment.

Ensure a sustainable income to provide the required health services according to the needs

A concerted effort has been made to provide well substantiated motivations to Treasury that reflect the performance against targets in relation to the allocated budgets. Related to this is the motivation for funding for the operational costs and on-going maintenance of Khayelitsha Hospital and Mitchells Plain Hospital that will be commissioned during 2011/12 and 2012/13 respectively.

The National Tertiary Services Grant and the Health Professions Training and Development Grant are insufficient to appropriately fund the cost of providing the required tertiary services and the costs associated with the training of health professionals. These grants are therefore supplemented with allocations from the Provincial Equitable Share.

Improve the quality of health services

The Department has identified the importance of improving the patient experience of the health service from both a subjective and objective perspective, as its priority. Examples of measures to address quality of care include monthly morbidity and mortality meetings and patient satisfaction surveys. The National Department of Health, in consultation with provinces, has developed a set of core standards for quality assurance. Six ministerial priorities were identified within these standards and the assessment of facilities against these priority standards will be phased in from 2011/12. The six ministerial priorities are:

- values and attitudes;
- waiting times;
- cleanliness;
- patient safety;
- infection prevention and control; and
- availability of medicines and supplies.

The Department continued to monitor and license private health facilities.

The Provincial Minister of Health appointed an external Independent Complaints Commission that will augment the current internal monitoring and management of compliments and complaints.

2.1.5 Overview of service delivery environment for 2010/11

Summary of services rendered by the department

In terms of section 27 of the Constitution of the Republic of South Africa, 1996 (Act 108 of 1996): "Everyone has the right to have access to health care services, including reproductive health care; and no-one may be refused emergency treatment" and the state must take reasonable legislative and other measures within its available resources, to achieve the progressive realisation of these rights.

The Western Cape Department of Health is primarily responsible for providing health services to the 4.6 million uninsured population of the province, i.e. approximately 78% of the total population of 5.8 million. In addition to this there is an obligation to provide tertiary services to people beyond the provincial boundaries, in line with funding received through the National Tertiary Services Grant.

The implementation of the Comprehensive Service Plan is improving patient care by managing the patients appropriately at the right level of care and at the right cost.

The range of services provided by the Department includes the following:

1) The delivery of comprehensive, cost-effective primary health care services including the prevention of disease and promotion of a safe and healthy environment.
2) The delivery of district, provincial and central hospital services.
3) The delivery of health programmes to deal with specific health issues such as nutrition, HIV and AIDS, tuberculosis, reproductive health, environmental and port health, etc.
4) The delivery of emergency medical and patient transport services.
5) The rendering of specialised orthotic and prosthetic services.
6) The rendering of forensic pathology and medico-legal services.
7) The delivery of support services to ensure efficient health services.
8) The overall management and administration of the delivery of public health care within the province.
9) The development of organisational structures that enables effective quality service delivery.
10) Effective communication.
11) The regulation of private health care.

1) Comprehensive, cost effective primary health care services

Primary health care (PHC) services are provided at 468 facilities that consist of mobiles, satellite clinics, clinics, community day centres (CDCs) and community health centres (CHCs). In total there are 32 sub-districts in the province, all of which provide a full package of PHC services.

The 16 206 552 clients seen at primary health care services during 2010/11 translates in a utilisation rate of 2.9 per member of the total population and 4.7 per member of the population under five years of age.

2) District, provincial and central hospital services

There are 34 district hospitals in the Western Cape. This includes the Khayelitsha and Mitchell's Plain district hospital hubs, which are currently located at Tygerberg and Lentegeur Hospitals respectively pending the construction of these hospitals. In total 237 292 inpatients and 565 801 outpatients were treated at district hospitals and twenty district hospitals (58.8%) conducted monthly mortality and morbidity (M & M) meetings.

Five general (regional) hospitals and three central hospitals provided level two or general specialist services to 174 307 inpatients and 580 840 outpatients. A total of 4 192 inpatients and 7 192 outpatients were treated at the six tuberculosis hospitals in the province. A further 5 690 inpatients and 31 152 outpatients were treated at the four psychiatric hospitals. The Western Cape Rehabilitation Centre treated 949 inpatients and 30 812 outpatients. All eight general (regional) hospitals, two TB hospitals, two psychiatric hospitals and one rehabilitation hospital conducted mortality and morbidity meetings every month. Twelve hospitals conducted an annual patient satisfaction survey and fifteen hospitals conducted an annual staff satisfaction survey.

In the three central hospitals 68 490 inpatients and 541 079 outpatients were treated. All three central hospitals conducted mortality and morbidity meetings every month. Furthermore, all three central hospitals conducted an annual patient and an annual staff satisfaction survey.

3) Health programmes to deal with specific health issues

The key priorities identified by the integrated nutrition programme (INP) in the 2010/11 APP are:

- Adequate and optimal feeding for children especially the 0 - 2 year age group:

  Promotion, protection and support of breastfeeding are the core components of the Baby Friendly Hospital Initiative (BFHI) implemented as a child survival strategy. The BFHI is implemented in both public and private birthing units. New BFHI facilities are accredited annually and formerly accredited facilities are re-assessed every three years. Accreditation of BFHI status is only awarded through a national assessment process. Birthing units that fail external re-assessments lose their status and have to start the process over again. The Western Cape has now increased the number of accredited birthing units to twenty-two (twenty public and two private).

  Training of health care workers in both the facility and community based services was completed to strengthen knowledge and understanding of optimal infant feeding practices. Resource material relating to infant and young child feeding was updated and new material was developed.

  The roll out of a new Road to Health Booklet (RTHB) was implemented to enhance child health care. The institutionalisation of the RTHB was initiated in 2010/11 and will be strengthened in 2011/12.

- Prevention and treatment of nutrition related diseases:

  Policy development and implementation of programmes aimed at reducing the occurrence of malnutrition in children was prioritised. This addresses three of the Millenium Development Goals, namely: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate (MDG 4), reduce by three quarters, between 1990 and 2015, the maternal mortality ratio, and have halted and begun to reverse the spread of HIV and AIDS and TB by 2015 (MDG 6).

  Nutrition supplements / specialised nutritional products are provided to clients identified as being nutritionally vulnerable for a minimum period of six months. Priority groups include: growth faltering infants and children younger than five years of age, underweight pregnant and lactating women, clients with HIV and AIDS and tuberculosis. A holistic approach in the management of these clients is applied.

- Improvement of nutrition status through targeted micronutrient supplementation:

  Vitamin A supplements are provided to children (6 - 59 months old) and post-partum women routinely at all public health facilities. The vitamin A supplementation programme is implemented to protect immunity, prevent blindness and reduce the risk of children dying from common childhood illnesses. The 6 – 11 months age group was excluded in the national Expanded Programme on Immunisation (EPI) campaign in 2010, but continued in routine services. Coverage of 77.2% was reached in the 6 – 11 months age group during the year.

HIV counselling and testing (HCT) services are available at all fixed PHC facilities in the province. During 2010/11 a total of 747 139 people were tested for HIV in addition to the antenatal women who are tested as part of the prevention of mother-to-child transmission (PMTCT) programme.

Anti-retroviral treatment (ART) was provided to 96 011 patients at 132 accredited ARV sites.

The smear positive TB cure rate increased to 80.7% and the TB treatment interruption decreased from 9.2% in 2008/09 to 6.9% in 2010/11.

4) Emergency medical and patient transport services

Emergency Medical Services (EMS) delivers ambulance, rescue and patient transport services from fifty stations across the Western Cape Province and a fleet of 250 ambulances. More than 500 000 public calls for emergency assistance were received during the year and 519 228 responses with ambulances and rescue vehicles were dispatched.

Approximately 6 640 patients are transported every month by HealthNET (patient transport service). Three thousand of these patients are transported to Cape Town hospitals from rural areas.

5) Specialised orthotic and prosthetic services

A total of 6 071 orthotic and prosthetic devices were manufactured and the waiting list for devices for more than six months decreased from 391 in 2009/10 to only 98 patients in 2010/11.

6) Forensic pathology and medico-legal services

Forensic pathology services are rendered via eighteen forensic pathology facilities across the province and 44 response vehicles. During 2010/11 a total of 9 417 incidents were logged and 9 249 medico-legal cases were examined.

Challenges and corrective steps / response to challenges

Some of the challenges experienced by the Department include:

1) The mass campaign for the Expanded Programme on Immunisation (EPI) led to clinic personnel being withdrawn from clinical duties in health facilities and placed in community response teams. This had a negative effect on the routine vaccine coverage and other Maternal, Child and Women's Health (MCWH) facility-level activities.
2) The National Tertiary Services Grant (NTSG) and the Health Professions Training and Development Grant (HPTDG) are insufficient to appropriately fund the cost of providing the required tertiary services and the costs associated with the training of health professionals. These grants are therefore supplemented with allocations from the Provincial Equitable Share.

3) The planned 90-bed expansion of palliative / sub-acute and chronic care beds did not realise as the site at Lentegeur earmarked for the expansion was allocated to the relocation of the supporting non-profit organisation Lifecare instead. Lifecare, which had been accommodated on the Conradie Hospital site, had to be relocated due to the sale of the property and during the course of the year it reduced its number of beds from 280 to 250.

4) Under spending on capital projects due to the lack of availability and delayed acquisition of appropriate sites, delays in planning, poor performance of service providers, i.e. professionals and contractors, and the current service delivery model.

   - Hospital Revitalisation Programme (HRP)

     The HRP budget was under-spent by R 9.3 million which is approximately 1.5% of the budget. Reasons for the under expenditure are delay in approval by National HRP of the 2010/11 project implementation plan for Tygerberg Hospital, slow progress on planning of Vredenburg Hospital Phase 2B and slow spending on George Hospital Phase 3 due to additional scope added for the emergency centre.

   - Infrastructure Grant to Provinces (IGP)

     The IGP was under-spent by R 7.6 million. Reasons for the under expenditure are delays in tender processes and delays in site handover or slow construction work.

5) The fundamental capacity constraints facing the Department include:

   - The challenge of recruiting and retaining highly skilled and experienced health care personnel.
   - The challenge of recruiting and retaining scarce skill categories of employees including skilled and experienced management/administrative personnel, particularly in human resource management, finance, information management and people with technical skills such as artisans, medical technicians and engineers.
   - The difficulty in replacing administrative staff, skilled in human resource and finance administration, especially in the rural areas, has a negative impact on service delivery.

Additions to or virement between the main appropriation allocations

Refer to Notes to the Appropriation Statement, number 4.

Roll-overs from the previous financial year

As indicated in the Western Cape Provincial Government - Adjusted Estimates of Provincial Expenditure 2010, roll-overs amounted to R 92 682 000:

- Programme 7: Health Care Support Services – R7 402 000

  R 7 402 000 has been rolled-over from 2009/10 in respect of the National Forensic Pathology Services Conditional Grant due to an under spending in 2009/10 as a result of the insolvency of contractors at Worcester, Paarl and Malmesbury.

- Programme 8: Health Facility Management - R85 280 000

  R42 774 000 has been rolled-over from 2009/10 in respect of the Hospital Revitalisation Schedule 5 Grant.

  R42 506 000 has been rolled-over from 2009/10 in respect of the Infrastructure Grant for Province (IGP) for Health due to delays in the planning process, largely as a result of lack of capacity in both the Department of Health and the Department of Public Works and Transport.

External developments that impacted on service delivery

The 16.7% increase in the population of the Western Cape from 4 524 335 in 2001 to 5 278 585 in 2007 reported in the Community Survey 2007, is reflected in a previously constant growth in patient numbers of approximately 3% per annum. However, over the past two years the growth in patient numbers slowed to approximately 1% on an annual basis.

An important issue is that the allocated budget only allows the Department to provide for 4% inflation in Year 2 of the MTEF, which is considered too low, in the light of the 16% per annum growth over the last two years. In Year 1 of the MTEF the Department is able to make provision for 7%, which will be challenging.

External activities and events relevant to budget decisions include:

- Some budget allocations are conditional and the Department can therefore not make any changes to the amounts as allocated, namely:
  - Hospital Revitalisation Programme (HRP —building projects).
  - Infrastructure Grant to Provinces (IGP -building projects).
  - HIV/AIDS
  - Modernisation of Tertiary Services.
- However, the Department had to add equitable share funding to address the service load for some of the grants that are conditional, namely:
  - Forensic Pathology Services.
  - National Tertiary Services Grant for the provision of tertiary services (Central Hospitals).
  - Health Professions Training and Development Grant (service costs of having students on the platform).
- Increases in salaries are decided nationally.

The budget allocated to the maintenance of buildings and equipment increased as a result of earmarked allocations.

EMS was allocated additional funding for support to the 2010 FIFA World Cup and these additional funds have been retained by Programme 3 over the MTEF to ensure improved response times.

Twelve outcomes of the Department of Performance Monitoring and Evaluation

The national government has agreed on twelve key outcomes as the key indicators for its Programme of Action for the period 2010 to 2014. The outcome that specifically relates to Health in order to achieve Government's vision of "A long and healthy life for all South Africans" is:
"Improve healthcare and life expectancy among all South Africans".

Output 1: Increasing life expectancy.
Output 2: Decreasing maternal and child mortality.
Output 3: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis.
Output 4: Strengthening health system effectiveness, with a focus on:
- Revitalisation of primary health care.
- Healthcare financing and management.
- Human resources for health.
- Quality of health and the accreditation of health establishments.

- Health infrastructure.
- Information, communication and technology and health information systems.

The Government of the Western Cape is committed to increasing the wellness of the people of the province. This will be achieved through the provision of a comprehensive health service by the Department of Health, and through a collective approach to address the upstream factors that impact on health for which all government departments and the whole of society is responsible. In terms of the Provincial Transversal Management System, a working group has been established to address each of the four key upstream factors identified, which are:

1) Promoting safety and reducing injuries.
2) Promoting healthy lifestyles.
3) Women and child health.
4) Infectious diseases, mainly HIV and TB.

The issues identified are addressed in more detail in the Programme Performance section.

2.1.6 Overview of organisational environment for 2010/11

The organisation and post structure is based on the Strategic Plan 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.

One of the Department's strategic objectives for 2010 - 2014 is to ensure the implementation and maintenance of 147 organisational and post structures that are aligned to the Comprehensive Service Plan. The implementation of organisational structures is dependent on the finalisation of the organisational work study reports and this makes the implementation timeframes (setting of targets) difficult to forecast. In total 94 organisational and post structures that are aligned with the CSP were completed by the end of the financial year against a target of 85 structures.

Following an organisational development investigation it was decided to strengthen the Chief Directorate: Professional Support Services by splitting the chief directorate into two new chief directorates with the following components:

Chief Directorate: Strategy and Health Support

The key focus of the chief directorate is to develop the medium to long term strategic planning framework and to ensure the annual plans are in keeping with the strategic direction of the Department. The chief directorate is also responsible for the monitoring and evaluation of progress in achieving annual targets, strategic goals, and a positive impact on the health status of the population. The chief directorate consists of the following directorates:

- Strategic Planning and Co-ordination;
- Information Management;
- Health Impact Assessment; and
- Professional Support Services.

Chief Directorate: Infrastructure Management

The key function of the chief directorate is to plan and co-ordinate infrastructure development and 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:

- Infrastructure Support;
- Hospital Revitalisation Programme; and
- Engineering and Technical Services.

Resignations and/or appointments in Senior Management Service

There were significant changes in the Senior Management Service (SMS) during 2010/11 as a result of attrition, relocation of key management personnel and the upgrading of the chief executive officer posts of certain hospitals to Level 13.

The following SMS members left the service of the Department during 2010/11:

- Mr AR Cunninghame, Chief Director: Professional Support Services, took the severance package.
- Mr PGH Koornhof, Director: Human Resource Management, took the severance package.
- Mr ER Hering, Director: Medical Physicist: Groote Schuur Hospital, retired.
- Mr GL Siwele, Director: Finance: Groote Schuur Hospital, resigned.
- Mr T Mabuda, Director: Nursing, resigned.
- Mr V Haas, Director: Internal Audit, was transferred to the Department of the Premier. (The function was transferred to the Department of the Premier).

The following SMS members joined the Department during 2010/11:

- Ms M van Leeuwen was appointed as Director: Infrastructure Management.
- Mr I de Vega was appointed as Director: Information Management.
- Dr L Angeletti-Du Toit was promoted and transferred from the Department of Transport and Public Works as Chief Director: Infrastructure Management.
- Ms PG Piedt was transferred from Provincial Treasury and is now the Director: Human Resource Management.
- Ms JO Arendse was promoted to Director: HIV and AIDS, and TB.
- Mr CW Barnado was promoted to CEO: Stikland Hospital.
- Mr HJ Human was promoted to CEO: Mowbray Maternity Hospital.
- Ms JA Hendry was promoted to CEO: Western Cape Rehabilitation Centre.
- Mr J Hough was promoted to Director: Medical Physicist: Groote Schuur Hospital.

The following SMS members were relocated to a new portfolio within the Department:

- Dr P von Zeuner was transferred from Information Management and is now the Director: Hospital Revitalisation Programme.
- Dr KN Vallabhjee was transferred from Regional Hospitals, APH and EMS and is now the Chief Director: Strategy and Health Support.

- Dr S Kariem was transferred from Groote Schuur Hospital and is now the Chief Director: General Specialist and Emergency Services.
- Dr T Carter was transferred from Tygerberg Hospital and is now the Chief Director: CEO: Groote Schuur Hospital.
- Dr DS Erasmus was transferred from Red Cross War Memorial Children's Hospital and is now the Chief Director: CEO: Tygerberg Hospital.
- Dr KLN Linda was transferred from Groote Schuur Hospital and is now the Chief Director: CEO: Red Cross War Memorial Children's Hospital.
- Ms NE Msindo-Mayeng transferred from the Central Karoo District and is now the Director: Advocacy and Social Mobilisation.

Strike actions

Wage strike

A wage strike was staggered over the period 29 July 2010 to 6 September 2010. Only 2% of staff in the Western Cape Department of Health participated in the strike.

Contingency plans were in place at all institutions. Strike committees were established to manage the strike. Through co-operation with organised labour and support from the relevant role-players within the strike management committees, there was minimal disruption of services.

Protest Action at Khayelitsha CHC

This was an unlawful strike / protest action at Khayelitsha CHC during the period from April 2010 to June 2010. There were work stoppages on the following days: 12 April 2010, 17 April 2010, 19 April 2010, 2 June 2010, and 23 June 2010. Staff members were unhappy with the conduct of one of the doctors and protested against his continued presence in the workplace. Approximately 30 - 40 staff members were involved but due to the repetition of their misconduct, ten staff members were dismissed.

Services were minimally disrupted during the times that staff left their points of duty.

System failures and cases of corruption

The Fraud Investigative Unit (FIU) revealed the following system failures and cases of corruption/ dishonesty during period 2010/11:

- Fraud involving accommodation fees at the Groote Schuur Hospital staff residence to the amount of R 59 344. The staff member was dismissed and monies will be recovered.
- Fraud / theft of hospital fees at Paarl Hospital to the amount of R 130 775. Failure of Delta-9 Fees system. The staff member was dismissed and monies are being recovered and criminal charges were laid.
- Procurement theft / stock losses at the Cape Medical Depot - loss not quantified. Failure of the Medical Stores Administration System (MEDSAS) and Windows Remote Demand Module (Win RDM) systems. Staff member dismissed.
- Procurement irregularity / stock losses in Directorate: Engineering and Technical Support Services. Failure of procurement system and stock control. Staff member resigned before disciplinary action was taken.

A significant risk that has been identified is that 3 202 employees of the Department are between the ages of 55 and 65 years and in view of the retirement provisions available within the public service, the possibility exists that a large percentage of these staff could exit 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.

2.1.7 Key policy developments and legislative changes

Negotiated Service Delivery Agreement (NSDA)

The following are the four key outputs and related interventions of the Negotiated Service Delivery Agreement between the President and the National Minister of Health in order to reach the national outcome of "A long and healthy life for all South Africans".

Increased life expectancy

- Rapidly scaling up access to anti-retroviral therapy (ART) for people living with HIV and AIDS especially identified vulnerable groups;
- Strengthen the national TB control programme;
- Protect South African children against vaccine preventable diseases;
- Increase the early detection of people with chronic conditions (hypertension and diabetes); and
- Implement upstream strategies to reduce intentional and non-intentional injuries.

Reduction in maternal and child mortality rates

- Enhancing the clinical skills of health workers in emergency obstetric care and comprehensive emergency obstetric care;
- Enforcing the use of clinical guidelines and protocols;
- Increasing the national immunisation coverage;
- Increasing the access to Highly Active Antiretroviral Therapy (HAART) for eligible pregnant women;
- Increasing access to safe Choice on Termination of Pregnancy (COTP) services for South African women; and
- Institutionalising the review of maternal and peri-natal deaths across the health sector.

Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis

- Implement health care provider initiated HIV counselling and testing (HCT) in all health facilities;
- Rapidly scale up condom distribution at all health facilities;
- Scale up access to anti-retroviral treatment;
- Enhance the clinical skills of health professionals in TB management; and
- Strengthen community involvement in the TB DOTS programme.

Strengthening health system effectiveness

- Strengthen the primary health care approach to service delivery;
- Produce a revised Human Resource Plan for Health by the end of 2010/11;
- Assess with partners the functionality, efficiency and appropriateness of the organisational structure of each hospital;
- Support public health facilities to produce and implement Quality Improvement Plans;
- Improve health care financing and strengthen financial management;
- Accelerate health infrastructure improvement; and
- Ensure that appropriate technologies are procured, maintained and supported.

National Department of Health Ten Point Plan

In addition to the NSDA addressed previously the National Department of Health's Ten Point Plan for the period 2010 to 2014, provides the overarching framework within which the Department plans. These priorities are:

- Provision of strategic leadership and creation of a social compact for better health outcomes;
- Implementation of National Health Insurance (NHI);
- Improve the quality of health services;
- Overhaul the health care system and improve its management;
- Improved human resources planning development and management;
- Revitalisation of infrastructure;
- Accelerated implementation of HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases;
- Mass mobilisation for better health for the population;
- Review of the drug policy; and
- Strengthening research and development.

Provincial Strategic Objectives

As indicated in Paragraph 2.1.5 the provincial strategic objective for health is to 'Increase wellness'. The key indicators of wellness are:

- Life expectancy;
- Patient experience of the health service;
- Maternal mortality;
- Child mortality;
- HIV incidence; and
- TB incidence.

Ill-health has two components both of which the provincial government seeks to address. The first concerns the "upstream causes" of ill-health. These drive what is known as "the burden of disease". The second concerns the quality of care provided by the public health service and the efficiency with which that care is rendered, in other words, the quality, efficiency and effectiveness of the state's response to managing the burden of disease.

In order to achieve increased wellness all of society needs to be mobilised towards this objective. This will require the resources, knowledge, creativity and concern of all role-players, including the three spheres of government, civil society, business, and individual citizens.

Development of a new vision and strategy towards 2020

The mandate of the Department of Health is the provision of a comprehensive package of health services, including the promotion of health, prevention of disease, curative care and rehabilitation, and training and education, delivered across all levels of care. In order to deliver on its mandate, the Department will develop a document outlining the vision for 2020 and an effective strategy to deliver on that vision by the end of the financial year 2011/12.

In preliminary work undertaken by the Department of Health, the following key principles of the strategy have been identified:

Patient centeredness

The quality of care, with a focus on patient experience, will lie at the heart of the new vision. This means that excellence in the clinical quality of care and the need for superior patient experience must inform every effort and endeavour of the public health sector in the Western Cape.

Strengthen the primary health care philosophy

The PHC philosophy means providing a comprehensive service, which includes preventive, promotive, curative and rehabilitative care. The primary care services are points of first contact for the patient. These services are supported and strengthened by all levels of care including acute and specialised referral hospitals and an efficient patient transport service. The philosophy is also premised on the understanding that wellness cannot be promoted in isolation from social, economic and political factors. As per the World Health Organisation, health and wellness is not seen as the mere absence of disease but a holistic state of physical, mental and emotional well-being. This therefore requires a strong inter-sectoral approach to improving health and wellness. A central component of the PHC philosophy is the community involvement in health. This implies not only taking ownership and responsibility for their own health care at a personal level, but as a community also being involved in the decision making of the provision of health services.

Strengthening the District Health Services (DHS) model

The DHS model gives the district health team the responsibility for achieving the health outcomes targeted for a specific geographical area. All health services (public and private) provided within the area, are co-ordinated by the district health management team. The district manager is accountable and also plays a stewardship role in securing and accessing the support of other levels of the service. The Department has begun to take early steps in this direction over the recent years. Health is delivered within well-defined sub-district and district boundaries in the province. Primary health care services and provincially aided district hospitals in the rural districts have been provincialised. This means that all public sector health services in the rural districts are provided by a single authority i.e. the province. District management structures and offices have been created. This consolidation will result in better co-ordination and improved efficiencies. The district model will be further strengthened to ensure the health outcomes necessary towards 2020.

A move towards an outcomes based approach

The Department will gear itself to focus on improving the health outcomes of patients and the broader population. This will include improving life expectancy and reducing maternal and child mortality. Targets will be guided by the Millennium Development Goals. A strong culture and system of monitoring and evaluation will be embedded at all levels of the organisation to ensure that the Department delivers on these targets.

Address equity

This important principle of social justice will continue to guide future planning and service delivery to ensure that each individual receives health care according to their need. This principle impacts issues such as equity of access, allocation of resources and health outcomes.

Address affordability of health services

Whilst the Department will continue to campaign vigorously for appropriate funding for health services it will operate within its allocated budget. The latter requires careful priority setting and improved organisational efficiencies to get the best value for money 'to stretch the health rand'.

Building Strategic Partnerships

Neither the Western Cape Department of Health nor the government as a whole can achieve increased wellness working alone. It is therefore essential that the provincial government seeks and builds creative partnerships with actors in the private sector, in civil society, in other spheres of government and internationally. This approach is also consistent with the government's vision of an open opportunity society for all in the Western Cape.

Delivering on a new vision and strategy requires analysis, strategic planning and, crucially, a change management process across the Department. If successful, delivery against a new vision would radically improve the provision of health services in the Western Cape by 2020, making the provincial health service and the health outcomes among the best in the world.

2.1.8 Departmental revenue

The table below provides a breakdown of the sources of revenue and the performance for 2010/11.

Table 2.1.1: Sources of Revenue (R'000)

	2007/08 Actual	2008/09 Actual	2009/10 Actual	2010/11 Target	2010/11 Actual	% deviation from target
Non-tax revenue	**486 288**	**429 196**	**390 534**	**417 361**	**428 871**	**2.76%**
Sale of goods and services	348 056	289 680	295 273	307 487	313 466	1.94%
Transfers received	137 607	138 174	93 878	108 593	112 976	4.04%
Fines, penalties	-	1	2	-	-	-
Interest, dividends	625	1 341	1 381	1 281	2 429	89.62%
Sales of capital assets	**10**	**11**	**7**	**9**	**3**	**(66.67%)**
Sales of capital assets	10	11	7	9	3	(66.67%)
Financial transactions (Recovery of loans and advances)	**11 548**	**7 937**	**23 269**	**6 220**	**16 558**	**166.21%**
TOTAL DEPARTMENTAL RECEIPTS	**497 846**	**437 144**	**413 810**	**423 590**	**445 432**	**5.16%**

The Department ended the 2010/11 year with a revenue surplus of R 21 842 million (5.16%). The surplus is the net effect of the over and under recoveries for the year:

- Sales of Goods and Services:

  The surplus (1.94%) is primarily due to the increase in requests for medical reports and the claims paid by the Department of Justice in respect of patient fees.
- Transfers:

  The surplus (4.04%) is due to an increased contribution from the respective universities to the academic hospitals in respect of joint-staff establishments and utilisation of hospital resources.
- Interest:

  The surplus (89.62%) resulted through the levying of interest in respect of patient fee accounts. The surplus is also attributed to improved performance in terms of interest collected on staff debt.
- Sales of capital assets:

  The deficit (-66.67%) can be attributed to fewer condemned / obsolete furniture and equipment sold than anticipated.
- Financial Transactions:

  The surplus (166.21%) resulted through the recovery of previous years' expenditure and improved performance in terms of staff debt recovery.

2.1.9 Departmental expenditure

Please refer to the appropriation statement and point 1, paragraph "Spending trends" in the Report of the Accounting Officer for the year ended 31 March 2011.

2.1.10 Transfer payments

During 2010/11 transfer payments were made to departmental agencies and accounts such as State Education and Training Authority (SETA) and the Cape Medical Depot (CMD), the Western Cape College of Nursing, and local governments and non-profit organisations that render a service on behalf of the Department of Health.

State Education and Training Authority (SETA)

An administration levy payment is made to SETA on an annual basis.

Cape Medical Depot (CMD)

The transfer payment made to the CMD was used to augment the trading account capital. The aim of the trading account is to manage the supply of pharmaceuticals and medical sundries to hospitals, community health centres and local authorities.

Local governments

The City of Cape Town received transfer payments during 2010/11 for the rendering of personal primary health care (PPHC) services in the Cape Metropole. This is the only municipality that still receives funding from the Department to render PPHC services. The Department of Health assumed responsibility for PPHC services in the rural areas in the province from 1 April 2005. Prior to this date the rural municipalities were also funded for rendering PPHC services by means of transfer payments.

In terms of the Global Fund grant programme, transfer payments were made to municipalities for the anti-retroviral (ARV) treatment capital works project and the community based response (CBR) programme. In 2010/11 the ARV treatment capital works project identified only one clinic operated by the Cape Town City Health Department in order to increase the physical capacity for the provision of ARV treatment services at the site, namely Luvuyo Clinic. Since the rolling continuation channel funding agreement between the Western Cape Department of Health and the Global Fund was concluded in September 2010, this delayed the initiation of further projects.

The Department entered into service level agreements with two municipalities during 2010/11 to implement the CBR programme, namely Cape Town and Central Karoo. The other district offices (Cape Winelands, Eden, West Coast and Overberg) manage the CBR programme themselves and fund non-profit organisations directly. The programme provides small grants to community based organisations to implement projects to address the effect of the HIV and AIDS epidemic on local communities. The focus areas of these projects are promotion of food security, community care for vulnerable children, community based emergency accommodation or short-term placement of children, the frail and terminally ill, job creation and income generation, and life skills and youth work targeting out-of-school youth.

Non-profit organisations (NPOs)

St Joseph's Home, Sara Fox, Booth Memorial and Lifecare

Transfer payments are made to specific institutions such as St Joseph's Home, Sarah Fox Hospital, Booth Memorial Hospital and Lifecare Centre.

Chronic inpatient care is provided to de-hospitalised patients with long term care needs e.g. head injuries or patients requiring longer periods of rehabilitation. For adults, this centralised care is provided by an organisation called Lifecare that is funded for 250 beds with an average length of stay (ALOS) of six months. For children, this service is offered by St Joseph's Home that is funded for 87 paediatric beds.

Sub-acute facilities provide care for de-hospitalised patients who are assessed as not well enough to be discharged home from an acute hospital bed and need continued close medical attention. The average length of stay for adults is a maximum of six weeks and for children, three months. Two funded NPOs manage 144 sub-acute beds: Booth Memorial Hospital (84 adult beds) and Sarah Fox Hospital (60 paediatric beds). The Department did a point prevalence survey that showed between 15 - 20% of patients currently in acute beds need sub-acute care before being referred to home based care.

In addition to the above-mentioned facilities, palliative care services provide care to respite and terminally ill patients (mainly AIDS and cancer) for an average length of stay of fourteen days. In 2010/11 there were 304 funded palliative care beds and the bed utilisation rate for the year was 80%. In the rural districts sub-acute and palliative care services are combined. The funding of these facilities is from the conditional grant and Global Fund.

HIV and AIDS

The HIV and AIDS Conditional Grant contracts NPOs to render front-line services in health care facilities and in the community. The funding to NPOs was utilised to render the following services:

- In high transmission areas (HTA), i.e. truckers at truck stops; men; refugees; commercial sex workers; lesbian, gay, bisexual, transgender and intersex (LGBTI) groups; deaf community and prisons. Seventy six intervention sites were reached by the end of the fourth quarter against a target of forty six intervention sites. In these intervention sites 2 857 trained peer educators are currently functioning.
- During the year eighteen step-down care facilities were funded to render care to clients who are either terminally ill, require palliative care or need support during the initiation of ART.
- To provide HCT services through 549 HIV counsellors in 100% of facilities. These counsellors play a critical role in achieving the HCT campaign targets, preparing clients for ART and keeping clients in care by providing adequate adherence support.

Global Fund

Global Fund Grant transfer payments to non-profit institutions were used to:

- Provide adherence counselling services at the Gugulethu ARV treatment site during the first quarter and then to eleven ART sites within Khayelitsha sub-district during the third and fourth quarters.
- Provide peer education services to modify risk-taking behaviour and to reduce HIV transmission amongst the youth in selected secondary schools in high HIV prevalence areas in the province (nine NPOs were contracted). The programme was successfully implemented in 99 secondary schools across the province and reached 63 390 learners with HIV prevention messages.
- Provide inpatient palliative care and respite services (six NPOs were funded).
- Fund two municipalities (City of Cape Town and Central Karoo) and 92 community based projects in the Cape Winelands, Overberg, Eden and West Coast Districts in respect of the community based response programme managed by these district offices.

- Fund the Networking AIDS Community of South Africa (NACOSA) for the support of their training, mentoring, networking and support of community based organisations across the province.

Home based care

Integrated home-based care delivers care to clients with a functional impairment and who need personal clinical care in their homes and/or community adherence counselling (individually or in groups) for chronic diseases including HIV and TB and/or prevention and promotion. Community based services are provided by 145 NPOs contracted by the Department and 100 of these deliver an integrated home based care service. The delivery of services is regulated by service level agreements to ensure quality of care and financial accountability.

The number of NPO appointed community care workers increased from 2 491 in 2009/10 to 2 584 in 2010/11 and provided home based care (HBC) to 43 191 clients (31 813 clients in 2009/10). Each care worker should do 5 - 10 visits per day depending on the category of the client and are supervised by NPO appointed professional nurses. The majority of the clients referred to HBC are in the above 60 year age group (36.2%).

The care workers are also involved in prevention and promotion campaigns and specifically the measles campaign held in the first quarter of 2010/11 where just over one million home visits were done. The momentum was sustained throughout the following three quarters and the total number of client visits for the year for HBC, adherence support and door-to-door campaigns amounted to 4 630 654, well above the target of three million client visits.

Care workers have also been trained in the Community Integrated Management of Childhood Illnesses (CIMCI) programme and 10% of total client visits were for children (465 846). Most of the children were seen during a home based care visit or during door-to-door visits.

Mental health

Community mental health services provide a continuum of care for mental health patients in the community. Sub-acute psychiatric care group homes and psycho-social rehabilitation groups are provided for psychiatric patients. This includes residential and special day care centres for intellectually disabled clients. These patients are de-hospitalised from psychiatric hospitals and a total of 1 592 patients are cared for through the various community mental health care services.

Health committees

Funding has been set aside for health committees and health forums to enhance community participation. The Health Act advocates for community participation structures that should assist health facilities in ensuring a good quality health service and to address problems and challenges that are identified. These structures serve as the link between communities and clinics. Currently, only the Metro District has a health forum. The other districts are incrementally setting up health committees in the sub-districts.

Nutrition

The Department also funds seven NPOs for nutrition rehabilitation and breast feeding peer counselling projects. More than 480 children benefited from the nutrition rehabilitation programme. Children are placed on the programme for a minimum of six months and results indicate that on average 80% of the children entered, show positive growth.

Peer counsellors are placed to support mothers antenatally, during labour and post-natally with infant and young child nutrition at maternity and basic antenatal care sites.

SA Red Cross Air Mercy Service

The SA Red Cross Air Mercy Service (AMS) is a non-profit organisation with bases in Oudtshoorn and Cape Town that provides an air ambulance network, outreach and emergency rescue service. AMS has a longstanding relationship with the Department of Health of more than forty years.

The year 2010 saw the introduction of an exciting night service for the months of June and July as part of the conditions of hosting the FIFA World Cup Soccer Tournament. The Cape Town rotor wing programme executed 717 missions with a combined flight time of 838 hours and transported 569 patients. The Oudtshoorn programme executed 404 missions with a combined flight time of 492 hours during their transfer of 275 patients. In addition, the presentation of these two programmes enables the Department of Health to offer an essential rescue platform the like of which sets the benchmark for all rotor-wing programmes in South Africa.

The fixed wing service is the stalwart in delivery of access to specialist health care services to remote rural communities in the Western Cape. During 2010/11 the programme covered in excess of 200 000 km during 756 hours flown. In doing so this programme transported an unprecedented 527 patients. This represents an increase of 15.5% over that achieved during 2009/10.

Maitland Cottage Home

Maitland Cottage Home is a provincially aided hospital that receives funding to provide highly specialised paediatric orthopaedic surgery and serves as an extension of Red Cross War Memorial Children's Hospital.

Expanded Public Works Programme (EPWP)

The EPWP is a nation-wide programme with the objective of drawing significant numbers of the unemployed into productive work, so that workers gain skills while they work, and increase their capacity to earn an income. Initially work opportunities were provided in the Home Community Based Care programme (including HIV and AIDS and TB care) and information management (the data capturer internship programme). However, the programme was expanded in 2010/11 to include the Assistant to Artisan (ATA) programme to improve maintenance of health facilities, the Pharmacist's Assistant programme, and the Human resources / Finance Internship programme. The EPWP funding is utilised to pay training providers and provide a monthly stipend to learners on the programmes.

District hospitals

Transfer payments were made to Radie Kotze Hospital for the period 1 April 2010 to 30 June 2010 and amounted to R 1 620 000. On 1 July 2010 the Radie Kotze Hospital was provincialised and is now a PGWC institution. Radie Kotze Hospital renders a district hospital service to the population in the Piketberg area in the West Coast.

Table 2.1.2 Summary of non-profit organisations funded per district

Programmes	Eastern / Khayelitsha	Klipfontein / Mitchells Plain	Northern / Tygerberg	Southern / Western	Metro District Health	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Western Cape
Tuberculosis	2	0	0	0	0	4	0	1	3	1	11
Chronic care	0	1	1	2	0	0	0	0	0	0	4
Health committees	2	3	13	3	1	0	0	2	0	8	32
Home based care	8	7	6	3	0	0	5	0	0	0	29
Mental health	5	9	7	9	0	8	0	0	7	0	45
AIDS: ART treatment	0	0	0	0	0	0	0	0	0	0	0
AIDS: Home based care	0	0	0	0	0	11	0	12	8	17	48
AIDS: HIV counselling & testing	3	4	6	4	0	5	2	9	3	2	38
AIDS: High transmission areas	1	0	6	0	0	7	0	0	0	0	14
AIDS: Regional Training Centre	0	0	0	0	0	0	0	0	0	0	0
AIDS: Step down care	2	3	3	2	0	3	1	0	1	1	16
Nutrition	1	1	1	1	0	0	1	2	0	0	7
GF: ART treatment	0	2	0	0	0	0	0	0	0	0	2
GF: community based response	2	0	0	0	0	20	1	22	14	12	71
GF: peer education	0	0	0	0	0	2	0	2	0	0	4
GF: palliative care	0	0	0	0	0	2	0	2	1	1	6
Total	**26**	**30**	**43**	**24**	**1**	**62**	**10**	**52**	**37**	**42**	**327**

Transfer payments in 2010/11

Refer to Annexure 1B, 1C, 1D, 1G, 1H and 1I in the annual financial statements.

Monitoring systems for transfer payments

In order to meet the requirements of Section 38(1) (j) of the PFMA, namely to obtain a written assurance from the recipient, that such recipient implements efficient, effective and transparent financial management and internal controls systems, the Department via a service provider, developed a standard operating procedure (SOP) for the management of transfer payments. The SOP was issued as departmental policy in 2009/10 (Circular G54/2009) which sets out the NPO funding procedure and the monitoring requirements for all transfers made to NPOs.

This circular was used to evaluate all requests for funding for the 2010/11 financial year. As a result of the new policy and processes to be followed, a number of NPOs were no longer considered for funding since they did not meet the policy requirements of the Department. The funding for eleven NPOs were discontinued – eight in the Metro, two in Eden District and one in West Coast District.

In 2011 the districts visited all recipients of transfers to establish if the recipients meet the requirements as set out in the Department's policy for making / receiving transfers and to check whether sound financial control is exercised by recipients. The district reports show a marked improvement in terms of NPOs meeting the requirements of the PMFA.

2.1.11 Conditional grants and earmarked funds

Comprehensive HIV and AIDS Grant

The HIV and AIDS Conditional Grant was implemented in 2001/02 and initially focused on voluntary counselling and testing with PMTCT included from 2002/03 onwards. Since 2004/05 a more comprehensive approach has been followed with the focus on anti-retroviral treatment (ART) interventions for HIV positive patients and enhanced response interventions such as:

- Home based care (HBC)
- High transmission areas (HTA)
- Post exposure prophylaxis (PEP) for victims of sexual assault
- Prevention of mother-to-child transmission of HIV (PMTCT)
- Programme management and strengthening (PM)
- Regional training centre (RTC)
- Step-down care (SDC)
- HIV counselling and testing (HCT)

In April 2010 the national HCT campaign commenced with a target of 1.1 million for this province for the period April 2010 to June 2011. The scale up of screening for TB symptoms, condom distribution, screening for certain chronic diseases (diabetes and hypertension) and access to care and treatment, was linked to this campaign.

Originally the budget for 2010/11 was R 554 054 000. An additional allocation of R 1 million was made to the Western Cape Department of Health in the adjustment budget in November 2010 for medical male circumcision, another priority HIV prevention intervention, which increased the total adjustment budget amount to R 555 054 000. The actual expenditure was R 554 684 961 (99.93%).

Monthly in-year monitoring (IYM) reports are used to confirm that all transfers were deposited into the accredited bank account. The outcomes and outputs set for 2010/11 are defined in the Comprehensive HIV and AIDS Integrated Business Plan 2010/11. These are summarised as follows:

- Although staff were employed against the business plan to manage the programme, there were challenges in filling the posts.
- All programmes were implemented and co-ordinated as per the business plan.
- The implementation of the programme was monitored and reports submitted as required.
- Fifty one new sites were assessed for treatment readiness to provide anti-retroviral treatment and services were implemented at these sites.
- Consumables, supplies and services were provided and available at all times.

Table 2.1.3: Performance measures for HIV and AIDS Conditional Grant

Intervention	Performance measure / indicator	Target 2010/11	Actual 2010/11
ART	Number of sub-districts having at least one accredited ART service point	28	29
	Number of new ART service points	33	51
	Number of registered ART patients	94 804	96 118
HTA	Number of HTA intervention sites	39 - 49	76
PMTCT	Percentage of fixed PHC Facilities offering PMTCT	100%	100%
	PMTCT number of antenatal clients tested for HIV	94 000	97 955
	Nevirapine dose to baby rate	95%	100%
	Transmission rate	3%	3.2%
RTC	RTC number of monthly expenditure reports submitted in time	12	12
	Number of quarterly output reports submitted in time	4	4
HCT	Percentage of fixed PHC facilities offering HCT	100%	100%
	Number of HIV Counsellors receiving stipend	549	646
	Percentage of the population over the age of 15 years tested for HIV	15%	21.5%

At the beginning of 2010/11, a target of thirty three new ART sites was set in addition to the existing eighty one service points of which sixty six were accredited. The National Department of Health replaced the indicator that addressed the accreditation of new sites and replaced it with a norm of district readiness.

By the end of 2010/11 there were 132 fully functional ART service points in the Western Cape Province of which 51 were new ART sites. The target for new ART sites was thus exceeded by 65%. There were 96 118 clients on ARV treatment at the end of March 2011 which is approximately 1.4% more than the target of 94 804.

The Western Cape Department of Health spearheaded and proved the value of an electronic client monitoring system within the ART programme to ensure accurate and reliable data collection and reporting. In addition, the electronic system reduced time spent on manual entries into paper based registers and was subsequently endorsed by the National Department of Health for roll out across the country in March 2011.

To address human resource challenges, the Department has begun implementing a "nurse-led, doctor supported" treatment model which has achieved extensive on-site nurse training in HIV and ARV management and will direct patients towards more appropriate providers of services. The two clinical specialist task teams that were constituted to address adults and paediatrics on clinical issues and protocols are fully functional.

The Western Cape Department of Health has successfully implemented the programmes under the Conditional Grant and met all except one indicator. Introducing an additional HIV service, in the form of the HCT campaign within the already constrained health services had been a challenge, particularly with regard to human resources and physical infrastructure. The Department has made progress in the renovation of facilities and the provision of small/minor works, to accommodate the programmes and ensure a more spacious and comfortable work environment.

The additional resources provided by the grant for medical male circumcision have been fruitfully utilised to procure equipment to perform medical circumcisions particularly at primary care level.

In terms of financial compliance, the Western Cape had an under-expenditure of R 369 039 of the adjusted budget.

National Tertiary Services Grant (NTSG)

The strategic goal of the NTSG is to enable provinces to plan, modernise, rationalise and transform the tertiary hospital service delivery platform in line with national policy objectives including improving access and equity. The purpose of the grant is to compensate tertiary facilities for the additional costs associated with spill over effects.

The NTSG is only allocated to the three central hospitals as follows:

Institution	**NTSG allocation for 2010/11 (R'000)**
- Groote Schuur hospital	838 908
- Tygerberg hospital	646 512
- Red Cross Hospital	277 814
Total	**1 763 234**

The NTSG remained insufficient to fund the tertiary activities as defined in the grant service level agreement. The funding deficit was bridged using other sources of funding pending a more appropriate allocation. The grant funding has also not been adjusted to compensate for the implementation of occupational specific dispensations or the actual impact of medical inflation. This reduces the purchasing power and subsequently the quantum of tertiary services that can be delivered. Several motivations highlighting the funding challenges have been submitted to the National Department of Health.

The Western Cape also delivers tertiary services beyond those funded by the NTSG, both in central hospitals as well as certain regional hospitals such as George Hospital. Motivations provided to the National Department of Health to have these services and George Hospital acknowledged and funded as tertiary services, have not been formally responded to.

In addition to the funding challenges, the national plan for the provision of tertiary services still needs to be finalised.

The NTSG expenditure per economic classification for 2010/11 was as follows:

Economic classification	**Provincial NTSG expenditure for 2010/11 (R '000)**
- Compensation of employees	1 057 940
- Goods and services	687 661
- Payment of capital assets (machinery and equipment)	17 633
Total	**1 763 234**[1]

1 The actual expenditure on the grant related activities exceeded the amount reflected. The Department is not allowed to reflect an over expenditure and the funding gap is bridged using other sources of funding.

The NTSG funding was fully spent and all transfers were deposited into the accredited bank account of the Provincial Treasury.

Table 2.1.3 below lists the outputs for all the accredited tertiary services. As a result of the funding gap not all these outputs are funded by the NTSG.

Table 2.1.4: Performance measures for the National Tertiary Services Conditional Grant

Performance measure / indicator	Actual 2009/10	Actual 2010/11
Day patient separations - Total	12 213	12 697
Inpatient days - Total	578 583	582 793
Outpatient first attendances	200 930	207 226
Outpatients all attendances	747 359	750 297

Compared to the 2009/10 performance outputs (actual performance) on day patient separations, inpatient days, outpatient first and all attendances, all service volumes were higher.

The Western Cape fully complied with the DORA requirements and submitted all the required clinical and financial quarterly reports to Treasury and the National Department of Health as per schedule. No funds were withheld as the Western Cape remained fully compliant with DORA requirements.

Health Professions Training and Development Grant (HPTDG)

The HPTDG contributes to the provision of quality training and development in health facilities in South Africa. The grant purpose is to fund the service costs related to training and having health science students on the service platform towards the national aim of expanding the number of health professionals. This platform accommodates students from four institutes of higher education (University of Stellenbosch, University of Cape Town, University of Western Cape and Cape Peninsula University of Technology).

The HPTDG to the Western Cape increased from R 362.93 million for the 2009/10 year to R 384.7 million (6%) in the 2010/11 year. Of the total HPTDG funding, 52% was allocated to Programme 5 and is in keeping with the findings of the student rotation survey, underpinned by the principle that funding follows students. In the Western Cape the funding is allocated only to facilities where students are trained. The funding assists to perform training activities as follows:

- Salary costs of senior staff who are provincial employees and who supervise and train health professional students.
- Funding the additional medical consumables required for student training.
- Maintaining the service platform in terms of other staff categories such as nurses, administrative and other support services.
- Funding the additional clinical and support staff required to maintain the same required service outputs when accommodating students on the service platform.

The grant amount was fully spent and all transfers were deposited into the accredited bank account of the Provincial Treasury.

The HPTDG funding allocation and expenditure in the Western Cape Department of Health for the years 2006/07 until 2010/11 were as follows:

	2006/07 R '000	2007/08 R '000	2008/09 R '000	2009/10 R '000	2010/11 R '000
Approved budget amount	323 278	339 442	356 414	362 935	384 711
Expenditure incurred	323 278	339 442	356 414	362 935	384 711

The full grant amount was spent in 2010/11. The Department is not allowed to show an over-expenditure and, as reflected in the 2010/11 HPTDG business plan, the grant funding gap of R 461.8 million was supplemented with other sources of funding to perform grant related activities. A recent report from the Technical Committee for Finance[2] demonstrated that the Western Cape carries the largest HPTDG under-funding burden. These findings are echoed by previous costing studies.

A key cost driver remains the human resource costs incurred when senior staff supervises junior staff. The grant has not been adjusted to absorb the implementation of the occupational specific dispensation (OSD) which further escalates funding pressures. The funding deficit is compounded by the fact that the year on year adjustments in grant funding has not kept pace with medical inflation.

Some information is provided below to reflect the cumulative funding shortfall of R 66.4 million over five years as a result of the grant funding not matching inflation. The commitment to recurrent expenditure for staff responsible for training and teaching places immense pressure on the funding and the deficit is currently funded via other sources.

The funding trends for the HPTDG and inflationary deficit are:

	2006/07 R '000	2007/08 R '000	2008/09 R '000	2009/10 R '000	2010/11 R '000
HPTDG actual allocated amounts	323 000	339 000	356 414	362 935	384 711
Actual growth in grant funding	0.0%	5.0%	5.1%	1.8%	6.0%
Inflation[3]	4.6%	7.2%	11.5%	7.1%	4.3%
HPTDG amount required to match inflation	337 858	362 184	403 835	432 507	451 105
Inflationary deficit	(14 858)	(23 184)	(47 421)	(69 572)	(66 394)

A policy gap exists as the grant's key strategic purposes and outputs require alignment with a quantified national workforce plan, which is not available. The Western Cape trains 30% of all medical officers and 45% of all dentists in the country but receives only 20% of the funding. A national platform must be established where these and other strategic HPTDG matters can be discussed by means of regular meetings. Submissions have been made to the National Department of Health.

As part of the grant reform process the Western Cape supports the consolidation of the HPTDG and NTSG in central hospitals into a single funding stream. This will improve integration of the two interdependent grant activities and reduce the duplication of administrative functions.

2 2010, November, Technical Committee for Finance, Financing clinical health science education and training, p2.
3 Rebased CPI from StatsSA.

Table 2.1.4 demonstrates the various categories of students from the various higher education institutions (HEI's) that were accommodated on the service platform for teaching and training activities, supported by the HPTDG. Setting of targets and reporting on the number of students remain a challenge as the grant funding period spans a financial year, whereas the student enrolments primarily follow a calendar year.

Table 2.1.5: Performance measures for the Health Professionals Training and Development Grant

Performance measure / indicator	Target 2010/11	Actual 2010/11
Number of undergraduate students	6 795	7 210[4]
Number of post graduate students	879	1 690[5]

The Western Cape fully complied with the DORA requirements and submitted all the required reports to Treasury and the NDoH as stipulated in the DORA.

Forensic Pathology Services (FPS) Grant

Cabinet resolved in April 1998 that the medico-legal service would transfer from the South African Police Services (SAPS) to the nine provincial health departments. National Treasury allocated funds to the National Department of Health in the 2002/03 and 2003/04 financial years in order to prepare for the transfer of the function. Only very small amounts of these grants were utilised owing to a variety of reasons that resulted in failure to transfer the services. The funds were then made available to the provincial health departments through "conditional grants" to address the maintenance backlog of the infrastructure used by SAPS prior to transfer. A detailed, recurrent and capital, service delivery model (based on the pilot in KwaZulu Natal) was developed for each provincial service and costed for a three-year MTEF period (2004/05, 2005/06 and 2006/07) with the fixed capital being projected for each facility over a five year period to 2009/10.

Since FPS was developed as a "new service" in Health, the initial approach was to fund the service through provincial conditional grants for a five year period after which the funding mechanism would be re-assessed. The grant comprises recurrent and capital components. It was decided that the conditional grant allocation would be phased out at the end of the 2011/12 financial year, despite a provincial request that the conditional grant allocation should be maintained.

The service transferred to the Department of Health on 1 April 2006 and since then provinces have embarked on the implementation of the service. A national vision was developed for FPS namely to render a standardised, objective, impartial and scientifically accurate service (following nationally uniform protocols and procedures) for the medico-legal investigation of death that serves the judicial process.

The following outcomes and outputs that were contained in the business plan for 2010/11 were evaluated (the indicators that overlap with the performance measure in the 2010/11 APP are not repeated here. For information on the Department's performance against these indicators, please refer to Sub-programme 7.3 in the section on Programme Performance):

4 The reported figure additionally reflects nursing students enrolled for undergraduate diplomas. A new academic year started on 1 January 2011 and a new enrolment and intake of students took place in quarter 4. The target was based on the 2010 academic year enrolment.

5 A new enrolment and intake of students started on 1 January 2011. The target was based on the 2010 academic year enrolment. An additional intake of students took place in July 2010 at UCT as posts became available. The reported figures also reflect all students enrolled in the postgraduate nursing diploma (UCT), post graduate dentistry, nursing and physiotherapy (UWC) and students enrolled for B Tech in occupational health (CPUT).

Table 2.1.6: Performance measures for the Forensic Pathology Services Conditional Grant

Outcome	Performance measure / indicator	Target 2010/11	Actual 2010/11	Comment / Corrective action
Vehicles active on the road.	Number of response vehicles	44	44	Target achieved.
Develop and implement audit tool to measure and improve on the quality of post mortem reports.	Audit tool developed and piloted	Audit tool	Audit tool piloted and evaluated	Target achieved.
Implement human resource plan.	Number of approved posts filled	254	242 / 254 posts filled	The approved post list was revised from 267 to 254 posts in line with affordability. Scarce skills also make it difficult to fill vacant posts. Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
Commission three FPS facilities (Worcester, Paarl, Malmesbury).	Worcester, Paarl, Malmesbury facilities commissioned	Worcester, Paarl, Malmesbury facilities commissioned	Worcester, Paarl, Malmesbury facilities commissioned during 2010	Target achieved.
Conduct annual staff satisfaction survey and implement action plan.	Annual staff satisfaction survey conducted	Survey conducted	Survey was conducted and draft report is available	Target achieved.
Implement the forensic pathology service.	% of budget allocation spent	100%	100.14% of conditional grant allocation spent	Allocation: R73.653 Spent: R73.753
Roll out the electronic content management system to all 20 FPS facilities.	ECM implemented in all 20 facilities	20	ECM was fully implemented at 18 / 20 facilities	Partial implementation at the remaining two facilities due to the inability to provide access to the PGWC network for the Departments of Forensic Medicine at the University of Stellenbosch (US) and the University of Cape Town (UCT). Access via the Internet was arranged by the service provider. However, full utilisation is not yet possible.

Infrastructure Grant to Provinces (IGP)

The Infrastructure Grant to Provinces is utilised in line with Healthcare 2010 and the Comprehensive Service Plan. The Western Cape Department of Health has an estimated infrastructure backlog of R 10 billion. Whilst the Hospital Revitalisation Programme is intended to address the hospital backlog through a small number of very large projects, the IGP is being utilised for a large number of smaller projects. These smaller projects are prioritised in terms of focus areas, where deficient or non-existent infrastructure is hampering the delivery of quality health care.

The budget allocation for 2010/11 (including roll-over funding) was R 203.5 million of which R 195.9 million (96.3%) was spent.

Provincial Treasury confirmed that all transfers were deposited into the accredited bank account of the Provincial Treasury.

The objectives for 2010/11 were largely met. In terms of the budget allocation versus expenditure for the year: A difference of R 7.6 million was recorded for 2010/11 which translates to 3.7% of the budget not being spent. The main contributing factors to this under expenditure were: delays in tender processes and delays in site handover or slow construction work. There was minor under expenditure on various other projects but the table below reflects the projects where major under expenditure occurred.

Table 2.1.7: Infrastructure Grant to Provinces – Projects with major under expenditure

Project name	Adjustment budget 2010/11 (R)	Expenditure 2010/11 (R)	Reason for under expenditure
Beaufort West Hospital: New Forensic Mortuary	3 440 000	1 200 000	Late acceptance before builders' holiday period resulted in a delay in the handing over of the site.
Grassy Park: New clinic	12 533 000	9 507 000	Delay on site in terms of design considerations.
Groote Schuur Hospital: Upgrade pharmacy	5 100 000	1 746 000	Delay with decanting.
Lambert's Bay Ambulance station	1 590 000	803 000	Delay with handing over the site.

Various measures are being taken to improve performance in the coming years. These include:

- Increasing the capacity of the Department's Chief Directorate: Infrastructure Management in terms of both its infrastructure planning and its client programme management role.
- Improving the quality of the briefing documents being provided to the Western Cape Department of Transport and Public Works (DTPW) as implementing agent.
- Implementing the cabinet-approved Western Cape Infrastructure Delivery Management System (WC IDMS).
- Streamlining procurement processes within the Department of Transport and Public Works.
- Working closely with Property Management in the Department of Transport and Public Works to ensure more efficient site acquisition.
- Implementing alternative construction procurement strategies to that of "design-by-employer" (e.g. targeted procurement through the NEC3 Engineering and Construction Contract).

- Improving the management of professional service providers and contractors by the Department of Transport and Public Works.
- Re-structuring the manner in which the Department of Health manages, implements, monitors and reports on its immovable asset maintenance programme.
- Standardisation based on approved space planning norms and standards, cost norms, standard drawings and technical specifications, and standard designs.

Hospital Revitalisation Programme (HRP) Grant

The Hospital Revitalisation Grant is allocated to projects that facilitate the implementation of Healthcare 2010 and the Comprehensive Service Plan.

For the period under review projects under construction were: Vredenburg Hospital, Worcester Hospital, George Hospital, Paarl Hospital, Khayelitsha Hospital and Mitchell's Plain Hospital. Valkenberg Hospital remained the only project in planning for this period.

The budget allocation for 2010/11 (including roll-over funding of R 42.8 million) was R 623.3 million. R 614.1 million (98.5%) of this allocation was spent.

Provincial Treasury confirmed that all transfers were deposited into the accredited bank account of the Provincial Treasury.

The objectives for 2010/11 were largely achieved. In terms of the budget allocation versus the expenditure incurred, a difference of R 9.3 million was recorded for 2010/11 which translates to 1.5% of the budget not being spent. The main contributing factors for this under-expenditure are:

- The delay in approval by National HRP of the 2010/11 project implementation plan for Tygerberg Hospital.
- Slow progress on planning of Vredenburg Hospital Phase 2B.
- Slow spending on George Hospital Phase 3 due to additional scope added for the emergency centre.

Table 2.1.8: Performance measures for the Hospital Revitalisation Programme Conditional Grant

Project name	No of beds	Level of care	Budget 2010/11 (R)	Actual 2010/11 (R)	Comment / Corrective action
George Hospital	265	Level 2	44 825	38 940	Spending slower due to additional scope added for emergency centre to address shortcomings highlighted by National HRP. Good progress is now being made on the project.
Khayelitsha Hospital	230	Level 1	256 036	250 428	Although very good progress is being made on this project, expenditure has been slightly slower than expected.
Mitchell's Plain Hospital	230	Level 1	112 113	114 522	Good progress is being made, with the contractor starting to accelerate the project programme.
Paarl Hospital	327	Level 2	127 213	138 411	Project progressed better than expected.

Project name	No of beds	Level of care	Budget 2010/11 (R)	Actual 2010/11 (R)	Comment / Corrective action
Tygerberg Hospital	1194	Level 2 and 3	2 000	0	Delays in receiving funding approval from National HRP. 2011/12 funding approval granted.
Valkenberg Hospital	400	Mental health	6 400	6 841	Planning proceeded slower than anticipated due to the complicated nature of the project. Special request has been made to Implementing Agent (Department of Transport and Public Works) to assist in improving progress on this project.
Vredenburg Hospital	80	Level 1	23 823	19 092	Planning of Phase 2B took longer than anticipated. Planning has been finalised and project is now proceeding smoothly.
Worcester Hospital	315	Level 2	45 418	40 163	Slow progress was being made by the contractor. Some stringent controls have been put in place, if these are not met, WCDTPW will terminate the agreement with the contractor.

Expanded Public Works Programme (EPWP) Incentive Grant

The Expanded Public Works Programme strengthens the sustainability of community based services at primary care level through the training of home based carers towards formal qualifications in ancillary health care and community health work. It contributes towards creating employment opportunities and alleviating poverty through stipend work opportunities and / or training to relief workers who are recruited from the community.

The EPWP is a nation-wide programme with the objective of drawing significant numbers of the unemployed into productive work, so that workers gain skills while they work, and increase their capacity to earn an income.

The home community based care programme has been prioritised as a cost effective response for substituting a significant proportion of AIDS related hospital care. The EPWP is a critical component of the effort to deliver holistic HIV and AIDS, and TB related services. It represents a strategic opportunity to address key pressure points in current interventions as in the extension of community based services as reflected in the Comprehensive Service Plan.

The programme has been expanded to include the data capturer internship programme (the 3535 national project), the recruitment and training of 3 535 young matriculants to be deployed as data capturers at community health centres and clinics throughout the country over a period of three years. Interns attend the Basic Routine Health Information Systems for Data Capturers (HISDC), a twenty-one day training programme. The Western Cape has recruited and trained 280 data capturer interns to date. The interns provide data management services including data capturing and records management related to the monitoring and evaluation of data at facilities. This initiative is aimed to address some of the challenges in public health facilities such as: data backlogs, poor record keeping and lack of data capturers.

The Assistant to Artisan (ATA) programme was introduced in 2010/11. The ATAs receive a short multi-skills programme at a further education and training college (FETC), the assistant to artisan course, and as an intern continuous in-service training under supervision of a mentor, the artisan foreman, at a health facility. This links to EPWP through creating work opportunities linked to skills development for the unemployed members of our community. The intervention will also address the human resource development and scarce skills need within the artisan cadre in the Department of Health as a medium to long term strategy. The impact of this intervention will ensure the enhanced maintenance and presentation of our health facilities.

2.1.12 Capital investment, maintenance and asset management plan

Capital investment

The table below lists the building projects that are currently in progress and the expected date of completion.

Table 2.1.9: Performance measures for the Hospital Revitalisation Programme Conditional Grant

No	Project name	District	Municipality	Project description/ Type of infrastructure	Date: start Note 1	Date: finish Note 2
NEW AND REPLACEMENT ASSETS						
OWN FUNDS						
1	Bonnievale Clinic	Cape Winelands	Breede River/ Winelands	New clinic	1-Apr-13	31-Mar-14
2	Leeu Gamka Ambulance Station	Central Karoo	Prince Albert	New ambulance station	1-Oct-10	31-Oct-11
3	Piketberg Ambulance Station	West Coast	Bergrivier	New ambulance station	17-Jan-11	15-Dec-12
4	Swellendam Mortuary	Overberg	Swellendam	Acquire property	1-Apr-10	31-Mar-11
5	Simondium Clinic	Cape Winelands	Drakenstein	New clinic	31-Jul-06	19-Nov-07
6	Tulbach Ambulance Station	Cape Winelands	Witzenberg	New ambulance station	17-Jan-11	15-Dec-12
INFRASTRUCTURE GRANT TO PROVINCES						
1	Asanda Clinic	City of Cape Town	Cape Town	New clinic	1-Apr-13	31-May-15
2	Beaufort West Hospital	Central Karoo	Beaufort West	Forensic mortuary	1-Oct-10	1-Oct-11
3	Beaufort West Hospital	Central Karoo	Beaufort West	New bulk store	9-Jan-09	16-Jul-09
4	Beaufort West	Central Karoo	Beaufort West	Office accommodation	15-Nov-10	30-Jun-11
5	Ceres Hospital	Cape Winelands	Witzenberg	New ambulance station	24-Jan-10	15-Feb-11
6	Delft Symphony Way	City of Cape Town	Cape Town	New CHC	30-May-11	30-Jul-13
7	District 6	City of Cape Town	Cape Town	New CHC	20-Jan-12	30-Jul-14
8	Du Noon CHC	City of Cape Town	Cape Town	New CHC	1-Apr-11	30-Jan-14
9	Grassy Park	City of Cape Town	Cape Town	New clinic	8-Mar-10	30-May-11
10	Helderberg Hospital	City of Cape Town	Cape Town	New OPD and wards	12-Oct-07	12-Dec-08

No	Project name	District	Municipality	Project description/ Type of infrastructure	Date: start Note 1	Date: finish Note 2
11	Hermanus	Overberg	Overstrand	New CHC	1-Apr-13	31-Oct-14
12	Hermanus	Overberg	Overstrand	Site acquisition	1-Apr-13	31-Oct-14
13	Knysna - Witlokasie	Eden	Knysna	New CHC	1-Apr-11	31-Mar-13
14	Khayelitsha Hospital	City of Cape Town	Cape Town	New shared service centre	1-Oct-10	31-May-11
15	Kwanokuthula	Eden	Bitou	New CDC	24-Jan-10	15-Mar-11
16	Kwanokuthula	Eden	Bitou	New ambulance station	24-Jan-10	31-Oct-10
17	Leeu Gamka Ambulance Station	Central Karoo	Prince Albert	New ambulance station	1-Oct-10	31-Oct-11
18	Malmesbury	West Coast	Swartland	New forensic laboratory	10-Nov-09	29-Jul-10
19	Malmesbury - Wesbank	West Coast	Swartland	New CDC	19-Mar-10	30-Sep-11
20	Malmesbury EMS	West Coast	Swartland	New ambulance station	1-Apr-11	30-May-12
21	Metro clinics	City of Cape Town	Cape Town	Facility audit to metro clinics	1-Nov-10	15-Mar-11
22	Paarl TC Newman CHC	Cape Winelands	Drakenstein	New forensic laboratory	10-Nov-09	31-Aug-10
23	Rawsonville	Cape Winelands	Breede Valley	New clinic	1-Apr-13	30-May-14
24	Salt River	City of Cape Town	Cape Town	Forensic mortuary	1-Apr-14	30-May-16
25	Vredendal Hospital	West Coast	Matzikama	New ambulance station	15-Mar-10	30-May-11
26	Worcester Hospital	Cape Winelands	Breede Valley	New forensic laboratory	10-Nov-09	31-Aug-10
27	Weltevreden Valley	City of Cape Town	Cape Town	New CHC	1-Apr-13	30-Jan-15
HOSPITAL REVITALISATION PROGRAMME						
1	Khayelitsha Hospital	City of Cape Town	Cape Town	Infrastructure installation	8-Aug-08	23-Mar-09
2	Khayelitsha Hospital	City of Cape Town	Cape Town	New hospital and ambulance station	5-Jan-09	4-Jan-12
3	Mitchell's Plain Hospital	City of Cape Town	Cape Town	New hospital	22-Sep-09	21-Oct-12
4	Worcester Hospital	Cape Winelands	Breede Valley	New DMC and ambulance station	14-Nov-06	9-Apr-09
UPGRADES AND ADDITIONS						
OWN FUNDS						
1	Brooklyn Chest TB Hospital	City of Cape Town	Cape Town	New MDR and XDR wards	1-Apr-11	31-Mar-15
2	George Harry Comay TB Hospital	Eden	George	Ward 1 & 2 upgrading	24-Nov-10	30-Jul-11
4	Paarl Sonstraal TB Hospital	Cape Winelands	Drakenstein	Repair and renovation to hospital and parking area	12-Jan-09	30-Oct-09
5	Upgrade of TB hospitals	-	-	-	1-Apr-10	1-Aug-11
6	Paarl Sonstraal TB Hospital	Cape Winelands	Drakenstein	UV lights and extraction	1-Apr-10	31-Mar-11
7	Red Cross Hospital	City of Cape Town	Cape Town	Ward upgrades	-	-
8	Stikland Hospital	City of Cape Town	Cape Town	Wards 1, 6, 7 & 11 upgrade	1-Oct-10	-
10	Tygerberg	Cape Metropole	Cape Town	Kitchen upgrade	1-Apr-10	31-Mar-11

No	Project name	District	Municipality	Project description/ Type of infrastructure	Date: start Note 1	Date: finish Note 2
INFRASTRUCTURE GRANT TO PROVINCES						
1	Bonnievale/ Happy Valley Clinic	Cape Winelands	Breede River/ Winelands	Extend clinic	30-Nov-09	30-Apr-10
2	Caledon Hospital	Overberg	Theewaters-kloof	Upgrade - phase 2	1-Feb-11	1-Feb-12
3	Ceres Hospital	Cape Winelands	Witzenberg	Emergency Centre	1-Dec-10	1-Dec-11
4	Dept of Health	City of Cape Town	Cape Town	4 Dorp Street Health upgrade	1-Apr-10	31-Mar-11
5	Dept of Health	City of Cape Town	Cape Town	Technical capacity Infrastructure CD	1-Apr-10	31-Mar-11
6	Eerste River Hospital	City of Cape Town	Cape Town	New casualty	5-Sep-08	8-Jul-10
7	Eerste River Hospital	City of Cape Town	Cape Town	Link passage	1-Dec-10	31-Mar-11
8	Eerste River Hospital	City of Cape Town	Cape Town	Safe ward	1-Dec-10	31-Mar-11
9	Groote Schuur Hospital	City of Cape Town	Cape Town	Alt TB patient areas	1-Jul-10	1-Mar-11
10	Groote Schuur Hospital	City of Cape Town	Cape Town	Fire detection phase 1	19-Oct-06	30-Sep-09
11	Groote Schuur Hospital	City of Cape Town	Cape Town	Master Plan	1-Apr-10	31-Mar-11
12	Groote Schuur Hospital	City of Cape Town	Cape Town	NMB fire detection phase 2	6-May-10	30-May-11
13	Groote Schuur Hospital	City of Cape Town	Cape Town	Relocation of engineering workshop	1-Mar-10	28-Feb-11
14	Groote Schuur Hospital	City of Cape Town	Cape Town	Security upgrade phase 1	11-Jun-09	12-Mar-10
15	Groote Schuur Hospital	City of Cape Town	Cape Town	Survey for space utilisation	12-Jan-09	31-Mar-10
16	Groote Schuur Hospital	City of Cape Town	Cape Town	Ugrade D23 department anaesthesia	4-Jun-09	16-Nov-09
17	Groote Schuur Hospital	City of Cape Town	Cape Town	Upgrade pharmacy	1-Sep-10	1-Sep-11
18	Groote Schuur Hospital	City of Cape Town	Cape Town	Conversion of coal fire boilers	15-Jan-11	31-Jul-11
19	Groote Schuur Hospital	City of Cape Town	Cape Town	PACS/RIS infrastructure	1-Nov-10	31-Mar-11
20	Gustrow Clinic	City of Cape Town	Cape Town	Relocation of BBC legacy infrastructure	15-Nov-10	20-Mar-11
21	Hermanus Hospital	Overberg	Overstrand	EC and new wards	1-Nov-10	30-Aug-13
22	Karl Bremer Hospital	City of Cape Town	Cape Town	Emergence centre	1-Apr-12	30-Apr-14
23	Knysna Hospital	Eden	Knysna	Emergence centre	1-Apr-13	31-Oct-14
24	Lamberts Bay	West Coast	Cederberg	Ambulance station	21-Apr-10	31-Mar-11
25	Lentegeur Hospital	City of Cape Town	Cape Town	Relocation of Lifecare	15-Dec-10	30-Jun-11
32	Malmesbury Hospital	West Coast	Swartland	Casualty extension	30-Nov-10	30-Sep-11
33	Melkhoutfontein Clinic	Eden	Hessequa	Upgrade	1-Feb-11	31-Oct-11
34	Mitchell's Plain Sub-district office	City of Cape Town	Cape Town	Upgrade existing Lentegeur facility	31-Jan-11	31-Jan-12

No	Project name	District	Municipality	Project description/ Type of infrastructure	Date: start Note 1	Date: finish Note 2
35	Mitchell's Plain CHC	City of Cape Town	Cape Town	Emergency centre & pharmacy	2-Jun-09	22-Jun-10
36	Mitchell's Plain CHC	City of Cape Town	Cape Town	Site acquisition	1-May-10	1-May-10
37	Riversdale Hospital	Eden	Hessequa	Forensic mortuary	1-Apr-13	31-Mar-15
38	Riversdale Hospital	Eden	Hessequa	Phase 2 upgrade	7-Feb-08	6-May-10
39	Riversdale Hospital	Eden	Hessequa	Phase 3 upgrade	15-Oct-10	15-Oct-11
40	Riversdale Hospital	Eden	Hessequa	Resurface roads	3-Mar-09	3-Sep-09
41	Robertson Hospital	Cape Winelands	Breede River/ Winelands	Maternity ward	1-May-11	1-Feb-12
42	Somerset Hospital	City of Cape Town	Cape Town	2010 enabling work	20-May-09	17-Mar-10
43	Somerset Hospital	City of Cape Town	Cape Town	Lift upgrade	29-Jul-10	30-Sep-11
44	Somerset Hospital	City of Cape Town	Cape Town	Shipley building renovation	19-Mar-09	14-Sep-09
45	Tygerberg Hospital	City of Cape Town	Cape Town	Emergency centre upgrade	30-Nov-10	30-Nov-11
46	Tygerberg Hospital	City of Cape Town	Cape Town	Electric fence	24-Mar-09	23-Apr-10
47	Tygerberg Hospital	City of Cape Town	Cape Town	Fire door upgrade phase 2	25-Jun-08	15-Oct-09
48	Tygerberg hospital	City of Cape Town	Cape Town	New helipad	1-Apr-09	31-Aug-09
49	Tygerberg Hospital	City of Cape Town	Cape Town	Lift upgrading	23-Oct-08	1-Feb-10
50	Tygerberg Hospital	City of Cape Town	Cape Town	Security fence - East Side	27-Jan-09	27-May-09
51	Tygerberg	Cape Metropole	Cape Town	CT scan installation	-	-
52	Tygerberg	Cape Metropole	Cape Town	Kitchen upgrade	1-Apr-10	31-Mar-11
53	Vredendal Hospital	West Coast	Matzikama	New chiller	12-Oct-09	30-Nov-09
54	Vredendal Hospital	West Coast	Matzikama	X-ray and CSSD upgrade/ construction	24-May-06	30-Nov-09
REHABILITATION, RENOVATIONS AND REFURBISHMENTS						
HOSPITAL REVITALISATION PROGRAMME						
1	George Hospital	Eden	George	Hospital upgrade phase 3	1-Apr-09	02-Sep-11
2	Paarl Hospital	Cape Winelands	Drakenstein	Hospital upgrade	10-Apr-06	1-Dec-10
3	Paarl Hospital	Cape Winelands	Drakenstein	New administration block	1-Apr-13	31-Mar-14
4	Paarl TC Newman CHC	Cape Winelands	Drakenstein	Community health centre upgrade (co-funded GF)	15-May-09	20-Dec-10
5	Valkenberg Hospital	City of Cape Town	Cape Town	Emergency repairs to admin building	17-Apr-09	31-Mar-10
6	Valkenberg Hospital	City of Cape Town	Cape Town	Hospital upgrading	1-Apr-12	31-Mar-17
7	Vredenburg Hospital	West Coast	Saldanha Bay	Upgrading phase 1B- various internal work	29-Oct-08	31-Mar-09
8	Vredenburg Hospital	West Coast	Saldanha Bay	Upgrading phase 2A	28-Jan-09	29-Jul-10
9	Vredenburg Hospital	West Coast	Saldanha Bay	Upgrading phase 2B	1-May-11	30-Apr-13
10	Worcester Hospital	Cape Winelands	Breede Valley	Hospital upgrade phase 3	26-Jun-03	31-Dec-08

No	Project name	District	Municipality	Project description/ Type of infrastructure	Date: start Note 1	Date: finish Note 2
11	Worcester Hospital phase 4	Cape Winelands	Breede Valley	Hospital upgrade phase 4	2-Nov-09	1-Nov-10
12	Worcester Hospital phase 5	Cape Winelands	Breede Valley	Hospital upgrade phase 5	1-Apr-12	30-Jun-13
OTHER CAPITAL PROJECTS						
GLOBAL FUND ARV CLINIC EXTENSIONS						
1	Crossroads CHC	City of Cape Town	Cape Town	Extension, pharmacy upgrade	11-Apr-08	28-Aug-09
2	Delft CHC	City of Cape Town	Cape Town	Extension, pharmacy upgrade	31-May-11	31-May-12
3	Insame Zabantu CDC	City of Cape Town	Cape Town	Extension, pharmacy upgrade	31-May-11	31-May-11
4	Gugulethu CHC	City of Cape Town	Cape Town	Extension, pharmacy upgrade	11-Apr-08	30-Jun-09
5	Kraaifontein CHC	City of Cape Town	Cape Town	Extension, pharmacy upgrade	2-Nov-07	11-Nov-08
6	Michael Mapongwana Community Health Centre	City of Cape Town	Cape Town	Extension, pharmacy upgrade	13-Nov-08	2-Feb-10
7	Mitchells Plain Community Health Centre	City of Cape Town	Cape Town	Extension, pharmacy upgrade (co-funded IGP)	2-Jun-09	1-Jun-10
8	Paarl TC Newman Community Health Centre	Cape Winelands	Drakenstein	Extension, pharmacy upgrade (co-funded HRP)	3-Jul-09	4-Oct-10
9	Retreat Community Health Centre	City of Cape Town	Cape Town	Extension, pharmacy upgrade	9-Sep-08	5-Aug-09
GLOBAL FUND PALLIATIVE CARE DEVELOPMENT PROJECT						
1	Stellenbosch Hospital	Cape Winelands	Stellenbosch	Hospice palliative care upgrade	1-Apr-10	31-Dec-10

Note 1: Site handover/commencement of construction – Date of letter of acceptance

Note 2: Construction completion date (take over date) – Practical completion date

Plans to close down or downgrade any current facilities

The table below reflects accommodation that has been identified for disposal:

Table 2.1.10: Accommodation identified for disposal

Asset description	Disposal rationale	Disposal year
Robbie Nurock – Community Health Centre	Newly purpose-built facilities will replace old facility not in correct position.	2015
Conradie Hospital	No longer required. Sold by Property Management in 2007.	2012
Woodstock Hospital	Not in correct position and condition poor. Sub district office to move to Mitchell's Plain office accommodation.	2015
Salt River – Forensic Pathology Laboratory	Facility to be replaced by purpose-built new facility, which will be conducive to research.	2016
Stikland Hospital – portion of estate	Estate too big to maintain in proper condition.	2012
Kwanokuthula Community Health Centre	New facility has been built. Old facility to be relinquished.	2012

Asset Management

All institutions have asset registers for both minor and major assets in place. Asset controllers per institution have been appointed to maintain the asset registers on a daily basis. Assets are purchased in accordance with an annual plan approved by the departmental Equipment Committee. This plan differentiates between vehicles, computer, medical and other assets per institution. Disposal of assets are done via disposal committees in accordance with departmental policies. The Department's assets are housed in SYSPRO (for central hospitals) and LOGIS (for all other institutions) and asset purchases on these systems are reconciled with the expenditure through BAS on a monthly basis.

As on 31 March 2011, the Department had movable major assets to the value of R 1 536 399 000, and 430 651 minor assets to the value of R 442 835 000. The condition of these assets fall either within the category of fair or good as items classified as bad are disposed of.

Maintenance

The budget allocation for maintenance in 2010/11 was R 102 million, of which a total of R 89 million, or 78.7% was spent. It must further be noted that maintenance work was also undertaken under the IGP grant which skews the actual amount spent on maintenance. Some reasons for the under expenditure is the lack of capacity and the project delivery process followed by the implementing agent, the Western Cape Department of Transport and Public Works(DTPW). This will be addressed with the implementation of the Western Cape Infrastructure Delivery Management System (WC IDMS), approved by Cabinet on 13 April 2011.

The maintenance expenditure is not in line with industry norms which recommend that the maintenance budget should be set at 2% of the infrastructure replacement value. The replacement value for Western Cape Department of Health facilities is estimated to be in the order of R 15 billion. In order to adhere to this standard, a budget allocation of R 300 million per annum would be required including the preventative maintenance for newly built facilities. The maintenance budget has not been increased enough to make a noticeable impact on the maintenance.

Significant progress has, however, been made during the period under review to reduce the maintenance backlog. This is evident in the following:

- New facilities currently being constructed, replaced, upgraded or revitalised – see list of projects above.
- Projects that are funded by means of the Hospital Revitalisation Programme and the Infrastructure Grant to Provinces.

Maintenance backlog and planned measures to reduce the maintenance backlog

It is difficult to measure the maintenance backlog. The maintenance backlog is estimated at R 400 million at present, but it is not viewed to be increasing as the Department is replacing facilities and upgrading existing facilities by means of the Infrastructure Grant to Provinces and the Hospital Revitalisation Programme. The said replacement and upgrading of facilities reduces the maintenance backlog. In addition to the afore-mentioned, the Department aims to utilise the following measures to reduce the backlog over the Medium Term Expenditure Framework period:

- By constructing new or upgrading those existing facilities with the most dilapidated infrastructure first;
- By continuing to improve planning and execution of projects;
- By the simultaneous undertaking of projects located within a specific radius; and
- The backlog of the Tygerberg Hospital is so great that a decision has been made to replace the hospital and a mega public private partnership (PPP) project has been registered in this regard.

The importance of ensuring that an accurate and up-to-date immovable asset register (IAR) of all facilities is readily available, including both owned and leased properties, cannot be over-emphasised. Currently the available immovable asset register is neither up-to-date nor sufficiently accurate which substantially limits the Department's ability to plan, manage and maintain health facilities in a fully co-ordinated manner.

Closely aligned to this is the need for regular and accurate facility condition assessments of all facilities operated under the auspices of the Department. The Government Immovable Asset Management Act (GIAMA) places the responsibility for the latter with the Department of Transport and Public Works. Unfortunately, however, to date the Department of Transport and Public Works have not had the necessary capacity to undertake such assessments and consequently, the Department of Health has had to perform this function within its own capacity limitations. The result is that the data available to inform the capital and maintenance requirements is sub-optimal. However, the Department of Health is fortunate to have a relatively accurate CSP document, and this, along with other management and implementation systems, has contributed to ensuring that work planned for the forthcoming financial year is sufficiently accurate in terms of budgets and time-frames, and moreover, meets the strategic goals of the Department.

One of the Department's constraints is that there is currently no up to date immovable asset register (IAR) of the Department's estate; without which it is difficult to plan, manage and maintain health facilities in a fully co-ordinated manner. The infrastructure development improvement programme (IDIP) is assisting the Department to update the immovable asset register which will comply with the legislative requirements and guidelines laid down by National Treasury, the National Department of Health and GIAMA. The IDIP technical assistant has assisted the Department to prepare its user asset management plan (U-AMP) which is also a GIAMA requirement. The latter will reflect the basic condition and suitability of health facilities.

Major Maintenance Projects

The major scheduled maintenance projects that have been completed during 2010/11 are listed in the table below.

Table 2.1.11: Accommodation identified for disposal

No	SP	District	Sub-district	Facility	Brief description of work	Actual expenditure (R)
1	8.2	City of Cape Town	Cape Town Western	Pinelands EMS	Insert drain pipes, sandblast, erect undercover parking, and construct sluice next to wash bay.	1 769 144
2	8.1	Overberg	Swellendam	Barrydale Clinic	R & R C/O (2009/10) C/O S007/10.	1 041 017
3	8.1	Overberg	Theewaterskloof	Villiersdorp Clinic	Structural damage, leak in waiting room, repair and paint, painting inside	965 307
4	8.1	City of Cape Town	Cape Town Western	Kensington CHC	Repairs and renovations to parking area, roof, interior and external painting entire building, disabled toilet facilities.	2 019 451
5	8.1	City of Cape Town	Cape Town Northern	Kraaifontein CHC	R & R: paint and repair cracks in CHC, remove carpets in MOU, replace with tiles in tea room, tile walls and floor, paint guard room.	2 932 702
6	8.1	Cape Winelands	Breede Valley	Worcester CHC	General repairs and renovations including electrical and mechanical.	1 684 205
7	8.3	Central Karoo	Beaufort West, Laingsburg and Prince Albert	Beaufort West Hospital	Minor capital: New carport for GG vehicles (2009/10) C/O G30/09.	1 317 682
8	8.3	City of Cape Town	Tygerberg	Karl Bremer Hospital	M7 and M8: Replace floors, 20% of windows and 25% of doors, upgrade plumbing and electrical supply service and repair 75% doors, repair and paint roof and gutters.	1 347 914
9	8.3	City of Cape Town	Tygerberg	Karl Bremer Hospital	Supply and deliver nine heat pumps.	2 109 456
10	8.3	City of Cape Town	Tygerberg	Karl Bremer Hospital	Supply and deliver medical air equipment.	1 488 116
11	8.3	Eden	Knysna	Knysna Hospital and Witlokasie CDC	Supply and deliver one 250KVA and one 400KVA standby generators.	1 390 458
12	8.3	West Coast	Swartland	Swartland Hospital	Replace boiler 2.	540 368
13	8.3	City of Cape Town	Klipfontein	GF Jooste Hospital	Refurbishment of ward 2.	3 191 633
14	8.3	Eden	Mossel Bay	Mossel Bay Hospital	Repair and replace hospital doors; paint hospital; upgrade of sluice room.	1 710 946
15	8.3	Eden	Hessequa	Riversdale Hospital	Internal road repairs.	909 398
16	8.3	Cape Winelands	Stellenbosch	Stellenbosch Hospital	Change kitchen in nurses home to rehab centre; create safety room for psychiatric patients.	718 682

No	SP	District	Sub-district	Facility	Brief description of work	Actual expenditure (R)
17	8.5	City of Cape Town		Cape Town: various hospitals lift maintenance (2010/11)	Maintenance and servicing of lift installations.	11 329 337
18	8.4	City of Cape Town	Cape Town Western	Alexandra Hospital	New electric security fence (2008/09) C/O S165/08.	7 157 929
19	8.4	City of Cape Town	Cape Town Western	Valkenberg Hospital	Repairs and renovations to ward 11.	3 845 012
20	8.5	City of Cape Town	Cape Town Western	Groote Schuur Hospital	Upgrading of lifts to old main building (Blocks 53 and 55).	1 048 771
21	8.5	City of Cape Town	Cape Town Western	Groote Schuur Hospital	Re-roof main block of old main building, with 5 year maintenance contract or 5 year warranty.	4 885 064
22	8.5	City of Cape Town	Tygerberg	Tygerberg Hospital	R & R of Carel Du Toit complex roof sheeting.	1 581 762
23	8.5	City of Cape Town	Tygerberg	Tygerberg Hospital	Repairs and renovations to ward D1.	2 534 651
24	8.4	Eden	George	Harry Comay Hospital	General repairs and renovations.	2 722 915
TOTAL						**60 241 919**

SP = Sub-programme

No facility was closed or down-graded during the 2010/11.

Major carry over maintenance projects

The major maintenance projects which will be carried forward to 2011/12 are listed in the table below.

Table 2.1.12: Major projects carried over to 2011/12

No	SP	District	Facility	Brief description of work	Total budget (R)	Estimated expenditure (R)
1	8.4	City of Cape Town	Alexandra Hospital	Supply and installation of water storage tanks.	1 041 267	628 324
2	8.4	City of Cape Town	Alexandra Hospital	General roofs and fire detection upgrading and new OPD centre.	5 200 000	5 200 000
3	8.4	City of Cape Town	Alexandra Hospital	Replace air conditioning system with dual cooling and heating system.	2 412 333	2 412 333
4	8.4	Cape Winelands	Brewelskloof Hospital	Replace water ring main.	1 749 189	432 140
5	8.4	City of Cape Town	Brooklyn Chest TB Hospital	External: replace main water line.	1 250 000	1 250 000
6	8.4	City of Cape Town	Brooklyn Chest TB Hospital	Paint wards; paint buildings externally; and repair/replace roof and ceiling.	840 515	138 210

No	SP	District	Facility	Brief description of work	Total budget (R)	Estimated expenditure (R)
7	8.4	City of Cape Town	Brooklyn Chest TB Hospital	Installation of UVGI lights and extraction; electrical, ventilation repairs and renovations.	900 000	900 000
8	8.1	Overberg	Caledon Clinic	Masonry, internal and external painting, carpentry and joinery e.g. shelving/drywall partitioning, cupboards, vinyl flooring, plumbing, tiling.	690 000	390 000
9	8.1	Cape Winelands	Dalevale Clinic	Painting, break through from waiting room into passage, replace existing fencing with higher weld mesh fence; include electrical and mechanical.	650 000	650 000
10	8.3	City of Cape Town	GF Jooste Hospital	Repairs and renovations, including electrical and mechanical work.	3 500 000	2 150 000
11	8.4	City of Cape Town	Green Point: Somerset Hospital and Oranjezitch: Booth Memorial Hospital	Main hospitals: lift installation modernisation, refurbishment and upgrade.	4 218 000	4 000 000
12	8.4	City of Cape Town	Green Point: Somerset Hospital	Repairs and renovations to the north block.	3 000 000	2 427 311
13	8.5	City of Cape Town	Groote Schuur Hospital	Replacement of master key/lock system on F-floor.	1 399 200	957 397
14	8.5	City of Cape Town	Groote Schuur Hospital	Replace the large four cooling towers on NMB and one cooling tower in L-block.	2 960 505	716 119
15	8.5	City of Cape Town	Groote Schuur Hospital	Various buildings: repairs and renovations.	2 300 000	2 029 555
16	8.1	Cape Winelands	JJ du Preez Clinic	Painting and changes to patient's toilet, including electrical and mechanical.	630 000	91 349
17	8.1	City of Cape Town	Khayelitsha CHC	Internal and external general repairs and painting.	2 336 702	2 336 702
18	8.3	West Coast	LAPA Munnik Hospital	Paint building, repairs to nurses home including shade parking and electrical upgrading.	1 066 619	447 684
19	8.4	City of Cape Town	Lentegeur Hospital	Painting wards 10, 13, 102 and 103.	1 619 035	1 284 117
20	8.3	Central Karoo	Murraysburg Hospital	Build new car port, parking, waiting area and tarring of roads.	1 200 000	1 150 000
21	8.4	Central Karoo	Nelspoort: Nelspoort TB Hospital: Water Supply: Repair Water Mains	Water supply: repair water mains and fire water system.	1 500 000	1 063 032
22	8.5	City of Cape Town	Red Cross Hospital	Main store upgrade.	1 300 000	650 000
23	8.5	City of Cape Town	Red Cross Hospital	Replacement of various roofs and external renovations of various buildings.	3 600 000	3 600 000

No	SP	District	Facility	Brief description of work	Total budget (R)	Estimated expenditure (R)
24	8.5	City of Cape Town	Red Cross Hospital	Service/replacement HT switch gear in hospital.	900 000	450 000
25	8.3	Cape Winelands	Robertson Hospital	Extensive repairs and renovation of hospital and nurses home, general road repairs.	2 750 000	2 750 000
26	8.4	City of Cape Town	Somerset Hospital	Replace existing fire alarm system (2010/11).	1 800 000	1 800 000
27	8.4	City of Cape Town	Somerset Hospital	Service existing chiller and supply and install new.	1 710 000	1 710 000
28	8.3	Cape Winelands	Stellenbosch Hospital	Lift installation modernisation, refurbishment and upgrade.	800 000	800 000
29	8.6	City of Cape Town	Tygerberg Forensics	Repairs and renovations: expansion of coldroom space and garages.	1 200 000	400 000
30	8.5	City of Cape Town	Tygerberg Hospital & Karl Bremer Hospital	Lift installation modernisation, refurbishment and upgrade.	18 000 000	15 000 000
31	8.5	City of Cape Town	Tygerberg Hospital	Phase 3 fire doors.	2 800 000	1 300 000
32	8.5	City of Cape Town	Tygerberg Hospital	Repairs and renovations to wards D2 and F4.	4 500 000	2 500 000
33	8.4	City of Cape Town	Valkenberg Hospital	Renovations of ward 12.	2 000 000	2 000 000
34	8.4	Cape Winelands	Worcester Hospital	Replacement of chiller on C-block roof.	2 244 000	135 245
35	8.4	Cape Winelands	Worcester Hospital	Replacement of a chiller and installation of air-conditioners.	386 057	50 000
Total					**84 067 365**	**63 664 273**

SP = Sub-programme

New major scheduled maintenance project for 2011/12

The major schedule maintenance projects that will commence in 2011/12 are listed below.

Table 2.1.13: New major projects scheduled for 2011/12

No	SP	District	Facility	Brief description of work	Total budget (R)	Estimated expenditure (R)
1	8.4	City of Cape Town	Alexandra Hospital	Painting of non-clinical buildings; painting and repairs of education buildings.	2 200 000	2 200 000
2	8.6	City of Cape Town	Athlone: WCCN	Replace sewerage piping; replace windowsills block A; provide and install built-in-cupboards to 300 rooms; repair roofs to blocks G and H; repairs to bathroom floors of residential blocks D, E , G and H.	4 000 000	4 000 000

No	SP	District	Facility	Brief description of work	Total budget (R)	Estimated expenditure (R)
3		City of Cape Town	Brooklyn Chest Hospital	Provide ventilation and extraction systems in wards: A, B, C, D, 3 and linen bank.	2 000 000	2 000 000
4		City of Cape Town	Brooklyn Chest Hospital	Ward A general repairs to floors and electrical, paint exterior walls and roof. Provide fire detection, escapes and signage. Upgrade the stoop.	1 000 000	1 000 000
5		City of Cape Town	Brooklyn Chest Hospital	Sewerage system: upgrade pumping station and reticulation.	2 000 000	2 000 000
6	8.4	City of Cape Town	Cape Town: various hospitals.	Maintenance and servicing of lift installations. Lift maintenance (2011/12) S248/10.	8 000 000	8 000 000
7	8.1	City of Cape Town	Elsies River MOU	Extension of MOU; air-conditioning and wall oxygen points, including general repairs.	3 500 000	3 000 000
8	8.4	City of Cape Town	Green Point: Somerset Hospital	West block: replace steel windows with aluminium (not already done) and cleaning of walls. Start late in 2011 - carryover in 2012/13.	3 800 000	1 100 000
9	8.4	City of Cape Town	Greenpoint: Somerset Hospital	Repairs and renovations to the north block.	3 000 000	2 427 311
10	8.5	City of Cape Town	Groote Schuur Hospital	Repair and renovate OPD roofing.	2 500 000	2 500 000
11	8.5	City of Cape Town	Groote Schuur Hospital	Replace master key lock system on E floor NMB; upgrade domestic water reticulation system, replace vinyl flooring and carpeting, general repairs and painting of passages, offices and wards, repairs to asphalt areas at E-zone.	4 250 000	4 250 000
12	8.5	City of Cape Town	Groote Schuur Hospital	Replacement of copper pipes, chilled water piping and heating coils of air-conditioners.	3 000 000	3 000 000
13	8.1	City of Cape Town	Gustrouw Clinic	Relocation of the BBC pre-fab building from Somerset Hospital.	2 000 000	2 000 000
14		Eden	Harry Comay TB Hospital	Repair roads, storm water drainage and upgrade streetlights.	2 400 000	2 400 000
15	8.3	City of Cape Town	Helderberg Hospital	Complete repairs and renovations, including painting and electrical / mechanical repairs.	6 000 000	5 000 000
16	8.1	Cape Winelands	Khayamandi Clinic	Urgent interior painting and general repairs to toilets, etc.	1 600 000	1 600 000
17	8.4	City of Cape Town	Lentegeur Hospital	General repairs to wards 31 and 96.	2 000 000	2 000 000
18	8.1	Cape Winelands	McGregor Clinic	Urgent external painting; replace floor tiles in certain areas. Internal painting and attention to cracks and damp areas in dentist area.	1 400 000	1 063 032

No	SP	District	Facility	Brief description of work	Total budget (R)	Estimated expenditure (R)
19	8.4	City of Cape Town	Mowbray Hospital	Supply and install one new chiller.	1 200 000	1 200 000
20	8.6	City of Cape Town	Mowbray Maternity Hospital	Refurbishment of lift installations in 2nd year.	3 420 000	3 000 000
21	8.1	Cape Winelands	Nieuwedrift Clinic	Serious structural problem, cracks in walls at window corners. Investigate and repair. Investigate and repair gutters. Paint interior and exterior.	1 500 000	1 500 000
22	8.6	City of Cape Town	Groote Schuur Hospital	Refurbishment of lift installations in 2nd year.	1 977 773	1 500 000
23	8.1	Cape Winelands	Phola Park Clinic	Re-lay the defective waste line at prefabricated toilet.	300 000	1 200 000
24		Central Karoo	Prince Albert Hospital	Provision of helipad and waiting area.	1 700 000	1 700 000
25	8.5	City of Cape Town	Red Cross Hospital	Refix roof, internal and external painting and minor repairs.	1 200 000	1 200 000
26	8.5	City of Cape Town	Red Cross Hospital: Maitland Cottage	Painting and general repairs.	1 400 000	1 400 000
27	8.6	City of Cape Town	Red Cross Hospital	Refurbishment of lift installations in 2nd year.	5 700 000	5 000 000
28		West Coast	Sonstraal TB	Provide prefabricated ward and minor alterations to various areas to create a better work flow and additional space.	1 500 000	1 500 000
29	8.3	Cape Winelands	Stellenbosch Hospital	Floors in hospital urgently need replacement / repair of vinyl tiles - start Jan/Feb 2012.	1 000 000	1 000 000
30		City of Cape Town	Stikland Hospital House Bowker - Old Stikland Hospital grounds	General repairs and painting of building internal / external and upgrading of bathrooms and toilets.	2 500 000	2 500 000
31	8.1	Cape Winelands	TC Newman CDC	Replace floor tiles in various areas, clean roofs, gutters, fascia and repaint. Waterproof old boiler house roof; minor alterations to toilets at boiler house.	1 270 000	1 270 000
32	8.5	City of Cape Town	Tygerberg Hospital	Repairs and painting of H10, H8, E7, E8 and passages.	2 500 000	2 500 000
33	8.5	City of Cape Town	Tygerberg Hospital	Painting and general repairs to toilets, floors, etc. in psychiatric department.	3 000 000	3 000 000
34	8.5	City of Cape Town	Tygerberg Hospital	Upgrade and expansion of the electronic surveillance system on the hospital premises and grounds.	3 000 000	3 000 000
35	8.5	City of Cape Town	Tygerberg Hospital	Waterproof and repair of B5 and administration.	2 050 000	2 000 000
36	8.1	Overberg	Waenhuiskrans Clinic	General repairs and internal / external painting. Will confirm terms.	100 000	2 500 000

No	SP	District	Facility	Brief description of work	Total budget (R)	Estimated expenditure (R)
37	8.3	City of Cape Town	Wesfleur Hospital	Repairs and Renovations, including electrical and mechanical work.	2 500 000	2 500 000
38	8.6	City of Cape Town	Victoria Hospital	Refurbishment of lift installations in 2nd year.	1 960 000	1 000 000
Total					**94 427 773**	**90 010 343**

Processes in place for the tendering of projects

The Department of Health has appointed the Department of Transport and Public Works as implementing agent for all its related infrastructure projects (except preventative maintenance). The process in place for the managing of infrastructure related projects is regulated by the Construction Industry Development Board.

2.2 Programme Performance

The activities of the Department of Health are organised in the following budget programmes:

Programme 1: Administration
Programme 2: District Health Services
Programme 3: Emergency Medical Services
Programme 4: Provincial Hospital Services
Programme 5: Central Hospital Services
Programme 6: Health Sciences and Training
Programme 7: Health Care Support Services
Programme 8: Health Facilities Management

2.2.1 Programme 1: Administration

Purpose

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

Analysis per sub-programme

Sub-programme 1.1: Office of the Provincial Minister

Rendering of advisory, secretarial and office support services.

Sub-programme 1.2: Management

Policy formulation, overall management and administration support of the department and the respective regions and institutions within the department to make limited provision and maintenance of accommodation needs.

Strategic Objectives

The programme is responsible for providing strategic leadership including overall departmental strategy development, monitoring and evaluation of the implementation thereof as well as the overall organisational administration and governance within the allocated resources.

The programme's strategic objectives for 2010/11 were:

- To provide sufficient staff with appropriate skills per occupational group.
- Development and maintenance of a financial efficiency programme to ensure under/over spending is within 1% of the annual allocated budget throughout the reporting period.
- To determine the educational qualifications and experience of 98% of the current staff by conducting a skills analysis by 2014/15.
- Ensure a 97% filled post rate within the finance components at head office throughout the reporting period.
- Ensure the implementation and maintenance of 147 organisational and post structures aligned to the CSP by 2014.

- Revitalisation and maintenance of the official website to increase optimal usage of site by 2014/15.
- Ensure that 63 institutions report monthly on financial compliance to the departmental predetermined list which addresses the shortcomings identified by the Auditor-General of South Africa.
- Maintain a 93% stock availability rate at Cape Medical Depot (CMD) during each reporting period.
- Ensure the policy maintenance of the Accounting Officers System (AOS) by end April of each reporting period.
- Development and maintenance of a procurement plan for minor and major assets by end April of each reporting period.
- Ensure that the 59 sites registered on the LOGIS or SYSPRO system account for all assets by compiling monthly reconciliation reports throughout the reporting periods.
- Improve the integrity of performance data by ensuring a 99% submission rate of prioritised data by 2014/15.
- Ensure a 98% implementation of the Hospital Information System (HIS) at all contracted hospitals by 2014/15.
- The institutionalisation and integration of QI (quality improvement) across all levels of care reflected by the timeous submission of composite reports on consumer and technical quality.

Service Delivery Objectives and Indicators

The strategic goals and objectives, as set out, in the Departmental Strategic Plan, Health Care 2010 and Comprehensive Service Plan include a detailed framework to achieve the maximum health outcomes for the people of the Western Cape.

To ensure compliance in terms of strategic objectives, strategies and action plans, human resource planning focuses on the following:

- The establishment of an effective workforce that will deliver maximum health outcomes to the people of the Western Cape;
- The development, implementation and maintenance of new aligned organisational and post structures for institutions and facilities, i.e. clinics, community health centres, district hospitals, regional hospitals, secondary hospitals as well as central hospitals;
- The relocation of staff to different places of work in accordance with the shift in services to other levels of service delivery. The major thrust being the shift of services to primary health care level; and
- The recruitment of staff according to the competencies required by the shift in focus of health service delivery.

Although relative stability exists when considering staff turnover, the occupations with the highest turnover rates are medical and other health related professions, and administrative staff, particularly at supervisory levels. This has a significant effect on the continuity of service delivery and cost of the service. The difficulty in replacing administrative staff, skilled in human resource and finance administration, especially in the rural areas, has a negative impact on service delivery.

There is an annual turnover of health professionals such as interns, registrars and community service nurses when their contracts conclude followed by an intake of new professionals in training. There is a high turnover of clinical technologists, pharmacists and technicians who are offered more lucrative packages in the private sector. It is anticipated that the occupation specific dispensation for pharmacist and allied health staff will have a positive impact on the retention and recruitment of these occupational groups.

An analysis of the competencies currently available to drive the core functions within the Department indicated that these are insufficient in certain occupational categories. A number of interventions have been identified to address scarce skills in consultation with higher education institutions (HEI's), nursing colleges, schools and key stakeholders with regard to training.

The Department has implemented internal and external bursary programmes and learnerships in an effort to attract and retain scarce skills. Incomplete information regarding employee qualifications/ skills / competencies captured on PERSAL will be addressed through specialised interventions obtained from an accredited service provider (HR Connect, a Department of Public Service Administration (DPSA) appointed outsourced service).

The Employee Health and Wellness Programme (EHWP) of the Department is an effective programme and has the potential to improve productivity, morale, motivation and work relationships. The services offered by the programme are available to all employees and their household members. Support to managers is available through the use of formal referrals and managerial consultancy services. The EHWP has two functional areas, namely:

- Individual wellness through counselling and educational efforts such as stress management, managing change and other wellness promotion strategies.
- The work-life balance programme promotes flexibility in the workplace to accommodate work, personal and family needs, which can result in benefits to the organisation due to high levels of employee satisfaction and motivation.

The overall engagement rate in the EHWP, which includes uptake of all services provided, amounted to 18.2% (4 939) during the period under review, compared to 12.7% (3 441) in the previous period. Employees formally referred for managerial consultancy during the review period amounted to 7.8% (194 cases) compared to 9.4% (267 cases) in the previous period. Approximately 3 677 face to face counselling sessions were provided for employees. Briefing sessions conducted for employees amounted to 2 490 and 154 for managers. In addition 108 interventions / training sessions were conducted and 16 wellness days / information sessions were provided. High risk groups were identified within the following areas: emergency medical services (EMS), forensic pathology services (FPS), TB hospitals and trauma units.

The Department's HIV workplace programme is guided by the transversal workplace policy on HIV and AIDS and is aimed at minimising the impact of HIV and AIDS in the workplace. A total of 4 211 employees were tested, of which 1 811 were male employees and 2 400 female employees.

The Department's sick leave profile indicates that the highest instance in the use of sick leave is captured against employees within salary levels 6 – 8, followed by employees within salary level 9 – 12. Additional awareness activities will be embarked on to prevent the abuse of sick leave. The trend in incapacity leave, applied in terms of the policy and procedure on incapacity leave and ill-health retirement (PILIR), indicates that the highest use is amongst the lower level occupational categories. However, in relation to the total workforce, the amount of employees using the Policy and procedure on incapacity leave and ill-health retirement (PILIR) is below 1%.

The approved Comprehensive Service Plan (CSP) includes maps of services per geographical area, service delivery models (from the entry level clinics to highly specialised services rendering institutions), organisation and staff establishments (per occupation / job category) for institutions, including management structures. The departmental strategic plan, Healthcare 2010, and specifically the CSP, guided the development and amendment of new and current organisational and post structures of the Department. This contributed to the development of new structures for the district health services for efficient rendering of primary health care services at district level.

The implementation of the Occupational 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. PERSAL has been updated to accommodate the new OSDs and the organisational and post structure must be aligned.

The management of the Department is highly decentralised. Administrative functions such as finance and HR are mainly performed at institutional level. The high level of decentralisation has the benefit of increased responsiveness to institutional needs, but raises challenges with respect to consistency and adherence to prescripts. An important function of the programme is to develop and implement mechanisms to achieve these objectives. One of the HR mechanisms, to ensure and monitor compliance to prescripts and procedures, is the HR Audit Action Plan which addresses risk areas identified by the Auditor-General. The afore-mentioned plan enforces monthly and quarterly monitoring and reporting on HR compliance throughout the Department.

To strengthen compliance to the application of departmental, provincial and national HR and finance policies and practices, an investigation was conducted to determine the human resource capacity required within the HR and finance components in posts on salary levels 5, 7 and 8. The outcome of the investigation was finalised and implemented during the period under review. Funding to the amount of R 18.952 million for critical supervisory level posts, which was held in Programme 1, was shifted to the various programmes during the adjustment estimates process.

As part of the Integrated Education and Training Framework of the Directorate Nursing Services, the Boland campus of the Western Cape College of Nursing (WCCN) has expanded its teaching facilities and office space for another intake of students and the appointment of more academic staff. With regards to post basic programmes, the second intake of students was admitted at the college for the Critical Care: Trauma Programme (R212). The programme for the post registration Diploma in Midwifery was approved by the South African Nursing Council and commenced at the WCCN during the 2010 academic year. The WCCN undertook a province-wide road-show to market and recruit candidates for the basic four-year programme. This resulted in improved quality of applications and increased the interest of males in the profession.

The programme performs an important role in driving cost containment and efficiencies. This is addressed at various management meetings, such as monthly top management, financial, and monitoring and evaluation meetings, where projections and saving measures are reviewed. In addition, focused project teams identify and formulate best practices, which are made available to managers for major cost items such as blood products, pharmaceuticals and medical supplies.

The Office of the Chief Financial Officer (CFO) has continued to improve financial accounting and management systems and processes. The goal is to continue to achieve an unqualified audit opinion on finance matters and reduce matters of emphasis by ensuring compliance and the strengthening of financial governance. This is achieved through progressive management action and the implementation of various dynamic management tools, namely:

- The Budget Management Instrument (BMI), whereby all expenditure is measured against budgets within respective economic classification throughout the programmes and entities of the Department on a monthly basis;
- A joint initiative with human resources exists to manage all funded posts as listed on the Approved Post List (APL);
- Review of the effectiveness of departmental expenditure through monthly reporting and assessment of its expenditure against performance indicators;
- Vetting, budgeting and reporting of results, per cost centre and/or functional business unit, are implemented at different stages of maturity throughout the Department; and

- Monthly reporting and monitoring of compliance to financial and supply chain prescripts and procedures by means of a Compliance Monitoring Instrument (CMI) that monitors departmental compliance to said prescripts.

The Department also developed a strategy to address audit findings on predetermined objectives:

- Improving the organisational culture around information management.
- Strengthening systems, processes and standard operating protocols to improve data quality.
- Developing a set of policies and instruments to acquire compliance with information management prescripts.
- Managing the risks including reducing the number of indicators and data elements that are routinely collected.
- Developing a proposal to strengthen information management capacity at various levels.
- Initiating a process to address the range of IT challenges.

Table 2.2.1: Public health personnel 2010/11

Categories	Number employed	% of total employed	Number per 1 000 people	Number per 1 000 uninsured people	Vacancy rate	% of total personnel budget	Annual cost per staff member
Medical officers	1 881	6.55%	0.33	0.07	4.37%	15.97%	573 407
Medical specialists	570	1.98%	0.10	0.01	3.88%	8.82%	1 044 408
Dental specialists	28	0.10%	0.00	0.01	3.45%	0.26%	620 830
Dentists	66	0.23%	0.01	0.00	5.71%	0.64%	650 649
Professional nurse	5 479	19.08%	0.97	0.37	3.06%	23.86%	293 991
Enrolled nurses	2 275	7.92%	0.40	0.11	2.11%	5.79%	171 830
Enrolled nursing auxiliaries	4 058	14.13%	0.72	0.12	1.60%	8.62%	143 486
Student nurses	-	-	-	-	-	-	-
Pharmacists	362	1.26%	0.06	0.02	7.42%	2.06%	83 297
Physiotherapists	126	0.44%	0.02	0.01	3.08%	0.45%	245 752
Occupational therapists	130	0.45%	0.02	0.01	2.26%	0.46%	177 504
Clinical psychologists	69	0.24%	0.01	0.01	6.76%	0.34%	1 640 275
Radiographers	417	1.45%	0.07	0.01	2.34%	1.68%	811 796
Emergency medical staff	1 619	5.64%	0.29	0.25	3.86%	5.01%	12 824
Dieticians	80	0.28%	0.01	0.01	10.11%	0.31%	3 338 843
Other allied health professionals and technicians	1 246	4.34%	0.22	0.14	8.38%	3.96%	1 18 365
Managers, administrators and all other staff	10 317	36.92%	1.83	0.80	5.38%	21.78%	654 451
Grand Total	**28 723**	**100%**	**5.10**	**1.97**	**4.10%**	**100%**	**235 072**

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2010/11 ANNUAL PERFORMANCE PLAN

Table 2.2.2: Human resources 2011/12

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Ensure and maintain organisational strategic management capacity and synergy.	1.1 To have an effective and efficient and skilled workforce.	1.1.1 To provide sufficient staff with appropriate skills per occupational group.	1) Number of medical officers per 100 000 people	32.42	21.83	33.38	32.18	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	1 808	1 230	1 881	-	
			Denominator:	5 576 765	5 634 323	5 634 323	-	
			2) Number of medical officers per 100 000 people in rural districts	14.64	15.96	17.12	16.80	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	286	305	327	-	
			Denominator:	1 953 305	1 909 976	1 909 976	-	
			3) Number of professional nurses per 100 000 people	91.42	92.30	97.24	88.57	Performance better than target set. The implementation of the occupation specific dispensation may have contributed to the recruitment and retention of professional nurses.
			Numerator:	5 098	5 201	5 479	-	
			Denominator:	5 576 765	5 634 323	5 634 323	-	
			4) Number of professional nurses per 100 000 people in rural districts	80.73	82.93	86.23	82.48	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	1 577	1 584	1 647	-	
			Denominator:	1 953 305	1 909 976	1 909 976	-	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			5) Number of pharmacists per 100 000 people	6.15	5.93	6.42	5.96	Performance better than target set. The implementation of the occupation specific dispensation may have contributed to the recruitment and retention of pharmacists.
			Numerator:	343	334	362	-	
			Denominator:	5 576 765	5 634 323	5 634 323	-	
			6) Number of pharmacists per 100 000 people in rural districts	5.63	5.55	5.92	5.91	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	110	109	113	-	
			Denominator:	1 953 305	1 909 976	1 909 976	-	
			7) Vacancy rate for professional nurses	1.9%	5.56%	3.06%	23%	Actual performance is based on vacant funded posts. The target was set on vacant funded and unfunded posts. The vacancy rate on funded and unfunded posts is 24.09%.
			Numerator:	-	306	173	-	
			Denominator:	-	5 507	5 652	-	
			8) Vacancy rate for medical officers	16%	5.73%	4.37%	13%	Actual performance is based on vacant funded posts. The target was set on vacant funded and unfunded posts. The vacancy rate on funded and unfunded posts is 15.45%.
			Numerator:	-	-	86	-	
			Denominator:	-	-	1 967	-	
			9) Vacancy rate for medical specialists	22%	6.64%	3.88%	19%	Actual performance is based on vacant funded posts. The target was set on vacant funded and unfunded posts. The vacancy rate on funded and unfunded posts is 12.46%.
			Numerator:	-	-	23	-	
			Denominator:	-	-	593	-	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			10) Vacancy rate for pharmacists	28%	12.34%	7.42%	24%	Actual performance is based on vacant funded posts. The target was set on vacant funded and unfunded posts. The vacancy rate on funded and unfunded posts is 27.19%.
			Numerator:	-	-	29	-	
			Denominator:	-	-	391	-	
			11) Attrition rate professional nurses	6.26%	7.00%	7.24%	6%	380 service terminations occurred in the fourth quarter of which 210 were community service contract terminations.
			Numerator:	-	327	380	-	
			Denominator:	-	4 666	5 252	-	
			12) Absenteeism professional nurses	2.68%	3.3%	1.5%	3%	Absenteeism has declined throughout the reporting period. The implementation of the occupation specific dispensation for nurses may have been a contributing factor.
			Numerator:	-	38 407	20 173	-	
			Denominator:	-	1 164 843	1 336 049	-	

Reasons for major variances

Human Resources (excluding health sciences and training

Strategic objective: To provide sufficient staff with appropriate skills per occupational group.

- Vacancy rates: The vacancy targets were determined on vacant funded and unfunded posts. The actual performance reported was, however, on vacant funded posts.

  The actual performance based on vacant funded and unfunded posts is as follows:
  Professional nurses: 24.09% against the target of 23%;
  Medical officers: 15.45% against the target of 13%;
  Medical specialists: 12.46% against the target of 19% and
  Pharmacists: 27.19% against the target of 24%.

- Attrition rate for professional nurses: The average attrition rate for the first three quarters was 2.60%. The attrition rate for the fourth quarter was 7.24% against a target of 6%. The reason for the high attrition rate in comparison to the first three quarters is as a result of the service termination of 210 community service nurses.

- Absenteeism for professional nurses: Absenteeism has declined in comparison to previous reporting years. The implementation of the occupational specific dispensation may have contributed to the decline in the absenteeism rate.

Table 2.2.3: Performance against targets from the 2010/11 Annual Performance Plan for the Administration Programme

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Ensure a sustainable income to provide the required health service.	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	2%	(1%)	0.51%	1%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department. The numerator for the target was incorrectly stated as the expenditure and should have been the budget minus the expenditure: (R 11.962 bn – R 11.843 bn = R 119 million). The actual expenditure for each year was: • R 8.655 bn (2008/09) • R 10.556 bn (2009/10) • R 12.344 bn (2010/11)
			Numerator:	0.215 bn	(0.093 bn)	0.064 bn	11.843 bn	
			Denominator:	8.870 bn	10.463 bn	12.408 bn	11.962 bn	
2. Develop and maintain a capacitated workforce.	2.1 Develop and maintain a comprehensive human resources 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 staff	-	31%	61.2%	62%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	-	8 883	18 331	17 766	
			Denominator:	-	28 656	29 951	28 656	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	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 period.	3) Percentage of filled finance posts at head office	-	88%	78.8%	95 %	The number of posts filled increased during the year under review from 136 to 156, but was still below the initial target of 169.
			Numerator:	-	157	156	169	
			Denominator:	-	178	198	178	
3. Ensure organisational strategic management capacity and synergy.	3.1 Implement and maintain the organisational and post structures of the Comprehensive Service Plan (CSP).	3.1.1 Ensure the implementation and maintenance of 147 organisational and post structures aligned to the CSP by 2014.	4) Number of organisational and post structures, aligned with the CSP, implemented by 2014/15	-	67	94	85	Performance better than target set. The implementation of organisational and posts structures are dependent on the finalisation of work study reports. This makes the implementation timeframes (setting of targets) difficult to forecast.
			5) Number of implemented organisational and post structures of head office	-	2	14	11	Performance better than target set. The implementation of organisational and posts structures are dependent on the finalisation of work study reports. This makes the implementation timeframes (setting of targets) difficult to forecast.
			6) Number of implemented organisational and post structures of central and dental hospitals	-	0	0	1	The implementation of organisational and posts structures are dependent on the finalisation of work study reports. This makes the implementation timeframes (setting of targets) difficult to forecast.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			7) Number of implemented organisational and post structures of the office of the Chief Director: Regional Hospitals, Mental Health & EMS	-	2	3	3	Target achieved.
			8) Number of implemented organisational and post structures of metro hospitals of the Chief Directorate: Regional Hospitals, Mental Health & EMS	-	0	1	1	Target achieved.
			9) Number of implemented organisational and post structures of TB and infectious diseases hospitals	-	2	4	2	Performance better than target set. The implementation of organisational and posts structures are dependent on the finalisation of work study reports. This makes the implementation timeframes (setting of targets) difficult to forecast.
			10) Number of implemented organisational and post structures of Associated Psychiatric Hospitals	-	2	3	2	Performance better than target set. The implementation of organisational and posts structures are dependent on the finalisation of work study reports. This makes the implementation timeframes (setting of targets) difficult to forecast.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			11) Number of implemented organisational and post structures of Emergency Medical Services	-	9	13	11	Performance better than target set. The implementation of organisational and posts structures are dependent on the finalisation of work study reports. This makes the implementation timeframes (setting of targets) difficult to forecast.
			12) Number of implemented organisational and post structures of Metro District Health Services (9 district hospitals & 4 PHC sub-structures)	-	0	4	4	Target achieved.
			13) Number of implemented and maintained organisational and post structures of rural District Health Services (25 district hospitals & 5 districts)	-	50	52	50	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	3.2 An effective and viable departmental website to serve as the primary source of communication for internal stakeholders.	3.2.1 Revitalisation and maintenance of the official website to increase optimal usage of site by 2014/15.	14) Number of Chief Directorates' policies and practices posted and maintained on the Department's official website	-	Website under re-construction	8	8	Target achieved.
	3.3 Provide an effective financial compliance reporting tool.	3.3.1 Ensure that 63 institutions report monthly on financial compliance to the departmental predetermined list which addresses the shortcomings identified by the Auditor-General of South Africa.	15) Number of institutions submitting monthly finance compliance reports	-	40	75	63	Performance better than target set. Due to an increase in the number of institutions having to report, with the implementation of the compliance monitoring instrument, the target was surpassed.
	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.	16) Percentage of pharmaceutical stock availability at the CMD	90%	93%	96%	93%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	661	685	720	685	
			Denominator:	735	735	749	735	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	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.	17) Provision of the Accounting Officers System policy	0	1	1	1	Target achieved.
		3.5.2 Development and maintenance of a procurement plan for minor and major assets by end April of each reporting period.	18) Provision of a procurement plan	1	1	0	1	The development of the procurement plan was divided into four equipment streams, namely vehicles, computer, medical and utilities. The procurement of the vehicles and computer equipment has been finalised. The remaining two streams i.e. medical and utilities, have not been finalised. The development of the procurement plan, as a whole, has therefore not been achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		3.5.3 Ensure that the 59 sites registered on the LOGIS or SYSPRO system account for all assets by compiling monthly reconciliation reports throughout the reporting periods.	19) Number of registered sites compiling asset reconciliation reports	Not required to report	Not required to report	58	59	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
	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.	20) Data submission rate of prioritised data sets	Not required to report	92%	93.2%	92%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	-	13 637	13 227	12 729	
			Denominator:	-	14 796	14 186	13 836	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
4. Ensure the provision of infrastructure that meets the needs of current and future development.	4.1 Provide infra-structure to support workforce development.	4.1.1 Ensure a 98% implementation of the Health Information System (HIS) at all contracted hospitals by 2014/15.	21) Percentage of hospitals where the HIS has been implemented	58.5%	71%	73.2%	78%	Due to human resource capacity constraints an embargo was placed on the further implementation of the HIS and an investigation conducted to determine the appropriate staffing levels required.
			Numerator:	24	29	30	32	
			Denominator:	41	41	41	41	
5. To improve the quality of health services.	5.1 The institu-tionalisation 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 institu-tionalisation and integration of QI across all levels of care reflected by the timeous submission of composite reports on consumer and technical quality.	22) Number or organisational structures (APH; central hospitals; districts; CD: Regional hospitals and EMS) submitting composite QI reports	-	6	8	8	Target achieved.

Reasons for major variances

HUMAN RESOURCES

Strategic objective: To determine the educational qualifications and experience of 98% of the current staff by conducting a skills analysis.

Percentage of occupational skills analysis completed for staff

All data regarding the experience and qualifications of staff have been recorded on the personnel files. The data is still to be captured onto the PERSAL system by human resource offices at district / regional level. The magnitude of this exercise was a challenge due to lack of staff capacity.

To assist in the capturing of the data on the PERSAL system, the recruitment of contract staff to perform this function for a specified timeframe is being considered. A pilot project has commenced with a view of expanding the project throughout the Department.

Strategic objective: Ensure the implementation and maintenance of 147 organisational and post structures aligned to the Comprehensive Service Plan.

Implementation of organisational and post structures

The implementation of organisational structures is dependent on the finalisation of the organisational work study reports. This makes the implementation timeframes (setting of targets) difficult to forecast. The targets that were exceeded / not achieved are as follows:

- Number of implemented organisational and post structures of head office: The Department succeeded in finalising and implementing three organisational and post structures above target.
- Number of implemented organisational and post structures of TB and infectious diseases hospitals: The Department succeeded in finalising and implementing two organisational and post structures above target.
- Number of implemented organisational and post structures of associated psychiatric hospitals: The Department succeeded in finalising and implementing one organisational and post structure above target.
- Number of implemented organisational and post structures of emergency medical services: The Department succeeded in finalising and implementing two organisational and post structures above target.
- Number of implemented organisational and post structures of rural district health services (25 district hospitals and 5 districts: The Department succeeded in finalising and implementing two organisational and post structures above target.
- Number of implemented organisational and post structures of central and dental hospitals: The target was not achieved. The final organisational work study report has been issued to the Department. Upon approval by the Head of Department, implementation of the organisational and post structures on PERSAL will commence.

FINANCIAL MANAGEMENT

Strategic objective: 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.

Percentage under/over spending of the annual allocated budget

The surplus at year end was equal to 0.5% of the budget of R12.408 billion.

Strategic objective: Ensure optimal staff levels within the finance components at Head Office.

Percentage of filled finance posts at head office

The number of posts filled increased during the year under review from 136 to 156, but was still below the initial target of 169. In addition, more posts were made available to Finance, to strengthen the application of departmental, provincial and national financial policies, practices and measures, resulting in a less than desirable percentage filled.

Strategic objective: Provide an effective financial compliance reporting tool.

Number of institutions submitting monthly finance compliance reports

The target was achieved. The Financial Reporting Tool (FRT) was replaced by the financial Compliance Monitoring Instrument (CMI). The revised reporting tool was aimed at improving financial compliance. Due to an increase in the number of institutions having to report, the target increased from 63 to 75.

Strategic objective: Raise supply chain management to level 3 compliance.

Provision of a procurement plan

The target was not achieved. The supply chain strategy for the equipment streams vehicles and computer equipment was finalised but the medical and utilities equipment was not finalised by the end of the reporting period.

STRATEGY AND HEALTH SUPPORT

Strategic objective: Provide infra-structure to support workforce development.

Ensure a 95% implementation of the Hospital Information System (HIS) at all contracted hospitals

The target was not achieved. A moratorium was placed on the further implementation of the HIS due to human resource capacity constraints. An organisational work study investigation was conducted during the reporting period to determine the required staffing levels.

2.2.2 Programme 2: District Health Services

Purpose

To render primary health care and district hospital services.

Analysis per sub-programme

Sub-programme 2.1: District Management

Planning and administration of services, managing personnel and financial administration and the co-ordinating and management of the day hospital organisation and community health services rendered by local authorities and non-governmental organisations within the Metro and determining working methods and procedures and exercising district control.

Sub-programme 2.2: Community Health Clinics

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

Sub-programme 2.3: Community Health Centres

Rendering a primary health 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.

Sub-programme 2.4: Community Based Services

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

Sub-programme 2.5: Other Community Services

Rendering environmental and port health etc.

Sub-programme 2.6: HIV and Aids

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

Sub-programme 2.7: Nutrition

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

Sub-programme 2.8: Coroner Services

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

Sub-programme 2.9: District Hospitals

Rendering of a hospital service at district level.

Sub-programme 2.10: Global Fund

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

Strategic Objectives

The programme's strategic objectives for 2010/11 were:

- Achieve a PHC utilisation rate of 3.84 visits per annum by 2014/15.
- Achieve a primary health care (PHC) expenditure of R 950 per uninsured person by 2015 (in 2009 rands).
- Employ 37 family medicine specialists and 80 family medicine registrars to work within the district health system.
- Establish 2 673 acute district hospital beds in the DHS by 2014/15.
- Achieve a provincial district hospital expenditure of R 365 per uninsured person by 2015 (in 2008/09 rands).
- Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15 – 24 years to 8% in 2015.
- Reduce the mortality in children under the age of 5 years to 30 per 1 000 live births by 2015.
- Reduce the maternal mortality ratio to 90 per 100 000 live births by 2015.

The performance indicators of the district health services programme for the year 2010/11 can be divided into five broad areas:

- District health system functionality and efficiency;
- District hospital functionality and efficiency;
- HIV and AIDS, STI and TB (HAST);
- Maternal, Child and Women's Health (MCWH); and
- Disease prevention and control.

Service Delivery Objectives and Indicators

DISTRICT HEALTH SYSTEM

The District Health System (DHS) should be seen as the vehicle for the delivery of a comprehensive primary health care (PHC) and district hospital service. The underlying principle is that the resident population of a geographical area (a district) have access to health services through tiered levels of care. Different packages of care are made available at each level within this tiered system.

Community Based Services (CBS), mainly provided by community care workers (CCW), are regarded as the base of the DHS. This is followed (in ascending order of complexity of health-care packages offered) by a range of staff competencies in the respective health facilities. The first level of contact being at nurse-led community clinics (some of which receive visiting doctor support), followed by community day centres, community health centres and then district hospitals. The Department strives to deliver these health service packages in as efficient a manner as possible.

The DHS should be viewed as a system in transition. The impetus is to establish a decentralised, district-based model of service delivery with a strong nurse-driven, doctor-supported system at its base that requires effective management and clinical governance oversight. It is therefore important to improve PHC facility supervision and expand the pool of family physicians in order to effect proper clinical governance.

In order to achieve efficiency gains and in line with the principle of client-centredness, the DHS endeavours to manage health-seeking clients at the most appropriate level of care in accordance with their health needs. This necessitates the strengthening of the entry level tiers of the system. Related to this goal, the DHS has implemented alternative models for the public to access services and medicines, through community based services and the chronic dispensing unit (CDU).

The overall picture to emerge from the DHS indicators, notwithstanding some data verification challenges, in particular in relation to supervision visits to PHC facilities, is one of a service shift to entry level tiers with good doctor cover and a growing level of clinical governance support. This is reflected in an increase in CBS headcounts and 47% of PHC headcounts seen at nurse-driven community health clinics.

This evolution of the system is occurring in the financial context of continuing to increase the year-on-year allocation of resources and spending in PHC services while staying within the financial target for the 2010/11 financial year.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2010/11 ANNUAL PERFORMANCE PLAN

Table 2.2.4: Performance against targets from the 2010/11 Annual Performance Plan for the District Health Services programme

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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 annum by 2014/15.	1) Utilisation rate – PHC	2.8	3.0	2.9	3.1	Below target. The rate is lower than target because the numerator (PHC total headcount) is 7% lower than the target. This carries through in all indicators that include PHC headcount as discussed in the narrative below the table.
			Numerator:	15 051 210	15 848 973	16 206 552	17 466 401	
			Denominator:	5 299 999	5 321 416	5 634 323	5 634 323	
			2) PHC total headcount	15 051 210	15 848 973	16 206 552	17 466 401	Below target. PHC headcount approximately 1.3 million below target. Discussed in the narrative below the table.
			3) Utilisation rate – PHC under 5 years	4.9	5.0	4.7	5.0	Below target. As for indicator 1 (Utilisation rate – PHC).
			Numerator:	2 436 479	2 527 588	2 453 947	2 636 075	
			Denominator:	495,993	497,995	527,215	527 215	
			4) PHC total headcount – under 5 years	2 436 479	2 527 588	2 453 946	2 636 075	Below target. As for indicator 2 (PHC total headcount).
			5) Supervision rate	70.3%	98.3%	88.9%	100%	Below target. The indicator definition was not consistent over the years (note varying denominator). The data also shows considerable variability in month-by-month performance and this may reflect poor data quality.
			Numerator:	785	3 526	263	296	
			Denominator:	1 116	3 588	296	296	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			6) Percentage of community health centres with a resident doctor	Not required to report	Not required to report	94.3%	100%	Three CHCs without a resident doctor reported from Metro district.
			Numerator:	-	-	50	53	
			Denominator:	-	-	53	53	
			7) Percentage of fixed clinics supported by a doctor at least once a week	75.3%	95.6%	90.0%	70%	Over target. In facilities where a doctor visits more than once in a week, each visit might be counted separately, rather than recording the fact that the site is being supported at least once during that week.
			Numerator:	280	283	208	162	
			Denominator:	372	296	231	232	
			8) Professional nurse clinical workload (PHC)	Not required to report	Not required to report	47.5	55	Below target. Rural districts, on average, approximate the target, but because a higher proportion of cases are seen by doctors in the Metro (12% of headcount versus 2 – 3% of headcount in the rural districts), the provincial average is lowered.
			Numerator:	-	-	14 822 459	17 466 401	
			Denominator:	-	-	311 729	317 571	
			9) Doctor clinical workload (PHC)	21	21	24.5	25	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	1 701 788	1 661 983	1 930 757	*(2 119 750)*	
			Denominator:	81 547	79 587	78 851	*(84 790)*	
			10) Number of NPO appointed home carers	2 455	2 491	2 584	2 245	Over target. Additional funding was received and more carers could be employed.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			11) Total CBS headcount	Not required to report	2 717 130	4 645 210	3 300 000	Over target. More CBS staff employed, concerted effort by DHS to shift services to CBS level, CBS workers involved in many mass campaigns during the year.
			12) Number of palliative / sub-acute and chronic care beds	Not required to report	774	743	872	Below target. Loss of planned beds due to transfer from the Conradie Hospital premises.
			13) Number of prescriptions dispensed through the CDU	Not required to report	Not required to report	1 711 152	1 938 354	Below target. Target erroneously set from incorrect baseline. Actual CDU dispensations in 2010/11 were 27% up from 2009/10. See narrative below table.
2. Ensure a sustainable income to provide the required health services according to the needs.	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 R 950 per uninsured person by 2015 (in 2009 rands).	14) Provincial expenditure per PHC headcount in 2008/09 prices[6] [7] Numerator: Denominator:	R 219 3 300 286 000 15 051 210	R 232 3 680 125 157 15 848 973	R 263 4 261 262 352 16 206 552	R 234 *(4 087 137 800)* *(17 466 401)*	The PHC headcount for the year was 7.2% less than expected and this, coupled with the higher than expected expenditure, resulted in a higher cost per PHC headcount. An explanation is provided for the decrease in the PHC headcount in the narrative below the table.

6 The historical information for 2008/09 and 2009/10 was changed from the figures reported in the 2009/10 Annual Report. Previously the expenditure and headcount information (numerator and denominator) excluded the data from the City of Cape Town Metropolitan Municipality. This has now been corrected to include the PGWC funding provided to City of Cape Town as well as the headcount (number of patients) seen by City of Cape Town facilities.

7 The expenditure per PHC headcount targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per PHC headcount reported in the Annual Report have also been multiplied by the same factor.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			15) Provincial PHC expenditure per uninsured person in 2008/09 prices[8] [9]	R 767	R 837	R 948	R 909	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	3 300 286 000	3 680 125 157	4 261 262 352	*(4 087 137 800)*	
			Denominator:	4 301 882	4 396 294	4 490 706	*(4 496 301)*	
3. Improve the quality of health services.	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) Number of family physicians appointed in the District Health System	13	19	18	20	Below target. Two clinicians resigned late in the year.
			17) Number of family medicine registrars employed in the District Health System	31	49	64	70	Below target. Target might have been over-ambitious since the actual performance over the last two years shows an average year-on-year increase of greater than 50% in the number of registrars employed.

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

8 The historical information for 2008/09 and 2009/10 was changed from the figures reported in the 2009/10 Annual Report. Previously the expenditure (numerator) excluded the data from the City of Cape Town Metropolitan Municipality. This has now been corrected to include the PGWC funding provided to City of Cape Town.

9 The expenditure per uninsured person targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per uninsured person reported in the Annual Report have also been multiplied by the same factor.

Reasons for major variances

PHC total headcount and other indicators derived from it

The primary health care services recorded about 1.3 million less headcounts than was targeted for the year (this amounts to 7% of total target). Possible reasons include:

(i) The target (10% increase on previous year's actual attainment) was set on the basis of an erroneously high projected PHC headcount during the previous financial year. The actual PHC headcount increase from 2008/09 to 2009/10 was only 5.3%.

(ii) The HCT and EPI campaigns mentioned above necessitated that staff were absent from facilities, and the activities of these campaigns were not recorded in the routine monitoring system. This effect is particularly evident in headcount data in the first quarter of the year.

(iii) The reduction of about 1.3 million is mirrored by a similar increase in community based services volumes for the year, indicating that some of the reduction in PHC headcount might be the effect of services shifting to the appropriate tier. With CBS set to assume an increasingly important role in service delivery in the future, it is incumbent on programme 2 to develop strong management support and monitoring and evaluation support for this tier.

Supervision rate

Of 296 fixed facilities, only 263 recorded a supervisor visit at least once a month. Data shows considerable variability in month-by-month performance and this may reflect poor data quality.

Number of NPO appointed home-carers

The target of 2 245 was derived from the 2009/10 baseline and no expansion was planned for 2010/11 as the European Union (EU), which was co-funding the programme, was due to exit in March 2010. However alternative funding was found within programme 2 and was allocated for staff. In addition, the Expanded Public Works Programme, which was also funding part of the HBC programme as part of the European Union exit strategy, was allocated an additional R 2 million.

Total CBS headcounts

The target for CBS headcount was 3.3 million and the achievement was 4.6 million (40.8% over target). This is because of the increased number of care-workers hired and the fact that there was a measles campaign in the first quarter in which the care-workers participated. There were also a number of prevention and promotion campaigns during the year in which the care-workers participated. These included the national HCT campaign, the women's health season and the infectious disease season as from December 2010.

Number of palliative / sub-acute and chronic care beds

The target was 872 and achievement 737 (15.5% below target). There was a planned expansion of 90 beds which had to be cancelled as the Lentegeur site, earmarked for this expansion, was allocated for the relocation of the supporting NGO Lifecare instead. Lifecare, which had been accommodated on the Conradie Hospital site, had to be relocated due to the sale of the property and during the course of the year it reduced its number of beds from 280 to 250.

Chronic Dispensing Unit

The Annual Performance Plan contained an erroneous target, based not just on the previous year's CDU performance, but also on other alternative drug distribution channels. When reviewing only the CDU's output between 2009/10 and 2010/11 the number of prescriptions issued increased from 1.35 million to 1.71 million, which is a 27% increase.

Provincial expenditure per PHC headcount in 2008/09 prices

The PHC headcount for the year was 7.2% less than expected and this, coupled with the higher than expected expenditure, resulted in a higher cost per PHC headcount.

DISTRICT HOSPITALS

The package of care provided at district hospitals includes emergency centre care, adult and children inpatient and outpatient care, and obstetric care. There is a varying quantum of general specialist services offered at the larger district hospitals to improve access and to facilitate easy referral to regional hospital facilities which deliver predominantly general specialist services. District hospitals need to deliver outreach and support to PHC facilities in their drainage areas and are often the custodians of clinical governance for the sub-districts.

They also serve as the first health-service contact point for many acutely ill clients requiring hospital admission. Furthermore, in most of the rural areas of the Western Cape Province, and some parts of the Metro, they directly receive, via the emergency medical services (EMS), serious medical or surgical emergencies.

The district hospital indicators demonstrate that access to district hospitals (number of beds, number of admissions, average length of stay, etc.) is generally good, while some district hospitals perform a significant number of caesarean sections (used as a proxy for access to emergency obstetrical care, and, more broadly, emergency care).

Table 2.2.5: Performance against targets from the 2010/11 Annual Performance Plan for District Hospital Services

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 Increase access to acute services/ district hospital services in the DHS in the Western Cape.	1.1.1 Establish 2 673 acute district hospital beds in the DHS by 2014/15.	1) Number of district hospital beds	2 312	2 464	2 482	2 452	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			2) Caesarean section rate for district hospitals	20.6%	21.8%	23.3%	20%	Over target. Performance brought up by three large hospitals that have an average caesarean section rate of 37%. Probably relates to the fact that these hospitals are located in high burden areas and have either taken on some level two responsibilities (skilled staff) or retained some level two responsibilities.
			Numerator:	6 093	6 587	6 761	*(6 382)*	
			Denominator:	29 648	30 078	29 019	*(31 912)*	
			3) Total separations in district hospitals	221 365	238 085	237 292	239 996	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			4) Patient day equivalents in district hospitals	963 020	986 481	999 260	1 067 814	Below target. Due to slightly less than expected numbers in the "inpatient days" component of the PDE definition.
			5) OPD total headcount in district hospitals	508 504	504 673	565 801	580 545	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			6) Average length of stay in district hospitals	3.1 days	3.0 days	2.9 days	3.1 days	Below target. Numerator (inpatient days) lower than expected.
			Numerator:	682 960	705 098	698 661	*(743 988)*	
			Denominator:	221 365	238 085	237 292	*(239 996)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			7) Bed utilisation rate (based on usable beds) in district hospitals	80.9%	78.4%	77.1%	82%	Below target. Numerator (In-patient days) lower than expected.
			Numerator:	682 960	705 098	698 661	*(782 969)*	
			Denominator:	843 880	899 360	905 959	*(954 840)*	
			8) District hospitals with mortality and morbidity meetings every month	62.5%	73.5%	58.8%	75%	Below target. See further explanation in narrative. All Metro Hospitals had 100% M & M rate. Data collection challenge.
			Numerator:	20	25	20	26	
			Denominator:	32	34	34	34	
			9) Percentage of district hospitals with clinical audit meetings every month	65.6%	47.1%	67.6%	80%	Below target. See further explanation in narrative. All Metro Hospitals had 100% clinical audit rate. Data collection challenge.
			Numerator:	21	16	23	28	
			Denominator:	32	34	34	34	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1 Allocate sufficient funds to ensure access to the full package of quality district hospital services by 2014.	2.1.1 Achieve a provincial district hospital expenditure of R 365 per uninsured person by 2015 (in 2008/09 rands).	10) Provincial district hospital expenditure per uninsured person[10]	R 270	R 317	R 375	R 359	Target exceeded due to OSD and inflationary pressure. (Expenditure includes infrastructure cost from Programme 8.)
			Numerator:	1 163 362 000	1 393 693 459	1 684 846 581	*(1 614 170 000)*	
			Denominator:	4 301 882	4 396 294	4 490 706	*(4 496 301)*	
			11) Expenditure per patient day equivalent (PDE) in district hospitals [Constant 2008/09 rands][11]	R 1 070	R 1 218	R 1 310	R 1 196	Above target. There was a slightly higher expenditure than projected within the district hospital account and a slightly lower than expected number of PDEs. See narrative.
			Numerator:	1 030 902 000	1 201 414 465	1 308 965 281	*(1 277 100 000)*	
			Denominator:	963 020	986 481	999 260	*(1 067 814)*	

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

10 The expenditure per uninsured person targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per uninsured person reported in the Annual Report have also been multiplied by the same factor.

11 The expenditure per PDE targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per PDE reported in the Annual Report have also been multiplied by the same factor.

Reasons for major variances

Caesarean section rate

The provincial performance is raised by three large hospitals (Karl Bremer, Khayelitsha and Helderberg Hospitals) that have an average caesarean section rate of 37%. The denominator for these hospitals excludes all the normal deliveries delivered at midwife obstetric units (MOUs) in their drainage areas, which reflects an erroneously high rate, as only "complicated cases" are referred to the hospitals. It should be noted that in terms of the Comprehensive Service Plan, two of the three hospitals have been re-assigned as district hospitals (whereas they previously offered some level two services) and the third is a district hospital service operating from the premises of a tertiary institution.

All indicators derived from inpatient days

The district hospitals are busy, carrying approximately 96 cases per bed per year. Nevertheless, the total inpatient days are slightly lower than target. In June and July of 2010 the ten busiest district hospitals recorded an average of 10% fewer inpatient days than in the first two month of the year. This may be seasonal variation but it is an interesting coincidence that the timing aligns with that of the Soccer World Cup held in South Africa.

Mortality and morbidity (M & M) meetings and clinical audit meetings

Clinical governance, using the proxy of M&M meetings and clinical audit meetings in district hospitals, underperformed against the target. It appears as if there may be confusion amongst clinicians as to what constitutes an M&M meeting (as well as the type of quorum required) and the same might apply to clinical audit meetings. Further support from managers might help raise the profile, and value, of these meetings amongst clinicians.

HIV AND AIDS, STI AND TB (HAST)

The principal mandate of the HAST sub-programme is to co-ordinate a provincial response to the causes and consequences of the HIV epidemic. As such it needs to focus both on prevention and treatment of the two major infectious diseases that beset the Western Cape.

In terms of HIV prevention, the focus areas are the prevention of adult sexual transmission of HIV (through sexually transmitted infection (STI) management and barrier contraceptive (condom) distribution) and the prevention of HIV transmission from mother-to-child.

One of the serious consequences of caring for a large population of HIV-infected individuals, who are at high risk for opportunistic infections, is a resurgent epidemic of drug-sensitive TB and an emerging epidemic of drug-resistant TB. Considerable attention needs to be given to this constant threat and early detection, and case-holding, of TB-infected individuals is paramount.

It is worth noting that the HAST program co-ordinated two major national campaigns in 2010/11. An HCT (HIV counselling and testing) campaign and an ART (anti-retroviral therapy) scale-up campaign. These campaigns went well and this is reflected in the performance of some indicators.

This sub-programme is performing well in terms of HIV testing, ART initiation and TB outcomes but more focused attention needs to be given to HIV prevention strategies and monitoring.

Table 2.2.6: Performance against targets from the 2010/11 Annual Performance Plan for HIV and AIDS, STI's and TB Control

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 MDG Goal 6: Have halted and begun to reverse the spread of HIV and AIDS and TB by 2015.	1.1.1 Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15-24 years to 8% in 2015.	1) HIV prevalence in women aged 15 – 24 years[12]	Not required to report	Not required to report	14.9%	10%	Below target. Figure based on an annual prevalence survey. Target might be too ambitious. Reducing prevalence in an age-band that spans 10 years might take longer than originally envisaged.
			2) Total registered patients receiving anti-retroviral therapy (ART patients)	54 703	75 002	96 284	90 968	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			3) Number of new ART patients	Not required to report	23 291	29 726	26 976	Above target. ART scale-up and revised criteria with regards to qualification for ART contributed to this
			4) Fixed facilities with any ARV drug stock out	0.2%	0.3%	0%	0%	Target achieved.
			Numerator:	10	1	0	0	
			Denominator:	4 944	296	296	296	
			5) Male condom distribution rate from public sector health facilities	33.6 (per male 15 years and older)	38.8 (per male 15 years and older)	44.2 (per male 15 years and older)	52(per male 15 years and older)	Below target. Underperformance in certain sub-districts. Possibly due to lack of designated individuals within each sub-district responsible for logistics. See narrative.
			Numerator:	63 830 181	74 081 286	89 376 081	104 000 000	
			Denominator:	1 901 372	1 909 053	2 021 542	2 000 000	

12 Data are reported from the national component of the HIV antenatal survey.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			6) STI partner treatment rate	19.9%	21.7%	29.2%	21%	Above target. This indicator relies on an accurate distinction between a "new" STI case and a "partner" STI case. This is a difficult distinction to maintain at the level of clinical consultation.
			Numerator:	19 110	15 514	20 292	19 320	
			Denominator:	96 270	71 350	69 406	91 000	
			7) Percentage of clients tested for HIV to those counselled (excluding antenatal)	95.6%	96.7%	97.4%	91%	Above target. A concerted national and provincial HCT campaign, which probably raised awareness of the importance of HIV testing amongst the general public, combined with a change in policy to provider-initiated HIV testing, probably accounts for the major increase in the number of clients who received counselling and testing.
			Numerator:	353 959	397 704	747 139	503 858	
			Denominator:	370 306	411 411	767 174	554 244	
			8) TB treatment interruption rate	9.2%	8.2%	7.0%	9%	Above target. Enhanced TB response interventions were instituted during the course of the year.
			Numerator:	1 534	1 322	1 103	1 446	
			Denominator:	16 703	16 194	15 761	16 076	
			9) TB sputa results received in less than 48 hours	53.9%	54.1%	59.7%	52%	Above target. A circular clarifying the sputum collection process and the assistance of the NHLS contributed to the over-performance.
			Numerator:	289 326	299 162	327 665	37 134	It appears as if one digit was inadvertently omitted when the target was set.
			Denominator:	536 834	552 883	548 903	71 412	
			10) New smear positive PTB cure rate	77.8%	79.4%	80.5%	79%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	12 990	12 853	12 689	12 700	
			Denominator:	16 703	16 194	15 761	16 076	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			11) Smear conversion rate at 2 months for new smear positive PTB cases	70.6%	72.1%	75.6%	74%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	11,516	11,263	11 683	11 896	
			Denominator:	16,317	15,620	15 458	16 076	
	1.2 MDG goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	1.2.1 Reduce the mortality in children under the age of 5 years to 30 per 1 000 live births by 2015.	12) Newborn baby NVP uptake	98.6%	98.3%	99.0%	95%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	12 718	12 666	13 123	13 300	
			Denominator:	12 894	12 886	13 255	14 000	
			13) Newborn baby AZT uptake	Not required to report	Not required to report	53.0%	95%	Below target. Policy change at the beginning of the year specified that neonates no longer required AZT. As a consequence, recording of this indicator was stopped.
			Numerator:	-	-	7 021	13 300	
			Denominator:	-	-	13 255	14 000	
			14) Antenatal client initiated on AZT during antenatal care	Not required to report	Not required to report	91.7%	90%	Above target. Clients on HAART were included in the numerator. Highly variable rates per sub-district are probably a reflection of data integrity.
			Numerator:	-	-	11 995	*(9 900)*	
			Denominator:	-	-	13 087	*(11 000)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			15) Antenatal client nevirapine uptake	66.9%	89.8%	72.1%	90%	Under performance. See narrative.
			Numerator:	8 982	11 218	6 703	*(9 900)*	
			Denominator:	13 432	12 494	9 300	*(11 000)*	
			16) PMTCT transmission rate	4.5%	3.6%	3.2%	3.00%	See narrative.
			Numerator:	487	404	388	*(399)*	
			Denominator:	10 797	11 223	12 149	*(13 300)*	

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

Reasons for major variances

Antenatal prevalence 15 – 24 year old women

Target was 10% and actual performance 13.8%. It is difficult to lower this rapidly because it incorporates ten distinct ages in a single 10-year age-range and, every successive year, only one of those ten ages exits from the age-range (women who are 24 going on 25), to be replaced by 14 going-on-15 year-old women. Assuming no deaths, the HIV prevalence in this youngest age-group is the only mechanism whereby the average for the entire age-range can be lowered, the HIV prevalence of women in each of the other age-groups being either established or increasing. Put simply, the only way the Department can decrease the prevalence in the whole age-group is by ensuring that those that enter at the bottom end of the age-group are uninfected and stay uninfected. This will take time to manifest as an overall reduction in the age group.

Note also that the indicator population is 15 – 24 year old women but the survey source is 15 – 24 year old pregnant women, a different risk group.

Male condom distribution rate from public sector health facilities

A number of populous sub-districts, with high burdens of HIV, are performing below the provincial average. Sub-districts in the Overberg, Cape Winelands and Eden are implicated as well as one sub-district in the Metro. Note that despite under-performance against target, absolute performance shows a 21% increase on the previous year, indicating that an ambitious target had been set. Nevertheless, indications are that detailed logistical challenges in each sub-district need to be addressed. It has also been suggested that condom advocacy campaigns be tailored to the specific populations being addressed as stigma prevails in many communities.

TB treatment interruption rate

Improvement seen was due to the enhanced TB response which allocates additional resources to high burden TB facilities to support them in achieving their targets e.g. in the Metro TB enhanced response funding was used to appoint TB assistants (lay community care workers) to support the follow-up of TB defaulters. Additionally each district is given the autonomy to decide which intervention is most suitable for them.

Antenatal client Nevirapine uptake

The target was 90% and the actual performance 72%. An annual trend shows that Nevirapine uptake month-by-month, on average, declined over the course of the year (from 82% to 66%) while the proportion of women on HAART triple therapy (therefore not qualifying for Nevirapine in labour) increased (from 25% to 40%) over the course of the year. Rates at individual facilities demonstrate even greater variability. A number of changes in policy with regard to HIV management in pregnancy were introduced during the year (new eligibility criteria for HAART for pregnant women, earlier initiation of dual therapy and new treatment in labour). Training updates for staff and closer scrutiny of labour ward registers might be warranted.

PMTCT transmission rate

Twenty of thirty five sub-districts show a PMTCT rate of more than the target of 3.0% (these twenty display a range of 3.1% to 33.3%). The rate of 33.3% can be discounted because of its sensitivity to small denominators (it represents one baby out of a total of three born to HIV-infected mothers in very sparsely populated sub-district) and the next highest transmission rate thereafter is 12%.

In general the picture shows a number of rural districts with quite high transmission rates (possibly a migrant population effect, with access to services being an issue) and three populous Metro sub-districts showing a range between 3.6% and 3.9%. Reducing the rate of transmission in the high-burden Metro sub-districts will reduce the overall provincial transmission rate quicker than would a more generalised response. These three sub-districts need targeted individualised interventions and need particular scrutiny in recording of PMTCT data.

MATERNAL, CHILD AND WOMEN'S HEALTH (MCWH) AND NUTRITION

Women and children bear a disproportionate burden of preventable disease, much of it the result of the marginalised status they are accorded within society. This inequity is borne out by the fact that many of the Millennium Development Goals (MDGs) focus on addressing health problems prevalent amongst these populations.

Effective prevention strategies that address this health imbalance include: complete immunisation coverage against common infectious agents for children, and effective management of the risks associated with pregnancy (including early booking to enable early detection of medical or surgical disease associated with pregnancy) and early detection of common female cancers, for women.

In 2010/11 the Provincial Department of Health responded to a call by the National Department of Health to conduct a mass expanded programme on immunisation (EPI) campaign. This was aimed at "catching up" immunisations in any high risk populations who had missed vaccination opportunities. The campaign required certain clinic personnel to be withdrawn from clinical duties in health facilities and be placed in community response teams. The activities of this campaign were not recorded through the routine monitoring system and as a result a reduction in MCWH facility-level activity is noted in the first quarter of the 2010/11 year.

Table 2.2.7: Performance against targets from the 2010/11 Annual Performance Plan for Maternal, Child and Women's Health (MCWH) and Nutrition

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 MDG goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	1.1.1 Reduce the mortality in children under the age of 5 years to 30 per 1 000 live births by 2015.	1) Under-5 mortality rate	Not required to report	Not required to report	36.6	37	Source: SA Health Review 2010, nationally modelled estimate. (2010 ASSA 2003), page 285.
			2) Immunisation coverage under 1 year	96.5%	100.2%	85.9%	95%	Below target. Coverage low in first two quarters due to the national EPI "catch-up" campaign. Clinical personnel were removed from facilities for the campaign and campaign activities were not recorded by the routine monitoring system. This explanation applies for all the subsequent immunisation under-performance.
			Numerator:	94 540	98 622	89 508	98 966	
			Denominator:	98 008	98 403	104 175	104 175	
			3) Vitamin A coverage under 1 year	88.8%	92.85%	77.2%	93%	Below target. Explanation above applies.
			Numerator:	87 011	91 371	80 411	96 883	
			Denominator:	98 008	98 403	104 175	104 175	
			4) Vitamin A coverage – new mothers	Not required to report	Not required to report	66.8%	85%	Below target. The recording of data for this indicator must still become part of the routine procedures when the service is delivered.
			Numerator:	-	-	66 837	*(85 285)*	
			Denominator:	-	-	100 082	*(100 366)*	
	1.2 MDG goal 5: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	1.2.1 Reduce the maternal mortality ratio to 90 per 100 000 live births by 2015.	5) Pneumococcal 1st dose coverage under 1 years	Not required to report	Not required to report	83.2%	93%	Below target. Coverage in first quarter affected by EPI campaign, coverage in latter half of year affected by intermittent stock-outs.
			Numerator:	-	-	86 663	96 883	
			Denominator:	-	-	104 175	104 175	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			6) Rotavirus 1st dose coverage under 1 year	Not required to report	Not required to report	74.5%	93%	Below target. As for "Pneumococcal 1st dose coverage under 1 year" above.
			Numerator:	-	-	77 655	96 883	
			Denominator:	-	-	104 175	104 175	
			7) Measles coverage under 1 year	99.7%	102.8%	89.2%	95%	Below target. As for "Immunisation coverage under 1 year" above.
			Numerator:	97 726	101 154	92 944	98 966	
			Denominator:	98 008	98 403	104 175	104 175	
			8) Maternal mortality rate	Not required to report	Not required to report	67.6	97	Survey information: Saving Mothers: Fourth report on confidential enquiries into maternal deaths in South Africa 2005 – 2007: page 38, 311.
			9) Institutional maternal mortality rate	Not required to report	Not required to report	42.4	52.3	Above target. Only 41 deaths recorded, none in PHC facilities and 71% in regional and tertiary hospitals, indicating referral systems are functional.
			Numerator:	-	-	41	*(52)*	
			Denominator:	-	-	96 774	*(98 273)*	
			10) Cervical cancer screening coverage	5.2%	5.7%	6.4%	10%	Below target. See narrative.
			Numerator:	63 127	70 345	82 125	128 998	
			Denominator:	1 213 224	1 218 127	1 289 981	1 289 981	
			11) Total deliveries in facilities	94 139	96 907	93 192	92 500	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			12) Delivery rate for women under 18 years	7.9%	7.3%	7.0%	7.50%	Marginally less deliveries in the under-18 age-group than expected.
			Numerator:	7 412	7 060	6 484	*(6 938)*	
			Denominator:	94 139	96 907	93 192	*(92 500)*	
			13) Antenatal visits before 20 weeks	40.6%	46.4%	52.7%	65%	Below target. Mostly due to Metro sub-districts lowering the provincial average. Possibly insufficient BANC access in populous areas. See narrative on page 98.
			Numerator:	43 413	48 351	54 520	*(68 091)*	
			Denominator:	106 909	104 256	103 447	*(104 756)*	

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

Reasons for major variances

Cervical cancer screening coverage

There is a low proportion of smears recorded in those Metro sub-districts which are populous and have a high degree of private health coverage. Information about cervical screening undergone by these women does not enter the public health information system (but these women are part of the denominator). Additionally, there may be limited access to some PHC facilities because very limited after-hours services are offered (an appointment system is used for this procedure) and there is a lack of clinicians skilled in this technique.

Antenatal visits before 20 weeks

Below target. It should nevertheless be noted that each year shows a consistent increase in performance. The under-performance is mainly localised to the Metro, where dual authorities deliver services so service fragmentation is a possible reason. Access to basic antenatal care needs to be enhanced and early attendance needs to be encouraged / incentivised.

DISEASE PREVENTION AND CONTROL

Water quality and disease outbreaks

The provincial health service is responsible for the monitoring of municipal health services and for maintaining provincial services in a state of preparedness to respond to disease outbreaks.

Preventing blindness

Cataract surgery on a large scale, as a means of addressing community blindness, is a responsibility of the Department of Health and as with previous years, was driven via a campaign from the National Department of Health. The campaign approach has been that of performing high-volume cataract surgery at designated sites.

Table 2.2.8: Performance against targets from the 2010/11 Annual Performance Plan for non-communicable disease control

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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 3.85 visits per person per annum by 2014/15.	1) Outbreaks responded to within 24 hours	100%	100%	66.7%	100%	Small denominator creates large fluctuations in the indicator.
			Numerator:	7	4	2	-	
			Denominator:	7	4	3	-	
			2) Malaria fatality rate (annual)	0%	0%	0%	0	Target achieved.
			Numerator:	-	0	0	-	
			Denominator:	-	62	72	-	
			3) Cholera fatality rate (annual)	0%	0%	0%	0	Target achieved.
			Numerator:	-	0	0	-	
			Denominator:	-	1	0	-	
			4) Percentage of bacteriological water samples taken from water services authorities conforming to standards	Not required to report	92%	91.6%	93%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	-	8 502	8 947	-	
			Denominator:	-	9 249	9 771	-	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			5) Percentage of households with access to potable water within 200m	Not required to report	98.5%	97.1%	80%	The target appears incorrect in light of performance recorded in 2009/10. These functions are performed by municipalities while the Department of Health's role is to monitor and provide feedback to municipalities.
			Numerator:	-	1 659 723	1 724 965	-	
			Denominator:	-	1 684 828	1 775 699	-	
			6) Cataract surgery rate (annual)	1 070	1 132	1 186	2 000	Below target. Capacity constraints within the service with regard to operating theatre and surgical/anaesthetic availability.
			Numerator:	5 670	6 022	6 681	*(11 269)*	
			Denominator:	5 299 999	5 321416	5 634 323	*(5 634 323)*	

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

2.2.3 Programme 3: Emergency Medical Services

Purpose

The rendering of pre-hospital emergency medical services including inter-hospital transfers and planned patient transport.

Analysis per sub-programme

Sub-programme 3.1: Emergency Transport

Rendering emergency medical services including ambulance services, special operations, communications and air ambulance services.

Sub-programme 3.2: Planned Patient Transport

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).

Strategic Objectives

The programme's strategic objectives for 2010/11 were:

- 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.
- To complete the implementation of the Comprehensive Service Plan by operationalising the EMS resources (542 vehicles, 54 bases and 2 366 personnel) necessary to the specified service levels of 156 rostered ambulances per hour in the CSP by 2014.
- 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 vs. non-emergency resources) of the EMS service by 2014.
- To meet the appropriate outpatient transfer needs of the Department through the intra-district and trans-district HealthNET transport system ensuring that patients are managed at the appropriate level of care by 2014.
- 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.
- To initiate a trauma and violence prevention program in Cape Town and each of the five rural districts by 2014.
- To ensure integrated management of emergency clients through competent EMS and support managers and the institution of 5 geographic co-operative emergency care management structures by 2014.
- To achieve a qualification of Certificate in Management for 100 shift and station managers by 2014.
- To achieve an HRM clerk, finance clerk, reception clerk, information clerk and admin clerk in each of 9 district / divisional structures by 2014.
- To complete institution of EMS Supply Chain Management structures and systems (LOGIS, personnel, administration, training) necessary to the continuous supply and maintenance of EMS equipment by 2014.

- To recruit, train and deploy all 2 366 staff necessary to achieve service levels in the CSP by 2014.
- 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.
- To imbed an Occupational Health and Safety structure in EMS with a dedicated OHS officer in each of the 9 districts / divisions by 2014.
- To institute a comprehensive Information Communication Technology Solution for EMS in Cape Town and the five rural districts integrated with hospital emergency centres to provide reliable, real time and accurate data in order to meet target emergency care outcomes (response times) by 2014.
- To institute 6 sponsorships, branding and business relationships that provide additional funding streams for EMS in order to achieve quality service levels by 2014.

Service Delivery Objectives and Indicators

In addition to the purpose stated above, the Emergency Medical Services (EMS) programme is also responsible for the clinical governance and co-ordination of emergency medicine within the Provincial Department of Health. EMS also took responsibility for the co-ordination of health and emergency medical services within the Department in preparation for the FIFA 2010 World Cup Soccer Tournament.

Emergency medical services include ambulance services, medical rescue services, emergency communications and air ambulance services. Planned patient transport services include local outpatient transport within the boundaries of a given town or local area and inter-city / town outpatient transport into referral centres.

FIFA World Cup Soccer Tournament

The Western Cape Department of Health was required to provide health and medical services in terms of the guarantee provided by the National Minister of Health to FIFA in support of the South African Football Association's bid to host the 2010 FIFA World Cup Soccer Tournament.

The obligations of the Department included:

- Providing a safe environment at the FIFA 2010 World Cup.
- Providing emergency medical support at any incidents of injury or illness during the event.
- Emergency medical response consisting of the strategic placement of staff and vehicles to accommodate timeous response, onsite evaluation, and evacuation (if required) to an appropriate hospital for definitive patient care.

The health planning towards FIFA 2010 began in January 2007 with the appointment of an emergency service specialist to project manage the integration of all health services and systems associated with the event. Significant funding of R 78 million was invested by both national and provincial government in the event over three years. There were eight match days at the Cape Town Stadium and twenty five days during which services were required at fan parks, the Fan Walk and the stadium.

A peak of 221 personnel and 34 vehicles were deployed for FIFA specific activities and over the event 1 571 patients were treated of which 97 were admitted to hospitals in Cape Town. Three FIFA event related deaths occurred.

EMS achieved peak operational ambulance numbers of up to ninety vehicles on a shift in the City and permission was obtained from the Civil Aviation Authority to undertake night operations with the two EMS helicopters during the tournament.

Three hundred new EMS staff were employed in response to the FIFA 2010 requirement, 1 000 staff were trained in Major Incident Medical Management and Support (MIMMS) – a multi-disciplinary approach for pre-hospital and hospital staff (medical and non-medical). The additional EMS practitioners are still within the EMS services and have played a vital role in improving EMS response times.

New equipment and resources were procured with the funding allocated to FIFA which included thirty new ambulances, medical utility vehicles, a medical procedures container, which can be used for rescue operations and mass casualty situations, and tents for mass casualty or major incidents. Funds were spent on medical equipment which was has been deployed in EMS and played a role in the improvement of patient care.

Health systems were improved through an Electronic Bed Bureau, improved medical relationships between relevant role players (EMS, SAMHS and the private sector), creation of a MIMMS manual for the South African context, better co-ordination between public and private health services and a disaster medicine program that was launched as part of FIFA 2010 preparations.

Emergency Medical Services

Table 2.2.9 below outlines the performance against specific indicators achieved by EMS.

The improved performance is reflected in the over-achievement of the priority 1 urban response time which exceeded the target of 60% for the province by the end of the reporting period. The improved performance resulted from investment in man hours through the FIFA World Cup but also a complete reorganisation of the dispatch model in Cape Town. Ambulances were linked to a geographic area, for dispatch, draining towards each city hospital in order to limit travel distance, reduce mission times, improve dispatcher orientation and ultimately improve response times.

HealthNET

Patient transport services continued to evolve and the most notable development is the roll-out of the HealthNET Electronic Booking System which facilitates efficient transport booking from clinics and hospitals. The numbers of health clients seeking transport to facilities is increasing.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2010/11 ANNUAL PERFORMANCE PLAN

Table 2.2.9: Performance against targets from the 2010/11 Annual Performance Plan for the EMS programme

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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	New indicator	New indicator	14	20	EMS has introduced a comprehensive quality management system to detect and manage adverse clinical incidents. No baseline data was available when the target was set. It is expected that initially more adverse incidents will be detected. The data for 2010 will provide the baseline in future.
			2) Percentage of staff surveyed per annum	New indicator	New indicator	20.5%	10%	More personnel were surveyed in the City of Cape Town than planned in order to get a more representative sample.
			Numerator:			360	*(172)*	
			Denominator:			1 760	*(1 722)*	
			3) Percentage of patients surveyed per annum	New indicator	New indicator	0%	10%	The survey tool was more complex than anticipated and could not be finalised in time to conduct the survey. No funding was budgeted for an externally contracted survey.
			Numerator:			0	*(47 000)*	
			Denominator:			446 566	*(470 000)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
	1.2 Fully implement the CSP model by 2014.	1.2.1 To complete the implementation of the Comprehensive Service Plan by operationalising the EMS resources (542 vehicles, 54 bases and 2 366 personnel) necessary to the specified service levels of 156 rostered ambulances per hour in the CSP by 2014.	4) Number of rostered ambulances	230	251	132	130	In previous financial years the number of ambulances in the fleet was reported. For 2010/11 the rostered ambulances were calculated by dividing the number of personnel hours worked by 365 x 24 x 2 which gives the average number of crewed operational ambulances available every hour in the Western Cape.
			Numerator:	-	-	2 313 129	-	
			Denominator:	-	-	17 520	-	
			5) Rostered ambulances per 1 000 people	0.043	0.047	0.02	0.05	As above.
			Numerator:	230	251	132	*(130)*	
			Denominator:	5 404 293	5 342 832	5 634 323	*(5 364[13])*	
			6) Percentage of operational rostered ambulances with single person crews	0%	0%	0%	0%	The Western Cape EMS has not had single crew ambulances since it provincialised in 2000.
			Numerator:	0	0	0	*(0)*	
			Denominator:	230	251	132	*(130)*	
			7) Percentage of CSP bases / stations established	94.4%	94.4%	100%	94.4%	The number of bases in the 2010 Comprehensive Service Plan has all been established although not in the specified geographic locations. The 2020 plan will detail further facilities. Steady progress is being made in replacing old buildings with new purpose built stations.
			Numerator:	44	44	47	*(44)*	
			Denominator:	47	47	47	*(47)*	

13 The denominator in the target shows the population divided by 1 000 whilst the actual performance shows the total population.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	1.3 Manage all patients at the appropriate level of care within the appropriate packages of care.	1.3.1 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 vs. non emergency resources) of the EMS service by 2014.	8) Percentage of ambulance patients transferred between facilities	21%	34%	30.4%	20%	This figure represents inter-facility (clinic to hospital) rather than inter-hospital transfers and is therefore higher. In order to measure performance of the health system against the CSP inter-hospital transfers should be measured. The target set was too low.
			Numerator:	-	-	135 800	*(87 614)*	
			Denominator:	-	-	446 566	*(470 000)*	
			9) Percentage of green triaged patients transferred by an ambulance	30.8%	28.7%	36%	30%	This number may represent inappropriate triage by EMS personnel. It may also reflect the lack of public transport in rural areas therefore placing a burden on emergency services to transport health clients.
			Numerator:	124 477	132 768	160 760	*(141 000)*	
			Denominator:	404 134	461 940	446 566	*(470 000)*	
			10) Percentage of ambulance trips used for inter-hospital transfers	20.8%	27.5%	30.4%	30%	This figure represents inter-facility (clinic to hospital) rather than inter-hospital transfers and is therefore higher. EMS was not able to measure inter-hospital transfers as these data elements were not included in the efficiency report. This was an oversight created by the absence of information management personnel. This is being addressed.
			Numerator:	84 035	113 830	135 800	*(130 458)*	
			Denominator:	404 134	414 154	446 566	*(434 861)*	
			11) Total number of EMS emergency cases	404 134	461 940	446 566	420 000	An unexplained peak in emergency cases occurred in the 4th Quarter. Less emergencies than expected were seen during the period of the FIFA World Cup Tournament.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	1.4 Efficiently and effectively manage chronic diseases.	1.4.1 To meet the appropriate outpatient transfer needs of the Department through the intra-district and trans-district HealthNET transport system ensuring that patients are managed at the appropriate level of care by 2014.	12) Number of patients transferred to tertiary level hospitals per annum	New indicator	36 000	79 685	30 000	The Western Cape has a very good HealthNET patient transport service. Outpatients transferred to central hospitals every month are increasing. An analysis of OPD patients presenting to Tygerberg Hospital revealed that most OPD patients come from within a distance of 100 km from the hospital and that most come by own transport. The most frequent consults are seen within the disciplines obstetrics and gynaecology, dermatology, urology, ophthalmology, and ear, nose and throat. Although EMS set this target it has no control over OPD referrals, the locus of control of which falls within the district health system. EMS set this target in order to reduce GMT costs because per kilometre tariffs for patient transport vehicles are higher than ambulances however EMS has been unsuccessful in influencing health facilities to reduce referrals. EMS has installed an electronic booking system which clinics and hospitals use to schedule patient transfers efficiently.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
	1.5 Provide roadside to bedside definitive emergency care within defined emergency time frames within and across geographic and clinical service platforms.	1.5.1 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.	13) Percentage of urban Priority 1 responses within 15 minutes	43.6%	40.1%	52.6%	60%	The performance reached in the fourth quarter and maintained since was 64.9%. Calculated over the whole year the performance was 52.6%. Significant changes to the dispatch model and additional resources made available through the FIFA World Cup contributed to the improved performance. 300 additional staff and 30 additional ambulances were added to EMS through the World Cup.
			Numerator:	35 908	39 320	59 276	*(65 709)*	
			Denominator:	82 410	95 231	112 773	*(109 515)*	
			14) Percentage of rural Priority 1 responses within 40 minutes	75.4%	79.2%	84.6%	85%	The target was achieved which given the long distances in rural areas is significant although the numbers of priority 1 calls in farming areas is low.
			Numerator:	7 607	7 050	8 646	*(7 650)*	
			Denominator:	10 090	8 907	10 218	*(9 000)*	
			15) All calls with a response time within 60 minutes	79.3%	78.5%	70.9%	65%	The improvement in priority 1 response times (mainly in Cape Town) caused a knock on effect in terms of priority 2 response times despite resources being concentrated on priority 1 responses which explains the lower performance than previous years.
			Numerator:	296 483	325 121	367 948	*(282 659)*	
			Denominator:	373 940	414 154	519 228	*(434 861)*	
	1.6 Institute trauma and violence prevention programs.	1.6.1 To initiate a trauma and violence prevention program in Cape Town and each of the five rural districts by 2014.	16) Number of prevention programs initiated	New indicator	New indicator	0	2	Although no formal provincial programs were established outside of participation by the directorate in the Provincial Government Strategic Objective Task Team there are several local community initiatives being run out of EMS stations. Prevention programmes are being managed through the Provincial Transversal Management System of PGWC.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
2. Ensure and maintain organisational strategic management capacity and synergy.	2.1 Develop integrated support and management structures to render effective clinical service.	2.1.1 To ensure integrated management of emergency clients through competent EMS and support managers and the institution of 5 geographic co-operative emergency care management structures by 2014.	17) The number of emergency medicine specialist led co-operative geographic structures operational out of 5 geographic areas	New indicator	New indicator	4	4	The target was met with structures in Cape Town East and Cape Town West, Cape Winelands and West Coast.
		2.1.2 To achieve a qualification of Certificate in Management for 100 shift and station managers by 2014.	18) Number of supervisors with a certificate in management	New indicator	New indicator	0	25	The 25 staff members enrolled in the programme will only complete the management programme in June 2011.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		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.	19) Number of support clerks appointed out of 36	New indicator	New indicator	14	23	Recruitment process is focusing on employing staff with capacity rather than just making up the numbers and so filling posts is taking more time than expected. In addition posts are reprioritised during the year.
	2.2 Ensure efficient and cost effective procurement.	2.2.1 To complete institution of EMS Supply Chain Management structures and systems (LOGIS, personnel, administration, training) necessary to the continuous supply and maintenance of EMS equipment by 2014.	20) Number of districts that can electronically requisition goods and services	New indicator	New indicator	4	3	The role out of LOGIS is dependent on IT infrastructure. It is not possible to establish fixed line IT communication with every station and SITA policy currently precludes the use of ADSL.
			21) The percentage of SCM personnel of the establishment appointed	New indicator	New indicator	72.9%	*(80%)*	A significant disciplinary case in SCM held up the recruitment of staff. EMS also had 7 unfunded posts on the establishment for supply chain management.
			Numerator:	-	-	35	*(39)*	
			Denominator:	-	-	48	*(48)*	
			22) The percentage of ambulances with a full suite of ambulance equipment	New indicator	New indicator	99.6%	75%	The counting and verification of assets is on-going. In this calculation defibrillator monitors were used as a proxy for complete ambulance inventory. Funds for the FIFA World Cup facilitated equipment procurement. R 12 million was allocated in the FIFA budget for equipment.
			Numerator:	-	-	249	*(190)*	
			Denominator:	-	-	250	*(253)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
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 2 366 staff necessary to achieve service levels in the CSP by 2014.	23) Percentage of CSP personnel out of 2 366 appointed	New indicator	72.8%	74.4%	72.8%	Finance is the principal limiting factor in recruiting personnel. The EMS budget has not matched CSP personnel calculations for 2010. A link must be made between an establishment of 72.4% and a response time performance on priority 1 responses of 64.9%.
			Numerator:	-	1 722	1 760	*(1 722)*	
			Denominator:	-	2 366	2 366	*(2 366)*	
	3.2 Become the employer of choice in the health sector by creating an environment for a satisfied workforce.	3.2.1 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, acknowledge-ment and rewards by 2014.	24) Percentage of personnel surveyed with a positive attitude and motivation	New indicator	New indicator	22.2%	50%	No baseline was available to set this target. The OSD for EMS which did not meet expectations is a major factor influencing attitudes within the EMS population. Interpersonal relationships at work seem to be a major factor.
			Numerator:	-	-	80	*(86)*	
			Denominator:	-	-	360	*(172)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		3.2.2 To imbed an Occupational Health and Safety structure in EMS with a dedicated OHS officer in each of the 9 districts / divisions by 2014.	25) Number of OHS officers appointed	New indicator	New indicator	0	2	The availability of funding precluded appointment of officers as funding was reprioritised to other posts.
4. Provide and maintain appropriate health technology and infra-structure.	4.1 To provide responsive and appropriate information technology for the Department.	4.1.1 To institute a comprehen-sive information communica-tion techno-logy solution for EMS in Cape Town and the five rural districts integrated with hospital emergency centres to provide reliable, real time and accurate data in order to meet target emergency	26) Number of districts out of six with fully solution	New indicator	New indicator	0	1	The pace of the bid for a new communication solution, through SITA and Ce-I, has been slower than anticipated.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		care outcomes (response times) by 2014.						
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 sponsorships, branding and business relationships that provide additional funding streams for EMS in order to achieve quality service levels by 2014.	27) Number of projects delivering sponsorship	New indicator	New indicator	0	1	The Wilderness Search and Rescue Trust obtains donor funding and funds the procurement of equipment for WSAR.

2.2.4 Programme 4: Provincial Hospital Services

Purpose

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

Analysis per sub-programme

Sub-programme 4.1: General Hospitals

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

Sub-programme 4.2: Tuberculosis Hospitals

To convert present tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalisation under conditions, which allow for isolation during the intensive phase of treatment, as well as the application of the standardised multi-drug resistant (MDR) protocols.

Sub-programme 4.3: Psychiatric/Mental Hospitals

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

Sub-programme 4.4: Chronic Medical Hospitals

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

Sub-programme 4.5: Dental Training Hospitals

Rendering an affordable and comprehensive oral health service and training, based on the primary health care approach.

Strategic Objectives

The programme's strategic objectives for 2010/11 were:

- Ensure access to the full package of regional hospital services by providing 2 384 regional hospital beds by 2014.
- Ensure access to the full package of TB hospital services by providing 1 284 TB hospital beds by 2014.
- Provide a total of 1 568 beds in specialist psychiatric hospitals by 2014.
- Provide a total of 72 step-down beds and maintain a bed occupancy rate of 85% in sub-acute facilities by 2014.

- Provide a total of 156 beds in specialist rehabilitation hospitals by 2014.
- Improve access to emergency services and improving the quality of care and the interface between the emergency services and the admitting hospital.
- Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies at a target of 35% in 2014/15.
- Perform and analyse one standardised patient satisfaction survey per year to measure patient satisfaction in regional, TB and psychiatric hospitals.
- Implement and maintain quality assurance measures in regional, TB and psychiatric hospitals to minimise patient risk by performing monthly mortality and morbidity meetings.
- Implement and maintain quality assurance measures in rehabilitation hospitals to minimise 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.
- Implement and maintain quality assurance measures in general and psychiatric hospitals to minimise patient risk.
- Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R 2 629 per PDE. (Constant 2008/09 rand)
- Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R 750 by 2014. (Constant 2008/09 rand)
- Ensure the cost effective management of psychiatric hospitals at a target expenditure of R 977 per PDE by 2014. (Constant 2008/09 rand)
- Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R 1 667 per PDE by 2014. (Constant R2008/09 rand)
- Perform and analyse one annual standardised staff satisfaction survey to measure workforce satisfaction in the regional, TB and psychiatric hospitals.
- Ensure optimum staffing levels for all facilities by ensuring that 97.5% of affordable staff establishment remains filled (regional, TB, psychiatric and rehabilitation hospitals).
- 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.
- Effectively manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 85 days.
- Appropriate management of bed utilisation within specialist psychiatric hospitals to achieve an average length of stay of 90 days and bed occupancy rate of 85% by 2014.
- Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilisation rate of 85% and an average length of stay of 50 days.
- Establish functional business units within provincial hospitals as a key support structure in ensuring that resources are adequately utilised within cost centres.
- Ensure the establishment of PCUs at all institutions (regional, psychiatric and rehabilitation hospitals).
- Ensure 5-year plan per institution (regional, psychiatric and rehabilitation hospitals).
- Appropriately manage the in-house and outsourced orthotic and prosthetic services.
- Reduce the waiting list for orthotic and prosthetic services by increasing productivity and outsourcing of services where more cost effective.
- Ensure dental patients attending clinics are seen by a specialist, a general dentist, an allied health professional or students with a target of 185 454 by 2014.
- Performing maxillofacial surgery procedures during which one or more incisions are made to the head and neck area and is performed in a registered operating theatre that is equipped for anaesthesia and able to provide sterile conditions for surgical procedures with a target of 1 700 by 2014.
- Provide quality removable prosthetic devices to patients with a target of 4 108 by 2014.
- Provide a quality orthodontic service to dental patients with a target of 297 by 2014.

Service Delivery Objectives and Indicators

Programme 4 remained 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 remains committed to reducing the impact of the burden of disease.

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 categorised in terms of the strategic goals of the Department:

1) Manage the burden of disease.
2) Ensure and maintain organisational 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.

SUB-PROGRAMME 4.1: GENERAL (REGIONAL) HOSPITALS

The priorities for 2010/11 were addressed in an integrated approach to service delivery across the health platform. Services were provided in the Metro and rural regions. The hospitals in the Metro are New Somerset and Mowbray Maternity and level 2 services were provided in Tygerberg, Groote Schuur and Red Cross War Memorial Children's Hospitals. The services in the rural regions were provided by Paarl, Worcester and George Hospitals.

1) Manage the burden of disease

Ensure access to general specialist hospital services

In line with the Comprehensive Service Plan (CSP), the major objectives in this sub-programme included the reconfiguration of services within these hospitals and the expansion and strengthening of rural regional hospitals. Service reconfiguration per discipline continued to enhance optimal health care provision and improve efficiencies.

The implications and implementation of the geographical service area model for the rural regions continued to be work in progress and the co-operation of all service levels within a geographical area proved to be vital in ensuring equity of access to services.

Outpatient department (OPD) clinics have been identified per level of care and work in this area is ongoing. Red Cross War Memorial Children's Hospital planned the devolution of patients visiting the OPD to the appropriate level of care within the relevant sub-districts for the identified clinical conditions of asthma, epilepsy and dermatology. OPD shifts continued in line with the planned service direction. However the challenge has been ensuring that adequate capacity exists at primary health care (PHC) level to absorb these patients.

The planning process has commenced to decant stable antiretroviral (ART) patients from the regional hospitals to the community health centres (CHCs) in the Metro West area.

Planning has started for the implementation of TB control measures in general hospitals aimed at the prevention of the intra-hospital spread of TB. The focus remained on the management of occupational health risks posed to staff and other patients by patients with TB.

The measles epidemic was appropriately managed and additional beds temporarily opened at New Somerset Hospital for the duration of the epidemic.

Ensure access to the package of regional hospital services by providing 2 384 regional hospital beds by 2014

In line with the Comprehensive Service Plan, the majority of level 2 services within the Cape Metro district were provided within the central hospitals. The reclassification of existing inpatient and outpatient services continued and the reconfiguration of services according to the package of care provided. Level 2 services in central hospitals were funded from the provincial equitable share in Programme 4, sub-programme 4.1.

The heads of general specialist services have been appointed for each of the general specialities in the Metro East and Metro West. They are accountable for the co-ordination of general specialist services within the geographic area and for the provision of general specialist services in their base hospital. In the Metro East all the heads of general specialist services are based at Tygerberg Hospital, but in the Metro West they are distributed between Groote Schuur and New Somerset Hospitals. The heads of paediatrics, obstetrics and gynaecology as well as anaesthetics are based at New Somerset Hospital. The heads of medicine, surgery and orthopaedics are based at Groote Schuur Hospital. Heads of general specialist services provided additional clinical support that assisted in ensuring the reduction of mortality rates, improving theatre starting times, acquiring the correct capital equipment as well as providing outreach and support to district hospital services.

The general specialist cadre has been strengthened within the regional hospitals.

- At Worcester Hospital a third general surgeon, a second psychiatrist, and a second orthopaedic surgeon were appointed. The recruitment of a third physician and a gynaecologist was also approved.
- Additional specialists appointed at New Somerset Hospital included: a third general surgeon, a second internal medicine specialist, a third paediatric specialist, a third obstetrics and gynaecology specialist, one orthopaedic surgeon and one anaesthetist.
- A second specialist is in place at all the major disciplines at Paarl Hospital.
- All major disciplines have a second specialist at George Hospital, with a third specialist appointed in the disciplines of general surgery, internal medicine and paediatrics.
- Level 2 beds have been increased at Groote Schuur Hospital within the general medicine discipline by fifteen beds.

The bed distribution plan for rural regional hospitals recommended that the final bed targets should initially be the totals as stated in the Comprehensive Service Plan. In the second phase the rural regional hospitals will work towards the bed totals as per the hospital revitalisation project.

Each of the rural regional hospitals provided a quantum of level one service for the immediate district. These services were differentiated from the specialist service within a separate functional business unit but remained part of Programme 4.1 responsibility. The entire service provided in a regional hospital remains the management responsibility of the regional hospital CEO and team.

Twenty level one beds remained fully operational at Mowbray Maternity Hospital and will be transferred to Mitchells Plain Hospital, once the latter has been commissioned. Service shifts will continue within the Metro once Khayelitsha and Mitchells Plain Hospitals have been completed.

Provide roadside to bedside definitive emergency care

Emergency medicine specialists have been appointed at Worcester, Tygerberg, Paarl, Somerset and Groote Schuur Hospitals. This is a significant development in improving emergency medicine across the platform.

Improve quality of care at all levels of care

Outreach and support agreements between institutions have been formalised between the regional and referring district hospitals. This ensured that patients were treated at the appropriate level of care. One challenging area was the lack of medical officers in the district health services that would ensure the transfer of skills from specialists at regional hospitals who perform outreach to the district services. Thirty four outreach and support contracts exist between Worcester Hospital and other facilities within their geographical service area. Outreach and support was provided by New Somerset Hospital to Wesfleur, Vredenburg, Hanover Park, Vanguard, and others.

At Mowbray Maternity Hospital, outreach and support remained an on-going service by visiting and supporting the midwife obstetric units (MOU) including representation at satellite MOU's audit meetings to enhance clinical governance.

Monthly morbidity and mortality meetings were held in all hospitals. Mortality in the medicine discipline remains high with most deaths due to terminal lung carcinoma. Joint planning processes have been implemented with the district services that would track patients across the paediatric service platform. This will hopefully reduce morbidity caused by malnutrition. At New Somerset Hospital a third of the deaths in internal medicine were HIV related. Of concern was that only one third of those patients were receiving ART. This will be addressed in the geographical service area (GSA) forum.

The regional hospitals also managed infection and prevention control processes with a specific focus on TB management in general hospitals.

Patient satisfaction was improved by conducting one comprehensive client satisfaction survey in all regional hospitals. The results demonstrated that:

- Empathy (which asks about nurse and doctor attitudes) as well as respect for privacy, received the highest scores with more than 50% satisfaction.
- General satisfaction also scored well at about 50%.
- The element that caused the most dissatisfaction was boredom. The waiting areas in outpatient departments could be improved to reduce patient boredom.
- Domains regarding satisfaction with cleanliness and hotel services scored less than 50% satisfaction but above 25%. Toilet cleanliness in busy emergency and outpatient areas remained a challenge despite the focus on the SEAT (safe environment around toilets) project that was fully implemented at regional hospitals.
- In the responsiveness domain, visiting hours were generally considered too short.
- In the reliability domain waiting times continued to be a challenge.

All regional hospitals placed some emphasis on monitoring safety and security risks. At New Somerset Hospital incidents of verbal and physical abuse to frontline staff by patients and visitors as well as fires caused by cigarette butts were the main theme. At George Hospital incidents of theft of personal belongings and break in to personnel motor vehicles were dominant. At Paarl Hospital incidents of damage to state property and assault as well as verbal abuse of staff by visitors were reported.

Reduce maternal mortality

Monthly maternal mortality meetings were held at Groote Schuur Hospital to review all the maternal deaths in the Metro West area. The major cause of maternal death is HIV and AIDS mostly with TB, then hypertensive disorders of pregnancy followed by haemorrhage, pregnancy related sepsis and medical disorders. Remedial activities included protocols for thromboprophylaxis, discussion of protocols for transferring unstable patients and expedited HAART for pregnant women with low CD4 counts.

2) Ensure and maintain organisational strategic management capacity and synergy

Strategic and operational structures to co-ordinate service delivery at provincial and local levels

Hospitals are in progress and at various stages of development and implementation of their functional business units (FBUs). Budgets have been allocated to the FBUs in the Business Intelligence system and a verification process has been established to ensure that expenditure is reflected against the correct cost centre within a FBU. The delegations of budgets and accountability responsibilities to FBU managers have not been implemented as the accuracy of data and regular reports are vital to support the FBU managers in decision-making.

An FBU co-ordinator will be appointed in the 2011/12 financial year to fast track and ensure the stabilisation of a reliable cost accounting system, ensure that clinical managers accept responsibility for their budgets, ensure fair resource allocations and establish a skills transfer process.

3) Develop and maintain a capacitated workforce to deliver the required health services

Become the employer of choice in the health sector by creating an environment for a satisfied workforce

Implementation of the organisational development investigation (ODI) recommendations remained slow and Mowbray Maternity and New Somerset Hospitals will commence the process in the 2011/12 financial year. The ODI implementation at Worcester Hospital has been progressing positively with all nursing and medical posts filled in line with the ODI report.

At the end of the financial year this sub-programme managed to fill 97.5% of its approved post list. A concerted effort was made to achieve this as the attrition rate within the programme is 4%, which is higher than the departmental average of 2.5%. Despite reaching this target, the sub-programme still under-spent on salaries and wages.

Essential Steps in the Management of Obstetric Emergencies (ESMOE) training was provided in regional hospitals.

As a result of the staff satisfaction surveys, additional support to staff members was provided in the following areas:

- Employee assistance programmes (EAP) were provided to support staff. Stress related issues were the most common reason for accessing the EAP service, followed by mental health problems, relationship and family challenges, and legal matters.
- Improved staff communication.
- Increased management visibility.
- Training and development.

4) Provide and maintain appropriate health technology and infrastructure

Ensure the provision of infrastructure that meets the needs of current and future development

Completed buildings were progressively commissioned at rural regional hospitals. The hospital revitalisation expenditure for the 2010/11 financial year totalled R 195.6 million for George, Paarl, Worcester and New Somerset Hospitals. This was an 18% increase from the 2009/10 expenditure.

Phase 2 of the hospital revitalisation programme (HRP) at Paarl Hospital will be completed in the next financial year. Projects completed during 2010/11 included: the new emergency centre, training department, endoscopy unit, and the stores and workshop. Phase 3 for the psychiatric wards is in planning and should be completed in March 2013.

The HRP project commenced in 2003 at Worcester Hospital and completion is scheduled for the 2011/12 financial year with a further phase planned for 2013/14. There have been challenges with the appointed contractor at Worcester Hospital and construction remained behind schedule with estimated completion during 2011. Three theatres at Worcester Hospital that were closed due to poor workmanship were all completed in November 2010.

The full commissioning plan for the HRP hospitals has been reviewed and a longer term plan has been developed which allows for the gradual scaling up of services and best utilisation of hospital space within the limited funding envelope and staffing constraints.

The HRP process is nearing completion at George Hospital and the new pharmacy was opened during 2010. The Clinicom system was introduced at George Hospital during 2010.

5) Ensure a sustainable income to provide the required health services according to the needs

Ensure the sustainable generation of financial resources to ensure funding for the provision of health services

Budgets were appropriately spent according to the expected deliverables and the sub-programme remained within its allocated budget with a surplus in the salaries and wages vote, despite the fact that 97.5% of the posts were filled on the approved post list.

A significant reduction in laboratory cost can be attributed to improved clinical governance.

Reconciling performance targets with the budget and the MTEF

Sub-programme 4.1 was allocated 68.8% of the programme 4 budget in 2010/11 in comparison to the 67.84% allocated in the revised estimate of the 2009/10 budget. This amounted to a nominal increase of R 252.361 million or 14.62%.

The budget for level 2 services within the central hospitals was included in sub-programme 4.1. A management decision will result in this budget being shifted back to programme 5 as it has been very difficult to reflect expenditure against the correct levels of care within the constraints of the current accounting and patient information systems.

Personnel

Personnel expenditure has increased significantly, but the programme under spent on its allocated salaries and wages budget. This was mainly caused by additional funding for OSD. The 4% attrition rate in this programme is significantly higher than the departmental average of 2.5%. OSD has been paid out to various staff categories including nurses, doctors and other health professionals.

Agency expenditure has been reduced from the previous financial year, but remained high. A specific focus ensured the reduction of agency staff in the nursing assistants and administrative staff categories.

Each institution had an approved post list (APL), which was strictly managed through the establishment control committee (ECC) of the chief directorate within the programme to ensure that hospitals remained within their allocated personnel budget. Posts were approved and filled according to the annual operational plans.

Goods and services

One of the main challenges was that the budget allocation did not match inflation over time, which was evident in the severe price increases for medical items and the increased tariffs for municipal services.

Financial management

Various controls have been implemented to improve financial governance and reduce the audit risks. A devolved internal control unit (DICU), which performs compliance audits, has been established within the regional office of the Chief Directorate: General Specialist and Emergency Services, supporting the hospitals within programme 4.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2010/11 ANNUAL PERFORMANCE PLAN

Table 2.2.10: Performance against targets from the 2010/11 Annual Performance Plan for general (regional) hospitals

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 Ensure access to general specialist hospital services.	1.1.1 Ensure access to the full package of regional hospital services by providing 2 384 regional hospital beds by 2014.	1) Number of regional hospital beds	2 490	2 364	2 385	2 367	The provincial database (SINJANI) was updated for Mowbray Maternity Hospital (to reflect level 1 beds) and New Somerset Hospital (to reflect actual beds). Beds also increased at Groote Schuur Hospital after the target was set for 2010/11.
			2) Total separations in regional hospitals	196 668	185 919	174 307	191 878	Some difficulties experienced in setting a combined target for regional and level 2 services in central hospitals. At the time when the target was set, insufficient historical data was available. Decanting occurred in HRP hospitals due to building projects.
			3) Patient day equivalents (PDE) in regional hospitals	1 122 369	1 051 150	1 022 675	1 033 812	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			4) OPD total headcounts in regional hospitals	718 131	628 931	580 840	741 500	The combined target set for regional and level 2 central hospitals were based on data trends in 2009. There is a downwards trend in 2010/11 in line with the policy to devolve patients.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	1.2 Provide roadside to bedside definite emergency care.	1.2.1 Improve access to emergency services and improving the quality of care and the interface between the emergency services and the admitting hospital.	5) Casualty / emergency and trauma headcount in regional hospitals	308 188	296 301	283 091	297 500	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
	1.3 Reduce maternal mortality.	1.3.1 Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies at a target of 35% in 2014/15.	6) Caesarean section rate for regional hospitals	33%	32.5%	36.4%	35%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	8 211	8 425	9 339	*(9 134)*	The caesarean section rate for level 2 central hospitals is reported as a combined figure with level 3 central hospitals in Programme 5.
			Denominator:	25 040	25 961	25 689	*(26 116)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	1.4 Improve quality of care at all levels of care.	1.4.1 Perform and analyse one standardised patient satisfaction survey per year to measure patient satisfaction in regional hospitals.	7) Percentage of regional hospitals with patient satisfaction survey using DoH template (8/8)	100%	100%	75%	100%	Although surveys were conducted at Worcester and Paarl Hospitals, the results were not officially published and these hospitals could therefore not be included in the numerator.
			Numerator:	9	5	6	*(8)*	
			Denominator:	9	5	8	*(8)*	
		1.4.2 Implement and maintain quality assurance measures in regional hospitals to minimise patient risk by performing monthly mortality and morbidity meetings.	8) Percentage of regional hospitals with mortality and morbidity meetings every month (8/8)	100%	100%	100%	100%	Target achieved.
			Numerator:	9	5	8	*(8)*	
			Denominator:	9	5	8	*(8)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
		1.4.3 Implement and maintain quality assurance measures in general hospitals to minimise patient risk.	9) Case fatality rate for regional hospitals for surgery separations	2.6%	1.7%	2.0%	3.9%	The target was set prior to a surgery audit that was performed for level 2 services in central hospitals.
			Numerator:	1 223	735	816	*(1 574)*	
			Denominator:	46 608	43 501	40 531	*(40 358)*	
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 the full package of quality general specialist hospital services.	2.1.1 Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R 2 629 per PDE. [Constant 2008/09 rand]	10) Expenditure per patient day equivalent (PDE) in regional hospitals[14]	R 1 397	R 1 355	R 1 704	R 1 663	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department. Improved conditions of service and occupational specific dispensation resulted in an increase in salaries.
			Numerator:	1,567,744,000	1,423,975,490	1,742,237,461	*(1 718 790 218)*	
			Denominator:	1 122 369	1 051 150	1 022 675	*(1 033 812)*	

14 The expenditure per PDE targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per PDE reported in the Annual Report have also been multiplied by the same factor.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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 analyse one annual standardised staff satisfaction survey to measure workforce satisfaction in the regional hospitals.	11) Percentage of regional hospitals with annual staff satisfaction survey completed	Not required to report	Not required to report	100%	100%	Target achieved.
			Numerator:	-	-	8	*(8)*	
			Denominator:	-	-	8	*(8)*	
		3.1.2 Ensure optimum staffing levels for all facilities by ensuring that 97.5% of affordable staff establishment remains filled.	12) 97.5% of affordable staff establishment filled for regional hospitals	Not required to report	Not required to report	100.2%	97.5%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	-	-	2 950	*(2 902)*	
			Denominator:	-	-	2 945	*(2 978)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
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.	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.	13) Bed utilisation rate (based on usable beds) in regional hospitals	86.1%	86.1%	84.4%	87%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	782 263	742 740	734 698	*(786 645)*	
			Denominator:	908 850	862 860	870 525	*(863 955)*	
			14) Average length of stay in regional hospitals	4 days	4 days	4 days	4 days	Target achieved.
			Numerator:	782 263	731 563	734 698	*(786 645)*	
			Denominator:	196 668	185 919	174 307	*(191 878)*	
		4.1.2 Establish functional business units within provincial hospitals as a key support structure in ensuring that resources are adequately utilised within cost centres.	15) Number of hospitals with fully Functional Business Units	Not required to report	Not required to report	3	5	The implementation of FBUs has proved complex and time consuming.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
5. Provide and maintain appropriate health technology and infra-structure.	5.1 Ensure the provision of infra-structure that meets the needs of current and future development.	5.1.1 Ensure the establishment of PCUs at all institutions.	16) Percentage of hospitals with PCUs (8/8)	Not required to report	Not required to report	100%	70%	Target was set in line with the HRP hospitals' planning and commissioning programme.
			Numerator:	-	-	8	*(5.6)*	
			Denominator:	-	-	8	*(8)*	
		5.1.2 Ensure 5-year plan per institution.	17) Percentage of hospitals with 5-year infrastructure plan (8/8)	Not required to report	Not required to report	100%	70%	Target was set in line with the HRP hospitals' planning and commissioning programme.
			Numerator:	-	-	8	*(5.6)*	
			Denominator:	-	-	8	*(8)*	

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

SUB-PROGRAMME 4.2: TUBERCULOSIS HOSPITALS

1) Manage the burden of disease

Tuberculosis disease is significantly associated with HIV co-infection. The HIV epidemic is resulting in serious HIV and TB co-morbidity, often requiring inpatient management. Many beds are occupied by patients with drug-resistant TB strains and a certain proportion of beds are occupied by patients who are failing all treatment where the only option is palliative care. This challenge in addressing the burden of disease has resulted in the development of a policy (to be implemented in 2011/12) that diverts a certain proportion of the TB inpatient case-load to community level care. This is possible because the service offered is the provision of (injectable) medication to ambulant patients. 2010/11 saw a small increase in the number of TB hospital beds and the development of the above-mentioned policy.

2) Ensure and maintain organisational strategic management capacity and synergy

There was a management shift of TB hospitals from programme 4 to district health services (programme 2) in order to align the service with the primary health care nature of TB treatment and improve communication and patient referral between the district health service platforms and TB hospitals.

3) Develop and maintain a capacitated workforce to deliver the required health services

This remains a challenge as TB hospitals perennially struggle to recruit personnel because of the threat of hospital-acquired infection to staff.

4) Provide and maintain appropriate health technology and infrastructure

The upgrading of TB hospital infrastructure is ongoing. The need for separate isolation wards for different resistant strains creates a further challenge to the service.

5) Ensure a sustainable income to provide the required health services according to the needs

Although managed by programme 2, funds for TB hospitals are received through programme 4. TB drug resistance and HIV co-infection means that new treatment modalities are frequently required or introduced, often not having been budgeted for. This poses challenges in the early stages of the planning cycle.

Table 2.2.11: Performance against targets from the 2010/11 Annual Performance Plan for TB hospitals

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 Ensure access to TB hospital services.	1.1.1 Ensure access to the full package of TB hospital services by providing 1 284 TB hospital beds by 2014.	1) Number of TB hospital beds	1 040	1 016	1 028	1 040	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			2) Total separations in TB hospitals	3 725	3 684	4 192	3 481	The increase in separations (discharges) is likely due to the implementation of the policy for the decentralisation and community management of drug-resistant TB.
			3) Patient day equivalents (PDE) in TB hospitals	304 302	305 833	302 828	289 411	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			4) OPD total headcount in TB hospitals	1 818	3 208	7 192	1 740	The target was set based on the previous years' data collection of service outputs which erroneously only reported the OPD headcounts for doctors. In line with the data element definition, hospitals started reporting all OPD headcounts in 2010/11 which included clients seen by allied health professionals, radiology, pharmacy etc.
	1.2 Improve quality of care at all levels of care.	1.2.1 Perform and analyse one standardised patient satisfaction survey per year to measure patient satisfaction in TB hospitals.	5) Percentage of TB hospitals with patient satisfaction survey using DoH template	100%	100%	33.3%	100%	Unfortunately did not receive the necessary attention. This matter will be addressed in 2011/12.
			Numerator:	6	6	2	*(6)*	
			Denominator:	6	6	6	*(6)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
		1.2.2 Implement quality assurance measures to minimise patient risk in TB hospitals by conducting monthly morbidity and mortality meetings.	6) TB hospitals with mortality and morbidity meetings every month (6/6)	67%	67%	66.7%	100%	Clinical capacity needs to be strengthened at Sonstraal and Malmesbury ID Hospitals in 2011/12.
			Numerator:	4	4	4	*(6)*	
			Denominator:	6	6	6	*(6)*	
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 the full package of quality general specialist hospital services by 2014.	2.1.1 Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R 750 by 2014. [Constant 2008/09 rand]	7) Expenditure per patient day equivalent (PDE) in TB hospitals[15]	R 446	R 478	R 511	R535	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department. National policy change in drug resistant TB management meant that more expensive drug therapy was indicated and needed to be acquired.
			Numerator:	135 635 000	146 297 263	154 884 314	*(154 933 609)*	
			Denominator:	304 302	305 828	302 828	*(289 411)*	

15 The expenditure per PDE targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per PDE reported in the Annual Report have also been multiplied by the same factor.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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 analyse one annual standardised staff satisfaction survey to measure workforce satisfaction in the TB hospitals.	8) Percentage of TB hospitals with annual staff satisfaction survey completed (6/6)	Not required to report	Not required to report	50.0%	100%	Unfortunately did not receive the necessary attention. This matter will be addressed in 2011/12.
			Numerator:	-	-	3	*(6)*	
			Denominator:	-	-	6	*(6)*	
		3.1.2 Ensure optimum staffing levels for all facilities by ensuring that 97.5% of affordable staff establishment remains filled.	9) 97.5% of affordable staff establishment filled for TB hospitals	Not required to report	Not required to report	94.2%	100%	TB hospitals perennially struggle to recruit personnel because of the threat of hospital-acquired infection in staff.
			Numerator:	-	-	631	-	
			Denominator:	-	-	670	-	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
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.	4.1.1 Effectively manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 85 days.	10) Average length of stay in TB hospitals	82 days	82.5 days	71.7 days	90 days	Despite the numerator (in-patient days) being slightly higher than targeted, the denominator (total separations) was considerably higher than targeted, thus bringing down the average length of stay. See indicator 2 (total separations) for an explanation.
			Numerator:	303 696	304 764	300 431	*(288 831)*	
			Denominator:	3 725	3 693	4 192	*(3 481)*	
			11) Bed utilisation rate in TB hospitals	80.0%	82.2%	80.1%	78 %	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	303 696	304 764	300 431	*(288 831)*	
			Denominator:	379 600	370 840	375 220	*(379 600)*	

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

SUB-PROGRAMME 4.3: PSYCHIATRIC HOSPITALS

There are four psychiatric hospitals and two sub-acute facilities in the Metro enhancing access to the full package of psychiatric hospital services. The four hospitals are Alexandra, Lentegeur, Stikland and Valkenberg. The sub-acute facilities are New Beginnings, supported by Stikland Hospital, and William Slater, supported by Valkenberg Hospital.

1) Manage the burden of disease

Improve quality of care at all levels of care

Significant progress has been made to improve the quality of mental health care within this province. The Mental Health Review Board remained very active and ensured compliance with the Mental Health Care Act. Hospitals were compliant with the Act and patients had access to trained staff. The focus on quality of care ensured that scarce resources were used in an efficient and effective way, promoting mental health, prevention and treatment.

Mortality and morbidity meetings in psychiatric hospitals take the form of a multi-disciplinary, quality assurance meeting, monitoring adverse and safety and security incidents.

Departmental client satisfaction surveys were conducted in all facilities. The results were very similar to those in the regional hospitals with empathy receiving the highest scores, visiting times being too short and boredom in hospital remaining a challenge despite active psycho-social rehabilitation programmes. The only hospitals in this programme to receive over 50% satisfaction for tangibles or catering, linen and cleanliness were Lentegeur Hospital and the Western Cape Rehabilitation Centre where these services are procured via a public private partnership (PPP).

Adverse incident reporting reflected a high incidence of patient-on-patient assaults particularly in the busy acute admission wards as well as long term wards for patients with intellectual disabilities. These long term wards now cater primarily for people with behavioural problems which make community living impossible so this would be expected.

Safety and security reports reflected the challenge for staff working in these services. The reports reflected a high incidence of staff abuse (including serious verbal threats of assault and physical assault). Despite this, the staff satisfaction surveys reflected a committed staff that enjoyed their work. The other significant reports were of damage to state property, which placed significant strain on maintenance budgets.

Long term quality improvement will be established through partnerships with inter-departmental forums, academic institutions and other professional groups outside the Department of Health.

Sub-acute services

The plan for 2010/11 anticipated the handover of William Slater to a non-profit organisation. This was based on the initial positive response received from Comcare Trust. However, after careful review of the full implications of this service for the organisation, the management and trustees of Comcare Trust were not able to take over this service from the Department. The Department of Health will continue to manage the service under the auspices of Valkenberg Hospital. The future of this service will be reviewed.

The services at New Beginnings, on the premises of Stikland Hospital, have been expanded from forty to one hundred and five beds towards the end of the 2010/11 financial year. The expansion was finalised within a tight timeframe and assisted in relieving the acute bed pressures in the system. The new bed numbers will be reflected on the various systems in the next financial year.

Acute services

The average length of stay was between 45 and 60 days for acute services, reflecting a significant throughput of patients, especially at Valkenberg Hospital. Analysis of waiting lists for transfer of patients from district hospitals to specialist services reflected the growing burden of illness throughout the service. This pressure was exacerbated by a surge in the third quarter of the year. Whilst this pressure was experienced throughout the platform, the overall shortage of acute, male admission beds was greatest in the Metro West geographic service area (GSA) which led to an executive decision to increase male acute beds at Valkenberg Hospital.

A three-way patient shift was required between Valkenberg, Lentegeur and New Beginnings. Additional funds were secured from programme 4 efficiencies and allocated to achieve the overall result of creating twenty two acute, male admission beds at Valkenberg Hospital within the existing bed totals and sixty five new, sub-acute, residential beds at New Beginnings. This entire move with the renovation of physical infrastructure and recruitment of additional personnel was completed in a three month period from January to March 2011.

The waiting list for forensic observations remained high, leading to overcrowding of the minimum and medium secure wards.

The relocation and consolidation of the acute services at Stikland Hospital was implemented as well as the upgrading of various wards, improving workflow and the admission of patients.

Due to funding constraints, a separate adolescent psychiatric ward at Tygerberg Hospital could not be commissioned. This remains a key priority.

2) Ensure and maintain organisational strategic management capacity and synergy

Develop integrated support and management structures to render effective clinical services

Functional business units (FBU's) have been established to varying degrees and most of the 2010/11 financial year was focused on the technical processes. A dedicated focus in the next financial year will enhance the implementation of FBU's as a mechanism assisting clinical managers in decision-making and accountability. Lentegeur Hospital in particular is commended for the excellent change management work in this regard.

Strengthen monitoring and evaluation capability and capacity

A service co-ordination framework has been established across the Department of Health. A mental health provincial co-ordinating committee ensured the co-ordination of mental health services across the service platform.

A mental health working group has been established under the directive from the Premier of the Western Cape and the group's focus was on substance abuse, children and adolescents.

An increasing number of mentally ill prisoners have been referred to the psychiatric services. This has highlighted the need for strengthening services within prisons. Furthermore, only Valkenberg Hospital is currently designated for treatment of mentally ill prisoners which places additional strain on an already extremely pressurised service.

3) Develop and maintain a capacitated workforce to deliver the required health services

Become the employer of choice in the health sector by creating an environment for a satisfied workforce

The psychiatric hospitals managed to fill 95.3% of their approved post list. Despite concerted efforts by this sub-programme, the set target of 97.5% was not achieved due to the high attrition rate. Contract workers were appointed as an interim measure until posts will be permanently filled. At Alexandra Hospital, twelve intellectually challenged interns were appointed with great success to the grounds, cleaning and household services.

Staff satisfaction surveys were completed in all four psychiatric hospitals to determine the level of satisfaction by using a specifically designed questionnaire. Participation ranged from 32% of staff at Lentegeur to 55% of staff at Stikland. Results varied significantly between hospitals and include:

- Staff is generally proud of the organisation ranging from 65% at Valkenberg to 86% at Stikland.
- Across the platform more than 70% of staff has job descriptions and 40 – 60% indicated having two performance appraisals.
- There was a high level of verbal abuse between staff ranging from 24% to 43% of respondents.
- Verbal and physical abuse from patients ranged from 46% to 62%.
- Motivation and teamwork scored between 60 and 78%.
- Despite the provision of a well-used Employee Assistance Programme, only 50% of respondents felt that they were well supported under stressful circumstances.
- Only Alexandra and Lentegeur Hospitals provide child care services and there is a need for this to be available for all staff.
- All hospitals have improvement plans which will be consulted with staff.

4) Provide and maintain appropriate health technology and infrastructure

Ensure the provision of infrastructure that meets the needs of current and future development

All hospitals have infrastructure plans. Maintenance to the psychiatric hospitals was completed according to these planned priorities. Regular planning and commissioning meetings were held separately as well as a combined planning and commissioning unit for the psychiatric hospitals.

The expenditure for the hospital revitalisation programme at Valkenberg Hospital totalled R 6.8 million. A large proportion was spent on repairing the main building, a national monument, at Valkenberg Hospital. The main building was refurbished with significant repair work to wooden floors and ceilings. The building is now not only being aesthetically restored it has also been improved from a safety perspective. Further funding was spent on the development of a framework for the new facility. This included historical studies of the precinct as well as developing a building and design framework for the new institution, which included the space required for the new facility within the historical and urban framework of the site.

5) Ensure a sustainable income to provide the required health services according to the needs

Reconciling performance targets with the budget and the MTEF

Performance and expenditure trends

Sub-programme 4.3 was allocated 17.47% of the programme 4 budget in 2010/11 in comparison to the 18.17% that was allocated in the 2009/10 budget. This amounted to a nominal increase of R40.101 million or 8.67%.

The sub-programme under-spent mainly due to a saving within the salaries and wages budget and despite all efforts made to fill posts.

The Department of National Justice paid an amount of R 15.2 million for the observation of awaiting trial prisoners at Valkenberg Hospital.

Table 2.2.12: Performance against targets from the 2010/11 Annual Performance Plan for specialist psychiatric hospitals

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 Ensure access to psychiatric hospital services.	1.1.1 Provide a total of 1 568 beds in specialist psychiatric hospitals by 2014.	1) Number of beds in psychiatric hospitals	1 934	1 792	1 742	1 696	Beds decreased from 2009/10 to 2010/11 due to a shift of step-down beds out of the psychiatric hospitals to dedicated step-down facilities as well as a reduction in beds at Lentegeur and Stikland Hospitals.
			2) Total separations in psychiatric hospitals	5 051	5 369	5 690	4 951	Inpatient discharges increased at Stikland and Lentegeur Hospitals. Patients are discharged to sub-acute facilities. The proportion of acute beds has increased and is reflected by the increased patient throughput.
			3) Patient day equivalents (PDE) in psychiatric hospitals	616 296	595 471	567 123	593 200	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			4) OPD total headcount in psychiatric hospitals	23 955	34 521	31 152	24 763	Part of managing acute service pressures includes the management of patients as outpatients instead of inpatients. Target was artificially set on planned closure of beds.
		1.1.2 Provide a total of 72 step-down beds and maintain a bed occupancy rate of 85% in sub-acute facilities by 2014.	5) Number of step-down beds	Not required to report	127	82	72	It was planned to transfer William Slater to Comcare (an NPO) with an overall reduction of 40 beds. However, the transfer did not realise due to contractual issues. Subsequently the acute care pressures increased and an expansion was planned at New Beginnings to manage this pressure. As a result 20 additional beds was opened during the fourth quarter (which is averaged out over the year) as the start of a 65 bed increase that was approved by the Department.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			6) Bed utilisation rate in step-down beds	Not required to report	79.3%	64.8%	85%	Step-down facilities use a manual data collection system and erroneously included patients on weekend leave as part of the inpatient days in previous years. This resulted in a higher utilisation rate against which the target was set. Data collection was corrected during the year to exclude weekend leave from inpatient days, resulting in a significant decrease in the bed utilisation rate.
			Numerator:	-	36 738	19 390	*(22 338)*	
			Denominator:	-	46 355	29 930	*(26 280)*	
			7) Total number of patient days in step down beds	Not required to report	36 738	19 390	28 543	Step-down facilities use a manual data collection system and erroneously included patients on weekend leave as part of the inpatient days in previous years. This resulted in a higher utilisation rate against which the target was set. Data collection was corrected during the year to exclude weekend leave from inpatient days, resulting in a significant decrease in the bed utilisation rate.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	1.2 Improve quality of care at all levels of care.	1.2.1 Implement and maintain quality assurance measures in psychiatric hospitals to minimise patient risk by performing monthly mortality and morbidity meetings to monitor the quality of hospital services.	8) Psychiatric hospitals with mortality and morbidity meetings every month	100%	25%	50%	100%	Psychiatric hospitals do not have dedicated monthly mortality and morbidity meetings. All hospitals however do have monthly quality assurance meetings which include clinical governance.
			Numerator:	4	1	2	4	
			Denominator:	4	4	4	4	
		1.2.2 Perform and analyse one standardised patient satisfaction survey per year to measure patient satisfaction in regional hospitals	9) Percentage of psychiatric hospitals with patient satisfaction survey using DoH template (4/4)	100%	100%	100%	100%	Target achieved.
			Numerator:	4	4	4	4	
			Denominator:	4	4	4	4	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.2.3 Implement and maintain quality assurance measures in psychiatric hospitals to minimise patient risk.	10) Psychiatric hospitals monitor adverse and safety and security incidents monthly and have a system for using the information to improve safety and reduce risks	Not required to report	Not required to report	100%	100%	Target achieved.
			Numerator:	-	-	4	4	
			Denominator:	-	-	4	4	
2. Ensure and maintain organisational strategic management capacity and synergy.	2.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	2.1.1 Appropriate management of bed utilisation within specialist psychiatric hospitals to achieve an average length of stay of 90 days and bed occupancy rate of 85% by 2014.	11) Average length of stay in psychiatric hospitals	118.3 days	109 days	98 days	100 days	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	606 826	583 871	556 739	*(532 374)*	
			Denominator:	5 131	5 369	5 690	*(5 324)*	
			12) Bed utilisation rate (based on usable beds) in psychiatric hospitals	86.8%	89.3%	87.6%	86%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	606 826	583 871	556 739	*(532 374)*	
			Denominator:	698 883	654 080	635 830	*(619 040)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
3. Ensure a sustainable income to provide the required health services according to the needs.	3.1 Allocate sufficient funds to ensure the sustained delivery of the full package of quality psychiatric hospital services.	3.1.1 Ensure the cost effective management of psychiatric hospitals at a target expenditure of R 977 per PDE by 2014. [Constant 2008/09 rand]	13) Expenditure per patient day equivalent (PDE) in psychiatric hospitals[16]	R 675	R 719	R 813	R 778	The increases due to the improved conditions of service and occupational specific dispensation are included in salaries.
			Numerator:	415 719 341	428 151 934	460 964 369	*(460 765 969)*	
			Denominator:	615 872	595 471	567 123	*(593 200)*	
4. Develop and maintain a capacitated workforce to deliver the required health services.	4.1 Become the employer of choice in the health sector by creating an environment for a satisfied workforce.	4.1.1 Ensure optimum staffing levels for all facilities by ensuring that 97.5% of affordable staff establishment remains filled.	14) 97.5% of affordable staff establishment filled for psychiatric hospitals	Not required to report	Not required to report	96.8%	100%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	-	-	1 925	*(1 989)*	
			Denominator:	-	-	1 989	*(1 989)*	

16 The expenditure per PDE targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per PDE reported in the Annual Report have also been multiplied by the same factor.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		4.1.2 Perform and analyse one standardised staff satisfaction survey to measure workforce satisfaction in the psychiatric hospitals every two years.	15) Percentage of psychiatric hospitals with staff satisfaction surveys conducted using DoH template (4/4)	Not required to report	Not required to report	100%	100%	Target achieved.
			Numerator:	-	-	4	4	
			Denominator:	-	-	4	4	
5. Provide and maintain appropriate health technology and infra-structure.	5.1 Ensure the provision of infra-structure that meets the needs of current and future development.	5.1.1 Ensure the establishment of PCUs at all institutions.	16) Percentage of hospitals with PCUs (4/4)	Not required to report	Not required to report	100 %	100%	Target achieved.
			Numerator:	-	-	4	4	
			Denominator:	-	-	4	4	
		5.1.2 Ensure 5-year plan per institution.	17) Percentage of hospitals with 5-year infrastructure plan (4/4)	Not required to report	Not required to report	100 %	75%	A combined PCU for psychiatric hospitals ensures that the infrastructure plans are appropriately developed.
			Numerator:	-	-	4	3	
			Denominator:	-	-	4	4	

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

SUB-PROGRAMME 4.4: REHABILITATION HOSPITALS

1) Manage the burden of disease

Ensure access to the full package of rehabilitation services by providing 156 rehabilitation beds by 2014.

Western Cape Rehabilitation Centre (WCRC)

Inter-disciplinary services continued to be delivered at WCRC in line with the Rehabilitation and Disability Management Service Plan in the Comprehensive Service Plan.

An important part of the services is the prevention of secondary complications in persons with disabilities, particularly in high risk groups such as the spinal cord injured.

The WCRC provided support to district health services to facilitate the development of quality rehabilitation services for persons with physical disabilities.

Orthotic and Prosthetic Centre (OPC)

The functionality of persons with disabilities was enhanced through the provision of an efficient and effective orthotic and prosthetic service on-site, off-site and outreach to all districts in the Western Cape. Outsourced orthotic and prosthetic services were rendered to the Eden and Central Karoo Districts.

A strategic plan was developed and implemented for orthotic and prosthetic services. This was also monitored and progress evaluated.

The waiting lists for orthotic and prosthetic devices, and in particular patients waiting between three to six months or longer than six months, were drastically reduced. This was largely due to increased productivity as additional staff was appointed.

Improve quality of care at all levels of care

A staff satisfaction survey and client satisfaction survey was conducted and the overall ratings for the WCRC were positive.

Infection and prevention control measures in respect of the transmission of TB in high risk areas have been improved.

Regular quality assurance meetings were held, addressing mortality and morbidity and clinical risks.

2) Ensure and maintain organisational strategic management capacity and synergy

The WCRC provided an oversight and co-ordinating structure for the provincial Mobility and Communication Assistive Devices Committee (MADAC) and Communication Assistive Devices Advisory Committee (CADAC). Matters raised at these forums requiring policy directives were tabled at the divisional executive management meetings for decision-making.

A technical workgroup for rehabilitation was established, with representation across the health platform.

The Provincial Rehabilitation Forum allowed a platform for the three universities to engage with the Department of Health regarding the placement of physiotherapy, occupational therapy and speech therapist students.

3) Develop and maintain a capacitated workforce to deliver the required health services

Become the employer of choice in the health sector by creating an environment for a satisfied workforce

Training of community-based peer supporters commenced in June 2010 and 95 persons with disabilities were trained.

Other training courses included basic, intermediate and advanced wheelchair seating and basic hemiplegia.

The WCRC provided a training and research platform to the three tertiary education institutions in the Western Cape for under- and post graduate students.

4) Provide and maintain appropriate health technology and infrastructure

Ensure the provision of infrastructure that meets the needs of current and future development

The outputs of the public private partnership (PPP) have been monitored through the various management structures to ensure compliance with contractual obligations, ensuring best value for money. No penalties have been incurred, with overall good performance by the private provider and the focus remained on planned preventative maintenance of buildings.

5) Ensure a sustainable income to provide the required health services according to the needs

Reconciling performance targets with the budget and the MTEF

Performance and expenditure trends

Sub-programme 4.4 was allocated 4.25% of the programme 4 budget in 2010/11 in comparison to the 4.42% that was allocated in 2009/10. This amounted to a nominal increase of R 9.785 million or 8.71%.

The monitoring of the PPP necessitated stringent financial controls through various management structures ensuring best value for money. The provision of facilities management and all associated services were provided at WCRC and Lentegeur Hospital. The payment obligations by the Department of Health totalled R 43 342 491 in the 2010/11 financial year. The variation under consideration is the formula for calculating the foreign exchange rate (FOREX). The cost of the PPP was proportionally divided between WCRC and Lentegeur Hospital in terms of contractual obligations.

Table 2.2.13: Performance against targets from the 2010/11 Annual Performance Plan for rehabilitation services

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 Ensure access to specialised rehabilitation services.	1.1.1 Provide a total of 156 beds in specialist rehabilitation hospitals by 2014.	1) Number of beds in rehabilitation hospitals	156	156	156	156	Target achieved.
			2) Total number of patient days in rehabilitation hospitals	49 176	48 431	41 505	49 747	Previously patients on weekend leave were erroneously included in the midnight count and targets were set against the "inflated" performance. Data collection corrected during the course of 2009/10 and this resulted in a decrease in the number of inpatient days.
			3) Total separations in rehabilitation hospitals	944	829	949	1 014	The separations target was set considerably higher than the actual 2009/10 performance.
			4) Patient day equivalents in rehabilitation hospitals	54 940	56 801	51 775	55 948	Previously patients on weekend leave were erroneously included in the midnight count and targets were set against the "inflated" performance. Data collection corrected during the course of 2009/10 and this resulted in a decrease in the number of inpatient days.
			5) OPD total headcount in rehabilitation hospitals	16 227	25 107	30 812	25 078	The Orthotic and Prosthetic Centre's OPD headcount is included in the figure for 2010/11 but was previously excluded. The target was based on the previous financial year which only included the WCRC.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	1.2 Improve quality of care at all levels of care.	1.2.1 Implement and maintain quality assurance measures in rehabilitation hospitals to minimise 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.	6) Rehabilitation hospitals with mortality and morbidity meetings every month (1/1)	100%	0%	0%	100%	Although formal mortality and morbidity meetings were not held, regular quality assurance meetings were held that addressed mortality and morbidity and clinical risks.
			Numerator:	1	0	0	*(1)*	
			Denominator:	1	1	1	*(1)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
2. Ensure and maintain organisational strategic management capacity and synergy.	2.1 Ensure that management provides sustained and strategic direction in the delivery of health services with well defined efficiency targets towards improving quality of care.	2.1.1 Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilisation rate of 85% and an average length of stay of 50 days.	7) Average length of stay in rehabilitation hospitals	52.1 days	58.4 days	43.7 days	52 days	Previously patients on weekend leave were erroneously included in the midnight count and targets were set against the "inflated" performance.
			Numerator:	49 176	48 431	41 505	*(49 747)*	Data collection corrected during the course of 2009/10 and this resulted in a decrease in the number of inpatient days.
			Denominator:	944	829	949	*(1 014)*	
			8) Bed utilisation rate (based on usable beds) in rehabilitation hospitals	86%	85%	72.9%	85%	Previously patients on weekend leave were erroneously included in the midnight count and targets were set against the "inflated" performance.
			Numerator:	49 176	48 431	41 505	*(49 747)*	Data collection corrected during the course of 2009/10 and this resulted in a decrease in the number of inpatient days.
			Denominator:	56 940	56 940	56 940	*(56 940)*	
3. Ensure a sustainable income to provide the required health services according to the needs.	3.1 Allocate sufficient funds to ensure the sustained delivery of the full package of quality rehabilitation hospital services by 2014.	3.1.1 Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R 1 667 per PDE by 2014. [Constant R2008/09 rands]	9) Expenditure per patient day equivalent (PDE) in rehabilitation hospitals[17]	R 1 387	R 1 383	R 1 609	R 1 455	The Orthotic and Prosthetic Centre's OPD headcount is included in the figure for 2010/11 but was previously excluded. The target was based on the previous financial year which only included the WCRC.
			Numerator:	68 207 112	78 565 716	83 295 482	*(81 929 886)*	An additional R1.2 million was paid in March due to the CPIX adjustment.
			Denominator:	49 176	56 801	51 775	*(55 948)*	

17 The expenditure per PDE targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per PDE reported in the Annual Report have also been multiplied by the same factor. For rehabilitation hospitals the proportional cost of the public private partnership was included in the expenditure figures.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
4. Develop and maintain a capacitated workforce to deliver the required health services.	4.1 Become the employer of choice in the health sector by creating an environment for a satisfied workforce.	4.1.1 Ensure optimum staffing levels for all facilities by ensuring that 97.5% of affordable staff establishment remains filled.	10) 97.5% of affordable staff establishment filled for rehabilitation hospitals (1/1)	Not required to report	Not required to report	94.3%	100%	APL target not achieved due to attrition rate.
			Numerator:	-	-	315	-	
			Denominator:	-	-	334	-	
5. Manage the burden of disease.	5.1 Ensure access to specialised orthotic and prosthetic services.	5.1.1 Appropriately manage the in-house and outsourced orthotic and prosthetic services.	11) Number of orthotic and prosthetic devices manufactured	5 462	4 408	6 071	5 626	Patients waiting for longer than 3 months for devices have been targeted to ensure they receive devices quicker. More interns appointed since June 2010 which have assisted in increasing the number of manufactured devices.
		5.1.2 Reduce the waiting list for orthotic and prosthetic services by increasing productivity and outsourcing of services where more cost effective.	12) Number of patients on waiting list for orthotic and prosthetic service for over 6 months	295	391	98	400	A number of job requests have been closed as patients do not respond. Increased manufactured devices for patients on waiting lists as per above.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
6. Provide and maintain appropriate health technology and infra-structure.	6.1 Ensure the provision of infra-structure that meets the needs of current and future development.	6.1.1 Ensure the establishment of PCUs at all institutions.	13) Establish PCUs per institution (1/1)	Not required to report	Not required to report	0%	100%	This function was transferred to the public private partnership (PPP) as part of their contract with the Department.
			Numerator:	-	-	0	*(1)*	
			Denominator:	-	-	1	*(1)*	
		6.1.2 Ensure 5-year plan per institution.	14) Percentage of hospitals with 5-year infrastructure plan (1/1)	Not required to report	Not required to report	0%	100%	This function was transferred to the public private partnership (PPP) as part of their contract with the Department. The infrastructure plan for the hospital is therefore included in the infrastructure plan for the PPP.
			Numerator:	-	-	0	*(1)*	
			Denominator:	-	-	1	*(1)*	

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

1) Manage the burden of disease

Ensure access to dental training hospitals

The dental training hospitals provided a service to patients at the oral health centres. Access was facilitated by adjusting the working hours for patient administration staff, screening and registering patients in the mornings and afternoons and introducing additional clinical sessions.

A permanent anaesthetist was appointed to ensure the maximum utilisation of both theatres to full capacity, performing maxillofacial surgery procedures.

Due to the high number of edentulous patients in the Western Cape a total of 4 103 dentures were provided, exceeding the set target of 3 988.

The student time table has been adjusted to make provision for more clinical sessions. Registrars qualifying at the end of the year influenced the patient throughput rates.

The dental laboratory has been restructured into different disciplines, while the newly appointed dental laboratory manager was responsible for the restructuring of the laboratory ensuring a more effective workforce.

The Oral Health Centre, University of Western Cape, supported the efforts of the provincial dental services to combat the high incidence of caries in the age group six years and younger, fluoridation of water and other projects.

The oral health plan was designed for a phased implementation approach.

Dental services have been registered on the Clinicom system and patients have been appropriately classified.

2) Ensure a sustainable income to provide the required health services according to the needs

Reconciling performance targets with the budget and the MTEF

Performance and expenditure trends

Sub-programme 4.5 was allocated 3.28% of the programme 4 budget for 2010/11 in comparison to the 3.21% that was allocated in 2009/10. This was a nominal increase of R12.680 million or 15.54%.

Table 2.2.14: Performance against targets from the 2010/11 Annual Performance Plan for academic dental services

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 Ensure access to dental training hospitals.	1.1.1 Ensure dental patients attending clinics are seen by a specialist, a general dentist, an allied health professional or students with a target of 185 454 by 2014.	1) Number of patient visits per annum	199 021	175 200	120 207	180 000	Target was based on manual data collected and will be adjusted in 2011/12. Dental services now on Clinicom system.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.1.2 Performing maxillofacial surgery procedures during which one or more incisions are made to the head and neck area and is performed in a registered operating theatre that is equipped for anaesthesia and able to provide sterile conditions for surgical procedures with a target of 1 700 by 2014.	2) Number of theatre cases per annum	1 523	1 578	1 162	1 616	For a period the theatres were not fully utilised as the emergency generator was out of order and both theatres could not be used affecting theatre time.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.1.3 Provide quality removable prosthetic devices to patients with a target of 4 108 by 2014.	3) Number of removable prosthetic devices manufactured (dentures)	2 519	3 026	4 103	3 988	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
		1.1.4 Provide a quality orthodontic service to dental patients with a target of 297 by 2014.	4) Number of new patients banded for orthodontic treatment (braces)	Not required to report	Not required to report	201	288	Targets to be aligned with student / registrar availability. The senior registrars are in their final year of study and no new patients are booked for orthodontic treatment.

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

2.2.5 Programme 5: Central Hospital Services

Purpose

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

Analysis per sub-programme

Sub-programme 5.1: Central Hospital Services

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

Strategic Objectives

The programme's strategic objectives for 2010/11 were:

- Perform appropriate 44% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.
- Ensure access to tertiary services by providing 1 460 tertiary beds for the reporting period.
- Manage bed utilisation to achieve bed occupancy rate of 85% in central hospitals by 2014/15.
- Implement quality assurance measures to minimise patient risk in the three central hospitals by performing monthly morbidity and mortality meetings to monitor the quality of hospital services by 2014/15.
- Perform and analyse one annual survey to measure patient satisfaction in each of the central hospitals by 2014/15.
- Implement quality assurance measures to minimise patient risk in the central hospitals by monthly monitoring of the surgical deaths (mortality) for the reporting period and maintaining a mortality rate of less than 4.0% for tertiary surgical services by 2014/15.
- Increase the ICD coding of inpatient activities to 80% by 2014/15.
- Ensure the cost effective management of central hospitals at a target cost of R 5 534 per patient day equivalent by 2014/15. (Constant R2008/09 rand)
- 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.
- Perform, analyse and respond to the findings of one annual standardised staff satisfaction survey to measure workforce satisfaction in each of the central hospitals by 2014/15.
- Ensure that a drug and therapeutic committee is established at each central hospital by 2014/15.
- An appointed, functional health facility board serves as key interface with the community at each central hospital by 2014/15.
- Effectively manage allocated resources to achieve the Comprehensive Service Plan target average length of stay of 6 days for central hospitals.
- 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.

Service Delivery Objectives and Indicators

This programme funds the delivery of highly specialised tertiary and quaternary services provided by the three central hospitals: Red Cross War Memorial Children's Hospital (RCWMCH), Tygerberg Hospital (TBH), and Groote Schuur Hospital (GSH).

Central hospitals provide highly specialised services for the province and receive referrals from across the country for these services.

The central hospitals also provide regional (general specialist) services to the immediate drainage area, as reported in Programme 4.1. Programme 5 also funds Maitland Cottage Home, a provincially aided hospital, which serves as an extension of Red Cross War Memorial Children's Hospital to provide highly specialised paediatric orthopaedic surgery. The central hospitals also serve as an important training platform to train under- and post graduate health professionals.

The programme's strategic objectives and goals were aligned to the Provincial and National Department of Health's goals and objectives. The programme focused on three key performance areas during 2010/11, namely:

1) Service delivery
2) Clinical governance and quality assurance
3) Corporate governance

1) Service delivery

Manage the burden of disease

The Acute Emergency Case Load Management Policy was implemented in the central hospitals and six hourly hospital bed status reports were submitted to Emergency Medical Services to ensure co-ordinated patient referrals across the platform.

Red Cross War Memorial Children's Hospital operated twenty-two critical care beds. In addition, Tygerberg Hospital commissioned two additional paediatric critical care beds and Groote Schuur Hospital operated four post anaesthetic high care beds during weekdays by January 2011. Groote Schuur Hospital also established twelve lodging beds for patients requiring de-hospitalised care and re-instated seven theatre slates during the course of 2010/11.

The central hospitals participated in the national HIV counselling and testing (HCT) campaign and performed more than 9 117 patient screening tests for HIV.

Some of the key tertiary service outputs during 2010/11 are highlighted below:

- Groote Schuur Hospital:
  - 199 heart valve replacements
  - 68 kidney transplants, 7 liver transplants and 1 heart transplant
  - 22 renal dialysis stations operated for patients with chronic renal failure
  - 221 hip replacements, 51 knee replacements
  - 32 bone marrow transplants (adults and children)

- Red Cross War Memorial Children's Hospital:
  - 409 cardiac and cardiothoracic operations
  - 1 039 children admitted and treated for burns
  - 13 complex spinal operations performed
  - 4 liver transplants, 8 kidney transplants

- Tygerberg Hospital:
  - 24 kidney transplants
  - 20 renal dialysis stations operated for chronic patients with chronic renal failure
  - 5 cochlear implants performed
  - 137 hip replacements, 59 knee replacements
  - 375 vitreoretinal surgical cases done

The central hospitals formed key strategic partnerships to enhance the delivery of clinical services that include the following:

- In partnership with the Smile Foundation, Red Cross War Memorial Children's Hospital commissioned additional surgical lists for a week to perform paediatric reconstructive facial surgery.
- Tygerberg Hospital played a clinical oversight role in the recently initiated Pink drive initiative aimed at performing radiological screening examinations for breast cancer in women.
- Tygerberg Hospital also contracted private providers in Paarl and Hermanus for the rendering of renal dialysis services.
- Tygerberg Hospital in association with the Cancer Association of South Africa (CANSA) commissioned twenty lodging beds to support the de-hospitalised care for oncology patients.
- In partnership with the Walter Sisulu Foundation, Red Cross War Memorial Children's Hospital established additional intensive care capacity for patients that underwent cardiac and cardiothoracic operations.

2) Clinical governance and quality assurance

Ensure and maintain organisational strategic management capacity and synergy

Managers and clinicians from the central hospitals play a key role in systems strengthening and clinical governance in the respective geographical service areas (GSA) as well as the clinical discipline specific provincial co-ordinating committees. A framework to guide decision-making for high cost consumables and procedures has been drafted.

Improve the quality of health services

Each central hospital performed monthly morbidity and mortality meetings to monitor the quality of services and patient outcomes. A patient satisfaction survey was conducted in each hospital and the findings serve as a departure point to plan interventions towards improving services.

A dedicated quality assurance manager is appointed at each central hospital and reports directly to the chief executive officer (CEO). Each central hospital has functional infection prevention and control committees. Key managers attended an infection, prevention and control training course.

3) Corporate governance

Ensure and maintain organisational strategic management capacity and synergy

Functional Business Units[18] (FBUs) for decentralised decision making, management and accountability were further strengthened.

Functional hospital boards in each hospital performed an oversight and governance role and held regular meetings with senior hospital management.

Develop and maintain a capacitated workforce

To ensure a capacitated workforce, 97% of funded posts were continually filled given a 7% attrition rate (excluding contract workers). Skills development plans were in place for each of the central hospitals.

Provide and maintain appropriate health technology and infrastructure

Each central hospital has a planning and commissioning unit/structure. The infrastructure needs of each hospital were documented in five year plan and the following key infrastructure projects were concluded in 2010/11:

- Red Cross War Memorial Children's Hospital
  - Renovation of a surgical ward

- Tygerberg Hospital
  - Renovation of the ear, nose and throat ward
  - Renovation of the pharmacy and lodging ward

- Groote Schuur Hospital
  - A new closed circuit television system was completed
  - The respiratory clinic air-conditioning system was modified to reduce exposure to TB

The total spending on medical and allied equipment for the central hospitals was R 56.7 million. Key equipment acquisitions include the following items:

- Groote Schuur Hospital:
  - fifteen ultrasound machines
  - four new anaesthetic machines
  - eight haemodialysis machines
  - neurosurgical camera stack
  - lung function system

18 FBUs are aggregated cost centres in a functional arrangement, supported with information on human and financial resources, expenditure trends, quality and patient activities.

- Tygerberg Hospital:
  - retinal imaging system
  - three theatre tables
  - ear, nose and throat surgical laser system
  - mobile C-arm unit
  - seven intensive care ventilators
  - five renal dialysis machines
  - mobile X-ray unit
  - high definition colonoscope

- Red Cross War Memorial Children's Hospital:
  - ultrasound machines
  - digital pan and cephalometric unit
  - ventilators
  - computed radiography system
  - video and fibre optic bronchoscopes
  - diagnostic otoacoustic emission monitor
  - hearing aid analyser
  - ethylene oxide steriliser

The allocated funding (R 33.71 million) for the Modernisation of Tertiary Services was used to improve the medical imaging and diagnostic service and key achievements were as follows:

- Roll out of the Picture Archiving and Communication System/Radiological Information System (PACS/RIS) solution to Groote Schuur Hospital.
- Concluding the PACS/RIS roll out at Tygerberg Hospital.
- The tender was drafted for the planned roll out of PACS/RIS to regional and district hospitals.
- Purchasing of a gamma camera at Tygerberg Hospital.

Funding of clinical engineering capacity at the central hospitals is essential for the maintenance of equipment.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2010/11 ANNUAL PERFORMANCE PLAN

Table 2.2.15: Performance against targets from the 2010/11 Annual Performance Plan for central hospitals

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 Reduce maternal mortality as a result of 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 for central hospitals	40.6%	43.9%[19]	46.1%[20]	44%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	4 915	5 052	6 024	5 235	
			Denominator:	12 123	11 509	13 055	11 930	
	1.2 Ensure the delivery of tertiary services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to tertiary services by providing 1 460 tertiary beds for the reporting period.	2) Number of designated tertiary beds in central hospitals	1 460	1 468	1 473	1 460	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			3) Total separations in central hospitals	62 555	68 231	68 490	70 610	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			4) OPD total headcounts in central hospitals	543 461	537 749	541 079	539 279	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.

19 Caesarean section rate is reported under level 3 central hospitals only in Programme 5.1 and not in Programme 4.1.
20 The reported caesarean section rate is for the general specialist and highly specialized services combined.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			5) Patient day equivalents in central hospitals	603 475	625 661	634 782	635 859	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
	1.3 Ensure optimal access to highly specialised services to manage the burden of disease.	1.3.1 Manage bed utilisation to achieve bed occupancy rate of 85% in central hospitals by 2014/15.	6) Bed utilisation rate (based on usable beds) in central hospitals	79.3%	83.3%	84.5%	84%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	422 267	446 411	454 423	*(446 910)*	
			Denominator:	1 460x365	535 820	537 645	*(532 900)*	
	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.	7) Number of central hospitals conducting monthly morbidity and mortality reviews	3	3	3	3	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.4.2 Perform and analyse one annual survey to measure patient satisfaction in each of the central hospitals by 2014/15.	8) Number of central hospitals that performed an annual patient satisfaction survey	3	3	3	3	Target achieved.
		1.4.3 Implement quality assurance measures to minimise patient risk in the central hospitals by monthly monitoring of the surgical deaths (mortality) for the reporting period and maintaining a mortality rate of less than 4.0% for tertiary surgical services by 2014/15.	9) Case fatality rate in central hospitals for surgery separations	2.4%	3.3%	3.3%	4.2%	The case fatality rate was lower than anticipated for both Groote Schuur and Tygerberg Hospital. Actual performance was better than initially estimated. Refer to individual hospitals comments.
			Numerator:	583	648	660	*(861)*	
			Denominator:	24 422	19 498	20 151	*(20 281)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
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% by 2014/15.	10) ICD 10 coding rate of 80% for inpatient activities in central hospitals by 2014/15	Not required to report	Not required to report	86.8%	75%	This indicator was not reported in the previous years so no baseline was available to inform an accurate target. The performance was better than originally estimated. ICD 10 coding is a requirement to raise accounts and revenue generation.
			Numerator:	-	-	59 483	*(52 958)*	
			Denominator:	-	-	68 490	*(70 610)*	
		2.1.2 Ensure the cost effective management of central hospitals at a target cost of R 5 534 per patient day equivalent by 2014/15. [Constant R2008/09 rand]	11) Expenditure per patient day equivalent in central hospitals[21]	R 3 247	R 3 385	R 3 654	R 3 546	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	1 959 752 249	2 117 695 125	2 319 491 392	*(2 254 756 014)*	
			Denominator:	603 476	625 661	634 782	*(635 859)*	

21 The expenditure per PDE targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per PDE reported in the Annual Report have also been multiplied by the same factor.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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.	12) Number of central hospitals with an approved skills development plan	Not required to report	Not required to report	3	3	Target achieved.
	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 each of the central hospitals by 2014/15.	13) Number of central hospitals that performed a staff satisfaction survey	Not required to report	Not required to report	3	3	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
4. Ensure 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.	14) Number of central hospitals with an appointed drug and therapeutic committee	Not required to report	Not required to report	3	3	Target achieved.
	4.2 Establish a health facility board as a key supportive governance structure.	4.2.1 An appointed, functional health facility board serves as key inter-face with the community at each central hospital by 2014/15.	15) Number of central hospitals with an appointed health facility board	Not required to report	Not required to report	3	3	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	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 manage allocated resources to achieve the Comprehen-sive Service Plan target average length of stay of 6 days for central hospitals.	16) Average length of stay in central hospitals	6.8 days	6.5 days	6.6 days	6.4 days	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	422 267	446 411	454 423	447 528	
			Denominator:	62 555	68 231	68 490	69 659	
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 commis-sioning 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.	17) Number of central hospitals with an appointed and functioning planning and commissioning unit	Not required to report	Not required to report	3	3	Target achieved.

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

Table 2.2.16: Performance against targets from the 2010/11 Annual Performance Plan for Groote Schuur Hospital

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 Reduce maternal mortality as a result of 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 for Groote Schuur Hospital	51.1%	52.5%[22]	54.3%[23]	54%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	2 587	2 861	3 875	*(4 070)*	
			Denominator:	5 094	5 452	7 139	*(7 548)*	
	1.2 Ensure the delivery of tertiary services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to tertiary services by providing 1 460 tertiary beds for the reporting period.	2) Provide 607 tertiary beds in Groote Schuur Hospital	695	625	630	617	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			3) Total separations in Groote Schuur Hospital	33 785	33 293	32 788	30 474	The number of separations was higher than originally expected. This is as a result of the bed utilisation being higher than originally planned as well as operating and reporting on 13 more beds than originally planned.

22 Caesarean section rate is reported only under level 3 central hospitals only in Programme 5.1 and not in Programme 4.1.
23 The reported caesarean section rate is for the general specialist and highly specialised services combined.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			4) OPD total headcounts in Groote Schuur Hospital	259 361	268 551	262 463	256 440	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			5) Patient day equivalents in Groote Schuur Hospital	302 817	300 397	301 512	304 072	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
	1.3 Ensure optimal access to highly specialised services to manage the burden of disease.	1.3.1 Manage bed utilisation to achieve bed occupancy rate of 85% in central hospitals by 2014/15.	6) Bed utilisation rate (based on usable beds) in Groote Schuur Hospital	85.5%	92.4%	93.1%	88%	Since Groote Schuur receives drainage from GF Jooste Hospital the bed utilisation rate increased. Neonatology, obstetrics and gynaecology and surgery were the main contributing disciplines.
			Numerator:	216 308	210 880	214 025	*(198 180)*	
			Denominator:	685x365	228 125	229 950	*(225 205)*	
	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.	7) Groote Schuur Hospital conducts monthly morbidity and mortality reviews	Yes (1)	Yes (1)	Yes (1)	1	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.4.2 Perform and analyse one annual survey to measure patient satisfaction in each of the central hospitals by 2014/15.	8) Groote Schuur Hospital performed an annual patient satisfaction survey	Yes (1)	Yes (1)	Yes (1)	1	Target achieved.
		1.4.3 Implement quality assurance measures to minimise patient risk in the central hospitals by monthly monitoring of the surgical deaths (mortality) for the reporting period and maintaining a mortality rate of less than 4.0% for tertiary surgical services by 2014/15.	9) Case fatality rate in Groote Schuur Hospital for surgery separations	3.0%	2.2%	2.1%	3.5%	The performance was better than initially estimated. Strategies included infection prevention and control and improved quality of care and patient safety.
			Numerator:	342	248	241	*(414)*	
			Denominator:	11 265	11 213	11 605	*(11 821)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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% by 2014/15.	10) ICD 10 coding rate of 80% for inpatient activities in Groote Schuur Hospital by 2014/15	Not required to report	Not required to report	85.0%	75%	This indicator was not reported in the previous years so no baseline was available to inform an accurate target. The performance was better than originally estimated. ICD 10 coding is a requirement to raise accounts and revenue generation.
			Numerator:	-	-	27 872	*(22 856)*	
			Denominator:	-	-	32 788	*(30 474)*	
		2.1.2 Ensure the cost effective management of central hospitals at a target cost of R 5 534 per patient day equivalent by 2014/15. [Constant R2008/09 rand]	11) Expenditure per patient day equivalent in Groote Schuur Hospital[24]	R 3 232	R 3 301	R 3 704	R 3 584	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	978 704 544	991 572 224	1 116 892 547	*(1 089 794 084)*	
			Denominator:	302 831	300 397	301 512	*(304 072)*	

24 The expenditure per PDE targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per PDE reported in the Annual Report have also been multiplied by the same factor.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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.	12) Groote Schuur Hospital with an approved skills development plan	Not required to report	Not required to report	1	1	Target achieved.
	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 each of the central hospitals by 2014/15.	13) Groote Schuur Hospital performed a staff satisfaction survey	Not required to report	Not required to report	1	1	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
4. Ensure 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.	14) Groote Schuur Hospital has appointed a drug and therapeutic committee	Not required to report	Not required to report	1	1	Target achieved.
	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.	15) Groote Schuur Hospital has appointed a health facility board	Not required to report	Not required to report	1	1	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	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 manage allocated resources to achieve the Comprehen-sive Service Plan target average length of stay of 6 days for central hospitals.	16) Average length of stay in Groote Schuur Hospital	6.4 days	6.3 days	6.5 days	6.5 days	Target achieved.
			Numerator:	218 308	210 880	214 025	*(198 081)*	
			Denominator:	33 785	33 293	32 788	*(30 474)*	
5. Provide and maintain appropriate health technology and infra-structure.	5.1 Ensure the provision of infra-structure that meets the needs of current and future development.	5.1.1 Ensure that a functional planning and commis-sioning 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.	17) Groote Schuur Hospital has an appointed and functioning planning and commissioning unit	Not required to report	Not required to report	1	1	Target achieved.

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

Table 2.2.17: Performance against targets from the 2010/11 Annual Performance Plan for Tygerberg Hospital

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 Reduce maternal mortality as a result of 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 for Tygerberg Hospital	33.2%	36.2%[25]	36.3%	35%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	2 328	2 191	2 149	2 205	
			Denominator:	7 029	6 057	5 916	6 341	
	1.2 Ensure the delivery of tertiary services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to tertiary services by providing 1 460 tertiary beds for the reporting period.	2) Provide 608 tertiary beds in Tygerberg Hospital	538	608	608	608	Target achieved.

25 Caesarean section rate is reported only under level 3 central hospitals only in Programme 5.1 and not in Programme 4.1.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			3) Total separations in Tygerberg Hospital	18 548	22 611	23 214	27 200	Separations have been under reported for highly specialised services. This is largely due to internal transfers from highly to general specialist services that cannot be recorded as separations. This reduces the number of separations in the highly specialised (L3) services, as the separation is often only recorded in the specialised general services reported under Programme 4.1.
			4) OPD total headcount in Tygerberg Hospital	203 643	187 654	197 259	202 391	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			5) Patient day equivalents in Tygerberg Hospital	205 995	225 672	232 604	233 066	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
	1.3 Ensure optimal access to highly specialised services to manage the burden of disease.	1.3.1 Manage bed utilisation to achieve bed occupancy rate of 85% in central hospitals by 2014/15.	6) Bed utilisation rate (based on usable beds) in Tygerberg Hospital	70.3%	73.5%	75.2%	80%	A number of tertiary beds in various highly specialised units de-escalate during weekends. Based on the nature of these services the majority of the service load and admissions occur during the normal working days therefore reducing the average bed utilisation.
			Numerator:	138 114	163 121	166 851	*(177 536)*	
			Denominator:	538x365	221 920	221 920	*(221 920)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	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.	7) Tygerberg Hospital conducts monthly morbidity and mortality reviews	Yes (1)	Yes (1)	Yes (1)	1	Target achieved.
		1.4.2 Perform and analyse one annual survey to measure patient satisfaction in each of the central hospitals by 2014/15.	8) Tygerberg Hospital performed an annual patient satisfaction survey	Yes (1)	Yes (1)	Yes (1)	1	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.4.3 Implement quality assurance measures to minimise patient risk in the central hospitals by monthly monitoring of the surgical deaths (mortality) for the reporting period and maintaining a mortality rate of less than 4.0% for tertiary surgical services by 2014/15.	9) Case fatality rate in Tygerberg Hospital for surgery separations	2.8%	4.9%	5.0%	5.4 %	The performance was better than initially estimated. Strategies included infection prevention and control and improved quality of care and patient safety.
			Numerator:	229	400	417	*(446)*	
			Denominator:	8 311	8 110	8 392	*(8 260)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
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% by 2014/15.	10) ICD 10 coding rate of 80% for inpatient activities in Tygerberg Hospital by 2014/15	Not required to report	Not required to report	83.9%	75%	This indicator was not reported in the previous years so no baseline was available to inform an accurate target. The performance was better than originally estimated. ICD 10 coding is a requirement to raise accounts and revenue generation.
			Numerator:	-	-	19 488	*(20 400)*	
			Denominator:	-	-	23 214	*(27 200)*	
		2.1.2 Ensure the cost effective management of central hospitals at a target cost of R 5 534 per patient day equivalent by 2014/15. [Constant R2008/09 rand]	11) Expenditure per patient day equivalent in Tygerberg Hospital[26]	R 3 331	R 3 580	R 3 765	R 3 333	The original cost per patient day equivalent was calculated based on the original allocated budget and the projected patient day equivalents. The original allocation was supplemented in the adjustment budget.
			Numerator:	686 169 345	807 998 460	875 826 470	*(776 808 978)*	
			Denominator:	205 995	225 672	232 604	*(233 066)*	

26 The expenditure per PDE targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per PDE reported in the Annual Report have also been multiplied by the same factor.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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.	12) Tygerberg Hospital with an approved skills development plan	Not required to report	Not required to report	1	1	Target achieved.
	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 each of the central hospitals by 2014/15.	13) Tygerberg Hospital performed a staff satisfaction survey	Not required to report	Not required to report	1	1	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
4. Ensure 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.	14) Tygerberg Hospital has appointed a drug and therapeutic committee	Not required to report	Not required to report	1	1	Target achieved.
	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.	15) Tygerberg Hospital has appointed a health facility board	Not required to report	Not required to report	1	1	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	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 manage allocated resources to achieve the Comprehen-sive Service Plan target average length of stay of 6 days for central hospitals.	16) Average length of stay in Tygerberg Hospital Numerator: Denominator:	7.5 days 138 114 18 584	7.2 days 163 121 22 611	7.2 days 166 851 23 214	6.5 days *(176 800)* *(27 200)*	The average length of stay was longer than planned. This is as of a result of the denominator (separations) being lower than expected. (See previous explanation for indicator 3).
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 commis-sioning 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.	17) Tygerberg Hospital has an appointed and functioning planning and commissioning unit	Not required to report	Not required to report	1	1	Target achieved.

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

Table 2.2.18: Performance against targets from the 2010/11 Annual Performance Plan for Red Cross War Memorial Children's Hospital

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the burden of disease.	1.1 Reduce maternal mortality as a result of 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 for Red Cross War Memorial Children's Hospital (RCWMCH)	Not applicable	Not applicable	Not applicable	Not applicable	Service not rendered by RCWMCH.
	1.2 Ensure the delivery of tertiary services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to tertiary services by providing 1 460 tertiary beds for the reporting period.	2) Provide 255 tertiary beds in RCWMCH	227	235	235	235	Target achieved.
			3) Total separations in RCWMCH	10 222	12 327	12 488	11 984	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			4) OPD total headcounts in RCWMCH	80 457	81 544	81 357	80 448	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			5) Patient day equivalents in RCWMCH	94 664	99 592	100 666	98 721	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	1.3 Ensure optimal access to highly specialised services to manage the burden of disease.	1.3.1 Manage bed utilisation to achieve bed occupancy rate of 85% in central hospitals by 2014/15.	6) Bed utilisation rate (based on usable beds) in RCWMCH	81.9%	84.4%	85.7%	83%	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	67 845	72 411	73 547	*(71 193)*	
			Denominator:	227x365	85 775	85 775	*(85 775)*	
	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.	7) RCWMCH conducts monthly morbidity and mortality reviews	Yes (1)	Yes (1)	Yes (1)	1	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.4.2 Perform and analyse one annual survey to measure patient satis-faction in each of the central hospitals by 2014/15.	8) RCWMCH performed an annual patient satisfaction survey	Yes (1)	Yes (1)	Yes (1)	1	Target achieved.
		1.4.3 Implement quality assurance measures to minimise patient risk in the central hospitals by monthly monitoring of surgical deaths (mortality) for the reporting period and maintaining a mortality rate of less than 4.0% for tertiary surgical services by 2014/15.	9) Case fatality rate in RCWMCH for surgery separations	0.2%	0%	1.3%	0.5%	The reporting framework was aligned to the national definition guidelines since 2009/10. According to the National Department of Health only deaths in patients older than 13 years can be recorded as surgical deaths. (Deaths in patients younger than 13 years will be recorded as paediatric deaths.) Red Cross War Memorial Children's Hospital specialises in the treatment of paediatric patients (under 13 years old) and therefore the nationally prescribed indicator is not appropriate for this hospital. The Department has communicated this to the National Department of Health but to date no response has been received. As a result of the small denominator, the indicator is very sensitive. It is more appropriate to peruse the numerator which reflects the number of deaths that occurred for the year.
			Numerator:	12	0	2	*(1)*	
			Denominator:	4 846	175	154	*(200)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
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% by 2014/15.	10) ICD 10 coding rate of 80% for inpatient activities in RCWMCH by 2014/15	Not required to report	Not required to report	97.1%	75%	This indicator was not reported in the previous years so no baseline was available to inform an accurate target. The performance was better than originally estimated. ICD 10 coding is a requirement to raise accounts and revenue generation.
			Numerator:	-	-	12 123	*(8 988)*	
			Denominator:	-	-	12 488	*(11 984)*	
		2.1.2 Ensure the cost effective management of central hospitals at a target cost of R 5 534 per patient day equivalent by 2014/15. [Constant 2008/09 rand]	11) Expenditure per patient day equivalent in RCWMCH[27]	R 3 115	R 3 194	R 3 246	R 3 520	Red Cross War Memorial Children's Hospital produced more patient day equivalents (denominator) than originally planned as a result of a higher bed occupancy rate. Transfer payments made to Maitland Cottage was excluded in the final calculation.
			Numerator:	294 878 360	318 124 442	326 772 375	*(347 497 920)*	
			Denominator:	94 664	99 592	100 666	*(98 721)*	

27 The expenditure per PDE targets in the 2010/11 APP were all given in 2008/09 rand values to be comparable to the latest available actual expenditure at that stage. To do this the 2010/11 targets were multiplied by 0.8686. To be comparable, the actual 2009/10 and 2010/11 expenditure per PDE reported in the Annual Report have also been multiplied by the same factor.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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.	12) RCWMCH with an approved skills development plan	Not required to report	Not required to report	1	1	Target achieved.
	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 each of the central hospitals by 2014/15.	13) RCWMCH performed a staff satisfaction survey	Not required to report	Not required to report	1	1	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
4. Ensure 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.	14) RCWMCH has appointed a Drug and Therapeutic committee	Not required to report	Not required to report	1	1	Target achieved.
	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.	15) RCWMCH has appointed a health facility board	Not required to report	Not required to report	1	1	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
	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 manage allocated resources to achieve the Comprehen-sive Service Plan target average length of stay of 6 days for central hospitals.	16) Average length of stay in RCWMCH	6.6 days	5.9 days	5.9 days	6 days	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	67 845	72 411	73 547	*(71 904)*	
			Denominator:	10 222	12 327	12 488	*(11 984)*	
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 commis-sioning 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.	17) RCWMCH has an appointed and functioning planning and commissioning unit	Not required to report	Not required to report	1	1	Target achieved.

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

2.2.6 Programme 6: Health Sciences and Training

Purpose

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

Analysis per sub-programme

Sub-programme 6.1: Nurse Training College

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

Sub-programme 6.2: Emergency Medical Services (EMS) Training College

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

Sub-programme 6.3: Bursaries

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

Sub-programme 6.4: Primary Health Care (PHC) Training

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

Sub-programme 6.5: Training (Other)

Provision of skills development interventions for all occupational categories in the department. Target group includes actual and potential employees.

Strategic Objectives

The programme's strategic objectives for 2010/11 were:

- Increase the availability of health science students to address scarce skills.
- 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.
- Ensure senior management and facilities' management have the required management competencies to deliver quality health services.
- Ensure optimum improvement and maintenance of competencies (iMOCOMP) of health and support professionals to address integrated health care including DHS burden of disease priorities.
- Ensure the integration of quality assurance into all levels of care.
- Expand community-based care services through the optimum training and development of home based carers as part of Expanded Public Works Programme (EPWP).

Service Delivery Objectives and Indicators

Human resource planning and human resource development are key to strengthening health system effectiveness and, within the Western Cape Department of Health context, to increasing the wellness of the people of the province through the provision of comprehensive quality health care services, from primary health care to highly specialised services.

Education, training and development strategies to alleviate skills shortages range from bursaries and learnerships to address scarce skills in health professional categories, to improvement and maintenance of competencies of medical practitioners (iMOCOMP) and continuous education, training and development opportunities linked to continuous professional development (CPD) of existing staff to address critical skills and capacity.

Sub-programmes 6.1, 6.2 and 6.3 (the Nurse Training College, Emergency Medical Services (EMS) Training College and Bursaries) respectively address the production of the health workforce related to the scarce health needs. All targets for the indicators have been exceeded due to the availability of additional bursary funding and increased output at the colleges. This resulted in an:

- Increase in medical officer (MBChB) output.
- Increase in nurse output (basic and advanced nurse students graduating).
- Increase in and strengthening of registrar development.

The target for the sub-programme 6.4 primary health care (PHC) training indicator, the number of health and support professionals receiving clinical training at the various levels of care to address the burden of disease priorities, has also been surpassed by 22%. The additional capacity and accessibility to iMOCOMP funding at the decentralised district level led to an increase in opportunities in clinical training within the district health services.

Within sub-programme 6.5 (Training (other)) the focus of skills development interventions has been on the community-based care services through the training of home based carers as part of the Expanded Public Works Programme (EPWP). The targets for the strengthening of facility management at all levels of care through higher education programmes and in-service training were met and exceeded respectively.

Targets however for the training of home community based carers (HCBCs) were not met due to a reduced intake and attrition in the third quarter. The number of data capturer interns exceeded targets based on the need and capacity to absorb the interns within the Department.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2010/11 ANNUAL PERFORMANCE PLAN

Table 2.2.19: Performance against targets from the 2010/11 Annual Performance Plan for health sciences and training

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Develop and maintain a capacitated workforce to deliver the required health services.	1.1 Develop, implement, monitor and evaluate a comprehend-sive 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 Comprehen-sive 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	Not required to report	Not required to report	1 003	643	Total number of health science students graduating = (4) basic nurse students graduating + (5) medical registrars graduating + (6) advanced nurse students graduating. The numbers of basic and advanced nurse students and medical registrars graduating at the nursing schools and universities respectively exceed the projected target. The targets for indicators (5) and (6) are set by external stakeholders, the higher education institutions, where actual performance has far exceeded the target.
			2) Intake of nurse students (HEIs and nursing colleges)	671	2 906	2 230	2 213	Actual performance reflects the intake for the 2010 academic intake. Additional intake of 17 students possible due to the available capacity at WCCN and UWC.
			3) Students with bursaries from the province	2 343	2 436	2 877	3 340	Decreased number of students with bursaries from the province due to increase in per capita bursary funding allocation. (Average R30 000 per capita).
			4) Basic nurse students graduating	111	171	437	400	The numbers of basic nurse students graduating at the nursing schools has exceeded the projected target. There were an additional 37 students in final year.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			5) Medical registrars graduating	44	25	83	44	The numbers of medical registrars graduating at the universities has exceeded the projected target. The target set was unrealistic taken into consideration the number of medical registrars in final year. Targets were set by the higher education institutions (HEIs).
			6) Advanced nurse students graduating	30	52	483	199	The numbers of advanced nurse students graduating at the universities has exceeded the projected target. The target set was unrealistic taken into consideration the number of advanced nurse students registrars in final year. Targets were set by the higher education institutions (HEIs).
			7) Average training cost per basic nursing graduate	R 12 650	R 14 000	R 14 908	R 15 300	The average training cost per basic nursing graduate has stabilised. The cost is calculated based on the cost of the available basic nurse training courses.
			Numerator:	-	-	R 29 816	-	
			Denominator:	-	-	2	-	
			8) Development component of HPTD grant spent	0%	0%	0%	0%[28]	Target achieved.

28 The Western Cape Department of Health does not receive a development component for the HPTDG.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		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.	9) Total number of health and support professionals trained and developed through formal and informal training	Not required to report	Not required to report	4 229	2 338	The initial target set was too conservative. The availability of funding and the accessibility of formal and informal courses at a centralised and decentralised level led to an increase in the total number of health and support professionals trained and developed. The districts, facilities and institutions used the 1% skills funding (1% of personnel expenditure) to fund the increased training.
			10) Number of EMC staff intake on HPCSA accredited programmes (one of these courses is a 2 year course)	Not required to report	Not required to report	297	207	This includes Basic Life Support (BLS), Intermediate Life Support (ILS) and Advanced Life Support (ALS) training. Intake had exceeded initial targets and the EMC college had the capacity to train this increased number of students. Initial target based on national policy directive to phase out short course training in favour of the accredited EMC practitioner qualification. This decision was later placed on hold and EMC was able to continue with HPCSA accredited programmes, having the additional capacity and resources available.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			11) Number of EMC staff accessing CME activities	Not required to report	2 617[29]	2 931	800	EMC staff accessing CME activities has far exceed targets due to the availability and accessibility of opportunities. Initial target based on national policy directive to phase out short course training in favour of the accredited EMC practitioner qualification. This decision was later placed on hold and EMC was able to continue with the short course curriculum, having the additional capacity and resources for additional short course training.
			12) Number of EMC staff in training in Rescue Qualifications	Not required to report	Not required to report	230	36	Initial target based on national policy directive to phase out short course training in favour of the accredited EMC practitioner qualification. This decision was later placed on hold and EMC was able to continue with the short course curriculum, having the additional capacity and resources for the training in Rescue Qualifications.
			13) Number of EMC students in training in the Contact Centre (communications) qualifications	Not required to report	15	39	35	The course scheduled in Oct 2010 had an intake of 39 students as opposed to the planned intake of 35. This was based on 4 additional applications and the capacity of the EMC college to absorb the extra students on training.

29 There has been a major boost to strengthening HRD within EMS. The 2 617 also contains the approximately 1 400 people trained for major incident management in preparation for the World Cup.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			14) Number of employees attending the Massified Induction Programme (MIP)	Not required to report	Not required to report	872	860	The number of employees attending the Massified Induction Programme (MIP) is dependent on the new appointments within the Department hence the deviation from the projected figure. In order to co-ordinate the additional numbers, additional MIP trainers were trained per district.
			15) Number of learnerships for employed personnel	Not required to report	Not required to report	105	250	Limited funding allocation from HWSETA led to a decrease in number of leanerships for employed personnel. The Department will investigate alternative funding mechanisms.
			16) Number of learnerships for unemployed personnel	Not required to report	Not required to report	39	150	Limited funding allocation from HWSETA led to decrease in number of leanerships for unemployed personnel. The Department will investigate alternative funding mechanisms, e.g. the Expanded Public Works Programme (EPWP).
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.	17) Number of bursaries awarded to managers for formal Leadership & Management training	Not required to report	Not required to report	49	53	Attrition of candidates: Three terminations in the second quarter added to an earlier withdrawal from the programme.
			18) Number of personnel attending Leadership & Management training programmes	Not required to report	Not required to report	901	893	The additional capacity and accessibility to skills development funding at the decentralised district level and within the central and regional hospitals led to an increase in the personnel attending Leadership & Management training programmes. The additional funding was sourced via the district and facility/ institution skills development budgets (1% of personnel expenditure) for the training.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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.	19) Number of health and support professionals receiving clinical training at the various levels of care on interdivisional burden of disease priorities	Not required to report	Not required to report	1 761	1 600	The additional capacity and accessibility to iMOCOMP funding at the decentralised district level led to an increase in opportunities in clinical training within the District Health Services. The iMOCOMP budget located within sub-programme 6.5 and the decentralised district, facility/ institution budgets accounted for the additional training. Many of these training interventions are also conducted internally at no direct cost.
		3.1.2 Ensure the integration of quality assurance into all levels of care.	20) Number of front line personnel on salary level 1 – 6 trained on Batho Pele principles	Not required to report	Not required to report	230	600	The contract of the service provider had ended in the 2nd quarter and therefore on review the targets set were too ambitious. No new service provider has been appointed at a central level. As a way forward, the decentralised units will engage training providers based on need.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
4. Manage the burden of disease.	4.1 Efficiently and effectively manage the de-hospitalisation 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).	21) Number of Home Community Based Carers (HCBCs)	1 792	1 896	1 614	2 200	The intake of learners took place in the first quarter as opposed to two six monthly intakes due to the HWSETA requirements on the one year qualification. The operational pressures of the NPOs led to a reduced intake. An additional spike in attrition in the third quarter due to learners exiting for full time employment. More relief workers will be employed as a contingency to release the carers for study.
			22) Number of data capturer interns	165	110	267	192	The total of 280 includes an overlapping intake of data capturer interns, where contracts of interns were extended past the 12 month internship period. 110 interns are carried forward from 2009/10 as their training has overlapped to 2010/11. Additional intakes took place in November 2010 and January 2011 of 170 interns in total. There was additional EPWP funding available of R 700 000 to cover the additional costs of stipends.

Reasons for major variances

Total number of health science students graduating

The total number of health science students graduating reflects the sum of indicators 4, 5 and 6, i.e. the basic nurse students graduating, medical registrars graduating and advanced nurse students graduating.

The numbers of basic and advanced nurse students and medical registrars graduating at the nursing schools and universities respectively exceed the projected target.

The targets for medical registrars and advanced nurse students graduating are set by external stakeholders, the higher education institutions, where actual performance has far exceeded the target.

2.2.7 Programme 7: Health Care Support Services

Purpose

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

Analysis per sub-programme

Sub-programme 7.1: Laundry Services

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

Sub-programme 7.2: Engineering Services

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

Sub-programme 7.3: Forensic Services

Rendering specialised forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death. This function has been transferred from sub-programme 2.8.

Sub-programme 7.4: Orthotic and Prosthetic Services

Rendering specialised orthotic and prosthetic services.

Sub-programme 7.5: Medicine Trading Account

Managing the supply of pharmaceuticals and medical sundries to hospitals, community health centres and local authorities.

Strategic Objectives

The strategic objectives for 2010/11 were:

Sub-programme 7.1: Laundry services

- Provide all health facilities with the quantity of clean disinfected linen required to deliver quality healthcare.
- Provide a laundry service using in-house laundries.
- Provide a laundry service using outsourced laundries in the private sector.
- Provide cost effective in-house laundry service.
- Provide cost effective outsourced laundry service.
- Ensure effective and efficient utilisation of the linen stock: In-house laundries.
- Ensure effective and efficient utilisation of the linen stock: Outsourced laundries.

Sub-programme 7.2: Engineering services

- Provide effective maintenance on facilities, plant and equipment.
- Provide preventative maintenance to critical equipment.
- Provide repairs and renovation to DoH infrastructure.
- Provide a service to deal with all infrastructure emergencies at institutions.
- Provide efficient engineering installations.
- Ensuring compliance with OHS Act.

Sub-programme 7.3: Forensic Pathology Services

- Provide an efficient Forensic Pathology Service through maintenance of average response times ≤ 40 minutes.
- Provide an efficient Forensic Pathology Service through maintenance of turnaround time from admission to examination done ≤ 3.5 days.
- Manage the turnaround time from admission to release of deceased (excluding unidentified persons) to below 5.5 days.
- Implement and maintain standard operating procedures across 20 forensic pathology facilities.
- Improve the management of unknowns by reducing the number of unknowns.
- Maintain the percentage of filled posts at 97.5% of the funded establishment by 2012/13.
- Pilot, implement and analyse one annual standardised staff satisfaction survey to measure workforce satisfaction in all FPS facilities by 2014.

Sub-programme 7.5: Medicine Trading Account

- Sufficient working capital to support adequate stock-holding.

SUB-PROGRAMME 7.1: LAUNDRY SERVICES

Service Delivery Objectives and Indicators

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

Approximately twenty million pieces of laundry are processed annually – fourteen million in-house and six million out-sourced to private sector laundries. Tygerberg Laundry currently processes eight million pieces per annum, while George and Lentegeur Laundries together process a further six million. Tygerberg Laundry has a staff compliment of 170, Lentegeur Laundry 72 and George Laundry 36. Laundry floor staff is regularly rotated and multi-skilled.

The priority has been to increase the efficiency of in-house services. Large volumes of work are essential in order for strategic laundries to be cost-competitive with the private sector.

Sub-Programme 7.1 supports the strategic goals of the Department by providing a reliable supply of clean and disinfected linen:

- An uninterrupted supply of linen is essential for the provision of health care 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 health care by ensuring patients have clean disinfected linen at all times.

The slight decrease in the number of linen pieces laundered by in-house laundries is due to:

- Lower volumes received due to lower bed occupancy. A decrease in admissions was noted during the fourth quarter.
- A number of pieces were out-sourced in order to sustain private sector back-up service.

There was an increase in the average cost per piece (in-house) due to the following reasons:

- There has been a significant increase in the cost of electricity, coal and water. This increase affected the cost of steam required for the laundry services.
- The increase in the cost of fuel resulted in increased transport costs.
- A decrease in the number of pieces laundered in-house.
- An increase in staff costs due to overtime worked on public holidays and due to machine breakdowns.

The increased costs in relation to the decrease in the number of pieces of laundry processed have resulted in a higher unit cost.

The Department has allocated R 7 million to replenish the linen at institutions. Furthermore, the linen policy has to be enforced at the institutions and the targets for the programme need to be reviewed.

It is planned to upgrade the Lentegeur Laundry as part of the new Mitchell's Plain Hospital revitalisation project, which will include the purchase of new equipment designed to reduce the consumption of water, electricity, steam and chemicals.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2010/11 ANNUAL PERFORMANCE PLAN

Table 2.2.20: Performance against targets from the 2010/11 Annual Performance Plan for laundry services

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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	20.0 m	20.0 m	20 286 486	20.5 m	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department. The demand for linen fluctuates depending on the bed occupancy at hospitals.
		1.1.2 Provide a laundry service using in-house laundries.	2) Total number of pieces laundered: in-house	14.5 m	13.5 m	13 996 985	15 m	Laundry services at GF Jooste, Brooklyn Chest and Stikland Hospitals were outsourced and brought back in-house with effect from 1 August 2010 and this resulted in a decrease in the number of pieces processed. A decrease in hospital admissions during the fourth quarter had a direct impact on the number of laundry pieces processed.
		1.1.3 Provide a laundry service using outsourced laundries in the private sector.	3) Total number of pieces laundered: outsourced	5.5 m	6.6 m	6 289 501	5.5 m	Laundry services at GF Jooste, Brooklyn Chest and Stikland Hospitals were outsourced until the end of July 2010 which resulted in an increase in the number of pieces processed.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.1.4 Provide cost effective in-house laundry service.	4) Average cost per item laundered: in-house	R 1.95	R 2.29	R 3.49	R 3.20	There has been a significant increase in the price of electricity, coal and water. This increase affected the cost of steam required for the laundry services. Overtime worked had a direct impact on the cost per piece.
			Numerator:	-	-	48 817 557	*(48 000 000)*	
			Denominator:	-	-	13 996 985	*(15 000 000)*	
		1.1.5 Provide cost effective outsourced laundry service.	5) Average cost per item laundered: outsourced	R 1.78	R 2.21	R 2.82	R 3.30	Due to the increase in volumes as stated under indicator (3), cost has decreased.
			Numerator:	-	-	17 707 724	*(18 150 000)*	
			Denominator:	-	-	6 289 501	*(5 500 000)*	
		1.1.6 Ensure effective and efficient utilisation of the linen stock: In-house laundries.	6) Turnaround time for laundered linen: in-house	Not required to report	Not required to report	24 hour weekday	24 hour weekday	Difficult to measure accurately but achieved a better than 24 hour turnaround time. This is a new indicator and no baseline information was available.
			Numerator:	-	-	-	-	
			Denominator:	-	-	-	-	
				Not required to report	Not required to report	72 hour weekend	72 hour weekend	Laundries work a 5 day workweek and do not report on turn around time for weekends. Monday to Friday soiled linen received is exchanged for clean linen within 24 hours on a 1-for-1 basis. Soiled linen received on a Friday is returned clean on a Monday on a 1-for-1 basis.
			Numerator:	-	-	-	-	
			Denominator:	-	-	-	-	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.1.7 Ensure effective and efficient utilisation of the linen stock: outsourced laundries.	7) Turnaround time for laundered linen: outsourced	Not required to report	Not required to report	24 hour weekday	24 hour weekday	Difficult to measure accurately but achieved a better than 24 hour turnaround time. Soiled linen is exchanged for clean linen 7 days a week.
			Numerator:	-	-	-	-	
			Denominator:	-	-	-	-	
				Not required to report	Not required to report	72 hour weekend	72 hour weekend	Soiled linen is exchanged for clean linen 7 days a week.
			Numerator:	-	-	-	-	
			Denominator:	-	-	-	-	

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

SUB-PROGRAMME 7.2: ENGINEERING SERVICES

Service Delivery Objectives and Indicators

The Directorate: Engineering and Technical Support Services is responsible for the repair and maintenance of hospital equipment, clinical engineering, engineering service 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 the day-to-day maintenance of health facilities such as hospitals, primary health care 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 are normally undertaken by the Department of Transport and Public Works.

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

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

The need to prioritise the maintenance of health facilities in the province was emphasised in Healthcare 2010, the long-term strategy of the Department published in 2003. This is accepted by the management of the Department as an urgent priority.

The Department has a history of inadequate funding for the maintenance of assets. Funding for the day-to-day maintenance activities required at each institution should be ring-fenced. The budget allocation should also be increased to 2% of the operational budget.

There is a shortage of workshop personnel at institutions and the directorate's engineering workshops due to the inability to attract suitably qualified staff as a result of scarce skills and remuneration factors. OSD requirements are making it more difficult to address this issue.

The filling of all vacant engineering posts is a priority in order to improve day-to-day maintenance and prevent the deterioration of buildings and equipment. This is particularly important for new buildings. In support of the Council for Scientific and Industrial Research (CSIR) study, National Treasury and the Comprehensive Service Plan requirements, the current human resource needs of the directorate must be addressed as soon as possible. In response to this challenge a proposal has been submitted to the office of the Chief Director: Human Resources for further investigation. The primary aim is to strengthen strategic engineering workshops with necessary resources in order to improve the current maintenance service delivery.

Table 2.2.21: Performance against targets from the 2010/11 Annual Performance Plan for engineering services

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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	11 817	17 401	20 249	13 100	The Metro District Health Services (MDHS) workshops were transferred and incorporated into the Bellville and Zwaanswyk Mobile Workshops. The job cards were included into the Directorate: Engineering's statistics as the work was funded from this directorate's budget. The target was therefore set too low.
		1.1.2 Provide preventative maintenance to critical equipment.	2) Number of preventative maintenance jobs completed	Not required to report	Not required to report	4 388	2 100	During the fourth quarter more preventative maintenance jobs were done. Clinics and MOU's in the Metropole were previously serviced by the Woodstock workshop which was transferred to the Directorate: Engineering Services. This included 13 staff and their personnel budget, but no funding for maintenance. The target was therefore too low and there is now a drive to increase preventative maintenance.
		1.1.3 Provide repairs and renovation to DoH infrastructure	3) Number of repairs completed	Not required to report	Not required to report	15 625	10 750	More jobs were completed based on the number of queries received. Targets were too low for same reasons as outlined for indicators 1 and 2 outlined above.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.1.4 Provide a service to deal with all infrastructure emergencies at institutions.	4) Number of emergencies handled	Not required to report	Not required to report	236	250	It is difficult to set accurate targets for emergencies as it include issues such as burst pipes, electrical outages, standby generator failures, leaking roofs, major sewerage leaks, etc. As facilities and services are upgraded / replaced there should be a decrease in the number of emergencies – balanced against the older facilities / equipment which are more liable to fail.
		1.1.5 Provide efficient engineering installations.	5) Average cost of utilities per bed	R 8 120	R 9 075	R 14 818	R 9 200	The average cost of utilities per bed is based on the total expenditure of utilities against the useable beds.
			Numerator:	-	-	137 040 373	-	Increases in costs were due to the rise in electricity, fuel, oil and gasses. Challenges exist in obtaining reliable information directly from the hospitals and therefore it is now supplied from Head Office: Finance.
			Denominator:	-	-	9 248	-	
		1.1.6 Ensuring compliance with OHS Act.	6) Number of reportable incidents	113	78	8	90	The awareness training in the Occupational Health and Safety (OHS) Act has reduced the number of incidents / injuries. Less incidents/injuries lead to lower absenteeism which lead to less cost implications. Information is based on the number of Workmen's Compensation Act (WCA) reported incidents.

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

SUB-PROGRAMME 7.3: FORENSIC PATHOLOGY SERVICES

Service Delivery Objectives and Indicators

The aim of sub-programme 7.3 is the provision of a forensic pathology service (FPS) for the province that is designed to contribute positively to ensure the development of a just South African society, to assist with the fight against and prevention of crime, to assist with the prevention of unnatural death, to establish the independence of the medical and related scientists and to ensure an equitable, efficient and cost effective service.

Sub-programme 7.3 supports the strategic goals of the Department by providing a forensic pathology service in order to facilitate:

- The management of the burden of disease by ensuring access to a quality forensic pathology service.
- Ensuring and maintaining organisational strategic management capacity and synergy by developing integrated support and management structures to render an effective clinical service.
- Developing and maintaining a capacitated workforce to deliver the required health services by implementing the human resource plan and becoming the employer of choice in the health sector by creating an environment for a satisfied workforce.

The focus areas during the 2010/11 financial year for forensic pathology services were:

- Maintaining response times.
- Maintaining turn around times.
- Improving the turn around time from admission to release.
- Compliance with standard operating procedures.
- Reducing the number of unknowns.
- Maintaining a high level of filled posts.
- Pilot, implement and analyse one annual standardised staff satisfaction survey to measure workforce satisfaction in all FPS facilities.

This service is rendered via eighteen forensic pathology facilities across the province which includes two M6 academic forensic pathology laboratories in the Metro, two 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.

During the 2010/11 financial year 9 249 medico-legal cases were examined in the Western Cape in order to establish the cause of death in cases as defined in The Inquest Act. This amounts to 1.64 post-mortems per 1 000 population. Of these 5 725 (61.9%) medico-legal post-mortems were performed in the metropolitan area and 3 524 (38.1%) in the rural districts.

<u>Progress as at end of March 2011</u>

The forensic pathology service is currently being rendered to the estimated 5.756 million population of the Western Cape.

During 2010/11 a total of 9 417 incidents were logged, resulting in 9 366 forensic pathology cases. A total of 51 cases were deferred. The average response time achieved across the province from the time that the incident was logged until the body was received on the scene was 34 minutes. A total of 44 response vehicles travelled 939 465 km during body transportation.

In total 9 366 case files were opened whilst 9 271 case files were closed (98.81%). A total of 3 371 case files were open for a period exceeding 90 days at the end of the last quarter. This is largely due to the backlogs experienced by the national and SAPS forensic laboratories and the time taken to process and report on toxicology and DNA results.

The average number of days from admission to release of body is 14.02 days (5.04 days excluding paupers). A total of 151 bodies were unidentified as at the end of March whilst 740 bodies were released for pauper burial during the period under review. Despite major inroads being made to the release of unidentified persons, the high number of persons being released as unidentified persons remains a matter of concern.

Twelve complaints and 251 compliments were received during the year. The number of occupational injuries that were reported reduced from 47 in 2009/10 to 30 in 2010/11.

For the financial year under review the Annual Performance Plan indicated a target of 267 filled posts by the financial year-end. The budget allocation (including equitable share) only allowed for the filling of 254 posts (Approved Post List). By the end of the year 242 posts were filled. 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.

The institutionalisation of a structured and dedicated employee assistance programme (EAP) within the forensic pathology service remains a priority. What is encouraging is the higher than "industry average" utilisation rate of EAP support. A staff satisfaction survey was conducted during February and March 2011 and delivered a survey uptake of 47.9%.

Training opportunities, aligned with the workplace skills plan and service priorities, were accessed by 208 employees. Despite the forensic pathology officer qualification being registered with the South African Qualifications Authority (SAQA), no formal training programme is available yet.

Equipment needs were identified and equipment was procured according to the priorities. R 2.784 million was spent during the financial year on procurement of equipment (major > R 5 000). A vehicle fleet of 66 vehicles is maintained by GMT.

Improvement to the physical infrastructure remains a priority. Three new forensic pathology laboratories (Worcester, Paarl and Malmesbury) were commissioned during the 2010/11 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 and Vredenburg. Construction of a new facility in Beaufort West (M1) commenced during 2010/11. Planning of the relocation of the Salt River (M6 academic) facility onto the Groote Schuur Hospital premises has continued and the identified site had been vacated in preparation.

Enhancements to the FPS system were developed internally despite the lack of additional funding. User acceptance was conducted and the enhancements were implemented during the year. The use of the Enterprise Content Management system was embedded during 2010/11 with the implementation across eighteen FPS facilities. However, the Departments of Forensic Medicine at the universities are unable to access this system due to their inability to access the PGWC network.

Table 2.2.22: Performance against targets from the 2010/11 Annual Performance Plan for Forensic Pathology Services

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1. Manage the consequences of the burden of disease.	1.1 Ensure access to a Forensic Pathology service.	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	39 minutes	37 minutes	34 minutes	≤ 40 minutes	Eleven out of eighteen facilities achieved an average response time of 40 minutes or below. A big contributor to the overall improved response time is the 31 minutes response time at Salt River and the 34 minutes response time at Tygerberg in the Metro. The Metro implemented call taking and dispatch via Metro EMS and not SAPS Radio Control as in the past. The Metro contributes 61.1% of the provincial case load.
			Numerator:	-	-	310 187	*(388 960)*	
			Denominator:	-	-	9 046	*(9 724)*	
		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	Not required to report	Not required to report	3.3 days	≤ 3.5 days	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	-	-	30 975	*(33 299)*	
			Denominator:	-	-	9 249	*(9 514)*	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.1.3 Manage the turnaround time from admission to release of deceased (excluding unidentified persons) to below 5.5 days.	3) Average turnaround time from admission to release of deceased (excluding unidentified persons)	Not required to report	Not required to report	5 days	≤ 5.5 days	During the 4th quarter the performance improved due to a decreased caseload and this impacted on the annual average.
			Numerator:	-	-	41 623	*(45 826)*	
			Denominator:	-	-	8 260	*(8 332)*	
	1.2 Integration of quality assurance into all levels of care.	1.2.1 Implement and maintain standard operating procedures across 20 forensic pathology facilities.	4) The percentage of standard operating procedures implemented across all facilities	Not required to report	Not required to report	100%	70%	The adoption and compliance with standard operating procedures was higher than planned. No baseline data was available and therefore the target was estimated.
			Numerator:	-	-	90	*(168)*	
			Denominator:	-	-	90	*(240)*	
3 Ensure and maintain organisational strategic management capacity and synergy.	1.3 Develop integrated support and management structures to render effective FPS service.	1.3.1 Improve the management of unknowns by reducing the number of unknowns.	5) Number of unknown persons exceeding 90 days	Not required to report	Not required to report	88	125	Target exceeded due to good co-operation from the SAPS. A Memorandum of Understanding (MOU) was implemented and regular liaison meetings are held. Unknowns are monitored and reported on a weekly basis to SAPS.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
2. Develop and maintain a capacitated workforce.	2.1 Implement the Human Resource Plan.	2.1.1 Maintain the percentage of filled posts at 97.5% of the funded establishment by 2012/13.	6) Percentage of funded posts filled	72.9%	74.2%	95.3%	97.5%	Approved post list revised from 267 to 254 due to affordability. Some difficulties experienced in recruitment of staff due to scarcity of skill. Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	223	227	242	260	
			Denominator:	306	306	254	267	
	2.2 Become the employer of choice in the health sector by creating an environment for a satisfied workforce.	2.2.1 Pilot, implement and analyse one annual standardised staff satisfaction survey to measure workforce satisfaction in all FPS facilities by 2014.	7) Annual staff satisfaction survey completed	Not required to report	Not required to report	1	Pilot (1)	Staff satisfaction survey implemented across all facilities. Draft report is available.

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

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.

SUB-PROGRAMME 7.5: MEDICINE TRADING ACCOUNT

Service Delivery Objectives and Indicators

During the 2010/11 financial year, the Department amended its management strategies and team at the Cape Medical Depot (CMD) in order to facilitate improved drug supply management that will result in a reduction in the number of medicines not consistently available for patients at all levels of care.

The working capital of the CMD was augmented to R 88.332 million which is in line with the current stockholding at the CMD and will allow the CMD to fully fund the current stockholding. The augmentation was done in line with sections of the Public Finance Management Act, as amended.

Chronic Dispensing Unit (CDU)

The CDU services have continued to grow organically and at present there are some 165 000 prescriptions that are pre-packed each month by the service provider and delivered to health facilities across the Metro District Health Service (MDHS) and the West Coast District.

The current service provider's contract will terminate during the next financial year and the Department has issued a bid for these services for a further five years in the latter part of 2011/12.

Table 2.2.23: Performance against targets from the 2010/11 Annual Performance Plan for the MEDPAS trading account

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
1.	1.1 Develop integrated support and management structures to render effective clinical service.	1.1.1 Sufficient working capital to support adequate stock-holding.	1) Working capital in the medicine trading account	R 46.792 million	R 48.507 million	R 88.332 million	R 62.9 million	The working capital was augmented to be in line with the current stockholding at the CMD and to allow the CMD to fully fund the current stockholding.

2.2.8 Programme 8: Health Facilities Management

Purpose

To provide for new health facilities, upgrading and maintenance of existing facilities, including the hospital revitalisation and provincial infrastructure grants.

Analysis per sub-programme

Sub-programme 8.1: Community Health Facilities

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

Sub-programme 8.2: Emergency Medical Rescue Services

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

Sub-programme 8.3: District Hospital Services

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

Sub-programme 8.4: Provincial Hospital Services

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

Sub-programme 8.5: Central Hospital Services

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

Sub-programme 8.6: Other Facilities

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

Strategic Objectives

The programme's strategic objectives for 2010/11 were:

- Allocate sufficient capital funding to ensure the infrastructure backlog is significantly reduced in the MTEF period.
- Complete the 10 PHC projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.
- Complete the 9 ambulance station projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.
- Complete the 14 district hospital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.

- Complete the 9 provincial hospital capital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.
- Complete the 8 central hospital capital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.
- Complete the 6 forensic mortuary and other projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.

Service Delivery Objectives and Indicators

Programme 8 performed very well in 2010/11 with 96.4% of the overall budget being spent. A review of programme expenditure from the different funding streams reflects a range of achievements in spending the allocated funds from 78.7% of the equitable share funds being spent, to 87.7% of the maintenance funds, 96.3% of the Infrastructure Grant to Provinces and 98.5% of the Hospital Revitalisation Grant.

Programme 8 is the responsibility of the Chief Directorate: Infrastructure Management. The responsibility to deliver infrastructure projects is, however, shared with the Department of Transport and Public Works which has been appointed as the implementing agent of the Department of Health. Projects are reported on in terms of the following stages: inception, planning, construction and completion. As stated above, the responsibility for projects is shared and responsibility within the different stages shifts between the two role-players as follows:

- Inception: Shared responsibility.
- Planning: Shared responsibility.
- Construction: Department of Transport and Public Works.
- Completion: Department of Transport and Public Works.

At the outset it is important to note that projects undertaken by Programme 8 are often multi-year projects. Each of the afore-mentioned stages (inception, planning, construction and completion) could span more than one quarter and most of the time spans much more than that.

The construction of the projects listed below was completed in 2010/11:

- Sub-programme 8.1: Community Health Facilities
    - Bonnievale: Happy Valley Clinic (upgrading)
    - Mitchell's Plain CHC (extensions to existing CHC)
    - Worcester CHC extension (donation in kind by the University of Stellenbosch)
    - Kwanokuthula CHC

- Sub-programme 8.2: Emergency Medical Services
    - Khayelitsha
    - Ceres
    - Kwanokathula

- Sub-programme 8.3: District Hospital Services
    - Riversdale (Phase 2 upgrade)
    - Eerste River (administration/casualty)

- Sub-programme 8.4: Provincial Hospital Services
    - Somerset (emergency centre, enabling work for FIFA)
    - Valkenberg (urgent repairs to historic admin building)
    - Paarl: Sonstraal TB upgrade

- Sub-programme 8.5: Central Hospital Services
    - Groote Schuur (phase 1 new main building: Replace fire detection system and upgrade)
    - Groote Schuur (Pharmacy bulk store: air-conditioning)
    - Groote Schuur (security upgrade phase 1)
    - Tygerberg (electrification to fence, intrusion alarms)
    - Tygerberg (lift upgrade)
    - Tygerberg (fire doors)
    - Red Cross (ward upgrade D2 – managed and co-funded by Red Cross Children's Hospital Trust)

- Sub-programme 8.6: Other facilities
    - Malmesbury Forensic Pathology Services laboratory
    - Paarl Forensic Pathology Services laboratory
    - Worcester Forensic Pathology Services laboratory

The above achievements have made a significant contribution in achieving one of the Department's strategic goals, namely "to provide and maintain appropriate health technology and infrastructure". 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 accessible health care.
- Planned to facilitate the level and quantum of health care 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.

These achievements are linked to the following:

- The National Government Medium Term Strategic Framework: A long and healthy life for all South Africans with the focus area: Health system effectiveness;
- The National Department of Health's Ten Point Plan; and
- The Draft Provincial Strategic Plan, strategic objective No 4: Increasing wellness.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2010/11 ANNUAL PERFORMANCE PLAN

Table 2.2.24: Performance against targets from the 2010/11 Annual Performance Plan for health facilities management

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
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 in the MTEF period.	1) Programme 8 capital funding as a percentage of total health expenditure	3.6%	Not required to report	7.4%	6.3%	Annual target exceeded. This achievement bodes well in the Chief Directorate's quest to reduce the infrastructure backlog of the Department.
			Numerator:	-	-	918 m	*(742 m)*	The additional funding was obtained by means of the roll-over funding received for IGP and HRP.
			Denominator:	-	-	12 345 m	*(11 752 m)*	
			2) Hospitals funded from the revitalisation programme	14.0%	14.0%	13.2%	14%	The denominator changed due the fact that the level 2 and level 3 services rendered by the three tertiary facilities (i.e. Groote Schuur, Tygerberg and Red Cross Children's Hospitals) are now being considered separately. This resulted in the addition of three additional level 2 (regional) hospitals.
			Numerator:	7	7	7	*(7)*	
			Denominator:	50	50	53	*(51)*	
			3) Equitable share capital programme as percentage of total health expenditure[30]	0.20%	0.48%	0.15%	0.26%	The implementing agent experienced some delays in making progress with planning in terms of stage 1 (report investigation) and stage 2 (concept design) which led to the annual target of 0.26% not being met.
			Numerator:	18 m	50 m	19 m	*(30)*	In terms of planning, one project was delayed to proceed to construction as a result of capacity problems experienced by the implementing agent. One project was targeted for inception and a total of five for planning.
			Denominator:	8 656 m	10 464 m	12 345 m	*(11 752 m)*	

30 Numerators and denominators for 2008/09 and 2009/10 restated per million.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			4) Expenditure on facility maintenance as % of total health expenditure[31]	0.99%	1.05%	0.72%	1.15%	Delays experienced by the implementing agent ranging from preparing specifications for work to be undertaken, the tender processes and making progress on site led to the annual target of 1.15% not being met. Maintenance work was also undertaken and funded under IGP which skewed this result.
			Numerator:	85 m	109 m	89 m	*(135 m)*	
			Denominator:	8 656 m	10 464 m	12 345 m	*(11 752 m)*	
			5) Fixed PHC facilities with access to piped water	100%	100%	100.0%	100%	Target achieved.
			Numerator:	357	357	296	*(296)*	
			Denominator:	357	357	296	*(296)*	
			6) Fixed PHC facilities with access to mains electricity	100%	100%	100.0%	100%	Target achieved.
			Numerator:	357	357	296	*(296)*	
			Denominator:	357	357	296	*(296)*	
			7) Fixed PHC facilities with access to fixed line telephone	100%	100%	100.0%	100%	Target achieved.
			Numerator:	357	357	296	*(296)*	
			Denominator:	357	357	296	*(296)*	

31 Numerators and denominators for 2008/09 and 2009/10 restated per million.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			8) Average backlog of service platform in fixed PHC facilities	Not required to report	Not required to report	18.4%[32]	-	A revised estimate of backlog was calculated which indicates that the backlog is higher than previously calculated. It is important to note that the said estimate will still be refined.
			Numerator:	R 255 m	R 255 m	R 300 m	R 240 m	
			Denominator:	-	-	R 1 630 m	-	
			9) Average backlog of service platform in district hospitals	Not required to report	Not required to report	62.3%[33]	-	Target achieved.
			Numerator:	R 2 000 m	R 2 000 m	R 2 000 m	R 2 000 m	
			Denominator:	-	-	R 3 212 m	-	
			10) Average backlog of service platform in regional hospitals	Not required to report	Not required to report	15.5%[34]	-	The calculation at the beginning of the financial year was based on the initial planning that George Hospital, Worcester Hospital (Phase 4) and Paarl Hospital would have reached completion by the end of the financial year. This has unfortunately not been achieved.
			Numerator:	R 250 m	R 250 m	R 200 m	R 100 m	
			Denominator:	-	-	R 1 289 m	-	

32 The method of calculation changed in 2010/11. Numerator is expenditure for PHC facilities to reach maintenance standard and coincides with figures reported for previous years. Denominator is replacement cost for all PHC facilities.

33 The method of calculation changed in 2010/11. Numerator is expenditure for district hospitals to reach maintenance standard and coincides with figures reported for previous years. Denominator is replacement cost for all district hospitals.

34 The method of calculation changed in 2010/11. Numerator is expenditure for regional hospitals to reach maintenance standard and coincides with figures reported for previous years. Denominator is replacement cost for all regional hospitals.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			11) Average backlog of service platform in specialised hospitals (including TB & psychiatric hospitals)	Not required to report	Not required to report	50.5 %[35]	-	Delays are experienced in the planning of the upgrade of Valkenberg hospital due to the complex nature of the facility. The denominator is based on a rough estimate and a full assessment is current under way with the implementation of GIAMA.
			Numerator:	R 2 030 m	R 2 030 m	R 2 020 m	R 2 030 m	
			Denominator:	-	-	R 4 000 m	-	
			12) Average backlog of service platform in tertiary and central hospitals	Not required to report	Not required to report	36.4%[36]	-	Target achieved.
			Numerator:	R 1 400 m	R 1 400 m	R 1 400 m	R 1 400 m	
			Denominator:	-	-	R 3 845 m	-	
			13) Average backlog of service platform in provincially aided hospitals	Not required to report	Not required to report	0.0%[37]	-	On 1 July 2010 the last provincially aided hospital in the province, Radie Kotze Hospital, was provincialised. There are no more provincially aided hospitals in the Western Cape.
			Numerator:	R 13 m	R 13 m	-	R 13 m	
			Denominator:	-	-	-	-	

35 The method of calculation changed in 2010/11. Numerator is expenditure for specialised hospitals to reach maintenance standard and coincides with figures reported for previous years. Denominator is replacement cost for all specialised hospitals.

36 The method of calculation changed in 2010/11. Numerator is expenditure for central hospitals to reach maintenance standard and coincides with figures reported for previous years. Denominator is replacement cost for all central hospitals.

37 The method of calculation changed in 2010/11. Numerator is expenditure for provincially aided hospitals to reach maintenance standard and coincides with figures reported for previous years. Denominator is replacement cost for all provincially aided hospitals.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2008/09	Actual performance 2009/10	Actual performance 2010/11	2010/11 APP target	Reasons for variance
			14) District hospital beds per 1 000 uninsured population	0.53	0.59	0.55	0.59	Variances of less than 5% are deemed to be within an acceptable range from the target by the Department.
			Numerator:	2 081	-	2 482	*(2 452)*	
			Denominator:	3 928 000	-	4 490 706	*(4 490 706)*	
			15) Regional Hospital beds per 1 000 uninsured population	0.61	0.63	0.53	0.63	Due to a printing error the target was incorrectly stated as 0.63 in the APP instead of 0.53: (2 367 ÷ 4 490 706) x 1 000 = 0.53.
			Numerator:	2 396	-	2 385	*(2 367)*	
			Denominator:	3 928 000	-	4 490 706	*(4 490 706)*	
		1.1.2 Complete the 10 PHC projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	16) Number of capital projects completed in PHC facilities that are funded by the Programme 8 capital budget [Sub-programme 8.1]	Not required to report	Not required to report	5	1	Projects are completed when all contractual issues have been resolved. Some projects that were due to be finalised in the previous financial years were only resolved during this year.
			17) Number of primary health care facility capital projects in inception, funded by the Programme 8 capital budget	Not required to report	Not required to report	7	1	Although the reported performance is higher than the target that was set, this is unfortunately not a true reflection of the situation. Projects were delayed in progressing to the next stage (e.g. securing of suitable sites, bulk services etc.)
			18) Number of primary health care facility capital projects in planning funded by the Programme 8 capital budget	Not required to report	Not required to report	7	10	Target was not met due to delays in securing suitable sites, appointment of consultants, etc.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
			19) Number of primary health care facility capital projects in construction funded by the Programme 8 capital budget	Not required to report	Not required to report	5	3	More projects are still in the construction phase than there should have been due to poor performance by service providers, scope changes etc.
		1.1.3 Complete the 9 ambulance station projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	20) Number of ambulance station projects completed funded by the Programme 8 capital budget [Sub-programme 8.2]	Not required to report	Not required to report	4	2	Projects are completed when all contractual issues have been resolved. Some of the projects that were due to be finalised in the previous financial years were only resolved during this financial year.
			21) Number of capital ambulance station infrastructure projects in inception funded by the Programme 8 capital budget	Not required to report	Not required to report	4	4	Target achieved.
			22) Number of ambulance station capital infra-structure projects in planning funded by the Programme 8 capital budget	Not required to report	Not required to report	3	3	Target achieved.
			23) Number of capital ambulance station projects in construction funded by the Programme 8 capital budget	Not required to report	Not required to report	5	4	More projects are still in the construction phase than there should have been due to poor performance by service providers, scope changes etc.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.1.4 Complete the 14 district hospital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	24) Number of capital projects completed in district hospitals funded by the Programme 8 capital budget [Sub-programme 8.3]	Not required to report	Not required to report	7	3	Projects are completed when all contractual issues have been resolved. Some of the projects that were due to be finalised in the previous financial years were only resolved during this financial year.
			25) Number of capital projects in district hospitals in inception funded by the Programme 8 capital budget	Not required to report	Not required to report	6	6	Target achieved.
			26) Number of capital projects in district hospitals in planning funded by the Programme 8 capital budget	Not required to report	Not required to report	6	3	Some projects remained in this stage due to delays in the finalisation of planning of these projects.
			27) Number of capital projects in district hospitals in construction, funded by the Programme 8 capital budget	Not required to report	Not required to report	7	7	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.1.5 Complete the 9 provincial hospital capital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	28) Number of capital projects completed in provincial hospitals funded by the Programme 8 capital budget [Sub-programme 8.4]	Not required to report	Not required to report	4	6	Target not achieved, due to poor service provider performance, scope changes, etc.
			29) Number of capital projects in provincial hospitals in inception funded by the Programme 8 capital budget	Not required to report	Not required to report	3	3	Target achieved.
			30) Number of capital projects in provincial hospitals in planning funded by the Programme 8 capital budget	Not required to report	Not required to report	3	2	Some projects remained in this stage due to delays in the finalisation of planning of these projects.
			31) Number of capital projects in provincial hospitals in construction, funded by the Programme 8 capital budget	Not required to report	Not required to report	7	2	Some projects remained in the construction phase due to poor performance by service providers, scope changes, etc.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.1.6 Complete the 8 central hospital capital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	32) Number of capital projects completed in central hospitals funded by the Programme 8 capital budget [Sub-programme 8.5]	Not required to report	Not required to report	8	3	Projects are completed when all contractual issues have been resolved. Some of the projects that were due to be finalised in the previous financial years were only resolved during this financial year.
			33) Number of capital projects in central hospitals in inception funded by the Programme 8 capital budget	Not required to report	Not required to report	3	3	Target achieved.
			34) Number of capital projects in central hospitals in planning funded by the Programme 8 capital budget	Not required to report	Not required to report	2	1	Some projects remained in this stage due to delays in the finalisation of planning of these projects.
			35) Number of capital projects in central hospitals in construction, funded by the Programme 8 capital budget	Not required to report	Not required to report	5	0	Some projects remained in the construction phase due to poor performance by service providers, scope changes, etc.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2010/11 APP target	Reasons for variance
				2008/09	2009/10	2010/11		
		1.1.7 Complete the 6 forensic mortuary and other projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	36) Number of projects completed in forensic mortuaries and other projects funded by the Programme 8 capital budget [Sub-programme 8.6]	Not required to report	Not required to report	3	1	Projects are completed when all contractual issues have been resolved. Some of the projects that were due to be finalised in the previous financial years were only resolved during this financial year.
			37) Number of capital projects in inception in forensic mortuaries and other projects funded by the Programme 8 capital budget	Not required to report	Not required to report	3	0	Although the reported performance is higher than the target that was set, this is unfortunately not a true reflection of the situation. Projects were delayed in progressing to the next stage (e.g. securing of suitable sites, bulk services etc.)
			38) Number of capital projects in planning in forensic mortuaries and other projects funded by the Programme 8 capital budget	Not required to report	Not required to report	4	2	Some projects remained in this stage due to delays in the finalisation of planning of these projects.
			39) Number of capital projects in construction in forensic mortuaries and other projects funded by the Programme 8 capital budget	Not required to report	Not required to report	2	1	Some projects remained in the construction phase due to poor performance by service providers, scope changes, etc.

Note: Numerators and denominators in brackets and *italic* font were not specified as part of the target in the 2010/11 Annual Performance Plan. These values have been included in the Annual Report to provide a better understanding of the quantitative measures on which the targets were based. Numerators and denominators were specified for all targets expressed as percentages or rates in the 2011/12 Annual Performance Plan.

3. ANNUAL FINANCIAL STATEMENTS

Table of contents Page

3.1 Department of Health

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE AUDIT COMMITTEE
for the year ended 31 March 2011

PROVINCIAL GOVERNMENT WESTERN CAPE
DEPARTMENT OF HEALTH (VOTE 6)
INCLUDING THE CAPE MEDICAL DEPOT (CMD)

Report of the Audit Committee

We are pleased to present our Report for the financial year ended 31 March 2011.

Audit Committee Members and Attendance

In terms of Cabinet Resolution 55/2007, The Department of Health is served by the Health Audit Committee. The Audit Committee consists of the members listed below and should meet at least 4 times per annum as per its approved terms of reference. During the financial year under review, 5 meetings were held.

Name of member	Number of Meetings Attended
Mr Ameen Amod (Chairperson)	4
Mr Lawrence Hyslop	5
Mr John Biesman-Simons	4
Ms Bianca Daries	5

Apologies were tendered and accepted for meetings not attended. A quorum of members was present at all meetings.

Audit Committee Responsibility

The Audit Committee reports that it has complied with its responsibilities arising from section 38(1)(a) of the Public Finance Management Act (PFMA) and Treasury Regulation 3.1.

The Audit Committee also reports that it has adopted appropriate formal terms of reference as its Audit Committee Charter, approved by Cabinet on 9th February 2011, and has conducted its affairs in compliance with this Charter and has discharged all its responsibilities as contained therein.

The Effectiveness of Internal Control

In line with the PFMA and the King III Report on Corporate Governance requirements, Internal Audit provides the Audit Committee and Management with assurance that the internal controls are adequate and effective. This is achieved by a risk-based Internal Audit Plan, Internal Audit assessing the adequacy of controls mitigating the risks and the Audit Committee monitoring implementation of corrective action.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE AUDIT COMMITTEE
for the year ended 31 March 2011

From our review of the reports of the Internal Auditors, the Audit Report on the Annual Financial Statements and the Management Report of the Auditor-General of South Africa, the Committee is still concerned about the system of internal control applied by the department:

- **Legal and Regulatory Compliance**

  We have noted the non-compliance with laws and regulations as it pertains to supply chain management. Notwithstanding the differences in the legal interpretation of the status of Practice Notes, the Committee has encouraged management to implement the Practice Notes.

- **Significant areas highlighted by Internal Audit for improvement**

  During the year, key control deficiencies were noted by Internal Audit in the following areas:

  - Cape Medical Depot – Warehousing
  - Interim Financial Statements Reporting
  - Supply Chain Management

  Corrective actions have been agreed by management and are being monitored by the Audit Committee.

- **CMD**

  During the second quarter, a new Management team was installed at the Cape Medical Depot. We note that the new team has made significant progress in improving operational efficiencies. We are, however, concerned that entity is vulnerable with regards to Internal Control and IT Control issues.

- **Information Technology**

  The Audit Committee previously reported on the limited progress that had been made towards implementation of the turn-around strategy to address the IT-related risks facing the Province. We are encouraged by the progress in this regard and continue to monitor progress against agreed actions.

- **The quality of In-Year Monitoring Reports and Quarterly Reports submitted in terms of the PFMA and the annual Division of Revenue Act**

  The Audit Committee is satisfied with the content and quality of quarterly reports prepared and issued by the Accounting Officer of the Department during the year under review.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE AUDIT COMMITTEE
for the year ended 31 March 2011

- **Enterprise Risk Management**

  Further progress has been made with the implementation of the Enterprise-wide Risk Management (ERM) methodology and the identification of the key risks and mitigating controls implemented by the Department. We commend the Department on its increased co-operation with the Centralised ERM Unit. The Audit Committee continues to review progress on a quarterly basis.

- **FIU**

  We are concerned about the apparent lack of progress within the Forensics Investigative Unit (FIU) to decrease the case load. FIU presented us with statistics that indicate that, as from 1 December 2010 to 31 March 2011, 8 cases were closed, whilst 15 new cases were opened. 28 cases were in progress as at 31 March 2011.

Evaluation of Financial Statements

The Audit Committee has:

- reviewed and discussed the audited Annual Financial Statements to be included in the Annual Report, with the Auditor-General and the Accounting Officer;
- reviewed the Auditor-General's Management Report and Management's response thereto;
- reviewed changes to accounting policies and practices as reported in the Annual Financial Statements;
- reviewed the Department's processes for compliance with legal and regulatory provisions;
- reviewed the information on predetermined objectives as reported in the Annual Report; and
- reviewed material adjustments resulting from the audit of the Department. In the case of CMD, the review included the material adjustments to the Statement of Financial Performance, Statement of Financial Position and Disclosure notes.

The Audit Committee concurs and accepts the Auditor-General's opinion regarding the Annual Financial Statements, and proposes that the Audited Annual Financial Statements be accepted and read together with the report of the Auditor-General.

Internal Audit

In the previous year, the Audit Committee reported that the Shared Internal Audit Unit experienced challenges relating to capacity and change management which impacted on its ability to achieve its plan. The Audit Committee is pleased to report that the Internal Audit plan for the year under review was completed. The final report (IT-Syspro) awaits management sign off as at 31 March 2011. The Department's response to the Internal Audit recommendations has been monitored as part of the review process.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE AUDIT COMMITTEE
for the year ended 31 March 2011

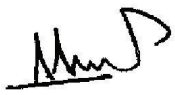
The Audit Committee is still concerned that further audit coverage is required to cover a significant percentage of High Risk Areas. There is a need for additional capacity to support the improved outputs of the Internal Audit team.

Auditor-General of South Africa

The Audit Committee has met with the Auditor-General of South Africa to ensure that there are no unresolved issues that emanated from the regulatory audit. Corrective actions on the detailed findings emanating from the current regulatory audit will be monitored by the Audit Committee on a quarterly basis.

Appreciation

The Audit Committee wishes to express its appreciation to the Management of the Department, the Auditor-General of South Africa and the Internal Audit Unit for the co-operation and information they have provided to enable us to compile this report.



Mr A Amod
Chairperson of the Governance and Administration Cluster Committee
Date: 11 August 2011

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2011

Report by the Accounting Officer to the Executive Authority and Parliament/Provincial Legislature of the Republic of South Africa.

1. General review of the state of financial affairs

- **Important policy decisions and strategic issues facing the Department**

The existing policy framework within which the Department functions is provided by legislation, the internationally accepted Millennium Development Goals, the National Department of Health's Ten Point Plan for 2009 – 2014 and the Medium-term Strategic Framework that subsequently became the Negotiated Service Delivery Agreement and the Western Cape's Draft Strategic Plan.

The Millennium Development Goals that are of particular relevance to the Department of Health are:

- Reduce the under-five mortality rate by two thirds between 1990 and 2015.
- Improve maternal health by reducing the maternal mortality rate.
- By 2015 to have halted and begun to reverse the spread of HIV and AIDS, malaria and other diseases.

The priorities of the National Department of Health as identified in the Ten Point Plan for 2009 – 2014 are:

- Provision of strategic leadership and creation of a social compact for better health outcomes.
- Implementation of the National Health Insurance.
- Improving quality of health services.
- Overhauling the health care system and improving its management.
- Improvement of human resources.
- Revitalisation of infrastructure.
- Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases.
- Mass mobilisation for the better health of the population.
- Review of drug policy.
- Research and development.

The key outcome and focus areas for health of the Medium Term Strategic Framework for National Government for the period 2009 – 2014 were confirmed in the Negotiated Service Delivery Agreement (NSDA).

The NSDA is an agreement between the President and the National Minister of Health on the desired outcome and focus areas for health.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2011

The outcome for health is: "A long and healthy life for all South Africans". The focus areas are:

- Increase life expectancy.
- HIV and AIDS.
- TB case load.
- Health system effectiveness.

Western Cape Province's Draft Strategic Plan

The vision of the Provincial Government of the Western Cape is to create an "open opportunity society for all". The provincial strategic objective of the Western Cape Department of Health in this plan was initially "Maximising health outcomes". This subsequently evolved into "Increasing Wellness" Strategic Objective 4 in the Provincial Strategic Plan.

The strategy to achieve this objective is two-pronged:

- Firstly, the focus is on the core business of providing a comprehensive package of quality health services.
- Secondly, there is an urgent need to address the transversal factors that contribute to the burden of disease by means of co-ordinated interventions at provincial government level. The four key upstream factors that were identified are:
    - Promoting safety and reducing injuries.
    - Promoting healthy lifestyles.
    - Women and child health.
    - Infectious diseases, mainly HIV and TB.

Departmental strategy towards 2020

The Department is in the process of developing a service transformation plan and strategy for the delivery of health services in 2020. The principles of the strategy are:

- Patient centred quality of care.
- Strengthen the primary health care philosophy.
- Strengthen district health services.
- Move towards an outcomes-based approach within a values-driven service.
- Address affordability of the health services.
- Strengthen strategic partnerships.
- Address equity.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2011

Legislation

The National Health Act, 2003 (Act 61 of 2003) ("the Act"), which was partially proclaimed on 2 May 2005, is still not fully in effect and the following sections still need to be proclaimed:

Section 11:	Health services for experimental or research purposes
Chapter 6:	Health establishments and issues relating to the certificate of need
Section 50:	Forum of Statutory Health Professional Councils
Section 51:	Establishment of academic health complexes
Section 71:	Research on or experimentation with human subjects
Parts of Chapter 10:	Health officers and Standards Compliance
Parts of Chapter 12:	General provisions

Some of the regulations that support the Act have been promulgated while others were drafted and circulated for comment but have not yet been finalised by the National Department of Health. In terms of the Act, new governance structures such as the Provincial Health Council, District Health Councils, a consultative forum and clinic and community health centre committees must be established by the province.

The Provincial Health Council has not met during the term of the current Provincial Minister of Health. The Premier has assented to the District Health Councils Act 5 of 2010, in terms of which the District Health Councils will be established. This Act must still be promulgated during 2011/12. The Provincial Minister will constitute both the Provincial and District Health Council during 2011/12.

The Premier has also assented to the Western Cape Ambulance Services Act 23 of 2010, which will regulate the delivery of ambulance services. This Act must still be promulgated during 2011/12.

- **<u>Some of the significant events that have taken place during the year</u>**

The following paragraphs provide a brief overview of some of the significant events that have occurred during the 2010/11 financial year. There are examples of collaboration and partnerships with the private sector and the attention to the key health focus areas are illustrated by the nature of the special projects undertaken.

Attrition and new appointments in the Senior Management Service

There were significant changes in the Senior Management Service (SMS) during 2010/11 as a result of resignations, retirement, relocation of key management personnel and the upgrading of the chief executive officer posts of certain hospitals to the SMS cadre.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2011

The span of control of the Chief Directorate: Professional Services was identified to be too extensive and was therefore separated into two chief directorates, i.e. Strategy and Health Support and Infrastructure Management.

The following is a list of the promotions, transfers and resignations from the SMS during 2010/11.

Mr AR Cunninghame	Chief Director: Professional Support Services	Granted a severance package
Dr L Angeletti-Du Toit	Chief Director: Infrastructure Management	Promoted and transferred to the Department of Health from the Department of Transport and Public Works
Ms M Van Leeuwen	Director: Infrastructure Management	New appointment
Dr P Von Zeuner	Director: Hospital Revitalisation Programme	Transfer from Information Management
Dr KN Vallabhjee	Chief Director: Health Strategy and Support	Transferred from Regional Hospitals, APH and EMS
Mr I De Vega	Director: Information Management	New appointment
Dr S Kariem	Chief Director: General Specialist and Emergency Services	Transfer from Groote Schuur Hospital
Dr T Carter	Chief Director: CEO: Groote Schuur Hospital	Transfer from Tygerberg Hospital
Dr DS Erasmus	Chief Director: CEO: Tygerberg Hospital	Transfer from Red Cross War Memorial Children's Hospital
Dr KLN Linda	Director: CEO: Red Cross War Memorial Children's Hospital	Transfer from Groote Schuur Hospital
Mr PGJ Koornhof	Director: Human Resource Management	Took the severance package
Ms PG Piedt	Director: Human Resource Management	Transfer from Provincial Treasury
Ms JO Arendse	Director: HIV/AIDS, and TB	Promotion
Mr CW Barnado	CEO: Stikland Hospital	Promotion
Mr HJ Human	CEO: Mowbray Maternity Hospital	Promotion
Ms JA Hendry	CEO: Western Cape Rehabilitation Centre	Updgrade / promotion
Mr ER Hering	Director: Medical Physicist: Groote Schuur Hospital	Retired
Mr J Hough	Director: Medical Physicist: Groote Schuur Hospital	Promotion

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2011

Mr GL Siwele	Director: Finance: Groote Schuur Hospital	Resigned
Mr T Mabuda	Director: Nursing	Resigned
Ms V Haas	Director: Internal Audit	Function transferred to the Department of the Premier

Infrastructure

The following are examples of infrastructure projects in progress or completed:

- Khayelitsha and Mitchell's Plain Hospital construction projects continued with estimated completion dates toward the latter half of 2011 and October 2012 respectively.
- Other capital projects completed during 2010/11 are the Kwanokathula Community Day Centre and Ambulance Station as well as the Ceres Ambulance Station.
- The new emergency centre at New Somerset Hospital, which was a designated hospital for the FIFA 2010 World Cup, was officially opened by the Western Cape Minister of Health on 29 April 2010. The Western Cape Department of Health invested more than R 25 million in this project and a further R 8.5 million was donated by corporate sponsors for the purchase of additional equipment such as a CAT scanner, medical equipment and furnishings for the paediatric ward.
- The new Mitchell's Plain Community Health Centre emergency centre and anti-retroviral treatment unit opened to the public on 23 September 2010. This community health centre provides a 24-hour service including trauma, emergency and midwife obstetric services to the Mitchell's Plain area. Approximately 24 000 patients, of which approximately 4 500 are trauma patients, are treated there per month.
- A newly upgraded specialist surgical ward was opened at Red Cross War Memorial Children's Hospital on 21 September 2010. This was made possible by the partnership between the Department and the Children's Hospital Trust. The total cost of the upgrade was R 11.5 million to which the Department contributed R 4.5 million. The upgraded ward will improve the experience of patients, their parents and the staff, for example there is a new comfortable waiting area and space for parents to stay at their children's bedside.

Donations

The Frauenhofer Institute for Biomedical Engineering in St Ingbert, Germany, donated a mobile laboratory to the Department. The laboratory contains a full biomedical laboratory, a patient area, sample storage facilities, an on-board autoclave, power supply and satellite-linked communications and has the capacity to screen forty patients per day. A research agreement has been signed between the Frauenhofer Institute, the Western Cape Department of Health and the University of Stellenbosch, in terms of which the Frauenhofer Institute will facilitate the provision of technical support and maintenance for the duration of the pilot period. Through the use of this laboratory it will be possible to evaluate patients' eligibility for anti-retroviral therapy (ART) and perform relevant baseline tests on the same day as diagnosing a patient's HIV status.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2011

The laboratory also offers screening facilities for infectious diseases such as tuberculosis and cervical cancer screening. The Department of Health will identify priority geographic areas and target populations that would benefit from the use of the laboratory, thereby improving access to the services that it provides, particularly in the rural areas. The laboratory was officially handed over to the Department on 16 March 2011.

On 21 July 2010 the Eskom General Manager handed over a cheque of R 50 000 to the Western Cape Rehabilitation Centre to assist the facility board with the arrangements for the annual wheelchair challenge.

The newly renovated oncology ward at Tygerberg Children's Hospital opened on 10 August 2010. The ward was transformed into a child friendly unit through the generous support of Dell Computers, which provided most of the funding for the upgrade. Funding was also provided by the parent support organisation for families with a cancer child patient, Childhood Cancer Foundation South Africa (CHOC) and Kanya.

The Oasis Crescent Fund Trust refurbished the dermatology unit at Groote Schuur Hospital and donated a skin laser machine. This machine, only the third of its kind in the country, is the only one that is available in a public sector facility. This makes the treatment of port-wine or strawberry stains accessible to patients in the public health sector.

The French government donated R 13 million to the Grabouw Community Health Centre for extensions and renovations which include the construction of a waiting area, counselling rooms and ablution facilities.

The Western Cape Minister of Health received a heart sonar machine on behalf of Groote Schuur Hospital from Rent Works that will be used in the cardiology clinic to measure all aspects of cardiac function. Phillips SA is sponsoring the maintenance of the unit, valued at approximately R 90 000 per annum. This machine will benefit the approximately 5 000 patients seen in this clinic annually.

Celebration of international awareness days

Celebrations for International AIDS day on 1 December, commenced on 30 November 2010 at the Middestad Mall in Bellville where the public was invited to be tested for HIV. Graeme Smith and other sporting and radio personalities set an example by being tested at the event.

The Provincial Employee AIDS Programme identified the areas / topics facilities could focus on if they were to commemorate the international day for persons with disabilities on 3 December, and facilitated the exhibitions. These included:

- Focus on issues related to the inclusion of persons with disabilities.
- Show casing and celebrating the contributions made by persons with disabilities as agents of development and change.
- Mainstreaming disability in all aspects of development.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2011

International Nurses' Day, is celebrated on 12 May, the anniversary of Florence Nightingale's birthday. Ms Nightingale died on 13 August 1910 at the age of ninety. The 2010 celebration of International Nurses' Day marked 100 years since her death. The theme for the celebration was: "Delivering quality health services, serving communities: nurses leading chronic care". The Department of Health celebrated the role of nurses and their dedication by hosting a Nurse's Day event at the Cape Town International Convention Centre where Mr Theuns Botha, the Western Cape Minister of Health, addressed more than 600 nurses. Smaller events were held at various facilities in the province to celebrate this day.

Visits

The National Director-General of Health visited the Western Cape Department of Health's Cape Medical Depot (CMD) and Chronic Dispensing Unit (CDU). The delegation embarked on a fact-finding visit to determine the staff establishment of the CMD and CDU, contract management, warehouse and systems used in the CMD, ordering and IT systems and how they are linked to facilities and pharmaceutical services.

A Vietnamese delegation led by the Deputy Chairperson of the Committee of Social Affairs of National Congress of the Socialist Republic of Vietnam visited the Department on 5 October 2010. The discussion focused on the implementation of social policies in public and private hospitals, the human and financial resources required to implement social and health policies, and the relationships with public and private research institutions.

A delegation from the Ministry of Health and Social Services of Namibia visited the Department between 6 and 10 December 2010. The delegation met with senior managers from the Department involved with rehabilitation and eye care services. These discussions were followed by site visits to the Western Cape Rehabilitation Services and Eerste River Hospital.

Other important events

On 15 April 2010 the Western Cape Minister of Health opened the newly installed Computerised Tomography (CT) unit in the radiology department of the Red Cross War Memorial Children's Hospital. This scanner rapidly acquires high resolution images of exceptional quality allowing the entire body to be scanned from head to toe in less than ten seconds. This is particularly advantageous in the treatment of children as it reduces the need for sedation and subjects the children to less radiation than the previous scanner.

The Radie Kotze Hospital in Piketberg, West Coast District, built in 1987, classified as a provincially aided hospital was provincialised during 2010. All of the staff were transferred onto the provincial staff establishment by 1 July 2010.

Three Metro rescue personnel received the Centrum Guardian Project Award, which is a national award for rescue and emergency medical service personnel who have gone beyond the call of duty. These personnel rescued a family when their car was swept off a bridge when the Breede River was in full flood.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2011

The Department participated in the National Mass Immunisation Campaign to immunise children against measles and poliomyelitis, that commenced in April 2010 and which were conducted at clinics and schools.

Mowbray Maternity Hospital received a generous donation of knitted baby caps and blankets from German citizens for distribution to South African hospitals. This was as a result of the "Knit One, Save One" campaign that was launched in the United States, United Kingdom, Germany and Korea as part of an international newborn survival campaign to help keep newborns warm.

The Western Cape Rehabilitation Centre hosted their fourth Jazz in the Park Concert at Maynardville Open-air Theatre on 20 March 2011. Funds raised from the event are used to continue health and wellness projects including the gym and hydrotherapy swimming pool projects.

- **Major projects undertaken or completed during the year:**

The detailed planning for the Department's 2020 strategy commenced during 2010/11 as indicated above. In addition, four workgroups which are aligned with the provincial management structure have been established to implement measures to achieve the provincial strategic objective of increasing wellness, i.e.:

- Promoting safety and reducing injuries workgroup.
- Healthy lifestyles workgroup.
- Women and children workgroup.
- HIV and TB workgroup.

The Department conducted a Barrett assessment of the values of different categories of staff in the organisation: administrative staff, doctors, nurses and other health professionals. This assessment analyses what the various categories of staff define as their personal values and the current and desired values of the organisation. The results of this survey are being used to engage with staff members on the issue of values and the impact that they have on service delivery and the quality of the patient experience of the service. This is linked to the initiative to enhance the quality of patient care both from a technical and experiential perspective.

On 26 May 2010 the Premier of the Western Cape launched the provincial HIV counselling and testing (HCT) campaign at the Michael Mapongwana Community Health Centre in Khayelitsha. This event marked the provincial roll-out of the largest HIV counselling and testing campaign in South Africa. The campaign will end in June 2011 which is aligned with the current National Strategic Plan on HIV, AIDS and STIs (2007 – 2011). The objectives of the campaign are:

- To mobilise people to know their status and motivate them to stay negative if they test negative and to take positive steps if they test positive.
- To get a more accurate measure of the magnitude of the problem of new infections.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2011

- To increase health seeking behaviour.
- To increase access to treatment, care and support services.

The Western Cape Department of Health provided the health and medical services for the FIFA World Cup Soccer Tournament as required in terms of the guarantees required of the host nation. The Department started preparing for this event in 2007 in order to secure the required funding, human resources both in terms of numbers and skills, and infrastructure which is of lasting benefit to health care in the province. Further detail on this project is provided in Part 2: Programme Performance, Programme 3: Emergency Medical Services.

The Western Cape Minister of Health established an Independent Complaints Commission. This Commission will function as an independent and objective body to which the MEC and Head of Department can refer complaints when the internal processes for dealing with complaints have not addressed the issues to the satisfaction of the complainant.

A lodging facility for oncology patients was opened on 20 September 2011 at the Tygerberg Hospital. This is the second such facility to be established in the Western Cape and is a joint venture between the Cancer Association of South Africa (CANSA) and Tygerberg Hospital to provide lodging facilities for oncology patients who need to travel long distances for their treatment. The facility accommodates twenty patients and the length of stay depends on the patient's treatment regime and meals are provided that are appropriate for the patient's condition.

The Head Office of the Western Cape Forensic Pathology Service and the office of the Metro Emergency Medical Services Northern District were officially opened in a renovated building on the Tygerberg Hospital site, by the Western Cape Minister of Health on 14 October 2010. The Department has completed the construction of five new forensic pathology facilities at Malmesbury, Paarl and Worcester during 2010/11 and Hermanus and George in 2008/09. Planning is in progress to replace the Salt River Pathology Unit and the construction of a new facility in Beaufort West commenced in February 2011.

In partnership with Vodacom, the Department of Health hosted a "Smile Week" at Tygerberg Hospital. From 15 – 19 November 2010 the Smile Foundation provided fourteen children with cranio-facial and cleft palate surgery at Tygerberg Hospital. Cleft lip and palate is the most common facial congenital anomaly which is remedied by a multi-disciplinary approach including surgery and post-operative care to ensure the best possible outcome for the child.

On 29 November 2010 a cataract operation marathon took place at Beaufort West Hospital where cataract surgery was performed on sixteen patients from Beaufort West, Nelspoort, Murraysburg, Merweville, Laignsburg and Prince Albert. This is an example of successful outreach and support from a regional to a district hospital.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2011

The Department of Health and Cause Marketing Fundraisers have partnered together on the Pink Drive Project which offers women free mammograms and breast health education. Since 21 February 2011 the Pink Drive mobile mammography unit visits Macassar, Kleinvlei and Gustrouw on Mondays, Tuesdays and Wednesdays respectively to facilitate the early detection of breast cancer.

The partnership between the Western Cape Department of Health and Clicks, the Helping Hand Trust, was launched in Gugulethu on 24 February 2011. In terms of this agreement Clicks has initiated a Moms and Babies project, which provides clinic services, baby education and healthcare advice, at selected stores every Thursday afternoon for mothers whose babies were born at state hospitals. The Western Cape is the first province where this project is being implemented but the project will soon be rolled out to selected stores countrywide with the long-term goal of extending the services to mobile clinics for mothers and babies in rural areas.

- **Spending trends**

The Department has spent an amount of R 12 344 628 000 on a budget of R 12 408 383 000 which constitutes under-expenditure of R 63 755 000.

- Programme 2: District Health Services

  The under-spending can be attributed to the delay in the Global Fund Rolling Continuation Channel (RCC-I) agreement only being signed in September 2010. This resulted in a delay in the administrative processes necessary for the contracting of services at the start of the RCC-I programme.

  The under-spending can also be attributed to an audit that was undertaken by DPSA before implementation of the Occupation Specific Dispensation (OSD): Allied Health, in mid March 2011. Some institutions could not finalise these payments timeously before the end of the financial year. The non-filling of posts also impacted on this under-spending.

- Programme 5: Central Hospital Services

  The under-spending is attributed to an audit that was undertaken by DPSA before implementation of the Occupation Specific Dispensation (OSD): Allied Health, in mid March 2011. Some institutions could not finalise these payments timeously before the end of the financial year. The non-filling of posts also impacted on this under-spending.

- Programme 6: Health Science and Training

  The under-spending is mainly due to a lesser intake of learners than projected resulting in under-spending on logistical costs and stipends.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2011

- Programme 7: Health Care and Support Services

  The under-spending is mainly due to the inability to recruit clinical engineering staff on the engineering establishment as well as the OSD not being fully implemented.

- Programme 8: Health Facilities Management

  The under-spending can be attributed to the following:

  - Hospital Revitalisation Grant – slow progress on site by various contractors, slow planning for new phases on projects and delays in the approval of the PIP for Tygerberg PPP.
  - Infrastructure Grant to Provinces – late acceptance of tenders before holiday period with subsequent delay with handing over of sites, delay on site in terms of design considerations and a delay with decanting.
  - Own funds – late acceptance of tenders before holiday period with subsequent delay with handing over of site, delay on site in terms of design considerations and delays with decanting.
  - Maintenance – slower than anticipated construction progress due to problems with materials supply and/or capacity of contractors. In one case the contractor defaulted and the contract was cancelled. A new contract has been awarded for the service. Capacity problems within Health and Public Works also resulted in slower than anticipated planning, design work, documentation and procurement.

Under-expenditure on Equitable Share

- The equitable share portion of the budget was under-spent by approximately R 31 656 000 and this under-expenditure can be attributed to the reasons as stated in respect of Programmes 2, 5, 6 and 7 above.

Unauthorised expenditure

- After application of final virements no unauthorised expenditure was recorded for the year under review.

Virements

- All virements applied are depicted on pages 272 to 289 and reasons for the application of these virements are indicated on pages 290 to 292 of the Annual Financial Statements. All virements where approved by the Accounting Officer.