SUBMISSION OF THE ANNUAL REPORT TO THE MINISTER

Western Cape Government
Health

HEAD OF DEPARTMENT
REFERENCE: 13/3/1
ENQUIRIES: Professor KC Househam

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 19/2012 (Programme and Guidelines for the 2011/12 Annual Report Process), I hereby submit the Western Cape Department of Health's Annual Report on performance indicators and departmental activities for the 2011/12 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 2012.

PROF KC HOUSEHAM
HEAD: HEALTH

Date: 30 August 2012

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DEPARTMENT OF HEALTH

VOTE 6

2011/12 ANNUAL REPORT

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1. GENERAL INFORMATION

1.1 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 quality health services 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
(5) Responsiveness
(6) Respect - this last value was included as a core value by the Department of Health during the course of 2011/12

The Western Cape Government conducted a Barrett Survey during 2010 which assessed the personal and organisational values of departments in which employees were requested to identify the values that they "desire" and those that they experience in the department. Top management participated in a 360-degree evaluation process and Barret Survey Values workshops involving middle management were held to create awareness of values and the impact on service delivery. A second Barret survey was undertaken in July 2011 across a broader sample of staff and the findings were similar to the initial survey, which confirmed the need for sustained effort to deepen this process effectively.

1.2 Organisational structure

Minister: Mr Theuns Botha

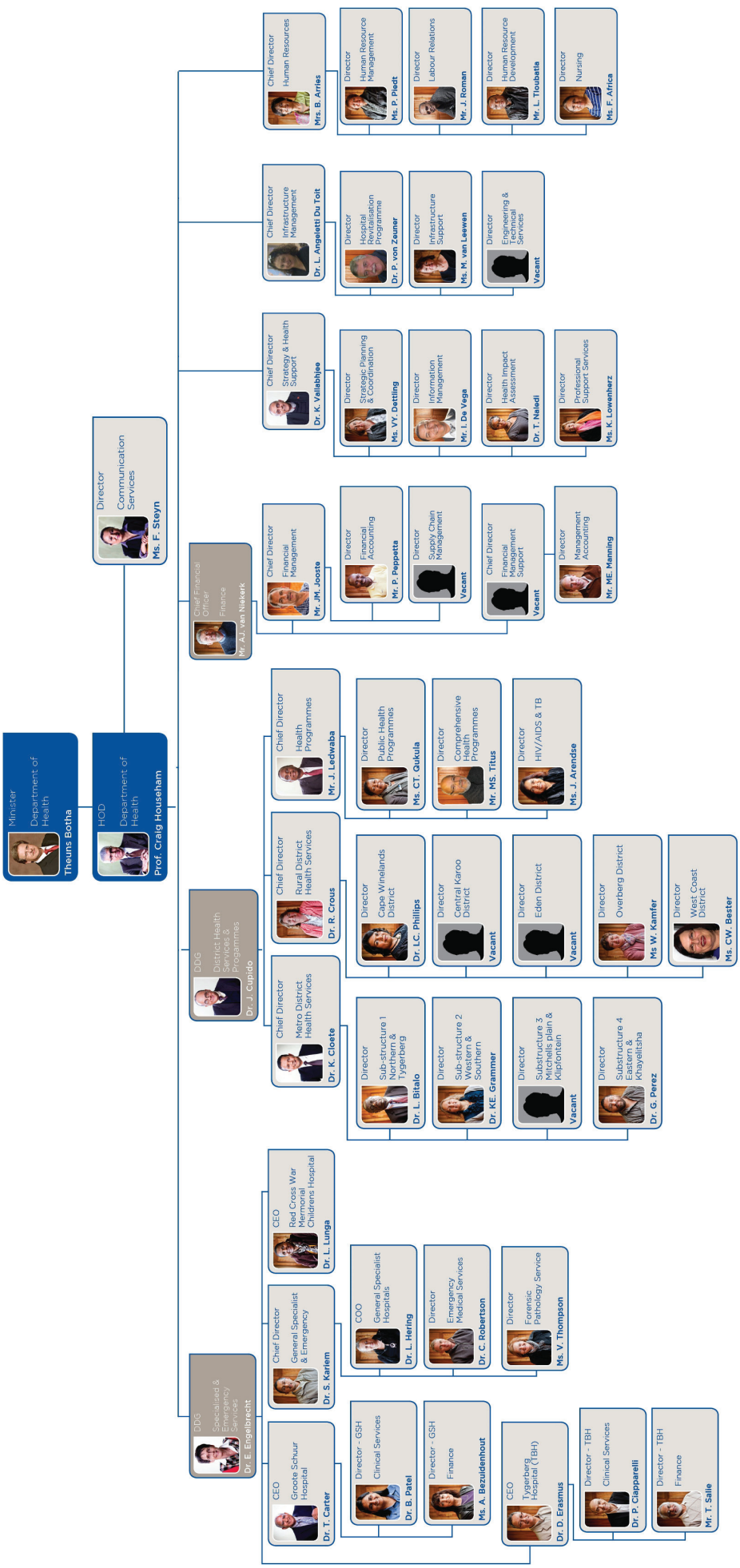
Superintendent General: Head of Department: Professor KC Household

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 shown in Figure 1 below.

Figure 1: Organogram of Senior Management in the Western Cape Department of Health



1.3 Legislative mandate

National Legislation

(1) Aged Persons Act, 81 of 1967
(2) Allied Health Professions Act, 63 of 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) Children's Act, 38 of 2005
(8) Choice on Termination of Pregnancy Act, 92 of 1996
(9) Compensation for Occupational Injuries and Diseases Act, 130 of 1993
(10) Constitution of the Republic of South Africa, 1996
(11) Constitution of the Western Cape, 1 of 1998
(12) Correctional Services Act, 8 of 1959
(13) Criminal Procedure Act, 51 of 1977
(14) Dental Technicians Act, 19 of 1979
(15) Division of Revenue Act (Annually)
(16) Domestic Violence Act, 116 of 1998
(17) Drugs and Drug Trafficking Act, 140 of 1992
(18) Employment Equity Act, 55 of 1998
(19) Environment Conservation Act, 73 of 1998
(20) Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972
(21) Government Immovable Asset Management Act, 19 of 2007
(22) Hazardous Substances Act, 15 of 1973
(23) Health Professions Act, 56 of 1974
(24) Higher Education Act, 101 of 1997
(25) Human Tissue Act, 65 of 1983
(26) Inquests Act, 58 of 1959
(27) Intergovernmental Relations Framework, Act 13 of 2005
(28) Institution of Legal Proceedings Against Certain Organs of State Act, 40 of 2002
(29) International Health Regulations Act, 28 of 1974
(30) Labour Relations Act, 66 of 1995
(31) Local Government: Municipal Demarcation Act, 27 of 1998
(32) Local Government: Municipal Systems Act, 32 of 2000
(33) Medical Schemes Act, 131 of 1996
(34) Medicines and Related Substances Control Amendment Act, 90 of 1997
(35) Mental Health Act, 18 of 1973
(36) Mental Health Care Act, 17 of 2002
(37) Municipal Finance Management Act, 56 of 2003
(38) National Health Act, 61 of 2003
(39) National Health Laboratories Service Act, 37 of 2000
(40) Non Profit Organisations Act, 71 of 1977
(41) Nuclear Energy Act, 46 of 1999
(42) Nursing Act, 33 of 2005

(43) Occupational Health and Safety Act, 85 of 1993
(44) Pharmacy Act, 53 of 1974
(45) Preferential Procurement Policy Framework Act, 5 of 2000
(46) Promotion of Access to Information Act, 2 of 2000
(47) Promotion of Administrative Justice Act, 3 of 2000
(48) Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000
(49) Protected Disclosures Act, 26 of 2000
(50) Prevention of and Treatment for Substance Abuse Act, 70 of 2008
(51) Public Audit Act, 25 of 2005
(52) Public Finance Management Act, 1 of 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, 35 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 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 Ambulance Services Act 3 of 2010
(6) Western Cape Direct Charges Act 6 of 2000
(7) Western Cape District Health Councils Act 5 of 2010
(8) Western Cape Health Care Waste Management Act 7 of 2007
(9) Western Cape Health Facility Boards Act 7 of 2001 and its regulations
(10) Western Cape Health Services Fees Act 5 of 2008 and its regulations
(11) Western Cape Land Administration Act 6 of 1998

New legislation

The National Health Act, 2003 (Act 61 of 2003) ("the Act"), which was partially proclaimed on 2 May 2005, is still not fully implemented. However, the following sections came into effect in terms of Proclamation 11 in Government Gazette No. 35081 on 27 February 2012:

- Chapter 2: Rights and duties of users and health care personnel: Section 11
- Chapter 6: Health establishments: Sections 35, 41, 42, 43, 44, 45 and 46
- Chapter 7: Human resource and academic health complexes: Sections 50 and 51

- Chapter 8: Control of use of blood, blood products, tissue and gametes in humans: Sections 54, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66 and 67
- Chapter 9: Health research and information: Section 71
- Chapter 12: General provisions: Section 93

The Western Cape District Health Councils Act, 5 of 2010 was enacted "to provide for certain matters relating to district health councils so as to give effect to section 31 of the National Health Act, 2003; and to provide for matters connected therewith". The Act came into operation on 24 August 2011.

According to section 7(8) of the Western Cape District Health Councils Act, the Minister or his representative must convene the first meeting of a district health council within ninety days of the commencement of the Act. The inaugural meetings of all the six district health councils were convened by 22 November 2011.

The Provincial Cabinet has approved the drafting and publishing for comment of the Western Cape Health Facility Boards Amendment Act, which seeks to amend section 21 of the Western Cape Health Facility Board Act, 7 of 2001.

1.4 Entities reporting to the Minister

Trading entity

(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.

A process has been initiated to incorporate the Cape Medical Depot, which is currently managed as a trading entity separate from the Department, into the Department, without altering the operations of the Depot. This will result in adjustments to the budget later in the 2012/13 financial year. The first step in this process is to repeal Provincial Ordinance 3 of 1962, which it is anticipated will be achieved by the end of the current financial year.

1.5 Minister's / MEC's Statement

The vision of the Western Cape Government is to offer every person equal access to opportunities through the Better Together motto. Together with each and every citizen, together with civil society, together with business, together with other spheres of government, we are Better Together.

The Better Together approach unfolds through our government's strategic objectives, all of which have been formulated to build an infrastructure to facilitate economic growth and new job opportunities.

The fourth strategic objective is creating wellness, meaning a whole of society approach that focuses on the prevention of disease in tandem with facing the challenges of the burden of disease.

In the past year I was personally involved in the establishment of district health councils, in accordance with the National Health Act. These councils will represent the province's six districts and ensure the co-ordination of all health services with their respective municipalities. This will ensure improved co-operation with local governments on health related matters.

The commissioning of Khayelitsha Hospital is an important milestone that demonstrates our government's commitment to bring the best possible services to communities that have been neglected in the past.

The primary health care service in this province has been tested and applauded all round for its success as a service that is nurse driven and supported by doctors. It provides basic medical services to the people who depend on the public health sector and is well supported by other levels of care in the Department. There is on-going pressure on this service, partly as a result of migration because the quality of health services provided in this province exceeds that of the services delivered in neighbouring provinces and neighbouring countries.

The report highlights the successes of the past year and focuses on the challenges for the future. Now, through Healthcare 2020, the Department will be shifting its focus to the patient experience. The shift will enable the Department to monitor health outcomes against five-year targets. The patient will be at the centre of the system and treated according to individual needs.

The annual report of the Western Cape Department of Health in 2011/12 is certainly a demonstration of good governance. I am very proud of every employee in the Department who has made it possible to achieve the successes described in this report.

A work of this nature requires discipline and efficiency. Through this channel I would like to congratulate and thank the Department on its achievements.

THEUNS BOTHA
WESTERN CAPE MINISTER OF HEALTH
MAY 2012

1.6 Accounting Officer's Overview

The opening of Khayelitsha Hospital at the latter end of 2011/12 was a significant development. It is a 230-bed world class facility that improves access to district and some specialist hospital services for one of the most historically disadvantaged communities in the Province. It provides tangible evidence of the intent of the Department to provide quality health services to all communities and to address equity. The hospital also signals a decisive shift in hospital design to become environmental friendly and to increase the Department's contribution to combat climate change and its consequences. A video of the hospital shown at the international COP 17 conference in Durban as a case study was positively received.

While the service pressures continued through 2011/12, the Department, through co-ordinated efforts with the City of Cape Town and other role-players significantly reduced the deaths from dehydration in children with diarrhoea. The impact of the rotavirus vaccine and sustained efforts to promote early use of sugar and salt solution by mothers to rehydrate their children was central to this positive impact. However, the provision of clean drinking water and sanitation to the poorest communities is the underlying solution to this challenge and must remain a focus of provincial and local government.

While the patient load appears to be stabilising, the Department continues to be a large busy service. Approximately 15.5 million patient visits took place at a primary care level in 2011/12, 2.4 million (approximately 15 per cent) of which were children under the age of five years. A total of 2 853 home based carers were employed via non-profit organisations. On the community based services platform, over 540 000 home visits were recorded and over 630 000 adherence support contacts were provided. Approximately 100 000 babies were born in the health service and about 23 000 caesarean sections were performed within our hospitals. The acute general hospitals admitted approximately 490 000 patients and had 1.98 million outpatient visits in 2011/12. A total of 83 235 women over the age of 30 were screened for cervical cancer and 6 700 cataract surgery operations were done. Close to 94 000 children under the age of one were fully immunised. This translated into an 88.2 per cent coverage.

A total of 471 652 emergency cases were responded to during 2011/12 and 106 608 outpatients were transferred by HealthNET to regional and central hospitals. Emergency medical services responded in under 15 minutes to priority 1 calls in urban areas almost 70 per cent of the time and within 40 minutes to priority 1 calls in rural areas 88 per cent of the time.

Approximately 905 000 people were tested for HIV and 80 000 HIV infections were identified. A further 20 000 people were started on anti-retroviral therapy and the year ended with 115 000 people being retained in care on anti-retroviral therapy. Ninety six per cent of pregnant women attending the health service were tested for HIV and approximately 15 000 HIV infected pregnant women were identified. Transmission rates of HIV to children of HIV-infected mothers dropped to below two per cent amongst those tested. This bears testimony to the effectiveness of the anti-retroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT) programmes.

Approximately 45 000 adults were treated for tuberculosis and the cure rate amongst new, smear-positive adult cases was 82 per cent.

The introduction of a new service provider to take over the Chronic Dispensing Unit (CDU) has been a major challenge. These transitional problems included amongst others, the lack of a phased hand over between the old and new contractor, the challenge of scaling up capacity to manage the full load of the current 140 000 chronic scripts and differences in systems between both providers.

An important long term strategy to address the burden of disease and service pressures described above is a focus on mitigating the upstream risk factors that cause ill health as described in Strategic objective 4: Improving Wellness of the Provincial Strategic Plan. The Premier's Summit on Wellness held in November 2011 was successful in lobbying widespread support across a range of stakeholders for a whole of society approach to addressing the upstream challenges. It culminated in the Cape Town Declaration on Wellness that was endorsed by all participants at the summit. The declaration signals an important commitment to working in partnership with stakeholders – working better together.

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 summit also recommended six working groups to focus on: promotion of safety and reduction of injuries, healthy lifestyles, HIV/TB, women's health, child health and mental health. These working groups are at varying stages of development and are busy finalising their project plans and deliverables.

The planning process for the next decade made some important strides during 2011. The principles, vision and values as well as the broad thinking towards 2020 strategy were published for public comment in December 2011. A range of dialogue sessions were facilitated with internal staff and structures as well as external stakeholders. The 2020 document was generally well received. Substantial comment was received and is being systematically considered before the next draft of the document is produced. There will then be a further opportunity for public comment before the framework is finalised.

The Department is already taking incremental steps in the direction of 2020. The focus on patient centred experience and quality of care lie at the heart of the vision of 2020. An extensive baseline audit on compliance with national core standards was conducted at all facilities in six priority areas identified by the national minister. The preliminary results are being used to develop quality improvement plans that are locally specific. This process has created a positive momentum towards a focus on quality.

A departmental framework has been developed to specifically address the patient-centred experience in the Province. This framework has three pillars viz. reception services, clinical governance and continuity of care. The Department also formally adopted a clinical governance policy in 2011/12.

The Department's 29 842 staff are the central vehicle to achieving good quality health services. The Department has started to pay greater attention to the findings of the staff satisfaction and Barret Survey. A series of values based workshops were held and the sample of the survey has been widened to include many more staff. This process is serving to increase the consciousness of living our values in our daily work across all cadres in the Department. In addition, the Department has gone out to tender for change management expertise to add greater momentum to this process.

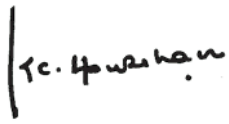
The passing of the District Health Councils Act in 2011 and the setting up of the six district health councils is an important step in providing a structured mechanism for broader public accountability and governance. The Department will provide enabling support to these structures to ensure they are functioning optimally. The district health councils and the facility boards are important statutory mechanisms for structured community involvement. The Department will be addressing the role of clinic committees and health forums in the light of these structures in 2012/13.

In terms of infrastructure delivery a number of small projects were executed under Programme 7 which made an important difference to the primary health care platform. The best example of this is the upgrade of the newly purchased building in Oudtshoorn which was transformed into a clinic.

The most noteworthy community day centres / clinics that were upgraded were Grassy Park, TC Newman and Melkhoutfontein. The completion of Khayelitsha Hospital as a world class facility was the highlight of the year. Other district hospitals to be completed were Vredenburg phase 2 A and Riversdale phase 3 upgrading. In terms of provincial and central hospitals, the completion of Paarl Hospital and the PET scan at Tygerberg Hospital stood out. The excellent relationship with the Red Cross Memorial Hospital Trust continued and saw the completion of ward C2. The Lamberts Bay and Vredendal ambulance stations were completed.

The Department was allocated a total budget of R13.428 billion and expenditure was within one per cent of the budget. The specific variances in different budget programmes or conditional grants are explained in the body of the report. The Department received an unqualified audit for 2010/11. The ability of the Department to stay within budget bears testimony to the strong leadership, commitment and institutionalised controls at various levels in the organisation.

I am proud of the achievements of the Department during the past financial year. My thanks go to the staff of the Department at all levels whose on-going commitment and dedication to service delivery and hard work enables the Western Cape Department of Health to make a difference in the lives of so many people of this province and indeed the country.



PROFESSOR CRAIG HOUSEHAM
HEAD HEALTH: WESTERN CAPE
DATE: 31 May 2012

INFORMATION ON PREDETERMINED OBJECTIVES

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	13 395 060	13 428 910	13 387 763	41 147
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 functions and responsibilities of the Western Cape Department of Health are to deliver a comprehensive package of health service to the people of the Province. This includes preventive, promotive, emergency and curative services, rehabilitation, intermediate and chronic care.

The Department implements effective interventions to reduce morbidity and mortality particularly in the high priority areas of HIV and AIDS, tuberculosis (TB), maternal, women and child health, trauma and chronic diseases. Tertiary and highly specialised health care services (largely funded from the National Tertiary Services Grant) are rendered to the people of the Western Cape and neighbouring provinces. Training facilities are also provided for health care workers and professionals in conjunction with higher education institutions.

In addition, the Department is responsible for the licensing and regulation of private hospitals and the provision of emergency medical services and a forensic pathology service within the Province.

The Department is required to develop and maintain appropriate enabling support services and infrastructure in order to provide the above services.

2.1.3 Summary of programmes

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

Programme 1: Administration

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

Programme 2: District Health Services

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

Programme 3: Emergency Medical Services

The rendering of pre-hospital emergency medical services including inter-hospital transfers and planned patient transport. The clinical governance and co-ordination of emergency medicine within the Provincial Health Department.

Programme 4: Provincial Hospital Services

The 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.

Programme 5: Central Hospital Services

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

Programme 6: Health Sciences and Training

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

Programme 7: Health Care Support Services

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

Programme 8: Health Facilities Management

To provide for new health facilities and the upgrading and maintenance of existing facilities.

2.1.4 Strategic outcome oriented goals

The strategic goals of the Department of Health focus on the Department's strategic objective of "Increasing wellness" which is one of the eleven strategic objectives of the Provincial Government of the Western Cape for the period 2010 - 2014.

The strategic goals identified in the Western Cape Department of Health's Strategic Plan for 2010 - 2014 are:

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

The strategic goals were revised during 2011/12 – refer to section 2.7.1 Key policy developments and legislative changes.

2.1.5 Overview of the service delivery environment for 2011/12

Summary of services rendered by the Department

The Western Cape Department of Health is primarily responsible for providing health services to the 4.58 million uninsured population of the Province, i.e. approximately 78 per cent of the total population of 5.87 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 range of services that the Department provide includes the following:

1) A comprehensive, cost-effective primary health care service that includes measures to prevent disease and promote a safe and healthy environment. These services are provided in community based care, clinics, community health/day centres and district hospitals.
2) Health programmes to deal with specific health issues such as nutrition, HIV and AIDS, tuberculosis, maternal, child and women's health; environmental and port health, etc.
3) District, provincial and central hospital services, which include acute and specialised hospitals such as tuberculosis, psychiatric, rehabilitation and dental hospitals.
4) Emergency medical and planned patient transport services.
5) Specialised orthotic and prosthetic services.
6) Forensic pathology and medico-legal services.

Quality of care and improving the patient experience is one of the cornerstones of the 2020 strategy that is being developed. The baseline assessments against the six priorities of the National Core Standards were conducted at all health facilities during 2011/12.

The Department will continue to develop a strong foundation of support services such as finances, human resource, strategic planning, information management and public health support, infrastructure and professional support services management, to strengthen health system effectiveness.

1) Comprehensive, cost effective primary health care services

The primary health care (PHC) services strive to provide a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities. There are 292 fixed PHC facilities (including nine community health centres, forty nine community day centres and approximately ninety fixed clinics managed by the City of Cape Town Metropolitan Municipality) and 173 non-fixed units offering PHC services in the Western Cape.

Approximately 15.5 million patient encounters took place at a primary care level in 2011/12, about 2.4 million (approximately 15 per cent) of which were children under the age of five. Of these encounters, approximately 45 per cent took place at clinics and 46 per cent at community day centres and community health centres. Five per cent of encounters occurred through mobile and satellite services, while midwife obstetric units accounted for just under 3 per cent of contacts.

Community Based Services (CBS)

CBS offers four core services:

- Home-based care within which three service delivery streams are recognised: a) Home-based care; b) Community adherence support; and c) Prevention/health promotion.
- Intermediate care was previously known as de-hospitalised or sub-acute care. With the assistance of external policy expertise the Department is negotiating a policy shift from de-hospitalised care to intermediate care. The shift in terminology emphasises a commitment to continuity between intermediate care facilities and the other components of the service platform, both at a tertiary and a primary or community based level. The name change also signifies a desired shift in the orientation of these facilities – from a passive to a more active and rehabilitative environment and one in which patients are assisted to function independently, and where necessary, with appropriate support in their home environment.
- Lifelong care is an institutional service offered for long-term clients suffering from severe mental or physical handicaps.
- Mental health services assist mental health clients to live more independently in the community and provide services to de-hospitalised mental health clients in order to prevent hospitalisation.

CBS services are delivered largely through lay people, employed by non-profit organisations (NPOs), who have received appropriate training. The NPO partners who employ care workers are in turn sub-contracted by the Provincial Department of Health. By the end of 2011/12 a total of 2 853 home based carers were employed via NPOs. On this platform, over 540 000 home visits were recorded and over 630 000 adherence support contacts were provided in the financial year.

2) Health programmes to deal with specific health issues

The primary mandate of the Division: District Health Services is to impact on the burden of disease as experienced by the population of the Western Cape. As part of that mandate, and in line with the Millennium Development Goals and local and international evidence-based practice, there is a special focus on:

- Improving maternal and child health.
- Improving woman's health.
- Preventing and/or managing HIV and AIDS, and TB.
- Detecting and managing chronic non-communicable diseases.
- Preventing and/or mitigating the impact of violence and injuries.

The Division: District Health Services, in the lead-up to Healthcare 2020, has placed special emphasis on improving the quality of services rendered across the platform. To this end, the Department has been working closely with the National Department of Health and other partners to evaluate primary health care facilities and district hospitals against nationally prescribed core standards.

In addition a process of orientating the services towards a positive patient-centred experience is being internally driven. This process pays special attention to the patient's first contact with the health services (reception services), the clinical governance of the subsequent consultation, and the follow up after the necessary service has been delivered (continuity of care).

Maternal, child and woman's health

The Department managed approximately 100 000 baby deliveries over the course of the year of which approximately 97 000 attended at least one antenatal assessment. Approximately 23 000 caesarean sections were performed in public health institutions, 45 per cent of which were at regional hospitals, 31 per cent in district hospitals and 25 per cent in central hospitals.

Close to 94 000 children under the age of one were fully immunised.

HIV testing rates amongst pregnant women exceeded 96 per cent and approximately 15 000 HIV-infected pregnant women were identified within the services. Transmission rates of HIV to children of HIV-infected mothers dropped to below 2 per cent (amongst those tested). This bears testimony to the effectiveness of the anti-retroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT) programmes.

A total of 83 235 women over the age of 30 were screened for cervical cancer.

The Department facilitated a reduction in both the maternal mortality rate and the infant and child mortality rates during the 2011/12 financial year.

HIV/AIDS and TB

Approximately 905 000 patients were tested for HIV and 80 000 HIV infections were identified. A further 20 000 patients were started on ART and the year ended with 115 000 patients being retained in care on ART.

Approximately 45 000 adults were treated for TB and the cure rate amongst new, smear-positive adult cases was 81.7 per cent.

3) District, provincial and central hospital services

District hospitals

There are 34 district hospitals in the Western Cape. This includes the Mitchell's Plain district hospital hub which is currently located at Lentegeur Hospital pending the construction of the hospital. Nine district hospitals are in the Cape Metro district and the remainder is distributed across the five rural districts.

Just less than 250 000 separations occurred from the district hospitals in 2011/12. With 2 477 district hospital beds on the platform, this equates to approximately 100 separations per bed per year, each having an average length of stay of 3.1 days.

District hospital outpatient departments (OPD) experienced a headcount of approximately 922 000 over the year, with an average annual OPD headcount of 47 000 per Metro district hospital and 20 000 per rural district hospital.

Khayelitsha District Hospital was officially opened towards the end of the financial year, increasing access to a range of acute and in-patient services for a previously under-serviced community.

General specialist hospital services

Five general (regional) hospitals provided level two or general specialist services to 107 713 inpatients and 235 530 outpatients.

The priorities within Programme 4 (Provincial Hospital Services) for the 2011/12 financial year focused on improving acute hospital services in order to manage the burden of disease.

One of the major objectives in 2011/12 was 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 acute bed pressures in regional hospitals were reflected in the bed utilisation rate of 86 per cent. (It should be noted that hospitals are regarded as full at a bed utilisation rate of 85 per cent.)

Clinical governance was strengthened across geographic service areas under the guidance of the heads of general specialist services.

Specialised hospital services

A total of 3 979 inpatients and 8 360 outpatients were treated at the six tuberculosis (TB) hospitals in the Province. TB hospitals admit acutely ill drug sensitive and drug resistant clients. There has been an increased demand for TB beds which has resulted in a policy response of decentralising the management of drug resistant cases in the community as soon as it is feasible.

The four psychiatric hospitals in the Province treated 5 822 inpatients and 26 621 outpatients. Mental health contributes significantly to the burden of disease through morbidity rather than mortality. The abuse of substances, especially drugs like TIK, has further exacerbated the burden of mental ill health on the public health service.

The Western Cape Rehabilitation Centre (WCRC) treated 859 inpatients and 10 980 outpatients. Inter-disciplinary services continued at the WCRC in line with the Rehabilitation and Disability Management Service Plan. An important part of the services was the prevention of secondary complications in persons with disabilities, particularly in high risk groups such as the spinal cord injured. Support was provided to the district health services to facilitate the development of quality rehabilitation services for persons with physical disabilities.

Central hospitals

Programme 5 (Central Hospital Services) funded the delivery of general and highly specialised (tertiary and quaternary) services in the three central hospitals. These hospitals also serve as an important platform for the teaching and training of health professionals, as well as research.

In 2011/12 a total of 134 818 inpatients and 822 871 outpatients were treated at the central hospitals. Between 2008/09 and 2010/11 the general specialist service outputs in central hospitals were reflected against sub-programme 4.1 (General (regional) hospitals). From 1 April 2011 all service activities in central hospitals are reflected against Programme 5 (Central hospital services). The service outputs in 2011/12 are therefore not necessarily comparable with previous year's performance.

The central hospitals assisted in the planning and commissioning of Khayelitsha Hospital and preparations ensued for the service reconfiguration. Service delivery in key bottleneck areas in central hospitals such as critical care, theatres and radiology services were strengthened. Specific focus was placed on improving women's health by supporting colposcopy services and improving the patient experience and safety during labour.

Managers and clinicians from the central and regional hospitals fulfil leadership roles in strengthening health systems and clinical governance in the respective geographical service areas (GSAs) as well as in the provincial co-ordinating committees (PCCs) for each of the disciplines. In addition, the central hospitals also play a vital role in performing outreach and support to other health facilities.

4) Emergency medical and planned patient transport services

Emergency Medical Services (EMS) delivers ambulance, rescue and patient transport services from fifty two stations across the Western Cape Province and with a fleet of 250 ambulances.

The emergency control centre (ECC) structure and process was re-engineered which resulted in a significant improvement in the response time performance. EMS responded in under 15 minutes to priority 1 calls in urban areas 69.6 per cent of the time and within 40 minutes to priority 1 calls in rural areas 88.1 per cent of the time.

A total of 471 652 EMS emergency cases were responded to during 2011/12 and 106 608 outpatients were transferred by HealthNET to regional and central hospitals.

5) Specialised orthotic and prosthetic services

The functionality of persons with disabilities was enhanced through the provision of an efficient and effective orthotic and prosthetic service by the Orthotic and Prosthetic Centre. Outsourced orthotic and prosthetic services were rendered to the Eden and Central Karoo Districts.

A total of 5 833 orthotic and prosthetic devices were manufactured and the number of patients on the waiting list for devices for more than six months decreased from 391 in 2009/10 to only 103 patients in 2011/12.

6) Forensic pathology and medico-legal services

Forensic pathology services are rendered via eighteen forensic pathology facilities across the province and a fleet of 69 vehicles. During 2011/12 a total of 9 359 medico-legal cases were admitted resulting in 9 226 examinations in the Western Cape to establish the cause of death in cases as defined in the Inquest Act. Of these 5 637 (61 per cent) medico-legal post-mortems were performed in the metropolitan area and 3 589 (39 per cent) in the rural districts.

Challenges and corrective steps / response to challenges

Some of the challenges experienced by the Department include:

1) The concept of geographic services areas (GSAs), which are functional arrangements that do not impinge on the statutory structures and powers of the districts and their management teams, has been developed in order to facilitate cohesion and co-ordination in service delivery between the various institutions, budget programmes and management structures within a specific geographic area.

   There are six districts in the Western Cape but five functional GSAs:

   - The Cape Town Metro District is divided into Metro West and Metro East GSAs.
   - Central Karoo and Eden are combined into the Eden/Central Karoo GSA.
     This has been done to address the difficulty of recruiting and retaining staff and effectively managing the Central Karoo District, which is a geographically large and sparsely populated area as an independent entity.
   - Winelands and Overberg have been combined into a single GSA for operational and logistical reasons.
   - West Coast:

     The boundaries for the West Coast GSA are co-terminous with the districts except in the sub-districts of Drakenstein and Stellenbosch which are formally part of the Winelands District and which fall within the West Coast GSA as patients from these communities are referred to Paarl Hospital in the West Coast GSA due to the topography and road links.

   The GSAs began to function during 2011 and the benefits of improved communication and co-ordination with a united focus on service priorities and joint problem solving are now being realised.
2) Provision of primary health care (PHC) services in the Cape Metropole District is fragmented and inefficient as a result of the service being provided by two health authorities. A joint management structure has been set up to align priorities and administer the dual authority model. However, this issue will only be resolved once the service is rendered by a single authority. In the current financial year the Department will move to consolidate services across the Cape Metropole District in terms of funding currently allocated to the City of Cape Town.
3) Community based services experienced some challenges due to a difference in the interpretation of contractual obligations between the Provincial Department of Health and some partner non-profit organisations. Stricter contract management processes were instituted to mitigate against this in the future.
4) The introduction of a new service provider to take over the Chronic Dispensing Unit (CDU) has been a major challenge. These transitional problems included amongst others, the lack of a phased hand over between the old and new contractor, the challenge of scaling up capacity to manage the full load of the current 140 000 chronic scripts and differences in systems between both providers.

5) The management of behaviourally disturbed patients presented a challenge to district and regional hospital emergency centres. The escalating burden of mental ill health compounded by the challenge of substance abuse is fuelling this challenge which requires a multi-pronged response. Many of the acute hospitals have expanded their capacity, including that for 72-hour observations, to manage these patients separately from other emergencies in the emergency centres.

   Specialists from the psychiatric hospitals are providing outreach and support to acute hospitals to help manage this challenge. Mechanisms have been set up between the acute hospitals and psychiatric hospitals to better manage the waiting lists of patients needing to be admitted to psychiatric hospitals. The outpatient services are also being strengthened to help contain these patients and relieve pressure on hospital beds. Assertive community teams (ACTs) have been set up to follow up patients that are frequently admitted. This has shown good results in reducing the frequency of admissions as well as the length of stay of these patients when they do get admitted.

6) Acute hospital services continue to operate under pressure. This is evidenced by the increased number of patients being transported by ambulance services and the frequent need to divert ambulances between institutions.

   The Department has put in a triage policy to ensure that the most sick patients are treated first. The appointment of emergency medicine physicians and registrars in emergency centres at several hospitals has strengthened clinical capacity to efficiently manage the patient load as well as improve the quality of care. The common bottleneck is the availability of vacant beds to admit patients from the emergency centres. The appointment of bed managers and the attempts to improve patient flow and discharge management are being incrementally addressed. The situation is being closely monitored.

7) In terms of EMS, response time performance continues to be a challenge although there was a significant improvement in the urban responses under 15 minutes (69.6 per cent). The improvement has been attributed to the increase in available resources through the funding of overtime.

8) There has been a consistent increase in the demand for planned patient transport. The Department is conducting an analysis and developing strategies to address the challenge. This requires a combined effort between EMS, and management and clinicians from all levels of hospitals to improve access to rural patients and reduce inappropriate referral to central hospitals.

9) Recruitment and retention of highly skilled medical and nursing staff remains a challenge. The shortage of professional nurses, in particular those with post basic qualifications in theatre technique, intensive care, paediatrics, mental health and advanced midwifery, impacted on the Department's capacity and ability to provide highly specialised services. Access to intensive care unit (ICU) beds remained a limiting factor for reducing theatre waiting time and waiting lists. The major contributing factor is the lack of trained nursing staff. There is also a shortage in skilled clinical technologists to provide key support services.

   In order to address the challenges around recruitment and retention of highly skilled staff, staff satisfaction surveys are conducted to measure the need and impact of various strategies to retain staff. Training programmes and opportunities are provided and focus on key staff (like nurses) to improve skills and achieve deployment in key services (like critical care, theatres, paediatrics, etc.). Strategies leveraging on bursary and training posts are under development to improve recruitment of clinical technologist. The Occupation Specific Dispensation (OSD) seems to have played a positive role in most instances to help recruit and retain clinical staff in the public service.

10) Theatre capacity remains restricted by a general shortage of nurses trained in theatre technique and anaesthetists. Agency staff must be sourced to continue to deliver services, which inflates expenditure. The Department has initiated a pilot training programme of theatre technicians to overcome the shortage of theatre scrub nurses. To optimise efficient use of theatres, the Department implemented the following strategies:

- Theatre performance is measured by recording theatre starting times and cancellation rates. This assists to ensure the optimal use of available theatre time.
- Implementation of the World Health Organisation checklist helps to ensure that quality services are maintained.
- Some hospitals had initiatives during the de-escalation period to scale up the number of operations performed for specific conditions.

11) There is limited capacity in the implementing department for infrastructure, the Western Cape Department of Transport and Public Works. The institutionalisation of the Western Cape Infrastructure Delivery Management System (WC-IDMS) has commenced, which will include, inter alia, the implementation of revised human resource structures in both the Department of Transport and Public Works and the Department of Health, alternative construction procurement strategies, prioritisation models and processes, norms and standards, standardisation of facility design etc.

12) The infrastructure backlog, especially in relation to emergency medical services, forensic pathology services and primary health care services, remains high. The Hospital Infrastructure and Hospital Revitalisation Grants are used to upgrade and build new facilities. However the backlog can only be addressed in an incremental manner over many years.

13) Some challenges have been experienced with the sub-standard quality of construction, procurement and management of professional service providers and contractors, and costly delays in project implementation by Western Cape Department of Transport and Public Works. A good example of this is the problems experienced on the Worcester Hospital Phase 4 project where the services of the previous contractor had to be terminated due to inferior quality and lack of progress and whereby the Department of Health had to make additional funds available to undertake remedial work and to complete the project. Membership of the Department of Transport and Public Works Tender Adjudication Committee has been granted to the Department of Health. In addition to this, the updated service delivery agreement between the Department of Health and the Department of Transport and Public Works allows intervention from the Department of Health in extreme cases.

14) The availability of land and the lengthy land acquisition process for new facilities, particularly between the three spheres of government, causes delays in infrastructure projects. The planning horizon with respect to determining the need for suitable sites has been increased to five years.

15) Ensuring the timeous preparation of provincial space planning norms and standards, standard drawings and technical specifications, design guidelines, and cost norms is being addressed through the establishment of a norms and standards committee. The committee has been tasked to establish acceptable norms and standards for the different types of health facilities which have made good progress.

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 2011, roll-overs amounted to R32 116 000:

- Programme 2: District Health Services - R15 121 000

  R15 121 000 was rolled-over from 2010/11 in respect of the Global Fund due to the Global Fund RCC-I Agreement (Global Fund Rolling Continuation Channel) being signed in

September 2010 only. This resulted in a delay of the administrative processes necessary for the contracting of services at the start of the RCC-I programme.

- Programme 6: Health Sciences and Training - R137 000

  R137 000 was rolled-over from 2010/11 in respect of National Conditional Grant: Social Sector Expanded Public Works Programme (EPWP) Incentive grant to provinces due to the late filling of some posts and resignations.

- Programme 8: Health Facilities Management - R16 858 000

  R9 257 000 was rolled-over from 2010/11 in respect of the Hospital Revitalisation Schedule 5 Grant due to the slow progress on site by various contractors.

  R7 601 000 was rolled-over from 2010/11 in respect of the Infrastructure Grant to Provinces (Health) Schedule 4 Grant due to the timing of the acceptance of the tender before the holiday period with subsequent delays in handing over the site, delays with decanting and delays in site handover in general.

Internal developments that impacted on service delivery

As a result of the fiscal tightening over the medium term expenditure framework period the Department's budget does not allow for growth in real terms. The newly commissioned Khayelitsha Hospital, the envisaged increased capacity of the chronic dispensing unit, the strengthened control to prevent and detect fraud and irregular expenses and other priorities were and will be funded through reprioritisation.

Khayelitsha Hospital

The new Khayelitsha Hospital was commissioned in the last quarter of the 2011/12 financial year. The commissioning process itself was a major challenge. A total of 76 815 applications were received for 329 posts at the hospital. Systematically working through this in time to have appointments made for the opening of the hospital was a commendable achievement to all involved.

This is a landmark development in the history of the Department, with the opening of a world-class, modern, environmental friendly facility in one of the most disadvantaged communities in the Province.

The budget for this hospital was secured through internal reprioritisation of the Department's allocation. The services and resources of the interim Khayelitsha Hospital that was located at Tygerberg Hospital was relocated to the new site. Similar shifts in services and resources will impact on other hospitals that will be relieved of the service load by the opening of the new Khayelitsha Hospital. The bed and staff capacity of general specialist services at Tygerberg Hospital has also been expanded and strengthened by the relocation of resources from Groote Schuur and Red Cross War Memorial Children's Hospitals, to be able to manage the referrals from the new hospital.

Early reports from the new Khayelitsha Hospital indicate full functionality in terms of bed utilisation and the large emergency centre patient numbers. The full impact of this development on the rest of the health service landscape in the metro will be better appreciated and understood in 2012/13.

External developments that impacted on service delivery

National Health Insurance

The National Department of Health released a policy paper on National Health Insurance (NHI) in South Africa for public comment. It is envisaged that the NHI will be phased in over a fourteen year period. The Western Cape Government has responded with an alternative proposal, Universal Health for All, which stresses the need to strengthen the health system using the current successful Western Cape public sector health delivery system as a model together with increased partnership with the private sector. There is agreement and support for some of the key initiatives in the policy paper such as steps to improve the quality of health services in the public sector and the strengthening of the district health system.

The national primary health care re-engineering strategy is an important pillar of the NHI. It has three components: provision of district specialist teams, strengthening of school health services and expansion of community based services. The Western Cape Department of Health has amended these strategies to fit with local conditions and developments.

Twelve outcomes of the Department of Performance Monitoring and Evaluation

The national government agreed to twelve 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.

1) Increasing life expectancy

The Premier convened a Wellness Summit in November 2011 to discuss the burden of disease and the "whole of society" approach to wellness. In preparation for the summit, data for 2009 was analysed and profiles for all six health districts were created. To facilitate a collective effort from all role-players to reduce the burden of disease, a declaration with ten key recommendations for action was developed and ratified by the stakeholders at the summit.

Progress on some of the transversal strategies across various departments include:

- Decrease the incidence of injury:

  A workgroup on injuries was established and alcohol related road traffic and interpersonal injuries were prioritised. Five high prevalence areas were identified for intervention and injury surveillance will be established in these areas. BoozaTV, a six-part health promotion television series, was developed to reduce alcohol demand.

  The set of DVDs has been widely distributed to NPOs for use within their constituencies. Brief motivational interventions will be piloted in two trauma units.

- Decrease the incidence of non-communicable diseases:

  A workgroup was established to develop strategies to reduce the burden of chronic diseases, e.g. diabetes and hypertension. Healthy eating, exercise and smoking cessation have been identified as priorities. The health promoting schools programme in the Western Cape Education Department will be strengthened and a work place programme in the provincial government was piloted in collaboration with the Sports Science Institute of South Africa.

- Other workgroups and initiatives include:
  - Women's health workgroup that has initiated a pilot project on intimate-partner violence.
  - Child health workgroup that is focussing on encouraging breast feeding.
  - HIV/TB workgroup that is well established and strongly advocating the preventive measures such as condom use, male medical circumcision and avoidance of concurrent multiple sexual partners.
  - Mental health workgroup that will begin to address the recommendations from a recent mental health summit and expand a pilot perinatal mental health intervention amongst pregnant mothers.

2) Decreasing maternal and child mortality

The initiatives identified to decrease the maternal mortality rate include the implementation of the Saving Mothers and Children's Plan to address the recommendations of the National Committee on the Confidential Enquiry into Maternal Deaths, prioritisation of emergency transport and accelerated staff training programmes. The public health facility maternal mortality rate for 2011/12 was 28.67 maternal deaths per 100 000 live births.

The strategies to decrease the incidence of childhood illness include the accelerated roll out of the Road-to-Health booklet, increasing immunisation coverage, conducting diarrhoeal disease campaigns, prevention of mother-to-child transmission of HIV and expanding the provision of anti-retroviral treatment to HIV positive children.

The infant and child mortality rates in public health facilities for 2011/12 were 11 deaths under one year per 1 000 live births and 13 deaths under five years per 1 000 live births respectively.

3) Combating HIV and AIDS and decreasing the burden of disease from tuberculosis

The Department aims to decrease the incidence of infectious diseases (HIV and TB) through implementing combined prevention/promotion strategies and conducting an HIV and AIDS counselling and testing (HCT) campaign. The focus of the campaign is advocacy, communication and social mobilisation (ACSM), promoting the use of barrier methods, prevention of mother-to-child transmission, increasing HIV treatment and providing medical male circumcision. The estimated HIV prevalence in women aged 15 – 24 years for 2011/12 is 12.7 per cent. By the end of 2011/12 a total of 115 087 adults and children were receiving anti-retroviral treatment in the Western Cape.

The incidence of TB and the prevalence of drug-resistant TB will be decreased through ACSM and integrated TB and HIV treatment and adherence support. A new smear positive TB cure rate of 81.7 per cent was achieved in 2011/12.

4) Strengthening health system effectiveness

Revitalisation of primary health care

The provincialisation of personal primary health care in the Metro District needs to be addressed through a political decision at national level and securing the necessary funding.

The Western Cape District Health Councils Act, No 5 of 2010, was drafted to give effect to section 31 of the National Health Act, No 61 of 2003 and came into effect on 22 August 2011. Inaugural meetings for all six district health councils were convened within 90 days of commencement of the Act.

There are several strategies and efforts to revitalise PHC services. These include, amongst others, the PHC re-engineering strategy described above, increased allocation of resources to the DHS over recent years, appointment of family physicians who take responsibility for clinical governance within the DHS, and the baseline audit assessment against national core standards which has helped to create a systematic focus on improving quality.

Healthcare financing and management

There is a constant tension between the need to provide adequate quality health services within a limited resource envelope. This is further aggravated by the recent recession. Thus there is a need to re-prioritise within the allocated baseline budget as well as the need for strong controls to prevent a ballooning of expenditure. The Department has instituted robust tools and mechanisms to closely monitor spending on staff and goods and services. The effectiveness of these measures is borne out by the fact that the Department's final 2011/12 expenditure was less than one per cent of the allocated budget.

The failure of the National Tertiary Services Grant (NTSG) and the Health Professions Training and Development Grant (HPTDG) to keep up with inflation and the adequate funding of current outputs continues to put pressure on the equitable share, which is used to cross subsidise this service especially in the central hospitals.

The financial statements for 2010/11 were not qualified (i.e. fairly represented the activities and status of the Department) and the Department continues to strive for improved performance in this area.

Human resources for health

A competency profile (skills audit) for prioritised occupational categories has been completed and the outcomes will be used to inform the Workplace Skills Plan, Human Resource Plan and action plans related to training and development.

Draft action plans to achieve priorities were completed and reported to the Department of Public Service Administration (DPSA) through the Department's Human Resource Implementation Plan dated 30 September 2012.

An operational plan is in place for the implementation of the provincial nursing strategy, focusing on nursing practice and nursing education and training. Peer reviews were conducted in health facilities in all six districts, the pilot of the Nursing Information Management System (NIMS) commenced, clinical nursing education units are being established and a co-ordinated clinical placement system was implemented.

A standardised education and training selection policy and a three year departmental nurse training plan (based on the outcomes of the OSD for nurses "Sunset Clause-analysis" and service delivery needs) was developed and implemented. Research in nursing was enhanced in collaboration with higher education institutions and services.

Quality of health and the accreditation of health establishments

Baseline audits on the six priority focus areas within the national core standards policy document were conducted at all facilities by the end of March 2012. Training will be undertaken for all quality assurance managers to develop and monitor facility level quality improvement plans.

Monitoring and evaluation of the quality of clinical care was done through conducting monthly mortality and morbidity meetings at health facilities. Central hospitals participated in the best care always (BCA) projects to reduce hospital acquired infections in selected areas. A follow-up workshop was held in November 2011 during which feedback on progress and improvements were provided.

In addition to the core standards approach, the Department has developed a strategy to focus on improving the patient experience. This is in keeping with the central vision of 2020. The strategy is being piloted in the DHS with a focus on reception services, clinical governance and the continuity of care.

Health infrastructure

One of the major highlights in 2011/12 was the completion and commissioning of Khayelitsha Hospital. The hospital provides world-class modern infrastructure and will render a district hospital service to one of the poorest communities in the Western Cape.

The construction of Mitchells Plain Hospital is in progress and is scheduled for completion by December 2012. The tender for the phase 2B construction at Vredenburg Hospital (33 months) was awarded in January 2012.

Some of the construction projects that were completed during the year include Grassy Park CDC, Melkhoutfontein Clinic, Lambert's Bay Ambulance Station upgrade, Vredendal Ambulance Station, the revitalisation of Paarl Hospital (phase 2) and the upgrade of Riversdale Hospital (phase 3).

A project officer was appointed for the public private partnership (PPP) for the new Tygerberg Hospital.

Information, communication and technology and health information systems

The Compliance Management Instrument for predetermined objectives (CMI-PO) was revised to ensure all issues identified during the audit of predetermined objectives are being addressed. The tool has been implemented at district offices as well as district, regional and central hospitals.

The Department has embarked upon an exercise to rationalise the indicators and data elements that are routinely collected. The amount of data collected puts a heavy strain on staff and the system especially as a significant part of the PHC data is manually collected.

There has been significant progress on rolling out some of the priority ICT systems. A full time project manager has been appointed to manage the PACS/RIS project. This project was rolled out from Tygerberg to Groote Schuur Hospital in 2011/12 and the infrastructure at Red Cross War Memorial Children's Hospital has been completed in preparation for PACS. PHCIS has been rolled out to 36 additional sites in the 2011/12 financial year (in total to 120 sites). The Department has received an international information technology award in Brussels, Belgium, for the PHCIS project. Enterprise Content Management (ECM) was implemented at the new Khayelitsha Hospital and was further expanded at Tygerberg Hospital.

2.1.6 Overview of organisational environment for 2011/12

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

Resignations and/or appointments in Senior Management Service

There were significant changes in the senior management service (SMS) during 2011/12 as a result of attrition.

The following SMS members left the service of the Department during 2011/12:

- Mr A Dakela, Director: Engineering and Technical Support, resigned.
- Mr NJ Oosthuizen, Director: Engineering and Technical Support, resigned.
- Dr JWB Claassen, Director: District Health Services, deceased.
- Dr R Nathan, Director: District Health Services, resigned.

The following SMS members joined the Department during 2011/12:

- Dr NTD Naledi, Director: Health Impact Assessment.
- Mr NJ Oosthuizen, Director: Engineering and Technical Support.
- Mr M Vonk, CEO: George Hospital.
- Ms A Bezuidenhout, Director: Finance, Groote Schuur Hospital.
- Dr L Martin, Director: Project Office, Tygerberg Hospital PPP.

The following staff members were promoted to senior management positions:

- Ms FP Africa was promoted to the position of Director: Nursing Services.
- Mr LR August was promoted to the position of CEO: GF Jooste Hospital.
- Mr BS Mashedi was promoted to the position of CEO: Victoria Hospital.
- Ms CD Dean was promoted to the position of CEO Valkenberg Hospital.
- Dr SE Fourie was promoted to the position of Director: Specialised Services Support.

Restructuring

Due to changes in the burden of disease a number of changes had to be made:

- Further organisational development investigations were conducted based on the Comprehensive Service Plan (CSP) and new organisational establishments were implemented at the Paarl, George and Worcester regional hospitals.
- The development of a macro modernisation structure included a new establishment for the Chief Directorate: General Specialist and Emergency Services and the Chief Directorate: Programmes in District Health Services.
- The commissioning of the Khayelitsha Hospital included an establishment to accommodate the hub for the hospital that was located at Tygerberg Hospital.

Strike actions

There was a protest action by COSATU related to the use of labour brokers. Only 29 staff members participated in this action. There was no disruption of services and no significant impact.

System failures and cases of corruption

There was an increase in the cases of corruption and sixty people were dismissed during this financial year. Dismissals were mainly related to absenteeism (21) and theft and bribery (23). There were 74 dismissals during 2010/11, mainly related to absenteeism (18,) theft and bribery (17) and an unprotected strike action in Khayelitsha (10). Serious misconduct cases are now handled centrally to improve the co-ordination and finalisation thereof.

Of the cases reported by the fraud investigative unit (FIU) for the 2011/12 financial year, four cases had a combined financial implication to the value of R2 940 724.14. Monies will be recovered from the pension benefits of the staff members involved. All four staff members were dismissed. Three cases related to procurement irregularities and one case related to fraud.

In the previous financial year (2010/11) three cases reported by the FIU had a combined financial implication to the value of R191 386.60 of which R96 962.45 was confirmed as recovered. All three staff members were dismissed. Two cases related to fraud and once case related to unauthorised use of state property.

2.1.7 Key policy developments and legislative changes

The policy initiatives that guide the strategy of the Department are outlined below:

Policy level	Policy framework
− International level	− Millennium Development Goals
− National Government (Transversal)	− Twelve outcomes of National Government
	− National Development Plan: National Planning Commission
− National Department of Health	− Negotiated Service Delivery Agreement
	− National Health Systems Priorities: The Ten Point Plan
	− National Health Insurance
	− Human Resources for Health
− Provincial Government	− Provincial Strategic Objective: Increasing wellness
	− Western Cape Infrastructure Delivery Management System (IDMS)
− Western Cape Department of Health	− 2020 strategic framework

Millennium Development Goals

The National Government supports the Millennium Development Goals (MDGs) and those that specifically relate to health are:

- Reduce child mortality.
- Improve maternal health.
- Combat HIV and AIDS, malaria and other diseases such as tuberculosis.

Twelve outcomes of National Government

Of the Twelve National Outcomes identified by the Presidency, the outcome that relates specifically to health is "Improving healthcare and life expectancy among all South Africans". In order to give effect to this outcome the President has entered into a Negotiated Service Delivery Agreement (NSDA) with the National Minister of Health. The focus areas of this agreement are:

- Increasing life expectancy.
- Decreasing maternal and child mortality.
- Combating HIV and AIDS and decreasing the burden of disease from tuberculosis.
- Strengthening health system effectiveness.

National Development Plan: National Planning Commission

In the Diagnostic Overview, published by the National Planning Commission in the Presidency, in June 2011, poverty and inequality were identified as the two main deterrents to achieving a better life for all in South Africa. The specific health related challenges identified were the massive burden of disease that confronts the public health system.

The National Planning Commission subsequently published the National Development Plan (NDP) for 2030 on 11 November 2011 which charts a new path for South Africa and which seeks to eliminate poverty and reduce inequality by 2030. The NDP identifies the following areas of reform in the public health system:

- Improved management, especially at institutional level.
- More and better trained health professionals.
- Greater discretion over clinical and administrative matters at facility level, combined with effective accountability.
- Better patient information systems supporting more decentralised and home-based care models.

Provincial Government

The Provincial Government has developed a Provincial Strategic Plan with eleven provincial strategic objectives in order to effectively pursue the vision of creating an "open opportunity society for all". The provincial strategic objectives are closely aligned with the national outcomes particularly in relation to concurrent functions such as health.

The provincial strategic objectives are:

(1) Creating opportunities for growth and jobs.
(2) Improving education outcomes.
(3) Increasing access to safe and efficient transport.
(4) Increasing wellness.
(5) Increasing safety.
(6) Developing integrated and sustainable human settlements.
(7) Mainstreaming sustainability and optimising resource use efficiency.
(8) Promoting social inclusion and reducing poverty (SO8 and 9 are being combined).
    Increasing social cohesion (SO8).
    Poverty reduction and alleviation (SO9).
(9) Integrating service delivery for maximum impact.
(10) Increasing opportunities for growth and development in rural areas.
(11) Building the best-run provincial government in the world.

Although the Department contributes to the achievement of many of the above provincial strategic objectives, the Department is the lead department for the strategic objective, "Increasing Wellness".

Increasing wellness introduces an important conceptual shift from focusing on the management of disease to the promotion of wellness. This requires a two-pronged approach to firstly focus on the primary prevention of disease before it happens by a whole of society approach. This is managed through the Provincial Transversal Management System described below. Secondly to improve the quality of care and the patient experience which is the core business of the Department of Health.

Provincial Transversal Management System (PTMS)

It is well documented that much of the burden of disease that confronts the Department on a daily basis is caused by upstream factors in society that are outside the mandate of the Department. The PTMS provides a structured opportunity to mobilise role players outside of health to address these upstream factors. These factors have been systematically identified in the burden of disease report undertaken by the Department in partnership with higher education institutions and the Medical Research Council (MRC).

The Provincial Transversal Management System is a priority of the Western Cape Government providing political support for effective inter-sectoral collaboration within the provincial government. This is informed by the philosophy that acting in a united manner around a common set of objectives as a "whole of society" and a "whole of government" will promote delivery.

In line with the quadruple burden of disease and the MDGs, the Department has formed six workgroups:

- Violence and road injuries prevention.
- Healthy lifestyles.
- Women's health.
- Maternal and child health.
- Infectious diseases (HIV and TB).
- Mental health.

Development of a new vision and strategy towards 2020

The Department is in the process of developing the 2020 strategy document that will outline the long-term strategy of the Department of Health in its endeavours to increase wellness.

Principles of 2020

The seven key principles of 2020 are listed below together with brief notes that provide some substance to what the principles are intended to represent.

1) Patient centred quality care will:
    - Provide a superior patient experience.
    - Provide appropriate clinical treatment.
    - Treat patients with dignity, respect, caring and empathy.
    - Patient safety will be a priority.
    - Improve waiting times to an acceptable standard.
    - Ensure that facilities are clean.

2) Health outcomes approach:
   - Health service interventions will focus on improving the health outcomes of the population.
   - This includes increasing life expectancy and reducing maternal and child mortality.
   - The focus areas are:
     - HIV and AIDS and TB.
     - Homicide / violence / road traffic accidents.
     - Chronic diseases of lifestyle.
     - Child health.
     - Women's health.

3) Primary health care (PHC) philosophy:
   - Provide a comprehensive service that includes preventive, promotive, curative and rehabilitative care.
   - Primary health care is usually the first point of patient contact and is supported by all levels of the service, including emergency medical services and planned patient transport.
   - Health and wellness are directly affected by social, economic and political factors.
   - There is inter-sectoral collaboration to address the upstream factors that contribute to the burden of disease.
   - There is community involvement in health:
     - The community is involved in the decision making and oversight process regarding the provision of their health services.
     - This also implies that on a personal level people take ownership and responsibility for their own health care, within their means.

4) Strengthening of the district health system model:
   - The District Management Team (DMT) is responsible for the health outcomes of a defined population within a particular geographic area.
   - The DMT is the custodian and accountable for services delivered and the health outcomes within the area.
   - The DMT ensures access to specialised services and support for the area.
   - The DMT co-ordinates the provision of all health services, both public and private, within the area.
   - Provincialisation of PHC services within the Metro.

5) Equity:
   - This is an important social justice principle.
   - There must be equity in terms of:
     - Access to services.
     - Allocation of resources.
     - Outcomes.
   - Patients receive the service that they require according to their need.

6) Affordable health service:
   - The health service must function within its allocated budget.
   - Health services planning must project required need for services and quantify what services will sustainably be provided within the projected budget.
   - There will be advocacy to address funding gaps between the projected funding allocation and the projected need for services.
   - Alternative sources of funding of health services must be pursued.
   - There must be optimal efficiency at all levels of the service to maximize the value of the health rand.

7) Strategic partnerships:
   - Strong relationships must be forged with strategic partners to facilitate the delivery of quality health services and improved health outcomes.
   - Strategic partners include:
     - Organised labour.
     - Higher education institutions.
     - Non-profit organisations / community based organisations.
     - Other government departments, e.g. Department of Transport and Public Works, Centre for e-Innovation.
     - Other spheres of government.
     - Private sector.

Values

The values of the Department are described in section 1.1 above. The values based approach is an important focus on the path to achieving the vision of 2020.

Vision 2020

The discussion document setting out the draft Vision for 2020 was tabled for public comment in December 2011. A patient centred experience and quality of care are at the centre of the vision. A detailed narrative describing a possible scenario for the service in 2020 from multiple perspectives was developed in which the perspectives of patients, communities, staff, the Department, provincial government and strategic partners are described. Actionable steps within the vision narrative are highlighted to guide the Department in achieving its future vision.

Next steps

A series of dialogue sessions were held with a variety of internal and external stakeholders. The document was generally positively received. Substantial comment was received which is being systematically considered before the next version is developed. A technical team is working through the reshaping of the service platform issues. The strategic document will be finalised and published during the 2012/13 financial year.

2.1.8 Departmental revenue, expenditure and other specific topics

The table below provides a breakdown of the sources of revenue and performance for 2011/12.

Table 2.1.1: Sources of Revenue (R'000)

	2008/09 Actual	2009/10 Actual	2010/11 Actual	2011/12 Target	2011/12 Actual	% deviation from target
Non-tax revenue	**429 196**	**390 534**	**428 871**	**476 844**	**514 725**	**7.94%**
Sale of goods and services	289 680	295 273	313 466	298 036	364 576	22.33%
Transfers received	138 174	93 878	112 976	178 005	148 570	(16.54%)
Fines, penalties	1	2	-	-	-	-
Interest, dividends	1341	1 381	2 429	803	1 579	96.64%
Sales of capital assets (Capital Revenue)	**11**	**7**	**3**	**4**	**15**	**275%**
Sales of capital assets	11	7	3	4	15	275%
Financial transactions (Recovery of loans and advances)	**7 937**	**23 269**	**16 558**	**6 343**	**18 795**	**196.31%**
TOTAL DEPARTMENTAL RECEIPTS	**437 144**	**413 810**	**445 432**	**483 191**	**533 535**	**10.42%**

The Department ended the 2011/12 year with a revenue surplus of R50.344 million (10.42 per cent). The surplus is the net effect of the over- and under-recoveries for the year:

- Sales of Goods and Services:
  The surplus (22.33 per cent) is primarily due to the claims paid by the Road Accident Fund in respect of patient fees and the net surplus recorded at the Cape Medical Depot in terms of the trading account.

- Transfers:
  The under collection (-16.54 per cent) is due to the Global Fund shortfall. The budget for the Global Fund was reduced in February 2012. Unfortunately the Adjustment Budget process was already concluded and therefore too late to reduce the appropriated Global Fund budget.

  As a measure to avoid an under collection, the Department will review the interaction timelines with the Global Fund to ensure timeous finalisation of the budget adjustments and collection of funds.

- Interest:
  The surplus (96.64 per cent) resulted through the levying of interest in respect of patient fee accounts. The surplus is also a result of improved performance in terms of interest collected on staff debt.

- Sales of capital assets:
  The surplus (275 per cent or R11 000) can be attributed to more condemned / obsolete furniture and equipment items sold than anticipated.

- Financial transactions:
  The surplus (196.31 per cent) resulted through the recovery of previous years' expenditure, recovery of staff debt and unallocated receipts.

New measures for increased revenue collection

Patient fees account for the bulk of the surplus revenue. New measures, amongst others, to improve on patient fee collections include the following:

- An A-team has been appointed, comprising of case managers and clerks, to vigorously address backlogs. These backlogs include ICD-10 coding, billing audits of patient folders, capturing of service charges and releasing of invoices, specifically in respect of medical scheme and Road Accident Fund claims.
- SMS messages are sent to debtors prior to the letter of demand stage.
- Performance reports in ICD-10 coding and obtaining debtor cell numbers and identity numbers have been introduced at hospital, district and central management meetings.
- Additional medical schemes have been taken onto the EDI (electronic data interchange) system which electronically submits claims to medical schemes.
- Regular meetings are maintained with the various medical schemes and administrators to transversally address unwarranted payment rejections to any of the hospitals. Training has also been given to the schemes on the patient fee tariffs in this regard.
- Fortnightly meetings are held with the Road Accident Fund.

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 2012.

The report indicates no substantial difference between the budget and the actual expenditure and these small differences had no impact on service delivery.

2.1.10 Transfer payments

Transfer payments were made during 2011/12 to departmental agencies and accounts such as the State Education and Training Authority (SETA) and the Cape Medical Depot (CMD), and local governments and NPOs 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 2011/12, in accordance with section 25 of the National Health Act, 2004 (Act No. 61 of 2003), for the rendering of personal primary health care (PPHC) services in the Cape Metropole. This is the only municipality that receives funding from the Department to render PPHC services. The PPHC services provided by the City of Cape Town includes amongst others: prevention and management of childhood illnesses (including vaccinations) to reduce childhood morbidity and mortality rates, family planning and antenatal care, management of sexually transmitted infections, basic curative medical care, tuberculosis and HIV management, and chronic disease management.

Monitoring mechanisms include monthly expenditure control, on-site visits by provincial staff, routine monthly data reports, annual audited financial statements and annual reports.

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 2011/12 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.

The Department entered into service level agreements with two municipalities during 2011/12 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 per cent 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 2011/12 there were 313 funded palliative care beds and the bed utilisation rate for the year was 80 per cent. 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.

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.

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:

- Interventions 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 intervention sites were reached by the end of the fourth quarter against a target of forty six intervention sites. In these intervention sites 1 844 trained peer educators are currently functioning.
- Sixteen 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 HIV counselling and testing (HCT) services through 646 HIV counsellors in 100 per cent 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 eleven ART sites within Khayelitsha sub-district.
- 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 108 secondary schools across the Province and reached 39 490 learners with HIV prevention messages. This is less than the 63 390 learners of 2009/10 because of a change in the peer education strategy.
- Provide inpatient palliative care and respite services (six NPOs were funded).
- Fund two municipalities (City of Cape Town and Central Karoo) and 198 community based projects in the Metro, Cape Winelands, Overberg, Eden, Central Karoo and West Coast Districts in respect of the CBR 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 92 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 2 853 in 2011/12 and provided home based care (HBC) to 47 949 clients (43 191 clients in 2010/11). Each care worker should do between six and ten visits per day, depending on the category of the client, and are supervised by the NPO appointed professional nurses. The majority of the clients referred to HBC are in the above 60 year age group (36 per cent).

The care workers are also involved in prevention and promotion campaigns, e.g. the measles campaign held in the first quarter of the previous financial year when 1.3 million home visits were done. The momentum was sustained throughout the following quarters and the total number of client visits for HBC, adherence support and door-to-door campaigns in 2011/12 amounted to 5 396 100 compared to 4 630 654 in 2010/11 – a 16.5 per cent increase in visits.

Care workers have also been trained in the Community Integrated Management of Childhood Illnesses (CIMCI) programme and 10 per cent of total client visits done were for children. 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 psychosocial 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 cared for through the various community mental health care services.

In 2011/12 the Department reviewed the funding norm to these services and allocated R10 million to this service. The special day care centres received a 68.4 per cent increase and the 24-hour residential care facilities for children a 74 per cent increase. A plan was developed during 2011/12 to address the court order on the Intellectual Disability Forum versus Government case. This required Government to ensure access to education for children and the implementation has been a collaborative effort between the Departments of Health, Education, Social Development, and Transport and Public Works.

Health councils and committees

Funding has been set aside for health committees 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. The Provincial Health Council and the District Health Councils that have been set up will strengthen community representation and legislation is being prepared to formalise the appointment and functioning of clinic and community health centre committees.

Nutrition

The Department funds eight NPOs for nutrition rehabilitation and breast feeding peer counselling projects. More than 1 500 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 per cent of the children entered show positive growth. Caregivers are referred to participate in income generation projects and appropriate health interventions.

Peer counsellors are placed to support mothers ante-natally, during labour and post-natally with infant and young child nutrition at maternity and basic antenatal care sites. Women benefit from group education sessions, individual counselling and support.

Red Cross Air Mercy Service (RCAMS)

The RCAMS is the current provider of aero-medical services to the Western Cape Emergency Medical Services (EMS). This service is critical in ensuring that all the inhabitants of the Western Cape have equitable access to all levels of acute specialised care regardless of the interests or geographic location.

Through the use of the fixed and rotor-wing programmes, critical patients in remote parts of the Province (and neighbouring provinces) have rapid access to tertiary and specialised services regardless of their financial or insurance status.

In addition, the judicious use of an aeromedical platform for the execution of long distance transfers ensures that ambulance resource availability is at an optimum in smaller, less well-resourced communities. This enables EMS to achieve priority 1 rural response times above the national target.

During the 2011/12 cycle, this service performed 1 520 missions transporting 1 405 patients to secondary and tertiary care facilities. Seventy eight rescue missions resulted in 83 patients being rescued from wilderness areas or the sea. In the process 316 006 kilometres were covered by the fixed-wing and 1 307 hours of flight by the helicopter programme.

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 interns / learners 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). The programme was expanded in 2010/11 to include the Assistant to Artisan (ATA) programme to improve maintenance of health facilities and in 2011/12, to include the pharmacist's assistant programme, the human resources / finance internship programme and the training of operating theatre practitioners.

The EPWP funding is utilised to pay training providers, logistics and provide a monthly stipend to learners on the programmes. In addition to the training of 1 919 home community based carers, 509 internships were created through the above-mentioned programmes.

Table 2.1.2 Summary of non-profit organisations funded per district and sub-structure

Programmes	Eastern / Khayelitsha	Klipfontein / Mitchells Plain	Northern / Tygerberg	Southern / Western	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Western Cape
Community health care	-	-	-	-	-	-	-	-	-	**-**
Tuberculosis	-	-	1	-	5	-	1	-	1	**8**
Chronic care	-	1	1	2	-	-	-	-	-	**4**
Health committees	4	8	12	3	-	-	4	-	8	**39**
Home based care	4	6	3	3	-	4	-	-	-	**20**
Mental health	6	10	6	9	8	1	-	2	2	**44**
AIDS: ART treatment	-	-	-	-	-	-	-	-	-	**-**
AIDS: High transmission areas	-	-	7	-	5	-	1	1	-	**14**
AIDS: HIV counselling and testing	4	14	6	4	4	1	8	3	1	**45**
AIDS: Home based care	-	-	-	-	11	-	12	8	17	**48**
AIDS: Mother-to-child transmission	-	-	-	-	-	-	-	-	-	**-**
AIDS: Regional training centre	-	-	-	-	-	-	-	-	-	**-**
AIDS: Step down care	2	3	3	2	4	2	1	1	1	**19**
Nutrition: Administration	-	-	-	-	-	-	-	-	-	**-**
Nutrition: Community based services	1	2	1	2	-	1	2	-	-	**9**
GF: ART treatment	-	-	-	-	-	-	-	-	-	**-**
GF: Community based response	-	-	-	-	13	1	43	13	13	**83**
GF: Palliative care	-	-	-	-	2	-	2	1	1	**6**
GF: Peer education	2	1	-	1	2	-	2	-	-	**8**
Total	**23**	**45**	**40**	**26**	**54**	**10**	**76**	**29**	**44**	**347**

Note:

- GF: Global Fund

Transfer payments in 2010/11

Refer to Annexure 1B, 1C, 1D, 1G and 1H 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 is used to evaluate all requests for funding and NPOs will not be considered for funding if the policy requirements of the Department are not met.

2.1.11 Trading entity

The Medicine Trading Account is used to fund the operations of the Cape Medical Depot (CMD).

The CMD's core function is the strategic procurement, storage and distribution of medicines and medical consumables to health facilities throughout the Province to ensure access to medicines for optimised service delivery. Procurement takes place in bulk and stock is stored and repackaged in smaller quantities for distribution to health care facilities and sites.

The CMD provides medicines and medical consumables to facilities within the District Health System in both the rural and metropolitan areas, including local authority facilities. There are some 600 facilities (including clinics) that receive medicines and other supplies from the CMD.

Stock received from medicine manufacturers and suppliers are pre-packed into "patient-ready" packs. The pack sizes are determined by the Standard Treatment Guidelines and relevant policy guidelines. This is a time and cost saving mechanism that supports service delivery in that pharmacy staff can dispense medicines in patient-ready packs without the need to count individual tablets to make up each item in the prescription. It also improves stock management within facilities (and thus the Department) and contributes to a reduction in medicine errors at facilities as well as bottlenecks due to workload pressures.

Contracts for the procurement of medicines are negotiated and concluded by the National Department of Health and National Treasury which impacts significantly on price efficiencies based on volume. Procurement contracts have a term of two years and a large number of contracts expired during the last two quarters of the reporting period. An extension of these contracts was only partly effected.

Given the strategic importance of the continued supply of medicines for the Department, performance is monitored through the number of line items in a particular pack size that are out of stock. Alternate pack sizes of these line items are communicated on a weekly basis to facilities to minimise stock unavailability. On average 32 items of the 752 line items carried by the CMD were not available during the reporting period. Alternate pack sizes were consistently available for these items thus medicine access and availability were maintained.

2.1.12 Conditional grants and earmarked funds

Health Infrastructure Grant (HIG)

The Health Infrastructure Grant (HIG) is utilised in line with Healthcare 2010 and the Comprehensive Service Plan, which is currently being reviewed. The Western Cape Department of Health has an estimated infrastructure backlog of approximately R10 billion. Whilst the Hospital Revitalisation Grant is intended to address the hospital backlog through a small number of very large projects, the HIG is being utilised for a large number of smaller projects, including hospitals, primary health care facilities, emergency centres etc. These smaller projects are prioritised in terms of focus areas, where deficient or non-existent infrastructure is hampering the delivery of quality health care. In line with the departmental strategy, primary health care projects are being prioritised.

The infrastructure backlog reported above was calculated in 2010, as follows:

- The condition and suitability of each facility was considered and a HFA (Healthcare Facility Assessment) rating was given.
- The infrastructure requirements as per the Healthcare 2010 Comprehensive Service Plan were applied and an infrastructure gap was determined (beds in the case of hospitals and consulting rooms in the case of PHC facilities).
- Based on cost per bed and cost per consulting room the additional infrastructure cost was determined for each facility.
- Based on the HFA condition a factor was applied to the replacement cost to determine the cost of upgrading required.
- The total cost (R10 billion) is the cost of additional infrastructure plus the cost of upgrading existing facilities based on the Healthcare 2010 Comprehensive Service Plan.

The budget allocation for 2011/12 (including roll-over funding) was R126.8 million.

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

The objectives for 2011/12 were largely met. Of the R126.8 million budget allocation for the year, R123.9 million, or 97.8 per cent was spent. The primary contributing factors to this under-expenditure include:

- Delays in the appointment of professional service providers.
- Delays in the tender processes.
- Delays in site handover.
- Slow construction work.

Whilst there was minor under-expenditure on various projects, the table below reflects the projects where primary under-expenditure occurred.

Table 2.1.3: Infrastructure Grant to Provinces – Projects with major under expenditure

No	Project name	2011/12 Adjustment Budget (R'000)	2011/12 Actual Expenditure (R'000)	Under-expenditure (R'000)	Reason for under-expenditure
1	Caledon Hospital (Phase 2 upgrade)	1 700	760	940	Delays in the design and tender processes.
2	Wesbank Community Health Centre	20 397	16 047	4 350	Contractor ran behind schedule; clarification items were required in terms of design. Practical completion could not take place within the financial year which would release retention funds as planned.
3	Riversdale Hospital (Phase 3 upgrade)	9 309	7 868	1 441	Approval was granted to increase the tender amount by 20% to make provision for additional work to be undertaken. However, all funding was not required to complete the project.

No	Project name	2011/12 Adjustment Budget (R'000)	2011/12 Actual Expenditure (R'000)	Under-expenditure (R'000)	Reason for under-expenditure
4	Vredendal Hospital (New Ambulance Station)	6 903	5 718	1 185	Savings due to re-measurement of Provisional Bill of Quantities. Final account still to be settled.

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

- The roll-out of the Infrastructure Delivery Management System Capacitation Framework which will see the implementation of an appropriately skilled and capacitated Chief Directorate: Infrastructure Management.
- Improving the quality of briefing documents provided to the Western Cape Department of Transport and Public Works (WCDTPW) as implementing department.
- The implementation (through a work streaming process) of the Cabinet-approved Western Cape Infrastructure Delivery Management System (WC-IDMS).
- Closely aligned to the above, the implementation of the Standard for an Infrastructure Delivery Management System (IDMS), Standard for a Construction Procurement System (CPS) and Provincial Treasury Instruction 16B.
- Collaboration with the National Department of Health, Council for Scientific and Industrial Research (CSIR) and the Development Bank of South Africa (DBSA) in the implementation of the Infrastructure Unit Systems Support (IUSS) for the development of norms and standards, capital project status reporting, project management information system, and cost modelling.
- Standardisation based on approved space planning norms and standards, cost norms, standard drawings and technical specifications, and standard designs.
- More formalised and closer interaction with Chief Directorate: Strategy and Health Support in terms of strategic infrastructure planning and project prioritisation which will assist in the development of a strategic planning and prioritisation model to ensure sustainable, efficient and accessible health facilities.
- Closer liaison with Property Management in the Western Cape Department of Transport and Public Works to ensure more efficient property acquisition inclusive of rentals and striving towards improving custodian property information and management.
- Structured interaction with end-users in terms of the Utilisation Improvement Plan, as contained in the User Asset Management Plan (U-AMP) to prioritise projects in a more rigorous manner.
- Re-structuring the manner in which the Department of Health manages, implements, monitors and reports on its immovable asset maintenance programme (three year planning cycle has been introduced).
- Implement the preventative maintenance programme for all new health facilities completed since 2006.

In the management of the Health Infrastructure Grant, the Western Cape fully complied with the Division of Revenue Act (DORA) requirements and submitted all the required reports to Treasury and the National Department of Health as stipulated.

Hospital Revitalisation Programme (HRP) Grant

The Hospital Revitalisation Grant is utilised in line with Healthcare 2010 and the Comprehensive Service Plan, which is currently being revised and updated. For the period under review projects in 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.

In addition, a business case has been prepared for the replacement of the GF Jooste Hospital. The business case has been approved by the National Department of Health and work has recently commenced on the briefing documents for the project.

The budget allocation for 2011/12 (including roll-over funding of R9.3 million) was R490.8 million.

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

The objectives for 2011/12 were largely achieved. Of the R490.8 million budget allocation for the year, R482.4 million, or 98.3 per cent, was spent. The primary contributing factors for the under-expenditure are:

- The delays in the roll-out of digital radiology (PACS/RIS) to George, Worcester, Paarl and Khayelitsha Hospitals and other health technology equipment; and
- The delay in appointing the project team for Tygerberg Hospital.

The table below provides a summary on financial performance and remedial action taken.

Table 2.1.4: Performance measures for the Hospital Revitalisation Programme Conditional Grant

No	Project name	No of beds	Level of care	2011/12 Adjustment Budget (R'000)	2011/12 Actual Expenditure (R'000)	Under / Over Expenditure (R'000)	Comments on performance and remedial action taken
1	George Hospital	265	Level 2	41 189	36 298	4 891	Comment: Spending slower than anticipated due to additional scope included for emergency centre to address shortcomings highlighted by National HRP. Remedial action: Good progress is now being made on the project.
2	Khayelitsha Hospital	230	Level 1	192 363	180 433	11 930	Comment: Achieved practical completion on 7 October 2011, some three months earlier than planned. Remedial action: None required.

No	Project name	No of beds	Level of care	2011/12 Adjustment Budget (R'000)	2011/12 Actual Expenditure (R'000)	Under / Over Expenditure (R'000)	Comments on performance and remedial action taken
3	Mitchell's Plain Hospital	230	Level 1	147 234	143 791	3 443	Comment: Good progress made with practical completion estimated for December 2012. This date may be affected by the fire on site on 9 May 2012, which damaged the emergency centre. Remedial action: Awaiting results of forensic tests to determine the cause of the fire and the impact on the project programme.
4	Lentegeur Laundry (undertaken as part of Mitchell's Plain Hospital project)	N/A	N/A	400	929	(529)	Comment: Good progress made. The fire at the Mitchell's Plain Hospital site could potentially impact on the project programme. Remedial action: None required, until clarity is obtained on the impact of the Mitchell's Plain fire.
5	Paarl Hospital	327	Level 2	35 839	43 659	(7 820)	Comment: Project progressed well, with practical completion (for this phase of the project) achieved on 23 March 2012. Scope had to be increased to align IT installation with Ce-I requirements. Remedial action: None required.
6	Paarl Hospital Psychiatric Unit	22	Level 2	800	0	800	Comment: Professional team appointed later than anticipated, but planning now well underway. Remedial action: None required.
7	TC Newman Community Health Centre	N/A	Primary health care	4 650	5 742	(1 092)	Comment: Practical completion achieved on 14 September 2011, works completion is still outstanding. Remedial action: remedial work to be completed and final account taken.
8	Tygerberg Hospital	Work in progress	Level 2 and 3	2 000	54	1 946	Comment: Delays in appointment of project team. Remedial action: Project officer appointed in January 2012 and appointment of support staff underway.

No	Project name	No of beds	Level of care	2011/12 Adjustment Budget (R'000)	2011/12 Actual Expenditure (R'000)	Under / Over Expenditure (R'000)	Comments on performance and remedial action taken
9	Valkenberg Hospital (Hospital upgrade)	432	Mental health	2 000	4 672	(2 672)	Comment: Combined efforts from Department of Health and Department of Transport and Public Works to achieve Stage 2 design and comprehensive documentation for peer review with the National Department of Health. This resulted in more funds being spent on professional fees than planned. Remedial action: Align revised budgets with revised estimated planning cash flows.
10	Valkenberg Hospital (Emergency repairs to historic administration building)	N/A	Mental health	215	212	3	Comment: Final account has been paid. Remedial action: None required.
11	Vredenburg Hospital (Phase 2A)	80	Level 1	8 671	8 019	652	Comment: Achieved practical completion on 12 November 2011. Remedial action: Final completion list issued to contractor to remedy outstanding issues.
12	Vredenburg Hospital (Phase 2B)	80	Level 1	7 600	8 150	(550)	Comment: Site handover occurred on 22 February 2012 and work is progressing well. Remedial action: None required.
13	Worcester Hospital (Phase 3)	315	Level 2	700	107	593	Comment: Delays experienced in finalisation of the final account due to the vast number of variation orders as a result of the project going to tender with only a provisional bill of quantities in place and also due to insufficient planning. Remedial action: Final account has been paid – no remedial action required.
14	Worcester Hospital (Phase 4)	315	Level 2	19 691	22 350	(2 659)	Comment: Agreement with previous contractor terminated due to inferior quality and lack of progress. Over-expenditure due to rework required to correct work done by previous contractor. Remedial action: New contractor appointed to do remedial work and complete this phase of the project. Public Works to assess the possible fruitless expenditure and take action against service providers.

No	Project name	No of beds	Level of care	2011/12 Adjustment Budget (R'000)	2011/12 Actual Expenditure (R'000)	Under / Over Expenditure (R'000)	Comments on performance and remedial action taken
15	Worcester Hospital (Phase 5)	315	Level 2	100	0	100	Comment: Project remained at inception. Remedial action: Implementing agent has again been requested to provide the estimated costing for this project as this is now long overdue.

In the management of the Hospital Revitalisation Grant, the Western Cape fully complied with the Division of Revenue Act (DORA) requirements and submitted all the required reports to Treasury and the National Department of Health as stipulated.

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 service costs associated with spill over effects of providing tertiary services as the Western Cape provides services to patients beyond provincial boundaries.

Although the NTSG is only allocated to the three central hospitals, as outlined below, the Western Cape also delivers tertiary services at selected regional hospitals such as George Hospital that delivers a significant component of tertiary services not funded by the NTSG. 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 acknowledged.

The NTSG allocation per institution for 2011/12 was as follows:

Institution	NTSG allocation for 2011/12 (R'000)
- Groote Schuur Hospital	846 708
- Tygerberg Hospital	877 078
- Red Cross War Memorial Children's Hospital	249 341
Total	**1 973 127**

The NTSG remained insufficient to fund all the tertiary activities, as defined in the grant service level agreement. The grant funding has not been adjusted to fully compensate for the implementation of occupational specific dispensations or for the actual impact of medical inflation. The highly specialised nature of these services and the premium costs incurred for consumable and equipment exceeds the general inflation rate (recorded as 6.4 per cent[1] for medical services as in StatsSA). This reduces the purchasing power and subsequently the quantum of tertiary services that can be provided. Motivations highlighting the funding challenges have been submitted to the National Department of Health. The funding deficit is bridged through using other sources of funding, pending a more appropriate allocation.

[1] 2012, March, Statistics South Africa publication P0141 – Consumer Price Index (CPI), publication date and time 18 April 2012 at 10:00.

In addition to the funding challenges, there is a lack of a clear national plan for the provision of tertiary services, as well as an associated human resource plan.

The NTSG expenditure per economic classification for 2011/12 was as follows:

Economic classification	**Provincial NTSG expenditure for 2011/12 (R '000)**
- Compensation of employees	1 338 167
- Goods and services	596 540
- Payment of capital assets (machinery and equipment)	38 421
Total	**1 973 127**[2]

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

Table 3 below lists the provincially accredited tertiary service outputs for 2011/12 in the Western Cape. As a result of the funding gap not all these outputs are funded by the NTSG.

Table 2.1.5: Performance measures for the National Tertiary Services Conditional Grant

Performance measure / indicator	Actual 2009/10	Actual 2010/11	Actual 2011/12
Day patient separations - total	12 213	12 697	12 479
Inpatient days - total	578 583	582 793	583 177
Outpatient first attendances	200 930	207 226	215 542
Outpatients all attendances	747 359	750 297	767 177

Performance outputs for the 2011/12 year remained consistent with previous years, but were higher for inpatient days as well as first and total outpatient department (OPD) attendances. This increase in the service outputs occurred despite a reduction in the real purchasing power of the NTSG.

The Western Cape fully complied with the Division of Revenue Act (DORA) requirements and submitted all the required clinical and financial quarterly reports to Treasury and the National Department of Health as per schedule and no funds were withheld.

Health Professions Training and Development Grant (HPTDG)

The Health Professional Training and Developmental Grant (HPTDG) contribute to funding the service costs related to training and having health science students on the service platform to achieve the national aim of expanding the number of health professionals. The Western Cape service platform accommodates students from four institutes of higher education, namely the University of Stellenbosch, the University of Cape Town, the Cape Peninsula University of Technology and the University of the Western Cape.

2 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 HPTDG to the Western Cape increased from R384.7 million in 2010/11 to R407.8 million (6 per cent) in 2011/12. In keeping with the findings of a student rotation survey, 63 per cent of the total HPTDG was allocated to Programme 5, underpinned by the principle that funding follows students. 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.

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 occupation 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. The accumulative funding shortfall over six years is R72.1 million. 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**	**2011/12 R '000**
HPTDG actual allocated amounts	323 000	339 000	356 414	362 935	384 711	407 794
Actual growth in grant funding	0.0%	5.0%	5.1%	1.8%	6.0%	6.0%
Inflation	4.6%	7.2%	11.5%	7.1%	4.3%	6.4%[3]
HPTDG amount required to match inflation	337 858	362 184	403 835	432 507	451 105	473 660
Inflationary deficit	(14 858)	(23 184)	(47 421)	(69 572)	(66 394)	(72 181)

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 per cent of all medical officers and 45 per cent of all dentists in the country but receives just over 20 per cent of the funding. During 2011/12 a National Conditional Grant Task Team has been established to review the Health Professional Training and Development Grant. The final recommendations and outcome of the task team will be available in 2012/13. It is anticipated that following this process a national platform with provincial representations will be established where strategic matters can be discussed on an on-going basis. This will improve integration of the two interdependent grant activities and reduce the duplication of administrative functions.

[3] 2012, March, Statistics South Africa publication P0141 – Consumer Price Index (CPI), publication date and time: 18 April 2012 at 10:00.

The full HPTDG grant amount (R407.8 million) was spent in 2011/12. The HPTDG funding remained insufficient to provide for all the grant related activities. A recent report from the Technical Committee for Finance[4] demonstrated that the Western Cape carries the largest HPTDG underfunding burden. These findings are echoed by previous costing studies. As reflected in the 2011/12 HPTDG business plan, the grant funding gap of R118.3 million was supplemented with other sources of funding to perform the grant related activities. Unfortunately the Department is not allowed to reflect an over expenditure.

Table 2.1.6 demonstrates the number of under- and post graduate students from the various higher education institutions (HEIs) that were accommodated on the health 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 2.1.6: Performance measures for the Health Professionals Training and Development Grant

Performance measure / indicator	Target 2011/12	Actual 2011/12
Number of enrolled undergraduate students receiving training	2 863	3 133
Number of medical interns receiving teaching	333	324
Number of medical officers receiving teaching and providing training	698	676
Number of registrars receiving teaching and providing training	681	714
Number of medical specialists providing training	804	836

Notes:

- A new enrolment of undergraduate students started on 1 January 2011. The target was based on the 2011 academic year enrolments. Due to the misalignment of the financial year and academic enrolment year there will be a degree of misalignment between the target and the actual enrolments.
- Number of medical interns, officers and registrars and specialists are for as the end of March 2012.

The Western Cape fully complied with the Division of Revenue Act (DORA) requirements and submitted all the required reports to Treasury and the National Department of Health as stipulated.

Comprehensive HIV and AIDS Grant

Since 2004/05 a more comprehensive approach has been followed with the focus of the HIV and AIDS Conditional Grant 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)

[4] 2010, November, Technical Committee for Finance, Financing clinical health science education and training, page 2.

- Regional training centre (RTC)
- Step-down care (SDC)

Further to this, voluntary counselling and testing (VCT) evolved into HIV counselling and testing (HCT) when a provider initiated counselling and testing (PICT) strategy commenced using the "advise, consent, test and support" (ACTS) model in 2009. Medical male circumcision (MMC) commenced in 2011/12 with the endorsement of the policy framework, training of staff and purchasing of equipment.

In terms of financial compliance, the Western Cape received a conditional grant allocation for 2011/12 of R660 614 000 and the actual expenditure was R660 578 000 (99.99 per cent), which reflects an under-expenditure of R36 000 (0.01 per cent) of the total budget. Monthly in-year monitoring (IYM) reports are used to confirm that all transfers were deposited into the accredited bank account.

The programme targets set for the year were defined in the Comprehensive HIV and AIDS Integrated Business Plan 2011/12. During the year the following achievements and challenges were experienced:

- All programmes were implemented, co-ordinated and maximised as per the business plan.
- Delays were experienced in the filling of posts, predominantly due to the limited number of qualified staff applying for advertised posts.
- The implementation of the programme was monitored and evaluated and reports were submitted quarterly to National Treasury via the National Department of Health.
- ART services were implemented in 45 new sites, increasing the total number of sites to 177.
- Consumables, supplies and services were provided and available at all times. Anti-retroviral drugs, to the value of R38 million, were received as a donation from the National Department of Health. This resulted in the business plan and budget being adjusted.

Table 2.1.7: Performance measures for HIV and AIDS Conditional Grant

Intervention	Performance measure / indicator	Target 2011/12	Actual 2011/12
ART	Number of facilities accredited as ART service points	163	177
	Number of registered ART patients	116 345	115 087
PMTCT	Number of antenatal clients tested for HIV	98 000	83 068
	Nevirapine dose to baby rate	95%	98.8%
	Transmission rate	3%	1.9%
RTC	Number of monthly expenditure reports submitted in time	12	12
	Number of quarterly output reports submitted in time	4	4
HCT	Number of lay counsellors receiving stipend	646	646
	HCT testing rate	95%	99.2%
MMC	Number of males > 15 years circumcised	-	1 911
SDC	Number of step down care facilities funded	16	17

By the end of 2011/12 there were 177 fully functional ART service points in the Western Cape Province, of which 45 were new sites against a target of 31. At these 177 sites, 115 087 patients were retained in care on ARV treatment. This is approximately 1 per cent below the set target.

To address human resource challenges, the Department started implementing a "nurse-led, doctor supported" treatment model during the previous financial year which was expanded in 2011/12. Nurse mentors were trained (40) to provide on-site clinical mentorship to the nurse initiators of HIV and ARV management. The adult and paediatric policy groups became fully functional during 2011/12 and provided clinical advice and support with regard to policy decisions.

The Western Cape Department of Health has successfully implemented all the programmes under this grant, but was challenged with the implementation of MMC, since this programme as an HIV prevention intervention was new to the Province. Considerable time and efforts were invested in putting systems in place for MMC and the outputs can mainly be attributed to the MMCs conducted while training staff.

In order to provide a care facility for tuberculosis drug resistant treatment failures, the seven bed Nelspoort step-down care facility in Central Karoo was commissioned and two patients have been admitted thus far. The Department has made significant progress in the renovation of facilities to accommodate the programmes.

The Western Cape fully complied with the Division of Revenue Act (DORA) requirements and submitted all the required reports to Treasury and the National Department of Health as stipulated.

Forensic Pathology Services (FPS) Grant

Since the FPS was developed as a "new service" when transferred from the South Africa Police Service it was decided that it would be financed initially through provincial conditional grants for a period of five years, during which the funding mechanism would be re-assessed. The grants comprised 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 in spite of the provincial request that the conditional grant should be maintained.

The national vision for the Forensic Pathology Service is 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.

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

Below, find the outcomes and outputs from the business plan for 2011/12 that were evaluated. The indicators that overlap with the performance measures in the 2011/12 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.

Table 2.1.8: Performance measures for the Forensic Pathology Services Conditional Grant

Outcome	Performance measure / indicator	Target 2011/12	Actual 2011/12	Comment / Corrective action
Integrated quality assurance into all levels of care.	Audit tool developed and implemented to measure the quality of post-mortem reports.	Audit tool implemented.	Audit tool was implemented.	Achieved.

Outcome	Performance measure / indicator	Target 2011/12	Actual 2011/12	Comment / Corrective action
A capacitated workforce to deliver a Forensic Pathology Service.	Achieve 97.5% of approved posts filled.	97.5% (253/259)	96.53% (250/259)	Approved post list revised to 259 due to affordability. Scarce skills make it difficult to fill vacant posts. Request for adjustments to the conditional grant allocation was not met.
Create a work environment and corporate culture nurturing a satisfied workforce.	Annual staff satisfaction survey conducted.	Conduct a staff satisfaction survey.	Survey conducted.	Departmental survey concluded.
Vehicles active on the road.	Number of response vehicles.	44	48	Target exceeded.
Construction of FPS facilities according to plan.	Construct Beaufort West, Plan Riversdale.	Beaufort West under construction, Riversdale in planning phase.	Beaufort West under construction, Riversdale in planning.	Target achieved.
Implement the Forensic Pathology Service.	% of conditional grant allocation spent	100%	99.96% (Allocation: R72.226 Spent: R72.199)	Target achieved.
Roll out the electronic content management (ECM) system to all 20 FPS facilities.	Implement ECM in all 20 facilities.	20	20	Access via the internet was arranged by the service provider.

Expanded Public Works Programme (EPWP) Incentive Grant

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

The co-ordination of these skills development opportunities is crucial to:

- maximise outcomes within primary health care and related programmes;
- ensure skills synergy with the human resource (HR) plan; and
- enhance service delivery.

Ultimately the objective is to translate the EPWP opportunities into real jobs in the provincial Department of Health and at its non-profit organisation (NPO) partners.

Western Cape Government Health was allocated an amount of R8 648 656 of the overall Social Sector EPWP Incentive Grant to:

- Increase job creation by focusing on the strengthening and expansion of social service delivery among home community based care programmes that have employment potential.
- Strengthen management capacity at NPO level to ensure efficient implementation of grant outputs.

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

This incentive grant was based on acknowledgement of the EPWP 2010/11 Health performance in creating job opportunities.

A meeting was held in August 2011 between the National Departments of Public Works, Social Development, Health and the Western Cape Department of Health to address and resolve the non-compliance issue to the Division of Revenue Act (DORA) on the payment of stipends to the community care workers.

Table 2.1.9: Performance measures for the Expanded Public Works Programme Incentive Grant

Total allocation	Portion for stipends	Portion for management capacity	Expected Incentive Grant (IG) full-time equivalents (FTEs)	IG % contribution to baseline
R8 648 656	R6 974 520 (80.5%)	R1 726 080 (19.5%)	502	15.3%

Of the earmarked portions, 80 per cent were utilised for stipends. This was used for the employment of an additional 438 community care workers (CCWs) in the eight metro sub-districts and the three rural districts with the lowest community care worker population coverage. Although the objectives were achieved, an under-expenditure of R1.6 million was recorded. Reasons for the under-expenditure are:

- Higher attrition than normal within the NPOs: 147 CCWs out of 3 000 funded CCWs (5 per cent) left the NPOs for other jobs.
- Delays in appointments of replacements CCWs and therefore delays in expenditure.
- Delays in claims for the last quarter: Many claims from districts were received late and were not processed before financial year end. Administrative processes are under review to ensure claims from districts are timeously filed and processed.

Of the earmarked portions, 20 per cent were allocated for management capacity. This will be used for the training of current CCWs in community rehabilitation as an identified need in the home-based care (HBC) programme. Delays in procurement of a training provider and awarding of the tender led to a request that the under-expenditure of R1.7 million be rolled-over into the 2012/13 financial year.

There is a request to roll-over an additional R1.6 million that was underspent in terms of payments to NPOs into the 2012/13 financial year to expand and sustain the funding of the additional 438 CCWs (expansion from 2 562 to 3 000 CCWs) required for home based care.

2.1.13 Capital investment, maintenance and asset management plan

Capital investment

The table below lists the building projects that are currently in progress (including planning) and the expected date of completion (practical completion).

Table 2.1.10: Performance measures for the Capital Infrastructure Programme

No	Project name	Region/ District	Municipality	Project description/ type of infrastructure	Project duration	
					Date: Start Note 1	Date: Finish Note 2
1. NEW AND REPLACEMENT ASSETS						
Equitable Share						
1	Heidelberg Ambulance Station	Eden	Hessequa	New ambulance station	Apr-11	Mar-15
2	Piketberg Ambulance Station	West Coast	Bergrivier	New ambulance station	Apr-10	Mar-15
3	Robertson Ambulance Station	Cape Winelands	Breede River/ Winelands	New ambulance station	Jul-11	Mar-14
4	Tulbagh Ambulance Station	Cape Winelands	Witzenberg	New ambulance station	Apr-10	Mar-13
Health Infrastructure Grant						
1	Beaufort West Forensic Pathology Laboratory	Central Karoo	Beaufort West	New forensic pathology laboratory	Apr-09	Jun-12
2	Ceres Ambulance Station	Cape Winelands	Witzenberg	New ambulance station	Apr-10	Feb-11
3	Du Noon CHC	City of Cape Town	Cape Town	New CHC	Apr-10	Jun-14
4	Grassy Park Clinic	City of Cape Town	Cape Town	New clinic	Apr-08	Sep-11
5	Kwanokuthula CDC	Eden	Bitou	New CDC	Apr-08	Apr-11
6	Kwanokuthula Ambulance Station	Eden	Bitou	New ambulance station	Apr-08	Apr-11
7	Leeu Gamka Ambulance Station	Central Karoo	Prince Albert	New ambulance station	Apr-08	Nov-11
8	Malmesbury – Wesbank CDC	West Coast	Swartland	New CDC	Nov-08	Mar-12
9	Melkhoutfontein Clinic	Eden	Hessequa	Clinic replacement	Sep-10	Dec-11
10	Oudtshoorn Clinic	Eden	Oudtshoorn	Clinic (property acquisition)	Apr-11	Mar-12
11	Paarl Forensic Pathology Laboratory	Cape Winelands	Paarl	New forensic pathology laboratory	Mar-09	Jan-11
12	Prince Alfred Hamlet Clinic	Cape Winelands	Witzenberg	New clinic	Feb-12	Apr-16
13	Rawsonville Clinic	Cape Winelands	Breede Valley	New clinic	Apr-11	Jun-14
14	Riversdale Forensic Pathology Laboratory	Eden	Hessequa	New forensic pathology laboratory	Mar-11	Dec-16
15	Strand Nomzamo: Asanda Clinic	City of Cape Town	Cape Town	New clinic	Apr-10	Apr-14
16	Vredendal Ambulance Station	West Coast	Matzikama	New ambulance station	Apr-10	Dec-11
17	Wolseley Clinic	Cape Winelands	Breede Valley	New clinic	Nov-11	Mar-16

No	Project name	Region/ District	Municipality	Project description/ type of infrastructure	Project duration	
					Date: Start Note 1	Date: Finish Note 2
PES: Infrastructure funding						
1	Delft Symphony Way CDC	City of Cape Town	Cape Town	New community day centre	Apr-10	Mar-15
2	District Six CDC	City of Cape Town	Cape Town	New community day centre	Apr-10	Mar-15
3	Hermanus CDC	Overberg	Overstrand	New community day centre	Apr-10	Mar-15
4	Khayelitsha Sub-district	City of Cape Town	Cape Town	New temporary accommodation	Dec-11	May-12
5	Knysna – Witlokasie CDC	Eden	Knysna	New community day centre	Apr-09	Mar-13
6	Napier Clinic	Overberg	Cape Agulhas	New clinic	Apr-12	Mar-15
7	Ruiterwacht CDC	City of Cape Town	Cape Town	New community day centre	Jul-11	Oct-12
Hospital Revitalisation Grant						
1	GF Jooste Hospital	City of Cape Town	Cape Town	New hospital	Apr-12	Mar-17
2	Khayelitsha Hospital	City of Cape Town	Cape Town	New hospital and ambulance station	Apr-05	Oct-11
3	Mitchell's Plain Hospital	City of Cape Town	Cape Town	New hospital	Apr-05	Dec-12
2. UPGRADES AND ADDITIONS						
Equitable Share						
1	Brooklyn Chest TB Hospital	City of Cape Town	Cape Town	New MDR and XDR wards	Apr-09	Mar-13
2	George Harry Comay TB Hospital	Eden	George	Ward 1 and 2 upgrading	Nov-10	Dec-11
3	George Harry Comay TB Hospital	Eden	George	Phase 2 upgrade	Apr-11	Dec-12
4	Malmesbury- Swartland Hospital	West Coast	Swartland	New ambulance station and extension to emergency centre	Apr-10	Mar-13
5	Paarl Sonstraal TB Hospital	Cape Winelands	Drakenstein	UV lights and extraction	Apr-10	Mar-12
6	Riversdale Hospital Phase 2	Eden	Hessequa	Phase 2 upgrade	Feb-08	Jun-11
7	Stikland Hospital	City of Cape Town	Cape Town	Wards 1, 6, 7 and 11 upgrade	Apr-09	Sep-11
8	Tygerberg Hospital	City of Cape Town	Cape Town	PET scan infrastructure installation	Apr-11	Mar-12
Health Infrastructure Grant						
1	Caledon Hospital	Overberg	Theewaterskloof	Upgrade – phase 2	Apr-09	Oct-13
2	Ceres Hospital	Cape Winelands	Witzenberg	Emergence centre	Apr-10	June-12
3	Groote Schuur Hospital	City of Cape Town	Cape Town	Ward E16 alternative TB patient areas	Apr-08	Mar-11
4	Groote Schuur Forensic Pathology Laboratory	City of Cape Town	Cape Town	New forensic pathology laboratory	Nov-11	Mar-17
5	Groote Schuur Hospital	City of Cape Town	Cape Town	Upgrade emergency centre	Apr-12	Mar-14

No	Project name	Region/ District	Municipality	Project description/ type of infrastructure	Project duration	
					Date: Start Note 1	Date: Finish Note 2
6	Groote Schuur Hospital	City of Cape Town	Cape Town	New main building fire detection phase 2	Apr-09	Jun-12
7	Groote Schuur Hospital	City of Cape Town	Cape Town	Relocation of engineering workshop	Apr-07	Jan-11
8	Groote Schuur Hospital	City of Cape Town	Cape Town	Security upgrade phase 1	Apr-08	Mar-10
9	Groote Schuur Hospital	City of Cape Town	Cape Town	Upgrade pharmacy bulk store	Jul-10	Sep-11
10	Hermanus Hospital	Overberg	Overstrand	Emergency centre, new wards and OPD	Apr-09	Sep-12
11	Karl Bremer Hospital	City of Cape Town	Cape Town	Emergence centre and main store	Apr-09	Mar-14
12	Knysna Hospital	Eden	Knysna	New emergency centre	Apr-09	Mar-14
13	Lentegeur Hospital	City of Cape Town	Cape Town	Relocation of Lifecare	Jan-11	Jan-12
14	Mitchell's Plain Sub-district	City of Cape Town	Cape Town	Sub-district office	Jun-10	Sep-11
15	Mitchell's Plain CHC	City of Cape Town	Cape Town	New emergency centre and pharmacy	Apr-07	May-10
16	Riversdale Hospital	Eden	Hessequa	Phase 3 upgrade	Oct-10	Dec-11
17	Robertson Hospital	Cape Winelands	Breede River/ Winelands	New bulk store	Apr-11	Mar-13
18	Somerset Hospital	City of Cape Town	Cape Town	Lift upgrade	Apr-09	Nov-11
19	Tygerberg Hospital Lift upgrade	City of Cape Town	Cape Town	Lift upgrade	Apr-09	Nov-11
PES: Infrastructure funding						
1	Groote Schuur Hospital	City of Cape Town	Cape Town	New main building fire detection phase 2	Apr-09	Jun-12
2	Groote Schuur Hospital	City of Cape Town	Cape Town	Upgrade pharmacy bulk store	Jul-10	Sep-11
3	Knysna Clinic	Eden	Knysna	Purchase clinic	Jul-11	Mar-12
4	Lamberts Bay Ambulance Station	West Coast	Lamberts Bay	Upgrade and addition to ambulance station	Jul-10	Sep-11
5	Stikland Hospital	City of Cape Town	Cape Town	Wards 1, 6, 7 and 11 upgrade	Apr-09	Sep-11
6	Tygerberg Hospital	City of Cape Town	Cape Town	Emergency centre upgrade	Apr-09	May-13
7	Tygerberg Hospital	City of Cape Town	Cape Town	PET scan infrastructure installation	Apr-11	Mar-12
3. REHABILITATION, RENOVATIONS AND REFURBISHMENTS						
Hospital Revitalisation Grant						
1	George Hospital	Eden	George	Hospital upgrade phase 3	Apr-08	Jul-12
2	Mitchell's Plain Hospital	City of Cape Town	Cape Town	Regional laundry upgrade	Apr-11	Mar-13
3	Paarl Hospital	Cape Winelands	Drakenstein	Hospital upgrade	Apr-00	Mar-12
4	Paarl Hospital	Cape Winelands	Drakenstein	New psychiatric unit	Apr-11	Mar-14

No	Project name	Region/ District	Municipality	Project description/ type of infrastructure	Project duration	
					Date: Start Note 1	Date: Finish Note 2
5	Paarl TC Newman CHC	Cape Winelands	Drakenstein	CHC upgrade (co-funded Global Fund)	Apr-06	Nov-11
6	Valkenberg Hospital	City of Cape Town	Cape Town	Hospital upgrading	Apr-09	Jul-17
7	Vredenburg Hospital	West Coast	Saldanha Bay	Upgrading phase 2A	Apr-06	Nov-11
8	Vredenburg Hospital	West Coast	Saldanha Bay	Upgrading phase 2B	Apr-07	Mar-15
9	Worcester Hospital	Cape Winelands	Breede Valley	Hospital upgrade phase 4	Apr-08	Jul-12
10	Worcester Hospital	Cape Winelands	Breede Valley	Hospital upgrade phase 5	Apr-12	Apr-14
INFRASTRUCTURE TRANSFERS CURRENT						
Donation to Red Cross War Memorial Children's Hospital Trust						
1	Red Cross Children Hospital	City of Cape Town	Cape Town	Various upgrade projects in partnership with Children Trust	Apr-09	Mar-16
OTHER CAPITAL PROJECTS						
Global Fund and Donation Funded Projects						
1	Delft CHC and other planning	City of Cape Town	Cape Town	New ARV counselling unit and upgrade	Apr-10	Dec-13
2	Grabouw CDC	Overberg	Grabouw	Extensions and alterations	Apr-09	Jun-12
3	Phillipi:Inzame Zabantu CDC	City of Cape Town	Cape Town	Infectious disease unit (IDU) and pharmacy upgrade	Apr-10	Dec-13

Notes:

Note 1 Start of project planning.

Note 2 Date practical completion is achieved.

Facilities that were closed down or downgraded during 2011/12

No facility was closed down or down-graded during 2011/12.

The table below reflects facilities that have been identified for disposal in the short to medium term:

Table 2.1.11: 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. Lifecare will vacate site in 2012.	2012
Woodstock Hospital	Not in correct position and condition poor. Sub-district office to move to Khayelitsha temporary office accommodation. Plans in hand to find alternative accommodation for CHC.	2013

Asset description	Disposal rationale	Disposal year
Salt River – Forensic Pathology Laboratory	Facility to be replaced by purpose-built new facility, which will be conducive to research.	2017
Stikland Hospital – portion of estate	Estate too big to maintain in proper condition.	Not applicable
Kwanokuthula Community Health Centre	New facility has been built. Old facility to be relinquished.	2012
Oudtshoorn Regent Street Clinic	New facility purchased.	2012

Asset Management

The value of assets in the Department amounted to R1 940 089 000, after adjustments, as on 1 April 2011. Additional assets to the value of R356 635 000 were either bought, received as donations or transferred into the Department during the period under review. Assets to the value of R129 926 000 were disposed of during the same period. The disposed assets include assets to the amount R386 637 that was lost due to possible theft. The value of the Department's assets as on 31 March 2012 amounted to R2 168 488 000.

All institutions have asset registers for both minor and major assets which are maintained on a daily basis. The Department's assets are housed on the SYSPRO asset management system (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.

During the year under review the Department also submitted documents and explanations to the Auditor-General that clarified all the discrepancies between the values of the opening balances as per the financial statements and the actual values on the asset registers as on 31 March 2011 meaning that the Auditor-General accepted the opening balances for 2011/12 and could concentrate the audit for 2011/12 on the movements during 2011/12 only.

Rigorous and continuous evaluation of the physical existence of assets over the last three years at the central hospitals, which house almost 50 per cent of the Department's assets, culminated in the Department being in a position to clear the records of numerous assets that were double counted as a result of the moving platform and vast premises presented by the central hospitals.

During this period the Department also completed a drive to clear its asset registers of all assets on the registers at nominal values and to value these assets at either actual or reasonable values through an acceptable accounting process of valuation.

The committees responsible for driving the annual acquisition plans for vehicles, computer, medical and other assets per institution, succeeded in completing their plans for 2011/12 before the end of the 2010/11 financial year enabling the procurement division to utilise and exploit the advantages of economies of scales by arranging contracts and standardising on certain equipment. Unfortunately the national contract for vehicles only became available during June 2011 which posed a challenge as some specific models of vehicles had to be changed because of unavailability on the new contract.

Disposal of assets are done via disposal committees in accordance with departmental policies. The condition of the Department's assets fall either within the category of fair or good as items that are classified bad are being disposed of.

Various standard operating procedures are in the process of being finalised and the first covering asset counts, has been issued during this period. The rest are planned to be finalised and issued during the new financial year.

Due to rigorous maintenance, replacement and disposal when necessary, all the Department's assets can currently be described as either in a fair or good condition even though some of the assets might be pass its normal useful life.

Major Maintenance Projects undertaken during 2011/12

The primary scheduled maintenance projects that have been completed during 2011/12 are listed in the table below.

No	SP	District	Facility Name	Brief description of work	Actual expenditure (R)
1	8.4	City of Cape Town	Athlone: WCCN	Boiler area and workshops – security spike fencing / gates, replacement of precast concrete fence including razor wire at western side.	894 761
2	8.4	City of Cape Town	Athlone: WCCN	Extraction fans in shower / bathrooms plus core drilling.	537 796
3	8.4	City of Cape Town	Athlone: WCCN	General repairs and renovations to various blocks.	1 300 325
4	8.4	City of Cape Town	Athlone: WCCN	Installation of new high mast lighting.	1 358 857
5	8.4	City of Cape Town	Athlone: WCCN	Repairs and renovations, replacement of roofs G, D, E, F and A.	1 959 102
6	8.4	City of Cape Town	Athlone: WCCN	Replacement of sewerage line.	1 022 775
7	8.1	Central Karoo	Beaufort West: Beaufort West CDC	Replace existing fence with palisade and pave parking area.	719 600
8	8.3	Central Karoo	Beaufort West: Beaufort West Hospital	Repairs and renovations: replace roof, ceilings and floor sheeting in west block.	524 356
9	8.3	City of Cape Town	Bellville: Karl Bremer Hospital	Supply and deliver calorifiers and steam coils.	286 048
10	8.3	City of Cape Town	Bellville: Karl Bremer Hospital	Supply and deliver medical air equipment.	769 753
11	8.3	City of Cape Town	Bellville: Karl Bremer Hospital	Supply and deliver standby generators.	2 100 108
12	8.2	Overberg	Bredasdorp: Bredasdorp EMS	Painting internal and external and general repairs and renovations.	546 871
13	8.4	City of Cape Town	Brooklyn: Brooklyn Chest Hospital	Perimeter fencing.	697 851
14	8.4	City of Cape Town	Brooklyn: Brooklyn Chest Hospital	Paint inside wards A, B, C, D, E; paint buildings externally, repair/replace roof and ceiling.	1 106 025
15	8.4	City of Cape Town	Brooklyn: Brooklyn Chest Hospital	Wards A, B & D: Installation of UVGI lights and extraction; electrical, ventilation repairs and renovations.	1 082 031

No	SP	District	Facility Name	Brief description of work	Actual expenditure (R)
16	8.1	Overberg	Caledon: Caledon Clinic	Repairs and renovations to patient areas including electrical and mechanical: Masonry, internal & external painting, carpentry & joinery e.g. shelving/drywall partitioning, cupboards, vinyl flooring, plumbing and tiling.	699 100
17	8.1 to 8.6	City of Cape Town	Cape Town: Metropole Region	Annual servicing of fire fighting equipment.	1 635 482
18	8.3	West Coast	Clanwilliam Hospital	Replace existing security perimeter fencing with new.	613 903
19	8.3	West Coast	Clanwilliam Hospital	Construct under cover parking for 4 vehicles, repairs and renovation of nurses home.	793 108
20	8.1	West Coast	Darling Clinic	New air conditioner; change garage to consulting room; paint building outside; create record room and reception; split consulting room and treatment room.	1 685 093
21	8.1	City of Cape Town	Delft CHC	General repairs and painting, supply workstations with cupboards to 4 consulting and 1 procedure room and shelving to record room, boardroom within staff area.	554 992
22	8.1	City of Cape Town	Delft CHC	Outside of building: improve security lights: electrical repairs and renovations.	673 461
23	8.1	City of Cape Town	Delft CHC	Paint and repair; restoration of MOU.	618 519
24	8.3	City of Cape Town	Eerste River: Eerste River Hospital	Relocation of pre-fabricated building from Eerste River Hospital to Kalsbaskraal to be utilised as a clinic and other portion of the pre-fabricated building to Robertson.	1 335 772
25	8.1	West Coast	Doringbaai and Elandsbaai Clinics	Internal repairs to both clinics including electrical upgrade.	514 853
26	8.2	Overberg	Grabouw EMS	Expand existing wash bay and sluice, remove walls between kitchen and station manager's office, enclose parking bay, relay all parking bay floors.	612 578
27	8.1	City of Cape Town	Gugulethu CHC	This project includes work performed at Nyanga CHC. Renovations of reception; paint inside and out.	2 119 378
28	8.1	City of Cape Town	Khayelitsha CHC: Site B	Internal and external general repairs and painting.	2 424 791
29	8.3 8.1	Eden	Knysna Hospital and Witlokasie CDC	Supply and deliver one 250KVA and one 400KVA standby generators.	1 390 458
30	8.3	Eden	Knysna Hospital	Supply and install extractor fans.	611 852
31	8.3	Eden	Knysna Hospital	Upgrade water supply and medical gas.	735 183
32	8.3	City of Cape Town	Maitland: Alexandra Hospital	General roofs and fire detection upgrading and new OPD centre. Convert nurse administration wing to six consulting rooms and roof repairs.	5 882 671
33	8.3	City of Cape Town	Maitland: Alexandra Hospital	New electric security fence.	7 360 638

No	SP	District	Facility Name	Brief description of work	Actual expenditure (R)
34	8.3	West Coast	Malmesbury: Swartland Hospital	General building repairs: internal painting.	880 164
35	8.3	City of Cape Town	Manenberg: GF Jooste Hospital	Repairs and renovations, including electrical and mechanical work.	3 432 022
36	8.3	City of Cape Town	Mitchell's Plain: Lentegeur Hospital	Painting wards 10 and 100.	1 629 049
37	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Repairs and resurfacing of C parking deck.	2 676 365
38	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Replace chilled water pipes, copper pipes and air conditioning coils.	7 122 716
39	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Replacement of master key/lock system on F-floor.	1 364 499
40	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Supply and install new security perimeter fence.	705 665
41	8.1	Cape Winelands	Paarl: JJ du Preez Clinic	Painting and changes to patient's toilet, including electrical and mechanical.	660 676
42	8.1	Cape Winelands	Paarl: Klein Drakenstein CHC	Enlarge pharmacy by bricking up garage door.	421 097
43	8.6	Cape Winelands	Paarl: Luthando Frail Care Centre	Structural defects inside lift shaft.	389 418
44	8.1	Cape Winelands	Paarl: Mbekweni CDC	Clean exterior of building and paint. Channelling of roof water, paint interior, replace floor tiles including electrical and mechanical.	1 237 389
45	8.2	Cape Winelands	Paarl: Paarl Ambulance Station	Revamp room, reinforce perimeter wall, remove fuel pumps.	451 878
46	8.1	Cape Winelands	Paarl: TC Newman CDC	Replacement of existing boundary fencing.	998 219
47	8.5	City of Cape Town	Parow: Tygerberg Hospital	Repairs and renovations of air handling units: F-block.	2 560 115
48	8.5	City of Cape Town	Parow: Tygerberg Hospital: Forensics	Repairs and renovations: Expansion of cold room space and garages. Conversion of garages into storage space and offices, public toilets need for disabled.	1 213 541
49	8.5	City of Cape Town	Parow: Tygerberg Hospital	Repairs and renovations to wards D2 and F4.	4 890 359
50	8.5	City of Cape Town	Parow: Tygerberg Hospital	Replacement of theatre doors.	836 258
51	8.5	City of Cape Town	Parow: Tygerberg Hospital	Refurbish main pharmacy including sterile unit: painting of stairwells.	1 471 540
52	8.3	West Coast	Porterville: Lapa Munnik Hospital	Paint building, repairs to nurses home including shade parking including electrical upgrading.	810 597
53	8.3	Cape Winelands	Robertson Hospital	Extensive repairs and renovations of hospital and nurses home, general road repairs.	4 897 674
54	8.5	City of Cape Town	Rondebosch: Red Cross Hospital	Supply deliver and install three heat pump units for the boiler house and staff residence.	1 393 783

No	SP	District	Facility Name	Brief description of work	Actual expenditure (R)
55	8.5	City of Cape Town	Rondebosch: Red Cross Hospital	Main store upgrade.	1 078 959
56	8.5	City of Cape Town	Rondebosch: Red Cross Hospital	New water storage tanks.	1 470 121
57	8.5	City of Cape Town	Rondebosch: Red Cross Hospital	Service/replacement high tension switch gear in hospital.	1 516 392
58	8.3 8.1	Eden	Central Karoo Hospital and Clinics	Servicing of fire fighting equipment.	503 829
59	8.2	Overberg	Villiersdorp EMS	Revamp kitchen, toilet and duty room area and paint inside and outside, construct sluice area.	649 117
60	8.1	Overberg	Villiersdorp: Willa Clinic	Repairs and renovations, extension including electrical and mechanical work.	944 725
61	8.1	City of Cape Town	Woodstock CHC	External re-align roof tiles, paint inside.	638 110
62	8.4	Cape Winelands	Worcester: Brewelskloof TB Hospital	Repairs and renovations to nurses home, convert room next to auditorium, re-tile floor area in front of lifts, shade ports for patients.	676 421
63	8.4	Cape Winelands	Worcester Hospital	Replacement of chiller on C-block roof.	2 162 095
64	8.3	City of Cape Town	Wynberg: Victoria Hospital	Install heat pumps for hot water.	612 101

Major Maintenance Projects that are carried forward to 2012/13

The major maintenance projects that are carried forward to 2012/13 are listed in the table below.

No	SP	District	Facility Name	Brief description of work	Project budget (R)	Estimated expenditure in 2012/13 (R)
1	8.6	City of Cape Town	Athlone: Western Cape College of Nursing	Extraction fans in bathroom / toilet.	800 000	13 000
2	8.6	City of Cape Town	Athlone: Western Cape College of Nursing	Replace roof blocks: G, D, E, F and A (S162/11).	3 000 000	864 433
3	8.3	City of Cape Town	Atlantis: Wesfleur Hospital	Repair and renovations, electrical and mechanical repair en renovation.	4 080 689	3 628 282
4	8.3	City of Cape Town	Bellville: Karl Bremer Hospital	Supply and deliver new steam generators.	1 000 000	569 830
5	8.3	City of Cape Town	Bellville: Karl Bremer Hospital	Supply and deliver chlorifiers and steam coils.	820 000	273 441
6	8.5	City of Cape Town	Bellville: Tygerberg Hospital	13 lift upgrades.	16 400 000	15 070 876
7	8.3	Overberg	Bredasdorp: Otto Du Plessis Hospital	Upgrade fire detection system.	528 442	19 238

No	SP	District	Facility Name	Brief description of work	Project budget (R)	Estimated expenditure in 2012/13 (R)
8	8.1	Overberg	Bredasdorp: Bredasdorp Clinic	Repair tar parking; motorised gate and new air conditioning.	400 000	10 000
9	8.2	Overberg	Bredasdorp EMS	Repairs and renovations: Painting inside and outside of ambulance station.	600 000	20 000
10	8.3	Overberg	Bredasdorp: Otto Du Plessis Hospital	Repairs and renovations: Replace back steel windows. Floor sheeting in various areas. Provide covered parking.	700 000	150 691
11	8.4	City of Cape Town	Brooklyn Chest Hospital	Ventilation system in various wards.	2 000 000	323 328
12	8.4	City of Cape Town	Brooklyn Chest Hospital	Replace main water line and upgrade pump station reticulation.	4 600 000	4 207 356
13	8.4	City of Cape Town	Brooklyn Chest Hospital nurses home	Gen repairs, bathroom upgrade internally including fire detection.	975 000	37 638
14	8.3	West Coast	Clanwilliam Hospital	External repairs and painting.	1 426 000	529 586
15		Eden	Eden and Karoo facilities	Servicing of fire alarms.	1 000 000	463 025
16	8.6	Engineering	George Laundry	Provide new dispatch area and repair internal roads.	500 000	455 294
17	8.4	Eden	George: Harry Comay Hospital	Repair roads, storm water and upgrade street lights.	5 649 123	5 212 255
18	8.1	Overberg	Grabouw CDC	New palisade fence.	850 000	372 873
19	8.1	Eden	Heidelberg Clinic	Replace floor sheeting, build 2 garages, replace paving, internal in clinic and external painting, general repairs and palisade fencing with gates.	1 000 000	630 171
20	8.1	Cape Winelands	Khayamandi Clinic	Repairs and renovations: Internal painting and general repairs to toilets.	850 000	183 063
21	8.1	City of Cape Town	Khayelitsha Site B	Internal and external general repairs and painting.	2 500 000	154 097
22	8.3	Eden	Knysna Hospital	Provision of medical air equipment.	500 000	236 547
23	8.3	Eden	Lady Smith: Alan Blythe Hospital	Enlarge the laundry to accommodate linen store.	300 000	286 345
24	8.3	City of Cape Town	Maitland: Alexandra Hospital	Wards replace air conditioning system.	3 140 000	410 216
25	8.3	City of Cape Town	Maitland: Alexandra Hospital	Painting and repair to non-clinical and education buildings.	3 250 000	2 050 000
26	8.1	Cape Winelands	McCrone House Clinic	Suitable fence, gates and road works.	1 000 000	269 588

No	SP	District	Facility Name	Brief description of work	Project budget (R)	Estimated expenditure in 2012/13 (R)
27	8.1	City of Cape Town	Mfuleni Clinic	General building repairs; internal and external.	150 000	150 000
28	8.4	City of Cape Town	Mitchell's Plain: Lentegeur Hospital	Internal repairs and renovation to wards 100 and 96.	3 902 700	768 722
29	8.3	Central Karoo	Murraysburg Hospital	Minor capital: Build new carport, parking area, waiting area & tarring roads.	1 592 300	372 724
30	8.3	Central Karoo	Murraysburg Hospital	Minor capital: Replace existing boundary fence and secure helipad.	800 000	127 000
31	8.4	Central Karoo	Nelspoort TB Hospital	Upgrade showers and toilets.	300 000	300 000
32	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Replacement of roof coverage: OPD and maternity buildings.	7 804 000	3 395 155
33	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Planned maintenance, replace air conditioning coils and pipes.	3 000 000	1 869 782
34	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Various buildings: Repairs and renovations.	2 850 000	814 464
35	8.1	Eden	Oudtshoorn: Bridgton Clinic	Install storm water system.	1 370 000	1 199 959
36	8.1	Eden	Oudtshoorn: Dysselsdorp CHC	General repairs, internal and external painting and change reception.	500 000	500 000
37	8.1	West Coast	Piketberg Clinic	Minor capital: Upgrade power supply; supply, deliver and install air-conditioners.	500 000	488 227
38	8.2	West Coast	Porterville EMS	Minor capital: Construct wash bay and sluice.	350 000	350 000
39	8.3	Central Karoo	Prince Albert Hospital	Internal and external painting and general repairs.	1 700 000	1 300 000
40	8.1	West Coast	Redelinghuys Clinic	Minor capital: Delivery and installation of air conditioning.	10 000	10 000
41	8.3	Cape Winelands	Robertson: Robertson Hospital	New fence.	750 000	500 000
42	8.5	Red Cross Hospital	Rondebosch: Red Cross Hospital	Replacement of various roofs and external renovations of various buildings.	3 600 000	886 877
43	8.4	City of Cape Town	Somerset Hospital	Replace steel windows with aluminium windows.	5 491 000	2 279 299
44	8.3	City of Cape Town	Somerset Hospital	Air conditioner chiller.	1 950 000	139 925
45	8.3	City of Cape Town	Somerset Hospital	Replace existing fire alarm.	1 800 000	764 051
46	8.3	City of Cape Town	Somerset Hospital	North block, repairs and renovation.	3 300 000	1 394 783

No	SP	District	Facility Name	Brief description of work	Project budget (R)	Estimated expenditure in 2012/13 (R)
47	8.3	City of Cape Town	Somerset Hospital	New roof covering for ambulance parking. (Capital project)	783 153	447 694
48	8.3	City of Cape Town	Somerset West: Helderberg Hospital	External repairs including external painting to existing main building.	5 000 000	1 037 032
49	8.1 to 8.4 & 8.6	Eden	Southern Cape	Service fire alarm systems.	200 000	185 432
50	8.3	Cape Winelands	Stellenbosch Hospital	Replace flooring with vinyl sheeting.	1 700 000	27 719
51	8.4	City of Cape Town	Stikland Hospital	Supply, deliver and install two canopies in kitchen.	412 000	209 238
52	8.4	City of Cape Town	Stikland Hospital	House Miles Bowker internal and external repairs and renovations.	3 300 000	3 000 000
53	8.4	City of Cape Town	Stikland Hospital	Resurfacing of existing roads.	4 000 000	2 000 000
54	8.3	West Coast	Swartland Hospital	Repair to boiler.	400 000	400 000
55	8.1	Cape Winelands	TC Newman CDC	Interior and external repairs and repaint.	5 939 000	2 832 605
56	8.2	Cape Winelands	Touwsriver EMS	General repairs and painting.	500 000	300 000
57	8.5	City of Cape Town	Tygerberg Hospital	Repairs and renovations to haematology block D8.	2 400 000	2 120 000
58	8.5	City of Cape Town	Tygerberg Hospital	EMS and psychiatric adolescent ward: Repairs and renovations internally and externally.	4 300 000	4 000 000
59	8.5	City of Cape Town	Tygerberg Hospital	General repairs and painting to passages and waterproofing to roofs of administrative block.	3 600 000	3 525 000
60	8.5	City of Cape Town	Tygerberg Hospital	Phase 3 fire doors.	2 800 000	800 000
61	8.5	City of Cape Town	Tygerberg Hospital	Supply and install new air handling units.	2 000 000	500 000
62	8.5	City of Cape Town	Tygerberg Hospital & Karl Bremer	17 lift installation modernisation, refurbishment and upgrade.	18 000 000	1 386 349
63	8.6	West Coast	West Coast District Office	General repairs, painting and fencing.	700 000	700 000
64	8.1 to 8.3 & 8.6	West Coast	West Coast Various buildings	Three year servicing of fire fighting equipment.	900 000	300 000
65	8.4	Cape Winelands	Worcester: Brewelskloof Hospital	Replace water ring main, repair ceilings.	2 000 000	42 800

Major Maintenance Projects that will commence in 2012/13

The major maintenance projects that will commence in 2012/13 are listed in the table below.

No	SP	District	Facility Name	Brief description of work	Project budget	Estimated expenditure in 2012/13 (R)
1	8.6	City of Cape Town	Athlone: Western Cape College of Nursing	Internal and external repairs and renovations.	2 300 000	2 000 000
2	8.3	Central Karoo	Beaufort West: Beaufort West Hospital	Repair and repaint hospital roof.	500 000	500 000
3	8.6	City of Cape Town	Bellville: Bellville Mobile Workshops	Emergency repairs to health facilities.	2 750 000	2 750 000
4	8.3	City of Cape Town	Bellville: Karl Bremer Hospital	Replace asbestos roof for hospital and nurses home building and seal all top floor windowsills.	1 000 000	1 000 000
5	8.3	City of Cape Town	Bellville: Karl Bremer Hospital	Replace window frames in nurses home with aluminium frames as majority of windows cannot open; hinges broken, rusted, etc.	500 000	500 000
6	8.4	City of Cape Town	Bellville: Stikland Hospital	Repairs and renovation of ward 13 (to accommodate doctors).	4 500 000	4 500 000
7	8.5	City of Cape Town	Bellville: Tygerberg Hospital	Replacement of underground fresh water and fire mains reticulation system.	600 000	600 000
8	8.5	City of Cape Town	Bellville: Tygerberg Hospital	Repairs and upgrade of paediatric isolation ward G10 negative pressure.	2 700 000	2 500 000
9	8.5	City of Cape Town	Bellville: Tygerberg Hospital	Repairs and upgrade of adult isolation ward D10 negative pressure.	2 700 000	1 000 000
10	8.5	City of Cape Town	Bellville: Tygerberg Hospital	Labour ward upgrade phase 2.	2 400 000	1 200 000
11	8.5	City of Cape Town	Bellville: Tygerberg Hospital	Gypsy toilet project.	3 700 000	700 000
12	8.5	City of Cape Town	Bellville: Tygerberg Hospital	Ventilation – wards still to be identified.	3 500 000	800 000
13	8.5	City of Cape Town	Bellville: Tygerberg Hospital	Service sprinkler control valves.	1 500 000	1 300 000
14	8.5	City of Cape Town	Bellville: Tygerberg Hospital	Service transformers.	6 000 000	500 000
15	8.5	City of Cape Town	Bellville: Tygerberg Hospital	Supply and install chiller on roof.	1 000 000	1 000 000
16	8.1	City of Cape Town	Bonteheuwel: Vanguard Drive Clinic	Improve emergency centre entrance - not through waiting area.	750 000	640 000

No	SP	District	Facility Name	Brief description of work	Project budget	Estimated expenditure in 2012/13 (R)
17	8.3	Overberg	Caledon: Caledon Hospital	Stores building: Repairs, renovations and paint. Repair roof and investigate replacing. Air conditioning work.	885 000	885 000
18	8.3	City of Cape Town	Cape Town: various hospitals	Lift upgrades.	45 000 000	500 000
19	8.1	Eden	Eden and Karoo facilities	Servicing of fire fighting equipment. (Two year period contract.)	500 000	250 000
20	8.1	Overberg	Elim Clinic	Extensions to existing clinic.	1 000 000	50 000
21	8.1	City of Cape Town	Elsies River CHC	Repairs and renovations, upgrade of pharmacy and maternity.	4 500 000	4 365 000
22	8.1	Cape Winelands	Franschhoek: Groendal (Franschhoek) Clinic	Internal repairs and renovations. Investigate and repair uneven floors in certain areas and closing sides.	600 000	300 000
23	8.1	City of Cape Town	Green Point CDC	Repairs and maintenance.	1 100 000	500 000
24	8.4	City of Cape Town	Green Point: Somerset Hospital	Upgrade labour ward. Do labour theatre plus decanting theatres.	1 100 000	1 100 000
25	8.1	Central Karoo	Laingsburg Clinic	Extensions.	1 000 000	200 000
26	8.4	City of Cape Town	Maitland: Alexandra Hospital	Replace current (asbestos and cast iron) main water pipeline with new water reticulation system.	4 800 000	1 400 000
27	8.4	City of Cape Town	Maitland: Alexandra Hospital	Demolition of old vacant (old run down, vandalised) buildings.	500 000	50 000
28	8.4	City of Cape Town	Maitland: Alexandra Hospital	Lower floor of old crèche facility and the vacant dormitory wing at education renovations.	1 000 000	1 000 000
29	8.4	City of Cape Town	Maitland: Alexandra Hospital	Physiotherapy and rehab wards.	2 000 000	1 000 000
30	8.1	West Coast	Malmesbury: Riverlands Clinic	New prefab clinic.	1 000 000	1 000 000
31	8.4	City of Cape Town	Mitchells Plain: Lentegeur Hospital	Repair and renovation work on four (4) wards (Wards 100, 89 and 99 in 2012/13).	4 300 000	2 000 000
32	8.4	City of Cape Town	Mitchells Plain: Lentegeur Hospital	Main hall upgrade.	2 400 000	200 000
33	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Replace air conditioning in old main building – phase 1 clinical therapy, admin, H-floor localised chillers.	1 000 000	500 000
34	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Revamp L-block air conditioning.	1 500 000	100 000

No	SP	District	Facility Name	Brief description of work	Project budget	Estimated expenditure in 2012/13 (R)
35	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Revamp induced draft fans and dust extractors boiler house.	1 200 000	1 000 000
36	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Crèche structural repairs.	2 000 000	1 800 000
37	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Replace water supply reticulation.	1 000 000	1 000 000
38	8.4.2	City of Cape Town	Paarl: Sonstraal Hospital	Correct workflow.	4 000 000	1 500 000
39	8.1	West Coast	Porterville Clinic	Upgrade and paint clinic, improve pharmacy, records, office, OT and physiotherapy areas.	700 000	100 000
40	8.1	Central Karoo	Prince Albert Hospital	Pharmacy and corridor, construct a waiting room with ablution facility.	700 000	500 000
41	8.2	Central Karoo	Prince Albert Hospital	Helistop, wash bay and renovate and add clinic maintenance.	900 000	600 000
42	8.5	City of Cape Town	Rondebosch: Red Cross Hospital	Upgrade 2 x air conditioning plants and adjacent areas in OPD.	1 500 000	1 500 000
43	8.5	City of Cape Town	Rondebosch: Red Cross Hospital	Internal and external painting in various areas at Maitland Cottage Hospital as well as repairs and renovations to the hospital.	2 300 000	2 000 000
44	8.5	City of Cape Town	Rondebosch: Red Cross Hospital	Replace electrical element water heating with 3 heat pumps for crèche, laundry, OPD, A7 and surrounding areas.	500 000	500 000
45	8.5	City of Cape Town	Rondebosch: Red Cross Hospital	Replacement of the chillers for ICU and pharmacy.	500 000	500 000
46	8.1	City of Cape Town	Ruiterwacht Clinic	Additions.	1 000 000	1 000 000
47	8.1	Cape Winelands	Stellenbosch: Cloetesville CDC	Minor capital works: extension of pharmacy.	1 000 000	700 000
48	8.1	Cape Winelands	Stellenbosch: Aan-het-pad Clinic	Interior and exterior repairs and renovations (historical building).	900 000	500 000
49	8.2	Overberg	Swellendam Hospital	Access road to new EMS and wash bay.	1 000 000	1 000 000
50	8.1	Cape Winelands	Tulbagh Clinic	Fix cracks, access roads and sputum booth.	700 000	700 000
51	8.1	Eden	Uniondale Clinic	Repairs and renovations.	600 000	300 000
52	8.3	Eden	Uniondale Clinic	Upgrade pharmacy to comply with regulations etc.	700 000	200 000
53	8.1	Cape Winelands	Wellington: McCrone House Clinic	External works.	500 000	500 000

Processes in place for the procurement of infrastructure projects

On 1 April 2012, Provincial Treasury published the Standard for a Construction Procurement System (CPS) the aim of which is to "establish a construction procurement system for an institution to use in fulfilling its obligations in the procurement of goods, services and engineering and construction works within the construction industry". In order to regulate this Standard, also on 1 April, Provincial Treasury Instruction (PTI) 16B was issued. PTI 16B applies to all "institutions engaged in the delivery and maintenance of infrastructure as clients, implementers or custodians" and compliance thereto will be progressive, with full compliance being prescribed for 31 March 2013.

The Western Cape Department of Health adheres to the prescripts of GIAMA and prepares a User Immovable Asset Management Plan (U-AMP) on an annual basis. The 2012/13 U-AMP was signed-off by the Head of Health: Western Cape on 29 February 2012.

Maintenance

The budget allocation for Programme 8 maintenance in 2011/12 was R125.5 million, of which a total of R125.8 million, or 100.24 per cent was spent. It is important to note that R17.4 million was transferred from Programme 8 to Programme 7 (Goods and services) during the adjustment budget period to address the shortage of funding and prevent under expenditure in Programme 8.

A baseline audit was undertaken by the National Department of Health in 2011. Once this information becomes available, it will assist in informing maintenance gaps.

A three-year maintenance planning cycle was introduced to ensure planning is in line with the cyclic nature of construction projects. The three-year cycle will assist in counter-acting the March spike in expenditure as planning and construction of projects will commence throughout the year.

The maintenance expenditure is not in line with industry norms, which recommends that the maintenance budget for health facilities should be set at 4 per cent of the infrastructure replacement value. The current budget allocation is significantly below this norm.

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 under the paragraph "Capital investment".
- Projects that are funded by means of the Hospital Revitalisation Grant and the Health Infrastructure Grant.

Maintenance backlog and planned measures to reduce the maintenance backlog

It is difficult to measure the maintenance backlog. The maintenance backlog is estimated at R400 million at present. The Department aims to utilise the following measures to reduce the backlog over the medium term expenditure framework period:

- By constructing new or upgrading 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.

- By increasing routine maintenance at facility level.
- By implementing the preventative maintenance programme for all new health facilities completed since 2006.

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. At this point in time, the IAR 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. This is the responsibility of the Western Cape Department of Transport and Public Works and they are addressing the matter.

Closely aligned to IAR 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 who is currently addressing this issue.

An updated facilities condition assessment is not available, but based on the current information available in the 2012/13 U-AMP as well as the maintenance budget allocated to Engineering and the health institutions, it is evident that, unless there is an increase in resources in the future, the maintenance backlog is going to increase.

Health facilities maintenance backlog (30 June 2012)

Financial Year	2012/2013	2013/2014	2014/2015
Estimated value of buildings	21 887 000 000	21 887 000 000	24 075 700 000
Total value of buildings escalated @10% p.a.	21 887 000 000	24 075 700 000	26 483 270 000
New buildings and replacements	480 031 000	611 839 000	686 967 000
Total value of buildings	22 367 031 000	24 687 539 000	24 762 667 000
Maintenance required @ 4% p.a. (average)	894 681 240	987 501 560	990 506 680
Accumulative maintenance required (inclusive of previous year backlog)	894 681 240	1 379 439 800	1 877 988 480
Actual maintenance budget (Programme 8 + Programme 7.2 + facilities)	363 383 000	394 198 000	416 294 000
Upgrading budget	139 360 000	97 760 000	44 638 000
Total maintenance + upgrading	502 743 000	491 958 000	460 932 000
Accumulative actual maintenance + upgrading	502 743 000	994 701 000	1 455 633 000
Backlog = Accumulative maintenance required – Accumulative actual maintenance	391 938 240	887 481 800	1 417 056 480

Note:

- Actual maintenance budget: Scheduled maintenance, preventative maintenance, engineering, and day to day maintenance at institutions.
- Total maintenance required at health facilities is 4% of the replacement cost.
- Engineering and day to day maintenance (at institution) forecast 6% increase per annum.

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 by the Provincial Minister and other members of management, implementing policy and organising the Health Department, managing personnel and financial administration, determining working methods and procedures and exercising central control. To make limited provision for maintenance and accommodation needs.

Strategic Goals

Programme 1 contributes to the following strategic goals of the Department:

1) Ensure and maintain organisational strategic management capacity and synergy.
2) Ensure a sustainable income to provide the required health services.
3) Develop and maintain a capacitated workforce.

Strategic Objectives

The strategic objectives for Programme 1 (Administration) are:

- To provide sufficient staff with appropriate skills per occupational group.
- Promote sound financial governance and management to ensure the under/over spending of the annual equitable share is within one per cent of the budget allocation.
- Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.

Performance indicators and targets

1) Ensure and maintain organisational strategic management capacity and synergy

To ensure alignment to the Department's strategic objectives, the strategies and action plans identified through the human resource planning process focuses on employing the correct number of people with the appropriate competencies and skills, within the available resources, to be able to deliver optimal health outcomes to the people of the Western Cape.

The implementation of the various occupational specific dispensations has resulted in specific occupational streams, within occupations, having new job titles and remuneration packages. This includes a new competency mix (scope of practice) of positions providing health services at ward/unit/clinic level. As a result, the entire organisational and post structures of the Department have been aligned in terms of the new occupational specific dispensations.

The following initiatives have been identified to improve the recruitment and retention of staff:

- Implementation of recruitment and retention strategies applicable to identified occupational groups.
- Development, implementation and monitoring of a succession planning policy.
- Conducting an attrition analysis and providing remedial measures.
- Implementing targeted career path strategies and talent management.
- Continuing to align individual performance plans/competency gaps with training plans.
- Mentoring should be formalised as a key strategy to improve and develop the skills within management, technical or clinical categories.
- Post course assessments to determine the impact of training.

Significant progress has been made with the employment of family physicians within the Metro District Health Services. The recruitment of family physicians in the rural districts must still be addressed.

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

The Department continues to improve and develop management accounting systems and processes. The Budget Management Instrument (BMI) has proven to be an effective tool whereby all expenditure is measured and monitored against the allocated budget on a monthly basis.

The implementation of the occupational specific dispensations resulted in significantly higher personnel costs. To control personnel expenditure, a joint initiative with the Directorate: Human Resource Management exists to manage all funded posts in accordance with the Approved Post List (APL).

Vetting, budgeting and reporting of results, per cost centre and/or functional business unit, are being implemented at different stages of maturity throughout the Department. Reports that reflect budget allocations, expenditure and efficiency parameters at functional business unit (FBU) and cost centre level are generated and distributed to managers.

3) Develop and maintain a capacitated workforce

Human resource capacity was strengthened to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis. The amended plan was submitted timeously to the Department of Public Service Administration (DPSA).

Table 2.2.1: Public health personnel as at 31 March 2012

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	1 899	6.36%	0.330	0.423	4.19%	15.54%	614 882
Medical specialists	606	2.03%	0.105	0.135	1.94%	8.61%	1 067 560
Dental specialists	27	0.09%	0.005	0.006	6.90%	0.25%	694 142
Dentists	70	0.23%	0.012	0.016	0.00%	0.53%	564 502
Professional nurse	5 720	19.17%	0.994	1.274	4.56%	23.89%	313 753
Enrolled nurses	2 344	7.85%	0.407	0.522	3.62%	5.71%	183 022
Enrolled nursing auxiliaries	4 141	13.88%	0.719	0.922	1.96%	8.35%	151 425
Student nurses	-	-	-	-	-	-	-
Pharmacists	374	1.25%	0.065	0.083	9.00%	2.20%	442 439
Physiotherapists	131	0.44%	0.023	0.029	2.24%	0.47%	269 215
Occupational therapists	136	0.46%	0.024	0.030	1.45%	0.47%	262 155
Clinical psychologists	76	0.25%	0.013	0.017	2.56%	0.43%	425 560
Radiographers	429	1.44%	0.075	0.096	2.28%	1.77%	310 681
Emergency medical staff	1 707	5.72%	0.297	0.380	13.44%	4.99%	219 771
Dieticians	85	0.28%	0.015	0.019	3.41%	0.31%	272 833
Other allied health professionals and technicians	1 494	5.01%	0.260	0.333	8.00%	4.48%	225 292
Managers, administrators and all other staff	10 603	35.53%	1.842	2.361	4.69%	22.00%	155 901
Grand Total	**29 842**	**100%**	**5.185**	**6.645**	**4.83%**	**100%**	**251 778**

Table 2.2.2: Human resources 2011/12

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
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	32.73	33.38	32.99	31.05	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	1 844	1 881	1 899	1 787	An additional 15 posts were funded during the reporting period which contributed to the variance of 6.30% from the target.
			Denominator:	5 634 323	5 634 323	5 755 607	5 755 607	
			2) Number of medical officers per 100 000 people in rural districts	15.97	17.12	17.37	15.47	Increase in staff mainly within the category medical officer grade 1 and registrar. An additional 11 posts were filled and funded during the reporting period which contributed to the variance of 14.60% from the target.
			Numerator:	305	327	345	301	
			Denominator:	1 909 976	1 909 976	1 945 872	1 945 872	
			3) Number of professional nurses per 100 000 people	92.31	97.24	99.38	91.25	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	5 201	5 479	5 720	5 252	An additional 341 posts were funded during the reporting period which contributed to the variance of 8.9% from the target.
			Denominator:	5 634 323	5 634 323	5 755 607	5 755 607	
			4) Number of professional nurses per 100 000 people in rural districts	82.93	86.23	89.99	82.22	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	1 584	1 647	1 751	1 600	An additional 117 posts were funded during the reporting period which contributed to the variance of 9.4% from the target.
			Denominator:	1 909 976	1 909 976	1 945 872	1 945 872	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
			5) Number of pharmacists per 100 000 people	5.93	6.42	6.50	5.77	Increase in staff mainly within the category pharmacy supervisor grade 1. An additional 20 posts were funded during the reporting period which contributed to the variance of 12.6% from the target.
			Numerator:	334	362	374	332	
			Denominator:	5 634 323	5 634 323	5 755 607	5 755 607	
			6) Number of pharmacists per 100 000 people in rural districts	5.71	5.92	6.06	5.65	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely. An additional 7 posts were funded during the reporting period which contributed to the variance of 6.40% from the target.
			Numerator:	109	113	118	110	
			Denominator:	1 909 976	1 909 976	1 945 872	1 945 872	
			7) Vacancy rate for professional nurses	5.56%	3.06%	4.56%	4.73%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	306	173	273	261	
			Denominator:	5 507	5 652	5 993	5 513	
			8) Vacancy rate for medical officers	5.73%	4.37%	4.19%	7.93%	Increase in appointments mainly within the staff category medical officer grade 1 and registrar.
			Numerator:	-	86	83	154	
			Denominator:	-	1 967	1 982	1 941	
			9) Vacancy rate for medical specialists	6.64%	3.88%	1.94%	11.35%	Increase in appointments mainly within the staff category medical specialist grade 2 and senior medical registrar.
			Numerator:	-	23	12	70	
			Denominator:	-	593	618	617	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
			10) Vacancy rate for pharmacists	12.34%	7.42%	9.00%	12.40%	Increase in appointments mainly within the staff category pharmacy supervisor grade 1.
			Numerator:	-	29	37	47	
			Denominator:	-	391	411	379	

Note:

Indicators 1 – 6: The 2010 population was used when the 2009/10 targets were set and therefore the same population figures are quoted for 2009/10 and 2010/11.

Reasons for variances

- The Approved Post List (APL) allows for funding to be shifted between various occupational categories to fill posts according to service delivery needs. Both the numerator (vacancies) and the denominator (filled and vacant funded posts) fluctuate during reporting periods making it difficult to determine targets.
- The recruitment and retention of staff was higher than anticipated, which may be attributed to the implementation of the Occupational Specific Dispensation (OSD).
- The movement on the departmental organisational establishment (filled and funded vacant posts), during the reporting period, is reflected in the reasons for variances in the table above.

Changes to planned targets

No changes were made to targets during the year.

Table 2.2.3: Performance against targets from the 2011/12 Annual Performance Plan for the Administration Programme

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Ensure a sustainable income to provide the required health services.	1.1 Promote efficient financial resource use.	1.1.1 Promote sound financial governance and management to ensure the under/over spending of the annual equitable share is within 1% of the budget allocation.	1) Percentage expenditure of the annual equitable share budget allocation	100.39%	99.46%	99.72%	100%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	7 519 280	8 756 933	9 664 344	9 676 807	
			Denominator:	7 489 777	8 803 710	9 690 810	9 676 807	
2. Develop and maintain a capacitated workforce.	2.1 Develop and maintain a comprehensive Human Resource Plan for the Department.	2.1.1 Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.	2) Amended Human Resource Plan submitted timeously to DPSA	Yes	Yes	Yes	Yes	Target achieved.

Note:

Global fund included in equitable share allocation.

2.2.2 Programme 2: District Health Services

Purpose

The purpose of the Division of District Health Services and Health Programmes (Programme 2) is to render facility-based district health services (at clinics, community health centres and district hospitals) and community based district health services (CBS) to the population of the Western Cape Province.

Analysis per sub-programme

Sub-programme 2.1: District Management

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

Sub-programme 2.2: Community Health Clinics

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

Sub-programme 2.3: Community Health Centres

Rendering a primary health care service with full-time medical officers 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 services.

Sub-programme 2.6: HIV and AIDS

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

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.

These services are reported in Sub-programme 7.3: Forensic Pathology Services.

Sub-programme 2.9: District Hospitals

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

Sub-programme 2.10: Global Fund

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

Tuberculosis (TB) hospitals are funded from Programme 4.2 but are managed as part of the District Health System (DHS) and are the responsibility of the district directors. The narrative and tables for TB hospitals is in Sub-programme 4.2.

DISTRICT HEALTH SERVICES

Strategic Goals

District health services contribute to the following strategic goals of the Department:

1) Manage the burden of disease.
2) Ensure a sustainable income to provide the required health services according to the needs.
3) Improve the quality of health services.

Strategic Objectives

The strategic objectives for District Health Services are:

- Achieve a PHC utilisation rate of 3.0 visits per person per annum by 2014/15.
- Achieve a primary health care (PHC) expenditure of R450 per uninsured person by 2015 (in 2009/10 rands).
- Achieve an 80 per cent client satisfaction rate by 2015.

Performance indicators and targets

1) Manage the burden of disease

The District Health System (DHS) is the vehicle for the delivery of a comprehensive primary health care (PHC) and district hospital service. The underlying principle is to prevent and mitigate illness through a primary health care approach, and, when illness cannot be averted, to ensure that the resident population of a geographical area (a district) have access to health services through tiered levels of care.

Community Based Services (CBS), provided largely by community care workers (CCW), are regarded as the base of the DHS. This is added to by a range of staff competencies and packages of care in the respective health facilities at the levels of clinic, community day centre, community health centre and district hospital.

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

Performance of the DHS reveals the following: contacts with the DHS platform, as reflected by total headcounts and headcounts under five years of age, are within target range and demonstrate that access to primary health care services is good.

With regards to clinical governance, the pool of family physicians is being maintained but challenges are being experienced with facility supervisory visits. This is largely due to a dual authority system of health provision in the largest district, the Cape Metro.

There are 292 fixed PHC facilities in the Western Cape Province, each of which should receive at least one supervisory visit per month. Of the 292 facilities, 92 fall under the authority of the City of Cape Town, which expects a different level of supervisory support, namely once every three months. When analysed by authority, clinics that fall under the City of Cape Town show a 43 per cent performance for the year, while the WGC facilities show a performance that ranges (across the districts) from 83 per cent to 93 per cent. The overall provincial performance is thus being significantly lowered by the fact that City of Cape Town sites do not subscribe to the same definition for adequacy of supervisory visits.

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

Provincial PHC expenditure per uninsured person and per PHC headcount

It should be noted that the definition for both the Provincial PHC expenditure per uninsured person and the Provincial expenditure per PHC headcount changed in 2011/12. Previously the entire expenditure for Programme 2 was used as the numerator. However, from 2011/12 the expenditure for sub-programme 2.1 to 2.5 (District Management, Community Health Clinics, Community Health Centres, Community Based Services and Other community services) only is used.

3) Improve the quality of health services

The good performance seen on the indicators that pertain to user complaints and assessment of facilities against core standards demonstrate the Department's on-going commitment to a quality health service that is client-centred.

The Province had planned to assess one PHC facility per rural district and one per Metro sub-structure, totalling 9 assessments, for compliance against the national core standards. This was set on the assumption that the assessments would be conducted using internal (Provincial Department of Health) capacity. However, Health Systems Trust (an NPO whose mandate is to provide health systems support) was contracted by the National Department of Health to provide country-wide assistance with these assessments. Their external support enabled the Western Cape Department to exceed the original target.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2011/12 ANNUAL PERFORMANCE PLAN

Table 2.2.4: Performance against targets from the 2011/12 Annual Performance Plan for the District Health Services programme

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
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 3.0 visits per person per annum by 2014/15.	1) Utilisation rate – PHC	3.0	2.9	2.7	2.8	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	15 848 973	16 206 552	15 535 613	16 291 503	
			Denominator:	5 321 416	5 634 323	5 755 607	5 755 607	
			2) PHC total headcount	15 848 973	16 206 552	15 535 613[5]	16 291 503	The Department views variances of less than 5% to be within an acceptable range from the target.
			3) Utilisation rate – PHC under 5 years	5.0	4.7	4.5	4.7	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	2 527 588	2 453 946	2 427 241	2 531 063	
			Denominator:	497 995	527 215	538 524	538 524	
			4) PHC total headcount – under 5 years	2 527 588	2 453 946	2 427 241	2 531 063	The Department views variances of less than 5% to be within an acceptable range from the target.

[5] The decrease in the headcount is as a result of all visits at the outpatient departments at district hospitals are now counted as OPD visits instead of a proportion of the visits being classified as PHC headcounts.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
			5) Fixed PHC facilities with a monthly supervisory visit rate[6]	66%	70%	72.3%	90%	There is a need to increase supervisory visits to ensure optimal functioning of health facilities and adherence to quality standards. The target of 90% was based on a joint undertaking by both local government (LG) and WCG facilities to increase the supervisory visits. Although the LG facilities conduct monthly support visits, their definition to record a supervisory visit indicate that only when the register is signed, which is every 3 months, a supervisory visits will be recorded. The monthly support visit of City of Cape Town (CoCT) facilities is equivalent to the WCG supervisory visit and for the 2012/13 year there is an agreement between the Chief Director: Metro District Health Services (MDHS) and Head of Health: CoCT to align the two definitions.
			Numerator:	198	207	211	266	
			Denominator:	299	296	292[7]	296	
			6) Percentage of CHCs and CDCs with a resident doctor	Not required to report	94.3%	84.5%	90%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	-	50	49	49	
			Denominator:	-	53	58[8]	54	

6 Based on a data verification process the historical data for this indicator was updated. The actual number of facilities in the Province has not decreased. An incorrect figure was reported in previous years.

7 The decrease in the number of facilities is as a result of some fixed clinics being reclassified as community day centres as per definition from the National Department of Health. The target was based on the 2010/11 count of facilities before the reclassification took place.

8 The increase in the number of facilities is as a result of some fixed clinics being reclassified as community day centres as per definition from the National Department of Health. The target was based on the 2010/11 count of facilities before the reclassification took place. The increase in the denominator resulted in a decrease in the percentage of CHCs and CDCs with a resident doctor from the previous year.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
			7) Number of NPO appointed home carers	2 491	2 584	2 853	3 000	The Department views variances of less than 5% to be within an acceptable range from the target.
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 R450 per uninsured person by 2015 (in 2009/10 rands).	8) Provincial PHC expenditure per uninsured person[9]	R 406	R 416	R 419	R 397	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	1 786 006 483	1 872 450 904	1 920 294 815	1 822 176 822	
			Denominator:	4 396 294	4 490 706	4 585 115	4 585 115	
			9) Provincial expenditure per PHC headcount[10]	R 113	R 116	R 124	R 112	The decrease in the PHC headcount coupled with the increase in the expenditure (which was only 5% more than anticipated) resulted in an increased expenditure per PHC headcount. Refer to the footnote for indicator 2 for an explanation on the decrease in the PHC headcount.
			Numerator:	1 786 006 483	1 872 450 904	1 920 294 815	1 822 176 822	
			Denominator:	15 848 973	16 206 552	15 535 613	16 461 036	
3. Improve the quality of health services.	3.1 Improve the experience of clients utilising the PHC services.	3.1.1 Achieve an 80% client satisfaction rate by 2015.	10) Percentage of complaints of users of PHC services resolved within 25 days	Not required to report	Not required to report	60.72%	60%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	-	-	252	750	
			Denominator:	-	-	415	1 250	

9 The definition for this indicator changed. In 2009/10 and 2010/11 the entire expenditure for Programme 2 was used as the numerator whereas the actual and target for 2011/12 only includes the expenditure and budget for sub-programmes 2.1 to 2.5 respectively. The historical information for 2009/10 and 2010/11 was updated according to the new definition. Also note that all expenditure figures are expressed in 2009/10 rand values to be comparable with the target.

10 Refer to previous comment.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
			11) Number of PHC facilities assessed for compliance against the core standards	Not required to report	Not required to report	147	9	At the time of target setting there was no clear directive from the National Department of Health (NDoH). Health Systems Trust (HST) was contracted by the NDoH to assist provinces with assessments. It was therefore possible to do additional assessments.

Changes to planned targets

No changes were made to targets during the year.

DISTRICT HOSPITAL SERVICES

Strategic Goals

District Hospital Services contribute to the following strategic goals of the Department:

1) Manage the burden of disease.
2) Ensure a sustainable income to provide the required health services according to the needs.
3) Improve the quality of health services.

Strategic Objectives

The strategic objectives for District Hospital Services are:

- Establish 2 673 acute district hospital beds in the DHS by 2014/15.
- Achieve a district hospital expenditure of R1 650 per PDE by 2014/15 (in 2009/10 rands).
- Achieve an 80% client satisfaction rate by 2014/15.

Performance indicators and targets

1) Manage the burden of disease

District hospitals are cornerstones of the district health system. The package of care provided at district hospitals includes emergency centre care, adult and children in-patient and out-patient 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.

District hospitals serve as the first health service contact point for many acutely ill clients requiring hospital admission. 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 is good (number of beds, number of separations, average length of stay and bed utilisation rate), while a small proportion of district hospitals account for a significant number of all district hospital caesarean sections. This is most likely a result of these specific hospitals having been re-classified as district hospital (from regional hospitals) yet they retained staff with the skill sets necessary to perform complex obstetrical procedures. A more detailed explanation is provided below.

Caesarean section rate for district hospitals

There are thirty four district hospitals in the Province of which twenty six recorded at least one caesarean section during the course of the year. Twenty district hospitals achieved a rate less than or equal to the target of 21.5 per cent and accounted for 38 per cent of all caesarean sections performed at district hospitals.

Of the six district hospitals that exceeded the target, three are large Cape Town Metro district hospitals (the Khayelitsha hub in Tygerberg Hospital, Karl Bremer and Helderberg Hospitals) which together averaged a caesarean rate of 36 per cent (and as a group accounted for 50 per cent of all caesarean section performed in district hospitals in the Province). It should be noted that two of the three (Karl Bremer and Helderberg Hospitals) have been re-assigned as district hospitals and previously offered some level two services. The third hospital (the Khayelitsha hub in Tygerberg Hospital) is a district hospital service that operated from the premises of a tertiary institution. These hospitals thus have a legacy of offering complex obstetric surgical services and this probably accounts for the higher rate of surgery.

The remaining three hospitals that exceeded the target are rural district hospitals (Beaufort West, Hermanus and Mossel Bay Hospitals) which together averaged a rate of 27.7 per cent and accounted for 12 per cent of all district hospital caesarean section procedures. In these hospitals the reason for a high caesarean rate is probably related to the distance to the next (higher) level of care.

OPD total headcounts in district hospitals

A definitional change (explained below) that was not taken into account when targets were set resulted in large deviations from the target in OPD headcounts and patient day equivalents. The higher than expected patient day equivalents had a knock-on effect in reducing those indicators which included PDEs in their denominator, principally expenditure per PDE in district hospitals.

Most annual performance targets are set using the previous year's performance as a baseline. In 2010/11, a large proportion of the "outpatient headcount" at district hospitals contributed towards the total primary health care headcount and not towards the district hospital patient day equivalent (PDE). Thus in the previous year, 2010/11, although patients would undergo a clinical consultation at the outpatient departments of district hospitals, the consultation was deemed to be "primary health care" in nature. Therefore the consultation technically contributed to the total primary health care headcounts accumulated across the Province and not to the hospital workload.

For 2011/12 the definition was changed by the National Department of Health and district hospital "outpatient headcount" instead contributed towards district hospital performance measures and not primary health care performance measures. This resulted in the target for district hospital OPD headcounts being "under-set" based on the previous year's artificially low district hospital OPD headcount (artificially low because the outpatient numbers had been diverted to the primary healthcare information stream in 2010/11).

Patient day equivalents in district hospitals

A patient day equivalent (PDE) is a metric constructed from four different elements: inpatient days and a proportion of day patients and the headcount of outpatients departments and emergency centres. The difference between this year and the previous year was the 24 per cent increase in the contribution to the provincial PDE made by the component "outpatient headcount" at district hospitals. Refer to the explanation provided above for "OPD total headcount in district hospitals".

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

Expenditure per patient day equivalent (PDE) in district hospitals

The actual Rand expenditure was almost exactly what was targeted (only a 0.7 per cent difference) but because the PDEs were 15 per cent higher than expected (for reasons explained above in the district hospital PDE indicator) the net mathematical effect was to lower the apparent expenditure per PDE in district hospitals by close to 15 per cent.

3) Improve the quality of health services

The good performance seen on the indicators that pertain to user complaints, assessment of facilities against core standards and patient satisfaction rates demonstrate the Department's on-going commitment to delivering a client-centred quality health service at this level of care.

District hospitals with mortality and morbidity meetings every month

This indicator records only the number of district hospitals that had a mortality and morbidity meeting every month for 12 months of the year. Although, on average, twenty five out of the thirty four district hospitals (i.e. 74 per cent) had a meeting in any given month, only eleven managed to sustain the performance of holding a meeting every single month.

The performance per district is as follows: Cape Winelands: two of four hospitals, Central Karoo: none of four hospitals, Cape Town Metro: three of eight hospitals, Eden: three of six hospitals, Overberg: one of four hospitals and West Coast: two of seven hospitals.

Number of district hospitals assessed for compliance against the core standards

The Department of Health assessed twenty four hospitals when it had planned to assess only two. There were two main reasons for this. Firstly, the tool was still being finalised by the National Department of Health and training still had to be done in the year under discussion. Secondly, the original target had been set on the assumption that the assessments would be conducted using internal (Provincial Department of Health) capacity. However, Health Systems Trust (a NPO whose mandate is to provide health systems support) was contracted by the National Department of Health to provide country-wide assistance with these assessments. Their external support enabled the Western Cape Department to exceed the original target.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2011/12 ANNUAL PERFORMANCE PLAN

Table 2.2.5: Performance against targets from the 2011/12 Annual Performance Plan for District Hospital Services

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
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	2 464	2 482	2 477	2 592	The Department views variances of less than 5% to be within an acceptable range from the target.
			2) Caesarean section rate in district hospitals	21.9%	23.3%	23.7%	21.5%	3 district hospitals (out of 26 that conducted caesarean sections) had very high caesarean section rates and pulled the provincial average above the target rate. See further detail in the narrative above.
			Numerator:	6 587	6 761	6 980	6 994	
			Denominator:	30 078	29 019	29 486	32 529	
			3) Total separations in district hospitals	238 085	237 292	246 329	240 620	The Department views variances of less than 5% to be within an acceptable range from the target.
			4) Patient day equivalents [PDE] in district hospitals	986 481	999 260	1 182 929	1 028 547	A change in the definition for OPD total headcount resulted in this over performance. See further detail in the narrative above.
			5) OPD total headcounts in district hospitals	504 673	565 801	921 914	510 150	A change in the definition for OPD total headcount that was not taken into account when the target was set resulted in this over performance. See further detail in the narrative above.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
			6) Average length of stay in district hospitals	3.0 days	2.9 days	3.1 days	2.9 days	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	705 098	698 661	766 202[11]	707 423	
			Denominator:	238 085	237 292	246 329	240 620	
			7) Bed utilisation rate (based on usable beds) in district hospitals	78.4%	77.1%	84.7%	79%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	705 098	698 661	766 202[12]	707 423	
			Denominator:	899 360	905 959	904 204	895 472	
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 2014/15.	2.1.1 Achieve a district hospital expenditure of R1 650 per PDE by 2014/15 (in 2009/10 rands).	8) Expenditure per patient day equivalent [PDE] in district hospitals[13]	R 1 330	R 1 172	R 1 127	R 1 306	The actual amount spent was within 1% of target but because the denominator was higher than expected (for reasons of technical error explained above) the indicator was lower than expected.
			Numerator:	1 312 166 179	1 156 526 905	1 333 641 092	1 343 488[14]	
			Denominator:	986 481	999 260	1 182 929	1 028 547	

11 The 10% increase in the number of patient days (inpatient days + ½ day patients) due to increases at the Mitchells Plain hub and Eerste River, Karl Bremer and Khayelitsha Hospitals.
12 The 10% increase in the number of patient days (inpatient days + ½ day patients) due to increases at the Mitchells Plain hub and Eerste River, Karl Bremer and Khayelitsha Hospitals.
13 All expenditure figures are expressed in 2009/10 rand values to be comparable with the target.
14 The expenditure in the target was expressed per R'000 whereas the reported information shows the full amount.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
3. Improve the quality of health services.	3.1 Improve the experience of clients utilising district hospital services.	3.1.1 Achieve an 80% client satisfaction rate by 2014/15.	9) Percentage of complaints of users of district hospital services resolved within 25 days	73.3%	68.1%	70.32%	70%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	498	383	436	420	
			Denominator:	679	562	620	600	
			10) Percentage of district hospitals with monthly mortality and morbidity meetings	73.5%	58.8%	32.4%	58.8%	This indicator records only the number of district hospitals that had a M & M meeting in every single month of the year. See further detail in the narrative above.
			Numerator:	25	20	11	20	(The definition was not strictly applied in previous financial years.)
			Denominator:	34	34	34	34	
			11) District hospital patient satisfaction rate	Not required to report	85.6%	84.05%	85%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	-	7 267	6 863	7 225	
			Denominator:	-	8 491	8 165	8 500	
			12) Number of district hospitals assessed for compliance against the 6 priorities of the core standards	Not required to report	Not required to report	24	2	At the time of target setting there was no clear directive from the National Department of Health (NDoH). Health Systems Trust (HST) was contracted by the NDoH to assist provinces with assessments. It was therefore possible to do assessments at many more facilities.

Changes to planned targets

No changes were made to targets during the year.

HIV AND AIDS, STI AND TB (HAST)

Strategic Goals

HIV and AIDS, STIs and TB control (HAST) contribute to the following strategic goal of the Department:

1) Manage the burden of disease.

Strategic Objectives

The strategic objective for HAST is:

- Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15 – 24 years to 8 per cent in 2015.

Performance indicators and targets

1) Manage the burden of disease

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. Early detection and case-holding of TB-infected individuals is paramount.

In general the HAST programme has performed well with most of its indicators but there is a need to enhance prevention efforts if the strategic objective (of an 8 per cent HIV prevalence in 15 – 24 year old females) is to be met by 2015. Such enhancement would likely take the shape of a co-ordinated multi-sectoral, multi-targeted programme of prevention. The new South African National Strategic Plan (2011 - 2016) and the departmental strategic objective 4 working group on HIV and TB will provide direction in this regard.

HIV prevalence in women aged 15 – 24 years

The target for HIV prevalence for 2011/12 was set at a level that was unrealistic relative to the 2010/11 baseline. The measured prevalence of HIV in 15 – 24 year old women in 2010/11 was 14.9 per cent. A target of 10 per cent for 2011/12 thus implied a 49 per cent reduction in HIV prevalence in one year. Prevalence by public health definition includes all new cases as well as existing cases.

It is difficult to lower this indicator rapidly because it incorporates ten different ages within a single 10-year age range and, every successive year, only one of those ten ages leaves the age range (women who are 24 going on 25), to be replaced by 14 going-on-15 year old women. Assuming no deaths (and no massive influx of HIV-negative women of this age), the HIV prevalence in the youngest age-group is the only mechanism whereby the average for the entire age-range can be lowered, since the HIV prevalence of women in each of the other age-groups is either established or increasing. 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 15 – 24 year age group.

Percentage of HIV TB co infected patients placed on ART

This is an unreliable indicator. It is meant to measure whether those HIV-infected patients who have TB and qualify for ART are actually receiving ART. The problem lies in determining which TB patients qualify for ART. The recommended initiation criterion in 2011/12 was all TB clients with a CD4 count less than 350. However, the system of tallying on the TB register (which records the information from which this indicator is derived) precludes differentiating between those with a CD4 count less than 350 who are "already on ART" and those with a CD4 count less than 350 who "are not yet on ART".

It is impossible thus to determine true need (true denominator) from the existing monitoring system, so the indicator does not provide any value. Note that this will change in 2012/13 since it has now been recommended that all TB patients (regardless of CD4 count) be initiated on ART. The need will now become a simple count of all HIV infected TB patients who are not yet on ART, and CD4 count need not enter the determination thereof.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2011/12 ANNUAL PERFORMANCE PLAN

Table 2.2.6: Performance against targets from the 2011/12 Annual Performance Plan for HIV and AIDS, STIs and TB Control

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
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	12.4%	13.9%	12.7%	10%	An ambitious target was set as the HIV/AIDS programme focusing on Women's Health was seen as a priority.
			Numerator:	545	492	516	450	
			Denominator:	4 405	3 527	4 058	4 500	
			2) Total number of patients (children and adults) on ART	75 002	96 284	115 087	116 345	The Department views variances of less than 5% to be within an acceptable range from the target.
			3) Male condom distribution rate	38.8 (per male 15 years and older)	44.2 (per male 15 years and older)	49.6 (per male 15 years and older)	52	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	74 081 286	89 376 081	102 346 532	102 564 800	
			Denominator:	1 909 053	2 021 542	2 065 191	2 015 000	
			4) New smear positive PTB defaulter rate	8.2%	7.0%	6.8%	6.5%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	1 322	1 103	1 058	1 034	
			Denominator:	16 194	15 761	15 569	15 915	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
			5) HCT testing rate[15]	96.7%	97.4%	99.2%	95%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	397 704	747 139	904 699	774 501	
			Denominator:	411 411	767 174	912 155	815 265	
			6) Percentage of HIV-TB co-infected patients placed on ART	40.9%	46.4%	74.0%	51.7%	This indicator is unreliable due to a technical reason. Further detail is provided in the narrative above.
			Numerator:	6 948	7 952	10 087	9 357	
			Denominator:	16 950	17 138	13 626	17 995	
			7) New smear positive PTB cure rate	79.4%	80.5%	81.7%	80.5%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	12 853	12 689	12 722	12 812	
			Denominator:	16 194	15 761	15 569	15 915	
			8) PTB two month smear conversion rate	72.1%	75.6%	74.5%	75%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	11 263	11 683	11 100	11 936	
			Denominator:	15 620	15 458	14 894	15 915	

Changes to planned targets

No changes were made to targets during the year.

[15] In previous years the HIV testing rate excluding antenatal clients were reported.

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

Strategic Goals

Maternal, Child and Women's Health and Nutrition (MCWH & N) contribute to the following strategic goal of the Department:

1) Manage the burden of disease.

Strategic Objectives

The strategic objectives for MCWH & N are:

- 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.

Performance indicators and targets

1) Manage the burden of disease

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 groups.

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.

A large number of the performance indicators for this section deviate from the acceptable range, and each one has a detailed accompanying explanation in the narrative below with an overview that might serve to provide a broader context to these deviations.

Mortality rates

The Department tracks, on an annual basis under five mortality rate, in-facility infant mortality rate, in-facility under five mortality rate and facility maternal mortality rate. For a number of reasons, mortality is difficult to track with 100 per cent accuracy.

The number of deaths in a given year is a very small proportion of the living population in that year (approximately one per cent of the total population). This means that small fluctuations in the absolute number of deaths can result in large changes in the estimated rates. In addition, not all deaths occur in medical institutions, so all deaths are not included, per definition, in in-facility mortality rates. Mortality is best viewed as a longer-term indicator, where the goal is a clear downward trend, rather than a year-on-year indicator which is too sensitive to fluctuations in data. Some time is required in order to retrospectively attend to the quality of death data.

The strategic objective target was to reduce under five mortality to below 30 per 1 000 live births by 2015 but this target was more than likely set based on an earlier model and/or earlier mortality estimates. So, although the Department has achieved an estimated rate below the target (26.5 deaths under five per 1 000 live births compared to a target of 36.6) it might be because the previous target was set on limited data and attempted to project too far ahead.

The strategic objective target for 2015 should, accordingly, simply be set at a more ambitious (lower) level. By way of comparison, under five death rates for South Africa as a whole are estimated to be 48.8 per 1 000 live births, while in Australia, the United Kingdom and the United States of America the respective rates are: 4.6 per 1 000, 5.2 per 1 000 and 7.1 per 1 000 live births.

A similar logic applies to maternal mortality rates. Revised and updated mortality data has resulted in revised estimates of the rate and there is no reason why the target for 2015 should not change to an equally ambitious one.

Under-5 mortality rate

True under five mortality rate refers to all deaths in children under five across the Province in a year, expressed as a rate per 1 000 live births in the Province. This definition implies that it will almost always be an estimate since it is not believed that death registration systems currently capture every single death under five.

There are different sources for these estimates; the two which the Department of Health choose to use are the Medical Research Council of South Africa (MRC) estimates of mortality and the ASSA2008 model of mortality. The advantage of the MRC estimates are that they reflect actual provincial data (although probably with about 90 per cent coverage of all deaths) while the disadvantage is that they are only published every three years. The advantage of the ASSA2008 model is that it produces a rate for every year but the disadvantage is that it is model based and thus dependent on other data sources (one of which is the MRC report).

2010/11's rate (and thus 2011/12's target) was not based on the ASSA2008 model which might explain the under-ambitious target relative to the current estimate.

Facility infant mortality rate (under 1 year)

As noted above, mortality estimates (and hence targets) are technically challenging data to prepare. There has been a public health specialist vacancy in the Division: District Health Services for the last two years. The position has now been filled and it is expected that target setting and measurements of mortality data should improve in the future.

Facility child mortality rate (under 5 year)

As noted above, mortality estimates (and hence targets), are technically challenging data to prepare. There has been a public health specialist vacancy in the division over the last two years. The result has been inaccuracies in target setting for the last two years. The position has now been filled and it is expected that target setting and measurements in these data should improve in the future.

Facility maternal mortality rate (annual)

The globally understood definition of maternal mortality rate refers to a woman's death at any stage while pregnant or within six weeks of termination of the pregnancy. By contrast, this provincial indicator measures only deaths as recorded in birthing units (therefore operationally excluding any deaths in the earlier stages of pregnancy or in the six week post-partum period).

Previous targets had been set based on the global understanding of maternal mortality rate and had used measurements from the annual "Saving mothers" report and were thus considerably higher. The maternal mortality rate for this year's "Saving mothers" report is 62.4 per 100 000, a good reduction from the target of 72.

It is believed that improved coverage of Essential Steps in the Management of Obstetric Emergencies (ESMOE) training led to improvements in the management of post-partum haemorrhage and gestational proteinuric hypertension, both of which are common causes of maternal mortality. Ambulance services have also improved their inter-facility transfer performance, possibly contributing further to the reduction in deaths.

Immunisation denominator figures

There are technical reasons to believe that the number of children in the Province under one (a figure used as denominator for all the immunisation indicators) is an overestimate by around six per cent. If this is so, it has the automatic effect of making all immunisation performances appear to be about six per cent lower than what they actually are. It is difficult to confirm this suspicion other than to wait for the results of the Census 2011 to be made public, which will hopefully happen towards the end of 2012.

Immunisation coverage under 1 year

Although the performance was within the range deemed acceptable, the impact of the denominator that is possibly inflated by six per cent should be borne in mind when considering performance in any of the immunisation variables.

Notwithstanding the possibility that the denominator is inflated, the indicator "Fully immunised" is different from the other immunisation indicators in that it is a retrospective measure. That is, all the other immunisation indicators record the real-time dispensing of the appropriate vaccine while this one records whether the road-to-health chart shows a record of all vaccines under one being given.

As such, any stock-out at any stage during the year will impact on this indicator and there were at least two separate recorded stock-out events. Another factor was that midway through the year the definition of fully immunised changed to include the two new vaccines, pneumococcal conjugate vaccine (PVC) and rotavirus (RV). This had the effect of confusing staff and having two different recording sheets in circulation on the primary health care platform at the same time.

Vitamin A coverage (12 – 59 months)

This intervention is routinely targeted at children between one year and five years of age. Historical trends (with corroboration from immunisation data) show a steady drop off in routine attendance to clinics as children get older. Mothers know to bring children for their first few immunisations (up to say, nine months) but, for various reasons including cost of attendance, cost-benefit of leaving employment for a day, possible migratory lifestyle and others, children over one tend not to be brought to the facility for routine visits, but only when acutely ill.

Alternative strategies based on health promotion communication and outreach to communities might be necessary to achieve the desired performance in this indicator.

Pneumococcal (PVC) 3rd dose coverage under 1 year

The denominator issues raised above in "immunisation coverage under 1 year" refer here as well. That notwithstanding, this vaccine is given at nine months and it is a recognised historical reality that immunisation uptake falls off by about ten per cent after the early (10 to 14 weeks) immunisations.

Rotavirus (RV) 2nd dose coverage under 1 year

The denominator issues raised above in "immunisation coverage under 1 year" refer here as well. There were also vaccine stock outs between November 2011 and January 2012. This was a problem on a national, not just a provincial, level and the National Department of Health is in the process of re-structuring its agreements with the vaccine providers.

Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks

The performance is better than expected, indicating some measure of success with the implementation of the PMTCT programme.

It should be noted however that it appears as if not all HIV-exposed children are receiving PCR tests at six weeks. For example, the 1.9 per cent transmission rate was obtained from about 12 000 PCR samples but it is believed that the number of infants annually exposed to HIV in the Province is closer to 16 000. The true rate of transmission of HIV from mother-to-child will only become evident once the number of PCR tests done at six weeks equals the number of HIV-exposed infants.

Diarrhoea incidence under 5 years

The performance on this indicator in the previous year (2010/11 – drawn from routine data) was about 47 000 incident cases, so it is not clear why the target was set higher than this (at 55 467).

The 15 per cent under target achieved (although a good thing in that it reflects less diarrhoea than expected) appears to be simply a function of an erroneous target. The actual number of incident cases in 2011/12 was virtually identical to 2010/11 but could be interpreted as a slight success in the face of an increasing under five population.

It is likely that in time the benefits of comprehensive rotavirus vaccine coverage might impact positively on this indicator.

It should be noted that diarrhoea incidence follows a seasonal pattern, peaking in summer.

Demand and uptake for maternal and woman's health

Cervical screening, antenatal booking and use of contraception all have in common the fact that they rely on voluntary uptake by the women concerned. Although there might be issues relating to access to the service and the distribution and coverage of contraceptive services, the real key here is to generate sufficient demand amongst affected women. If targets are to be achieved with these indicators, there is a need for health promotion on a commensurate scale, informing women of the benefits of these interventions and encouraging them to take up the service. With regard to vitamin A provision, a similar line of argument can be applied for mothers of young children.

Cervical cancer screening coverage

The target of 134 414 screenings was set in error. This is evident when considering the previous year's performance for this indicator which was 82 125. The Department achieved 83 235 screenings which is a marginal improvement on the previous year's performance.

Analogous to the problem experienced with contraception distribution, an unknown number of women receive cervical screenings in private medical institutions and in clinics at their place of work, and these do not contribute to this provincial total, despite all insured and working women in the Province contributing to the denominator.

Antenatal visits before 20 weeks

The underperformance for this indicator locates to the Metro, with rural districts achieving a combined performance of 67 per cent while the Metro district achieves in the low 50's. Many factors are likely to contribute to this. One is that the Metro, despite its population density (with 68 per cent of all provincial pregnancies), has relatively less booking sites per pregnant women than the rural areas.

The rural districts saw 29 804 bookings at 234 booking sites, at an average of 118 women per booking site over the year. By contrast the Metro saw 62 750 bookings at 54 booking sites, at an average of 1 162 bookings per site. This relative busyness might represent an access problem for pregnant women.

Other considerations include the dual authority of management in the Metro, with City of Cape Town performing bookings but not deliveries and thus needing to refer women between authorities during their pregnancy. In the interim there is a need for more Basic antenatal care (BANC) services to be provided at clinic level in the Metro. It is felt likely that this contributes to some loss of clients to the health system. It is also believed that health promotion efforts, encouraging women to book early, could be improved within certain areas of the Metro.

Couple year protection rate (annual)

This indicator uses as its denominator the total number of women of reproductive age in the Province. This would include women covered by private medical insurance (about 20 per cent of the total) as well as woman who do not have medical insurance but receive contraception from clinics at their place of work. Technically, both these groups should be excluded from the denominator since they do not access public health services for their contraceptive needs.

Furthermore, there is a proportion (unknown) of women who do utilise public health services for health reasons other than contraceptive ones, but choose to purchase contraception (e.g. the oral contraceptive pill) from private providers like chemists. All of which is to say that the reported figure is probably an underestimate of the state of female contraceptive cover in the Province.

Another issue is that the couple year protection rate is calculated as the weighted sum of different contraceptive strategies, and not all of them are equally weighted. For instance, the intra-uterine contraceptive devices (IUCD) and male and female sterilisation are heavily weighted in the calculation of the indicator but significantly under-promoted in the Province. There remains room for improvement in the measurement, promotion and distribution of contraceptive interventions in the Province.

Table 2.2.7: Performance against targets from the 2011/12 Annual Performance Plan for Maternal, Child and Women's Health (MCWH) and Nutrition

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
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	38.6	36.6	26.5	35	Over-performance was due to a technical reason related to a change in the data source. Further narrative in the text above the table.
			2) Immunisation coverage under 1 year	100.2%	85.9%	88.2%	95%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	98 622	89 508	93 820	101 092	However, concerns about the denominator have been raised in the text above the table.
			Denominator:	98 403	104 175	106 413	106 413	
			3) Vitamin A coverage 12 – 59 months[16]	37%	30.9%	36.0%	54%	The target of 54 % was based on the outreach/campaigns that was done but that is not included in the routine data as per the NDoH policy framework. Also note that in past years where campaigns was held certain districts managed to achieve well over 50%.
			Numerator:	307 038	261 714	311 397	435 901	
			Denominator:	827 938	846 080	864 222	807 224	
			4) Pneumococcal vaccine (PCV) 3rd dose coverage[17]	Not required to report	67.8%	83.1%	95%	The vaccine was implemented two years ago and it is expected that uptake will increase over time hence the incremental target. Measles is also highly infectious and the recommendation from national and international subject experts is, to be effective, you should achieve performance of at least 95 %.
			Numerator:	-	70 629	88 468	101 092	
			Denominator:	-	104 175	106 413	106 413	

[16] In previous reports the Vitamin A coverage under 1 year was reported. The actual performance against this indicator for 2010/11 was 77.2% (80 411 / 104 175).
[17] In previous reports the PCV 1st dose coverage was reported. The actual performance against this indicator for 2010/11 was 83.2% (86 663 / 104 175).

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
								It is then logical to set the vaccine targets at 95% since the target group should receive their injections with their measles injection.
			5) Rotavirus (RV) 2nd dose coverage[18]	Not required to report	60.3%	82.3%	95%	A combination of concerns about the denominator and at least two stock-outs during the financial year. See further narrative.
			Numerator:	-	62 803	87 574	101 092	
			Denominator:	-	104 175	106 413	106 413	
			6) Measles 1st dose under 1 year coverage	102.8%	89.2%	91.19%	95%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	101 154	92 944	97039	101 092	But the previously mentioned denominator issue pertains here too.
			Denominator:	98 403	104 175	106 413	106 413	
			7) Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	3.6%	3.2%	1.9%	3%	The PMTCT program is performing better than projected but there are concerns about complete coverage of the intervention. See further narrative.
			Numerator:	404	388	230	420	
			Denominator:	11 223	12 149	11 836	14 000	
			8) Facility infant mortality (under 1) rate	10.3 per 1 000 live births	11.6 per 1 000 live births	11.5 per 1 000 live births	16.2 per 1 000 live births	Target not aligned with previous year's performance. See narrative for further detail.
			Numerator:	952	1 077	1 044	1 587	
			Denominator:	92 861	92 594	90 689	98 799	

[18] In previous reports the RV 1st dose coverage was reported. The actual performance against this indicator for 2010/11 was 74.5% (77 655 / 104 175).

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
			9) Facility child (under 5) mortality rate	11.2 per 1 000 live births	13.3 per 1 000 live births	13.2 per 1 000 live births	23.5 per 1 000 live births	Target not aligned with previous year's performance. See narrative for further explanation.
			Numerator:	1 043	1 235	1 200	12 384	
			Denominator:	92 861	92 594	90 689	527 215	
			10) Diarrhoea incidence under 5 years	14.8%	9.08%	9.04%	10.3%	Lack of proper sanitation, water and a declining economic climate resulted in the department expecting more incidence of diarrhoea therefore the 12.6% deviation of performance versus target. The successful implementation of the "diarrhoea season" interventions, which was a package of interventions delivered across the primary health care platform, also contributed towards the better than expected performance.
			Numerator:	73 389	47 887	48 701	55 467	
			Denominator:	495 991	527 215	538 524	538 524	
			11) Pneumonia incidence under 5 years	8.6%	6.6%	6.9%	7.5%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	42 614	34 582	37 140	40 389	
			Denominator:	495 991	527 215	538 524	538 524	
	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.	12) Facility maternal mortality rate	102.9 per 100 000	44.3 per 100 000	28.67 per 100 000	72 per 100 000	Data challenges resulted in the erratic target setting since 2009/10 to 2011/12.The department has identified a more robust and reliable data source for facility maternal deaths which are the confidential maternity report.
			Numerator:	100	41	26	71	
			Denominator:	97 185	92 594	90 689	98 185	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
			13) Cervical cancer screening coverage[19]	57.7%	63.7%	63.2%	102.0%	The target of 134 414 was an error that was only detected after the APP had been printed. A working target similar to the previous year's performance was set for internal review.
			Numerator:	70 345	82 125	83 235	134 414	
			Denominator:	121 812	128 998	131 779	131 779	
			14) Delivery rate for women under 18 years	7.3%	7.0%	6.8%	6.7%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	7 060	6 484	6 320	6 566	
			Denominator:	96 907	93 192	93 199	98 000	
			15) Antenatal visits before 20 weeks rate	46.4%	52.7%	56.2%	68%	The Department prioritised women's health specifically maternal health and therefore decided to have the incremental target of 68%. The reason for the target was further justified since the explanation for under performance in previous years was identified. Poor performance was contributed to CoCT LG facilities which did not provide the service in all their health facilities being identified as the barrier. The Department then embarked on and continues discussion with CoCT to roll out antenatal services to all their health facilities.
			Numerator:	48 351	54 520	54 488	85 782	
			Denominator:	104 256	103 447	96 959	126 150	

[19] The definition of this indicator changed to include only 10% of women aged 30 years and older since women in this age category should be screened once every 10 years. The historical data was updated according to the new definition.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
			16) Couple year protection rate	40.7%	40.6%	42.5%	60%	Very ambitious target was set on the assumption that the Department will be able to rapidly expand training of health workers in reproductive health services especially IUCD. Unfortunately the training centre at Karl Bremer Hospital has since been devolved and the Department is in the process to revitalise this training unit. The target for 2012/13 year was also brought down to 43 %
			Numerator:	550 014	560 684	599 310	865 197	
			Denominator:	1 350 892	1 380 714	1 410 535	1 441 995	

Changes to planned targets

No changes were made to targets during the year. (Changes are only allowed to targets during the course of the year if there are major resource shifts or policy changes.)

DISEASE PREVENTION AND CONTROL

Strategic Goals

Disease Prevention and Control contribute to the following strategic goal of the Department:

1) Manage the burden of disease.

Strategic Objectives

The strategic objectives for Disease Prevention and Control are:

- Ensure that all districts have plans to deal with outbreaks and epidemics.
- Increase cataract surgery rate.

Performance indicators and targets

1) Manage the burden of disease

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.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2011/12 ANNUAL PERFORMANCE PLAN

Table 2.2.8: Performance against targets from the 2011/12 Annual Performance Plan for Disease Prevention and Control

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Manage the burden of disease.	1.1 Preparation for the dealing with epidemics and disasters.	1.1.1 Ensure that all districts have plans to deal with outbreaks and epidemics.	1) Malaria fatality rate (annual)	0%	1.4%	1.9%	0%	Because the 'target' was zero, any fatality will automatically result in a minimum deviation of 100% from target. Note that it is difficult to interpret health system performance or the effectiveness of prevention strategies from this indicator since malaria in the Western Cape is invariably imported (i.e. the disease is contracted elsewhere, in high risk areas, and is then diagnosed in the Western Cape, sometimes at a late stage.)
			Numerator:	0	1	1	0	
			Denominator:	62	72	54	0	
			2) Cholera fatality rate (annual)	0%	0%	0%	0%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	0	0	0	0	
			Denominator:	1	0	0	0	
	1.2 Chronic disease management.	1.2.1 Increase cataract surgery rate.	3) Cataract surgery rate (annual)	1 132	1 186	1 172	1 200	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	6 022	6 681	6 748	6 907	
			Denominator:	5 321 416	5 634 323	5 755 608	5 755 607	

Changes to planned targets

No changes were made to targets during the year.

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.

The clinical governance and co-ordination of emergency medicine within the Provincial Health Department.

Analysis per sub-programme

Sub-programme 3.1: Emergency Medical Services

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

Emergency medicine is reflected as a separate objective within Sub-programme 3.1: Emergency Medical Services.

Sub-programme 3.2: Planned patient transport (PPT) – HealthNET

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

Strategic Goals

Programme 3 contributes to the following strategic goal of the Department:

1) Manage the burden of disease.

Strategic Objectives

The strategic objectives for Programme 3 (Emergency Medical Services) are:

- To complete the implementation of the Comprehensive Service Plan by operationalising the EMRS 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 response time performance for urban (90 per cent P1 within 15 minutes) and rural (90 per cent P1 within 40 minutes) clients and ensure the shortest time to definitive care by integrated management of pre-hospital and hospital emergency care resources by 2014.
- To meet the patient response, transport and inter hospital transfer needs of the Department in line with the 90:10 CSP model by realigning the configuration of the EMRS Service by 2014.
- To meet the appropriate outpatient transfer needs of patients per year through intra-district and trans-district HealthNET transport system ensuring that patients are managed at the appropriate level of care by 2014.

Performance indicators and targets

1) Manage the burden of disease

Response time performance

The 2011/12 performance cycle saw a renewed and focused pursuit of this key performance measure following the momentum generated in the last quarter of the previous cycle. Committed and aggressive planning on the part of Emergency Medical Services (EMS) operations augmented the re-engineered emergency control centre (ECC) structure and process. The end result was that the priority 1 urban response time targets, as set for 2011/12, were not only met but also exceeded. The highest ever quarterly response time for priority 1 responses in less than 15 minutes in an urban area (73.9 per cent) was achieved during the fourth quarter of 2011/12. This resulted in an annual response time of 69.6 per cent.

A consequence of the improved priority 1 response time performance was a related deterioration in the priority 2 response time performance, for which the proxy measure is: All calls with a response time within 60 minutes. However, this was successfully managed and the trend has been reversed. The focus of the 2012/13 strategy is to determine the acceptable level of performance for priority 2 calls and implement measures to achieve the target response times for all calls within 60 minutes.

The re-engineering that has been done in the emergency control centres has improved performance and this will be further enhanced once the computer-aided dispatch and information communication technology solutions are implemented. The finalisation of the bid for this system has been a lengthy process and had not yet been finalised at year-end while appropriate funding for this project remains a challenge.

EMS resources

The impact that increased resources have made on performance can also be observed during the 2011/12 performance cycle. Overtime funding was prematurely exhausted during 2011/12 as a result of the aggressive resourcing strategy adopted by EMS operational management to improve response times and is reflected in the performance of the second and third quarters when no overtime was worked. The Department subsequently made additional overtime funding available for the latter part of 2011/12. It is recognised that dependency on overtime is not sustainable and a concerted effort is being made to address the gap between existing and target staffing levels.

Outpatient transport needs

The upward trend in planned patient transport (PPT) demand has been consistently demonstrated through all four quarters. This can be regarded as a measure of the degree to which the specialised health services are accessible to patients in the more remote parts of this Province. It is evident that future EMS strategy must include a thorough and far more detailed analysis of the HealthNET service. One of the barriers to this process has been the lack of reliable data tools (ICT system). To this end, the existing online booking system within HealthNET is being assessed for the provision of reliable data to better manage the service.

Table 2.2.9: Performance against targets from the 2011/12 Annual Performance Plan for the EMS programme

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Manage the burden of disease.	1.1 Fully implement the Comprehensive Service Plan model for EMS by 2014.	1.1.1 To complete the implementation of the Comprehensive Service Plan by operationalising the EMRS 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.	1) Rostered ambulances per 10 000 people[20]	0.47	0.23	0.25	0.22	2011/12 target setting was based on full-time staff numbers. Overtime carried through from the FIFA Soccer World Cup, deployed to fund hours worked, resulted in an increase in the number of hours worked and operational ambulance availability. The rostered ambulance numerator is a calculated number based on the hours worked by operational crew and provides a good indicator of available hourly capacity.
			Numerator:	251	132	142	126	
			Denominator:	534	563	576	575	
			2) Total number of EMS emergency cases	461 940	446 566	471 652	429 000	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely. The increase in workload is a cause for concern and will be further analysed and monitored.

[20] During the period from 2007/08 to 2009/10, the number of ambulances in the fleet was used for this indicator. From 2010/11 onwards, the number of rostered ambulances is used i.e. the average number of ambulances available per hour.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance 2009/10	Actual performance 2010/11	Actual performance 2011/12	2011/12 APP target	Reasons for variance
	1.2 Provide roadside to bedside definitive emergency care within defined emergency time frames within and across geographic and clinical service platforms.	1.2.1 To meet the response time performance for urban (90% P1 within 15 minutes) 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.	3) Percentage of urban Priority 1 responses within 15 minutes	41.3%	52.6%	69.6%	65%	Variances between 5% and 10% are deemed to be within an acceptable range from the target by the Department but will be monitored closely.
			Numerator:	39 320	59 276	76 129	64 100	The almost 70% achievement is significant in the history of the service.
			Denominator:	95 231	112 773	109 332	98 600	
			4) Percentage of rural Priority 1 responses within 40 minutes	79.2%	84.6%	88.2%	80%	The rural P1 performance is very close to the national 90% target probably because numbers are very low.
			Numerator:	7 050	8 646	14 419	6 860	The Air Mercy Service plays an important role in maintaining rural performance.
			Denominator:	8 907	10 218	16 357	8 580	
			5) All calls with a response time within 60 minutes	78.5%	70.9%	77.1%	80%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	325 121	367 948	401 046	343 200	This measure is a proxy for P2 response performance which is 80% of ambulance work. Future research must include an analysis of response time relative to patient outcome for various triage categories.
			Denominator:	414 154	519 228	520 131	429 000	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
	1.3 Manage all patients at the appropriate level of care within the appropriate packages of care.	1.3.1 To meet patient response, transport and inter hospital transfer needs of the Department in line with the 90:10 CSP model by realigning the configuration of EMRS by 2014.	6) Percentage of ambulance patients transferred between facilities[21]	27.5%	21.4%	27.2%	30%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely. This indicator is perhaps more a function of health institutional capacity to resolve patient contacts. The decreasing provincial trend is encouraging. 40% of ambulance work in the City of Cape Town is generated by health institutions (clinics, hospitals) the other 60% being primary responses to the public.
			Numerator:	127 033	132 345	128 419	128 700	
			Denominator:	461 940	619 090	471 652	429 000	
	1.4 Efficiently and effectively manage chronic diseases.	1.4.1 To meet the appropriate outpatient transfer needs per year through the intra district and trans district HealthNET transport system ensuring that patients are managed at the appropriate level of care by 2014.	7) Number of outpatients transferred by HealthNET to regional and central hospitals	113 830	79 685	106 608	86 250	Target setting and the need for definition clarification is illustrated in this performance measure. It is clear that trends observed in EMS OPD services will assume far greater importance in the strategic planning moving forward. The significant increase from the previous year is a major cause of concern and has multiple plausible explanations that are being addressed within the Department.

Changes to planned targets

No changes were made to targets during the year.

[21] Historical data updated for 2009/10 and 2010/11.

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 (regional) hospitals

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

Sub-programme 4.2: Tuberculosis hospitals

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

Sub-programme 4.3: Psychiatric hospitals

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

Sub-programme 4.4: Rehabilitation services

Rendering of 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 for complicated dental patients and provide a platform for training and research.

SUB-PROGRAMME 4.1: GENERAL (REGIONAL) HOSPITALS

Sub-programme 4.1 funded regional hospital services in New Somerset and Mowbray Maternity Hospitals in the Cape Town Metro District and Paarl, Worcester and George Hospitals in the rural districts. The reconfiguration and strengthening of these hospitals, particularly in the rural districts, continued as they focused on the provision of general specialist services with continued outreach and support to district hospitals.

Since 1 April 2008 the level 2 beds in the central hospitals have been funded from sub-programme 4.1. This differentiation of services within the central hospitals proved difficult to implement and monitor and therefore from 1 April 2011/12, funding for the level 2 beds in the central hospitals reverted back to Programme 5.

The reporting of performance information for general specialist services in central hospitals was aligned with the allocation of funding and was reported in sub-programme 4.1 for the period 2008/09 to 2010/11. From 1 April 2011, in line with the funding shift, the performance information for these services in central hospitals was reported in Programme 5. Cognisance must be taken of these shifts when the data trends are analysed.

Heads of general specialist services have been appointed to facilitate the process of reconfiguring and strengthening regional hospital services and improving clinical governance. In the five geographic service areas (GSAs); i.e. Metro West, Metro East, Winelands and Overberg, Central Karoo and Eden, and West Coast; structures have been created to enable better service co-ordination and communication between institutions and across levels of care.

The focus areas for the regional hospitals during 2011/12 were:

1) Service transformation
2) Acute hospital services
3) Ambulatory care
4) Infectious disease management
5) De-hospitalised care

The priorities for 2011/12 were addressed in an integrated approach to service delivery across the health platform.

Strategic Goals

Programme 4 contributes to the following strategic goals of the Department:

1) Manage the burden of disease.
2) Ensure sustainable income to provide the required health services according to the needs.
3) Ensure and maintain organisational strategic management capacity and synergy.
4) Quality of health care services.

Strategic Objectives

The strategic objectives for general (regional) hospitals are:

- Ensure access to regional hospitals services by providing 1 340 regional hospital beds by 2014.
- Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies at a target of 35 per cent by 2014.
- Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R2 100 per PDE by 2014. (Constant 2009/10 rand).
- Efficiently manage the allocated resources of regional hospitals to achieve a target bed utilisation rate of 85 per cent and an average length of stay of 4 days by 2014.
- Implement quality assurance measures to minimise patients risk in regional hospitals by monthly mortality and morbidity meetings by 2014.

1) Manage the burden of disease

Ensure access to general specialist hospital services

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.

An additional thirteen day surgery beds opened at Paarl Hospital in August 2011, increasing the total beds to 1 355 for regional hospitals. The set target of 1 340 beds was reflected in the Annual Performance Plan (APP) as the opening of the day surgery beds were still in planning phase. Four family medicine beds were commissioned at Paarl Hospital during March 2012, but the opening of the family medicine ward beds will only be reflected in the 2012/13 Annual Report.

Two (2) additional new theatres were commissioned at Paarl Hospital during August 2011, increasing the surgery capacity. Cataract surgery was started and 274 cataract operations were performed from August 2011 to March 2012. Ear, nose and throat outreach services from Tygerberg Hospital commenced during November 2011.

A successful partnership between GVI Oncology, George Hospital and Groote Schuur Hospital provided radiotherapy to cancer patients in George ensuring that patients did not have to travel to Cape Town for treatment.

The day surgery capacity was improved at George Hospital with appropriate equipment and anaesthetists to run the day theatres five days per week. Ear, nose and throat (ENT) services in George Hospital were expanded with an additional outpatient department (OPD) clinic and a formal ENT operating list.

OPD clinics have been identified per level of care and work in this area remains on-going. OPD follow-up visits were closely monitored and in line with the APP target. The reduction in OPD numbers in regional hospitals were in line with the service transformation strategy. The shifting of a thousand (1 000) stable ARV patients at Worcester Hospital to the district health services (which started in December 2010) was concluded during the financial year. An additional eight hundred (800) stable chronic patients were shifted from the medicine OPD.

The high burden of malnutrition (especially kwashiorkor) impacted on bed availability at Worcester Hospital. An agreement reached between the hospital and a local non-profit organisation (NPO) ensured the transfer of these patients for further nursing care at the local NPO. The added benefit was the follow-up of these cases by the NPO once children were discharged, reducing frequent readmission for malnutrition.

Reduce facility maternal mortality

The increase in the obstetrics population at New Somerset Hospital, which is a referral hospital draining the city bowl area, Hanover Park, south of the N7 including Vanguard MOU, Wesfleur and Vredenburg Hospital, have forced a change in service outputs. The caesarean section rate at New Somerset Hospital is appropriate for the level of service provided as most midwife obstetric unit (MOU) referrals are for obstructed labour and foetal distress, requiring emergency caesarean sections to prevent poor foetal outcomes.

Mowbray Maternity Hospital's caesarean section rate remains high as it is the referral hospital for complicated obstetric cases.

The extension of colposcopy services in George Hospital will in the long run decrease the number of patients with cervical carcinoma who present with late-stage disease. Colposcopy services were rolled out to two district hospitals in the Worcester area, supported by Worcester Hospital.

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

Allocate sufficient funds to ensure the sustained delivery of the full package of quality general specialist hospital services

Budgets were appropriately spent according to the expected deliverables and the sub-programme remained within its allocated budget.

Each institution has been allocated an Approved Post List (APL) which was strictly monitored. Additional funding was allocated to the sub-programme during the Adjustments Estimates.

Focused saving initiatives within the sub-programme contributed towards the saving in Goods and Services, specifically in the areas of blood, laboratories, medicine, medical supplies and agency staff. The significant reduction in agency expenditure over a period has impacted positively as the funding was used towards the creation and filling of permanent posts.

The programme balanced its budget after the application of virements in the final estimates.

3) Ensure and maintain organisational strategic management capacity and synergy

Ensure that management provides sustained support and strategic direction in the delivery of health services

Implementation of phases of the functional business units (FBUs) within regional hospitals included:

- The scope of all clinical and administration FBU's have been changed.
- The relevant cost-centres have been mapped to all the clinical and administration FBUs.
- The relevant costs have been mapped to the relevant cost-centres for all the clinical and administration FBUs.
- Based on the above a budget has been developed for the FBUs.
- Additional FBU objectives have been created on BAS and staff was linked on PERSAL to the new objectives. This exercise was concluded by end March 2012.
- Further implementation of measures to improve the functionality of FBUs will continue during 2012/13.

4) Quality of health care services

Improve the quality of health services

Monthly morbidity and mortality meetings were held in all hospitals.

Resolving complaints within 25 days remained a challenge specifically at Worcester and New Somerset Hospitals. This has been addressed and all complaints are now being discussed at management meetings to ensure that it is resolved within the 25 day period.

The patient satisfaction rate has improved following the comprehensive client satisfaction surveys in all regional hospitals. A greater awareness was created amongst staff to improve the patient experience.

The following areas in the patient satisfaction surveys were highlighted:

- In the access domain, the cost incurred by patients to get to facilities is a challenge.
- In the empathy domain, all hospitals scored reasonably well.
- General satisfaction scored well, however 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 also remain a challenge, especially the toilet cleanliness in the busy emergency centres and outpatient departments, 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.

The National Core Standards (NCS) baseline audits were completed at all general specialist hospitals by December 2011. Quality improvement plans were developed in line with findings and form part of the annual operational plans for all facilities.

Table 2.2.10: Performance against targets from the 2011/12 Annual Performance Plan for general (regional) hospitals

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Manage the burden of disease.	1.1 Ensure access to general specialist hospital services.	1.1.1 Ensure access to regional hospitals services by providing 1 340 regional hospital beds by 2014.	1) Number of regional hospital beds	2 364	2 385	1 355	1 340	Increase of beds in day surgery (general) at Paarl Hospital from 272 to 285 beds (additional 13 beds). Planning was still in process at the time of target setting. Final beds totals are based on the annual average. (At the end of 2010/11 there was 1 346 beds in regional hospitals, excluding level 2 beds in central hospitals.)
			2) Total separations in regional hospitals	185 919	174 307	107 713	111 306	The Department views variances of less than 5% to be within an acceptable range from the target.
			3) Patient day equivalents [PDE] in regional hospitals	1 051 150	1 022 675	556 383	569 019	The Department views variances of less than 5% to be within an acceptable range from the target.
			4) OPD total headcounts in regional hospitals	628 931	580 840	235 530	262 799	The target was in line with the 2010/11 reported figure of 259 653 for the 5 regional hospitals. In 2010/11 the outpatient statistics for service groups was incorrectly calculated by the HIS software. The software incorrectly counted an inpatient seen by a service group staff member as an OPD headcount instead of only an OPD visit to the service group. The calculations on the HIS software has been corrected with effect from 1 April 2011. The correction had an effect on the targets that were already set for the 2011/12 APP.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
	1.2 Reduce facility maternal mortality.	1.2.1 Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies at a target of 35% by 2014.	5) Caesarean section rate for regional hospitals	32.5%	36.4%	38.9%	35%	The caesarean section rate is driven up by Mowbray Maternity and New Somerset Hospitals which make up 65% of deliveries in regional hospitals. Refer to narrative for more detail. Mowbray Maternity Hospital's caesarean section rate remains high as they are the referral hospital for complicated cases. The target has been appropriately adjusted in the 2012/13 APP to 39%.
			Numerator:	8 425	9 339	10 211	9 134	
			Denominator:	25 961	25 689	26 219	26 116	
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 R2 100 per PDE by 2014. [Constant 2009/10 rand].	6) Expenditure per patient day equivalent [PDE] in regional hospitals[22]	R 1 626	R 1 641	R 1 624	R 1 609	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	1 709 636 442	1 724 604 581	903 721 951	915 427 153	
			Denominator:	1 051 150	1 022 675	556 383	569 019	

22 All expenditure figures are expressed in 2009/10 rand values to be comparable with the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1 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 by 2014.	7) Bed utilisation rate (based on usable beds) in regional hospitals	86.1%	84.4%	86%	89%%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	742 740	734 698	425 307	433 538	
			Denominator:	862 860	870 525	494 508	489 100	
			8) Average length of stay in regional hospitals	4.0 days	4.2 days	3.9 days	4 days	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	742 740	734 698	425 307	433 538	
			Denominator:	185 919	174 307	107 713	111 306	
4. Quality of health services.	4.1 Improve the quality of health services.	4.1.1 Implement quality assurance measures to minimise patients risk in regional hospitals by monthly mortality and morbidity meetings by 2014.	9) Percentage of regional hospitals with monthly mortality and morbidity meetings	100%	100%	100%	100%	Target achieved. Note: The general specialist services (level 2) in the three central hospitals were reflected as separate reporting units in 2010/11.
			Numerator:	8	8	5	5	
			Denominator:	8	8	5	5	
			10) Percentage of complaints of users of regional hospitals resolved within 25 days	82.5%	83.0%	81.0%	85%	The Department views variances of less than 5% to be within an acceptable range from the target. A strategy was implemented to discuss all complaints at management meetings.
			Numerator:	552	484	328	510	
			Denominator:	669	583	405	600	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
			11) Regional hospital patient satisfaction rate	Not required to report	74.7%	90.6%	75%	The national core standards created a greater awareness amongst staff focusing on improving the patient experience.
			Numerator:	-	2 484	3 102	2 625	
			Denominator:	-	3 324	3 424	3 500	
			12) Number of regional hospitals assessed for compliance with the 6 priorities of the core standards	Not required to report	Not required to report	5	1	At the time of target setting there was no clear directive from the National Department of Health (NDoH). Health Systems Trust (HST) was contracted by the NDoH to assist provinces with assessments. It was therefore possible to do additional assessments.

Note:

During 2008/09 to 2010/11 the general specialist service (level 2) outputs in central hospitals were reflected in Programme 4.1. As from 1 April 2011 all service activities in central hospitals are reflected in Programme 5.

Changes to planned targets

No changes were made to targets during the year.

SUB-PROGRAMME 4.2: TUBERCULOSIS HOSPITALS

Strategic Objectives

The strategic objectives for tuberculosis hospitals are:

- Ensure access to the full package of TB hospital services by providing 1 284 TB hospital beds by 2014.
- Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R510 per PDE by 2014. (Constant 2009/10 rand.)
- Effectively manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 90 per cent and an average length of stay of 85 days by 2014.
- Implement quality assurance measures to minimise patient risk in TB hospitals by monthly mortality and morbidity meetings by 2014.

Performance indicators and targets

1) Manage the burden of disease

Any appraisal of TB hospital performance should take into account the wider context within which the hospitals find themselves. South Africa is experiencing a country-wide TB epidemic, with a marked resurgence of drug-sensitive and drug-resistant tuberculosis. Both these phenomena are largely being driven by the HIV epidemic and are resulting in changes to the profile of the "TB hospital inpatient".

TB hospitals currently serve either the acutely ill drug-sensitive client who is often HIV-infected; or the new drug resistant client; admitted to be stabilised and, hopefully, to sputum convert or the sick drug resistant patient, who is again, often HIV-infected. The net result of this is an increased demand for TB beds which has resulted in a policy response of decentralisation to manage drug-resistant patients in the community as soon as is clinically feasible.

The decentralisation policy is reflected by the patient day equivalents (PDEs) and patient separations being maintained within targets. However, drug-resistant TB remains a significant challenge to the Department and will continue to pose problems for years to come as the HIV-infected population in the Province stabilises on anti-retroviral treatment. The average length of stay of 73 days hides considerable inter-hospital variation, much of which is due to drug-resistant patients occupying some hospitals to a greater degree than others. The demand for multi-drug resistant (MDR) beds exceeds the supply, and the same applies to extreme drug resistant (XDR) and pre-XDR beds.

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

TB hospitals maintained their services within the allocated budget over the course of the year.

3) Ensure and maintain organisational strategic management capacity and synergy

TB hospital management, although the sub-programme is technically located under Programme 4 (Provincial Hospital Services) in order to align with National Department of Health reporting requirements, was functionally shifted to fall under the management of district directors. This was done in order to maintain greater managerial coherence between the TB primary care service and the TB hospitals.

4) Quality of health services

The poor performance in the morbidity and mortality meetings reflects the broader problem of clinical governance. Clinical practices, admission and discharge criteria that are currently experienced in the TB hospitals need to be standardised across the Province.

Table 2.2.11: Performance against targets from the 2011/12 Annual Performance Plan for TB hospitals

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
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	1 016	1 028	1 033	1 040	The Department views variances of less than 5% to be within an acceptable range from the target.
			2) Total separations in TB hospitals	3 684	4 192	3 979	3 796	The Department views variances of less than 5% to be within an acceptable range from the target.
			3) Patient day equivalents [PDE] in TB hospitals	305 833	302 828	293 815	316 171	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			4) OPD total headcount in TB hospitals[23]	3 208	7 192	8 360	3 308	2010/11 performance data incorrectly included inpatients seen by other service groups (allied health practitioners). The system was corrected (for the 2011/12 target) to exclude these patients – in line with the definition. However the data collection processes on the ground in 2011/12 did not correct themselves from their previous (erroneous) methodology.

[23] Prior to 2010/11 the data collection of service outputs erroneously reported the OPD headcounts for doctors only. 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.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
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 TB hospital services.	2.1.1 Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R510 per PDE by 2014. [Constant 2009/10 rand].	5) Expenditure per patient day equivalent [PDE] in TB hospitals[24]	R 515	R 503	R 539	R 491	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	157 626 336	152 306 954	158 398 146	155 290 227	
			Denominator:	305 828	302 828	293 815	316 171	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1 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 by 2014.	6) Bed utilisation rate (based on usable beds) in TB hospitals	82.2%	80.1%	77.2%	83%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	304 764	300 431	291 028	315 068	
			Denominator:	370 840	375 220	377 086	379 600	
			7) Average length of stay in TB hospitals	82.5 days	71.7 days	73.1 days	83 days	Decanting of patients at Harry Comay due to renovations resulted in a reduced ALOS. It is also affected by a low ALOS at the West Coast Complex.
			Numerator:	304 764	300 431	291 028	315 068	
			Denominator:	3 693	4 192	3 979	3 796	

[24] All expenditure figures are expressed in 2009/10 rand values to be comparable with the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
4. Quality of health services.	4.1 Improve the quality of health services.	4.1.1 Implement quality assurance measures to minimise patient risk in TB hospitals by monthly mortality and morbidity meetings by 2014.	8) Percentage of TB hospitals with monthly mortality and morbidity meetings	66.7%	66.7%	33.3%	67%	As per the definition only hospitals that conducted a meeting for 12 months of the year are counted. DP Marais and Harry Comay managed to achieve this. The West Coast Complex (Malmesbury ID and Sonstraal Hospitals) experienced difficulty in conducting M & M meetings due to under-staffing. Brewelskloof was unable to conduct a meeting in December due to staff on leave.
			Numerator:	4	4	2	4	
			Denominator:	6	6	6	6	
			9) Percentage of complaints of users of TB hospitals resolved within 25 days	72.1%	72.1%	93.0%	75%	Although the relative performance was better than the target, the absolute number of complaints recorded was considerably less than predicted. This could be interpreted as a positive event.
			Numerator:	129	129	40	150	
			Denominator:	179	179	43	200	
			10) TB hospital patient satisfaction rate	Not required to report	83.5%	84.5%	85%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	-	506	361	510	
			Denominator:	-	606	427	600	
			11) Number of TB hospitals assessed for compliance with the 6 priorities of the core standards	Not required to report	Not required to report	6	1	At the time of target setting there was no clear directive from the National Department of Health (NDoH). Health Systems Trust (HST) was contracted by the NDoH to assist provinces with assessments. It was therefore possible to do additional assessments.

Changes to planned targets

No changes were made to targets during the year.

SUB-PROGRAMME 4.3: PSYCHIATRIC HOSPITALS

There are four psychiatric hospitals and two sub-acute facilities in the Cape Town Metro District. These facilities support the integration of mental health services into general care settings in line with the Mental Health Care Act, 17 of 2002, and 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.

The services provided were:

- Intellectual disability services, both acute and chronic, for patients with intellectual disability and mental illness, or severe challenging behaviour at Lentegeur and Alexandra Hospitals.
- Acute psychiatric services at Lentegeur, Stikland and Valkenberg Hospitals including a range of specialised therapeutic programmes in accordance with the Mental Health Care Act, 17 of 2002.
- Forensic psychiatric services including observation services for awaiting trial prisoners at Valkenberg Hospital only and state patient services for people who have been found unfit to stand trial at Valkenberg and Lentegeur Hospitals.
- Support and outreach programmes to all Metro district and regional hospitals with one to two specialist visits per week have been established.
- Integrated assertive community team (ACT) services formed part of the acute services continuum of care and resorted under the senior psychiatrists in these services. The ACT services improved quality of care and treatment adherence.
- Ambulatory services have been strengthened by identifying and incrementally improving the implementation of the full package of specialist ambulatory services, which supports district and regional hospitals.
- The focus was on psychosocial rehabilitation aspects of the service and involvement of the full multi-disciplinary team. This was largely provided in day and outpatient services with the residential programme delivered at the William Slater and New Beginnings sub-acute facilities.

In accordance with the Mental Health Care Act, the Province has a single Mental Health Review Board with five members. The Western Cape was the first province to successfully implement a Mental Health Review Board and has established a benchmark for the country. Other provinces have used the Western Cape model and the Province continues to share best practices with interested parties. The functions of the board relate to protection of the rights of mental health care users and their families and interfacing closely with the Cape High Court in this regard.

Priorities for psychiatric services during 2011/12 were:

- Ensure access to psychiatric hospital services.
- Clinical governance and quality of care.
- Ensure that management provides sustained support and strategic direction in the delivery of health services.
- Allocate sufficient funds to ensure the sustained delivery of the full package of quality psychiatric hospital services.

Strategic Objectives

The strategic objectives for psychiatric hospitals are:

- Ensure access to the full package of psychiatric hospital services by providing 1 528 psychiatric hospital beds by 2014.
- Allocate sufficient funds to ensure the delivery of the full package of psychiatric hospital services at a rate of R850 per PDE by 2014. (Constant 2009/10 rands.)
- Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 90 per cent and an average length of stay of 90 days by 2014.
- Implement quality assurance measures to minimise patients risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014.

Performance indicators and targets

1) Manage the burden of disease

Ensure access to psychiatric hospital services

Psychiatric services continued to ensure a balanced provision for the continuum of care in the acute services, in primary health care and district hospitals, in sub-acute residential and day programmes and supported community residential options for both the mentally ill and the intellectually disabled people who cannot live independently. The total beds in psychiatric facilities are 1 698. The sub-acute beds total 145.

Waiting lists were actively managed between district and psychiatric hospitals. Vulnerable groups, namely children, adolescents and the elderly are now included in a weekly waiting list review. The additional acute beds at Valkenberg Hospital were fully commissioned and remain at full capacity. The opioid detoxification inpatient service at Stikland Hospital has been reviewed to improve efficiency.

A maternal health clinic was started at Stikland Hospital to provide advisory services to the public and private providers as well as follow-up services for high risk pregnant clients. It provides a one stop service for addressing psycho-pharmacological and other clinical management issues. The pre- and post-partum period poses a high risk for the mental health of the mother and this is even higher in mothers suffering from pre-existing mental illness. This dedicated service is a first in the Metro East GSA.

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

Ensure the sustained delivery of the full package of quality psychiatric hospital services

Budgets were appropriately spent according to the expected deliverables.

The Department of National Justice refunded a total of R8 695 596 to the Western Cape for the observation of awaiting trial prisoners at Valkenberg Hospital.

Maintenance programmes and funding were allocated to deal with the most urgent priorities. Four acute wards were renovated at Stikland Hospital, Alexandra Hospital has relocated their outpatient department and Lentegeur Hospital has upgraded various wards.

All hospitals have managed a number of in-house and ad-hoc funded projects which have contributed to significant improvement in the therapeutic environment.

3) Ensure and maintain organisational strategic management capacity and synergy

Ensure that management provides sustained support and strategic direction in the delivery of health services

The implementation of functional business units is at the same level of development as that of the regional hospitals and implementation continued as a mechanism to assist managers and clinicians in decision-making and accountability.

The hospital revitalisation programme at Valkenberg Hospital has been approved by Cabinet and officially communicated at a Media Conference in January 2012 by the MECs of Health and Transport and Public Works.

4) Quality of health services

Improve the quality of health services

The mortality and morbidity meetings in psychiatric hospitals have a multi-disciplinary team approach that includes quality assurance matters such as adverse, 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 hospitals remaining a challenge despite active psycho-social rehabilitation programmes.

A food service audit was performed at Stikland Hospital and the hospital scored a gold star rating of 92 per cent.

Table 2.2.12: Performance against targets from the 2011/12 Annual Performance Plan for specialist psychiatric hospitals

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Manage the burden of disease.	1.1 Ensure access to psychiatric hospital services.	1.1.1 Ensure access to the full package of psychiatric hospital services by providing 1 528 psychiatric hospital beds by 2014.	1) Number of psychiatric hospital beds	1 792	1 742	1 698	1 716	The Department views variances of less than 5% to be within an acceptable range from the target. Lentegeur Hospital reduced beds from 760 to 740 .The target was set prior to bed changes registered. Final beds totals are based on the annual average. (At the end of 2010/11 there was 1 718 beds in psychiatric hospitals.)
			2) Total separations in psychiatric hospitals	5 369	5 690	5 822	6 263	The Department views variances of less than 5% to be within an acceptable range from the target.
			3) Patient day equivalents [PDE] in psychiatric hospitals	595 471	567 123	551 611	573 853	The Department views variances of less than 5% to be within an acceptable range from the target.
			4) OPD total headcounts in psychiatric hospitals	34 521	31 152	26 621	30 440	The target was in line with the 2010/11 reported figure of 31 125. The data prior to April 2011 incorrectly included inpatients seen by service groups (allied health practitioners). The system was corrected for 2011/12 to exclude these patients in line with the definition. This was not taken into account when setting the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
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 psychiatric hospital services.	2.1.1 Allocate sufficient funds to ensure the delivery of the full package of psychiatric hospital services at a rate of R850 per PDE by 2014. [Constant 2009/10 rands).	5) Expenditure per patient day equivalent [PDE] in psychiatric hospitals[25]	R 753	R 815	R 874	R 791	Overspending is mainly attributed to arrear accounts in respect of municipal services.
			Numerator:	448 360 000	462 051 869	482 156 215	454 195 000	
			Denominator:	595 471	567 123	551 611	573 853	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1 Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 90 days by 2014.	6) Bed utilisation rate (based on usable beds) in psychiatric hospitals	89.3%	87.6%	87.6%	89%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	583 871	556 739	542 738	563 706	
			Denominator:	654 080	635 830	619 838	626 340	
			7) Average length of stay in psychiatric hospitals	109 days	98 days	93.2 days	90 days	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	583 871	556 739	542 738	563 706	
			Denominator:	5 369	5 690	5 822	6 263	

[25] All expenditure figures are expressed in 2009/10 rand values to be comparable with the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
4. Quality of health services.	4.1 Improve the quality of health services.	4.1.1 Implement quality assurance measures to minimise patients risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014.	8) Percentage of psychiatric hospitals with monthly mortality and morbidity meetings	25%	50%	75%	100%	Stikland Hospital did not have a meeting in December 2011 as most committee members were on leave. The CEO has addressed this to ensure monthly meetings going forward.
			Numerator:	1	2	3	4	
			Denominator:	4	4	4	4	
			9) Percentage of complaints of users of psychiatric hospitals resolved within 25 days	59.8%	59.8%	68.9%	65%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	52	52	82	59	
			Denominator:	87	87	119	90	
			10) Psychiatric hospital patient satisfaction rate	Not required to report	79.4%	85.4%	80%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	-	467	497	480	
			Denominator:	-	588	582	600	
			11) Number of psychiatric hospitals assessed for compliance with the 6 priorities of the core standards	Not required to report	Not required to report	4	1	At the time of target setting there was no clear directive from the National Department of Health (NDoH). Health Systems Trust (HST) was contracted by the NDoH to assist provinces with assessments. It was therefore possible to do additional assessments.

Changes to planned targets

No changes were made to targets during the year.

SUB-PROGRAMME 4.4: REHABILITATION HOSPITALS

The Western Cape Rehabilitation Centre (WCRC) provided rehabilitation services for people with physical disabilities.

The Orthotic and Prosthetic Centre (OPC) resorts under the management of the WCRC. The increasing prevalence of physical disability in the Western Cape has resulted in an ever-increasing demand for orthotic and prosthetic devices, such as artificial limbs, orthopaedic footwear and spinal braces (amongst others) to facilitate the functional independence of clients.

There is a Western Cape public private partnership for the provision of equipment, facilities management and all associated services at the WCRC and Lentegeur Hospital which is on the same site.

Priorities for rehabilitation services during 2011/12 were:

- Ensured access to specialised rehabilitation services.
- Ensured and maintained organisational strategic management capacity and synergy.
- Allocated sufficient funds to ensure the sustained delivery of the full package of quality rehabilitation hospital services.

Strategic Objectives

The strategic objectives for rehabilitation services are:

- Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014.
- Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R2 300 per PDE by 2014. (Constant R2009/10 rands).
- Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilisation rate of 75 per cent and an average length of stay of 50 days by 2014.
- Implement quality assurance measures to minimise patients risk rehabilitation hospitals by monthly mortality and morbidity meetings by 2014.

Performance indicators and targets

1) Manage the burden of disease

Ensure access to rehabilitation hospital services

Western Cape Rehabilitation Centre (WCRC)

Inter disciplinary services continued at WCRC in line with the Rehabilitation and Disability Management Service Plan. An important part of the services was 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 the district health services to facilitate the development of quality rehabilitation services for persons with physical disabilities.

Funding received from the Health and Welfare Sector Education and Training Authority (HWSETA) was allocated towards training community based peer supporters. Thirty eight (38) disabled learners successfully completed the unit standard: provide optimal care and support to a person with a physical disability. The learners are employed at various branches of the Association for People with Disabilities in Breede Valley, Drakenstein, Oudtshoorn, Tygerberg, Cape Town and Olifantsriver.

The backlog in respect of hearing aids and mobility assistive devices were reduced through additional funding created within the programme's overall savings.

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.

The reduced waiting lists for patients waiting three to six months and six months and longer for orthotic and prosthetic devices continued to be addressed through various strategies to increase productivity, the appointment of additional medical orthotists and prosthetists and the development of clinical guidelines and standard operating procedures for the prescription of orthotic and prosthetic devices.

Planning continued for the relocation of the orthotic and prosthetic services from the Conradie site in Pinelands to a new modern facility on the grounds of the WCRC. An amount of R31 000 000 has been budgeted for the relocation of the OPC. The briefing document will be prepared during the next financial year for the planning phase which will involve the consultant team to commence during 2013.

Challenges at the OPC have been identified, including financial risks. The risks have been evaluated and procurement processes were implemented to minimise further risks in this area.

Management of the Public Private Partnership (PPP) contract

There is a Western Cape public private partnership (PPP) for the provision of hard and soft facilities management at the WCRC and selected soft facilities at the Lentegeur Hospital which is on the same site. The partnership was signed in December 2006 and full service commenced from 1 March 2007 for a period of twelve years.

Services were appropriately rendered by the private party in line with the expected deliverables as specified in the contractual terms.

The annual cost to the Department totalled R46 798 996. The CPI increase was 4.14 per cent.

The total number of helpdesk calls logged to the private party were 4 837 for WCRC and 2 234 for Lentegeur Hospital.

No significant disputes were raised during the reporting period.

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

Ensure the sustained delivery of the full package of quality rehabilitation hospital services

Budgets were appropriately spent according to the expected deliverables and the sub-programme remained within its allocated budget. As mentioned previously, funding received was channelled towards training and addressing backlogs impacting positively on waiting lists.

The monitoring of the PPP continued through the various management structures ensuring best value for money.

3) Ensure and maintain organisational strategic management capacity and synergy

Ensure that management provides sustained support and strategic direction in the delivery of health services

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.

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

4) Quality of health services

Improve the quality of health services

A client satisfaction survey was conducted and the overall rating for the WCRC was positive.

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

Table 2.2.13: Performance against targets from the 2011/12 Annual Performance Plan for rehabilitation services

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Manage the burden of disease.	1.1 Ensure access to rehabilitation services.	1.1.1 Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014.	1) Number of rehabilitation hospital beds	156	156	156	156	Target achieved.
			2) Total separations in rehabilitation hospitals	829	949	859	860	The Department views variances of less than 5% to be within an acceptable range from the target.
			3) Patient day equivalents [PDE] in rehabilitation hospitals	56 801	51 775[26]	45 672	48 762	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			4) OPD total headcounts in rehabilitation hospitals	25 107	30 812	10 980	25 004	The data prior to April 2011 incorrectly included inpatients seen by service groups (allied health/ rehabilitation practitioners). The system was corrected for 2010/11 to exclude these patients in line with the definition. This was not taken into account when the target was set. The Western Cape Rehabilitation Centre OPD headcount now includes OPD headcounts from the Orthotic and Prosthetic Centre.

26 From April 2010 weekend leave and other leave is excluded from the count on Clinicom (Patients discharged over weekends are not counted as suspensions) and this led to a reduction in the number of PDEs.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
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 rehabilitation hospital services by 2014.	2.1.1 Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R2 300 per PDE by 2014. [Constant R2009/10 rands].	5) Expenditure per patient day equivalent [PDE] in rehabilitation hospitals[27]	R 1 945	R 1 310	R 1 854	R 2 281	A proportional 40% of the PPP was added. A saving in the PPP budget was seen due to decommissioning of beds at Lentegeur Hospital, causing a saving in the unitary fee.
			Numerator:	110 461 638	74 412 123	84 681 112	111 246 867	
			Denominator:	56 801	51 775	45 672	48 762	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained and strategic direction in the delivery of health services with well-defined efficiency targets towards improving quality of care.	3.1.1 Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilisation rate of 75% and an average length of stay of 50 days by 2014.	6) Bed utilisation rate (based on usable beds) in rehabilitation hospitals	85%	72.9%	73.8%	70.7%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	48 431	41 505	42 012	40 262	
			Denominator:	56 940	56 940	56 946	56 940	
			7) Average length of stay in rehabilitation hospitals	58.4 days	43.7 days	48.9 days	47 days	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	48 431	41 505	42 012	40 427	
			Denominator:	829	949	859	860	

[27] All expenditure figures are expressed in 2009/10 rand values to be comparable with the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
4. Quality of health services.	4.1 Improve the quality of health services.	4.1.1 Implement quality assurance measures to minimise patients risk in rehabilitation hospitals by monthly mortality and morbidity meetings by 2014.	8) Percentage of rehabilitation hospitals with monthly mortality and morbidity meetings	0%	0%	0%	100%	Previously quarterly meetings took place. There are few deaths and traditionally due to the nature of the hospital, monthly M & M meetings were not seen as appropriate. Monthly meetings started taking place in May 2011. Eleven meetings were held out of twelve.
			Numerator:	0	0	0	1	
			Denominator:	1	1	1	1	
			9) Percentage of complaints of users of rehabilitation hospitals resolved within 25 days	86.7%	86.7%	88%	88%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	13	13	22	14	
			Denominator:	15	15	25	16	
			10) Rehabilitation hospital patient satisfaction rate	Not required to report	95.7%	96.8%	95%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	-	176	152	190	
			Denominator:	-	184	157	200	
			11) Number of rehabilitation hospitals assessed for compliance with the core standards	Not required to report	Not required to report	1	1	Target achieved. At the time of target setting there was no clear directive from the National Department of Health (NDoH). Health Systems Trust (HST) was contracted by the NDoH to assist provinces with assessments.

Changes to planned targets

No changes were made to targets during the year.

SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

Oral health services were provided within clinics, community health centres or district hospitals and dental training hospitals.

The package of care provided at primary health care facilities is in line with the national policy and consists of promotive and primary preventive services as well as basic treatment services. School children and pre-school children were the priority patient groups.

Priorities during 2011/12 were:

- Ensured access to an integrated oral health service and training platform.
- Implementation of the oral health plan.

Strategic Objectives

The strategic objectives for dental training hospitals are:

- Ensure access to an integrated oral health service and training platform by providing for 185 454 patient visits per annum 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.

Performance indicators and targets

1) Manage the burden of disease

Ensure access to dental training hospitals

The targets for oral health visits and theatre cases were overestimated as it was based on manual data collected and not Clinicom data. Clinicom was implemented during 2010 at dental services.

Theatre outputs decreased from the previous year despite additional theatre time provided by Tygerberg Hospital. An anaesthetist post became vacant during the third quarter and this impacted on available theatre capacity.

The students contribute mostly to the service outputs and during periods when the students are on vacation and examination leave, the outputs are reduced. The impact of students on service delivery and expected outputs will be analysed.

Additional funding of R2 million had been approved by the program during the fourth quarter to address the capital needs of Dental Services, which were mostly dental chairs.

The implementation of the Oral Health Plan is being implemented in a phased manner in line with the availability of funds.

Table 2.2.14: Performance against targets from the 2011/12 Annual Performance Plan for dental training hospitals

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Manage the burden of disease.	1.1 Ensure access to dental training hospitals.	1.1.1 Ensure access to an integrated oral health service and training platform by providing for 185 454 patient visits per annum by 2014.	1) Number of oral health patient visits per annum	175 200	120 207	112 424	170 000	The target was over-estimated as it was based on manual data collected and not Clinicom data. The reported data for 2011/12 was Clinicom data. The target has been corrected for the 2012/13 financial year.
		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 equipped for anaesthesia and able to provide sterile conditions for surgical procedures with a target of 1 700 by 2014.	2) Number of oral health theatre cases per annum	1 578	1 162	1 104	1 556	The target was over-estimated as it was based on manual data collected and not Clinicom data. The reported data for 2011/12 was Clinicom data. The target has been corrected for the 2012/13 financial year.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
		1.1.3 Provide quality removable prosthetic devices to patients with a target of 4 108 by 2014.	3) Number of removable oral health prosthetic devices manufactured (dentures)	3 026	4 103	5 436	3 988	This indicator previously recorded patients provided with prosthetic devices. However, as for all prosthesis provided in the state service, this indicator now reflects the number of prosthesis provided and some patients may have received two prosthesis (an upper and a lower prosthesis).
		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	201	214	180	The annual performance of 214 cases banded is in line with the annual performance of 2010/11. This indicator is dependent on patient compliance and will vary within limits.

Changes to planned targets

No changes were made to targets during the year.

2.2.5 Programme 5: Central Hospital Services

Purpose

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

Analysis per sub-programme

Sub-programme 5.1: Central Hospital Services

Rendering of general and highly specialized health services on a national basis and maintaining a platform for the training of health workers, as well as for research.

Strategic Goals

Programme 5 contributes to the following strategic goals of the Department:

1) Manage the burden of disease.
2) Ensure a sustainable income to provide the required health services according to the needs.
3) Ensure organisational strategic management capacity and synergy.
4) Quality of health services.

Strategic Objectives

The strategic objectives for Programme 5 (Central Hospitals) are:

- Perform appropriate 43 per cent clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.
- Ensure access to central hospital services by providing 2 536 beds.
- Efficiently manage resources to achieve the bed occupancy rate of 84 per cent by 2014/15.
- Ensure the cost effective management of central hospitals at a target cost of R3 000 per patient day equivalent. (Constant 2009/10 rands.)
- Effectively manage allocated resources to achieve the target average length of stay of 5.5 days for central hospitals by 2014/15.
- To ensure appropriate mechanisms to measure improvement in quality of health services.

Strategic objectives were determined collectively for central hospitals in the 2011/12 APP and were not specifically formulated per central hospital. It is therefore not repeated for each hospital.

General Overview

This Programme funds the delivery of highly specialised services as well as a component of general specialist services provided by the three central hospitals: Red Cross War Memorial Children's Hospital (RCWMCH), 290 beds, Tygerberg Hospital (TBH), 1 310 beds, and Groote Schuur Hospital

(GSH) 945 beds[28].

The central hospitals also serve as an important training platform for under and post graduate health professionals. It should be noted that during the year the categorisation of the central hospitals was changed and in future while Groote Schuur and Tygerberg Hospitals remain as central hospitals, the Red Cross War Memorial Children's Hospital becomes a tertiary hospital.

Central hospitals provide services for the Province and receive referrals from across the country. The lists of services provided are detailed below. Tertiary services are partially funded / subsidised through the National Tertiary Services Conditional Grant.

Highly specialised services provided in the central hospitals:

Discipline	Sub discipline
• Critical care (intensive care)	- Adult critical care
	- Paediatric critical care
	- Neonatal critical care
• Obstetrics and gynaecology	- Maternal-foetal medicine
	- Oncology
	- Reproductive medicine
	- Urogynaecology
• Surgery	- General surgery, including hepatobiliary and abdominal surgery
	- Cardiothoracic surgery
	- Neurosurgery
	- Ophthalmology
	- Plastic and reconstructive surgery
	- Urology
	- Ear, nose and throat
	- Maxillofacial surgery
	- Vascular surgery
	- Trauma surgery
• Orthopaedics	- Hand surgery
	- Orthopaedics
	- Spinal surgery
	- Paediatric orthopaedics
• Paediatric Surgery	- Paediatric general surgery
	- Paediatric cardiothoracic surgery
	- Paediatric neurosurgery
	- Paediatric ophthalmology
	- Paediatric otolaryngology
	- Paediatric urology

[28] Operational beds as at 31 March 2012. The performance tables reflect average beds for the year.

Discipline	Sub discipline
• Paediatric Medicine	- General paediatrics
	- Paediatric cardiology
	- Paediatric clinical haematology/oncology
	- Paediatric gastroenterology
	- Paediatric infectious diseases
	- Paediatric nephrology
	- Paediatric neurology
	- Paediatric pulmonology
• Medicine	- Allergology
	- Cardiology
	- Clinical haematology/oncology
	- Dermatology
	- Emergency medicine
	- Endocrinology
	- Gastroenterology
	- General medicine
	- Geriatrics
	- Hepatology
	- Infectious diseases
	- Nephrology
	- Neurology
	- Pulmonology
	- Rheumatology
• Radiation and Imaging Medicine	- Radiation medicine
	- Radiology
	- Nuclear medicine
• Psychiatry	- General psychiatry
	- Forensic psychiatry
	- Child and adolescent psychiatry

Maitland Cottage Home

Programme 5 also funds Maitland Cottage Home, a provincially aided orthopaedic hospital, which serves as an extension of Red Cross War Memorial Children's Hospital to provide highly specialised paediatric orthopaedic surgery.

The following services are provided by Maitland Cottage Home:

- General paediatric orthopaedic elective surgery.
- Pre- and post-surgery management of spinal surgery patients from Red Cross War Memorial Children's Hospital.
- Non-operative orthopaedic management of patients for instance hosting a specialised outpatient club foot clinic.

The facility operated 85 beds, admitted 898 patients and performed 480 operations during the 2011/12 year.

Regular management meetings are held to ensure good service governance. The hospital completed the construction of a new physiotherapy gym that will enhance the quality of rehabilitative services.

Performance indicators and targets

The Programme's strategic objectives and goals were aligned to the Provincial and National Department of Health goals and objectives. This following section should be read in conjunction with the performance reported in the tables below as well as the achievements of each of the central hospitals.

1) Key Performance Area: Service Delivery

Strategic Goal: Manage the Burden of Disease

Apart from service delivery at the hospital, central hospitals strengthened the health system within the geographic service areas (GSA) to better manage the burden of disease as follows:

- Performing outreach and support to district health services in all disciplines.
- Assisted in the planning and commissioning of the Khayelitsha District Hospital. Patients that were previously managed in the Metro West are now referred to hospitals in Metro East, and specifically Tygerberg Hospital. In order to accommodate the shift in services, which are aligned with the departmental strategic plan and the appropriate management of the burden of disease, Tygerberg Hospital commissioned 74 beds. These beds are not additional to the programme but are derived from the internal shift of resources, so as to remain within the allocated budget: 54 beds from Groote Schuur Hospital and 20 beds from Red Cross War Memorial Children's Hospital. The change in health seeking behaviour of patients will be monitored during 2012/13 in the light of the opening of Khayelitsha Hospital.

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

The Programme has, over time, systematically reprioritised expenditure within its baseline funding to ensure sustainability. The focus was on increasing efficiencies and using savings to strengthen the services to better respond to the large service need.

The conditional grants (HPTDG and NTSG) continued to contribute a significant portion of the central hospital budget, but have not kept pace with the actual costs of the services provided, nor were these grants adjusted to fully compensate for inflation and the costs related to the occupational specific dispensation.

The central hospitals, however, through various strategies, have maintained and in some cases improved the patient activity outputs. Strategies followed include the following:

- Reducing expenditure on laboratory services by means of an electronic gatekeeping system, and redirecting funding to other service needs.
- Converting funds paid for agency staff to fund and fill permanent posts. This improved human resource capacity and has positively impacted on quality of care.

2) Key Performance Area: Clinical Governance and Quality Assurance

Strategic Goal: Ensure and maintain organisational strategic management capacity and synergy

Managers and clinicians from the central hospitals fulfil leadership roles in health systems strengthening and clinical governance in the respective geographical service areas (GSA) as well as in the provincial co-ordinating committees (PCCs) for each of the disciplines. The PCCs focus on developing clinical guidelines, protocols, conduct clinical audits and conduct surveys. Recent clinical guidelines were developed to manage burns and head injuries in the Province.

Strategic Goal: Improve the quality of health services

Clinical disciplines in each of the central hospitals held monthly morbidity and mortality meetings to monitor the quality of services and patient outcomes. A patient satisfaction survey was conducted in each of the central hospitals. The findings of this survey served to inform interventions necessary towards improving services.

The three central hospitals were assessed for compliance against the national core standards. Each hospital developed short and medium term actions to improve compliance against the norms.

Dedicated quality assurance manager posts are established at each central hospital, reporting to the CEO. Each central hospital has functional infection prevention and control committees.

3) Key Performance Area: Corporate Governance

Strategic Goal: Ensure and maintain organisational strategic management capacity and synergy

The hospitals established functional business units to decentralise decision making, governance and accountability at the level of the various clinical disciplines, whether general or highly specialised, as well as administrative components. Functional business units are aggregated cost centres and the manager has responsibility for service outcomes, patient experience, quality of care and resource management.

Hospital boards in each hospital performed an oversight and governance role, held regular meetings with senior hospital management and remained an important link to the communities the hospitals serve.

The introduction of compliance monitoring instruments for financial management, human resources as well as performance information ensured the monitoring of performance and adherence to audit requirements.

Strategic Goal: Develop and maintain a capacitated workforce

To ensure a capacitated workforce the hospital aimed to have 97 per cent of funded posts filled at any point of time. Skills development plans were in place for each of the central hospitals.

Each hospital conducted a staff satisfaction survey to better inform focused strategies to improve retention, general working conditions and recruitment of staff.

Higher education institutions partnered with the Province for the training of health sciences learners. The central hospitals form a substantive part of the platform where training and research takes place. Despite producing health workers that contribute to a sustained workforce, research also informs the provision and practice of appropriate health care to attain the best health outcomes.

Strategic Goal: Provide and maintain appropriate health technology and infrastructure

Each central hospital has a planning and commissioning unit/structure in place to ensure the streamlining and appropriate specifications are drafted for infrastructure projects. The infrastructure needs of each hospital were documented in a five year plan.

The hospital also procured key equipment, required to deliver the highly specialised tertiary services. Examples of the equipment procured are reflected below:

- Groote Schuur Hospital
  - Neurosurgical microscope
  - Angiographic theatre table
  - New floor loaded Sterilization Unit
  - Ear Nose Throat/ Neurosurgical Camera Stack
  - Ultrasound machine
- Tygerberg Hospital
  - Mammography Machine
  - Neuronavigation for neurosurgery
  - Lung Capacity /Body Box
  - Cardiology monitors
  - Reverse osmosis water treatment system
- Red Cross War Memorial Children's Hospital
  - Diagnostic ultrasound
  - Nitric oxide dosing system
  - EEG System 32 channel
  - Transcutaneous specialised monitors

The allocated funding (R35.7 million) for the modernisation of tertiary services was used to improve the medical imaging and diagnostic service and key achievements were as follows:

- Funding of clinical engineering capacity at the central hospitals essential for the maintenance of equipment.
- Roll out of the Picture Archiving and Communication System/Radiological Information System (PACS/RIS) solution to Groote Schuur Hospital and Red Cross War Memorial Children's Hospital as follows:
  - PACS was deployed throughout Groote Schuur Hospital and the RIS project was initiated with expected completion by the end of 2012.
  - The functional PACS in Tygerberg Hospital was supplemented with the deployment of the RIS for radiology service.
  - Site preparation tasks at Red Cross War Memorial Children's Hospital, such as the server room, end user equipment and network preparation, was completed.
  - At regional and district hospitals (Worcester, George and Khayelitsha Hospitals) end user equipment such as computers, work surfaces and screens have been deployed and most network and server room preparation was completed.

Table 2.2.15: Performance against targets from the 2011/12 Annual Performance Plan for central hospitals

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Manage the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in central hospitals	43.9%	46.1%	47.7%	44%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	5 052	6 024	5 604	5 882	
			Denominator:	11 509	13 055	11 742	13 400	
	1.2 Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to central hospital services by providing 2 536 beds.	2) Number of operational beds in central hospitals	1 468	1 473	2 541	2 520	The Department views variances of less than 5% to be within an acceptable range from the target.
			3) Total separations in central hospitals	68 231	68 490	134 818	135 593	The Department views variances of less than 5% to be within an acceptable range from the target.
			4) OPD total headcounts in central hospitals	537 749	541 079	822 871	873 325	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			5) Patient day equivalents [PDE] in central hospitals	625 661	634 782	1 078 909	1 109 467	The Department views variances of less than 5% to be within an acceptable range from the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
	1.3 Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/15.	6) Bed utilisation rate (based on usable beds) in central hospitals	83.3%	84.5%	81.8%	84%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	446 411	454 423	758 432	773 692	
			Denominator:	535 820	537 645	927 506	919 800	
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, central hospital services	2.1.1 Ensure the cost effective management of central hospitals at a target cost of R3 000 per patient day equivalent. [Constant 2009/10 rands].	7) Expenditure per patient day equivalent [PDE] in central hospitals[29]	R 3 733	R 3 591	R2 954	R 2 804	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	2 335 490 820	2 279 440 394	3 187 214 983	3 110 902 343	
			Denominator:	625 661	634 782	1 078 909	1 109 467	
3. Ensure organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of health services with well-defined efficiency targets for central hospital services.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 5.5 days for central hospital by 2014/15.	8) Average length of stay in central hospitals	6.5 days	6.6 days	5.6 days	5.7 days	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	446 411	454 423	758 432	773 692	
			Denominator:	68 231	68 490	134 818	135 593	

[29] All expenditure figures are expressed in 2009/10 rand values to be comparable with the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
4. Quality of health services.	4.1 Improve the quality of health services.	4.1.1 To ensure appropriate mechanisms to measure improvement in quality of health services.	9) Number of central hospitals with monthly mortality and morbidity meetings	3	3	3	3	Target achieved.
			10) Percentage of complaints of users of central hospital services resolved within 25 days	87.8%	90.0%	64.3%	90%	Reliable baseline information was not available to set appropriate targets. Tygerberg and Groote Schuur Hospital appointed Quality Assurance managers to strengthen the process and improve performance. The nature and complexity of complaints often necessitated further investigation and various actions, before a resolution can be recorded. This hampered the ability to resolve complaints within 25 days. The Department will conclude a more refined definition of a complaint resolution to ensure a uniform interpretation and continue to strengthen mechanisms to achieve the desired performance in 2012/13.
			Numerator:	618	630	313	630	
			Denominator:	704	700	487	700	
			11) Central hospital patient satisfaction rate	Not required to report	88.4%	92.0%	90%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	-	2 936	5 066	2 970	
			Denominator:	-	3 323	5 504	3 300	
			12) Central hospitals assessed for compliance with core standards	Not required to report	Not required to report	3	1	At the time of target setting there was no clear directive from the National Department of Health (NDoH). Health Systems Trust (HST) was contracted by the NDoH to assist provinces with assessments. It was therefore possible to do additional assessments.

Note:

During 2008/09 to 2010/11 the general specialist service (level 2) outputs in central hospitals were reflected in Programme 4.1. As from 1 April 2011 all service activities in central hospitals are reflected in Programme 5.

Changes to planned targets

No changes were made to targets during the year.

GROOTE SCHUUR HOSPITAL

General Overview

Groote Schuur Hospital provided a full package of adult general specialised and highly specialised (tertiary) services, and is the referral centre for the following unique services:

- Heart, liver and bone marrow transplants.
- Cardiac electrophysiology.
- Neurosurgical coiling.
- Neuronavigational surgery.
- Neuropsychiatry with special focus on HIV related psychiatric problems.
- Ocular oncology services.

Performance indicators and targets

Key achievements for Groote Schuur Hospital include:

1) Acute services were strengthened to improve the management of the burden of disease towards an increased life expectancy and improved health outcomes. This included establishing three additional general specialist theatre lists for orthopaedics and general surgery and an additional list for urgent theatre cases.
2) Waiting times were measured and strategies developed to improve the quality of the patient experience in emergency services. One of the strategies is to improve the flow of patients through the emergency centre.
3) The delivery of woman's health services was improved by supporting an outreach colposcopy clinic at Victoria Hospital.
4) The services rendered in theatres and critical care were bolstered by:
   - Increased post anaesthetic high care unit capacity to a total of three beds.
   - Reinstating seven theatre operating lists.
   - Appointing four operating theatre practitioners as a pilot project.
   - Extending the scanning hours for computerised tomography (CT) diagnostic services.
5) Improved infection control by implementing the lessons from the Best Care Always initiatives to prevent central line infections in selected clinical areas.
6) The infrastructure changes to accommodate the Picture Archive Communication System (PACS) system were completed.

Table 2.2.16: Performance against targets from the 2011/12 Annual Performance Plan for Groote Schuur Hospital

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Manage the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Groote Schuur Hospital	52.5%	54.3%	53.2%	54%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	2 861	3 875	2 921	4 032	
			Denominator:	5 452	7 139	5 491	7 400	
	1.2 Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to central hospital services by providing 2 536 beds.	2) Number of operational beds in Groote Schuur Hospital	625	630	941	920	The Department views variances of less than 5% to be within an acceptable range from the target.
			3) Total separations in Groote Schuur Hospital	33 293	32 788	50 334	50 916	The Department views variances of less than 5% to be within an acceptable range from the target.
			4) OPD total headcounts in Groote Schuur Hospital	268 551	262 463	388 930	373 000	The Department views variances of less than 5% to be within an acceptable range from the target.
			5) Patient day equivalents [PDE] in Groote Schuur Hospital	300 397	301 512	439 733	434 261	The Department views variances of less than 5% to be within an acceptable range from the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
	1.3 Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	6) Bed utilisation rate (based on usable beds) in Groote Schuur Hospital	92.4%	93.1%	86.5%	88%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	210 880	214 025	296 950	296 928	
			Denominator:	228 125	229 950	343 442	335 800	
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, central hospital services	2.1.1 Ensure the cost effective management of central hospitals at a target cost of R3 000 per patient day equivalent. [Constant 2009/10 rands]	7) Expenditure per patient day equivalent [PDE] in Groote Schuur Hospital[30]	R 3 640	R 3 640	R3 074	R 2 983	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	1 093 531 419	1 097 607 000	1 351 821 995	1 295 286 429	
			Denominator:	300 397	301 512	439 773	434 261	
3. Ensure organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of health services with well-defined efficiency targets for central hospital services.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 5.5 days for central hospital by 2014/15.	8) Average length of stay in Groote Schuur Hospital	6.3 days	6.5 days	5.9 days	5.8 days	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	210 880	214 025	296 950	296 928	
			Denominator:	33 293	32 788	50 334	50 916	

[30] All expenditure figures are expressed in 2009/10 rand values to be comparable with the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
4. Quality of health services.	4.1 Improve the quality of health services.	4.1.1 To ensure appropriate mechanisms to measure improvement in quality of health services.	9) Groote Schuur Hospital with monthly mortality and morbidity meetings	Yes (1)	Yes (1)	Yes (1)	Yes	Target achieved.
			10) Percentage of complaints of users of Groote Schuur Hospital resolved within 25 days	84.1%	90.0%	70.9%	90%	Reliable baseline information was not available to set an appropriate target. A quality assurance manager was appointed to assist in strengthening the process. The nature and complexity of complaints often necessitated further investigation and various actions, before a resolution can be achieved, which hampered the ability to resolve within 25 days. The Department will continue to strengthen mechanisms to achieve the desired performance in 2012/13.
			Numerator:	385	432	141	432	
			Denominator:	458	480	199	480	
			11) Patient satisfaction rate in Groote Schuur Hospital	Not required to report	89.3%	88.5%	90%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	-	2 055	2 567	2 052	
			Denominator:	-	2 302	2 902	2 280	
			12) Groote Schuur Hospital assessed for compliance with core standards	Not required to report	Not required to report	Yes (1)	No	At the time of target setting there was no clear directive from the National Department of Health (NDoH). Health Systems Trust (HST) was contracted by the NDoH to assist provinces with assessments. It was therefore possible to do additional assessments.

Note:

During 2008/09 to 2010/11 the general specialist service (level 2) outputs in central hospitals were reflected in Programme 4.1. As from 1 April 2011 all service activities in central hospitals are reflected in Programme 5.

Changes to planned targets

No changes were made to targets during the year.

TYGERBERG HOSPITAL

General Overview

Apart from paediatric cardiac surgery and heart, liver and bone marrow transplantation which are centralised in Groote Schuur and Red Cross War Memorial Children's Hospitals, Tygerberg Hospital provided a full spectrum of adult and paediatric general and highly specialised tertiary services.

Tygerberg Hospital provides the following unique services:

- Adult burns unit, which includes critical care.
- Cochlear implantation.
- Dedicated academic infection prevention and control (IPC) services. (All the central hospitals perform an IPC function but Tygerberg Hospital has a dedicated academic unit that does research and provides specialised support in this field.)
- Craniofacial surgical services.
- Intra-operative radiotherapy for breast carcinoma.
- Functional three Tesla MRI (magnetic resonance imaging) in conjunction with the Health Sciences Faculty: University of Stellenbosch.
- Hyperbaric oxygen therapy in conjunction with the Health Sciences Faculty: University of Stellenbosch.

Performance indicators and targets

Key achievements for Tygerberg Hospital include:

1) Strengthening general medicine services by appointing a head of general medicine in Tygerberg Hospital to oversee general medicine services in the GSA.
2) Two emergency medicine specialists were appointed to strengthen the management of acute emergencies.
3) Improved the delivery of woman's health services by:
   - Reorganising the labour ward to achieve single bed delivery rooms for improved patient privacy and clinical care.
   - Implementing a dedicated labour ward specialist consultant to assist with and oversee deliveries.

4) Bolstered the services rendered in theatres and critical care by:
   - Sustainably operating ten paediatric intensive care beds.
   - Commissioning four additional neonatal high care beds.
   - Appointing five operating theatre practitioners as a pilot project, to bolster theatre operating capacity.
   - Implementing extended scanning hours for CT and MRI scanning to improve access to both emergency and elective scans.
5) Improved the quality of health services by:
   - Implementing the Best Care Always initiatives to reduce the occurrence of ventilator acquired infections in respiratory ICU, central line associated blood infections in surgical ICU and expansion of the hospital's infection prevention and control manual.
6) Established and maintained sufficient health infrastructure and technology to support service delivery by:
   - Completing the infrastructure changes to accommodate the Western Cape Positron Emission Tomography (PET)-CT scanner as well as a new cardiac catheterisation theatre and cardiac echocardiography suite scanner.
   - Concluding the planning for infrastructure work towards establishing the emergency centre and re-organisation of the haematology services to protect immuno-compromised patients from hospital acquired infections.

Table 2.2.17: Performance against targets from the 2011/12 Annual Performance Plan for Tygerberg Hospital

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Manage the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Tygerberg Hospital	36.2%	36.3%	42.9%	31%	Data used from 2010/11 to set the target was incorrect. This data has been corrected following a data quality review and implementation of a more rigorous data collection process. The targets have subsequently been adjusted for 2012/13.
			Numerator:	2 191	2 149	2 683	1 850	
			Denominator:	6 057	5 916	6 251	6 000	
	1.2 Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to central hospital services by providing 2 536 beds.	2) Number of operational beds in Tygerberg Hospital	608	608	1 310	1 310	Target achieved.
			3) Total separations in Tygerberg Hospital	22 611	23 214	61 893	62 974	The Department views variances of less than 5% to be within an acceptable range from the target.
			4) OPD total headcounts in Tygerberg Hospital	187 654	197 259	315 264	360 895	The target was set inclusive of inpatients seen in service group clinics. A correction in the data extraction process from Clinicom excluded these from the reported outputs as from 2011/12.The impact was most noticeable at Tygerberg and Red Cross War Memorial Children's Hospital due to the outpatient service configuration.
			5) Patient day equivalents [PDE] in Tygerberg Hospital	225 672	232 604	499 486	524 662	The Department views variances of less than 5% to be within an acceptable range from the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
	1.3 Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	6) Bed utilisation rate (based on usable beds) in Tygerberg Hospital	73.5%	75.2%	78.5%	81%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	163 121	166 851	375 622	386 363	
			Denominator:	221 920	221 920	478 202	478 150	
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, central hospital services	2.1.1 Ensure the cost effective management of central hospitals at a target cost of R3 000 per patient day equivalent. [Constant 2009/10 rands].	7) Expenditure per patient day equivalent in Tygerberg Hospital[31]	R 3 949	R 3 700	R2 819	R 2 662	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	891 123 563	860 703 446	1 408 118 182	1 396 631 059	
			Denominator:	225 672	232 604	499 486	524 662	
3. Ensure organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of health services with well-defined efficiency targets for central hospital services.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 5.5 days for central hospital by 2014/15.	8) Average length of stay in Tygerberg Hospital	7.2 days	7.2 days	6.1 days	6.1 days	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	163 121	166 851	375 622	386 363	
			Denominator:	22 611	23 214	61 893	62 974	

31 All expenditure figures are expressed in 2009/10 rand values to be comparable with the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
4. Quality of health services.	4.1 Improve the quality of health services.	4.1.1 To ensure appropriate mechanisms to measure improvement in quality of health services.	9) Tygerberg Hospital has monthly mortality and morbidity meetings	Yes (1)	Yes (1)	Yes (1)	Yes	Target achieved.
			10) Percentage of complaints of users of Tygerberg Hospital resolved within 25 days	94.4%	90.0%	50.2%	90%	Reliable baseline information was not available to set an appropriate target. The vacant quality assurance manager post was filled in Quarter 3, resulting in an improvement in performance over the subsequent quarters. The nature and complexity of complaints often necessitated further investigation and various actions, before a resolution can be achieved, which hampered the ability to resolve within 25 days. The Department will continue to strengthen mechanisms to achieve the desired performance in 2012/13.
			Numerator:	202	180	110	180	
			Denominator:	214	200	219	200	
			11) Patient satisfaction rate in Tygerberg Hospital	Not required to report	88.1%	96.2%	90%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	-	385	860	387	
			Denominator:	-	437	894	430	
			12) Tygerberg Hospital assessed for compliance with core standards	Not required to report	Not required to report	Yes (1)	No	At the time of target setting there was no clear directive from the National Department of Health (NDoH). Health Systems Trust (HST) was contracted by the NDoH to assist provinces with assessments. It was therefore possible to do additional assessments.

Note:

During 2008/09 to 2010/11 the general specialist service (level 2) outputs in central hospitals were reflected in Programme 4.1. As from 1 April 2011 all service activities in central hospitals are reflected in Programme 5.

Changes to planned targets

No changes were made to targets during the year.

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

General Overview

Red Cross War Memorial Children's Hospital provided general specialist, tertiary and quaternary services for children. The hospital is a referral centre for:

- Paediatric liver and kidney transplants.
- The separation of conjoined twins.
- Paediatric cardiac surgery.
- Specialised burns care for children.

Performance indicators and targets

Key achievements for Red Cross War Memorial Children's Hospital include:

1) Managed the burden of disease towards an increased life expectancy and improved health outcomes for patients by strengthening acute hospital services by:
   - Increasing access to ENT services by re-designating four additional beds.
   - Appointing a provincial co-ordinator for burns and formulating a plan for the re-organisation of provincial burns services as well as conducting lecture courses in burn care to primary health care personnel.
2) Improved the patient experience and the quality of emergency services by:
   - Concluding the basic requirements for the upgrading of the emergency centre infrastructure to improve patient and work flow.
   - Participating with the Walter Sisulu Paediatric Cardiac Foundation by providing theatre and ICU services to perform 51 additional cardiothoracic operations.
3) Bolstered the services rendered in theatres and critical care by:
   - Performing 54 additional general paediatric surgery and ENT operations through performing elective theatre cases on Saturdays as part of a dedicated project.
   - Hosting a facial surgery project focussing on facial reconstruction in children with an associated training course for registrars.
   - Hosting an initiative of the Smile Foundation and operating on 22 children with cleft lips and palates.
4) Improved the quality of health services with on-going implementation of the Best Care Always initiatives policies to prevent ventilator associated pneumonia.
5) Established and maintained sufficient health infrastructure and technology to accommodate the PACS system by appointing PAC/RIS administrators, upgrading server rooms and purchasing the required equipment.

Table 2.2.18: Performance against targets from the 2011/12 Annual Performance Plan for Red Cross War Memorial Children's Hospital

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Manage the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Red Cross War Memorial Children's Hospital (RCWMCH) Numerator: Denominator:	Not applicable - -	Not applicable - -	Not applicable - -	Not applicable - -	
	1.2 Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to central hospital services by providing 2 536 beds.	2) Number of operational beds in RCWMCH	235	235	290	290	Target achieved.
			3) Total separations in RCWMCH	12 327	12 488	22 591	21 703	The Department views variances of less than 5% to be within an acceptable range from the target.
			4) OPD total headcounts in RCWMCH	81 544	81 357	118 677	139 430	The target was set inclusive of inpatients seen in service group clinics. A correction in the data extraction process from Clinicom exclude these from the reported outputs as from 2011/12.The impact was most noticeable at Tygerberg and Red Cross War Memorial Children's Hospital due to the outpatient service configuration.
			5) Patient day equivalents [PDE] in RCWMCH	99 592	100 666	139 691	150 545	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
	1.3 Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	6) Bed utilisation rate (based on usable beds) in RCWMCH	84.4%	85.7%	81.1%	85%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	72 411	73 547	85 860	90 401	
			Denominator:	85 775	85 775	105 862	105 850	
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, central hospital services	2.1.1 Ensure the cost effective management of central hospitals at a target cost of R3 000 per patient day equivalent. [Constant 2009/10 rands].	7) Expenditure per patient day equivalent [PDE] in RCWMCH[32]	R 3 523	R 3 190	R 3 059	R 2 783	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	350 835 838	321 129 948	427 274 805	418 984 855	
			Denominator:	99 592	100 666	139 691	150 545	
3. Ensure organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of health services with well-defined efficiency targets for central hospital services.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 5.5 days for central hospital by 2014/15.	8) Average length of stay in RCWMCH	5.9 days	5.9 days	3.8 days	4.2 days	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	72 411	73 547	85 860	90 401	
			Denominator:	12 327	12 488	22 591	21 703	

32 All expenditure figures are expressed in 2009/10 rand values to be comparable with the target.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
4. Quality of health services.	4.1 Improve the quality of health services.	4.1.1 To ensure appropriate mechanisms to measure improvement in quality of health services.	9) RCWMCH has monthly mortality and morbidity meetings	Yes (1)	Yes (1)	Yes (1)	Yes	Target achieved.
			10) Percentage of complaints of users of RCWMCH resolved within 25 days	96.7%	90.0%	89.9%	90%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	30	18	62	18	
			Denominator:	31	20	69	20	
			11) Patient satisfaction rate in RCWMCH	Not required to report	88.1%	96.0%	90%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely.
			Numerator:	-	385	1 639	531	
			Denominator:	-	437	1 708	590	
			12) RCWMCH assessed for compliance with core standards	Not required to report	Not required to report	Yes (1)	Yes	Target achieved. At the time of target setting there was no clear directive from the National Department of Health (NDoH). Health Systems Trust (HST) was contracted by the NDoH to assist provinces with assessments. It was therefore possible to do additional assessments.

Note:

During 2008/09 to 2010/11 the general specialist service (level 2) outputs in central hospitals were reflected in Programme 4.1. As from 1 April 2011 all service activities in central hospitals are reflected in Programme 5.

Changes to planned targets

No changes were made to targets during the year.

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

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

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

Sub-programme 6.3: Bursaries

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

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

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

Sub-programme 6.5: Training (Other)

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

Strategic Goals

Programme 6 contributes to the following strategic goal of the Department:

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

Strategic Objectives

The strategic objectives for Programme 6 (Health Sciences and Training) are:

- Number of basic nurse students graduating (output).
- Ensure optimum competency levels of health and support professionals through education, training and development.

- Expand community based care services through the optimum training and development of home based carers as part of Expanded Public Works Programme (EPWP).
- Increase the number of data capturer interns required at health care facilities.
- Expand the number of pharmacy assistant basic and post-basic learnerships to meet the needs of health care facilities.
- Increase the numbers of Assistant to Artisans (ATAs) interns to address the maintenance of health care facilities.
- Increase the number of human resource and finance interns.

Performance indicators and targets

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

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 the 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 met with minor variances:

- Intake of nurse students (at higher education institutions and the nursing colleges).
- Students with bursaries from the Province.
- Basic nurse students graduating (at higher education institutions and the nursing colleges). This indicator reflected a 20 per cent variance, the target of 400 was exceeded by 81 as a result of an improved pass rate which included 90 "end of academic year" completions in the fourth quarter.
- Number of emergency medical care (EMC) staff intake on Health Professions Council of South Africa (HPCSA) accredited courses.

In sub-programme 6.5 (Training (Other)) the focus of skills development interventions has traditionally been on the community based services through the training of home based carers as part of the Expanded Public Works Programme (EPWP). All targets for the following indicators were met with nominal variances:

- Number of home community based carers trained.
- Number of data capturer interns. This indicator reflected a 6 per cent variance, the target of 140 was exceeded by 9.
- Number of pharmacist's assistants in training.
- Number of Assistant to Artisan (ATA) interns.
- Number of human resource (HR) and finance interns.

Table 2.2.19: Performance against targets from the 2011/12 Annual Performance Plan for health sciences and training

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Develop and maintain a capacitated workforce to deliver the required health services.	1.1 Develop, implement, monitor and evaluate a comprehensive Training Plan guided by the Human Resource Plan for health and support professionals in line with the Comprehensive Service Plan (CSP).	1.1.1 Number of basic nurse students graduating (output).	1) Intake of nurse students (HEIs and nursing colleges)	2 906[33]	2 230	2 496	2 495	The Department views variances of less than 5% to be within an acceptable range from the target.
			2) Students with bursaries from the province	2 436	2 877	2 953	3 674	The target was based on erroneous double counting and should have been 2 900.
			3) Basic nurse students graduating	256[34]	437	474	400	There was a 20% variance as a result of improved pass rate with 90 end of academic year completions in the 4th quarter.
		1.1.2 Ensure optimum competency levels of health and support professionals through education, training and development.	4) EMC intake on accredited HPCSA courses	Not required to report	297	134	132	The Department views variances of less than 5% to be within an acceptable range from the target. After 2010/11 the numbers were cut as the EMC college introduced the formal EMC practitioner course.

33 Higher intake in 2009/10 based on need and funding availability.

34 The original figure reported for 2009/10 was 171. This figure was updated to 256 based on feedback from the Directorate: Nursing that the original figure did not include basic nurse students graduating at UWC.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
	1.2 Use the Expanded Public Works Programme (EPWP) to create employment opportunities linked to training in line with the Human Resource Plan.	1.2.1 Expand community based care services through the optimum training and development of home based carers as part of Expanded Public Works Programme (EPWP).	5) Number of Home Community Based Carers (HCBCs) trained	1 896	1 614	1 919	2 000	The Department views variances of less than 5% to be within an acceptable range from the target.
		1.2.2 Increase the number of data capturer interns required at health care facilities.	6) Number of data capturer interns	110	267	149	140	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely. Additional data capturers appointed due to demand and availability of funding. The figure for 2010/11 reflects two intakes – the 2009/10 intake carried over into this financial year.
		1.2.3 Expand the number of pharmacy assistant basic and post-basic learnerships to meet the needs of health care facilities.	7) Number of pharmacy assistants in training	40	100	110	110	Target achieved.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
		1.2.4 Increase the numbers of Assistant to Artisans (ATAs) interns to address the maintenance of health care facilities.	8) Number of Assistant to Artisans (ATAs) interns	Not required to report	147	115	120	The Department views variances of less than 5% to be within an acceptable range from the target.
		1.2.5 Increase the number of human resource and finance interns.	9) Number of HR and finance interns	Not required to report	Not required to report	111	100	Additional HR and finance interns were appointed due to demand and availability of funding.

Changes to planned targets

No changes were made to targets during the year.

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. This service has been transferred to sub-programme 4.4.

Sub-programme 7.5: Medicine Trading Account

Managing the supply of pharmaceuticals and medical sundries to hospitals, community health centres and local authorities.

SUB-PROGRAMME 7.1: LAUNDRY SERVICES

Strategic Goals

Laundry services contribute to the following strategic goal of the Department:

1) Provide and maintain appropriate health technology and infrastructure.

Strategic Objectives

The strategic objectives for laundry services are:

- 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.

Performance indicators and targets

1) Provide and maintain appropriate health technology and infrastructure

The focus for the five year period 2010 – 2014 is to increase operational efficiency by:

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

The following challenges were experienced by the sub-programme:

- The reasons for reductions in linen stocks at institutional level must be analysed and appropriate systems implemented to curtail these reductions, which occur outside the control of the laundry service management. The Department allocated R7 million to address shortages of linen.
- The demand for linen is unpredictable which makes it difficult to set accurate targets. Targets are set at the maximum expected demand.
- The use of steam required by laundries must be effectively managed due to the high input costs of electricity, coal and water. The upgrade of the Lentegeur Laundry, as part of the new Mitchell's Plain Hospital revitalisation project will include the purchase of new equipment designed to reduce the consumption of water, electricity and chemicals, making the services more steam efficient.
- The growing difference in the cost between in-house and outsourced laundry per piece, with the latter being more cost effective. The possibility of a public private partnership for the laundry service will be investigated.

Table 2.2.20: Performance against targets from the 2011/12 Annual Performance Plan for laundry services

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10[35]	2010/11	2011/12		
1. Provide and maintain appropriate health technology and infra-structure.	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	20.5 m *(20 500 000)*	20.2 m *(20 286 486)*	21.1 m *(21 114 408)*	20.5 m *(20 500 000)*	The Department views variances of less than 5% to be within an acceptable range from the target.
		1.1.2 Provide a laundry service using in-house laundries.	2) Total number of pieces laundered: in-house	15 m *(15 000 000)*	13.9 m *(13 996 985)*	14.9 m *(14 901 058)*	15 m *(15 000 000)*	The Department views variances of less than 5% to be within an acceptable range from the target.
		1.1.3 Provide a laundry service using outsourced laundries in the private sector.	3) Total number of pieces laundered: outsourced	5.5 m *(5 500 000)*	6.3 m *(6 289 501)*	6.2 m *(6 213 350)*	5.5 m *(5 500 000)*	Demand for laundry services was higher than expected due to the opening of Khayelitsha Hospital which resulted in laundry services being temporarily outsourced.
		1.1.4 Provide cost effective in-house laundry service	4) Average cost per item laundered: in-house	R 1.90	R 3.49	R 3.77	R 3.60	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	28 500 000	48 817 557	56 224 819	54 000 000	
			Denominator:	15 000 000	13 996 985	14 901 058	15 000 000	

[35] Information for 2009/10 updated.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10[35]	2010/11	2011/12		
		1.1.5 Provide cost effective outsourced laundry service.	5) Average cost per item laundered: outsourced	R 1.70	R 2.82	R 2.90	R 3.30	Tenders were more competitive than estimated, hence the reason for a lower average cost per item laundered (outsourced).
			Numerator:	9 350 000	17 707 724	18 026 171	18 150 000	
			Denominator:	5 500 000	6 289 501	6 213 350	5 500 000	

Changes to planned targets

No changes were made to targets during the year.

SUB-PROGRAMME 7.2: ENGINEERING SERVICES

Strategic Goals

Engineering services contribute to the following strategic goal of the Department:

1) Provide and maintain appropriate health technology and infrastructure.

Strategic Objectives

The strategic objectives for engineering services are:

- Provide effective maintenance on facilities, plant and equipment.
- Provide preventative maintenance to critical equipment.
- Provide repairs and renovation to DoH infrastructure.

Performance indicators and targets

1) Provide and maintain appropriate health technology and infrastructure

A successful maintenance programme requires the following:

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

In the five year period the Department will strive to address these requirements.

Engineering services experienced the following challenges during 2011/12:

- Setting realistic targets for the number of maintenance jobs done is a challenge as minor maintenance is often reactive rather than planned. Targets are therefore usually based on historical data. More accurate performance measures for the different categories of maintenance are being considered.
- Insufficient funds for the maintenance of existing assets. Currently approximately 2.4 per cent of the total asset value is allocated for maintenance but it should be 4 per cent of the total value of immovable assets.
- The responsibility for maintenance is divided between Programmes 7 and 8 and the capacity at institutions and the engineering workshops is insufficient to successfully address the maintenance backlogs. It is a priority to create capacity at engineering and facility workshops to improve the day-to-day repairs and preventive maintenance.

The intention is to provide the engineering workshops with the necessary resources and to strengthen the work flow systems by means of the "hub-and-spoke" model.

- Difficulty in placing "assistant to artisan" (ATA) trainees from the Expanded Public Works Programme (EPWP) in permanent employment. Earmarked posts for maintenance at the various facilities need to be ring-fenced to ensure that allocated posts are available for the trainees exiting the EPWP.
- Implementation of Treasury Regulation 16 (B) and Construction Industry Development Board (CIDB) rules. Regulation 16 (B) changes the way in which infrastructure is procured, including maintenance, and will have a major impact on engineering services. Procurement will have to follow CIDB rules. Additional procurement capacity will be needed to handle the new requirements. Information sessions and workshops with relevant role-players were held to ensure compliance and to address shortcomings.

Some of the achievements for 2011/12 include:

- The increase in the number of jobs completed did not have a negative effect on the expenditure for engineering.
- Additional funding (approximately R17 million) shifted from Programme 8 and was spent within the financial year.
- Most of the posts for the programme were filled and the programme retained the APL without any changes.
- The programme managed to fill the chief engineer post, deputy director for occupational health and safety and deputy director for laundry services posts.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2011/12 ANNUAL PERFORMANCE PLAN

Table 2.2.21: Performance against targets from the 2011/12 Annual Performance Plan for engineering services

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
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	17 401	20 249	26 190	13 200	Target set for maintenance too low. The mobile workshops are undertaking all the work at PHC facilities and metro sub-district offices due to a lack of maintenance staff at institutions. Under estimate of maintenance jobs due to improved reporting/ record keeping of jobs (now individually itemised instead of just an order for each institution). Implications of the new record keeping system were not known when targets were set.
		1.1.2 Provide preventative maintenance to critical equipment.	2) Number of preventative maintenance jobs completed	Not required to report	4 388	6 754	2 100	Target set for maintenance too low. The mobile workshops are undertaking all the work at PHC facilities and metro sub-district offices due to a lack of maintenance staff at institutions. Under estimate of maintenance jobs due to improved reporting/ record keeping of jobs (now individually itemised instead of just an order for each institution). Implications of the new record keeping system were not known when targets were set.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
		1.1.3 Provide repairs and renovation to DoH infrastructure.	3) Number of repairs completed	Not required to report	15 625	19 436	11 100	Target set for maintenance too low. The mobile workshops are undertaking all the work at PHC facilities and metro sub-district offices due to a lack of maintenance staff at institutions. Under estimate of maintenance jobs due to improved reporting/ record keeping of jobs (now individually itemised instead of just an order for each institution). Implications of the new record keeping system were not known when targets were set. Small ad-hoc requests that are added by institutions are now also being recorded.

Changes to planned targets

No changes were made to targets during the year.

SUB-PROGRAMME 7.3: FORENSIC PATHOLOGY SERVICES

Strategic Goals

Forensic pathology services contribute to the following strategic goals of the Department:

1) Manage the consequences of the burden of disease.
2) Ensure and maintain organisational strategic management capacity and synergy.

Strategic Objectives

The strategic objectives for forensic pathology services (FPS) are:

- Provide an efficient forensic pathology service through maintenance of average response time ≤ 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.
- Develop integrated support and management structures to render effective FPS service.

Performance indicators and targets

1) Manage the consequences of the burden of disease

The aim 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.

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 2011/12 financial year 9 359 medico-legal cases were admitted resulting in 9 226 examinations in the Western Cape in order to establish the cause of death in cases as defined in the Inquest Act. (A total of 65 cases were deferred.) This amounts to 1.60 post-mortems per 100 000 population. Of these 5 637 (61 per cent) medico-legal post-mortems were performed in the metropolitan area and 3 589 (39 per cent) in the rural districts.

A total of 48 response vehicles travelled 908 039 km during body transportation.

A total of 9 359 case files were opened whilst 10 193 case files were closed (case file closure rate 109 per cent). A total of 3 271 case files were open for a period exceeding 90 days at the end of the last quarter. This is largely due to the backlogs being experienced by the National and SAPS forensic laboratories and the time taken to process and report on toxicology and DNA results.

During the period under review 13 complaints and 242 compliments were received. The number of occupational injuries reported remains high at 46.

Improvement to the physical infrastructure remains a priority. One new forensic pathology laboratory (Beaufort West) was under construction during the 2011/12 financial year and will be commissioned during the 2012/13 financial year. 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. Planning of the relocation of the Salt River (M6 academic) facility onto the Groote Schuur Hospital premises has continued and the identified site has been vacated in preparation.

User requirement specifications were drafted for enhancements to be developed to the FPS system. These enhancements will be funded by an external stakeholder. The use of the Enterprise Content Management system continued to be embedded during the 2011/12 financial year with the implementation across eighteen FPS facilities. Access to information by the departments of forensic medicine is still affected by the inability to access the provincial government network.

Average response time from dispatch to arrival of FPS on scene

Thirteen of the eighteen facilities achieved an average response time under 40 minutes from dispatch to arrival of FPS on the scene. The average response time was 34 minutes, with 78 per cent of responses being within the 40 minute target.

The target for the 2011/12 financial year was set conservatively as there are a number of unpredictable factors impacting on response times such as case load, location of cases, surges in demand and delays on scene.

Reasons for exceeding target are:

- Improved dispatching of vehicles in the Metro. This is achieved through constant monitoring of response times across the two facilities and facilities responding across GSAs when the need arise.
- Constant management of the relationship with SAPS through standing SAPS liaison meetings where operating procedures are discussed and agreed to.

Average turnaround time from admission to examination done

Twelve of the eighteen facilities achieved an average turnaround time under 3.5 days from admission until the examination is done.

The target for the 2011/12 financial year was set conservatively as there are a number of unpredictable factors impacting on the admission to examination times such as case load, location of cases, surges in demand and delays in obtaining hospital records.

Reasons for exceeding target are:

- Improvement in the availability of hospital records. This was achieved through implementation of a referral procedure and the availability of SAPS liaison officers in some of the larger hospitals.
- The filling of vacant clinical posts has also contributed specifically in the Winelands and Overberg GSA.

Average turnaround time from admission to release of deceased (excluding unidentified persons)

The average number of days from admission to release of deceased is 13.04 days (4.6 days if paupers are excluded). Sixteen of the eighteen facilities achieved an average turnaround time under 5.5 days from admission until release of the deceased (excluding paupers).

The target for the 2011/12 financial year was set conservatively as there are a number of unpredictable factors impacting on the admission to examination times such as case load, location of case, surges in demand and delays in obtaining hospital records.

Reasons for exceeding target are:

- Improvement in the availability of hospital records. This was achieved through implementation of referral procedure and availability of SAPS liaison officers in some of the larger hospitals.
- The filling of vacant clinical posts has also contributed specifically in the Winelands and Overberg GSA.
- A reduction of cases covered by the normal staff component improved turnaround times.

2) Ensure and maintain organisational strategic management capacity and synergy

For the financial year under review 250 posts out of an approved post list of 259 posts were filled.

The implementation of the occupation specific dispensation for the forensic officer category regrettably did not have the desired outcome in achieving improvement in the salary position of this specific category. The supervisory and management cadre was also excluded from this dispensation.

In line with the workplace skills plan and service priorities, 332 training opportunities were accessed by 238 employees.

Equipment needs were identified and equipment was procured according to the priorities. R3.122 million was spent during the financial year on procurement of equipment.

A vehicle fleet of 69 vehicles is maintained by Government Motor Transport (GMT).

Number of unknown persons exceeding 90 days

A total of 128 deceased were unidentified as at the end of March 2012 whilst 943 deceased 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 unidentified persons remains a matter of concern. This is largely due to the Department's reliance on SAPS with regard to the formal identification process.

A conservative target was set based on the 2009/10 data. It is very difficult to accurately forecast this target as it is also dependent on the number of deceased that may possibly not be identifiable through means of fingerprint analysis or visual identification.

Reliance on external parties such as the SAPS to perform the necessary level of scientific investigation required for scientific means of identification, such as DNA analysis and facial reconstruction, impacts on the time before the deceased can be released for internment. The relationship between SAPS investigating officers and forensic laboratories to prioritise the cases is being well managed. This needs to continue to maintain this improvement.

Information on all unidentified persons within the Province is submitted to the provincial SAPS commissioner's office on a weekly basis for investigation and follow-up. The number of unidentified persons (exceeding 90 days) has been managed down from an average of 192 cases in the 2008/09 financial year and currently the average for an unidentified person within FPS is 98 days.

TABULAR REPORTING ON PERFORMANCE AGAINST THE 2011/12 ANNUAL PERFORMANCE PLAN

Table 2.2.22: Performance against targets from the 2011/12 Annual Performance Plan for Forensic Pathology Services

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Manage the consequence 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	37 minutes	34 minutes	34.2 minutes	≤ 40 minutes	Improved dispatching of vehicles in the Metro through constant monitoring of response times and SAPS liaison meetings. Refer to narrative above for more detail.
			Numerator:	-	310 187	293 579	388 000	
			Denominator:	-	9 046	8 585	9 700	
		1.1.2 Provide an efficient Forensic Pathology Service through maintenance of turnaround time from admission to examination done ≤ 3.5 days.	2) Average turnaround time from admission to examination done	3.6 days	3.3 days	3.0 days	≤ 3.5 days	Improvement in the availability of hospital records through implementation of referral procedures and availability of SAPS liaison officers in some of the larger hospitals. The filling of vacant clinical posts specifically in the Winelands and Overberg GSA. Refer to narrative above for more detail.
			Numerator:	-	30 975	28 063	33 271	
			Denominator:	-	9 249	9 226	9 506	
		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)	5.1 days	5 days	4.6 days	≤ 5.5 days	Improvement in the availability of hospital records through implementation of referral procedures and availability of SAPS liaison officers in some of the larger hospitals. The filling of vacant clinical posts specifically in the Winelands and Overberg GSA. A reduction of cases covered by the normal staff component improved turnaround times. Refer to narrative above for more detail.
			Numerator:	-	41 623	38 101	46 521	
			Denominator:	-	8 260	8 341	8 458	

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
2. Ensure and maintain organisational strategic management capacity and synergy.	2.1 Develop integrated support and management structures to render effective FPS.	2.1.1 Develop integrated support and management structures to render effective FPS service.	4) Number of unknown persons exceeding 90 days	111	88	99	≤125	A conservative target was set based on 2009/10 data. Performance dependent on ability to identify deceased through fingerprint analysis or visual identification. Rely on external parties e.g. SAPS to perform scientific investigations such as DNA analysis and facial reconstruction. Refer to narrative above for more detail.

Changes to planned targets

No changes were made to targets during the year.

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

Strategic Goals

The Medicine Trading Account contributes to the following strategic goal of the Department:

1) Ensure and maintain organisational strategic management capacity and synergy.

Strategic Objectives

The strategic objective for the Medicine Trading Account is:

- Increase working capital annually in line with the projected inflator.

Performance indicators and targets

1) Ensure and maintain organisational strategic management capacity and synergy

During 2011/12, with the change in management structures at the Cape Medical Depot (CMD), there was a significant reduction in the number of medicines not consistently available for patients at all levels of care.

The working capital remained in line with stockholding at the CMD and its expenditure for medicines during the reporting period was R599 million.

Chronic Dispensing Unit (CDU)

The CDU services have continued to grow and at present there are some 170 000 prescriptions that are pre-packed 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 awarded a new contract for these services for a further five years to a new service provider. This process was unfortunately delayed and complicated by repeated legal challenges from the current service provider.

Table 2.2.23: Performance against targets from the 2011/12 Annual Performance Plan for the Medicine trading account

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10	2010/11	2011/12		
1. Ensure and maintain organisational strategic management capacity and synergy.	1.1 To ensure adequate working capital to allow for efficient stockholding of 184et184esent 184ed184l and non-pharmaceuticals at the Cape Medical Depot.	1.1.1 Increase working capital annually in line with the projected inflator.	1) Working capital in the medicine trading account	R 48.507 million	R 88.332 million	R 100.867 million	R 68 million	The CMD must ensure that adequate funding is made available to purchase stock and fully fund stock held at any given time. This necessitated a request to augment the working capital. Medical inflation and in particular the cost of pharmaceuticals resulted in a significantly higher stock value at the CMD. Poor supplier performance led to an increase in the procurement and stock holding at the CMD. Stock holding was increased to meet increased service needs. This resulted in a disjuncture negatively affecting Departmental cash flow as the stock value exceeded the working capital available. The request for augmentation was granted on 31/03/2011 by Provincial Treasury.

Changes to planned targets

No changes were made to targets during the year.

2.2.8 Programme 8: Health Facilities Management

Purpose

To provide for new health facilities and the upgrading and maintenance of existing facilities.

Analysis per sub-programme

Sub-programme 8.1: Community Health Facilities

Construction of new community health centres, community day care centres, and community health clinics, and the upgrading and maintenance of community health facilities.

Sub-programme 8.2: Emergency Medical Services

Construction of new emergency medical service facilities, and the upgrading and maintenance of all emergency medical service facilities.

Sub-programme 8.3: District Hospital Services

Construction of new district hospitals, and the upgrading and maintenance of all district hospitals.

Sub-programme 8.4: Provincial Hospital Services

Construction of new provincial hospitals, and the upgrading and maintenance of all provincial hospitals.

Sub-programme 8.5: Central Hospital Services

Construction of new central hospitals, and the upgrading and maintenance of all central hospitals.

Sub-programme 8.6: Other Facilities

Construction of other new health facilities, and the upgrading and maintenance of all other facilities.

Strategic Goals

Programme 8 contributes to the following strategic goal of the Department:

1) Provide and maintain appropriate health technology and infrastructure.

Strategic Objectives

The strategic objectives for Programme 8 (Health Facilities Management) are:

- Allocate 6 per cent of the total health budget to Programme 8 capital funding by 2014/15.
- Ensure and maintain appropriate access per 1 000 uninsured population to acute hospital beds by 2014/15.

Performance indicators and targets

1) Provide and maintain appropriate health technology and infrastructure

Programme 8 performed well in 2011/12 with 98.8 per cent of the overall budget being spent. A review of programme expenditure from the different funding streams reflects spending of the allocated funds ranging from 100.2 per cent of maintenance funds, to 98.3 per cent of the Hospital Revitalisation Grant, 97.7 per cent of the equitable share funds, and 97.8 per cent of the Health Infrastructure 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 department of the Department of Health. Projects are reported on in terms of the following stages: inception, planning, construction and completed. 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.
- Completed: 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 completed) could span more than one quarter and in most cases spans a longer period than that.

The construction of the projects listed below was completed in 2011/12:

- Sub-programme 8.1: Community Health Facilities
    - Grassy Park CDC (new)
    - Melkhoutfontein Clinic (new)
    - Oudtshoorn Clinic (upgrade)
    - TC Newman CDC (upgrade and additions)

- Sub-programme 8.2: Emergency Medical Services
    - Lambert's Bay Ambulance Station
    - Vredendal Ambulance Station

- Sub-programme 8.3: District Hospital Services
  - Riversdale Hospital Phase 3 upgrade
  - Khayelitsha Hospital (new)
  - Vredenburg Hospital Phase 2A
  - Ceres Hospital (partial handover – Emergency Centre handed over)
  - Mitchell's Plain Lentegeur Hospital Lifecare (alterations and additions)

- Sub-programme 8.4: Provincial Hospital Services
  - Paarl Hospital Phase 2
  - Paarl Sonstraal Hospital (UV lights)
  - Somerset Hospital (lift upgrade)
  - Stikland Hospital (ward upgrade)
  - Harry Comay Hospital (Phase 1 upgrade)

- Sub-programme 8.5: Central Hospital Services
  - Groote Schuur Hospital (pharmacy)
  - Tygerberg Hospital (PET Scan)
  - Red Cross Hospital (ward C2 upgrade)

- Sub-programme 8.6: Other facilities
  - Mitchell's Plain District Office Accommodation

Programme 8 directly supports the strategic goal by providing infrastructure that is:

- Located as indicated in the service plan to ensure accessible health care.
- Planned to facilitate the level and quantum of health care as defined in the service plan.
- Designed to ensure the efficient and effective utilisation of both human and material resources and to function in an environmental friendly manner.
- 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 Provincial Strategic Plan Strategic Objective: Improving Wellness.

R17.14 million was transferred from Programme 8 to Programme 7 (Goods and Services) during the adjustment budget period to address the shortage of funding for maintenance at facilities. The reason for the availability of these funds was a delay in the appointment of professional service providers which resulted in slower than expected expenditure in Programme 8. The remainder of the funding allocated to the Programme was spent.

In order to promote future expenditure according to the allocated budget, a three year maintenance plan is being developed which will improve planning and expenditure in future years.

Table 2.2.24: Performance against targets from the 2011/12 Annual Performance Plan for health facilities management

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10[36]	2010/11	2011/12		
1. Provide and maintain appropriate health technology and infrastructure.	1.1 Fund, construct and commission new health care facilities and upgrade and maintain all health facilities to ensure access to the integrated comprehensive health platform.	1.1.1 Allocate 6% of the total health budget to Programme 8 capital funding by 2014/15.	1) Programme 8 capital funding as a percentage of total health expenditure	4.78%	7.44%	5.97%	6%	The Department views variances of less than 5% to be within an acceptable range from the target. Performance is measured in terms of Programme 8 expenditure expressed as a percentage of the total health expenditure.
			Numerator:	473 m	918 m	799 m	816 m	
			Denominator:	9 893 m	12 345 m	13 387 m	13 395 m	
			2) Equitable share capital programme as percentage of total health expenditure	0.47%	0.15%	0.50 %	0.54%	The Department views variances of between 5% and 10% to be within an acceptable range from the target. These indicators are however monitored closely. Reporting on this indicator reflects the equitable share capital programme expenditure as a percentage of the total health expenditure.
			Numerator:	50 m	19 m	67 m	73 m	
			Denominator:	10 556 m	12 345 m	13 387 m	13 395 m	
			3) Expenditure on facility maintenance as percentage of total health expenditure	1.04%	0.72%	0.94 %	1.07%	Performance is measured in terms of facility maintenance expenditure expressed as a percentage of the total health expenditure. R17.14 million was transferred to Programme 7 due to a delay in appointing professional service providers. The remainder of the budget was spent. To minimise future under expenditure a 3-year maintenance plan is being developed to improve planning and expenditure.
			Numerator:	110 m	89 m	126 m	143 m	
			Denominator:	10 556 m	12 345 m	13 387 m	13 395 m	

36 2009/10 data updated.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10[36]	2010/11	2011/12		
			4) Hospitals funded from the revitalisation programme	13.2%	13.2%	14%	16%	Delays in preparing of the project brief for Brooklyn Chest due to re-prioritisation of projects.
			Numerator:	7	7	8	9	HRP priorities changed due to the need to replace GF Jooste and revitalise Groote Schuur. The GF Jooste project brief is in process and will be submitted to NDoH for peer review. The business case for Groote Schuur is underway.
			Denominator:	53	53	57	56	
			5) Average backlog of service platform in fixed PHC facilities	Not required to report	18.4%[37]	41.9%	42%	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	-	R 300 m	R 482 m	R 480 m	It is important to note that this indicator only takes rural primary health care facilities into consideration since the majority of the Metro PHC facilities have not been transferred to WCG yet.
			Denominator:	-	R 1 630 m	R 1 150 m	R 1 150 m	
		1.1.2 Ensure and maintain appropriate access per 1000 uninsured population to acute hospital beds by 2014/15.	6) Level 1 (district hospital) beds per 1 000 uninsured population	0.57	0.55	0.55	0.58	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	2 464	2 482	2 477	2 592	
			Denominator:	4 301 882	4 490 706	4 490 706	4 491[38]	

37 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.

38 The expenditure in the target was expressed per R'000 whereas the reported information shows the full amount.

Strategic goal	Strategic objective: Title	Strategic objective	Performance indicator	Actual performance			2011/12 APP target	Reasons for variance
				2009/10[36]	2010/11	2011/12		
			7) Level 2 (regional hospital) beds per 1 000 uninsured population	0.55	0.53	0.30	0.30	The Department views variances of less than 5% to be within an acceptable range from the target.
			Numerator:	2 364	2 385	1 355	1 340	
			Denominator:	4 301 882	4 490 706	4 490 706	4 491	

Note:

Indicator 7: Reduction in the numerator between 2010/11 and 2011/12 is the result of the shift of general specialist (level 2) beds from Sub-Programme 4.1 to Programme 5.

Changes to planned targets

No changes were made to targets during the year.

ANNUAL
FINANCIAL STATEMENTS

WESTERN CAPE DEPARTMENT OF HEALTH
VOTE 6

ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

3. ANNUAL FINANCIAL STATEMENTS

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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 2012.

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 four times per annum as per its approved terms of reference. During the financial year under review, six meetings were held.

Name of member	Number of Meetings Attended
Mr Ameen Amod (Chairperson)	6
Mr Lawrence Hyslop	6
Ms Bianca Daries	6
Mr John Biesman-Simons (resigned 17 November 2011)	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 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 regulated 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.

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 with the effectiveness of the system of internal control applied by the Department.

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- **Legal and Regulatory Compliance**

  There has been significant improvement in compliance with laws and regulations as it pertains to supply chain management.

- **Significant areas highlighted by Internal Audit for improvement**

  During the year, key control deficiencies were noted by Internal Audit at certain institutions in the following areas:

  - Pharmacy
  - Finance
  - HR
  - Supply Chain Management

  Corrective actions have been agreed by management and are being monitored by the Audit Committee.

- **CMD**

  CMD has achieved a clean external audit report in the year under review. The new management team continues to make significant progress in improving operational efficiencies. We remain concerned that the entity is vulnerable with regards to Internal Control and IT Control issues.

- **Information Technology**

  The Audit Committee notes the limited progress that has been made towards implementation of the turn-around strategy to address the IT-related risks. These risks are both, departmental and transversal. The Department is aware that it is ultimately responsible for mitigating its own IT-related risks.

- **The quality of In-year Management Reports and Quarterly Reports submitted in terms of the PFMA and the 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.

- **Enterprise Risk Management**

  We note that the Department has taken full responsibility and ownership for the implementation of the Enterprise-wide Risk Management (ERM) methodology and function.

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- **FIU**

  The Provincial Forensics Investigative Unit (FIU) has been outsourced, resulting in improved services to the Department. FIU presented us with statistics that indicate that, for the year under review, 26 cases were closed, whilst 43 new cases were opened. 43 cases were in progress as at 31 March 2012.

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;
- 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; and
- reviewed and where appropriate recommended changes to the interim financial statements as presented by the Department for the six months ending 30 September 2011.

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 previous years, the Audit Committee reported that the Shared Internal Audit Unit experienced challenges relating to capacity, which impacted on its ability to achieve its plan. The Internal Audit plan for the year under review was incomplete, with a 58 per cent completion rate as at 31 March 2012. As at 31 July 2012, 89 per cent of the Internal Audit plan of the 2011/2012 financial year was completed. In August 2011 the Audit Committee had informed the Accounting Officer and the Chief Audit Executive that, in its view, the Internal Audit plan for the year would not be completed. Although further resources were made available, they were too late to complete the plan by year end.

The Department's response to the Internal Audit recommendations has been monitored as part of the review process.

The Audit Committee remains concerned that further audit coverage is required to cover a significant percentage of high risk areas. The need is now urgent for more resources for the Internal Audit team.

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Auditor-General South Africa

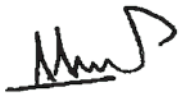
The Audit Committee has met with the Auditor-General South Africa to ensure that there are no unresolved issues that emanated from the regulatory audit. Corrective actions on the detailed findings emanating from the current regulatory audit will be monitored by the Audit Committee on a quarterly basis.

Combined Assurance

We are encouraged that the concept of Combined Assurance has been accepted by Internal Audit, External Audit and Management.

Appreciation

The Audit Committee wishes to express its appreciation to the Management of the Department, the Auditor-General South Africa and the Internal Audit Unit for the co-operation and information they have provided to enable us to compile this report.



Mr Ameen Amod

Chairperson of the Department of Health Audit Committee

Date: 10 August 2012

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REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2012

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

- **<u>Important policy decisions and strategic issues facing the Department</u>**

Strategic direction of the Department of Health

The strategic direction of the Department going towards 2020 and beyond will be captured in the Healthcare 2020 strategy which is being developed within the framework of international, national and provincial policy guidelines for health. The latter is set out in Strategic Objective 4 of the Provincial Strategic Plan. The key components of the Healthcare 2020 strategy include:

- A change management strategy to institutionalise a values-driven and client centred approach to patient care and service delivery.
- A gap analysis to identify the factors that are required to deliver a quality patient experience and the development of appropriate action plans.
- The technical planning of a financially sustainable service platform to meet the demand for services in terms of access, equity and type of service.

The guiding principles of Healthcare 2020 are:

- Patient centred quality of care;
- Health outcomes approach;
- Primary health care philosophy;
- Strengthening of the District Health System model;
- Equity;
- Affordable health care; and
- Strategic partnerships.

Further relevant documents include:

The Millennium Development Goals

The Millennium Development Goals 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.

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The National Development Plan

The National Planning Commission in the Presidency published the National Development Plan (NDP): Vision for 2030 on 11 November 2011 as a step to charting a new path for South Africa which seeks to eliminate poverty and reduce inequity by 2030. In terms of this plan the health system should provide quality health care to all, free at the point of service or paid for by publicly or privately funded insurance.

Negotiated Service Delivery Agreement (NSDA)

The desired outcome for Health, as expressed by the National Government in the Negotiated Service Delivery agreement between the President of South African and the National Minister of Health, is to improve health care and life expectancy among all South Africans. The focus areas of this agreement are:

- Increasing life expectancy.
- Decreasing maternal and child mortality.
- Combating HIV and AIDS and decreasing the burden of disease from tuberculosis.
- Strengthening health system effectiveness.

The National Health Systems (NHS) priorities

The National Health Systems (NHS) priorities for 2009 – 2014 on the National Department of Health Ten Point Plan are:

- Provision of strategic leadership and creation of a social compact for better health outcomes.
- Implementation of the National Health Insurance.
- Improving the 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 better health of the population.
- Review the drug policy.
- Research and development.

Western Cape Government: Provincial Strategic Plan

The Provincial Strategic Plan of the Western Cape Government is reflected in eleven strategic objectives i.e.:

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- Creating opportunities for growth and jobs.
- Improving education outcomes.
- Increasing access to safe and efficient transport.
- Increasing wellness.
- Increasing safety.
- Developing integrated and sustainable human settlements.
- Mainstreaming sustainability and optimising resource use efficiency.
- Promoting social inclusion and reducing poverty.
- Integrating service delivery for maximum impact.
- Increasing opportunities for growth and development in rural areas.
- Building the best run provincial government in the world.

Although the Department contributes to the achievement of many of the above provincial strategic objectives, the Department is the lead department for the strategic objective "Increasing wellness".

The primary role of the Department of Health is the provision of comprehensive health care for which Healthcare 2020 is being developed to facilitate the sustainable delivery of the appropriate service in the long-term but also to address strategies to reduce the burden of disease.

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. However, the following sections came into effect in terms of Proclamation 11 in Government Gazette No: 35081 on 27 February 2012.

Chapter	**Section**	
2: Rights and duties of users and health care personnel	11	Health services for experimental or research purposes
6: Health establishments	35	Classification of health establishments
	41	Provision of health services at public health establishments
	42	Clinics and community health centre committees
	43	Health services at non-health establishments and at public health establishments other than hospitals
	44	Referral from one public health establishment to another
	45	Relationship between public and private health establishments

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Chapter	Section	
	46	Obligations of private health establishments
	51	Establishment of academic health complexes
8: Control of use of blood, blood products, tissue and gametes in humans	54	Designation of authorised institution
	57	Prohibition of reproductive cloning of human beings
	58	Removal and transplantation of human tissue in hospital or authorised institution
	59	Removal, use or transplantation of tissue and administering of blood and blood products by medical practitioner or dentist
	60	Payment in connection with the importation, acquisition or supply of tissue, blood, blood products or gametes
	61	Allocation and use of human organs
	62	Donation of human bodies and tissue of deceased persons
	63	Human bodies, tissue, blood, blood products or gametes by donated to prescribed institution or person
	64	Purposes of donation of body, tissue, blood or blood products of deceased persons
	65	Revocation of a donation
	66	Post mortem examination of bodies
	67	Removal of tissue at post mortem examination and obtaining of tissue by institutions and persons
9: Health research and information	71	Research on or experimentation with human subjects
12: General provisions	93	Repeal of laws and savings

The following sections of the Act therefore still need to be proclaimed:

- Chapter 6: Health establishments: Sections 36, 37, 38, 39, 40 and 47.
- Chapter 10: Health officers and standards compliance.
- Chapter 12: General provisions: Sections 91, and 92.

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The Western Cape District Health Councils Act, 5 of 2010 came into effect on 24 August 2011 (Provincial Government Gazette Extraordinary 6901). As required in terms of the Western Cape District Health Councils Act the inaugural meetings for the different District Health Councils were held within 90 days of the commencement of the Act, as follows:

- West Coast District Health Council: 31 October 2011
- Central Karoo District Health Council: 2 November 2011
- Metro District Health Council: 15 November 2011
- Overberg District Health Council: 18 November 2011
- Eden District Health Council: 21 November 2011
- Cape Winelands District Health Council: 22 November 2011

The Provincial Cabinet has approved drafting and publishing for comment the Western Cape Health Facility Boards Amendment Act, which seeks to amend section 21 of the Western Cape Health Facility Board Act 7 of 2001 which deals with the compilation of Financial Statements and the auditing thereof.

- **Significant events that have taken place during the year**

The following SMS members joined the Department during 2011/12:

- Dr NTD Naledi — Director: Health Impact Assessment.
- Mr NJ Oosthuizen — Director: Engineering and Technical Support.
- Mr M Vonk — Chief Executive Officer: George Hospital.
- Ms A Bezuidenhout — Director: Finance, Groote Schuur Hospital.
- Dr L Martin — Director: Project Office, Tygerberg Hospital PPP.

The following staff members were promoted to senior management positions:

- Ms FP Africa — Director: Nursing Services — Promotion.
- Mr LR August — Chief Executive Officer: GF Jooste Hospital — Promotion.
- Mr BS Mashedi — Chief Executive Officer: Victoria Hospital — Promotion.
- Ms CD Dean — Chief Executive Officer: Valkenberg Hospital — Promotion.
- Dr SE Fourie — Director: Specialised Services Support — Promotion.

The following SMS members left the service of the Department during 2011/12:

- Mr A Dakela — Director: Engineering and Technical Support — Resigned.
- Mr NJ Oosthuizen — Director: Engineering and Technical Support — Resigned.
- Dr JWB Claasen — Director: District Health Services — Deceased.
- Dr R Nathan — Director: District Health Services — Resigned.

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Infrastructure

The new Kwanokuthula Community Day Centre (CDC) in Plettenberg Bay was officially opened by Minister Theuns Botha on 18 April 2011. This facility provides primary health care services to approximately 46 000 people in the Bitou Sub-district.

On 10 June 2011 the new Paarl Forensic Pathology Laboratory, which is on the premises of TC Newman Community Day Centre in Paarl East, was opened. The facility will serve the communities of Paarl, Paarl East, Franschhoek, Groot Drakenstein, Wellington, Klapmuts, Mbekweni and Philadelphia.

The Malmesbury Forensic Laboratory was opened on 23 September 2011 and the new Worcester Regional Forensic Pathology Services was opened on 27 September 2011.

The newly upgraded Paediatric Burns Unit at the Red Cross War Memorial Children's Hospital was officially opened on 15 September 2011. The ward is the only specialised paediatric burns unit in Africa.

The new Kwanokuthula Emergency Medical Services (EMS) station was officially opened on 3 October 2011. The ambulance station serves the Bitou Sub-district community of approximately 60 000 residents. The station is equipped to handle both medical and rescue emergencies and provides a waiting room for patients being transported on the HealthNET ambulances (patient transport between facilities).

The new Melkhoutfontein Clinic in the Hessequa Valley was officially opened on 28 November 2011. The facility brings access to quality health care closer to the community of Melkhoutfontein and will service the approximately 4 000 residents.

On 23 January 2012 new health facilities at Riversdale Hospital was officially opened. These include the Riversdale Hospital and Clinic that have both been extensively renovated over the past four years.

The Grassy Park Clinic was relocated to a new improved building and was officially reopened by Minister Botha as the Grassy Park Community Day centre (CDC) on 6 March 2012. The services provided by the CDC have been extended and now include, among others, women and child health and services for the treatment of tuberculosis and sexually transmitted infections.

The construction of Khayelitsha Hospital was completed and the first patients were admitted on 16 January 2012. This is the culmination of planning that commenced in 2005 and the construction contract that was awarded in January 2009. The hospital provides world-class modern infrastructure to render district hospital services to one of the poorest communities in the Province. Khayelitsha Hospital hosted an open day on 16 February 2012 to introduce the facility to stakeholders other than patients.

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The construction of the Mitchells Plain Hospital is in progress and is scheduled for completion in December 2012.

The trauma unit at Ceres Hospital recently underwent renovations worth more than R12 million as part of the hospital's revitalisation project.

Donations

GF Jooste Hospital received equipment items and the refurbishment of its emergency centre to the value of over R2 million from the Ibn Sina Institute of Tibb, a family trust managed by the Oasis Crescent Fund. The hospital has one of the highest volumes of emergency cases in the Western Cape and last underwent infrastructural improvement in 1996. The Oasis Crescent Fund Trust recognised the pressures placed on the existing emergency unit and took the opportunity to assist.

On 1 July 2011 Groote Schuur Hospital's Renal Unit received a generous donation of R525 000 paid into the Health Facilities Board account from Dr Arnold Tollman's family in honour of his memory. Dr Tollman suffered from kidney disease for an extensive period of his life and required a kidney transplant. This donation will provide essential state-of-the-art equipment that will improve care for patients with acute and chronic renal failure, reduce costs and make treatment safer.

Medi-Clinic donated twenty-eight cardiac intensive care unit beds to Tygerberg Hospital on 4 October 2011 which enabled the hospital to replace these beds with upgraded equipment.

The Department received two new golf carts on 11 October 2011 that were donated by the Wembley Group to Groote Schuur Hospital. The new carts will be used to transport patients and visitors, especially people that need assistance walking long distances, to the correct areas of the hospital timeously.

The Children's Hospital Trust handed over two fully equipped paediatric ambulances to the Western Cape Department of Health on 18 October 2011. The equipment currently in ambulances is not specific to the management of children. This donation enables staff of Emergency Medical Services (EMS) to help children get the necessary medical care en route to the medical facility.

Commemoration and celebration of international awareness days and other significant events

The Department commemorated International Nurses Day on 12 May 2011. The commitment and dedicated hard work of nurses was honoured at an event hosted at the Nelson's Creek wine farm in the Boland where attention was drawn to the invaluable role played by nurses in delivering quality health care to the people of the Western Cape.

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On 1 June 2011 the National Minister of Public Works hosted a business breakfast and handed out gifts to children in two wards at Red Cross War Memorial Children's Hospital in celebration of International Children's Day.

On 18 July 2011 the Department honoured Nelson Mandela Day in various ways. The message of the Mandela Day campaign is that Mr Mandela gave 67 years of his life fighting for the rights of humanity and on Mandela Day people are encouraged to give 67 minutes of their time in service to their chosen charity or community.

The Department, in association with the Division of Psychiatry at the University of Cape Town and Stellenbosch University, hosted the Annual Mental Health Update at Lentegeur Hospital on 7 October 2011.

On 28 October 2011 the Department hosted its annual Provincial Cecilia Makiwane Nurse's Recognition Awards Ceremony at the Nico Malan Hall at Groote Schuur Hospital. Marlene Davis, an auxiliary nurse with thirty-seven years' experience, is the 2011 Western Cape Provincial Cecilia Makiwane winner.

Mowbray Maternity Hospital celebrated its 95th birthday on 23 November 2011. As part of the celebration the Hospital Board launched the Centenary Campaign with the aim of raising R5 million over the next five years for capital projects, education and service training programmes. All the projects are aimed at ensuring quality health care for mothers and new born babies and achieving the Millennium Development Goal of reducing the rate of child mortality.

On 2 December 2011, the Western Cape Rehabilitation Centre commemorated International Day for People with Disabilities with participative activities for past and present clients.

Visits

Jean de Villiers, Stormers and Springbok rugby player and Resolution Health Medical Scheme brand ambassador, visited Tygerberg Children's Hospital on 9 June 2011 for a special blood drive as part of the medical scheme's corporate social responsibility programme.

Baby-Friendly Hospitals

Vredenburg Hospital hosted a celebration ceremony on 17 November 2011 and Alan Blyth Hospital in Ladismith celebrated its baby-friendly status on 13 February 2012 after achieving accreditation from the Baby-Friendly Hospital Initiative (BFHI).

The BFHI is an international accreditation process that requires a hospital to reach specific standards related to the Ten Steps for Successful Breastfeeding. The initiative is an effort to promote breastfeeding by encouraging and giving recognition to hospitals and birthing centres that offer an optimal level of care to breastfeeding women and their babies.

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Other important events

Valkenberg Hospital hosted a Forensic Mental Health Conference from 20 – 21 April 2011 to provide an overview of the current practices and issues in criminal and civil forensic mental health.

The new Surgical Skills Training Centre at the Red Cross War Memorial Children's Hospital was officially opened on 22 June 2011 which is the first of its kind in Sub-Saharan Africa to offer specialised training in paediatric endoscopic surgery.

From 25 to 29 July 2011 Red Cross War Memorial Children's Hospital hosted the Adcock Ingram Smile Week where more than twenty children with facial abnormalities received corrective plastic and reconstructive surgery, courtesy of the Smile Foundation and Adcock Ingram. The Smile Foundation partners with central hospitals to help underprivileged children with facial conditions.

On 26 July 2011 the Department celebrated the achievement of having 100 000 patients on anti-retroviral treatment (ART) at an event at the New Somerset Hospital, where the first ART clinic was established in South Africa ten years ago.

The World Health Organisation's (WHO) series of milestones in a Global Campaign for Violence Prevention meetings came to Africa for the first time. The meeting was jointly hosted by the WHO and Western Cape Department of Health at the Cape Town International Convention Centre (CTICC) on 6 and 7 September 2011. The Fifth Milestones Meeting was opened by Premier Helen Zille and the National Minister of Health, Dr Aaron Motsoaledi, and brought together leading public health experts from around the world to share the latest scientific knowledge on preventing violence-related deaths and disabilities.

On Tuesday, 25 October 2011, the new dermatology clinic at the Mitchell's Plain Community Health Centre was opened. This new development came a year after a new 24-hour emergency / trauma unit was opened at the facility, which provides a full range of services at primary level.

The Western Cape Minister of Health, Theuns Botha, and Western Cape Minister of Education, Donald Grant, officially opened the new Brooklyn Chest Hospital School on 28 October 2011. The school has been providing schooling to children admitted to the hospital for long-term TB treatment since 1997. The new school has been renovated and equipped through private sector contributions facilitated by the South African Medical and Education Foundation.

On 8 November 2011 the Premier of the Western Cape, Helen Zille, delivered the opening address at the first Wellness Summit hosted by Western Cape Government. The summit provided an important opportunity for Western Cape Government to communicate the shift in focus from treatment of disease to the promotion of health and wellness, which is one of the provincial government's strategic objectives, to relevant partners and stakeholders. The participants at the summit adopted The Cape Town Declaration on Wellness.

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The Health Department hosted its first Provincial Research Day at Valkenberg Hospital on 11 November 2011. The meeting convened researchers and service managers from the Western Cape Provincial and City of Cape Town Health Departments and provided them with an opportunity to showcase a sample of the research being done in the Province.

The refurbished Maternity Patient Centre Lounges at Groote Schuur Hospital, funded by The Foschini Group, was officially opened on 29 November 2011. Approximately fifteen mothers with their babies use the lounges daily.

On 19 January 2012, the Western Cape Government announced the revitalisation of Valkenberg Hospital is to start in January 2013.

Awards

The Head of Health in the Western Cape, Professor KC Householm, won the Top Performing Government Leader Award at the annual African Access National Business Awards held at the Sandton Convention Centre in Johannesburg on 23 June 2011. The annual award ceremony recognises and honours the top performers of the year in both business and industry, and government.

Dr Elbie van der Merwe, Head of the Tygerberg Hospital Burns Unit, was awarded the Giuseppe Whitaker International Burns Prize.

Dr Elmi Muller, a full-time surgeon at Groote Schuur Hospital, was recently awarded the Shoprite Checkers Women of the Year Award in the health care-givers category. Dr Muller and her team attracted worldwide attention in October 2008 when they were the first in the world to transplant a kidney from an HIV-positive donor to an HIV-positive recipient.

The late Professor Cas Motala, the former Head of the Allergy Clinic at Red Cross War Memorial Children's Hospital, was recently selected as the recipient of the World Allergy Organisation's Distinguished Service Award, in recognition of his life-long contribution to the field of allergy, asthma and immunology. The award was made at the 2011 World Allergy Congress held in Mexico.

- **<u>Major projects undertaken or completed during the year</u>**

The development of the draft Healthcare 2020 strategy continued during 2011/12 and a discussion document was published for comment in November 2011. Extensive technical work has been done to develop a model for the health service platform and this is still work in progress.

As part of the Provincial Transversal Management System to address the provincial strategic objectives, the Department of Health set up the six working groups to address the burden of disease:

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- Violence and road injuries prevention.
- Healthy lifestyles.
- Women's health.
- Maternal and child health.
- Infectious diseases (HIV and TB).
- Mental health.

Since 2009 the Western Cape Department of Health has adopted a seasonal approach to health promotion and prevention. These seasons are:

- Child Health season: 1 April to 30 June.
- Women's Health season: 1 July to 30 September.
- Mental Health in October and diabetes and home-based care in November.
- Infectious diseases: 1 December to 30 March.
- Chronic diseases of lifestyle are addressed in all four seasons.

The aim of the seasonal approach is to create a heightened awareness and increased active case detection through the collaboration of provincial departments, non-government organisations, civil society, industry and academic institutions.

Child Health season

The Child Health Season Campaign ran from 1 April to 30 June 2011 and drew on the good practices established during the 2010 national Measles and Polio Mass Campaign. The target group was children aged six years and younger based in crèches and day care centres. The focus of the campaign was active case finding (a retrospective record review), screening of children for dental caries and malnutrition and conducting interventions such as administering catch up immunisation, deworming and Vitamin A.

Diarrhoea is a significant cause of child mortality and is especially prevalent during the summer months from November to the end of April when infection spreads through fly infestation and contaminated food and water. Children under the age of five years and infants are especially vulnerable. As a result of the diarrhoea campaign approximately 16 per cent fewer children were admitted to hospital with diarrhoea in 2011 in comparison to 2010.

The Department launched a four-month vaccination campaign from 1 February to 31 May 2012 to ensure that all children between the ages of eighteen months and three years, and high-risk children between eighteen months and six years receive the best possible protection from pneumococcal diseases such as meningitis and pneumonia. The aim is for all these children to receive a booster dose of the pneumococcal conjugate vaccine PCV13, which offers a broader spectrum of protection than the PCV7 that was previously used.

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Women's Health season

The focus of the 2011 Women's Health Season was health services for working women. The campaign focussed on:

- Promoting maternal care including antenatal and postnatal care.
- Female cancer management: increased case findings for cervical and breast cancer.
- Reproductive health: increasing access to family planning services for contraceptive users.

In an effort to achieve this certain facilities extended their operating hours to accommodate working women.

Mental Health, Diabetes and Home-Based Care season

In addition to the Annual Mental Health update, various institutions and non-profit organisations held events to promote mental health awareness during October 2011, such as Mental Health Sport Days. The purpose of which is to enhance the self-worth of clients of mental health services. Another highlight is the annual CT International Kite Day organised by non-profit organisations.

During November 2011 the Western Cape Department of Health partnered with Diabetes South Africa to host the annual diabetic walk in Green Point in order to promote awareness. The valuable contribution of home-based care was also recognised and promoted during November 2011.

Infectious Diseases season

During 2010 the National Department of Health adopted medical male circumcision (MMC) as one of the new HIV prevention strategies and each province was given a target for 2011/12. The target for 2011/12, negotiated between the National Department of Health and the Western Cape Department of Health, was 19 400 and the programme was launched on 19 May 2011 at the Heideveld Community Health Centre.

The Western Cape target for the HIV Counselling and Testing (HCT) campaign commenced on 1 April 2010 until 30 June 2011 and the aim was to target 1.1 million people over the age of twelve years who are sexually active. Additional staff was trained to deal with the anticipated increased need for anti-retroviral therapy.

Cataracts, which account for in excess of 50 per cent of the causes of blindness, can be corrected by a simple operation that takes less than half an hour and which can restore a client's sight with life-changing effects. Promoting high volumes of cataract surgery is therefore a priority project and 6 978 surgeries were performed during 2011/12.

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The Western Cape Department of Health marketed and created awareness of its Disability Internship Programme across the Province. This programme aims to create awareness and inform the public of the employment opportunities available to disabled persons within the Department and to assist students with the transition between tertiary education and a career.

An InterTel telephonic interpreting service has been introduced at fifty public health facilities in the Western Cape in order to bridge the communication gap between health care workers and patients. To use the service, staff members must call the number designated for their facility and select the mother tongue language of the patient. An interpreter for the requested language will become available within thirty seconds and will translate questions or instructions to the patient, and the patient's response to the health care worker. This leads to improved understanding and patient care and can be used for consulting, counselling and pharmaceutical services.

The Western Cape Department of Health's Emergency Medical Services and Forensic Pathology Services participated in a planned major incident training exercise held in Worcester on 21 July 2011 together with Traffic Services, the South African Police Service and local Fire and Rescue Services. The exercise simulated a joint exercise between 18:00 and 22:00 to test the readiness of the services to respond in unison to a major incident.

The Red Cross War Memorial Children's Hospital is nationally and internationally renowned for performing complex surgical procedures on children from all the surgical specialities. This results in a significant demand for services and some less critical, but no less important, surgical needs are sometimes postponed to make place for life-saving operations resulting in long waiting lists for general and ear, nose and throat (ENT) surgery. Although elective surgery is not usually performed over weekends, in order to address this issue, the hospital and the Children's Hospital Trust partnered with Medi-Clinic Southern Africa to fund the first ever Saturday-surgeries initiative at the hospital to shorten long waiting lists for life-changing surgical procedures. The project was launched on Saturday 22 October 2011 and ended on Saturday 10 December 2011.

- **<u>Spending trends</u>**

The Department has spent an amount of R13 387 763 000 on a budget of R13 428 910 000 which constitutes overall under-expenditure of R41 147 000.

Reasons for the expenditure trends in the main are:

- Programme 2: District Health Services

  The under-spending is attributed to a reduction in anti-retroviral drug prices and revised laboratory protocols. In addition certain tenders for pharmaceuticals, although compliant with the Medicine Control Council (MCC) protocols, were not pre-qualified in terms of World Health Organisation standards. As a result funds allocated by the

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Global Fund could not be utilised to purchase these drugs which contributed to the surplus.

- Programme 3: Emergency Medical Services

The over-expenditure can mainly be attributed to the payment of overtime to meet minimum operational response times.

- Programme 5: Central Hospital Services

The over-expenditure can be attributed to outstanding sewerage and utility charges which were paid after protracted interactions with the Department of Transport and Public Works and the City of Cape Town.

Equipment scheduled for payment in the 2012/13 financial year was also paid due to early delivery from service providers. Payments were made to reduce the number of accruals/commitments to be carried forward into the 2012/13 financial year.

In a further effort to reduce accruals/commitments orders were followed-up and paid during March 2012. In order to ensure a balanced budget, BAS system reports had to be drawn on a daily basis to monitor expenditure against budget. During March 2012 it was not possible to draw reports from the system which attributed to the fact that the budget could not be controlled and balanced.

- Programme 6: Health Science and Training

The under-spending on the social sector EPWP Grant for Provinces was due to a delay in fully implementing the planned programme as well as the late submission of claims. Furthermore, the delay in finalising the contract for data capture training also resulted in a delay. Expenditure in training and related logistical costs did not occur for the first three months of the financial year.

- Programme 8: Health Facilities Management

The under-spending can be attributed to the following:

- Equitable share: Slower than anticipated acceptance of a tender for Brooklyn Chest TB Hospital. The contract on Harry Comay Hospital could not be extended and a new bidding process had to be followed. Slower expenditure than anticipated on Malmesbury Ambulance Station and Tulbagh Ambulance Station.
- Health Infrastructure Grant: Construction by the Wesbank CHC contractor was behind schedule and clarification was required in terms of design.
- Hospital Revitalisation Grant: Delay in PACS/RIS bid roll out as well as delay in delivery of equipment to Khayelitsha Hospital and George Hospital also resulted in under-expenditure.

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Over-expenditure on Equitable Share

- The Equitable Share portion of the budget was overspent by approximately R46 744 000 and this over-expenditure can be attributed to reasons as stated above and in Programmes 3 and 5 of the notes to the appropriation statement.

Unauthorised expenditure

- After application of final virements the Department recorded an over-expenditure of R2 332 000 in Programme 3 and R51 410 000 in Programme 5 in the year under review.

Virements

- All virements applied are depicted on pages 250 to 271 and reasons for the application of these virements are indicated on pages 272 to 275 of the annual financial statements. All virements were approved by the Accounting Officer.

The Vote (Department) consists of the following programmes described in brief:

Programme 1: Administration
The Ministry, Head Office.

Programme 2: District Health Services
District- and Sub-structure Offices, primary health care services and district hospital services.

Programme 3: Emergency Medical Services
Pre-hospital emergency medical services and inter-hospital transfers.

Programme 4: Provincial Hospital Services
General specialist, psychiatric, TB, chronic and dental hospitals.

Programme 5: Central Hospital Services
The tertiary component of the three central hospitals and Deputy Director General's office.

Programme 6: Health Sciences and Training
Training, mainly that of nurses.

Programme 7: Healthcare Support Services
Minor building maintenance, engineering installations and the Cape Medical Depot Capital Augmentation account.

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Programme 8: Health Facility Management

Construction, upgrading and maintenance of facilities including the hospital revitalisation and provincial infrastructure conditional grants.

Actual expenditure per programme

		R'000	%
1	Administration	410 028	3%
2	District Health Services	4 875 956	36%
3	Emergency Medical Services	637 208	5%
4	Provincial Hospital Services	2 149 535	16%
5	Central Hospital Services	4 011 137	30%
6	Health Sciences and Training	231 451	2%
7	Health Care Support Services	272 962	2%
8	Health Facility Management	799 486	6%
	Total for Department	**13 387 763**	**100%**

Actual expenditure per economic classification

		R'000	%
-	Compensation of employees	7 665 447	57%
-	Goods and services	4 132 882	31%
-	Interest (financial leases)	19	0%
-	Financial transaction in assets and liabilities	3 524	0%
-	Transfers to municipalities	302 280	2%
-	Transfers to departmental agencies (CMD and SITA)	15 651	0%
-	Transfers to universities and technikons	6 025	0%
-	Transfers to non-profit institutions	313 931	3%
-	Transfers to households	106 714	1%
-	Gifts and donations	9 853	0%
-	Buildings and other fixed structures	551 486	4%
-	Machinery and equipment	279 790	2%
-	Software and other intangible assets	161	0%
	Total for Department	**13 387 763**	**100%**

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Revenue

The Department's revenue budget of R483 191 000 was exceeded by R50 344 000. An amount of R533 535 000 was collected for the period under review of which R364 575 000 can be attributed to hospital fee accounts paid.

Actions planned to avoid a re-occurrence of under and over-expenditure in the Department

All vacancies are filled according to a process where the posts to be filled are identified beforehand according to an "Approved Posts List" (APL) to ensure that the posts to be filled are funded in the budget. Vetting and expenditure monitoring processes have also been introduced on goods and services expenditure to ensure that expenditure does not exceed the budgets as allocated to the respective SCOA items at institutional level.

In respect of the under-expenditure on the capital building projects and capital maintenance the following actions are in the process of implementation:

- Both the Department of Health and the Department of Transport and Public Works are implementing the Infrastructure Development Management System. The Department of Transport and Public Works is the implementing agent for the Department of Health and a service delivery agreement (SDA) was signed between the two Departments to regulate these functions.

2. Services rendered by the Department

The services rendered by the Department are indicated in the Programme Performance section of the Annual Report.

Tariff policy

The fees charged for services rendered at the institutions under the control of the Department have been determined and calculated according to the principles of the Uniformed Patient Fee Schedule (UPFS) as formulated by the National Department of Health.

The Department has adopted and implemented the UPFS in respect of both the externally funded patients (previously known as private and private hospital patients) and the subsidised hospital patients. Due to the size of the document setting out the UPFS tariffs, the detail is not included as part of this report, but is available on request.

Certain sundry tariffs are also charged. The basis of these tariffs is market related. These sundry tariffs apply to:

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- Meals
- Laundry
- Incineration of waste
- Lecture notes
- Day care fees
- Private accommodation

Free services

Certain free services are rendered at institutions that fall under the control of the Department. In certain instances, patients treated by a private practitioner and externally funded patients are excluded from the benefit of the free services. The criteria that apply are in line with policies as determined by the National Department of Health in this regard, and include the following:

- Children under the age of six years
- Pregnant women
- Family planning
- Infectious, formidable and notifiable diseases
- Involuntary (certified) psychiatric patients
- Termination-of-pregnancy patients
- Children attending school who are referred to hospital
- Medico-legal services
- Oral health services (scholars, examination and mobile clinics only)
- Immunisations
- Hospital personnel employed before 1976
- Committed children
- Boarders, live-in children and babies, relatives and donors
- Primary health care series
- Social grantees/pensioners
- Formally unemployed
- Anti-retroviral (ARV) services
- Examination purposes
- Home visits to H0, H1, H2 and H3 category patients
- Medical male circumcision
- Medical reports
- Patient transport
- Ambulance transport except externally funded, foreigners and H3 patients
- Air transport except externally funded, foreigners and H3 patients

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It is not possible to quantify the cost of these free services since it is dependent on the operational costs, which varies across the institutions where these services are rendered.

3. Capacity constraints

It is a challenge to recruit and retain personnel with the correct skills mix in the rural areas and special strategies and programmes are required to address gaps in occupations that are essential to deliver the required service.

The objectives of the community service placements and the rural allowance address the skills gap in remote and rural facilities.

A particular challenge is to recruit and retain the services of certain highly trained and skilled professionals in the public service. These include specialised nurses in areas such as theatres and intensive care units, pharmacists, and certain categories of medical specialists. Other areas include technical, financial and human resource staff with a high level of skills.

Budgetary constraints limit the ability of the Department to meet the full service delivery need and thus it is necessary to prioritise certain services over others which will result in the greatest impact on the health status of the Western Cape population.

4. Utilisation of donor funds

French donor funding for the upgrading of Grabouw CDC has been accepted in the books of the Department. An amount of R3 411 000 was brought forward from the 2010/11 financial year and payments amounting to R7 623 000 was made during the 2011/12 financial year. As a result of additional funding not being made available by the donor a receivable of R4 212 000 was registered in the 2011/12 financial year. An audit was requested by the donor and further tranches will be paid on receipt of the Audit Report which is in the process of being finalised.

Donor funding received has been accounted for in donor fund accounts within the financial system of the Department.

An amount of R181 583 000 was donated by the Global Fund towards HIV and AIDS prevention. Global funding has not been accounted for separately as the case with the donation mentioned above. The donation in this regard has been incorporated into the main accounting structure of the Department as a separate sub-programme as approved by the Provincial Treasury.

5. Trading entity

The Cape Medical Depot has been established as a trading entity in terms of National Treasury Regulations as from 1 April 2005.

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The Cape Medical Depot is responsible for procuring pharmaceutical, medical and surgical, and other related supplies. Bulk buying results in cost effectiveness as well as standardisation of products. A further advantage of maintaining a depot is to minimise stockholding on products at institutional level.

The trading entity charges a levy of 8 per cent on store stock and 5 per cent on direct delivery purchases to fund its operational costs.

A separate set of financial statements on the Cape Medical Depot have been included in this report. The financial statements of the Department and the Cape Medical Depot have not been consolidated. The financial statements of the Department have been prepared on a modified cash basis of accounting whilst the Cape Medical Depot financial statements have been prepared in accordance with SA GAAP.

6. Organisations to whom transfer payments have been made

During the 2011/12 financial year transfers to households were made in the form of bursaries allocated, medico-legal claims paid, leave pay-outs etc.

The City of Cape Town received transfer payments for the rendering of personal primary health care services in the Cape Town Metropolitan area as well as certain rural municipalities for HIV and AIDS prevention.

Transfer payments were also made to non-governmental organisations from Global Fund contributions and the HIV and AIDS conditional grant.

Global funding was used towards the community based response programmes and AIDS funding was provided to fund lay counsellors for home based care.

SETA administration costs contributions, payments made to SA Red Cross Air Mercy Services and the augmentation of the Cape Medical Depot capital account were also funded as transfer payments.

For more detailed information in this regard please refer to Note 8 of the notes to the statement of financial performance.

7. Public private partnerships (PPP)

The status of public private partnership in the Department is as follows:

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Western Cape Rehabilitation Centre (WCRC) PPP Project

The 2007/08 year was the first year of the twelve year concession period of the agreement concluded between the Department and the Mplisweni Consortium. The services provided by the consortium are hard and soft facilities management, the refreshment, maintenance and replacement of medical equipment on the site of the Western Cape Rehabilitation Centre and the soft facilities management on the Lentegeur Hospital site for an annual unitary fee.

Assets to the value of R1 400 000 were transferred to the Mpilisweni Consortium from the Department, in accordance with the PPP agreement, for the concession period. At the end of the concession period, assets to the same value (escalated by CPI) will be returned to the Department.

An amount of R46 799 000 was paid as unitary fees for the 2011/12 financial year. (Note 30 refers).

8. Corporate governance arrangements

Audit Committee

The Department has an Audit Committee which consisted of four independent members, until the resignation of one member on 17 November 2011. At year-end the Audit Committee comprised of three independent members.

The Audit Committee meets on a regular basis (at least quarterly) and operates in terms of an approved Audit Committee Charter. The committee has effectively fulfilled its role overall and maintained good relations with Executive Management and the Head of the Department. The specific focus of the Committee was on the following:

- the effectiveness of the internal control systems;
- the effectiveness of the internal audit function;
- the risk areas of the Department's operations to be covered in the scope of internal and external audits;
- the adequacy, reliability and accuracy of the financial and performance information provided to management and other users of such information;
- any accounting and auditing concerns identified as a result of internal and external audits;
- the Department's compliance with legal and regulatory provisions; and
- the activities of the internal audit function, including its annual work programme, co-ordination with the external auditors, the reports of significant investigations and the responses of management to specific recommendations.

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Enterprise Risk Management

The Western Cape Government's (WCG) Enterprise Risk Management (ERM) policy constitutes the Province's overall intention and direction in respect of ERM and was approved by the Director-General on 7 March 2012, after consultation with Provincial Top Management.

The Directorate: Enterprise Risk Management in the Department of the Premier provided some support to the Department to address risk management and governance practices. A service level agreement covering the specific ERM services and obligations of all parties is in place.

For the financial year under review the Department of Health (DoH) embraced ERM within the Department as follows:

- Approved an Enterprise Risk Management implementation plan.
- Approved a risk management strategy, issued under Circular H94 of 2011.
- The establishment of a separate Enterprise Risk Management Committee (ERMCO) consisting of representatives from programmes, the risk champion as the chairperson and the CFO as the co-chairperson.
- A new risk champion was appointed in February 2012.
- The departmental Strategic Risk Register was compiled and is included in Part A of the Annual Performance Plan for 2012/13.
- The Department identified key risks per programme during March 2012.

Internal Audit

Internal Audit continued to be offered by the shared Internal Audit function that was corporatised in the Corporate Services Centre in the Department of the Premier.

A risk based rolling three year Strategic and Annual Operational Internal Audit Plan was approved by the Audit Committee, and the Audit Committee monitored the execution of the operational plan. Quarterly reports containing the progress of audits completed during the 2011/12 financial year were submitted to the Audit Committee and Accounting Officer.

An area of concern is the low level of risk coverage in the Department on the Internal Audit plans, which necessitates significant prioritisation of Internal Audit resources on an on-going basis. It is envisaged that in the near future the increased maturity in the risk management processes will further improve value-added services from Internal Audit, allowing Internal Audit to focus and apply its scarce resources on risks with significant impact to the strategic intent of the Department. The Department raised the concern with Internal Audit management and augmented capacity was provided which will potentially improve the coverage in the next financial year.

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9. Discontinued activities / activities to be discontinued

No services were discontinued during the review period.

10. New / proposed activities

The Khayelitsha Hospital services were fully commissioned from 15 January to 31 March 2012, with significant impact across the service delivery platform in the Cape Town Metro District.

New procedures and technologies are being introduced and existing services improved.

11. Asset management

All institutions have asset registers for both minor and major assets which are maintained on a daily basis. The Department's assets are housed in the SYSPRO Asset Management System (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. During the year under review the Department also submitted documents and explanations to the Auditor-General of South Africa that clarified all the discrepancies between the values of the opening balances as per the Financial Statements and the actual values on the asset registers as on 31 March 2011 meaning that the Auditor-General of South Africa accepted the opening balances for 2011/12 and could concentrate the audit for 2011/12 on the movements during 2011/12 only. Rigorous and continuous evaluation of the physical existence of assets over the last three years at the central hospitals also culminated in the Department being in a position to clear it's records of numerous assets that were double counted as a result of the moving platform and vast premises presented by the central hospitals.

During this period the Department also completed a drive to clear its asset registers of all assets on the registers at nominal values and to value these assets at either actual or reasonable values through an acceptable accounting process of valuation.

The committees responsible for driving the Annual Acquisition Plans for vehicles, computer, medical and other assets per institution, succeeded in completing their plans for 2011/12 before the end of the 2010/11 financial year enabling the procurement division to utilise and exploit the advantages of economies of scales by arranging contracts and standardising on certain equipment. Vehicles are purchased through Government Motor Transport on an annual basis. Unfortunately the national contract arranged by the National Department of Transport and Public Works for vehicles only became available during June 2011 which posed a challenge as some specific models of vehicles had to be changed because of unavailability on the new contract. Disposal of assets are done via disposal committees in accordance with departmental policies. The condition of the Department's assets fall either within the category of fair or good as items that are classified bad are being disposed of.

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Various standard operating procedures are in the process of being finalised and the first, covering asset counts, has been issued during this period. The rest are planned to be finalised and issued during the new financial year.

12. Inventories

Inventory opening and closing balances are reflected on Annexure 6 of the annual financial statements.

The Department embarked on a process to procure an "Off the Shelf" pharmaceutical inventory management system for those institutions where the Departmental Pharmaceutical Management System (JAC) will not be rolled out. The bid had to be cancelled as the costs of the system provided in the bid exceeded the available budget. As a result inventory movements at these pharmacies could not be recorded. The under-mentioned pharmacies did not conduct a stock count resulting in the stock balances recorded on Annexure 6 being understated:

Elsies River, Westridge, Albow Gardens, Grassy Park, Greenpoint, Hout Bay, Kensington, Lady Michaelis, Lotus River, Maitland, Mamre, Retreat, Robbie Nurock, Vanguard and Woodstock.

13. Events after the reporting date

Central hospitals asset write-off

During 2007/08 a Consortium was appointed to assist the central hospitals with the identification, marking and recording of assets. It was very difficult at the time to distinguish between assets belonging to the hospitals, universities and privately owned assets. Since 2007/08 annual asset counts have been conducted and as a result of the above-mentioned, assets registered on the asset registers of the hospitals have been overstated as university and privately owned assets were also incorporated into the register initially. Assets that could not be traced over the last three years have been identified for write-off.

The value of the assets to be written-off as per asset registers is as follows:

	R'000
Groote Schuur Hospital	43 700
Tygerberg Hospital	11 900
Red Cross War Memorial Children's Hospital	1 400
Oral Health Centre	3 300
Total	**60 300**

A submission for write-off has subsequently been forwarded to the Head of Department for consideration and approval, where after the Asset Register will be corrected.

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14. Information on predetermined objectives

Processes to deliver performance information

Service delivery performance data is collected from 468 primary health care facilities, 53 hospitals, 50 ambulance stations and 18 forensic pathology laboratories in the Province. In addition, performance data is also collected from several non-profit organisations that render home-based and step-down care and private facilities such as general practitioners, pharmacies, clinics and hospitals that render HIV counselling and testing, family planning and immunisation services from stock provided by government.

Due to the dispersed nature of the organisation and the fact that data is collected daily as health services are rendered to clients, the systems and processes to collect and verify performance data are complex. Pre-determined data elements are collected at the point of service delivery by medical and administrative staff working in health facilities. The collection processes range from manual tick registers to automated transaction processing systems where such systems have been implemented.

The pre-determined data that is collected is based on the reporting requirements from National and Provincial Treasury, specific reports such as the Negotiated Service Delivery Agreement (NSDA), datasets prescribed by the National Department of Health and datasets required by managers in the Western Cape Department of Health. Based on the reporting requirements, data collection tools, processes and systems are developed, documented and implemented in a standardised manner as far as possible throughout the Department.

The data collected on a routine basis is collated at the end of the reporting period, which is usually a month, and then aggregated into facility, sub-district, district, programme and provincial totals. During the processing of performance data at each level, several data quality checks are performed to ensure good quality and reliable performance data. The data flow policy describes the route from the facility to the provincial office whilst the standard operating procedures provide the detailed processes and functions that must be performed at each level.

Data capturing takes place at the hospital or, in the case of primary health care facilities, at sub-district level. Information officers have been appointed at different levels in the organisation to take responsibility for managing the information functions and to ensure that data is captured and verified within the prescribed time-frames.

Managers at various levels are accountable for the data submitted and each submission of data to the next level is approved by the appropriate manager - from the service point to the Head of Department.

At the provincial level, the Directorate: Information Management is responsible for providing management with the performance information required for statutory reporting. This data is

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discussed and validated by each programme at mini-Monitoring and Evaluation meetings held prior to the quarterly Provincial Monitoring and Evaluation Committee meeting.

Processes adopted to achieve requirements

Progress on the measurable objectives, indicators and targets specified in the Annual Performance Plan (APP) is monitored on a quarterly basis by means of the Monitoring and Evaluation (M & E) Committee. The committee is chaired by the Head of Department and consists of budget programme managers and support staff as well as representatives from the Chief Directorate: Strategy and Health Support. The discussions at the meetings focus on the identification and explanation of variances between the actual performance and the targets that were set in the APP, trends, and challenges experienced by the programmes.

Several internal policies and standard operating procedures have been formally documented to ensure data collection and processing is standardised across the organisation. These policies and standards include:

- Data element and indicator definitions.
- Standard operating procedures (SOPs) for data collection and processing at facility, sub-district and district levels.
- Provincial data flow policy.
- Data quality standards related to completeness, accuracy and timeliness.

An information management supervisory visit tool has been developed to ensure compliance with policies and standard operating procedures at facility, sub-district and district level.

A Joint Information Management Initiative (JIMI) process is being established with each one of the eight budget programmes. The aim of the project is to establish sound information management practices in each programme and to ensure that the necessary data collection tools and documents are implemented that will provide the required audit trail for performance information. The JIMI projects have been established for District Health Services, Emergency Medical Services, Forensic Pathology Services, Provincial Hospital Services, Central Hospital Services and Health Sciences and Training.

The Department is also in the process of incorporating all performance information into a central repository housed with the Directorate: Information Management. Historically datasets were implemented and managed by various health programmes within the Department and this led to unnecessary duplication and limited control over data quality processes and standards. Although a concerted effort has been invested in this project over the last two years, as yet not all datasets have been incorporated into the central repository. The process of incorporating the data is complex and time-consuming as it involves the documentation of system descriptions, data sources, data flow outlines, data element definitions, indicator definitions, calculated field definitions and validation rules in the standardised formats. After the necessary documentation has been completed, the software is updated and training is provided prior to implementation.

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One of the audit risks identified by the Department is the vast amount of data that is currently being collected. The Department has and continues to review the national and provincial datasets in order to reduce the number of indicators that are being monitored and in the process decrease the burden on staff working at health facilities.

Data sign-off procedures and tools have been developed to ensure that managers authorise the data submitted from their area of responsibility and are thus held accountable for it. The procedures include data quality checks, in line with the data quality standards mentioned above, that must be performed and reviewed before the data can be signed off.

In response to the audit findings for the 2009/10 financial year, a Compliance Monitoring Instrument (CMI) for predetermined objectives was developed for facility, sub-district, district and programme managers. The aim of the CMI is to monitor the implementation of existing and new prescripts that have been developed in response to audit findings. The CMI was revised for 2012/13 in line with the 2010/11 audit findings, short comings and changes in processes implemented for the new financial year.

Progress made on reporting of performance information

A detailed action plan was developed in response to the audit findings for the 2010/11 financial year. The action plan included the development/revision and implementation of the following tools mentioned above:

- Information management supervisory visit tool.
- Data sign-off procedures.
- Data quality reports on the SINJANI software required for sign-off procedures.
- Compliance Monitoring Instrument for predetermined objectives.

Through the implementation of these tools, and workshops conducted with information staff from across the Province, the awareness of staff and managers on data quality issues and the audit in general has increased significantly.

In addition the Province instituted a pre-audit process aligned to the processes of the Auditor-General of South Africa to assess the compliance and audit readiness of the selected facilities. The pre-audit and subsequent feedback served to highlight shortcomings but also helped to increase the awareness of staff and managers on data quality issues and the audit in general and reinforce standards and processes established by the Directorate: Information Management.

As the custodian of performance information, the Directorate: Information Management now takes responsibility for providing the performance information reported in all statutory and internal reports. This facilitates better control over the information that is reported in the Quarterly Performance Reports and Annual Report and ensures that, where available, only information from the central repository is used. By using information from the central repository, a certain level of data quality is guaranteed.

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Electronic systems used by the Western Cape Department of Health

Some of the electronic systems used by the Department to generate performance information are listed below:

- Hospital Information System (HIS): Patient based information system used at hospitals.
- Delta-9: Patient based information system used at hospitals. This software is being phased out with the implementation of the HIS software.
- Primary Health Care Information System (PHCIS): Patient based information system that is being developed for PHC facilities.
- Patient Record and Health Management Information System (PREHMIS): Patient based information system used by the City of Cape Town Metropolitan Municipality.
- eKapa: Patient based information systems for the clinical management of patients treated for HIV and AIDS.
- e-Register: Patient based information system for the registration and management of patients treated for HIV and AIDS.
- Electronic Tuberculosis Register (ETR.net): Patient based information system for the registration and management of patients treated for tuberculosis.
- Central Reporting of All Delivery data on Local Establishment (CRADLE): Patient based information system for the clinical management of obstetric and neonatal patients.
- Perinatal Problem Identification Program (PIPP): Tool for auditing perinatal deaths and determining the cause of death and specific avoidable factors (i.e. actions of the mother, health personnel or health system).
- GEMC 3: Computer Aided Dispatch System for emergency medical services.
- HealthNET booking system: Booking system for patient transport in emergency medical services.
- Fleetman: Fleet management system used by emergency medical services.
- C-Track: Vehicle tracking system used by emergency medical services.
- Forensic Pathology Information System (FPS): Management of forensic pathology services.
- Standard Information Jointly Assembled by Networked Infrastructure (SINJANI): Software used to record individual records and aggregated performance information for various health programmes and services.
- Basic Accounting System (BAS): Financial management system.
- Logistics Information System (LOGIS): Supply chain management system.
- Personnel and Salary System (PERSAL): Human resource management system.

15. SCOPA resolutions

Matters from the Report of the Standing Committee on Public Accounts dated 24 June 2011 are as follows:

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Background / Reference to audit report	**Resolution / Concerns**	**Department response**
The report, commissioned by the Head of the Department of Transport and Public Works, from an independent advisor expressed views with regard to alleged fruitless and wasteful expenditure on infrastructure projects, namely Western Cape Nurses College, Valkenberg High Care Nurses Admission Unit and schools. The recommendations made by the advisor relating to business processes and controls have been addressed, final accounts have been compiled and the State Attorney has been mandated to recall guarantees. The process forward is to recover any fruitless and wasteful expenditure and to consider the write-off of any irrecoverable fruitless and wasteful expenditure. It was agreed with the Provincial Accountant-General on 16 July 2009, that the transactions will only be recorded in the books of account once the irrecoverable amount is quantified. It was further confirmed that any write-off will be recorded in the books of account of the client Department as the provisions for infrastructure delivery in terms of the Division of Revenue Act is vested in the votes of the client Departments, namely Health and Education.	(a) The Committee resolved that the Department must ensure that between its service level agreement and that of the Department of Transport and Public Works, the companies that are awarded the contracts have the capacity to do and complete the work.	A Service Delivery Agreement (SDA) which governs the relationship between the implementing department, Department of Transport and Public Works (DTPW) and the client department, Department of Health (DoH) is reviewed and signed annually by the Heads of both Departments. This SDA is supported by the Western Cape Infrastructure Delivery Management System (WC-IDMS) – as approved by the Provincial Cabinet in April 2011. The WC-IDMS articulates uniform processes that must be followed by the DoH, WCED, DTPW and Provincial Treasury (PT) in the planning and delivery of health and education infrastructure in the Province. Of particular relevance here, the WC-IDMS prescribes greater client department involvement in the procurement and awarding of construction tenders through representation on the three Bid Committees, namely, Bid Specification Committee, Bid Evaluation Committee and Bid Adjudication Committee. The WC-IDMS further notes that, in the event of a failure to agree on a recommendation from a Bid Committee, the WCDoH representative can inform the Head of Department who has the right to object.

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REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2012

Background / Reference to audit report	**Resolution / Concerns**	**Department response**
Notwithstanding the afore-mentioned, the accounting treatment for fruitless and wasteful expenditure and losses that may arise will be provided by the Provincial Accountant-General.		If consensus is not reached between the two departments the matter is then referred to the Provincial Treasury who is the arbitrator to resolve the dispute. In terms of the WC-IDMS, it is the DTPW's responsibility to ensure that the procurement leader undertakes the following: - Make use of the requisite professional skills in the procurement process. - Oversee the development of the procurement documents and manage the procurement process from the advertisement of tenders to the award of the contract as a single point of responsibility. It is thus clear that the onus of choosing the most appropriate and competent contractor resides with DTPW.
	(b) Awards made to suppliers were not based on preference points that were allocated and calculated in accordance with the requirements of the Preferential Procurement Policy Framework Act, 2000 (Act No. 5 of 2000) and its regulations and National Treasury Instruction Note of 15 September 2010.	The requirements of the PPPFA effective from 7 Dec 2011 has been rolled-out and incorporated in provincial departmental procurement procedures. Registration of suppliers on the Western Cape Suppliers Database has become compulsory as per the Provincial Treasury Instructions issued during March 2012, effective from 1 April 2012.

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for the year ended 31 March 2012

Background / Reference to audit report	Resolution / Concerns	Department response
	The Committee resolved that there must be a process in place to control the access of suppliers who do not meet the required PPPFA.	This will ensure compliance to all governance related issues, as well as a monitoring mechanism for the Provincial Treasury. In terms of the new Preferential Procurement Regulations tenderers can only be considered for B-BBEE preferential points if they submit their original and valid B-BBEE status level verification certificate or a certified copy thereof. The Provincial Treasury, through its Service Provider is in the process of approaching the 7 000 active suppliers on the database to obtain B-BBEE certificates issued by a verification agency accredited by the South African Accreditation System and application declaration. This process is managed by Provincial Treasury and the DTPW will use this database for the procurement of service providers. The Department is not aware of instances where tenders were adjudicated and preference points or applicable CIDB registration was not applied other than instances of joint ventures where the applicable CIDB registration of both partners was not considered. Adjudication of tenders in the event of joint ventures has been revised to be CIDB compliant to our knowledge.

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for the year ended 31 March 2012

Background / Reference to audit report	**Resolution / Concerns**	**Department response**
		The CIDB grading does not guarantee competence and ability of the tenderer in question and each tender adjudication process considers the information available at the time in terms of tender's financial capability, resources available, previous projects completed etc. The nature of the built environment does not guarantee the successful completion of a project or the non-bankruptcy of a prospective tenderer in future. To give effect to the resolution pertaining to the SDA, the WC-IDMS has been adopted by Cabinet and implemented by both the Department of Health and Transport and Public Works.
As disclosed in notes 26.2 and 26.4 to the financial statements (pages 327 and 329 to 330) irregular expenditure totalling R119.2 million (2009-10: R27.2 million) was discovered and/or incurred during the year under review as result of non-compliance with laws and regulations relating to procurement and contract management and human resource management and compensation.	(a) The Committee is pleased to note that there was no unauthorised expenditure in the current year, however, it expresses its concern on the significant increase of irregular expenditure from R27 million to R119.2 million and R106.7 million which was detected during the audit process, not by the Department's internal control activities.	**<u>SCM in general</u>** It should be noted that SCM was treated as a specific and focused audit by the Auditor-General during the 2010/11 financial year. Irregular expenditure declared was the cumulative amounts on contracts concluded dating back to the 2006/07 financial year. The Department also identified irregular expenditure through internal auditing processes during the course of the year.

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REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2012

Background / Reference to audit report	**Resolution / Concerns**	**Department response**
Included in this amount is irregular expenditure of R106.7 million (2009/10: R5.6 million) which was detected during the audit of procurement and contract management and human resource management and compensation, which was not prevented or detected by the Department's internal control activities. Irregular expenditure totalling R89.4 million (2009/10: R5.6 million) was identified during the audit of procurement and contract management. This, as well as other material instances of non-compliance with procurement and contract management regulations identified during the audit, includes the following:		Corrective measures are addressed in the section on Internal Control Improvements hereunder.
• Awards were made to suppliers who failed to provide written proof from the South African Revenue Service that their tax matters are in order as required by the Preferential Procurement Regulations 16 and Treasury Regulation 16A9.1(d) *[par. 16 on page 268 of the annual report]*.		Although the Department ensured that Tax Clearance Certificates be obtained as part of the Supply Chain Management Reform initiative, the filing and safekeeping of these certificates were not actively policed. Corrective measures are addressed in the section on Internal Control Improvements hereunder.

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for the year ended 31 March 2012

Background / Reference to audit report	**Resolution / Concerns**	**Department response**
• Goods and services with a transaction value of over R500 000 were not procured by means of a competitive bidding process as required by Treasury Regulations 16A6.1 and 16A6.4 and National Treasury Practice Note 6 and 8 of 2007/08 *[par. 17 on page 268 of the annual report]*.		Most Competitive Bidding issues pertain to the procurement of agency staff. These issues mostly occur when the companies on the contract cannot supply staff or promised staff and at the last moment failed to deliver. In other cases limited bidding processes should have been followed with sole and preferred suppliers. Corrective measures are addressed in the section on Internal Control Improvements hereunder.
• Awards were made to suppliers who did not submit a declaration of past supply chain practices such as fraud, abuse and non-performance as required by Treasury Regulation 16A9.1(a) and National Treasury Practice Note 4 of 2006 *[par. 18 on page 268 of the annual report]*.		As with Tax Clearance Certificates the monitoring of Declarations of past supply chain practices and Declarations of suppliers with connections to the State was not afforded adequate attention. Corrective measures are addressed in the section on Internal Control Improvements hereunder.
• Awards were made to suppliers who did not submit a declaration on whether they are employed by the state or connected to any person employed by the state as required by Treasury Regulation 16A8.3 and National Treasury Practice Note 7 of 2009-10 *[par. 19 on page 268 of the annual report]*.		As above.

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Background / Reference to audit report	**Resolution / Concerns**	**Department response**
• Employees performed remunerative work outside their employment in the Department without written permission from the relevant authority as required by section 30 of the Public Service Act, 1994 (Act No. 103 of 1994) *[par. 20 on page 268 of the annual report]*.		The Department sends out circulars regarding RWOPS on an annual basis for applications to be made in the following year. In this regard Circular H185/2010 dated 27 December 2010 was distributed to all institutions responsible to maintain registers. Disciplinary measures have been taken in cases where RWOPS were performed but approval was not obtained beforehand. Furthermore RWOPS is monitored through the quarterly HR Audit Action Plan and monthly HR Compliance Monitoring Instrument where managers confirm compliance. With regard to joint staff personnel, the clinical academic head of component and the Dean of the Faculty of Health Sciences have a co-responsibility pertaining to the control, supervision and monitoring of RWOPS to ensure compliance with academic responsibilities. This has also been discussed at the Joint Standing Advisory Committee where the CEO's and Deputy Dean must report.

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for the year ended 31 March 2012

Background / Reference to audit report	**Resolution / Concerns**	**Department response**
• Awards were made to suppliers that are listed on the National Treasury's database as persons prohibited from doing business with the public sector in contravention of Treasury Regulations 16A9.1l *[par. 21 on page 269 of the annual report]*.		Awards made to prohibited suppliers pertain to one case. **<u>Internal control improvements</u>** The Department issued a Finance Instruction where the importance of obtaining the following documents were again re-iterated: - Tax clearance certificate (WCBD 2) - Combined Declaration of Interest of government Officials, Declaration of Bidders past practices and collusion with other Companies form (WCBD 4) - Contract Acceptance (WCBD 7) Templates were also designed and provided to SCM practitioners where a step by step process needs to be followed to ensure that the appropriate procurement process is achieved. A Compliance Unit has been established to ensure continuous training and also to evaluate the implementation and effectiveness of the SCM templates.

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for the year ended 31 March 2012

Background / Reference to audit report	Resolution / Concerns	Department response
		Post audits to be conducted by Devolved Internal Control Units (DICU's) will report on the use of procurement templates on a monthly basis to ensure the strengthening of controls. As from 1 April 2012 the statutory documentation mentioned above viz. the WCBD 2 (Tax Clearance Certificate) and WCBD 4 (Declaration of Interest of Government Officials, Declaration of Bidders past Practises and Collusion with other companies) will be housed on the Western Cape Supplier Database. Companies will not be registered on the Western Cape Supplier Database if they were found none compliant with any of the statutory requirements and the Department will not engage the services of companies not registered on the database. This will ease the administrative burden on the Department as companies registered on the database can be regarded as being compliant to SCM prescripts as far as statutory documentation is concerned.

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REPORT OF THE ACCOUNTING OFFICER
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Background / Reference to audit report	**Resolution / Concerns**	**Department response**
		With regards to Formal Bids the existence of statutory documentation must be indicated in the memorandum submitted to the Bid Adjudication Committee for consideration. The Provincial Treasury in close co-operation with the Departments of Health and Transport and Public Works developed a form called the WCDB 4 form that simplified and combined the WCDB 4, 8 and 9 forms.
Irregular expenditure totalling R17.3 million (2009/10: R0) was identified during the audit of human resource management and compensation. This, as well as other material instances of non-compliance with the Public Service Regulations identified during the audit, includes the following:		**<u>Human Resource Management</u>** The irregular expenditure has been discussed with all CEO's as well as HR managers after the Management Report was received to ensure compliance with the Public Service Regulations. The necessary control measures as indicated below have been put into place:
- The executive authority did not appoint selection committees to make recommendations on appointments as required by Public Service Regulation 1/VII/D.1. Furthermore, the required verifications to confirm that candidates qualify in all respects for posts and		Although the Department had a policy in place to deviate in exceptional circumstances from the normal recruitment and selection process the AGSA has indicated that contract appointments are not excluded from the requirements contained in the Public Service Regulations.

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for the year ended 31 March 2012

Background / Reference to audit report	**Resolution / Concerns**	**Department response**
that their claims in applications for posts have been confirmed, were either not performed or not documented as required by Public Service Regulation 1/VII/D.8 [par. 22 on page 269 of the annual report].		The Department has therefore issued Circular H137/2011 to inform all institutions that the recruitment and selection process should be followed in the case of contract appointments as well. The quarterly HR Audit Action Plan as well as the monthly HR Compliance Monitoring Instrument (CMI) has been amended accordingly in order to ensure compliance.
- Contrary to the requirements of Public Service Regulation 1/VII/B.5.3, employees acted in higher vacant posts for an uninterrupted period exceeding 12 months *[par. 23 on page 269 of the annual report]*.		The Department has taken this matter up with the DPSA to obtain an official directive in this regard as the e-mail from officials of the DPSA was not regarded as sufficient. The response is still awaited. The Department has amended the HR CMI and managers have been requested not to allow acting for a period longer than 12 months until a response has been received from DPSA. There are however circumstances where there is no-one else and the acting period exceed 12 months as a result of operational requirements. In such exceptional cases a submission is made to the HoD to grant approval for the payment of an acting allowance and the condonation of non-compliance to the directive.

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Background / Reference to audit report	**Resolution / Concerns**	**Department response**
- The accounting officer did not implement adequate processes of monitoring to ensure that employees do not abuse sick leave, as required by Public Service Regulation 1/V/FI *[par. 24 on page 269 of the annual report]*.		The Department has issued Circular H130/2011 to ensure that managers manage and monitor sick leave on a regular basis. The quarterly HR Audit Action Plan as well as the monthly HR CMI has been amended in this regard to ensure compliance. The Department has identified 3 681 employees in June 2011 who have utilised more than 18 days of their sick leave in the 3 year cycle and issued letters to each one and managers were requested to discuss the utilisation of sick leave with them. This process was repeated in February 2012 where 3 681 letters have been issued to employees who have 12 and less sick leave credits left. Managers were also provided with a list of the sick leave records of all their employees to monitor and manage the possible abuse of sick leave.
- The accounting officer did not implement adequate processes to ensure that all leave taken by an employee was recorded accurately and in full as required by Public Service Regulation 1/V/F(b) *[par. 25 on page 269 of the annual report]*.		Leave management is part of the quarterly HR Audit Action Plan as well as the monthly HR CMI. The Directorate: HRM has discussed the findings of the AGSA with all CEOs and HR managers after the AGSA Management Report was received. In addition to this the HoD had a video conference in this regard with all role players.

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Background / Reference to audit report	**Resolution / Concerns**	**Department response**
		The Department has also sent various circulars to all institutions to ensure that the necessary control measures are in place. The Advisory Service component of the Directorate: HRM also conducts regular audits to ensure compliance.
One material misstatement totalling R106.7 million was corrected in respect of the disclosure of irregular expenditure (2009/10: two material misstatements totalling R206.7 million in respect of major and minor assets). In addition to this, other misstatements totalling R71.6 million (2009/10: R61.1 million) in respect of various disclosure notes were corrected during the audit. Scope limitations totalling R28.1 million (2009/10: R43 million) remained at reporting date. Had the non-material misstatements of R71.6 million not been corrected during the audit process it would have had a material impact on the financial statements when aggregated with the scope limitations.	(b) The Committee further raised a concern on the indication of a breakdown of internal control to the amount of R71m as well as the inadequacy of the manual and/or automated systems to collate information relating to disclosure notes to ensure accurate and complete financial reporting.	The Department took the following steps to ensure that irregular transactions be detected: - Implement a bidding template which must be attached to all procurement batches. The bidding template require that the responsible official certify that the correct procurement procedure has been followed. In cases where the correct process has not been followed the procurement process is to be ceased until all the steps have been followed. In cases where irregular procurement still occurs, it can be attributed to negligence or the override of the control.

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for the year ended 31 March 2012

Background / Reference to audit report	**Resolution / Concerns**	**Department response**
The material misstatements, together with other corrections that had to be made to the financial statements, are indicative of a breakdown in internal control, as well as the adequacy of the manual and/or automated systems to collate information relating to disclosure notes to ensure accurate and complete financial reporting.		- Instructed that all goods and services procured be approved by a quotation committee, which is normally chaired by the CEO of an institution. - Instructed institutions to procure as much as possible consumables on mini contracts in order to reduce the number of cases of procurement. This is a new process and the effect has not as yet been measured. In order to strengthen management control the Department has implemented the following controls: - Amended the CMI (Compliance Management Instrument). CEOs of all institutions must certify monthly that his/her institution is compliant with regard to the issues (control issues) listed in the CMI. - Devolved Internal Control Units (DICU) functioning independently from institutions have been established and deployed to perform a post payment audit process to ensure that due process had been followed with a view to training and the correction of incorrect processes applied.

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Background / Reference to audit report	Resolution / Concerns	Department response
		DICU's have been strengthened to check on a random sampling basis payment batches of institutions for correctness/compliance. The amended CMI require of DICU's to monthly check a sample of batches for correctness. The Department conducted a pre-audit from October 2011 to Jan 2012 during which time a large sample of batches at a number of high risk institutions were checked according to a checklist, which was specifically designed to detect irregular expenditure. This action resulted in quite a number of irregular transactions being detected which was submitted to the Accounting Officer for condonement. This action will be performed monthly at all institutions in future.

16. Prior modifications to audit reports

Although the Department received unmodified audit opinions for the past five years the matters reported by the AGSA in the Management Reports and the Audit Reports for the 2011/12 and prior financial years were extrapolated and collated in a reporting template. This template contains issues to be addressed at head office level, monitoring mechanism to be applied at district level and actions to be taken by all institutions to ensure compliance to the various issues highlighted by the AGSA. Institutions are required to report on compliance via district offices to head office on a monthly basis. This process has been applied since 1 October 2006 and has been substantially improved in 2010 and 2011 to provide the Accounting Officer with regular information regarding compliance to date.

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A process of internally auditing vouchers and procurement processes was also conducted from November 2011 to the end of the financial year where errors were identified and corrective measures implemented.

17. Exemptions and deviations received from the National Treasury

In terms of section 79 of the PFMA, the National Treasury approved a departure from the disclosure of amortisation tables for finance lease expenditure in respect of GG vehicles as required in terms of the Departmental Reporting Framework Guide. Steps are being implemented to ensure full disclosure of GG vehicle expenditure as finance leases, including amortisation tables, for the 2012/13 financial year.

In terms of section 66 of the PFMA, read with National Treasury Practice Note 5 of 2006/07, the Minister of Finance, Economic Development and Tourism in the Western Cape has granted approval for all finance lease commitments in respect of GG vehicle expenditure that has been entered into or will be entered into that exceeds 60 months.

18. Interim Financial Statements

The Department presented Interim Financial Statements to the Provincial Treasury on a quarterly basis. These statements were evaluated by Provincial Treasury and no significant errors were found.

19. Other

Occupational Specific Dispensation for nurses

The Occupational Specific Dispensation (OSD) for nurses was implemented in the Western Cape Department of Health with effect from 1 July 2007 and was completed by 30 March 2008. The OSD was implemented in terms of Resolution 3 of 2007 and various departmental circulars indicating policy decisions to be applied with the translation. The Directorate: Human Resource Management as well as Directorate: Nursing conducted audits on the implementation process at the various Institutions. Over and above this investigation a further investigation was also conducted by the Auditor-General of South Africa (AGSA) on request of the National Department of Health. This investigation revealed overpayments amounting to R43 244 000 and underpayments amounting to R23 034 000. The Department differed with the outcome of the AGSA investigation.

These differences were taken up with the National Department of Health in collaboration with the other Provincial Departments of Health and the matter must still be addressed by National Department of Health and the Auditor-General of South Africa.

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However, overpayments of R2 177 000 and underpayments of R907 853 have been identified by the Department. These overpayments/underpayments as already indicated differ with the calculations of the AGSA as the Department has not been afforded the opportunity to engage with the AGSA on their findings. The Department was in the process of rectifying the discrepancies but was interdicted and restrained by a Labour Court Ruling during November 2008. In terms of a Labour Court Order on 24 April 2009 no salary deductions of any alleged overpayment, increase or decrease of salary notches and corrections of any kind in respect of the translation of nursing staff to the new OSD salary structures could be made in the three following months. It was envisaged that during the aforesaid three months, conclusion would be reached on the permanency of the aforesaid court order. The Department disclosed the relevant overpayments as Contingent Assets and the underpayments as Contingent Liabilities in the disclosure notes of the annual financial statements. To date no further response despite numerous requests has been forthcoming from the National Department of Health.

Environmental Rehabilitation Liability

The following activities of the Department have an impact on the environment according to the Sustainable Development Implementation Plan of the Department of Environmental Affairs in terms of NEMA.

- Medical Waste Management
- Industrial Waste Management
- Nuclear Waste Management
- Industrial Effluent
- Electricity
- General

Medical and Industrial Waste Management

The Department contracted service providers to collect and dispose medical and industrial waste at all institutions.

Nuclear Waste Management

Nuclear waste is removed from hospitals and shipped to the Nuclear Energy Corporation for further disposal.

Industrial Effluent

Municipalities are contracted to process industrial effluent generated by laundries and laboratories to ensure the degradation of the effluent. To curtail the usage of water the Department is, for example, purchasing continuous batch washers for laundries that use as little as six litres of water per kilogram of linen compared to the 24 litres used by the traditional washers.

WESTERN CAPE – DEPARTMENT OF HEALTH
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for the year ended 31 March 2012

Given the fact that eight million kg of linen is washed the potential water saving is 144 million litres per year if this technology is applied throughout the laundry service. Over and above the saving of water there is also a saving in steam that reduces carbon emissions and air pollution.

Electricity (Energy efficiency)

The Department is constantly reviewing the use of electricity to minimise usage to reduce the carbon emissions into the atmosphere. Examples are Khayelitsha Hospital which is an environmentally friendly hospital and the installation of heat pumps to produce hot water at hospitals. These machines consume one third of the electricity required to produce the same amount of hot water.

General

The above examples indicate that the Department is committed to minimise the impact of its activities on the environment. The Department has appointed contractors to restore the environment and it is therefore not necessary to provide for a contingent liability in the annual financial statements.

Related Party Transactions

During the year under review the following related parties provided services to the Department:

The Department of Transport and Public Works

The Department occupied office buildings, hospitals, clinics etc. provided by the Department of Transport and Public Works free of charge.

The Department of the Premier

The Department used IT related infrastructure provided by the Department of the Premier free of charge.

Cape Medical Depot

The Department was supplied with medical and surgical sundries by the Cape Medical Depot and the Oudtshoorn Sub-depot. These transactions are at arm's length.

WESTERN CAPE – DEPARTMENT OF HEALTH
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for the year ended 31 March 2012

Government Motor Transport

The Department of Health makes use of 1500 GG vehicles provided by Government Motor Transport. Daily tariffs as approved by the Provincial Treasury are paid on a monthly basis.

The Department of Community Safety

The Department received security advisory services and security operations from the Department of Community Safety in the Western Cape Province.

Cape Medical Depot

Amounts pertaining to the Cape Medical Depot have been removed from the Trial Balance of the Department. Separate annual financial statements have been compiled on the activities of the Cape Medical Depot. The difference on the Trial Balance has been indicated as a receivable in the books of the Department and a payable in the books of the Cape Medical Depot.

Infrastructure matters

The following is the true reflection of the meeting as confirmed by the Provincial Accountant-General on 17 July 2009 per e-mail which the Department of Health did not attend.

The report, commissioned by the Head of the Department of Transport and Public Works, from an independent advisor expressed views with regard to alleged fruitless and wasteful expenditure on infrastructure projects, namely Western Cape Nurses College, Valkenberg High Care Nurses Admission Unit and schools. The recommendations made by the advisor relating to business processes and controls have been addressed, final accounts have been compiled and the State Attorney has been mandated to recall guarantees. The process forward is to recover any fruitless and wasteful expenditure and to consider the write-off of any irrecoverable fruitless and wasteful expenditure. It was agreed with the Provincial Accountant-General on 16 July 2009, that the transactions will only be recorded in the books of account once the irrecoverable amount is quantified. It was further confirmed that any write-off will be recorded in the books of account of the client department as the provisions for infrastructure delivery in terms of the Division of Revenue Act is vested in the votes of the client departments, namely Health and Education. Notwithstanding the afore-mentioned, the accounting treatment for fruitless and wasteful expenditure and losses that may arise will be provided by the Provincial Accountant-General.

Although it is required that the Department accounts for the fruitless and wasteful expenditure the Department is not in agreement that it can be held accountable for fruitless and wasteful expenditure of this nature. The Department is not in a position to influence the procurement processes, the adjudication of bids, the final award of contracts or the quality control processes applied by the Department of Transport and Public Works.

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for the year ended 31 March 2012

This Department is therefore of the opinion that fruitless and wasteful expenditure be recorded in the books of the Department of Transport and Public Works.

The under mentioned has been reported in the Accounting Officer's Report of the Department of Transport and Public Works for the 2010/11 financial year on these projects:

Western Cape Nurses College and Valkenberg High Care Admission Unit

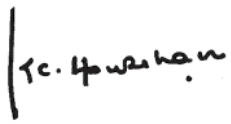
Project	Guarantee	Claim against contractor
Western Cape Nursing College	Called up and paid out.	Preparation for possible litigation is being undertaken by Legal Services.
Valkenberg High Care Unit	Claim with State Attorney Court date 2012.	Preparation for possible litigation is being undertaken by Legal Services.

Worcester Hospital

During June 2011 the contract of Sibongile Engineering at Worcester Hospital was terminated and Basil Read (Pty) Ltd was awarded the contract to complete the outstanding work. The Department of Transport and Public Works must determine to what extent "Fruitless and Wasteful" expenditure was incurred and to what extent it should be recovered.

20. Approval

The annual financial statements set out on pages 250 to 346 have been approved by the Accounting Officer.



PROFESSOR KC HOUSEHAM
ACCOUNTING OFFICER
DATE: 31 May 2012

WESTERN CAPE – DEPARTMENT OF HEALTH
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REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2012

REPORT OF THE AUDITOR-GENERAL TO THE WESTERN CAPE PROVINCIAL PARLIAMENT VOTE 6: WESTERN CAPE DEPARTMENT OF HEALTH

REPORT ON THE FINANCIAL STATEMENTS

Introduction

1. I have audited the financial statements of the Western Cape Department of Health set out on pages 250 to 326, which comprise the appropriation statement, the statement of financial position as at 31 March 2012, the statement of financial performance, statement of changes in net assets and the cash flow statement then ended, and the notes, comprising a summary of significant accounting policies and other explanatory information.

Accounting officer's responsibility for the financial statements

2. The accounting officer is responsible for the preparation of these financial statements in accordance with the *Departmental financial reporting framework* prescribed by the National Treasury and the requirements of the Public Finance Management Act of South Africa, 1999 (Act No. 1 of 1999) (PFMA) and Division of Revenue Act of South Africa, 2011 (Act No. 6 of 2011) (DoRA), and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor-General's responsibility

3. My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA), the *General Notice* issued in terms thereof and International Standards on Auditing. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

4. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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for the year ended 31 March 2012

5. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

6. In my opinion, the financial statements present fairly, in all material respects, the financial position of the Western Cape Department of Health as at 31 March 2012, and its financial performance and cash flows for the year then ended in accordance with the *Departmental financial reporting framework* prescribed by the National Treasury and the requirements of the PFMA and DoRA.

Emphasis of matters

7. I draw attention to the matters below. My opinion is not modified in respect of these matters.

Significant uncertainties

8. With reference to note 20.1 to the financial statements, the department is a defendant in the following legal claims against the department:

    - Medico legal claims : New cases totalling R62,3 million during the financial year, with a closing balance of R87,3 million
    - Civil and legal claims, including labour relations claims : New cases totalling R1,1 million during the financial year, with a closing balance of R45,1 million

9. The ultimate outcome of these matters cannot presently be determined and no provision for any liability that may result has been made in the financial statements.

Material impairments

10. As disclosed in note 25 to the financial statement the Western Cape Department of Health had receivables for departmental revenue (patient fee debtors) totalling R507 million at 31 March 2012. Of this balance the total recoverable debt is estimated at R241 million. Patient fee debt of R202,6 million was written off during the 2011-12 financial year.

Additional matters

11. I draw attention to the matters below. My opinion is not modified in respect of these matters.

Unaudited supplementary schedules

12. The supplementary information set out on pages 327 to 346 does not form part of the financial statements and is presented as additional information. I have not audited these schedules and accordingly I do not express an opinion thereon.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2012

Financial reporting framework

13. The financial reporting framework prescribed by the National Treasury and applied by the department is a compliance framework. The wording of my opinion on a compliance framework should reflect that the financial statements have been prepared in accordance with this framework and not that they "present fairly". Section 20(2)(a) of the PAA, however, requires me to express an opinion on the fair presentation of the financial statements. The wording of my opinion therefore reflects this requirement.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

14. In accordance with the PAA and the *General Notice* issued in terms thereof, I report the following findings relevant to performance against predetermined objectives, compliance with laws and regulations and internal control, but not for the purpose of expressing an opinion.

Predetermined objectives

15. I performed procedures to obtain evidence about the usefulness and reliability of the information in the annual performance report as set out on pages 11 to 190 of the annual report.

16. The reported performance against predetermined objectives was evaluated against the overall criteria of usefulness and reliability. The usefulness of information in the annual performance report relates to whether it is presented in accordance with the National Treasury annual reporting principles and whether the reported performance is consistent with the planned objectives. The usefulness of information further relates to whether indicators and targets are measurable (i.e. well defined, verifiable, specific, measurable and time bound) and relevant as required by the *National Treasury Framework for managing programme performance information*.

17. The reliability of the information in respect of the selected programmes is assessed to determine whether it adequately reflects the facts (i.e. whether it is valid, accurate and complete).

18. There were no material findings on the annual performance report concerning the usefulness and reliability of the information.

Additional matter

19. Although no material findings concerning the usefulness and reliability of the performance information were identified in the annual performance report, I draw attention to the following matter below.

WESTERN CAPE – DEPARTMENT OF HEALTH
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for the year ended 31 March 2012

Achievement of planned targets

20. Of the total number of planned targets, only 119 were achieved during the year under review. This represents 39% of total planned targets that were not achieved during the year under review. This was mainly due to the fact that the indicators being measured are demand driven, which makes it difficult to determine accurate targets, other than using prior periods' data as a predictive target. Adequate explanations were reported where targets were not met, except for programme 2 where the targets were incorrectly set.

Compliance with laws and regulations

21. I performed procedures to obtain evidence that the entity has complied with applicable laws and regulations regarding financial matters, financial management and other related matters. My findings on material non-compliance with specific matters in key applicable laws and regulations as set out in the *General Notice* issued in terms of the PAA are as follows:

Procurement and contract management

22. Awards were made to suppliers that are listed on the National Treasury's database as persons prohibited from doing business with the public sector in contravention of Treasury Regulations 16A9.1(c).

23. The accounting officer did not maintain appropriate measures to ensure compliance with section 30(b) of the Public Service Act, 1994 (Proclamation No. 103 of 1994). These sections outline that no officer or employee shall perform or engage him or herself to perform remunerative work outside his or her employment in the public service, without permission granted by the relevant executing authority or an officer authorised by the said authority. The instances identified during the audit included employees who had an interest in suppliers which transacted with other state departments, as well as employees who had an interest in suppliers which transacted with the Western Cape Department of Health.

Expenditure management

24. The accounting officer did not take effective and adequate steps to prevent and detect irregular expenditure as required by section 38(1)(c)(ii) of the PFMA and Treasury Regulation 9.1.1.

Internal control

25. I considered internal control relevant to my audit of the financial statements, the annual performance report and compliance with laws and regulations. The matters reported below under the fundamentals of internal control are limited to the significant deficiencies that resulted in the findings on compliance with laws and regulations included in this report.

WESTERN CAPE – DEPARTMENT OF HEALTH
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REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2012

Leadership

26. The department developed a plan to address internal and external audit findings by introducing a compliance monitoring instrument and decentralised internal control units, which reduced the instances of non-compliance identified during the audit of the 2011-12 financial year compared to the prior financial year. The challenge for the department in this regard is to ensure that the implementation and monitoring of this instrument and the functions of the internal control units are institutionalised so that it can contribute to sustainable processes which will continue improving audit outcomes.

Financial and performance management

27. Although the compliance monitoring instrument developed by the department placed extensive focus on compliance with laws and regulations, it is evident from the extent of non-compliance relating to procurement and contract management that full adherence to the instrument has not yet been established by the department throughout all institutions. Implementation of amendments to supply chain management policies were not adequately monitored by management.

Governance

28. Although management addressed the prior year findings on procurement and contract management in the fraud prevention plan, they omitted to include specific measures for preventing and detecting fraud in the procurement process to ensure that supply chain management fraud risks were pro-actively addressed. The annual internal audit plan for procurement and contract management was not completed for the year under review and focussed mostly on follow-up audits.

OTHER REPORTS

Investigations

29. Eighty three cases relevant to the Western Cape Department of Health appeared on the forensic investigating unit's register during the year under review. The status of these cases are as follows :

- Thirty cases relating to alleged corruption, financial irregularities, nepotism, procurement fraud, human resource irregularities and theft that were reported to the forensic investigating unit between January 2010 and March 2012 have not yet been investigated.
- Eighteen cases relating to alleged corruption, financial irregularities, procurement fraud, theft and conflict of interest that have been reported to the forensic investigating unit between November 2009 and April 2012 are in progress.
- Eight cases relating to nepotism, procurement fraud and human resource irregularities were reported to the forensic investigating unit between June 2010 and October 2011 have been referred back to the department.

WESTERN CAPE – DEPARTMENT OF HEALTH
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REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2012

- Twenty seven cases relating to alleged corruption, financial irregularities, procurement fraud, human resource irregularities and theft that were reported to the forensic investigating unit between July 2006 and January 2012 have been investigated and completed. In six of the cases no fraud or irregularities were identified and in 21 of the cases fraud and/or irregularities were identified.

Performance audits

30. During the year under review a performance audit was conducted on the Readiness of Government to report on its performance. The focus of the audit is on how government institutions are guided and assisted to report on their performance, as well as the systems and processes that they have put in place. The audit is currently in the reporting phase and the findings will be reported on in a separate report.

Agreed-upon procedures engagement

31. As requested by the department, an engagement was conducted during the year under review concerning the expenditure incurred by the department relating to funds received from Agence Francaise De Developpement to support the renovation and extension of the community health centre in Grabouw. The report covered the period March 2010 to March 2011 and confirmed that the conditions of the grant agreement were adhered to.

Other audits

32. As requested by the department, an audit was conducted during the year under review on the financial statements prepared for the donor funding received by programme 2.10, Global Fund. The audit in respect of the 2010-11 financial year will be reported on in a separate report in August 2012. A similar audit in respect of the 2011-12 financial year will commence in August 2012. These audit reports are for the purpose required by the donor and will not be tabled.

Auditor General

Cape Town

31 July 2012

AUDITOR-GENERAL
SOUTH AFRICA

Auditing to build public confidence

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

APPROPRIATION STATEMENT
for the year ended 31 March 2012

Appropriation per Programme									
	2011/12							2010/11	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
1. ADMINISTRATION									
Current payment	381 000	-	(10 382)	370 618	370 553	65	100.0%	299 088	298 717
Transfers and subsidies	21 948	-	-	21 948	21 946	2	100.0%	10 932	10 929
Payment for capital assets	10 757	-	6 780	17 537	17 507	30	99.8%	6 103	6 102
Payment for financial assets	-	-	22	22	22	-	100.0%	5 733	5 733
	413 705	-	*(3 580)*	*410 125*	*410 028*	*97*		*321 856*	*321 481*
2. DISTRICT HEALTH SERVICES									
Current payment	4 312 976	-	(1 545)	4 311 431	4 288 462	22 969	99.5%	3 835 638	3 831 320
Transfers and subsidies	575 778	-	755	576 533	541 052	35 481	93.8%	485 672	471 234
Payment for capital assets	60 558	-	(184)	60 374	45 468	14 906	75.3%	62 664	60 376
Payment for financial assets	-	-	974	974	974	-	100.0%	4 454	4 450
	4 949 312	-	-	*4 949 312*	*4 875 956*	*73 356*		*4 388 428*	*4 367 380*
3. EMERGENCY MEDICAL SERVICES									
Current payment	572 123	-	10 345	582 468	519 336	63 132	89.2%	545 824	545 823
Transfers and subsidies	35 355	-	-	35 355	35 458	(103)	100.3%	37 446	37 446
Payment for capital assets	14 938	-	1 340	16 278	81 639	(65 361)	501.5%	12 051	12 050
Payment for financial assets	-	-	775	775	775	-	100.0%	792	791
	622 416	-	*12 460*	*634 876*	*637 208*	*(2 332)*		*596 113*	*596 110*

APPROPRIATION STATEMENT
for the year ended 31 March 2012

Appropriation per Programme									
	2011/12							2010/11	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
4. PROVINCIAL HOSPITAL SERVICES									
Current payment	2 137 979	-	(19 883)	2 118 096	2 118 074	22	100.0%	2 899 406	2 899 341
Transfers and subsidies	2 885	-	1 224	4 109	4 109	-	100.0%	3 140	3 055
Payment for capital assets	22 434	-	4 580	27 014	27 014	-	100.0%	32 778	32 492
Payment for financial assets	-	-	338	338	338	-	100.0%	354	353
	2 163 298	-	*(13 741)*	*2 149 557*	*2 149 535*	*22*		*2 935 678*	*2 935 241*
5. CENTRAL HOSPITAL SERVICES									
Current payment	3 850 795	-	-	3 850 795	3 894 723	(43 928)	101.1%	2 586 425	2 584 066
Transfers and subsidies	13 627	-	-	13 627	16 183	(2 556)	118.8%	13 515	13 515
Payment for capital assets	95 305	-	(249)	95 056	99 982	(4 926)	105.2%	83 995	83 761
Payment of financial assets	-	-	249	249	249	-	100.0%	398	397
	3 959 727	-	-	*3 959 727*	*4 011 137*	*(51 410)*		*2 684 333*	*2 681 739*
6. HEALTH SCIENCES AND TRAINING									
Current payment	122 311	-	(8 593)	113 718	115 169	(1 451)	101.3%	112 407	108 645
Transfers and subsidies	114 269	-	7 455	121 724	113 231	8 493	93.0%	131 406	131 406
Payment for capital assets	875	-	(5)	870	1 908	(1 038)	219.3%	999	1 322
Payment of financial assets	-	-	1 143	1 143	1 143	-	100.0%	1	1
	237 455	-	-	*237 455*	*231 451*	*6 004*		*244 813*	*241 374*

WESTERN CAPE – DEPARTMENT OF HEALTH
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APPROPRIATION STATEMENT
for the year ended 31 March 2012

Appropriation per Programme										
		2011/12							2010/11	
		Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
		R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
7.	**HEALTH CARE SUPPORT SERVICES**									
	Current payment	246 367	-	5 591	251 958	250 452	1 506	99.4%	217 778	217 654
	Transfers and subsidies	12 953	-	(236)	12 717	12 702	15	99.9%	52 443	52 416
	Payment for capital assets	8 847	-	(517)	8 330	9 785	(1 455)	117.5%	13 625	12 478
	Payment for financial assets	-	-	23	23	23	-	100.0%	321	321
		268 167	-	*4 861*	*273 028*	*272 962*	*66*		*284 167*	*282 869*
8.	**HEALTH FACILITIES MANAGEMENT**									
	Current payment	165 747	-	-	165 747	176 215	(10 468)	106.3%	163 020	149 112
	Transfers and subsidies	9 772	-	-	9 772	9 773	(1)	100.0%	9 900	4 559
	Payment for capital assets	639 311	-	-	639 311	613 498	25 813	96.0%	780 075	764 763
		814 830	-	-	*814 830*	*799 486*	*15 344*		*952 995*	*918 434*
	TOTAL	**13 428 910**	**-**	**-**	**13 428 910**	**13 387 763**	**41 147**	**99.7%**	**12 408 383**	**12 344 628**
Reconciliation with Statement of Financial Performance										
Add:										
	Departmental receipts				50 344				21 842	
	Aid assistance				4 212				4 819	
Actual amounts per Statement of Financial Performance (Total Revenue)					**13 483 466**				**12 435 044**	
Add:	Aid assistance					7 623				1 890
Actual amounts per Statement of Financial Performance (Total Expenditure)						**13 395 386**				**12 346 518**

APPROPRIATION STATEMENT
for the year ended 31 March 2012

Appropriation per Economic classification									
	2011/12							2010/11	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current payments									
Compensation of employees	7 698 894	-	(19 350)	7 679 544	7 665 447	14 097	99.8%	6 839 093	6 808 175
Goods and services	4 090 404	-	(5 136)	4 085 268	4 067 518	17 750	99.6%	3 820 477	3 826 487
Interest and rent on land	-	-	19	19	19	-	100.0%	16	16
Transfers & subsidies									
Provinces & municipalities	322 763	-	-	322 763	302 280	20 483	93.7%	271 087	263 107
Departmental agencies & accounts	16 415	-	(764)	15 651	15 651	-	100.0%	55 488	55 341
Universities & technikons	1 926	-	5 325	7 251	6 025	1 226	83.1%	1 522	1 400
Non-profit institutions	336 613	-	-	336 613	313 931	22 682	93.3%	287 662	281 488
Households	99 098	-	4 637	103 735	106 714	(2 979)	102.9%	118 580	118 599
Gifts and donations	9 772	-	-	9 772	9 853	(81)	100.8%	10 115	4 624
Payment for capital assets									
Buildings & other fixed structures	551 807	-	(522)	551 285	551 486	(201)	100.0%	756 373	740 528
Machinery & equipment	296 089	-	13 742	309 831	279 790	30 041	90.3%	235 557	232 674
GG Vehicles	-	-	-	-	65 364	(65 364)	-100.0%	-	-
Software & other intangible assets	5 129	-	(1 475)	3 654	161	3 493	4.4%	360	143
Payment for financial assets	-	-	3 524	3 524	3 524	-	100.0%	12 053	12 046
Total	**13 428 910**	**-**	**-**	**13 428 910**	**13 387 763**	**41 147**	**99.7%**	**12 408 383**	**12 344 628**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

Detail of Programme 1 – ADMINISTRATION
for the year ended 31 March 2012

Statutory Appropriation									
		2011/12						2010/11	
Details per Sub-programme		Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
		R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
1.1	**OFFICE OF THE PROVINCIAL MINISTER**									
	Current payment	8 739		(340)	8 399	8 394	5	99.9%	6 880	6 878
	Transfers and subsidies	3		(2)	1	-	1	-	5	5
	Payment for capital assets	129		-	129	99	30	76.7%	32	32
	Payment for financial assets			-	-	-	-	-	3	3
1.2	**MANAGEMENT**									
	Current payment	372 261		(10 042)	362 219	362 159	60	100.0%	292 208	291 839
	Transfers and subsidies	21 945		2	21 947	21 946	1	100.0%	10 927	10 924
	Payment for capital assets	10 628		6 780	17 408	17 408	-	100.0%	6 071	6 070
	Payment for financial assets	-		22	22	22	-	100.0%	5 730	5 730
	Total	**413 705**	**-**	**(3 580)**	**410 125**	**410 028**	**97**	**100.0%**	**321 856**	**321 481**

Detail of Programme 1 – ADMINISTRATION
for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Programme 1 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of Final Appropriation**	**Final Appropriation**	**Actual Expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	165 615	-	(7 590)	158 025	157 965	60	100.0%	124 215	123 843
Goods and services	215 385	-	(2 792)	212 593	212 588	5	100.0%	174 873	174 874
Transfers & subsidies									
Households	21 948	-	-	21 948	21 946	2	100.0%	10 927	10 924
Gifts and donations	-	-	-	-	-	-	-	5	5
Payment for capital assets									
Machinery & equipment	9 702	-	7 792	17 494	17 464	30	99.8%	6 085	6 084
Software & other intangible assets	1 055	-	(1 012)	43	43	-	100.0%	18	18
Payment for financial assets	-	-	22	22	22	-	100.0%	5 733	5 733
Total	**413 705**	**-**	**(3 580)**	**410 125**	**410 028**	**97**	**100.0%**	**321 856**	**321 481**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

Detail of Programme 2 – DISTRICT HEALTH SERVICES
for the year ended 31 March 2012

Statutory Appropriation									
		2011/12						2010/11	
Details per Sub-programme		Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
		R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
2.1	**DISTRICT MANAGEMENT**									
	Current payment	257 278	-	(12 124)	245 154	244 273	881	99.6%	226 710	226 709
	Transfers and subsidies	130	-	755	885	884	1	99.9%	3 023	3 023
	Payment for capital assets	7 194	-	-	7 194	6 876	318	95.6%	6 740	5 559
	Payment for financial assets	-	-	369	369	369	-	100.0%	3 039	3 038
2.2	**COMMUNITY HEALTH CLINICS**									
	Current payment	758 568	-	(9)	758 559	731 199	27 360	96.4%	691 876	690 388
	Transfers and subsidies	214 947	-	-	214 947	215 206	(259)	100.1%	188 729	187 594
	Payment for capital assets	7 755	-	-	7 755	6 466	1 289	83.4%	10 787	13 411
	Payment for financial assets	-	-	9	9	9	-	100.0%	42	41
2.3	**COMMUNITY HEALTH CENTRES**									
	Current payment	1 032 742	-	(242)	1 032 500	1 048 491	(15 991)	101.5%	929 660	925 529
	Transfers and subsidies	784	-	-	784	677	107	86.4%	740	864
	Payment for capital assets	8 744	-	-	8 744	8 048	696	92.0%	8 532	8 205
	Payment for financial assets	-	-	242	242	242	-	100.0%	709	708
2.4	**COMMUNITY BASED SERVICES**									
	Current payment	36 210	-	(189)	36 021	37 457	(1 436)	104.0%	34 000	32 946
	Transfers and subsidies	111 987	-	-	111 987	109 224	2 763	97.5%	93 720	95 446
	Payment for capital assets	80	-	-	80	86	(6)	107.5%	17	90
	Payment for financial assets	-	-	189	189	188	1	99.5%	18	17
2.5	**OTHER COMMUNITY SERVICES**									
	Current payment	1	-	-	1	-	1	-	1	-

Detail of Programme 2 – DISTRICT HEALTH SERVICES for the year ended 31 March 2012

Statutory Appropriation									
		2011/12						2010/11	
Details per Sub-programme		Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
		R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
2.6	**HIV AND AIDS**									
	Current payment	485 673	-	-	485 673	501 283	(15 610)	103.2%	410 807	415 578
	Transfers and subsidies	165 634	-	-	165 634	155 253	10 381	93.7%	140 277	137 262
	Payment for capital assets	9 307	-	-	9 307	4 042	5 265	43.4%	3 970	2 131
	Payment for financial assets	-	-	-	-	1	(1)	-		
2.7	**NUTRITION**									
	Current payment	18 718	-	-	18 718	17 871	847	95.5%	15 011	15 011
	Transfers and subsidies	5 962	-	-	5 962	5 935	27	99.5%	5 668	4 759
	Payment for financial assets	-	-	-	-	-	-	-	84	84
2.8	**CORONER SERVICES**									
	Current payment	1	-	-	1	-	1	-	1	-
2.9	**DISTRICT HOSPITALS**									
	Current payment	1 624 186	-	11 019	1 635 205	1 652 638	(17 433)	101.1%	1 475 245	1 477 102
	Transfers and subsidies	1 793	-	-	1 793	2 625	(832)	146.4%	4 940	4 938
	Payment for capital assets	20 035	-	(184)	19 851	18 101	1 750	91.2%	26 540	24 526
	Payment for financial assets	-	-	165	165	165	-	100.0%	403	403
2.10	**GLOBAL FUND**									
	Current payment	99 599	-	-	99 599	55 250	44 349	55.5%	52 327	48 057
	Transfers and subsidies	74 541	-	-	74 541	51 248	23 293	68.8%	48 575	37 348
	Payment for capital assets	7 443	-	-	7 443	1 849	5 594	24.8%	6 078	6 454
	Payment for financial assets	-	-	-	-	-	-	-	159	159
	Total	**4 949 312**	**-**	**-**	**4 949 312**	**4 875 956**	**73 356**	**98.5%**	**4 388 428**	**4 367 380**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

Detail of Programme 2 – DISTRICT HEALTH SERVICES
for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Programme 2 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of Final Appropriation**	**Final Appropriation**	**Actual Expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	2 727 436	-	(15 366)	2 712 070	2 685 224	26 846	99.0%	2 377 519	2 354 906
Goods and services	1 585 540	-	13 802	1 599 342	1 603 219	(3 877)	100.2%	1 458 103	1 476 398
Interest and rent on land	-	-	19	19	19	-	100.0%	16	16
Transfers & subsidies									
Provinces & municipalities	322 763	-	-	322 763	302 280	20 483	93.7%	271 087	263 107
Non-profit institutions	249 374	-	-	249 374	233 291	16 083	93.6%	206 721	200 252
Households	3 641	-	755	4 396	5 401	(1 005)	122.9%	7 654	7 814
Gifts and donations	-	-	-	-	80	(80)	-	210	60
Payment for capital assets									
Buildings & other fixed structures	6 645	-	370	7 015	2 479	4 536	35.3%	5 423	6 482
Machinery & equipment	53 539	-	(320)	53 219	42 989	10 230	80.8%	57 241	53 895
Software & other intangible assets	374	-	(234)	140	-	140	-	-	-
Payment for financial assets	-	-	974	974	974	-	100.0%	4 454	4 450
Total	**4 949 312**	**-**	**-**	**4 949 312**	**4 875 956**	**73 356**	**98.5%**	**4 388 428**	**4 367 380**

Detail of Programme 3 – EMERGENCY MEDICAL SERVICES
for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Details per Sub-programme	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
3.1 EMERGENCY TRANSPORT									
Current payment	522 176	-	9 200	531 376	467 247	64 129	87.9%	501 333	501 332
Transfers and subsidies	35 355	-	-	35 355	35 458	(103)	100.3%	37 446	37 446
Payment for capital assets	14 938	-	1 340	16 278	81 639	(65 361)	501.5%	12 051	12 050
Payment for financial assets	-	-	775	775	775	-	100.0%	792	791
3.2 PLANNED PATIENT TRANSPORT									
Current payment	49 947	-	1 145	51 092	52 089	(997)	102.0%	44 491	44 491
Total	**622 416**	**-**	**12 460**	**634 876**	**637 208**	**(2 332)**	**100.4%**	**596 113**	**596 110**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

Detail of Programme 3 – EMERGENCY MEDICAL SERVICES
for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Programme 3 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of Final Appropriation**	**Final Appropriation**	**Actual Expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	394 204	-	1 700	395 904	398 136	(2 232)	100.6%	369 191	369 212
Goods and services	177 919	-	8 645	186 564	121 200	65 364	65.0%	176 633	176 611
Transfers & subsidies									
Non-profit institutions	35 281	-	-	35 281	35 281	-	100.0%	37 058	37 058
Households	74	-	-	74	177	(103)	239.2%	388	388
Payment for capital assets									
Buildings & other fixed structures	-	-	-	-	81	(81)	-	-	-
Machinery & equipment	14 938	-	1 340	16 278	16 194	84	99.5%	12 051	12 050
GG Vehicles	-	-	-	-	65,364	(65,364)	-100.0%	-	-
Payment for financial assets	-	-	775	775	775	-	100.0%	792	791
Total	**622 416**	**-**	**12 460**	**634 876**	**637 208**	**(2 332)**	**100.4%**	**596 113**	**596 110**

Detail of Programme 4 – PROVINCIAL HOSPITAL SERVICES for the year ended 31 March 2012

Statutory Appropriation										
		2011/12							2010/11	
Details per Sub-programme		Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
		R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
4.1	**GENERAL HOSPITALS**									
	Current payment	1 137 024	-	(20 514)	1 116 510	1 115 665	845	99.9%	1 995 940	1 995 884
	Transfers and subsidies	1 362	-	180	1 542	1 542	-	100.0%	1 703	1 703
	Payment for capital assets	17 099	-	(340)	16 759	16 736	23	99.9%	22 781	22 635
	Payment for financial assets	-	-	99	99	99	-	100.0%	145	145
4.2	**TUBERCULOSIS HOSPITALS**									
	Current payment	193 970	-	2 000	195 970	195 974	(4)	100.0%	174 984	174 983
	Transfers and subsidies	230	-	169	399	458	(59)	114.8%	217	205
	Payment for capital assets	2 319	-	70	2 389	2 326	63	97.4%	3 244	3 182
	Payment for financial assets	-	-	9	9	9	-	100.0%	58	57
4.3	**PSYCHIATRIC/MENTAL HOSPITALS**									
	Current payment	567 547	-	3 365	570 912	571 761	(849)	100.1%	512 619	512 618
	Transfers and subsidies	963	-	635	1 598	1 597	1	99.9%	877	854
	Payment for capital assets	2 473	-	906	3 379	3 379	-	100.0%	2 744	2 743
	Payment for financial assets	-	-	220	220	220	-	100.0%	136	136
4.4	**CHRONIC MEDICAL HOSPITALS**									
	Current payment	136 188	-	(2 745)	133 443	133 413	30	100.0%	121 224	121 223
	Transfers and subsidies	209	-	240	449	449	-	100.0%	229	229
	Payment for capital assets	530	-	(50)	480	470	10	97.9%	456	436
	Payment for financial assets	-	-	10	10	10	-	100.0%	13	13

WESTERN CAPE – DEPARTMENT OF HEALTH
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Detail of Programme 4 – PROVINCIAL HOSPITAL SERVICES
for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Details per Sub-programme	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
4.5 DENTAL TRAINING HOSPITALS									
Current payment	103 250	-	(1 989)	101 261	101 261	-	100.0%	94 639	94 633
Transfers and subsidies	121	-	-	121	63	58	52.1%	114	64
Payment for capital assets	13	-	3 994	4 007	4 103	(96)	102.4%	3 553	3 496
Payment for financial assets	-	-	-	-	-	-	-	2	2
Total	**2 163 298**	**-**	**(13 741)**	**2 149 557**	**2 149 535**	**22**	**100.0%**	**2 935 678**	**2 935 241**

Detail of Programme 4 – PROVINCIAL HOSPITAL SERVICES
for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Programme 4 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of Final Appropriation**	**Final Appropriation**	**Actual Expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	1 537 112	-	(1 204)	1 535 908	1 535 899	9	100.0%	2 017 154	2 016 945
Goods and services	600 867	-	(18 679)	582 188	582 175	13	100.0%	882 252	882 396
Transfers & subsidies									
Households	2 885	-	1 224	4 109	4 109	-	100.0%	3 140	3 055
Payment for capital assets									
Buildings & other fixed structures	-	-	56	56	56	-	100.0%	173	173
Machinery & equipment	22 376	-	4 504	26 880	26 880	-	100.0%	32 605	32 319
Software & other intangible assets	58	-	20	78	78	-	100.0%	-	-
Payment for financial assets	-	-	338	338	338	-	100.0%	354	353
Total	**2 163 298**	**-**	**(13 741)**	**2 149 557**	**2 149 535**	**22**	**100.0%**	**2 935 678**	**2 935 241**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

Detail of Programme 5 – CENTRAL HOSPITAL SERVICES
for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Details per Sub-programme	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
5.1 CENTRAL HOSPITAL SERVICES									
Current payment	3 850 795	-	-	3 850 795	3 894 723	(43 928)	101.1%	2 586 425	2 584 066
Transfers and subsidies	13 627	-	-	13 627	16 183	(2 556)	118.8%	13 515	13 515
Payment for capital assets	95 305	-	(249)	95 056	99 982	(4 926)	105.2%	83 995	83 761
Payment for financial assets	-	-	249	249	249	-	100.0%	398	397
Total	**3 959 727**	**-**	**-**	**3 959 727**	**4 011 137**	**(51 410)**	**101.3%**	**2 684 333**	**2 681 739**

Detail of Programme 5 – CENTRAL HOSPITAL SERVICES
for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Programme 5 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of Final Appropriation**	**Final Appropriation**	**Actual Expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	2 668 680	-	-	2 668 680	2 681 706	(13 026)	100.5%	1 762 607	1 759 828
Goods and services	1 182 115	-	-	1 182 115	1 213 017	(30 902)	102.6%	823 818	824 238
Transfers & subsidies									
Non-profit institutions	8 157	-	-	8 157	8 157	-	100.0%	7 695	7 695
Households	5 470	-	-	5 470	8 026	(2 556)	146.7%	5 820	5 820
Payment for capital assets									
Buildings & other fixed structures	-	-	-	-	70	(70)	-	-	-
Machinery & equipment	91 663	-	-	91 663	99 912	(8 249)	109.0%	83 653	83 658
Software & other intangible assets	3 642	-	(249)	3 393	-	3 393	-	342	103
Payment for financial assets	-	-	249	249	249	-	100.0%	398	397
Total	**3 959 727**	**-**	**-**	**3 959 727**	**4 011 137**	**(51 410)**	**101.3%**	**2 684 333**	**2 681 739**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

Detail of Programme 6 – HEALTH SCIENCES AND TRAINING
for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Details per Sub-programme	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
6.1 NURSING TRAINING COLLEGE									
Current payment	48 572	-	-	48 572	50 934	(2 362)	104.9%	46 248	46 247
Transfers and subsidies	2 593	-	-	2 593	704	1 889	27.2%	1 801	1 659
Payment for capital assets	336	-	(5)	331	325	6	98.2%	522	521
Payment for financial assets	-	-	5	5	5	-	100.0%	1	1
6.2 EMERGENCY MEDICAL SERVICES TRAINING COLLEGES									
Current payment	13 240	-	-	13 240	14 046	(806)	106.1%	9 795	9 725
Transfers and subsidies	5	-	-	5	-	5	-	5	-
Payment for capital assets	539	-	-	539	1 570	(1 031)	291.3%	477	801
6.3 BURSARIES									
Current payment	7 723	-	-	7 723	7 782	(59)	100.8%	8 724	8 724
Transfers and subsidies	63 990	-	2 894	66 884	66 884	-	100.0%	90 223	90 222
Payment for financial assets	-	-	1 138	1 138	1 138	-	100.0%	-	-
6.4 PRIMARY HEALTH CARE TRAINING									
Current payment	1	-	-	1	-	1	-	1	-
6.5 TRAINING OTHER									
Current payment	52 775	-	(8 593)	44 182	42 407	1 775	96.0%	47 639	43 949
Transfers and subsidies	47 681	-	4 561	52 242	45 643	6 599	87.4%	39 377	39 525
Payment for capital assets	-	-	-	-	13	(13)	-	-	-
Total	**237 455**	**-**	**-**	**237 455**	**231 451**	**6 004**	**97.5%**	**244 813**	**241 374**

Detail of Programme 6 – HEALTH SCIENCES AND TRAINING
for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Programme 6 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of Final Appropriation**	**Final Appropriation**	**Actual Expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	46 358	-	-	46 358	51 060	(4 702)	110.1%	44 169	43 309
Goods and services	75 953	-	(8 593)	67 360	64 109	3 251	95.2%	68 238	65 336
Transfers & subsidies									
Departmental agencies & accounts	3 880	-	(764)	3 116	3 116	-	100.0%	3 189	3 042
Universities & technikons	1 926	-	5 325	7 251	6 025	1 226	83.1%	1 522	1 400
Non-profit institutions	43 801	-	-	43 801	37 202	6 599	84.9%	36 188	36 483
Households	64 662	-	2 894	67 556	66 888	668	99.0%	90 507	90 481
Payment for capital assets									
Machinery & equipment	875	-	(5)	870	1 908	(1 038)	219.3%	999	1 322
Payment for financial assets	-	-	1 143	1 143	1 143	-	100.0%	1	1
Total	**237 455**	**-**	**-**	**237 455**	**231 451**	**6 004**	**97.5%**	**244 813**	**241 374**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

Detail of Programme 7 – HEALTH CARE SUPPORT SERVICES
for the year ended 31 March 2012

Statutory Appropriation									
		2011/12						2010/11	
Details per Sub-programme		Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
		R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
7.1	**LAUNDRY SERVICES**									
	Current payment	64 321	-	2 050	66 371	66 472	(101)	100.2%	59 414	59 665
	Transfers and subsidies	271	-	(231)	40	40	-	100.0%	6	5
	Payment for capital assets	49	-	512	561	560	1	99.8%	252	252
	Payment for financial assets	-	-	18	18	18	-	100.0%	315	315
7.2	**ENGINEERING SERVICES**									
	Current payment	85 992	-	431	86 423	86 306	117	99.9%	71 445	69 786
	Transfers and subsidies	147	-	(5)	142	122	20	85.9%	138	112
	Payment for capital assets	6 460	-	(1 029)	5 431	5 431	-	100.0%	4 927	4 926
	Payment for financial assets	-	-	5	5	5	-	100.0%	6	6
7.3	**FORENSIC SERVICES**									
	Current payment	96 053	-	3 110	99 163	97 674	1 489	98.5%	86 918	88 203
	Transfers and subsidies	-	-	-	-	5	(5)	-	-	-
	Payment for capital assets	2 338	-	-	2 338	3 794	(1 456)	162.3%	8 446	7 300
7.4	**ORTHOTIC AND PROSTHETIC SERVICES**									
	Current payment	1	-	-	1	-	1	-	1	-
7.5	**MEDICINE TRADING ACCOUNT**									
	Transfers and subsidies	12 535	-	-	12 535	12 535	-	100.0%	52 299	52 299
	Total	**268 167**	**-**	**4 861**	**273 028**	**272 962**	**66**	**100.0%**	**284 167**	**282 869**

Detail of Programme 7 – HEALTH CARE SUPPORT SERVICES
for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Programme 7 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of Final Appropriation**	**Final Appropriation**	**Actual Expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	142 019	-	3 110	145 129	140 190	4 939	96.6%	124 712	123 811
Goods and services	104 348	-	2 481	106 829	110 262	(3 433)	103.2%	93 066	93 843
Transfers & subsidies									
Departmental agencies & accounts	12 535	-	-	12 535	12 535	-	100.0%	52 299	52 299
Households	418	-	(236)	182	167	15	91.8%	144	117
Payment for capital assets									
Buildings & other fixed structures	5 140	-	(948)	4 192	4 231	(39)	100.9%	10 362	8 157
Machinery & equipment	3 707	-	431	4 138	5 554	(1 416)	134.2%	3 263	4 321
Payment for financial assets	-	-	23	23	23	-	100.0%	321	321
Total	**268 167**	**-**	**4 861**	**273 028**	**272 962**	**66**	**100.0%**	**284 167**	**282 869**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

Detail of Programme 8 – HEALTH FACILITIES MANAGEMENT for the year ended 31 March 2012

Statutory Appropriation										
		2011/12							2010/11	
Details per Sub-programme		Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of Final Appropriation	Final Appropriation	Actual Expenditure
		R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
8.1	**COMMUNITY HEALTH FACILITIES**									
	Current payment	17 117	-	-	17 117	26 293	(9 176)	153.6%	13 361	19 341
	Payment for capital assets	68 621	-	-	68 621	64 371	4 250	93.8%	82 223	86 381
8.2	**EMERGENCY MEDICAL RESCUE SERVICES**									
	Current payment	2 853	-	-	2 853	1 040	1 813	36.5%	-	1 653
	Payment for capital assets	29 918	-	-	29 918	27 259	2 659	91.1%	24 266	22 648
8.3	**DISTRICT HOSPITAL SERVICES**									
	Current payment	44 006	-	-	44 006	57 248	(13 242)	130.1%	22 702	32 222
	Payment for capital assets	386 835	-	-	386 835	373 277	13 558	96.5%	405 020	400 518
8.4	**PROVINCIAL HOSPITAL SERVICES**									
	Current payment	41 010	-	-	41 010	43 476	(2 466)	106.0%	50 886	32 898
	Payment for capital assets	118 052	-	-	118 052	114 524	3 528	97.0%	209 006	204 070
8.5	**CENTRAL HOSPITAL SERVICES**									
	Current payment	47 471	-	-	47 471	37 506	9 965	79.0%	59 162	49 122
	Transfers and subsidies	9 772	-	-	9 772	9 773	(1)	100.0%	9 900	4 559
	Payment for capital assets	21 168	-	-	21 168	19 254	1 914	91.0%	24 130	24 134
8.6	**OTHER FACILITIES**									
	Current payment	13 290	-	-	13 290	10 652	2 638	80.2%	16 909	13 876
	Payment for capital assets	14 717	-	-	14 717	14 813	(96)	100.7%	35 430	27 012
	Total	**814 830**	**-**	**-**	**814 830**	**799 486**	**15 344**	**98.1%**	**952 995**	**918 434**

Detail of Programme 8 – HEALTH FACILITIES MANAGEMENT for the year ended 31 March 2012

Statutory Appropriation									
	2011/12							2010/11	
Programme 8 per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of Final Appropriation**	**Final Appropriation**	**Actual Expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	17 470	-	-	17 470	15 267	2 203	87.4%	19 526	16 321
Goods and services	148 277	-	-	148 277	160 948	(12 671)	108.5%	143 494	132 791
Transfers & subsidies									
Gifts and donations	9 772	-	-	9 772	9 773	(1)	100.0%	9 900	4 559
Payment for capital assets									
Buildings & other fixed structures	540 022	-	-	540 022	544 569	(4 547)	100.8%	740 415	725 716
Machinery & equipment	99 289	-	-	99 289	68 889	30 400	69.4%	39 660	39 025
Software & other intangible assets	-	-	-	-	40	(40)	-	-	22
Total	**814 830**	**-**	**-**	**814 830**	**799 486**	**15 344**	**98.1%**	**952 995**	**918 434**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2012

1. Detail of transfers and subsidies as per Appropriation Act (after Virement):

Detail of these transactions can be viewed in the note on Transfers and subsidies, Disclosure notes and Annexure 1 (A-H) to the annual financial statements.

2. Detail of specifically and exclusively appropriated amounts voted (after Virement):

Detail of these transactions can be viewed in note 1 (Annual Appropriation) to the annual financial statements.

3. Detail on payment for financial assets

Detail of these transactions per programme can be viewed in the note on Payment for financial assets to the annual financial statements.

4. Explanations of material variances from Amounts Voted (after Virement):

Per programme	Final Appropriation	Actual Expenditure	Variance	Variance as a % of Final Appropriation
	R'000	R'000	R'000	%
Administration	**410 125**	**410 028**	**97**	**0%**
This programme is in budget after the application of virements.				
District Health Services	**4 949 312**	**4 875 956**	**73 356**	**1%**
The under-spending is attributed to a reduction in anti-retroviral drug prices and revised laboratory protocols. In addition certain tenders for pharmaceuticals, although compliant with the Medicine Control Council (MCC) protocols, were not pre-qualified in terms of World Health Organisation standards. As a result, funds allocated by the Global Fund could not be utilised to purchase these drugs which contributed to the surplus.				
Emergency Medical Services	**634 876**	**637 208**	**(2 332)**	**0%**
The over-expenditure can mainly be attributed to the payment of overtime to meet minimum operational response times.				

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2012

Per programme	Final Appropriation	Actual Expenditure	Variance	Variance as a % of Final Appropriation
	R'000	R'000	R'000	%
Provincial Hospital Services	**2 149 557**	**2 149 535**	**22**	**0%**

This programme is in budget after the application of virements.

Central Hospital Services	**3 959 727**	**4 011 137**	**(51 410)**	**(1%)**

The over-expenditure can be attributed to outstanding sewerage and utility charges which were paid after protracted interactions with the Department of Transport and Public Works and the City of Cape Town.

Equipment scheduled for payment in the 2012/13 financial year was also paid due to early delivery from service providers. Payments were made to reduce the number of accruals/commitments to be carried forward into the 2012/13 financial year.

In a further effort to reduce accruals/commitments orders were followed-up and paid during March 2012. In order to ensure a balanced budget BAS system reports had to be drawn on a daily basis to monitor expenditure against budget. During March 2012 it was not possible to draw reports from the system which attributed to the fact that the budget could not be controlled and balanced.

Health Sciences and Training	**237 455**	**231 451**	**6 004**	**3%**

The under-spending on the Social Sector EPWP Grant for Provinces was due to a delay in fully implementing the planned programme as well as the late submission of claims. Furthermore, the delay in finalising the contract for data capture training also resulted in a delay. Expenditure in training and related logistical costs did not occur for the first 3 months of the financial year.

Health Care Support Services	**273 028**	**272 962**	**66**	**0%**

This programme is in budget after the application of virements.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2012

Per programme	Final Appropriation R'000	Actual Expenditure R'000	Variance R'000	Variance as a % of Final Appropriation %
Health Facilities Management	**814 830**	**799 486**	**15 344**	**2%**

The under-spending can be attributed to the following:

Equitable share: Slower than anticipated acceptance of a tender for Brooklyn Chest TB Hospital. The contract on Harry Comay Hospital could not be extended and a new bidding process had to be followed. Slower expenditure than anticipated on Malmesbury Ambulance Station and Tulbagh Ambulance Station.

Health Infrastructure Grant: Construction by the Wesbank CHC contractor was behind schedule and clarification was required in terms of design.

Hospital Revitalisation Grant: Delay in PACS/RIS bid roll out as well as delay in delivery of equipment to Khayelitsha District Hospital and George Hospital also resulted in under-expenditure.

4.2 Per Economic classification

Per economic classification	Final Appropriation R'000	Actual Expenditure R'000	Variance R'000	Variance as a % of Final Appropriation R'000
Current expenditure				
Compensation of employees	7 679 544	7 665 447	14 097	0%
Goods and services	4 085 268	4 067 518	17 750	0%
Interest and rent on land	19	19	-	0%
Transfers and subsidies				
Provinces and municipalities	322 763	302 280	20 483	6%
Departmental agencies and accounts	15 651	15 651	-	0%
Universities and technikons	7 251	6 025	1 226	17%
Non-profit institutions	336 613	313 931	22 682	7%
Households	103 735	106 714	(2 979)	(3%)
Gifts and donations	9 772	9 853	(81)	(1%)

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2012

Per economic classification	Final Appropriation R'000	Actual Expenditure R'000	Variance R'000	Variance as a % of Final Appropriation R'000
Payments for capital assets				
Buildings and other fixed structures	551 285	551 486	(201)	0%
Machinery and equipment	309 831	279 790	30 041	10%
GG vehicles	-	65 364	(65 364)	-100.0%
Software and other intangible assets	3 654	161	3 493	96%
Payments for financial assets	3 524	3 524	-	0%

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

STATEMENT OF FINANCIAL PERFORMANCE
for the year ended 31 March 2012

	Note	2011/12 R'000	2010/11 R'000
REVENUE			
Annual appropriation	1	13 428 910	12 408 383
Departmental revenue	2	50 344	21 842
Aid assistance	3	4 212	4 819
TOTAL REVENUE		**13 483 466**	**12 435 044**
EXPENDITURE			
Current expenditure			
Compensation of employees	4	7 665 447	6 808 175
Goods and services	5	4 067 518	3 764 971
Interest and rent on land	6	19	16
Aid assistance	3	-	86
Total current expenditure		**11 732 984**	**10 573 248**
Transfers and subsidies			
Transfers and subsidies	8	754 454	724 559
Aid assistance	3	-	392
Total transfers and subsidies		**754 454**	**724 951**
Expenditure for capital assets			
Tangible capital assets	9	904 263	1 036 130
Software and other intangible assets	9	161	143
Total expenditure for capital assets		**904 424**	**1 036 273**
Payments for financial assets	7	3 524	12 046
TOTAL EXPENDITURE		**13 395 386**	**12 346 518**
SURPLUS FOR THE YEAR		**88 080**	**88 526**
Reconciliation of Net Surplus for the year			
Voted funds		41 147	63 755
Annual appropriation		26 465	31 656
Conditional grants		14 682	16 978
Global Fund		-	15 121
Departmental revenue	15	50 344	21 842
Aid assistance	3	(3 411)	2 929
SURPLUS FOR THE YEAR		**88 080**	**88 526**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

STATEMENT OF FINANCIAL POSITION
as at 31 March 2012

	Note	2011/12 R'000	2010/11 R'000
ASSETS			
Current assets		**211 924**	**287 441**
Unauthorised expenditure	*10*	53 742	70 473
Cash and cash equivalents	*11*	108 390	105 824
Prepayments and advances	*12*	1 004	1 884
Receivables	*13*	48 788	109 260
TOTAL ASSETS		**211 924**	**287 441**
LIABILITIES			
Current liabilities		**194 602**	**271 930**
Voted funds to be surrendered to the Revenue Fund	*14*	41 147	63 755
Departmental revenue to be surrendered to the Revenue Fund	*15*	29 447	11 763
Bank overdraft	*16*	25 995	76 103
Payables	*17*	98 013	116 898
Aid assistance unutilised	*3*	-	3 411
TOTAL LIABILITIES		**194 602**	**271 930**
NET ASSETS		**17 322**	**15 511**
Represented by:			
Recoverable revenue		17 322	15 511
TOTAL		**17 322**	**15 511**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

STATEMENT OF CHANGES IN NET ASSETS
for the year ended 31 March 2012

	Note	2011/12 R'000	2010/11 R'000
Recoverable revenue			
Opening balance		15 511	20 307
Transfers		**1 811**	**(4 796)**
Irrecoverable amounts written off	*7.3*	(2 626)	(11 333)
Debt movement		4 437	6 537
Closing balance		**17 322**	**15 511**
TOTAL		**17 322**	**15 511**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

CASH FLOW STATEMENT
for the year ended 31 March 2012

	Note	2011/12 R'000	2010/11 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts		**13 966 642**	**12 858 631**
Annual appropriated funds received	1.1	13 428 910	12 408 383
Departmental revenue received	2	533 520	445 429
Aid assistance received	3	4 212	4 819
Net decrease in working capital		59 198	101 823
Surrendered to Revenue Fund		(579 606)	(545 847)
Current payments		(11 732 984)	(10 573 248)
Payments for financial assets		(3 524)	(12 046)
Transfers and subsidies paid		(754 454)	(724 951)
Net cash flow available from operating activities	18	**955 272**	**1 104 362**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for capital assets	9	(904 424)	(1 036 273)
Proceeds from sale of capital assets	2.3	15	3
Net cash flows from investing activities		(904 409)	(1 036 270)
CASH FLOWS FROM FINANCING ACTIVITIES			
Increase/(decrease) in net assets		1 811	(4 796)
Net cash flows from financing activities		**1 811**	**(4 796)**
Net increase in cash and cash equivalents		52 674	63 296
Cash and cash equivalents at beginning of period		29 721	(33 575)
Cash and cash equivalents at end of period	19	**82 395**	**29 721**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

ACCOUNTING POLICIES
for the year ended 31 March 2012

The financial statements have been prepared in accordance with the following policies which have been applied consistently in all material aspects unless otherwise indicated. However, where appropriate and meaningful additional information has been disclosed to enhance the usefulness of the financial statements and to comply with the statutory requirements of the Public Finance Management Act, Act 1 of 1999 (as amended by Act 29 of 1999) and the Treasury Regulations issued in terms of the Act and the Division of Revenue Act, Act 1 of 2010.

5 Presentation of the Financial Statements

5.1.1 Basis of preparation

The financial statements have been prepared on a modified cash basis of accounting except where stated otherwise. The modified cash basis constitutes the cash basis of accounting supplemented with additional disclosure items. Under the cash basis of accounting transactions and other events are recognised when cash is received or paid.

5.2 Presentation currency

All amounts have been presented in the currency of the South African Rand (R) which is also the functional currency of the Department.

5.3 Rounding

Unless otherwise stated all financial figures have been rounded to the nearest one thousand Rand (R'000).

5.4 Comparative figures

Prior period comparative information has been presented in the current year's financial statements. Where necessary figures included in the prior period financial statements have been reclassified to ensure that the format in which the information is presented is consistent with the format of the current year's financial statements.

5.5 Comparative figures – Appropriation Statement

A comparison between actual amounts and final appropriation per major classification of expenditure is included in the Appropriation Statement.

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

ACCOUNTING POLICIES
for the year ended 31 March 2012

6 Revenue

6.1 Appropriated funds

Appropriated funds comprises of departmental allocations as well as direct charges against revenue fund (i.e. statutory appropriation).

Appropriated funds are recognised in the financial records on the date the appropriation becomes effective. Adjustments made in terms of the adjustments budget process are recognised in the financial records on the date the adjustments become effective.

Unexpended appropriated funds are surrendered to the National/Provincial Revenue Fund. Any amounts owing to the National/Provincial Revenue Fund at the end of the financial year are recognised as payable in the statement of financial position.

Any amount due from the National/Provincial Revenue Fund at the end of the financial year is recognised as a receivable in the statement of financial position.

6.2 Departmental revenue

All departmental revenue is recognised in the statement of financial performance when received and is subsequently paid into the National/Provincial Revenue Fund unless stated otherwise.

Any amount owing to the National/Provincial Revenue Fund at the end of the financial year is recognised as a payable in the statement of financial position.

No accrual is made for amounts receivable from the last receipt date to the end of the reporting period. These amounts are however disclosed in the disclosure notes to the annual financial statements.

6.3 Direct Exchequer receipts

All direct exchequer receipts are recognised in the statement of financial performance when the cash is received and is subsequently paid into the National/Provincial Revenue Fund unless stated otherwise.

Any amount owing to the National/Provincial Revenue Funds at the end of the financial year is recognised as a payable in the statement of financial position.

WESTERN CAPE – DEPARTMENT OF HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2012

6.4 Direct Exchequer payments

All direct exchequer payments are recognised in the statement of financial performance when final authorisation for payment is effected on the system (by no later than 31 March of each year).

6.5 Aid assistance

Aid assistance is recognised as revenue when received.

All in-kind aid assistance is disclosed at fair value on the date of receipt in the annexures to the annual financial statements.

The cash payments made during the year relating to aid assistance projects are recognised as expenditure in the statement of financial performance when final authorisation for payments is effected on the system (by no later than 31 March of each year).

The value of the assistance expensed prior to the receipt of funds is recognised as a receivable in the statement of financial position.

Inappropriately expensed amounts using aid assistance and any unutilised amounts are recognised as payables in the statement of financial position.

All CARA funds received must be recorded as revenue when funds are received. The cash payments made during the year relating to CARA earmarked projects are recognised as expenditure in the statement of financial performance when final authorisation for payments are effected on the system (by no later than 31 March of each year).

Inappropriately expensed amounts using CARA funds are recognised as payables in the statement of financial position. Any unutilised amounts are transferred to retained funds as they are not surrendered to the revenue fund.

7 Expenditure

7.1 Compensation of employees

7.1.1 Salaries and wages

Salaries and wages are expensed in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

WESTERN CAPE – DEPARTMENT OF HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2012

Other employee benefits that give rise to a present legal or constructive obligation are disclosed in the disclosure notes to the financial statements at its face value and are not recognised in the statement of financial performance or position.

Employee costs are capitalised to the cost of a capital project when an employee spends more than 50 per cent of his/her time on the project. These payments form part of expenditure for capital assets in the statement of financial performance.

7.1.2 Social contributions

Employer contributions to post employment benefit plans in respect of current employees are expensed in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

No provision is made for retirement benefits in the financial statements of the Department. Any potential liabilities are disclosed in the financial statements of the National Revenue Fund and not in the financial statements of the employer department.

Employer contributions made by the Department for certain of its ex-employees (such as medical benefits) are classified as transfers to households in the statement of financial performance.

7.2 Goods and services

Payments made during the year for goods and/or services are recognised as an expense in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

The expense is classified as capital if the goods and/or services were acquired for a capital project or if the total purchase price exceeds the capitalisation threshold (currently R5 000). All other expenditures are classified as current.

Rental paid for the use of buildings or other fixed structures is classified as *goods and services* and not as *rent on land*.

7.3 Interest and rent on land

Interest and rental payments are recognised as an expense in the statement of financial performance when the final authorisation for payment is effected on the system (by no later than 31 March of each year). This item excludes rental for the use of buildings or other fixed structures. If it is not possible to distinguish between payment for the use of land and the fixed structures on it the whole amount should be recorded under goods and services.

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ACCOUNTING POLICIES
for the year ended 31 March 2012

7.4 Payment for financial assets

Debts are written off when identified as irrecoverable. Debts written-off are limited to the amount of savings and/or under-spending of appropriated funds. The write off occurs at year-end or when funds are available. No provision is made for irrecoverable amounts but an estimate is included in the disclosure notes to the financial statements amounts.

All other losses are recognised when authorisation has been granted for the recognition thereof.

7.5 Transfers and subsidies

Transfers and subsidies are recognised as an expense when the final authorisation for payment is effected on the system (by no later than 31 March of each year).

7.6 Unauthorised expenditure

When confirmed unauthorised expenditure is recognised as an asset in the statement of financial position until such time as the expenditure is either approved by the relevant authority, recovered from the responsible person or written off as irrecoverable in the statement of financial performance.

Unauthorised expenditure approved with funding is derecognised from the statement of financial position when the unauthorised expenditure is approved and the related funds are received.

Where the amount is approved without funding it is recognised as expenditure in the statement of financial performance on the date of approval.

7.7 Fruitless and wasteful expenditure

Fruitless and wasteful expenditure is recognised as expenditure in the statement of financial performance according to the nature of the payment and not as a separate line item on the face of the statement. If the expenditure is recoverable it is treated as an asset until it is recovered from the responsible person or written off as irrecoverable in the statement of financial performance.

7.8 Irregular expenditure

Irregular expenditure is recognised as expenditure in the statement of financial performance. If the expenditure is not condoned by the relevant authority it is treated as an asset until it is recovered or written off as irrecoverable.

WESTERN CAPE – DEPARTMENT OF HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2012

8 Assets

8.1 Cash and cash equivalents

Cash and cash equivalents are carried in the statement of financial position at cost.

Bank overdrafts are shown separately on the face of the statement of financial position.

For the purposes of the cash flow statement, cash and cash equivalents comprise cash on hand, deposits held, other short-term highly liquid investments and bank overdrafts.

8.2 Other financial assets

Other financial assets are carried in the statement of financial position at cost.

8.3 Prepayments and advances

Amounts prepaid or advanced are recognised in the statement of financial position when the payments are made and are derecognised as and when the goods/services are received or the funds are utilised.

Prepayments and advances outstanding at the end of the year are carried in the statement of financial position at cost.

8.4 Receivables

Receivables included in the statement of financial position arise from cash payments made that are recoverable from another party (including departmental employees) and are derecognised upon recovery or write-off.

Receivables outstanding at year-end are carried in the statement of financial position at cost plus any accrued interest. Amounts that are potentially irrecoverable are included in the disclosure notes.

8.5 Investments

Capitalised investments are shown at cost in the statement of financial position.

Investments are tested for an impairment loss whenever events or changes in circumstances indicate that the investment may be impaired. Any impairment loss is included in the disclosure notes.

WESTERN CAPE – DEPARTMENT OF HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2012

8.6 Loans

Loans are recognised in the statement of financial position when the cash is paid to the beneficiary. Loans that are outstanding at year-end are carried in the statement of financial position at cost plus accrued interest.

Amounts that are potentially irrecoverable are included in the disclosure notes.

8.7 Inventory

Inventories that qualify for recognition must be initially reflected at cost. Where inventories are acquired at no cost or for nominal consideration their cost shall be their fair value at the date of acquisition.

All inventory items at year-end are reflected using the weighted average cost or FIFO cost formula.

8.8 Capital assets

8.8.1 Movable assets

Initial recognition

A capital asset is recorded in the asset register on receipt of the item at cost. Cost of an asset is defined as the total cost of acquisition. Where the cost cannot be determined accurately, the movable capital asset is stated at fair value. Where fair value cannot be determined, the capital asset is included in the asset register at R1.

All assets acquired prior to 1 April 2002 are included in the register at R1.

Subsequent recognition

Subsequent expenditure of a capital nature is recorded in the statement of financial performance as "expenditure for capital assets" and is capitalised in the asset register of the Department on completion of the project.

Repairs and maintenance is expensed as current "goods and services" in the statement of financial performance.

WESTERN CAPE – DEPARTMENT OF HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2012

8.8.2 Immovable assets

Initial recognition

A capital asset is recorded on receipt of the item at cost. Cost of an asset is defined as the total cost of acquisition. Where the cost cannot be determined accurately, the immovable capital asset is stated at R1 unless the fair value for the asset has been reliably estimated.

Subsequent recognition

Work-in-progress of a capital nature is recorded in the statement of financial performance as "expenditure for capital assets". On completion, the total cost of the project is included in the asset register of the Department that is accountable for the asset.

Repairs and maintenance is expensed as current "goods and services" in the statement of financial performance.

8.8.3 Intangible assets

Initial recognition

An intangible asset is recorded in the asset register on receipt of the item at cost. Cost of an intangible asset is defined as the total cost of acquisition. Where the cost cannot be determined accurately the intangible asset is stated at fair value. Where fair value cannot be determined, the intangible asset is included in the asset register at R1.

All intangible assets acquired prior to 1 April 2002 can be included in the asset register at R1.

Subsequent expenditure

Subsequent expenditure of a capital nature is recorded in the statement of financial performance as "expenditure for capital asset" and is capitalised in the asset register of the Department.

Maintenance is expensed as current "goods and services" in the statement of financial performance.

WESTERN CAPE – DEPARTMENT OF HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2012

9 Liabilities

9.1 Payables

Recognised payables mainly comprise of amounts owing to other governmental entities. These payables are carried at cost in the statement of financial position.

9.2 Contingent liabilities

Contingent liabilities are included in the disclosure notes to the financial statements when it is possible that economic benefits will flow from the Department, or when an outflow of economic benefits or service potential is probable but cannot be measured reliably.

9.3 Contingent assets

Contingent assets are included in the disclosure notes to the financial statements when it is probable that an inflow of economic benefits will flow to the entity.

9.4 Commitments

Commitments are not recognised in the statement of financial position as a liability or as expenditure in the statement of financial performance but are included in the disclosure notes.

9.5 Accruals

Accruals are not recognised in the statement of financial position as a liability or as expenditure in the statement of financial performance but are included in the disclosure notes.

9.6 Employee benefits

Short-term employee benefits that give rise to a present legal or constructive obligation are disclosed in the disclosure notes to the financial statements. These amounts are not recognised in the statement of financial performance or the statement of financial position.

WESTERN CAPE – DEPARTMENT OF HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2012

9.7 Lease commitments

Finance lease

Finance leases are not recognised as assets and liabilities in the statement of financial position. Finance lease payments are recognised as an expense in the statement of financial performance and are apportioned between the capital and interest portions. The finance lease liability is disclosed in the disclosure notes to the financial statements.

Operating lease

Operating lease payments are recognised as an expense in the statement of financial performance. The operating lease commitments are disclosed in the disclosure notes to the financial statement.

9.8 Impairment

The Department tests for impairment where there is an indication that a receivable, loan or investment may be impaired. An assessment of whether there is an indication of possible impairment is done at each reporting date. An estimate is made for doubtful loans and receivables based on a review of all outstanding amounts at year-end. Impairments on investments are calculated as being the difference between the carrying amount and the present value of the expected future cash flows / service potential flowing from the instrument.

9.9 Provisions

Provisions are disclosed when there is a present legal or constructive obligation to forfeit economic benefits as a result of events in the past and it is probable that an outflow of resources embodying economic benefits will be required to settle the obligation and a reliable estimate of the obligation can be made.

10 Receivables for departmental revenue

Receivables for departmental revenue are disclosed in the disclosure notes to the annual financial statements.

WESTERN CAPE – DEPARTMENT OF HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2012

11 Net Assets

11.1 Capitalisation reserve

The capitalisation reserve comprises of financial assets and/or liabilities originating in a prior reporting period but which are recognised in the statement of financial position for the first time in the current reporting period. Amounts are recognised in the capitalisation reserves when identified in the current period and are transferred to the National/Provincial Revenue Fund when the underlying asset is disposed and the related funds are received.

11.2 Recoverable revenue

Amounts are recognised as recoverable revenue when a payment made in a previous financial year becomes recoverable from a debtor in the current financial year. Amounts are either transferred to the National/Provincial Revenue Fund when recovered or are transferred to the statement of financial performance when written-off.

12 Related party transactions

Specific information with regards to related party transactions is included in the disclosure notes.

13 Key management personnel

Compensation paid to key management personnel including their family members where relevant is included in the disclosure notes.

14 Public private partnerships

A description of the PPP arrangement, the contract fees and current and capital expenditure relating to the PPP arrangement is included in the disclosure notes.

15 GG vehicle expenditure and commitments

The National Treasury approved a departure from the disclosure of apportioning finance lease expenditure and future financial commitments between capital and interest as prescribed by the accounting policy in paragraph 5.7 above, due to the late finalisation of the disagreement on the accounting treatment for the GG vehicles. Future finance lease commitments have been disclosed using the CPIX rate as the basis for annual increments.

WESTERN CAPE – DEPARTMENT OF HEALTH
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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

1. Annual Appropriation

1.1 Annual Appropriation

	2011/12			2010/11
	Final Appropriation	Actual funds received	Funds not requested/ not received	Appropriation received
Programmes	**R'000**	**R'000**	**R'000**	**R'000**
Administration	410 125	410 125	-	321 856
District Health Services	4 949 312	4 949 312	-	4 388 428
Emergency Medical Services	634 876	634 876	-	596 113
Provincial Hospital Services	2 149 557	2 149 557	-	2 935 678
Central Hospital Services	3 959 727	3 959 727	-	2 684 333
Health Sciences and Training	237 455	237 455	-	244 813
Health Care Support Services	273 028	273 028	-	284 167
Health Facilities Management	814 830	814 830	-	952 995
Total	**13 428 910**	**13 428 910**	**-**	**12 408 383**

1.2 Conditional grants

	Note	2011/12 R'000	2010/11 R'000
Total grants received	*Annex 1A*	3 738 100	3 604 673
Provincial grants included in total grants received		**3 738 100**	**3 604 673**

2. Departmental revenue

Sales of goods and services other than capital assets	*2.1*	364 575	313 466
Interest, dividends and rent on land	*2.2*	1 580	2 429
Sales of capital assets	*2.3*	15	3
Transactions in financial assets and liabilities	*2.4*	18 795	16 558
Transfer received	*2.5*	148 570	112 976
Total revenue collected		**533 535**	**445 432**
Less: Own revenue included in appropriation		483 191	423 590
Departmental revenue over collected		**50 344**	**21 842**

WESTERN CAPE – DEPARTMENT OF HEALTH
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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

	Note	2011/12 R'000	2010/11 R'000
2.1 Sales of goods and services other than capital assets			
Sales of goods and services produced by the Department		**363 682**	**312 369**
Administrative fees		5 851	6 627
Other sales		357 831	305 742
Sales of scrap, waste and other used current goods		893	1 097
Total	*2*	**364 575**	**313 466**
2.2 Interest, dividends and rent on land			
Interest		1 580	2 429
Total	*2*	**1 580**	**2 429**
2.3 Sale of capital assets			
Tangible assets		**15**	**3**
Machinery and equipment	*32.2*	15	3
Total	*2*	**15**	**3**
2.4 Transactions in financial assets and liabilities			
Receivables		17 752	15 733
Other Receipts including Recoverable Revenue		1 043	825
Total	*2*	**18 795**	**16 558**
2.5 Transfers received			
Universities and technikons		22 552	15 927
International organisations		126 018	97 049
Total	*2*	**148 570**	**112 976**

WESTERN CAPE – DEPARTMENT OF HEALTH
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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

	Note	2011/12 R'000	2010/11 R'000
3. Aid Assistance			
3.1 Aid assistance received in cash from other sources			
Foreign			
Opening Balance		3 411	482
Revenue		4 212	4 819
Expenditure		**(7 623)**	**(1 890)**
Current		-	(86)
Capital		(7 623)	(1 412)
Transfers		-	(392)
Closing Balance		**-**	**3 411**
3.2 Total assistance			
Opening Balance		3 411	482
Revenue		4 212	4 819
Expenditure		**(7 623)**	**(1 890)**
Current		-	(86)
Capital		(7 623)	(1 412)
Transfers		-	(392)
Closing Balance		**-**	**3 411**
3.3 Analysis of balance			
Aid assistance unutilised		**-**	**3 411**
Other sources		-	3 411
Closing balance		**-**	**3 411**

WESTERN CAPE – DEPARTMENT OF HEALTH
VOTE 6

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

	Note	2011/12 R'000	2010/11 R'000
4. Compensation of Employees			
4.1 Salaries and Wages			
Basic salary		5 011 490	4 439 548
Performance award		90 464	81 638
Service based		13 332	13 438
Compensative/circumstantial		673 733	619 930
Periodic payments		14 631	15 513
Other non-pensionable allowances		1 011 045	896 777
Total		**6 814 695**	**6 066 844**
4.2 Social contributions			
4.2.1 Employer contributions			
Pension		550 638	482 139
Medical		299 167	258 253
Bargaining council		876	881
Official unions and associations		2	-
Insurance		69	58
Total		**850 752**	**741 331**
Total compensation of employees		**7 665 447**	**6 808 175**
Average number of employees		29 158	28 261

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	Note	2011/12 R'000	2010/11 R'000
5. Goods and services			
Administrative fees		1 002	950
Advertising		17 761	17 574
Assets less than R5 000	*5.1*	56 733	43 625
Bursaries (employees)		7 782	8 724
Catering		4 882	5 366
Communication		64 598	66 298
Computer services	*5.2*	76 944	64 875
Consultants contractors and agency/outsourced services	*5.3*	993 425	939 409
Entertainment		198	217
Audit cost – external	*5.4*	21 325	14 755
Inventory	*5.5*	1 979 156	1 897 713
Operating leases		15 135	17 147
Property payments	*5.6*	571 777	464 130
Rental and hiring		292	733
Transport provided as part of the departmental activities		986	1 456
Travel and subsistence	*5.7*	185 604	164 511
Venues and facilities		3 077	3 645
Training and staff development		49 236	43 401
Other operating expenditure	*5.8*	17 605	10 442
Total		**4 067 518**	**3 764 971**

5.1 Assets less than R5 000

Tangible assets		**56 715**	**43 389**
Buildings and other fixed structures		10	4
Machinery and equipment		56 705	43 385
Intangible assets		**18**	**236**
Total	*5*	**56 733**	**43 625**

5.2 Computer services

SITA computer services		27 548	18 790
External computer service providers		49 396	46 085
Total	*5*	**76 944**	**64 875**

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	Note	2011/12 R'000	2010/11 R'000
5.3 Consultants, contractors and agency/outsourced services			
Business and advisory services		71 568	100 506
Infrastructure and planning		6	990
Laboratory services		422 607	407 390
Legal costs		5 945	4 839
Contractors		198 840	136 715
Agency and support/outsourced services		294 459	288 969
Total	5	**993 425**	**939 409**
5.4 Audit cost – External			
Regularity audits		21 283	13 931
Performance audits		13	692
Investigations		29	132
Total	5	**21 325**	**14 755**
5.5 Inventory			
Food and food supplies		99 605	96 024
Fuel, oil and gas		28 086	31 833
Other consumable materials		122 076	111 359
Materials and supplies		38 868	40 278
Stationery and printing		58 634	53 232
Medical supplies		865 583	778 418
Medicine		766 304	786 569
Total	5	**1 979 156**	**1 897 713**
5.6 Property payments			
Municipal services		194 372	137 040
Property management fees		169 175	161 228
Property maintenance and repairs		208 230	165 862
Total	5	**571 777**	**464 130**

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	Note	2011/12 R'000	2010/11 R'000
5.7 Travel and subsistence			
Local		185 104	164 266
Foreign		500	245
Total	*5*	**185 604**	**164 511**
5.8 Other operating expenditure			
Learnerships		11 064	4 142
Professional bodies, membership and subscription fees		434	544
Resettlement costs		3 050	2 978
Other		3 057	2 778
Total	*5*	**17 605**	**10 442**
6. Interest and rent on land			
Interest paid		19	16
Total		**19**	**16**
7. Payment for financial assets			
Material losses through criminal conduct		**16**	**28**
Theft	*7.4*	16	25
Other material losses	*7.1*	-	3
Other material losses written off	*7.2*	882	685
Debts written off	*7.3*	2 626	11 333
Total		**3 524**	**12 046**
7.1 Other material losses			
Nature of other material losses			
Other loss		-	3
Total	*7*	**-**	**3**

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	Note	2011/12 R'000	2010/11 R'000
7.2 Other material losses written off			
Nature of losses			
Government vehicle losses		882	685
Total	7	**882**	**685**
7.3 Debts written off			
Nature of debts written off			
Salary overpayments		845	1 585
Guarantees		27	125
Tax		92	156
Bursaries		1 142	3 481
Accommodation		11	54
Telephone account		3	4
Services rendered		80	939
NGO advance payments		-	2 205
Nutrition programme debt		-	420
Dishonoured cheques debt		-	17
Insolvent debt collector		-	2 249
Other		426	98
Total	7	**2 626**	**11 333**
7.4 Detail of theft			
Nature of theft			
GG vehicles		-	20
GG vehicles accessories		5	5
Other		11	-
Total	7	**16**	**25**

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8. Transfers and subsidies

	Note	2011/12 R'000	2010/11 R'000
Provinces and municipalities	*Annex 1B*	302 280	263 107
Departmental agencies and accounts	*Annex 1C*	15 651	55 341
Universities and technikons	*Annex 1D*	6 025	1 400
Non-profit institutions	*Annex 1G*	313 931	281 488
Households	*Annex 1H*	106 714	118 599
Gifts, donations and sponsorships made	*Annex 1K*	9 853	4 624
Total		**754 454**	**724 559**

9. Expenditure for capital assets

Tangible assets		**904 263**	**1 036 130**
Buildings and other fixed structures	*34*	559 109	741 940
Machinery and equipment		279 790	232 674
GG vehicles		65 364	61 516
Software and other intangible assets		**161**	**143**
Computer software	*33.1*	161	143
Total		**904 424**	**1 036 273**

9.1 Analysis of funds utilised to acquire capital assets – 2011/12

	Departmental funds R'000	Aid assistance R'000	Total R'000
Tangible assets	**896 640**	**7 623**	**904 263**
Buildings and other fixed structures	551 486	7 623	559 109
Machinery and equipment	279 790	-	279 790
GG vehicles	65 364	-	65 364
Software and other intangible assets	**161**	**-**	**161**
Computer software	161	-	161
Total	**896 801**	**7 623**	**904 424**

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	Note	2011/12 R'000	2010/11 R'000

9.2 Analysis of funds utilised to acquire capital assets – 2010/11

	Voted funds R'000	Aid assistance R'000	Total R'000
Tangible assets	**1 034 718**	**1 412**	**1 036 130**
Buildings and other fixed structures	740 528	1 412	741 940
Machinery and equipment	232 674	-	232 674
GG vehicles	61 516	-	61 516
Software and other intangible assets	**143**	**-**	**143**
Computer software	143	-	143
Total	**1 034 861**	**1 412**	**1 036 273**

GG vehicle daily tariff expenditure was reclassified from operating lease expenditure to finance lease expenditure in the 2011/12 AFS and hence restated for the 2010/11 comparatives.

10. Unauthorised expenditure

10.1 Reconciliation of unauthorised expenditure

Opening balance	70 473	159 652
Unauthorised expenditure – discovered in current year	53 742	-
Less: Amounts approved by Parliament/Legislature with funding	(70 473)	(89 179)
Unauthorised expenditure awaiting authorisation	**53 742**	**70 473**

10.2 Analysis of unauthorised expenditure awaiting authorisation per economic classification

Current	53 742	70 473
Total	**53 742**	**70 473**

10.3 Analysis of unauthorised expenditure awaiting authorisation per type

Unauthorised expenditure relating to overspending of the vote or a main division within a vote	53 742	70 473
Total	**53 742**	**70 473**

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10.4 Details of unauthorised expenditure – current year

Incident	Disciplinary steps taken/criminal proceedings	2011/12 R'000
Over-expenditure on programme 3 and 5	No disciplinary steps or criminal proceedings will take place. The matter will be dealt with in a Finance Act.	53 742
Total		**53 742**

	Note	2011/12 R'000	2010/11 R'000
11. Cash and cash equivalents			
Cash receipts		56	40
Cash on hand		248	50
Investments (Domestic)		108 086	105 734
Total		**108 390**	**105 824**
12. Prepayments and advances			
Travel and subsistence		106	210
Advances paid to other entities		898	1 674
Total		**1 004**	**1 884**

13. Receivables

		2011/12				2010/11
		R'000	R'000	R'000	R'000	R'000
	Note	Less than one year	One to three years	Older than three years	Total	Total
	Annex 4					
Claims recoverable	13.1	7 167	82	-	7 249	68 694
Staff debt	13.2	13 145	6 834	9 927	29 906	26 750
Other debtors	13.3	(706)	11 518	821	11 633	13 816
Total		**19 606**	**18 434**	**10 748**	**48 788**	**109 260**

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	Note	2011/12 R'000	2010/11 R'000
13.1 Claims recoverable			
National departments		3 453	66 001
Provincial departments		1 122	318
Public entities		2 674	2 375
Total	*13*	**7 249**	**68 694**
13.2 Staff debt			
Salary Reversal Control		1 093	1 366
Sal: Deduction Disallowance Account		36	31
Sal: Tax Debt		190	54
Debt Account		28 587	25 299
Total	*13*	**29 906**	**26 750**
13.3 Other debtors			
Disallowance Miscellaneous		8 719	12 972
Disallowance Damage and losses		178	178
Damage Vehicles		902	666
MEDSAS Claims Recoverable		1 834	-
Total	*13*	**11 633**	**13 816**
14. Voted funds to be surrendered to the Revenue Fund			
Opening balance		63 755	92 682
Transfer from statement of financial performance		41 147	63 755
Paid during the year		(63 755)	(92 682)
Closing balance		**41 147**	**63 755**
15. Departmental revenue to be surrendered to the Revenue Fund			
Opening balance		11 763	19 496
Transfer from statement of financial performance		50 344	21 842
Own revenue included in appropriation		483 191	423 590
Paid during the year		(515 851)	(453 165)
Closing balance		**29 447**	**11 763**

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	Note	2011/12 R'000	2010/11 R'000
16. Bank Overdraft			
Consolidated Paymaster General Account		25 995	76 103
Total		**25 995**	**76 103**
17. Payables – current			
Clearing accounts	*17.1*	98 013	104 424
Other payables	*17.2*	-	12 474
Total		**98 013**	**116 898**
17.1 Clearing accounts			
Description			
Patient fee deposits		2 183	1 969
Sal: Pension fund		142	4 805
Sal: Income tax		2 845	8 814
Sal: Bargaining councils		4	5
Advances from Western Cape		53 742	70 473
Advances from public entities		(2 559)	(3 014)
Advances from public corporations and private entities		41 466	21 375
Sal: Finance other institutions		-	1
Sal: Insurance deductions		(1)	-
Sal: Medical Aid		191	(4)
Total	*17*	**98 013**	**104 424**
17.2 Other payables			
Description			
Cape Medical Depot loss		-	12 474
Total	*17*	-	12 474

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	Note	2011/12 R'000	2010/11 R'000

18. Net cash flow available from operating activities

Net surplus as per statement of financial performance	88 080	88 526
Add back non cash/cash movements not deemed operating activities	867 192	1 015 836
Increase in receivables – current	60 472	28 046
Increase in prepayments and advances	880	806
Decrease in other current assets	16 731	89 179
Increase in payables – current	(18 885)	(16 208)
Proceeds from sale of capital assets	(15)	(3)
Expenditure on capital assets	904 424	1 036 273
Surrenders to Revenue Fund	(579 606)	(545 847)
Own revenue included in appropriation	483 191	423 590
Net cash flow generated by operating activities	**955 272**	**1 104 362**

19. Reconciliation of cash and cash equivalents for cash flow purposes

Consolidated Paymaster General account	(25 995)	(76 103)
Cash receipts	56	40
Cash on hand	248	50
Cash with commercial banks (local)	108 086	105 734
Total	**82 395**	**29 721**

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These amounts are not recognised in the annual financial statements and are disclosed to enhance the usefulness of the annual financial statements.

		Note	2011/12 R'000	2010/11 R'000
20. Contingent liabilities and contingent assets				
20.1 Contingent liabilities				
Liable to	**Nature**			
Housing loan guarantees	Employees	*Annex 3A*	738	978
Claims against the Department		*Annex 3B*	132 479	96 365
Other departments (interdepartmental unconfirmed balances)		*Annex 5*	1 681	17
Other: Occupational Specific Dispensation (OSD) payments		*Annex 3B*	908	908
Total			**135 806**	**98 268**
20.2 Contingent assets				
Nature of contingent asset				
Occupational Specific Dispensation (OSD) payments (awaiting approval)			2 177	2 177
Total			**2 177**	**2 177**
21. Commitments				
Current expenditure			**404 625**	**383 878**
Approved and contracted			371 789	382 381
Approved but not yet contracted			32 836	1 497
Capital expenditure			**607 119**	**657 536**
Approved and contracted			603 821	655 156
Approved but not yet contracted			3 298	2 380
Total			**1 011 744**	**1 041 414**

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	Note	2011/12 R'000	2010/11 R'000

22. Accruals

	30 Days	30+ Days	Total	Total
Goods and services	134 504	25 431	159 935	115 871
Transfers and subsidies	36 300	11 373	47 673	41 868
Capital assets	17 303	1 347	18 650	14 224
Other	13 496	3 277	16 773	13 967
Total	**201 603**	**41 428**	**243 031**	**185 930**

Listed by programme level			
Administration		26 860	6 234
District Health Services		95 341	80 532
Emergency Medical Services		4 781	916
Provincial Hospital Services		19 671	12 431
Central Hospital Services		87 799	79 620
Health Sciences and Training		2 032	1 762
Health Care Support Service		1 001	519
Health Facility Management		5 546	3 916
Total		**243 031**	**185 930**
Confirmed balances with departments	*Annex 5*	291	-
Total		**291**	**-**

23. Employee benefits

Leave entitlement	173 525	150 549
Service bonus (Thirteenth cheque)	179 870	158 636
Performance awards	88 473	83 484
Capped leave commitments	270 154	265 921
Total	**712 022**	**658 590**

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Leave Entitlement	
PERSAL Report	(R162 643 036.10)
Negative leave credits included	(R26 676 789.98)
Leave captured after 1 April 2012	R15 795 271.50
Recalculated Leave Entitlement	**(R173 524 554.58)**
Capped leave Commitments	
PERSAL Report	(R270 153 713.92)
Negative leave credits included	(R0.00)
Recalculated Capped Leave Entitlement	**(R270 153 713.92)**

Negative balances mostly result from an over grant of leave which is discovered when leave files are audited.

24. Lease commitments

24.1 Operating leases expenditure

2011/12	**Machinery and equipment**	**Total**
	R'000	**R'000**
Not later than 1 year	12 167	12 167
Later than 1 year and not later than 5 years	16 482	16 482
Total lease commitments	**28 649**	**28 649**

2010/11	**Machinery and equipment**	**Total**
	R'000	**R'000**
Not later than 1 year	76 496	76 496
Later than 1 year and not later than 5 years	156 565	156 565
Later than 5 years	19 042	19 042
Total lease commitments	**252 103**	**252 103**

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24.2 Finance leases expenditure

2011/12	Machinery and equipment R'000	Total R'000
Not later than 1 year	116	116
Later than 1 year and not later than 5 years	39	39
Total lease commitments	**155**	**155**
LESS: finance costs	10	10
Total present value of lease liabilities	**145**	**145**

2010/11	Machinery and equipment R'000	Total R'000
Not later than 1 year	116	116
Later than 1 year and not later than 5 years	155	155
Total lease commitments	**271**	**271**
LESS: finance costs	16	16
Total present value of lease liabilities	**255**	**255**

	Note	2011/12 R'000	2010/11 R'000

25. Receivables for departmental revenue

Sales of goods and services other than capital assets	506 846	492 669
Total	**506 846**	**492 669**

The receivables of Departmental revenue amounts to R507 000 000 comprising of:

	2011/12	2010/11
Road Accident Fund (RAF)	R364 000 000	R334 000 000
Other	R143 000 000	R159 000 000
Total	**R507 000 000**	**R493 000 000**

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The amount of R507 000 000 must be reduced by the following:
2011/12 RAF payments received, but not credited to the billing systems = R36 000 000.
Debt older than 3 years and debt to be removed from the system according to departmental policy = R9 000 000.
Remaining valid debt = R462 000 000.
Of this amount, R364 000 000 (72 per cent) consists of RAF debt.
The Department estimates that a quarter of the RAF debt is irrecoverable due to the rules for shared accountability. The recovery cost of RAF debt is 17 per cent of amounts recovered which is considerably high.
The Department therefore considers 50 per cent of the RAF debt as recoverable on a nett basis.
However, despite on-going payments, it may take years to recover this debt.
The remaining valid debt = R280 000 000.

Of this amount, R81 000 000 relates to debt owed by individuals of which only 57 per cent is deemed recoverable due to the low income of the Department's clients.
The remaining valid debt = R245 000 000.
Of this amount, R26 000 000 relates to medical aid debt, of which 89 per cent is estimated to be recoverable since medical aids, on average, pay according to the benefits available. The balance is therefore the individuals' share of the cost, and is more difficult to recover.
The total recoverable debt is therefore estimated at R241 000 000.
The above debt includes a credit balance of R 9 328 000 due to the incorrect allocation of payments to invoices within the same account holder, simultaneous write-off and payment, and duplicate payments.
Patient Fees debt written off during the year = R202 576 000.
Interest on patient fee debt, as levied by the Department's debt collector, amounted to R6 721 000 for 2011/12 and R7 650 000 for 2010/11.
The recoverability of the interest is estimated at 10 per cent.

	Note	**2011/12**	**2010/11**
		R'000	**R'000**

25.1 Analysis of receivables for departmental revenue

Opening balance		492 669	397 369
Less: Amounts received		315 102	283 019
Add: amounts recognised		534 481	519 604
Less: amounts written-off/reversed as irrecoverable	*7.3*	205 202	141 285
Closing balance		**506 846**	**492 669**

Amount written-off/reversed as irrecoverable is made up as follows:	
Patient fees debt written off during the year	R202 576 000
Debts written off	R 2 626 000
Total	**R205 202 000**

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	2011/12 R'000	2010/11 R'000

26. Irregular expenditure

26.1 Reconciliation of irregular expenditure

Opening balance	118 136	33 151
Add: Irregular expenditure – relating to prior year	7 114	22 786
Add: Irregular expenditure – relating to current year	67 363	95 321
Less: Amounts condoned	(107 632)	(33 122)
Less: Amounts recoverable (not condoned)	(7)	-
Irregular expenditure awaiting condonation	**84 974**	**118 136**
Analysis of awaiting condonation per age classification		
Current year	67 357	94 263
Prior years	17 617	23 873
Total	**84 974**	**118 136**

26.2 Details of irregular expenditure – current year

Incident	Disciplinary steps taken / criminal proceedings	2011/12 R'000
No valid contract (Mowbray)	Written warning issued	232
No valid contract (Mowbray)	No disciplinary action	11
No tax clearance certificate (Stikland)	Await submission of tax certificate	82
No tax clearance certificate (Stikland)	Await submission of tax certificate	122
No valid contract (Alexandra)	Corrective counselling	30
No valid contract (Alexandra)	Corrective counselling	276
No valid contract (Alexandra)	Corrective counselling	7
No valid contract (Paarl)	Limited bid approved for 2 year period	1 043
No tax clearance certificate (Paarl)	Await submission of tax certificate	998
No tax clearance certificate (Paarl)	Await submission of tax certificate	329
No tax clearance certificate (Paarl)	Await submission of tax certificate	281
Missing processed batches (Paarl)	Dismissal. Criminal charges laid	2 148
Non-compliance with delegation (Paarl)	Verbal warning	41
Non-compliance with delegation (Paarl)	Correct procedures explained to officials	9
No valid contract (George)	New contract 1 May 2012	1 265
No valid contract (George)	Written warning issued	249
No valid contract (George)	Written warning issued	201
No valid contract (George)	Written warning issued	210
No valid contract (George)	Written warning issued	455

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Incident	Disciplinary steps taken / criminal proceedings	2011/12 R'000
No valid contract (George)	Written warning issued	544
No valid contract (George)	Written warning issued	5 193
Missing processed batches (George)	Written warning issued	66
No valid contract (George)	Written warning issued	1 195
No valid contract (George)	Written warning issued	96
No valid contract (George)	Written warning issued	144
No valid contract (George)	Written warning issued	62
Missing processed batches (George)	Written warning issued	90
Missing processed batches (George)	Written warning issued	44
Missing processed batches (George)	Written warning issued	36
Missing processed batches (George)	Written warning issued	35
Missing processed batches (George)	Written warning issued	1 653
Missing processed batches (George)	Written warning issued	60
Missing processed batches (George)	Written warning issued	180
Missing processed batches (George)	Written warning issued	146
Non-compliance with delegation (George)	Still being investigated	41
No valid contract (Somerset)	New contract 1/4/2011	11
No valid contract (Somerset)	Contract to be concluded	135
No valid contract (Somerset)	Limited bid approved 10 February 2012	2 371
No valid contract (Somerset)	Limited bid approved 10 February 2012	489
Non-compliance with delegation (Somerset))	Tax clearance certificate	230
No valid contract (Mitchell's Plain SSO)	Prescribed procedures explained to PHC Manager	9
No valid contract (Mitchell's Plain SSO)	Prescribed procedures explained to PHC Manager	33
No valid contract (Mitchell's Plain SSO)	Prescribed procedures explained to PHC Manager	11
No valid contract (Mitchell's Plain SSO)	Prescribed procedures explained to PHC Manager	12
No valid contract (Mitchell's Plain SSO)	New contract 1 Apr 2011	13
No valid contract (GF Jooste)	Agreement to be signed	762
No valid contract (GF Jooste)	Agreements signed	34
No valid contract (GF Jooste)	Limited bid will be applied	156
No valid contract (GF Jooste)	New contract 1 Nov 2011	257
No valid contract (GF Jooste)	Agreement to be signed	82
No valid contract (GF Jooste)	Corrective counselling	508
No valid contract (Mitchells Plain Day Hospital)	Limited bid to be applied	833
No valid contract (Karl Bremer)	Limited bid to be applied	245
No valid contract (Karl Bremer)	New contract 1 June 2011	23
No valid contract (Karl Bremer)	New contract being awarded	251
No valid contract (Karl Bremer)	New contract being awarded	54
No valid contract (Karl Bremer)	Prescribed procedures explained to PHC Manager	207
No valid contract (Karl Bremer)	Prescribed procedures explained to PHC Manager	499
Restricted supplier (Karl Bremer)	Quotation Committee verify validity of suppliers	38
Tax clearance certificate (Karl Bremer)	Quotation Committee verify validity of suppliers	1 582
No valid contract (Karl Bremer)	Prescribed procedures explained to PHC Manager	144
No valid contract (Karl Bremer)	Prescribed procedures explained to PHC Manager	298

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Incident	Disciplinary steps taken / criminal proceedings	2011/12 R'000
Non-compliance with delegations (Karl Bremer)	Prescribed procedures explained to PHC Manager	19
No valid contract (Victoria)	New contract 1 August 2011	264
No valid contract (Victoria)	Prescribed procedures explained to PHC Manager	27
No valid contract (Victoria)	Contracted supplier utilised from 1 Feb 2012	14
No valid contract (Victoria)	Procuring from 1 Aug 2011 from contracted	114
No valid contract (Victoria)	New contract 1 August 2011	113
No valid contract (Victoria)	Prescribed procedures explained to PHC Manager	9
Non-compliance with delegation (Brooklyn Chest)	Still being investigated	469
Non-compliance with delegation (DP Marais)	Still being investigated	1 874
No valid contract (Mossel Bay)	Contracted supplier utilised after detection	43
No valid contract (Mossel Bay)	Limited bid to be applied	378
No valid contract (Harry Comay)	Verbal counselling	614
No valid contract (EMS)	Corrective counselling	33
No valid contract (Engineering)	Limited bid approved for second phase	392
No valid contract (Engineering)	Limited bid approved for second phase	608
No valid contract (Groote Schuur)	Limited bid approved	7 843
No tax clearance certificate (Groote Schuur)	Await submission of tax certificate	1 484
No valid contract (Groote Schuur)	Written warning issued	298
No valid contract (Groote Schuur)	Contracted supplier utilised from 1/4/2012	220
Non-compliance with delegations (Hermanus)	Corrective counselling	2
Non-compliance with delegations (Hermanus)	Still being investigated	154
No valid contract (Overberg)	Services terminated 30/4/2012	124
Non-compliance with delegations (Overberg)	Still being investigated	161
Non-compliance with delegations (Overberg)	Still being investigated	18
Non-compliance with delegations (Overberg)	Tax clearance certificate	695
No valid contract (Overberg)	New contract effective 1 May 2012	479
Non-compliance with delegations (MDHS)	Condoned	6
Non-compliance with delegations (MDHS)	Still being investigated	5 395
Non-compliance with delegations (Oral)	Prescribed procedures implemented 1 Mar 2012	1 296
Non-compliance with delegations (WCCN)	Still being investigated	86
Non-compliance with delegations (WCCN)	Still being investigated	345
No valid contract (Vredendal)	Limited bid to be applied	259
Non-compliance with delegations (West Coast DO)	Corrective counselling	137
Non-compliance with delegations (West Coast DO)	Corrective counselling	21
Non-compliance with delegations (West Coast DO)	Corrective counselling	10
No valid contract (Eerste River)	Still being investigated	105
No valid contract (Eerste River)	Still being investigated	305
No valid contract (Eerste River)	Still being investigated	1 018
No valid contract (Khayelitsha)	Still being investigated	39
No valid contract (Khayelitsha)	Still being investigated	104
No valid contract (Khayelitsha)	Still being investigated	85
No valid contract (Khayelitsha)	Still being investigated	21
No valid contract (Khayelitsha)	Still being investigated	6
No valid contract (Khayelitsha)	Still being investigated	18
No valid contract (Khayelitsha)	Still being investigated	5

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Incident	Disciplinary steps taken / criminal proceedings	2011/12 R'000
No valid contract (Khayelitsha)	Still being investigated	13
No valid contract (Khayelitsha)	Still being investigated	10
No valid contract (Khayelitsha)	Still being investigated	7
Non-compliance with delegation(Khayelitsha)	Corrective counselling	540
Non-compliance with delegation(Khayelitsha)	Corrective counselling	16
Non-compliance with delegation (Khayelitsha)	Still being investigated	17
Non-compliance with delegation (Khayelitsha)	Still being investigated	27
Non-compliance with delegation (Khayelitsha)	Still being investigated	20
Non-compliance with delegation (Khayelitsha)	Tax clearance certificate	135
Non-compliance with delegation (Khayelitsha)	Still being investigated	23
No valid contract (Helderberg)	Still being investigated	209
No valid contract (Helderberg)	Still being investigated	380
No valid contract (Helderberg)	Still being investigated	1 167
Non-compliance with delegation (Helderberg)	Tax clearance certificate	48
Non-compliance with delegation (RXH)	Corrective counselling	1
Non-compliance with delegation (RXH)	Corrective counselling	13
Non-compliance with delegation (RXH)	Still being investigated	37
Non-compliance with delegation (Tygerberg)	Still being investigated	366
Non-compliance with delegation (George)	Still being investigated	205
Non-compliance with delegation (George)	Officials dismissed	545
Restricted supplier 2011/12 (various)	Still being investigated	2 767
Non-compliance with delegation (RXH)	Still being investigated	17
Non-compliance with delegation (George)	Still being investigated	122
Non-compliance with delegation (TBH)	Still being investigated	53
Non-compliance with delegation (TBH)	Still being investigated	538
Non-compliance with delegation (Caledon)	Still being investigated	4
Non-compliance with delegation (TBH)	Still being investigated	501
Non-compliance with delegation (Caledon Clinic)	Tax clearance certificate	64
Non-compliance with delegation (Worcester)	Tax clearance certificate	330
Non-compliance with delegation (GSH)	Tax clearance certificate	19
Non-compliance with delegation (GSH)	Still being investigated	52
Non-compliance with delegation (WCCN)	Still being investigated	317
Non-compliance with delegation (CWDO)	Still being investigated	54
Non-compliance with delegation (Various)	Still being investigated	158
Non-compliance with PSR (MDHS)	Still being investigated	11
Non-compliance with PSR (Eerste River)	Still being investigated	5 224
Non-compliance with delegation (Various)	Still being investigated	782
Total		**67 363**

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26.3 Details of irregular expenditure condoned

Incident	Condoned by (condoning authority)	2011/12 R'000
No valid contract for services rendered and paid (HO)	Accounting Officer	1
No valid contract for services rendered and paid (Paarl)	Accounting Officer	120
Non-compliance with delegations (EMS)	Accounting Officer	196
No valid contract for services rendered and paid (MDHS)	Accounting Officer	18
Non-compliance with delegations (Somerset)	Accounting Officer	12
Non-compliance with delegations (Somerset)	Accounting Officer	605
Non-compliance with delegations (Somerset)	Accounting Officer	36
Non-compliance with delegations (Somerset)	Accounting Officer	512
Non-compliance with delegations (Somerset)	Accounting Officer	220
Non-compliance with delegations (Somerset)	Accounting Officer	589
Non-compliance with delegations (Somerset)	Accounting Officer	1 677
Non-compliance with delegations (George)	Accounting Officer	227
Non-compliance with delegations (George)	Accounting Officer	778
Procured outside valid contract (GF Jooste)	Accounting Officer	12
Non-compliance with delegations (Khayelitsha)	Accounting Officer	368
Non-compliance with delegations (DP Marais)	Accounting Officer	3 080
Non-compliance to PSA	Accounting Officer	114
Acting allowance remuneration more than 12 months	Accounting Officer	474
No selection committees appointed	Accounting Officer	16 740
Lady Hamilton Hotel	Accounting Officer	11
George Lodge International	Accounting Officer	1
Out 'n About Catering	Accounting Officer	1
Henry Williams Plantscape	Accounting Officer	2
African Equation	Accounting Officer	9
Monas Supplies	Accounting Officer	168
Pine Lodge Chalets	Accounting Officer	45
Nathan Maalie	Accounting Officer	3
Social Development UCT	Accounting Officer	48
Z-Card	Accounting Officer	100
Microzone	Accounting Officer	1
Multilayer Trading	Accounting Officer	98
Secureforce Security Services	Accounting Officer	4
Food and Beverage Services	Accounting Officer	1
Food and Beverage Services	Accounting Officer	1
Columbus Cleaning System	Accounting Officer	1
Pronto Kleen	Accounting Officer	4
Metro Hospital Service	Accounting Officer	2
Nadia Mason Consulting	Accounting Officer	88
Riverside Printers	Accounting Officer	13

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Incident	Condoned by (condoning authority)	2011/12 R'000
Air Mercy Agency	Accounting Officer	30
Charisma Nursing Agency	Accounting Officer	144
Non-compliance with delegations MDHS	Accounting Officer	6
2006/07 cases found during 2010/11 audit	Accounting Officer	18 494
2007/08 cases found during 2010/11 audit	Accounting Officer	927
2008/09 cases found during 2010/11 audit	Accounting Officer	348
2009/10 cases found during 2010/11 audit	Accounting Officer	3 017
Bid documentation	Accounting Officer	3 633
Competitive biding	Accounting Officer	29 188
Tax Certificate	Accounting Officer	23 099
Other	Accounting Officer	2 366
Total		**107 632**

26.4 Details of irregular expenditure recoverable (not condoned)

Incident	Condoned by (condoning authority)	2011/12 R'000
Non-compliance to PSA	-	7
Total		**7**

26.5 Details of irregular expenditures under investigation

Incident	2011/12 R'000
Kenza Health PTY Suds Laundry (RXH ultra sound machine)	154
Non-compliance with delegations (Eerste River Hospital)	158
Procured outside valid contract (Knysna)	118
Procured outside valid contract (Alan Blyth)	40
Procured outside valid contract (Alan Blyth)	16
Non-compliance with delegations (Overberg)	2
Non-compliance with delegations (Paarl)	145
Non-compliance with delegations (Helderberg)	1 521
Competitive bidding	978
Formal bidding process not followed	3 908
Other	3 462
Restricted suppliers – 2010/11 various still being investigated	3 857
Restricted suppliers – 2009/10 various still being investigated	3 192
Restricted suppliers – 2008/09 various still being investigated	65
Total	**17 616**

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	2011/12 R'000	2010/11 R'000

27. Fruitless and wasteful expenditure

27.1 Reconciliation of fruitless and wasteful expenditure

Opening balance	252	251
Fruitless and wasteful expenditure – relating to current year	6	1
Fruitless and wasteful expenditure awaiting condonement	**258**	**252**

27.2 Analysis of awaiting condonation per economic classification

Current	258	252
Total	**258**	**252**

27.3 Analysis of current year's fruitless and wasteful expenditure

Incident	Disciplinary steps taken/criminal proceedings	2011/12 R'000
Transportation costs. Cheapest quote not accepted	Liability to be determined	2
Returned VAT handbook to Post Office	Liability to be determined	1
Interest charged on overdue account	Liability could not be determined	1
Overpayment of invoices	Money to be recovered from supplier	2
Total		**6**

	2011/12 R'000	2010/11 R'000

28. Related party transactions

Goods and services		
GG vehicle expenditure	-	194 603
Total	-	**194 603**

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During the year under review the following related parties provided services to the Department:

The Department of Transport and Public Works

The Department occupied office buildings, hospitals, clinics, etc. provided by the Department of Transport and Public Works free of charge.

The Department of the Premier

The Department used IT related infrastructure provided by the Department of the Premier free of charge.

Cape Medical Depot

The Department was supplied with medical and surgical sundries by the Cape Medical Depot and the Oudtshoorn Sub-depot. These transactions are at arm's length.

Government Motor Transport

The Department of Health makes use of 1 500 GG vehicles provided by Government Motor Transport. Daily tariffs as approved by the Provincial Treasury is paid on a monthly basis.

The Department of Community Safety

The Department of Health received Security Advisory Services and Security Operations from the Department of Community Safety in the Western Cape Province.

29. Key management personnel

	No of Individuals	2011/12 R'000	2010/11 R'000
Political office bearers	1	1 582	1 493
Officials:			
Level 15 to 16	4	5 232	4 962
Level 14	11	9 451	7 718
Family members of key management personnel	3	964	955
Total		**17 229**	**15 128**

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	2011/12 R'000	2010/11 R'000

30. Public Private Partnership

Contract fee paid	**46 799**	**43 342**
Fixed component	46 799	43 342
Total	**46 799**	**43 342**

The Report of the Accounting Officer, paragraph 7 provides more detail on this issue.

31. Impairment

Debtors	266 454	238 370
Total	**266 454**	**238 370**

32. Movable Tangible Capital Assets

MOVEMENT IN MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Opening balance	Current year adjustments to prior year balances	Additions	Disposals	Closing balance
	R'000	R'000	R'000	R'000	R'000
MACHINERY AND EQUIPMENT	**1 532 918**	**(9 961)**	**293 150**	**101 877**	**1 714 230**
Transport assets	1 995	1 242	982	9	4 210
Computer equipment	140 556	3 087	42 679	12 282	174 040
Furniture and office equipment	32 719	20 159	13 700	2 096	64 482
Other machinery and equipment	1 357 648	(34 449)	235 789	87 490	1 471 498
TOTAL MOVABLE TANGIBLE CAPITAL ASSETS	**1 532 918**	**(9 961)**	**293 150**	**101 877**	**1 714 230**

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32.1 Additions

ADDITIONS TO MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Cash	Non-cash	(Capital work in progress current costs and finance lease payments)	Received current, not paid (Paid current year, received prior year)	Total
	R'000	R'000	R'000	R'000	R'000
MACHINERY AND EQUIPMENT	**255 435**	**28 500**	**-**	**9 215**	**293 150**
Transport assets	932	-	-	50	982
Computer equipment	41 827	708	-	144	42 679
Furniture and office equipment	12 650	504	-	546	13 700
Other machinery and equipment	200 026	27 288	-	8 475	235 789
TOTAL ADDITIONS TO MOVABLE TANGIBLE CAPITAL ASSETS	**255 435**	**28 500**	**-**	**9 215**	**293 150**

32.2 Disposals

DISPOSALS OF MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Sold for cash	Transfer out or destroyed or scrapped	Total disposals	Cash received actual
	R'000	R'000	R'000	R'000
MACHINERY AND EQUIPMENT	**55**	**101 822**	**101 877**	**10**
Transport assets	-	9	9	-
Computer equipment	-	12 282	12 282	-
Furniture and office equipment	-	2 096	2 096	-
Other machinery and equipment	55	87 435	87 490	10
TOTAL DISPOSAL OF MOVABLE TANGIBLE CAPITAL ASSETS	**55**	**101 822**	**101 877**	**10**

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32.3 Movement for 2010/11

MOVEMENT IN MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2011

	Opening balance	Additions	Disposals	Closing balance
	R'000	R'000	R'000	R'000
MACHINERY AND EQUIPMENT	**1 361 234**	**270 588**	**98 904**	**1 532 918**
Transport assets	837	13 880	12 722	1 995
Computer equipment	106 834	40 037	6 315	140 556
Furniture and office equipment	15 599	18 951	1 831	32 719
Other machinery and equipment	1 237 964	197 720	78 036	1 357 648
TOTAL MOVABLE TANGIBLE ASSETS	**1 361 234**	**270 588**	**98 904**	**1 532 918**

32.4 Minor assets

MOVEMENT IN MINOR ASSETS PER THE ASSET REGISTER FOR THE YEAR ENDED AS AT 31 MARCH 2012

	Intangible assets	Machinery and equipment	Total
	R'000	R'000	R'000
Opening balance	1 859	440 972	442 831
Current year adjustments to prior year balances	(169)	(29 029)	(29 198)
Additions	18	60 999	61 017
Disposals	-	28 019	28 019
TOTAL MINOR ASSETS	**1 708**	**444 923**	**446 631**

	Intangible assets	Machinery and equipment	Total
Number of minor assets at cost	595	431 601	432 196
TOTAL NUMBER OF MINOR ASSETS	**595**	**431 601**	**432 196**

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Minor assets

MOVEMENT IN MINOR ASSETS PER THE ASSET REGISTER FOR THE YEAR ENDED AS AT 31 MARCH 2011

	Intangible assets	Machinery and equipment	Total
	R'000	R'000	R'000
Opening balance	1 777	425 030	426 807
Current year adjustments	(151)	(6 055)	(6 206)
Additions	237	45 612	45 849
Disposals	4	23 615	23 619
TOTAL MINOR ASSETS	**1 859**	**440 972**	**442 831**

	Intangible assets	Machinery and equipment	Total
	R'000	R'000	R'000
Number of minor assets at cost	660	429 991	430 651
TOTAL NUMBER OF MINOR ASSETS	**660**	**429 991**	**430 651**

33. Intangible Capital Assets

MOVEMENT IN INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Opening balance	Current year adjustments to prior year balances	Additions	Disposals	Closing balance
	R'000	R'000	R'000	R'000	R'000
Computer software	1 541	73	945	-	2 559
TOTAL INTANGIBLE CAPITAL ASSETS	**1 541**	**73**	**945**	**-**	**2 559**

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33.1 Additions

ADDITIONS TO INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Cash	Non-cash	(Development work in progress – current costs)	Received current year, not paid (Paid current year, received prior year)	Total
	R'000	R'000	R'000	R'000	R'000
Computer software	161	-	-	784	945
TOTAL ADDITIONS TO INTANGIBLE CAPITAL ASSETS	**161**	**-**	**-**	**784**	**945**

33.2 Movement for 2010/11

MOVEMENT IN INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2011

	Opening balance	Additions	Disposals	Closing balance
	R'000	R'000	R'000	R'000
Computer software	1 177	364	-	1 541
TOTAL INTANGIBLE CAPITAL ASSETS	**1 177**	**364**	**-**	**1 541**

34. Immovable Tangible Capital Assets

MOVEMENT IN IMMOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Opening balance	Current year adjustments to prior year balances	Additions	Disposals	Closing balance
	R'000	R'000	R'000	R'000	R'000
BUILDINGS AND OTHER FIXED STRUCTURES	**4 036**	**(461)**	**1 523**	**30**	**5 068**
Other fixed structures	4 036	(461)	1 523	30	5 068
TOTAL IMMOVABLE TANGIBLE CAPITAL ASSETS	**4 036**	**(461)**	**1 523**	**30**	**5 068**

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34.1 Additions

ADDITIONS TO IMMOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Cash	Non-cash	(Capital work in progress current costs and finance lease payments)	Received current, not paid (Paid current year, received prior year)	Total
	R'000	R'000	R'000	R'000	R'000
BUILDING AND OTHER FIXED STRUCTURES	**559 109**	**44**	**(557 630)**	**-**	**1 523**
Non-residential buildings	557 630	-	(557 630)	-	-
Other fixed structures	1 479	44	-	-	1 523
TOTAL ADDITIONS TO IMMOVABLE TANGIBLE CAPITAL ASSETS	**559 109**	**44**	**(557 630)**	**-**	**1 523**

34.2 Disposals

DISPOSALS OF IMMOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Sold for cash	Transfer out or destroyed or scrapped	Total disposals	Cash received actual
	R'000	R'000	R'000	R'000
BUILDINGS AND OTHER FIXED STRUCTURES	**30**	**-**	**30**	**-**
Other fixed structures	30	-	30	-
TOTAL DISPOSALS OF IMMOVABLE TANGIBLE CAPITAL ASSETS	**30**	**-**	**30**	**-**

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34.3 Movement for 2010/11

MOVEMENT IN IMMOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2011

	Opening balance	Additions	Disposals	Closing balance
	R'000	R'000	R'000	R'000
BUILDINGS AND OTHER FIXED STRUCTURES	**3 072**	**1 050**	**86**	**4 036**
Other fixed structures	3 072	1 050	86	4 036
TOTAL IMMOVABLE TANGIBLE ASSETS	**3 072**	**1 050**	**86**	**4 036**

35. Finance Lease Commitments

The arrangement between the Department of Health and GMT constitutes finance leases. The obligation in respect of the finance leases are presented below:

Future Lease Payments

35.1 2011/12

	Within 1 year	2 - 5 years	More than 5 years	Total
	R'000	R'000	R'000	R'000
Total lease payments to be made	**73 138**	**122 820**	**27 458**	**223 416**
Finance costs	73 138	122 820	27 458	223 416
TOTAL FINANCE LEASE COMMITMENTS AS AT 31 MARCH 2012	**73 138**	**122 820**	**27 458**	**223 416**

35.2 2010/11

	Within 1 year	2 - 5 years	More than 5 years	Total
	R'000	R'000	R'000	R'000
Total lease payments to be made	**68 779**	**155 759**	**25 299**	**249 837**
Total future daily tariffs	68 779	155 759	25 299	249 837
TOTAL FINANCE LEASE COMMITMENTS AS AT 31 MARCH 2011	**68 779**	**155 759**	**25 299**	**249 837**

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The Department of Health leased 1 500 vehicles from GMT during 2012 (2011: 1 432). Daily tariffs are payable on a monthly basis, covering the operational costs, capital costs of replacement of vehicles.

Provincial Treasury approves tariffs for GMT on an annual basis. The Department utilises the vehicles for most of the useful life. The agreement does not provide for contingent lease payments, and at the end of the useful life as determined by the lessor, the vehicles are returned where it is sold on auction for the benefit of the lessee.

GG vehicle daily tariff commitments were reclassified from operating lease commitments to finance lease commitments in the 2011/12 AFS and hence restated for the 2010/11 comparatives.

36. Movable Tangible Capital Assets

MOVEMENT IN MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Opening balance	Current year adjustments to prior year balances	Additions	Disposals	Closing balance
	R'000	R'000	R'000	R'000	R'000
GG vehicles	**-**	**243 951**	**39 605**	**20 896**	**262 660**
GG motor vehicles	-	243 951	39 605	20 896	262 660
TOTAL MOVABLE TANGIBLE CAPITAL ASSETS	**-**	**243 951**	**39 605**	**20 896**	**262 660**

36.1 Additions

ADDITIONS TO MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Cash	Non-cash	Received current, not paid (Paid current year, received prior year)	Total
	R'000	R'000	R'000	R'000
GG vehicles	**-**	**39 605**	**-**	**39 605**
GG motor vehicles	-	39 605	-	39 605
TOTAL ADDITIONS TO MOVABLE TANGIBLE CAPITAL ASSETS	**-**	**39 605**	**-**	**39 605**

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36.2 Disposals

DISPOSALS OF MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2012

	Transfer out or destroyed or scrapped	Total disposals
	R'000	R'000
GG vehicles	**20 896**	**20 896**
GG motor vehicles	20 896	20 896
TOTAL DISPOSALS TO MOVEABLE TANGIBLE CAPITAL ASSETS	**20 896**	**20 896**

Annexure 1A
STATEMENT OF CONDITIONAL GRANTS RECEIVED

NAME OF DEPARTMENT	GRANT ALLOCATION					SPENT			2010/11	
	Division of Revenue Act/ provincial grants	Roll overs	DORA adjustments	Other adjustments	Total available	Amount received by department	Amount spent by department	% of available funds spent by department	Division of Revenue Act	Amount spent by department
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
National Tertiary Services Grant	1 973 127	-	-	-	1 973 127	1 973 127	1 973 127	100%	1 763 234	1 763 234
Health Professions Training and Development Grant	407 794	-	-	-	407 794	407 794	407 794	100%	384 711	384 711
Comprehensive HIV and AIDS Grant	660 614	-	-	-	660 614	660 614	660 578	100%	555 054	554 971
Forensic Pathology Services Grant	70 226	-	-	-	70 226	70 226	70 199	100%	73 653	73 753
Hospital Revitalisation Grant	481 501	9 257	-	-	490 758	490 758	482 429	98%	623 328	614 071
Infrastructure Grant to Provinces	119 179	7 601	-	-	126 780	126 780	123 957	98%	203 505	195 904
Expanded Public Works Programme Grant for the Social Sector	5 812	137	-	2 852	8 801	8 801	5 334	61%	1 188	1 051
Total	**3 718 253**	**16 995**	**-**	**2 852**	**3 738 100**	**3 738 100**	**3 723 418**		**3 604 673**	**3 587 695**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
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Annexure 1B
STATEMENT OF UNCONDITIONAL GRANTS AND TRANSFERS TO MUNICIPALITIES

NAME OF MUNICIPALITY	GRANT ALLOCATION				TRANSFER		SPENT			2010/11
	Amount	Roll Overs	Adjustments	Total available	Actual transfer	% of available funds transferred	Amount received by municipality	Amount spent by municipality	% of available funds spent by municipality	Total available
	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	%	R'000
City of Cape Town	313 968	6 995	-	320 963	300 873	94%	300 873	300 873	100%	267 938
Overberg District	-	-	-	-	-	-	-	-	-	493
West Coast District	-	-	-	-	-	-	-	-	-	450
Central Karoo District	1 468	332	-	1 800	1 407	78%	1 407	1 407	100%	1 438
Eden District	-	-	-	-	-	-	-	-	-	768
Total	**315 436**	**7 327**	**-**	**322 763**	**302 280**		**302 280**	**302 280**		**271 087**

ANNEXURE 1C
STATEMENT OF TRANSFERS TO DEPARTMENTAL AGENCIES AND ACCOUNTS

DEPARTMENT / AGENCY / ACCOUNT	TRANSFER ALLOCATION				TRANSFER		2010/11
	Adjusted appropriation	Roll overs	Adjustments	Total available	Actual transfer	% of available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Cape Medical Depot	12 535	-	-	12 535	12 535	100%	52 299
SETA	3 880	-	(764)	3 116	3 116	100%	3 189
Total	**16 415**	**-**	**(764)**	**15 651**	**15 651**		**55 488**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

ANNEXURE 1D
STATEMENT OF TRANSFERS TO UNIVERSITIES AND TECHNIKONS

UNIVERSITY / TECHNIKON	TRANSFER ALLOCATION				TRANSFER			2010/11
	Adjusted appropriation	Roll overs	Adjustments	Total available	Actual transfer	Amount not transferred	% of available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000
Cape Peninsula University of Technology	1 926	-	5 325	7 251	6 025	1 226	83%	1 522
	1 926	**-**	**5 325**	**7 251**	**6 025**	**1 226**		**1 522**

ANNEXURE 1G
STATEMENT OF TRANSFERS TO NON-PROFIT INSTITUTIONS

NON-PROFIT INSTITUTIONS	TRANSFER ALLOCATION				TRANSFER		2010/11
	Adjusted appropriation	Roll overs	Adjustments	Total available	Actual transfer	% of available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Transfers							
Community Health Clinics	1 324	-	-	1 324	1 477	112%	285
Tuberculosis	-	-	-	-	-	-	1 490
Booth Memorial	12 094	-	-	12 094	12 094	100%	11 409
Life Esidimeni	33 423	-	-	33 423	32 208	96%	31 531
Sarah Fox	6 109	-	-	6 109	6 109	100%	5 763
St Josephs	9 345	-	-	9 345	9 345	100%	8 816
Health Committees	11 391	-	-	11 391	10 434	92%	10 143
Home Base Care	4 224	-	-	4 224	3 317	79%	4 010
Mental Health	35 205	-	-	35 205	35 439	101%	21 863
HIV and AIDS	101 488	-	-	101 488	90 985	90%	84 066
Nutrition	1 942	-	-	1 942	1 954	101%	1 832
Radie Kotze	-	-	-	-	-	-	1 620
Vredendal Hospital (Step-down care)	-	-	-	-	-	-	160
Global Fund contributions to NGOs	32 829	-	-	32 829	29 928	91%	23 733
SA Red Cross Air Mercy	35 281	-	-	35 281	35 281	100%	37 058
Maitland Cottage	8 157	-	-	8 157	8 157	100%	7 695
EPWP	43 801	-	-	43 801	37 203	85%	36 188
Total	**336 613**	**-**	**-**	**336 613**	**313 931**		**287 662**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

ANNEXURE 1H
STATEMENT OF TRANSFERS TO HOUSEHOLDS

HOUSEHOLDS	TRANSFER ALLOCATION				TRANSFER		2010/11
	Adjusted appropriation	Roll overs	Adjustments	Total available	Actual transfer	% of available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Transfers							
Employee social benefits-cash residents	18 204	-	2 688	20 892	23 761	114%	24 379
Claims against the state: households	16 826	-	(913)	15 913	16 024	101%	3 895
Bursaries	63 990	-	2 894	66 884	66 884	100%	90 223
Payment made an as act of grace	78	-	(32)	46	45	98%	83
Total	**99 098**	**-**	**4 637**	**103 735**	**106 714**		**118 580**

ANNEXURE 1I
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS RECEIVED

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2011/12	2010/11
		R'000	R'000
Received in kind			
Gifts & Donations and sponsorships received for the year ending 31 March 2011		-	46 887
Alexandra Hospital	Computer hardware and systems	116	-
Alexandra Hospital	Consumables	25	-
Alexandra Hospital	Domestic equipment	43	-
Alexandra Hospital	Domestic furniture	23	-
Alexandra Hospital	Kitchen appliances	5	-
Alexandra Hospital	Medical and allied equipment	1	-
Alexandra Hospital	Office equipment	11	-
Beaufort West Hospital	Medical and allied equipment	6	-
Brewelskloof Hospital	Domestic equipment	5	-
Brewelskloof Hospital	Domestic furniture	11	-
Brewelskloof Hospital	Kitchen appliances	1	-
Brewelskloof Hospital	Medical and allied equipment	31	-
Brewelskloof Hospital	Office equipment	4	-
Brooklyn Chest Hospital	Consumables	29	-
Brooklyn Chest Hospital	Domestic equipment	3	-
Brooklyn Chest Hospital	Kitchen appliances	7	-
Brooklyn Chest Hospital	Medical and allied equipment	8	-
Citrusdal Hospital	Domestic equipment	2	-

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2011/12	2010/11
		R'000	R'000
Citrusdal Hospital	Domestic furniture	1	-
Eerste River Hospital	Domestic equipment	12	-
Eerste River Hospital	Kitchen appliances	5	-
Eerste River Hospital	Medical and allied equipment	832	-
Emergency Medical Services	Consumables	7	-
Emergency Medical Services	Domestic equipment	9	-
Emergency Medical Services	Domestic furniture	16	-
Emergency Medical Services	Medical and allied equipment	1 629	-
False Bay Hospital	Domestic equipment	17	-
False Bay Hospital	Kitchen appliances	11	-
False Bay Hospital	Medical and allied equipment	5	-
False Bay Hospital	Office equipment	6	-
Forensic Pathology Services	Domestic equipment	195	-
Forensic Pathology Services	Kitchen appliances	1	-
George Hospital	Computer hardware and systems	99	-
George Hospital	Domestic equipment	15	-
George Hospital	Medical and allied equipment	194	-
GF Jooste Hospital	Computer hardware and systems	1	-
GF Jooste Hospital	Consumables	2	-
GF Jooste Hospital	Domestic equipment	184	-
GF Jooste Hospital	Domestic furniture	184	-
GF Jooste Hospital	Kitchen appliances	9	-
GF Jooste Hospital	Medical and allied equipment	2 890	-
GF Jooste Hospital	Office equipment	71	-
Groote Schuur Hospital	Computer hardware and systems	37	-

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2011/12	2010/11
		R'000	R'000
Groote Schuur Hospital	Consumables	1 558	-
Groote Schuur Hospital	Domestic equipment	68	-
Groote Schuur Hospital	Domestic furniture	164	-
Groote Schuur Hospital	Kitchen appliances	14	-
Groote Schuur Hospital	Medical and allied equipment	1 888	-
Groote Schuur Hospital	Office equipment	11	-
Groote Schuur Hospital	Security equipment, system, mater: fix	1	-
Groote Schuur Hospital	Transport assets	120	-
Harry Comay Hospital	Kitchen appliances	77	-
Harry Comay Hospital	Medical and allied equipment	1 690	-
Helderberg Hospital	Office equipment	4	-
Hermanus Hospital	Domestic furniture	27	-
Hermanus Hospital	Medical and allied equipment	13	-
Hermanus Hospital	Buildings and other fixed structures	13	-
Karl Bremer Hospital	Consumables	4	-
Karl Bremer Hospital	Domestic equipment	93	-
Karl Bremer Hospital	Domestic furniture	22	-
Karl Bremer Hospital	Kitchen appliances	6	-
Karl Bremer Hospital	Office equipment	9	-
Lentegeur Hospital	Computer hardware and systems	171	-
Lentegeur Hospital	Consumables	7	-
Lentegeur Hospital	Office equipment	14	-
Mossel Bay Hospital	Consumables	33	-
Mossel Bay Hospital	Domestic equipment	1	-
Mossel Bay Hospital	Domestic furniture	8	-

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2011/12	2010/11
		R'000	R'000
New Somerset Hospital	Computer hardware and systems	1	-
New Somerset Hospital	Consumables	49	-
New Somerset Hospital	Domestic furniture	293	-
New Somerset Hospital	Domestic furniture	14	-
New Somerset Hospital	Kitchen appliances	46	-
New Somerset Hospital	Medical and allied equipment	622	-
New Somerset Hospital	Office equipment	132	-
New Somerset Hospital	Telecommunication equipment	10	-
New Somerset Hospital	Workshop equipment and tools	28	-
Oral Health Centre Tygerberg	Domestic furniture	167	-
Oral Health Centre Tygerberg	Medical and allied equipment	45	-
Paarl Hospital	Domestic equipment	7	-
Red Cross War Memorial Children's Hospital	Computer hardware and systems	83	-
Red Cross War Memorial Children's Hospital	Consumables	77	-
Red Cross War Memorial Children's Hospital	Domestic equipment	795	-
Red Cross War Memorial Children's Hospital	Domestic furniture	506	-
Red Cross War Memorial Children's Hospital	Kitchen appliances	50	-
Red Cross War Memorial Children's Hospital	Medical and allied equipment	1 857	-
Red Cross War Memorial Children's Hospital	Office equipment	26	-
Red Cross War Memorial Children's Hospital	Security equipment, system, mater: fix	4	-
Red Cross War Memorial Children's Hospital	Telecommunication equipment	44	-
Red Cross War Memorial Children's Hospital	Workshop equipment & tools	7	-
Red Cross War Memorial Children's Hospital	Domestic equipment	8	-
Stikland Hospital	Computer hardware and systems	8	-
Stikland Hospital	Domestic equipment	13	-

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2011/12	2010/11
		R'000	R'000
Stikland Hospital	Domestic furniture	16	-
Stikland Hospital	Kitchen appliances	1	-
Stikland Hospital	Medical and allied equipment	7	-
Stikland Hospital	Office equipment	4	-
Tygerberg Hospital	Computer hardware and systems	9	-
Tygerberg Hospital	Consumables	452	-
Tygerberg Hospital	Domestic equipment	194	-
Tygerberg Hospital	Domestic furniture	87	-
Tygerberg Hospital	Kitchen appliances	2	-
Tygerberg Hospital	Medical and allied equipment	17 700	-
Tygerberg Hospital	Office equipment	7	-
Valkenberg Hospital	Domestic equipment	4	-
Valkenberg Hospital	Domestic furniture	30	-
Valkenberg Hospital	Kitchen appliances	2	-
Valkenberg Hospital	Office equipment	5	-
Victoria Hospital	Domestic equipment	6	-
Victoria Hospital	Medical and allied equipment	13	-
Vredenburg Hospital	Medical and allied equipment	1	-
Vredenburg Hospital	Office equipment	57	-
Vredendal Hospital	Computer hardware and systems	65	-
Vredendal Hospital	Medical and allied equipment	493	-
Wesfleur Hospital	Consumables	3	-
Wesfleur Hospital	Domestic furniture	5	-
Wesfleur Hospital	Medical and allied equipment	10	-
Western Cape Rehab Centre	Domestic equipment	4	-

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2011/12	2010/11
		R'000	R'000
Worcester Hospital	Domestic equipment	4	-
Worcester Hospital	Kitchen appliances	1	-
TOTAL		**36 849**	**46 887**

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

ANNEXURE 1J
STATEMENT OF AID ASSISTANCE RECEIVED

NAME OF DONOR	PURPOSE	OPENING BALANCE R'000	REVENUE R'000	EXPENDITURE R'000	CLOSING BALANCE R'000
Received in cash					
French Fund	Upgrading of Grabouw CDC	3 411	4 212	7 623	-
TOTAL		**3 411**	**4 212**	**7 623**	**-**

The French Donor Fund overspent with an amount of R 4,217 million. The Department augmented the over expenditure and a receivable was raised to be recovered in the 2012/2013 financial year.

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

ANNEXURE 1K
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS MADE AND REMMISSIONS, REFUNDS AND PAYMENTS MADE AS AN ACT OF GRACE

NATURE OF GIFT, DONATION OR SPONSORSHIP	2011/12	2010/11
	R'000	R'000
Paid in cash		
Donation for Western Cape Provincial Pharmacy Services Conference	80	60
Donation to The Children's Hospital Trust	9 773	4 559
Donation towards Woman's Manyano Choir	-	5
Sub-total	**9 853**	**4 624**
Made in kind		
Active Social Development	31	-
Elsies River High School	18	-
Church of St. Francis	8	-
Gender and Youth Network	35	-
These Numbers Have Faces	38	-
Rosies Angels Playground	29	-
Subtotal	**159**	**-**
Remissions, refunds, and payments made as an act of grace		
Payment made as an act of grace	45	83
Sub-total	**45**	**83**
TOTAL	**10 057**	**4 707**

ANNEXURE 3A
STATEMENT OF FINANCIAL GUARANTEES ISSUED AS AT 31 MARCH 2012

Guarantor institution	Guarantee in respect of	Original guaranteed capital amount	Opening balance 1 April 2011	New guarantees issued during the year	Guarantees repayments/ cancelled/ reduced/ released during the year	Revaluations	Closing balance 31 March 2012
		R'000	R'000	R'000	R'000	R'000	R'000
Standard Bank	Housing	126	126	158	16	-	268
Nedbank (Cape of Good Hope)	Housing	24	24	-	24	-	-
First Rand	Housing	212	212	-	84	-	128
Nedbank (Inc BOE)	Housing	55	55	-	46	-	9
Absa	Housing	334	334	114	254	-	194
Old Mutual Fin Ltd	Housing	52	52	-	-	-	52
Peoples Bank FBC Fid	Housing	74	74	15	27	-	62
Nedbank Ltd (NBS)	Housing	18	18	-	18	-	-
FNB (Former Saambou)	Housing	72	72	41	113	-	-
Community Bank	Housing	11	11	-	11	-	-
NHFC (MASIKHEN)	Housing	-	-	25	-	-	25
Old Mutual (Nedbank/Perm)	Housing	-	-	15	15	-	-
	Total	**978**	**978**	**368**	**608**	**-**	**738**

During the 2010/11 financial year audit, the Auditor-General identified housing loan guarantees made to officials who had been transferred to other Departments. The disclosure was subsequently reduced with the amounts in question. These amounts should not have been reduced as the guarantees remain the responsibility of the Department until such time it is accepted by the Department where the official has been transferred to. This understatement has been corrected during the 2011/12 financial year.

ANNEXURE 3B
STATEMENT OF CONTINGENT LIABILITIES AS AT 31 MARCH 2012

Nature of Liability	Opening balance 1 April 2011	Liabilities incurred during the year	Liabilities paid / cancelled / reduced during the year	Liabilities recoverable (provide details hereunder)	Closing balance 31 March 2012
	R'000	R'000	R'000	R'000	R'000
Claims against the Department					
Medico Legal	52 080	62 267	27 007	-	87 340
Civil & legal claims including Labour Relations claims	44 285	1 114	260	-	45 139
Sub-total	96 365	63 381	27 267	-	132 479
Other					
Occupational Specific Dispensation (OSD) for nurses	908	-	-	-	908
Sub-total	908	-	-	-	908
TOTAL	**97 273**	**63 381**	**27 267**	**-**	**133 387**

ANNEXURE 4
CLAIMS RECOVERABLE

Government Entity	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2012	31/03/2011	31/03/2012	31/03/2011	31/03/2012	31/03/2011
	R'000	R'000	R'000	R'000	R'000	R'000
Department						
WESTERN CAPE PROVINCE						
Department of Social Development	-	-	-	2	-	2
Department of Transport & Public Works	-	-	167	-	167	-
Department of Community Safety	-	-	28	-	28	-
Department of Education	-	-	484	-	484	-
Department of the Premier	-	19	2	-	2	19
PROVINCE OF THE EASTERN CAPE						
Department of Health	43	35	98	52	141	87
GAUTENG PROVINCE						
Department of Health	104	139	77	-	181	139
NORTHERN CAPE PROVINCE						
Department of Health	-	-	27	53	27	53
FREE-STATE PROVINCE						
Department of Health	61	-	31	-	92	-

ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

Government Entity	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2012	31/03/2011	31/03/2012	31/03/2011	31/03/2012	31/03/2011
	R'000	R'000	R'000	R'000	R'000	R'000
KWAZULU-NATAL PROVINCE						
Department of Health	-	-	-	3	-	3
PROVINCE OF MPUMALANGA						
Department of Health	-	-	-	15	-	15
NATIONAL DEPARTMENTS						
Department of Health	-	-	-	62 610	-	62 610
Department of Correctional Services	-	-	265	197	265	197
South African Social Security Agency	-	939	3 158	2 164	3 158	3 103
Limpopo Province: Department of Health	-	7	2	15	2	22
Department of Water Affairs	-	-	11	-	11	-
Department of Justice	-	-	-	21	-	21
Parliament	-	-	17	13	17	13
South African Police Services	-	25	-	10	-	35
Sub-total	208	1 164	4 367	65 155	4 575	66 319
Other Government Entities						
Pension Recoverable	-	-	(125)	(1 066)	(125)	(1 066)
Agency Service	-	-	(1 418)	(259)	(1 418)	(259)
Claims receivable : Public Entities -VAT refunds	-	-	-	1 116	-	1 116
French Donor Fund	-	-	4 217	-	4 217	-
Sub-total	-	-	2 674	(209)	2 674	(209)
TOTAL	**208**	**1 164**	**7 041**	**64 946**	**7 249**	**66 110**

ANNEXURE 5
INTER-GOVERNMENT PAYABLES

Government Entity	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2012	31/03/2011	31/03/2012	31/03/2011	31/03/2012	31/03/2011
	R'000	R'000	R'000	R'000	R'000	R'000
DEPARTMENTS						
Current						
WESTERN CAPE PROVINCE						
Department of Social Development	104	-	-	-	104	-
Department of Education	23	-	-	-	23	-
Government Motor Transport	-	-	151	-	151	-
Department of Premier	-	-	19	-	19	-
GAUTENG PROVINCE						
Department of Health	164	-	-	-	164	-
EASTERN CAPE PROVINCE						
Department of Health	-	-	99	-	99	-
NORTHERN CAPE PROVINCE						
Department of Health	-	-	-	17	-	17
NATIONAL DEPARTMENTS						
Department of Justice & Constitutional Development	-	-	1 332	-	1 332	-
South African Police Services	-	-	80	-	80	-
Total	**291**	**-**	**1 681**	**17**	**1 972**	**17**

ANNEXURE 6
INVENTORY

Inventory	2011/12	
	Quantity	R'000
Opening balance	24 862 546	192 163
Add/(Less): Adjustments to prior year balance	(4 290 546)	16 928
Add: Additions/Purchases – Cash	143 400 230	1 519 414
Add: Additions – Non-cash	14 867 978	29 486
(Less): Disposals	(49 883)	(1 687)
(Less): Issues	(164 285 955)	(1 563 310)
Add/(Less): Adjustments	9 629 944	95 935
Closing balance	**24 134 314**	**288 929**

Inventory	2010/11	
	Quantity	R'000
Opening balance	12 236 379	121 535
Add/(Less): Adjustments to prior year balance	(31 930)	(187 716 830)
Add: Additions/Purchases – Cash	85 761 617	1 105 885
Add: Additions – Non-cash	22 748 760	49 363
(Less): Disposals	(78 577)	(1 562)
(Less): Issues	(107 961 321)	(1 259 579)
Add/(Less): Adjustments	12 187 618	187 893 352
Closing balance	**24 862 546**	**192 163**

WESTERN CAPE – DEPARTMENT OF HEALTH
CAPE MEDICAL DEPOT

ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

3.2 Cape Medical Depot

WESTERN CAPE – DEPARTMENT OF HEALTH
CAPE MEDICAL DEPOT

ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

3.2.1 General information

Domicile	South Africa
Nature of business and principle activities	The Cape Medical Depot is responsible for the supply of essential medicines and disposable surgical sundry items to provincial health care facilities in the Western Cape. The Depot operates as a trading entity and charges levies of 5 to 8 per cent on stock issues to the provincial health care facilities.
Legal form of entity	Trading entity [as defined by the Public Finance Management Act (Act No. 1 of 1999) as amended by Act No. 25 of 1999].
Ultimate parent / controlling entity	Western Cape Department of Health
Registered office	Private Bag X 9036 Cape Town 8000
Business address	16 Chiappini Street Cape Town 8001
Postal address	Private Bag X 9036 Cape Town 8000
Auditor	Auditor-General South Africa

WESTERN CAPE – DEPARTMENT OF HEALTH
CAPE MEDICAL DEPOT

ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

3.2.2 Statement of Responsibility

The Public Finance Management Act, 1999 (Act No. 1 of 1999), as amended, requires the accounting officer to ensure that the Cape Medical Depot keeps full and proper records of its financial affairs. The annual financial statements should fairly present the state of affairs of the Depot, its financial results, its performance against predetermined objectives and its financial position at the end of the year in terms of the basis of accounting as set out in note 1 to the financial statements.

The annual financial statements are the responsibility of the accounting officer. The Auditor-General is responsible for independently auditing and reporting on the financial statements. The Auditor-General has audited the entity's financial statements and the Auditor-General's report appears on page 362.

The annual financial statements have been prepared in accordance with the basis of accounting as set out in note 1 to the financial statements. These annual financial statements are based on appropriate accounting policies, supported by reasonable judgements and estimates.

The accounting officer has reviewed the entity's budgets and cash flow forecasts for the year ended 31 March 2012. On the basis of this review, and in view of the current financial position, the accounting officer has every reason to believe that the entity will be a going concern in the year ahead and has continued to adopt the going concern basis in preparing the financial statements.

The accounting officer sets standards to enable management to meet the above responsibilities by implementing systems of internal control and risk management that are designed to provide reasonable, but not absolute assurance against material misstatements and losses. The entity maintains internal financial controls to provide assurance regarding:

- The safeguarding of assets against unauthorised use or disposition.
- The maintenance of proper accounting records and the reliability of financial information used within the business or for publication.

The controls contain self-monitoring mechanisms, and actions are taken to correct deficiencies as they are identified. Even an effective system of internal control, no matter how well designed, has inherent limitations, including the possibility of circumvention or the overriding of controls. An effective system of internal control therefore aims to provide reasonable assurance with respect to the reliability of financial information and, in particular, financial statement presentation. Furthermore, because of changes in conditions, the effectiveness of internal financial controls may vary over time.

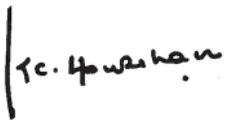
The accounting officer has reviewed the entity's systems of internal control and risk management for the period from 1 April 2011 to 31 March 2012. The accounting officer is of the opinion that the entity's systems of internal control and risk management were effective for the period under review.

WESTERN CAPE – DEPARTMENT OF HEALTH
CAPE MEDICAL DEPOT

ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

In the opinion of the accounting officer, based on the information available to date, the annual financial statements fairly present the financial position of the fund at 31 March 2012 and the financial performance and cash flow information for the year then ended and that the Code of Corporate Practices and Conduct has been adhered to.

The annual financial statements for the year ended 31 March 2012, set out on pages 366 to 396, were submitted for auditing on 31 May 2012 and approved by the accounting officer in terms of section 40(1) l of the PFMA, 1999 (Act No. 1 of 1999), as amended and are signed on its behalf by:



PROFESSOR KC HOUSEHAM
ACCOUNTING OFFICER

WCG: Department of Health
Date: 31 May 2012

WESTERN CAPE – DEPARTMENT OF HEALTH
CAPE MEDICAL DEPOT

REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2012

Report of the Accounting Officer

Report by the Accounting Officer to the Executive Authority and to the Parliament/Provincial Legislature of the Republic of South Africa.

1. General review of the state of financial affairs

The operational expenditure of the Cape Medical Depot (CMD), which includes compensation of employees, goods and services and payments for capital assets, is recovered from institutions by means of a levy charged for goods supplied. Only augmentation of the CMD's capital is included in the Budget Statement of the Department of Health. The CMD surrenders any cash surplus (to be distinguished from a GAAP surplus) to the Department, but the Department has to fund any cash deficits. The cash surpluses and deficits are disclosed in the statement of changes in equity.

The levy is determined such that the CMD should always show a profit on an accrual basis. However, the CMD had a cash loss in the 2010/11 year but has managed through improved internal control processes to generate a cash profit for the year under review.

In a business such as the CMD it is important to monitor the gross profit percentage (GP%), as unexplained variances may be indications of unrecorded losses or accounting errors. With the weighted average levy of about 7 per cent, from which freight charges of about 1.5 per cent (of turnover) and packaging materials of 0.2 per cent must be deducted, the GP% should be approximately 5.3 per cent before stock losses.

In the year under review the net GAAP stock losses is just less than R4 million, which is 0.6 per cent of turnover. GP% should therefore be 4.7 per cent.

During the year under review the CMD's capital was significantly augmented by about R12.6 million due to the need to better manage the Department's cash flow. (The underfunding of the CMD creates cash flow problems for the Department.) Capital now stands at about R101 million.

Due to the low GP%, the CMD showed a small net GAAP profit of about R1.9 million in the current year. Operational expenditure decreased by 1 per cent.

The closing stock (R114 million) is 9 per cent more than at the end of the previous year.

2. Services rendered by the Trading Entity

The CMD provides pharmaceutical and non-pharmaceutical supplies to health institutions after bulk buying from suppliers, thereby enabling health institutions to keep lower stock levels and rely on shorter delivery lead-times. Better control is exercised over purchases and the advantage of bulk-buying results in lower costs.

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The CMD is responsible for the storage and management of this stock, to service provincial hospitals, provincial-aided hospitals, old age homes, day hospitals, local authorities and clinics.

The warehouse operationally consists of four sections, namely pharmaceutical depot, non-pharmaceutical depot, DDV (Direct Delivery Voucher) depot and Oudtshoorn medical depot. The Oudtshoorn medical depot is a sub-depot of the CMD and supplies pharmaceuticals to the Eden and Central Karoo Districts. The CMD also manages a pre-packing unit where bulk items of stock are packed into smaller patient ready quantities.

3. Tariff policy

A levy is charged and added to the ledger price of goods purchased to determine the costs of goods supplied to clients. These levies are evaluated by Treasury and are reviewed annually and adjusted if required. The levies mentioned below have not been adjusted since 1994:

- Pharmaceutical and non-pharmaceutical depot stock — 8% levy on average prices
- Direct delivery items — 5% levy on average prices

Levies are not intended to result in a profit or loss accruing, but should fund the operating expenditure in full.

4. Capacity constraints

The working capital has to be increased annually in order to meet the increasing demands for particularly stock holding, which is driven by the relatively high medical inflation.

The warehouse is a multi-level facility with no surrounding vacant land for expansion. It has a central shaft system with two old goods lifts. The relocation of the CMD to a more suitable location is therefore deemed as a priority.

The CMD uses the MEDSAS procurement system that interfaces into the Basic Accounting System (BAS). In terms of Treasury Regulations, trading entities must compile annual financial statements in terms of GAAP. The conversion of the MEDSAS information to comply with GAAP is extremely time consuming and complex. Cabinet has approved the incorporation of CMD into the Department of Health therefore separate GAAP compliant financial statements will no longer be a requirement for the depot beyond the current year of review.

The Depot has successfully recruited three pharmacists during the 2011/12 financial year but even after the occupational specific dispensation for pharmacists, recruitment of skilled pharmacists is a challenge.

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5. Utilisation of donor funds

No donor funding was received at the CMD.

6. Business address

16 Chiappini Street
Cape Town
8001

Private Bag X9036
Cape Town
8000

7. New / proposed activities

No new activities are proposed.

8. Events after the reporting period

From 1 April 2012, the Cape Medical Depot will be incorporated within the programmes of the Western Cape Department of Health.

9. Performance information

The following performance indicators are available as standard reports on the MEDSAS system:

	2011/12	**2010/11**	**2009/10**
Inventory turnover	4.88	4.82	4.46
Dues out	4.3%	3.8%	6.5%
Service level	92%	88%	86%

The CMD inventory turnover has increased mainly due to more efficient purchasing of pharmaceutical stock. The service level (defined as the number of orders satisfied within 48 hours of receipt) has remained approximately the same over the past three years showing small increases each year.

10. SCOPA resolutions

Matters from the report of the standing committee on public accounts dated 24 June 2011 are as follows:

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The Committee expressed its concern regarding the regression of the Entity from a financially unqualified audit opinion with no findings on predetermined objectives or compliance with laws and regulations, to a financially unqualified audit opinion with find on compliance with laws and regulations.

The Committee raised the following concerns:

Background / Reference to audit report	**Resolution / Concerns**	**Departmental Responses**
As disclosed in note 25 to the financial statements (page 401) irregular expenditure totalling R2.5 million (2009/10: R0) was discovered and/or incurred during the year under review as result of non-compliance with laws and regulations relating to procurement and contract management. The full amount of irregular expenditure was detected during the audit of procurement and contract management and was not prevented or detected by the Department's internal control activities. Sole source bidding was utilised, but adequate documentation did not exist to substantiate such a bidding process, as required by paragraph 9.3.3 of the Western Cape Department of Health Accounting Officer's System for Procurement, Supply Chain and Asset Management, issued in terms of section 38(1)(a)(iii) of the PFMA [par. 13 on page 371 of the annual report].	(a) The irregular expenditure totalling R2.5 million which was discovered and/or incurred during the year under review as a result of non-compliance with laws and regulations relating to procurement and contract management; (b) The Committee also noted that the full amount of irregular expenditure was detected during the audit of procurement and contract management and was not prevented or detected by the Department's internal control activities;	All irregular expenditure of the prior year has subsequently been condoned by the Accounting Officer. Occurrences of irregular expenditure were identified for the 2011/12 financial year through internal control processes and condonation requested prior to the preparation of financial statements. Many of the pharmaceutical contracts expired in December 2011 and resulted in the Depot having to source medication through normal supply chain procurement processes. All individuals involved in ordering have been trained with regard to procurement prescripts and regulations and a delegation increase for CMD to purchase up to R500 000 has been granted as many pharmaceutical orders are usually for high volumes and costs.

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Background / Reference to audit report	**Resolution / Concerns**	**Departmental Responses**
Five material misstatements totalling R38.3 million were corrected in respect of inventory (R15.2 million), cost of sales (R7.8 million), payables (R12.3 million), disclosure of irregular expenditure (R2.5 million) and employee costs (R0.4 million). The adjustments to the inventory and related accounts were mainly as a result of incorrect journals being processed in respect of generally accepted accounting practice (GAAP). The GAAP journals are processed as the financial management systems are not appropriate to facilitate the preparation of the financial statements in terms of Standards of GAAP. These journals are therefore processed at year-end to convert the transactions that have been processed during the year on the modified cash basis of accounting to the accrual basis of accounting. Material transactions and journals were not adequately reviewed for completeness and accuracy as is evidence by the number and extent of material misstatements identified. Due to consultants being used in the past to convert the financial records of the entity from a cash basis of accounting to accrual accounting, there is a general lack of understanding of the accounting treatment of the purchases and sales of inventory.	(c) Material misstatements: Five material misstatements totalling R38.3 million were corrected in respect of inventory and the adjustments to the inventory and related accounts were mainly as a result of incorrect journals being processed in respect of generally accepted accounting practice (GAAP);	This was predominantly due to the lack of technical expertise which existed within the Depot to prepare GAAP compliant financial statements. Cabinet has subsequently approved the incorporation of the Depot into the main Department, (Health) therefore separate GAAP compliant financial statements will no longer be a requirement for the Depot beyond the 2011/12 financial year. The Cape Medical Depot will be accounted for as part of the Department of Health's financial statements and no yearly GAAP journals will have to be produced and separately audited.

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Background / Reference to audit report	**Resolution / Concerns**	**Departmental Responses**
The amounts included for purchases, sales and balances of inventory are not well understood by the entity's staff and therefore financial consultants are used to perform weekly reconciliations between the MEDSAS and BAS systems after the interface between the two systems. This contributes to a lack of monitoring and review of the work performed by such consultants.		
See (a) and (b) above.	(d) There were no documents to substantiate the mismanagement. Irregular expenditure totalling R2.5 million was identified during the audit of procurement and contract management. Sole source bidding was utilised, but adequate documentation was not available to substantiate such a bidding process;	All of the instances of irregular expenditure identified were orders placed for medication where the contracted supplier was the sole supplier. The required sole sourcing documentation has been subsequently obtained and all officials involved in ordering have received the required training [See response to (a)].
See (c) above.	(e) The adjustments to the inventory and related accounts were mainly as a result of incorrect journals being processed in respect of generally accepted accounting practice (GAAP).	See response to (c).

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Background / Reference to audit report	**Resolution / Concerns**	**Departmental Responses**
	The GAAP journals are processed as the financial management systems are not appropriate to facilitate the preparation of the financial statements in terms of the standards of GAAP;	
See (a) and (b) above.	(f) Compliance with laws and regulations: The Accounting Officer did not take effective and appropriate steps to prevent and detect irregular expenditure as required by the PFMA and Treasury Regulation 9.1.1;	Detection and prevention controls, such as appointing a Quotation Committee who approve all orders placed out of contract, have been implemented. The committee does not approve orders without all necessary supporting documentation attached to the order. Also see response to (a), (b) and (d).
See (c) above.	(g) The Accounting Officer submitted financial statements for auditing which were not prepared in all material aspects in accordance with "Statements of Generally Accepted Accounting Practice", as required by the PFMA;	The financial statements have been subsequently corrected and steps has been taken to ensure that the errors identified are not repeated during the preparation of the 2011/12 financial statements. Also see response to (c).

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Background / Reference to audit report	**Resolution / Concerns**	**Departmental Responses**
Lack of adequate processes to ensure that inventory management is compliant with all requirements [par. 19 on page 372 of the annual report].	(h) Inventory Management: The Accounting Officer did not ensure that adequate processes and procedures are in place for the effective, efficient, economical and transparent management of and accounting for the entity's inventory. No proper control systems are in place to eliminate the risk of theft, losses, wastage and misuse as required by chapter 16 of the "Western Cape Department of Health Accounting Officer's System" for Procurement, Supply Chain and Asset Management, issued in terms of section 38 of the PFMA;	Effective stock control measures have since been implemented, such as: - Access controls (turnstiles, biometric fingerprint identification). - Installation of cameras and a security control room. - Critical vacant pharmacist posts have been filled. - On-going training of warehouse staff on inventory rotation, theft identification and storage requirements of pharmaceutical items (good warehouse practices). - Appointment of an effective Board of Survey who investigate stock losses and write offs.
The entity has no information technology (IT) department, nor does it have formal IT structures in place. The majority of IT services have been outsourced to the Department of Health except for MEDSAS, which is used by the Department. The entity is currently in the process of evaluating whether to establish an IT department or structures which should either manage certain aspects independently and/or formally co-ordinate with the Department of Health. The following is a synopsis of the findings and their causes per each focus area:	(i) The Entity has no Information Technology (IT) Department, nor does it have formal IT structures in place. The majority of IT services have been outsourced to the Department of Health, except for MEDSAS, which is used by the Department. The following is a synopsis of the findings: (i) Security management; (ii) User access control; (iii) Program change management;	The Depot relies on the Department's IT support services. The Cape Medical Depot and the Information Management unit of the Department of Health have had discussions on how to address the concerns and risks associated with IT at the Depot. An action plan on improving the controls on the MEDSAS system is in draft phase and will be presented to SITA during the 2012/13 financial year, including the re-location of the server room.

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Background / Reference to audit report	**Resolution / Concerns**	**Departmental Responses**
• Security management: There is no formal IT security policy which addresses essential security elements such as operating system, database security and network/ infrastructure management. One of the direct consequences of this is that there are weak password settings in existing applications. • User access control: There are no user account management policies and procedures for departmental applications such as MEDSAS and BAUD asset management system. This is due to management oversight with respect to policies for departmental applications (e.g. MEDSAS and BAUD).	(iv) Facilities and environment control; and (v) Information technology service continuity.	Management is in the process of investigating the possibility of a more suitable operating system for the Depot as the MEDSAS system does not allow for changes to its source code. In the interim, two additional servers and a backup server have been purchased and all access control concerns have been fully addressed in the 2011/12 financial year.

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REPORT OF THE ACCOUNTING OFFICER
for the year ended 31 March 2012

Background / Reference to audit report	**Resolution / Concerns**	**Departmental Responses**
• Programme change management: There is no formal entity change management policy. This is attributed to management oversight with respect to CMD applications such as MEDSAS and BAUD. • Facilities and environment control: The CMD currently has no server room. The server is housed in the contracted system administrators' office therefore there are no adequate access controls and environmental controls. This is attributed to lack of formal policies, inadequate budget allocation and management oversight. • Information technology service continuity: There is no business continuity/disaster recovery plan (DRP) in place. There are no backup procedures in place. This is attributed to lack of prioritisation of IT risks, lack of governance and management oversight.		

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Background / Reference to audit report	Resolution / Concerns	Departmental Responses
	(j) The delay in FIU cases where the two investigations were conducted relating to preference being given to a particular supplier during procurement processes and inventory theft, respectively.	The two cases investigated by the FIU has been subsequently reported on. All the necessary actions, such as dismissal, recovery of losses and criminal and civil cases as recommended in the report have been executed by management.

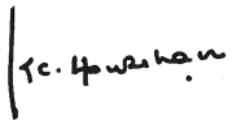
The Committee acknowledged the entity on obtaining a financially unqualified audit opinion with findings on compliance with laws and regulations.

11. Other

The financial statements have been compiled in line with the South African Statements of Generally Accepted Accounting Practice.

12. Approval

The annual financial statements set out on pages 366 to 396 have been approved by the Accounting Officer.



PROFESSOR KC HOUSEHAM
ACCOUNTING OFFICER
DATE: 31 MAY 2012

WESTERN CAPE – DEPARTMENT OF HEALTH
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REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2012

REPORT OF THE AUDITOR-GENERAL TO THE WESTERN CAPE PROVINCIAL PARLIAMENT ON THE CAPE MEDICAL DEPOT

REPORT ON THE FINANCIAL STATEMENTS

Introduction

1. I have audited the financial statements of the Cape Medical Depot set out on pages 366 to 396, which comprise the statement of financial position as at 31 March 2012, the statement of comprehensive income, statement of changes in net equity and the statement of cash flows for the year then ended, and the notes, comprising a summary of significant accounting policies and other explanatory information.

Accounting officer's responsibility for the financial statements

2. The accounting officer is responsible for the preparation and fair presentation of these financial statements in accordance with South African Statements of Generally Accepted Accounting Practice (SA Statements of GAAP) and the requirements of the Public Finance Management Act of South Africa, 1999 (Act No. 1 of 1999) (PFMA), and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor-General's responsibility

3. My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA), the *General Notice* issued in terms thereof and International Standards on Auditing. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

4. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2012

5. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

6. In my opinion, the financial statements present fairly, in all material respects, the financial position of the Cape Medical Depot as at 31 March 2012, and its financial performance and cash flows for the year then ended in accordance with SA Statements of GAAP and the requirements of the PFMA.

Emphasis of matter

7. I draw attention to the matter below. My opinion is not modified in respect of this matter.

Restatement of corresponding figures

8. As disclosed in note 15 to the financial statements, the corresponding figures for 31 March 2010 and 31 March 2011 have been restated as a result of errors discovered during the 2011-12 financial year in the financial statements of the Cape Medical Depot at, and for the year ended, 31 March 2010 and 31 March 2011.

Additional matter

9. I draw attention to the matter below. My opinion is not modified in respect of this matter.

Subsequent event

10. The Western Cape Provincial Cabinet has approved the incorporation of the Cape Medical Depot into the Western Cape Department of Health and therefore the Cape Medical Depot will no longer exist as a separate trading entity with effect from 1 April 2012. The impact of this is that the operations of the Cape Medical Depot will continue as a warehousing facility for pharmaceutical supplies, but that separate financial statements will not be prepared at year-end.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

11. In accordance with the PAA and the *General Notice* issued in terms thereof, I report the following findings relevant to performance against predetermined objectives, compliance with laws and regulations and internal control, but not for the purpose of expressing an opinion.

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REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2012

Predetermined objectives

12. I performed procedures to obtain evidence about the usefulness and reliability of the information in the annual performance report as set out on pages 183 to 184 of the annual report.

13. The reported performance against predetermined objectives was evaluated against the overall criteria of usefulness and reliability. The usefulness of information in the annual performance report relates to whether it is presented in accordance with the National Treasury annual reporting principles and whether the reported performance is consistent with the planned objectives. The usefulness of information further relates to whether indicators and targets are measurable (i.e. well defined, verifiable, specific, measurable and time bound) and relevant as required by the *National Treasury Framework for managing programme performance information*.

14. The reliability of the information in respect of the selected programmes is assessed to determine whether it adequately reflects the facts (i.e. whether it is valid, accurate and complete).

15. There were no material findings on the annual performance report concerning the usefulness and reliability of the information.

Compliance with laws and regulations

16. I performed procedures to obtain evidence that the entity has complied with applicable laws and regulations regarding financial matters, financial management and other related matters.

17. I did not identify any instances of material non-compliance with specific matters in key applicable laws and regulations as set out in the *General Notice* issued in terms of the PAA.

Internal control

18. I considered internal control relevant to my audit of the financial statements, the annual performance report and compliance with laws and regulations.

19. I did not identify any deficiencies in internal control which I considered sufficiently significant for inclusion in this report.

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REPORT OF THE AUDITOR-GENERAL
for the year ended 31 March 2012

OTHER REPORTS

Investigations

20. A complaint relating to procurement irregularities at the Cape Medical Depot is presently being investigated by the Forensic Investigating Unit.

Auditor General

Cape Town

31 July 2012

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ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

Statement of Financial Position as at 31 March 2012

	Note	2011/12 R'000	Restated 2010/11 R'000	Restated 2009/10 R'000
ASSETS				
Non-current assets		**2 540**	**2 864**	**3 493**
Property, plant and equipment	2	2 540	2 864	3 493
Current assets		**142 163**	**126 338**	**163 221**
Inventories	3	114 446	104 590	110 613
Trade and other receivables	4	27 717	12 490	52 608
Other financial assets	8	-	9 257	-
Total assets		**144 702**	**129 202**	**166 713**
EQUITY AND LIABILITIES				
Funds and reserves		**95 989**	**98 722**	**52 771**
Trading fund	5	100 867	88 332	48 507
Accumulated surplus/(deficit)		(4 878)	10 390	4 265
Non-current liabilities		**461**	**609**	**664**
Finance lease liabilities	9	47	61	133
Provisions	6	414	549	531
Current liabilities		**48 253**	**29 871**	**113 278**
Provisions	6	306	383	211
Trade and other payables	7	45 496	29 477	45 737
Other financial liabilities	8	2 436	-	67 309
Short-term portion of finance lease liability	9	14	11	20
Total equity and liabilities		**144 702**	**129 202**	**166 714**

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ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

Statement of Comprehensive Income

	Note	2011/12 R'000	Restated 2010/11 R'000
Revenue	*10a*	606 144	551 855
Cost of Sales	*11*	(574 422)	(528 249)
Gross Profit		**31 722**	**23 606**
Other Income	*10b*	**75**	**22**
Profit on sale of Assets	*10c*	**21**	**52**
Operating expenditure	*12*	**(29 832)**	**(29 993)**
Administrative expenses	*12a*	(824)	(1 225)
Staff costs	*12b*	(22 429)	(21 353)
Audit fees	*12c*	(2 642)	(1 496)
Depreciation	*12d*	(1 147)	(1 172)
Other operating expenses	*12e*	(2 790)	(4 748)
Operating profit/(loss)		1 986	(6 314)
Other expenses	*13*	-	(14)
Finance charges	*14*	(11)	(21)
Profit/(loss) before tax		**1 976**	**(6 349)**
Income tax expense	*27*	-	-
PROFIT/(LOSS) FOR THE YEAR		**1 976**	**(6 349)**
Other comprehensive income		**-**	**-**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE YEAR		**1 976**	**(6 349)**

WESTERN CAPE – DEPARTMENT OF HEALTH
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ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

Statement of Changes in Equity for the year ended 31 March 2012

	Note	Trading fund R'000	Accumulated surplus R'000	Total R'000
Balance at 1 April 2009		**46 792**	**13 798**	**60 590**
Changes in equity for 2009/10				
Total profit for the year		-	1 357	1 357
Transfers from /(to) Department of Health		1 715	(10 810)	(9 095)
Prior period error adjustment	*15*	-	(80)	(80)
Restated balance at 31 March 2010		**48 507**	**4 265**	**52 772**
Changes in equity for 2010/11				
Total profit/(loss) for the year		-	(6 349)	(6 349)
Transfers from /(to) Department of Health		39 825	12 474	52 299
Balance at 31 March 2011		**88 332**	**10 390**	**93 722**
Changes in equity for 2011/12				
Total profit/(loss) for the year		-	1 976	1 976
Transfers from/(to) Department of Health		12 535	(17 243)	(4 708)
Balance at 31 March 2012		**100 867**	**(4 878)**	**95 990**

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ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2012

Statement of Cash Flows for the year ended 31 March 2012

	Note	201/12 R'000	Restated 2010/11 R'000
Cash flows from operating activities			
Cash generated from/(utilised in) operations	*16*	(6 184)	24 834
Net cash from operating activities		**(6 184)**	**24 834**
Cash flows from investing activities			
Acquisition of property, plant and equipment	*2*	(822)	(566)
Disposal of property, plant and equipment	10	21	-
Net cash from investing activities		**(802)**	**(566)**
Cash flows from financing activities			
Transfers from /(to) Provincial Department of Health		(4 708)	52 299
Increase/(decrease) in other financial liabilities		11 693	(76 566)
Net cash used in financing activities		**6 985**	**(24 268)**
Net (decrease)/increase in cash and cash equivalents		-	-
Cash and cash equivalents at beginning of the year		-	-
Cash and cash equivalents at end of the year		-	-

WESTERN CAPE – DEPARTMENT OF HEALTH
CAPE MEDICAL DEPOT

ACCOUNTING POLICIES
for the year ended 31 March 2011

1. Accounting policies

The annual financial statements were prepared in accordance with Statements of Generally Accepted Accounting Practice and the Public Finance Management Act (Act No. 1 of 1999) as amended by the Public Finance Management Amendment Act (Act No. 29 of 1999).

In the process of applying the Cape Medical Depot's accounting policies, management has made the following significant accounting judgements, estimates and assumptions, which have the most significant effect on the amounts recognised in the financial statements:

- **Property, plant and equipment**

  In assessing the remaining useful lives and residual values of property, plant and equipment, management have made judgements based on historical evidence as well as the current condition of property, plant and equipment under its control.

- **Trade and other receivables**

  Trade and other receivables are evaluated at year-end, and based on the evaluation and past experience; an estimate is made of the provision for impairment of debtors (bad debts), to bring trade and other receivables in line with its fair value.

The following are the principle accounting policies of the Depot which are, in all material respects, consistent with those applied in the previous year, except as otherwise indicated:

1.1 Basis of preparation

The financial statements were prepared on the historical cost basis.

1.2 Presentation currency

These financial statements are presented in South African Rand, rounded off to the nearest thousand rand.

1.3 Revenue recognition

Revenue from the sale of goods is recognised when significant risks and rewards of ownership of the goods have been transferred to the buyer. Revenue is measured at the fair value of the consideration received or receivable.

WESTERN CAPE – DEPARTMENT OF HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2011

1.4 Expenditure

1.4.1 Compensation of employees

Salaries and wages comprise payments to employees. Salaries and wages are recognised as an expense in the statement of comprehensive income when the final authorisation for payment is effected on the system.

Social contributions include the entity's contribution to social insurance schemes paid on behalf of the employee.

1.4.2 Short-term employee benefits

The cost of short-term employee benefits is expensed in the statement of comprehensive income in the reporting period when the final authorisation for payment is effected on the system.

A liability is recognised for benefits accruing to employees in respect of wages and salaries, annual leave and long service leave when it is probable that settlement will be required and they are capable of being measured reliably. Liabilities recognised in respect of employee benefits expected to be settled within twelve months, are measured at their nominal values using the remuneration rate expected to apply at the time of settlement.

1.5 Retirement benefit cost

All post-retirement benefits are for the account of the Chief Directorate: Pension Administration in Pretoria, i.e. the National Department of Treasury. The Cape Medical Depot therefore has no obligation towards post-retirement benefits.

1.6 Irregular, fruitless and wasteful expenditure

Irregular expenditure means expenditure incurred in contravention of, or not in accordance with, a requirement of any applicable legislation, including:

- The PFMA, or
- Any provincial legislation providing for procurement procedures in that provincial government.

Fruitless and wasteful expenditure means expenditure that was made in vain and would have been avoided had reasonable care been exercised.

All irregular, fruitless and wasteful expenditure is charged against income in the period in which they are incurred.

WESTERN CAPE – DEPARTMENT OF HEALTH
CAPE MEDICAL DEPOT

ACCOUNTING POLICIES
for the year ended 31 March 2011

1.7 Unusual items

All items of income and expense arising in the ordinary course of business are taken into account in arriving at income. Where items of income and expense are of such size, nature or incidence that their disclosure is relevant to explain the performance of the Cape Medical Depot, they are separately disclosed and appropriate explanations are provided.

1.8 Property, plant and equipment

Property, plant and equipment are stated at cost less accumulated depreciation.

Depreciation is charged so as to write off the cost or valuation of assets over their estimated useful lives, using the straight-line method, on the following bases:

The estimated useful lives, residual values and depreciation method are reviewed at the end of each annual reporting period based on the condition of the item of property, plant and equipment as well as the entity's replacement policy, with the effect of any changes recognised on a prospective basis.

Depreciation is charged so as to write off the cost or valuation of assets, over their estimated useful lives, using the straight-line method, on the following basis:

Classification of Assets	Depreciation Rates
Plant and equipment	**20% p.a.**
Furniture and fittings	20% p.a.
Office equipment	20% p.a
Workshop equipment and tools	20% p.a
Kitchen appliances	20% p.a
Domestic equipment	20% p.a
Medical allied equipment	**10% p.a.**
Vehicles	**6.6 – 25% p.a.**
Computer equipment	**33⅓% p.a.**

Gains and losses on the disposal of motor vehicles are recognised in the statement of comprehensive income once they accrue to the entity.

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1.9 Impairment of property, plant and equipment

At each reporting date, the Cape Medical Depot reviews the carrying amounts of its tangible assets to determine whether there is any indication that those assets may be impaired. If any such indication exists, the recoverable amount of the asset is estimated in order to determine the extent of the impairment loss (if any).

If the recoverable amount of an asset is estimated to be less than its carrying amount, the carrying amount of the asset is reduced to its recoverable amount. Impairment losses are immediately recognised as an expense. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of its recoverable amount, but so that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior years. A reversal of an impairment loss is recognised as income immediately.

1.10 Inventories

Inventories are stated at the lower of cost and net realisable value. Net realisable value represents the estimated selling price in the ordinary course of business less any costs of completion and costs to be incurred in marketing, selling and distribution. Costs are assigned to inventory on hand by the method most appropriate to each particular class of inventory, with all classes of inventories currently being valued at weighted average cost.

1.11 Financial instruments

Financial assets

The Cape Medical Depot's principal financial assets are accounts receivable and cash and cash equivalents.

- Trade receivables

  Trade receivables are initially measured at cost, which represents its fair value and subsequently measured at amortised cost, stated at their nominal value as reduced by appropriate allowances for estimated irrecoverable amounts.

Financial liabilities

The Cape Medical Depot's principle financial liabilities are accounts payable, cash and cash equivalents, and the financial liability arising from the amount owed to the Department of Health.

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All financial liabilities are initially measured at cost, which represents its fair value and subsequently measured at amortised cost, comprising original debt less principle payments and amortisations.

- Trade payables

  Trade and other payables are stated at their normal value.

1.12 Cash and cash equivalents

Cash and cash equivalents comprises of money owing by the Cape Medical Depot to the Department of Health and is represented by the financial liability note as included in the annual financial statements. Where applicable, bank overdrafts are shown in current liabilities in the statement of financial position. There were however no bank overdrafts for the current or prior year financial periods.

1.13 Provisions

Provisions are recognised when the Cape Medical Depot has a present obligation as a result of a past event and it is probable that this will result in an outflow of economic benefits that can be estimated reliably. The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation.

1.14 Changes in accounting estimates and errors

When an entity has not applied a new standard or interpretation that has been issued but is not yet effective, the entity discloses:

(a) this fact; and
(b) known or reasonably estimated information relevant to assessing the possible impact that application of the new standard or interpretation will have on the entity's financial statements in the period of initial application.

1.15 Lease commitments

Leases are classified as finance leases where substantially all the risks and rewards associated with ownership of an asset are transferred to the entity. Assets subject to finance lease agreements are capitalised at their cash cost equivalent. Corresponding liabilities are included in the statement of financial position as finance lease obligations. The cost of the item of property, plant and equipment is depreciated at appropriate rates on the straight-line basis over its estimated useful life.

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Lease payments are allocated between the lease finance cost and the capital repayment using the effective interest rate method. Lease finance costs are expensed when incurred.

Operating leases are those leases that do not fall within the scope of the above definition. Operating lease rentals are recognised on the straight-line basis over the term of the relevant lease.

Lease commitments for the period remaining from the reporting date until the end of the lease contract are disclosed as part of the disclosure notes to the annual financial statements.

1.16 Contingent liabilities

A contingent liability is defined as a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the entity, or a present obligation that arises from past events but is not recognised because:

(a) it is not probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation, or
(b) the amount of the obligation cannot be measured with sufficient reliability.

The entity discloses, for each class of contingent liability at the reporting date, a brief description of the nature of the contingent liability and, where practicable:

(a) an estimate of its financial effect;
(b) an indication of the uncertainties relating to the amount or timing of any outflow; and
(c) the possibility of any reimbursement.

1.17 Events after reporting date

The Cape Medical Depot considers events that occur after the reporting date for inclusion in the annual financial statements. Events that occur between the reporting date and the date on which the audit of the financial statements is completed are considered for inclusion in the annual financial statements.

The entity considers two types of events that can occur after the reporting date, namely those that:

(a) provide evidence of conditions that existed at the reporting date (adjusting events after the reporting date); and
(b) were indicative of conditions that arose after the reporting date (non-adjusting events after the reporting date).

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All adjusting events are taken into account in the financial statements as the necessary adjustments are made to the financial statements. Where non-adjusting events after the reporting date are of such importance that non-disclosure would affect the ability of the users of the financial statements to make proper evaluations and decisions, the entity discloses the following information for each significant category of non-adjusting event after the reporting date:

(a) The nature of the event.
(b) An estimate of its financial effect or a statement that such an estimate cannot be made.

1.18 Related parties

The Depot operates in an economic environment currently dominated by entities directly or indirectly owned by the South African Government. All national departments of government and state-controlled entities are regarded as related parties in accordance with Circular 4 of 2005: Guidance on the term "state controlled entities" in context of IAS 24 (AC 126) – Related Parties, issued by the South African Institute of Chartered Accountants. Other related party transactions are also disclosed in terms of the requirements of the accounting standard.

1.19 Comparative information

Prior year comparatives

When the presentation or classification of items in the annual financial statements is amended, prior period comparative amounts are reclassified. The nature and reasons for the reclassification are disclosed.

1.20 Leases

Lease classification

Leases are classified as finance leases where substantially all the risks and rewards associated with ownership of an asset are transferred to the entity.

Leases of property, plant and equipment, in which a significant portion of the risks and rewards of ownership are retained by the lessor are classified as operating leases.

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Finance leases

Where the entity enters into a finance lease; property, plant and equipment or intangible assets subject to finance lease agreements are capitalised at amounts equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease. Corresponding liabilities are included in the statement of financial position as finance lease liabilities. The corresponding liabilities are initially recognised at the inception of the lease and are measured as the sum of the minimum lease payments due in terms of the lease agreement, discounted for the effect of interest. In discounting the lease payments, the entity uses the interest rate that exactly discounts the lease payments and unguaranteed residual value to the fair value of the asset plus any direct costs incurred. Lease payments are allocated between the lease finance cost and the capital repayment using the effective interest rate method. Lease finance costs are expensed when incurred.

Subsequent to initial recognition, the leased assets are accounted for in accordance with the stated accounting policies applicable to property, plant and equipment or intangibles. The lease liability is reduced by the lease payments, which are allocated between the lease finance cost and the capital repayment using the effective interest rate method. Lease finance costs are expensed when incurred. The accounting policies relating to de-recognition of financial instruments are applied to lease payables. The lease asset is depreciated over the shorter of the asset's useful life or the lease term.

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1. Adoption of South African Accounting Standards

The financial statements for the year ended 31 March 2012 have been prepared in accordance with the South African Statements of Generally Accepted Accounting Practice.

2. Property, plant and equipment

	2011/12			Restated 2010/11		
Owned equipment	**Cost R'000**	**Acc Dep R'000**	**Carrying value at end of year R'000**	**Cost R'000**	**Restated Acc Dep R'000**	**Carrying value at end of year R'000**
Machinery and equipment	6 186	(4 244)	1 942	5 944	(3 783)	2 161
Office furniture	1 658	(1 106)	552	1 458	(808)	650
Vehicles	85	(39)	46	85	(31)	54
	7 929	**(5 389)**	**2 540**	**7 487**	**(4 623)**	**2 864**

Reconciliation of carrying amount

2011/12 **Owned equipment**	**Carrying value at beginning of year R'000**	**Additions R'000**	**Disposals R'000**	**Depreciation R'000**	**Carrying value at end of year R'000**
Machinery and equipment	2 161	622	-	(841)	1 942
Office furniture	650	201	-	(298)	552
Vehicles	54	-	-	(8)	46
	2 864	**822**	**-**	**(1 147)**	**2 540**

Restated 2010/11 **Owned equipment**	**Carrying value at beginning of year R'000**	**Additions R'000**	**Disposals R'000**	**Depreciation R'000**	**Carrying value at end of year R'000**
Machinery and equipment	2 647	401	(14)	(873)	2 161
Office furniture	773	165	-	(288)	650
Vehicles	73	-	(10)	(10)	54
	3 493	**566**	**(24)**	**(1 172)**	**2 864**

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Restated 2009/10 Owned equipment	Carrying value at beginning of year R'000	Additions R'000	Disposals R'000	Depreciation R'000	Carrying value at end of year R'000
Machinery and equipment	3 342	54	-	(749)	2 647
Office furniture	946	82	-	(255)	773
Vehicles	-	-	-	-	73
	4 288	136	-	(1 004)	3 493

	2011/12 R'000	2010/11 R'000
3. Inventories		
Work in progress	3 126	995
Packaging material	38	26
Finished goods	111 281	103 569
Total	**114 446**	**104 590**

During the current year stock amounting to R4 643 229 (2011: R5 219 493) was written off. Stock surpluses amounted to R5 342 568 (2012: R700 484).

4. Trade and other receivables		
Trade receivables	18 205	7 493
Other receivables	9 754	5 837
Less: Provision for impairment of doubtful debts	(242)	(839)
Total	**27 717**	**12 490**

4.1 Credit quality of trade and other receivables

Credit risk with respect to trade receivables is limited due to the majority of receivables being owed by state entities. Trade receivables are non-interest bearing and are generally on 30 day collection terms. The maximum exposure to credit risk at the reporting date is the fair value of each class of receivable mentioned above. The Depot does not hold any collateral as security.

In determining the recoverability of a receivable, management considers any change in the credit quality of the debtor. Any provision for impairment on receivables (loans and receivables) exists predominantly due to the possibility that these debts will not be recovered. Management assesses these debtors individually for impairment and group them together in the statement of financial position as financial assets with similar credit risk characteristics.

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4.2 Fair value of trade and other receivables

The fair value of receivables (upon initial recognition) is stated at amortised cost, comprising original debt according to the invoice amounts less principle payments and amortisations.

Management considers the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements to approximate their fair values on 31 March 2012, as a result of the short-term maturity of these assets and liabilities.

4.3 Trade and other receivables past due but not impaired

2011/12	Current:	Past due:			Total
	0 – 30 days	31 – 60 days	61 – 90 days	90 days +	
Trade receivables	18 205	-	-	-	18 205
Other receivables	3 668	3 449	1 539	1 098	9 754
Less: Provision for impairment	-	-	-	(242)	(242)
Total	**21 873**	**3 449**	**1 539**	**856**	**27 717**

2010/11	Current:	Past due:			Total
	0 – 30 days	31 – 60 days	61 – 90 days	90 days +	
Trade receivables	6 491	-	-	1 002	7 493
Other receivables	3 306	2 299	232	-	5 837
Less: Provision for impairment	-	-	-	(839)	(839)
Total	**9 797**	**2 299**	**232**	**163**	**12 490**

Trade and other receivables which are past due are not necessarily considered to be impaired.

4.4 Classification of financial assets

In accordance with IAS 39.09 the financial assets of the Depot is classified as follows:

Financial Assets	**Classification**
Trade and other receivables	Loans and receivables

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	2011/12 R'000	2010/11 R'000

4.5 Reconciliation of provision for impairment of financial assets

Balance at beginning of year	839	91
Impairment losses recognised	9	748
Impairment losses reversed	(606)	-
Balance at end of year	**242**	**839**

5. Trading fund

The Cape Medical Depot's trading fund account was increased with R12 535 000 (2011: R39 825 000) from R88 332 000 to R100 867 000.

Capital is used for operating expenses and the purchasing of inventory. The Western Cape Department of Health provided the capital after Treasury approval.

Opening balance	88 332	48 507
Transfer from Department of Health	12 535	39 825
Closing balance	**100 867**	**88 332**

6. Provisions

Provision for performance bonuses		
Opening amount	383	211
Provisions made during the year	306	383
Amount used during the year	(383)	(211)
Unused amounts reversed during the year	-	-
Closing amount	**306**	**383**
Transferred to current	(306)	(383)
Carrying amount of non-current	**-**	**-**

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	2011/12 R'000	2010/11 R'000
Provision for capped leave		
Opening amount	549	531
Provisions made during the year	46	71
Amount used during the year	(180)	(53)
Unused amounts reversed during the year	-	-
Closing amount	**414**	**549**
Transferred to current	-	-
Closing amount of non-current	**414**	**549**
Total provisions	720	931
Transferred to current	(306)	(383)
Carrying amount of non-current	**414**	**549**

7. Trade and other payables

Trade payables	43 729	26 177
Accruals	538	1 663
Staff creditors	1 181	937
Other	48	700
Total	**45 496**	**29 477**

7.1 Credit quality of trade and other payables

Trade payables are non-interest bearing and are generally on 30 day payment terms. The Cape Medical Depot does not pledge any of its assets as security for the payables. The Depot has internal operating procedures and controls in place to ensure that all payables are paid within the credit timeframe.

7.2 Fair value of trade and other payables

The fair value of the trade and other payables (upon initial recognition) are equal to the invoice amounts related to these payables.

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7.3 Classification of financial liabilities

Financial liabilities	Classification
Trade and other payables	
Trade payable	Financial liabilities at amortised cost
Other accruals	Financial liabilities at amortised cost
Staff creditors	Financial liabilities at amortised cost
Other	Financial liabilities at amortised cost

8. Other financial liabilities

	2011/12 R'000	2010/11 R'000
Owing to (owed by) the Western Cape Department of Health	2 436	(9 257)
Total	**2 436**	**(9 257)**

The carrying amount of this balance is considered to be equal to its fair value.

8.1 Classification of financial liabilities

In accordance with IAS 39.09 the other financial liabilities of the Depot is classified as follows:

Financial liabilities	Classification
Amounts owing to the Department	Financial liabilities at amortised cost

9. Finance lease liabilities

	2011/12 R'000	Restated 2010/11 R'000
LONG-TERM LIABILITIES		
Finance lease liabilities	61	72
Sub-total	**61**	**72**
Less: Current portion transferred to current liabilities	(14)	(11)
Finance lease liabilities	(14)	(11)
Total long-term liabilities	**47**	**61**

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The management of CMD is of the opinion that the carrying value of long-term liabilities recorded at amortised cost in the annual financial statements approximate their fair values.

Obligations under finance lease liabilities

CMD as lessee:

Finance leases relate to a vehicle with a lease term of seven years (2011: 7 years). The effective annual interest rate on the finance lease is 15.89 per cent (2011: 15.89%).

The obligations under finance leases are as follows:

	Minimum lease payments		Present value of minimum lease payments	
	2011/12	2010/11	2011/12	2010/11
	R'000	R'000	R'000	R'000
Amounts payable under finance leases:				
Within one year	23	22	14	11
In the second to fifth years, inclusive	51	73	47	61
Over five years	-	-	-	-
	73	**95**	**61**	**72**
Less: Future Finance Obligations	(13)	(23)	-	-
Present Value of Minimum Lease Obligations	**61**	**72**	**61**	**72**
Less: Amounts due for settlement within 12 months (Current Portion)	**-**	**-**	(14)	(11)
Finance Lease Obligations due for settlement after 12 months (Non-current Portion)	**-**	**-**	**47**	**61**

GMT has finance lease agreements for the following significant classes of assets:

- Motor vehicles

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Included in these classes are the following significant leases:

GVY536 (Registration number of vehicle)

Instalments are payable monthly in arrears

-	Average effective interest rate	15.89%
-	Average monthly instalment	R 1 958
-	Annual escalation	5.30%

10. Revenue

		2011/12	Restated 2010/11
		R'000	R'000
a.	Sales of medical supplies to hospitals, NGO's, provincially aided hospitals and local authorities	606 144	551 855
b.	Other income	75	22
c.	Profit on sale of assets	21	52
Total revenue		**606 240**	**551 929**

There were no discontinued operations for the period under review.

Sales stated above constitute revenue from exchange transactions.

11. Cost of sales

	2011/12 R'000	2010/11 R'000
Freight service	8 813	7 112
Packaging	1 399	1 917
Purchases	564 210	519 220
	574 422	**528 249**

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12. Operating expenditure

An analysis of the Depot's expense is as follows:

		2011/12	Restated 2010/11
		R'000	R'000
a.	**Administrative expenses**	**824**	**1 225**
	General administrative expenses	358	664
	Stationery and printing	312	472
	Training and staff development	154	89
b.	**Staff costs**	**22 429**	**21 353**
	Wages and salaries	18 283	17 223
	Basic salaries	15 385	14 329
	Performance bonuses	110	475
	Periodic payments	16	88
	Other non-pensionable allowance	2 239	1 976
	Leave payments	158	36
	Overtime pay	456	319
	Defined Pension Contribution Plan Expense	1 952	1 583
	Pension contributions	1 952	1 583
	Employer's contribution	2 112	2 547
	Medical	1 345	1 029
	Official unions and associations	4	4
	Other salary-related costs	764	1 513
c.	**Audit fees**	**2 642**	**1 496**
	Auditor's remuneration	2 642	1 496
d.	**Depreciation**	**1 147**	**1 172**

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		2011/12	Restated 2010/11
		R'000	R'000
e.	**Other operating expenses**	**2 790**	**4 748**
	Consultants, contractors and special services	582	453
	Equipment items expensed as per entity policy	-	-
	Maintenance, repairs and running costs	106	421
	Property and buildings	-	70
	Machinery and equipment	106	350
	Impairment / (write back of impairment) of disallowance accounts	(597)	833
	Travel and subsistence	185	208
	Communication costs	319	363
	Other	2 009	2 131
	Rentals in respect of operating leases	187	338
	Plant, machinery and equipment	187	338
Total		**29 832**	**29 993**

The Cape Medical Depot occupies a building owned by the Department of Transport and Public Works for which no rental is paid and is provided security services at the premises by the Department of Community Safety for no charge. The Depot utilises the Human Resources Services and Audit Committee Services provided by the Department of Health free of charge, as well as the Internal Audit services provided by the Department of the Premier.

	2011/12	2010/11
	R'000	R'000

13. Other expenses

Losses on asset disposals	-	14
Total	**-**	**14**

14. Finance charges

Finance charges on finance leases	11	21
Total	**11**	**21**

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15. Prior period errors and reclassifications

In previous years the entity accounted for Government Garage motor vehicles expenditure as operating leases. In the current year, Provincial Treasury came to the conclusion that it constitutes a finance lease.

As a result, all permanently allocated motor vehicles (provided by GMT) will be accounted for by the entity.

	2011/12 Increase / (Decrease)	2010/11 Restated
Effect of corrections on the Statement of Comprehensive Income		
Depreciation for the year	9 850	(1 171 736)
Finance charges	21 375	(21 375)
Profit on the disposal of assets	(51 757)	51 757
Operating Leases	(40 937)	(338 485)
Effect of corrections on the Statement of Financial Position		
Property, Plant and equipment cost	84 879	7 486 880
Accumulated depreciation	(31 046)	(4 622 816)
Finance lease liability	(71 921)	(71 921)
Statement of changes in equity		
Retained earnings (opening balance)	79 558	

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	2011/12 R'000	Restated 2010/11 R'000

16. Cash generated from / (utilised in) operations

Reconciliation of profit for the year to cash generated from operations:

Net profit per statement of comprehensive income	1 976	(6 349)
Adjusted for:		
Depreciation on property, plant and equipment	1 147	1 172
Profit on disposal of assets	(21)	(52)
Loss on disposal of assets	-	24
Increase/(decrease) in accrual for goods and services received	(1 125)	87
Increase/(decrease) in provision for doubtful debts	(597)	748
Increase/(decrease) in provisions	(211)	189
Operating cash flows before working capital changes	**1 169**	**(4 190)**
Working capital changes	**(7 363)**	**29 025**
(Increase)/decrease in inventories	(9 856)	6 023
(Increase)/decrease in receivables	(14 644)	39 368
Increase/(decrease) in finance lease liabilities	(11)	(20)
Increase/(decrease) in payables	17 144	(16 347)
Increase/(decrease) in income received in advance	-	-
Cash generated from / (utilised in) operations	**(6 184)**	**24 834**

17. Risk Management

The Cape Medical Depot monitors and manages the financial risks relating to the operations through internal policies and procedures. These risks include interest rate risk, credit risk and liquidity risk. The risk management process relating to each of these risks is discussed under the headings below. Compliance with policies and procedures is reviewed by internal and external auditors on a continuous basis. The entity does not enter into or trade financial instruments, including derivative financial instruments, for speculative purposes.

Price risk

This risk becomes applicable when suppliers purchase raw material from international suppliers and is subject to foreign exchange rate fluctuations.

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Price risk is managed as follows:

This is an external factor that cannot be managed by the Cape Medical Depot. Where a price adjustment is identified the additional amounts are paid based on approval and an invoice. This is a journal transaction and must be approved by senior personnel before payment, both on manual documents and electronically. The additional amount paid is expensed and recovered in the year it is paid. Where a supplier is not able to supply goods in terms of a contract, the Department has the right to buy the goods from other suppliers and claim the additional cost from the contracted suppliers.

Interest rate risk

The Cape Medical Depot is not directly exposed to interest rate risk as it does not hold any interest bearing financial instruments. No formal policy exists to hedge volatilities in the interest rate market.

Market risk

No significant fluctuations in the market occurred during the year that management is aware of.

Credit risk

Credit risk refers to the risk that counterparties will default on contractual obligations resulting in financial loss to the entity. Potential concentrations of credit risk consist principally of trade accounts receivable.

Financial assets, which potentially subject the Cape Medical Depot to the risk of non-performance by counter parties, consist of accounts receivable, comprising trade receivables and other receivables.

Credit risk with regards to receivables is managed as follows:

Trade receivables consist of a small number of customers, comprising clinics and hospitals spread across the Western Cape. A debtors' policy has been adopted as a means of mitigating the risk of financial loss from defaults. An allowance for impairment is established based on management's estimate of any identified potential losses in respect of trade receivables. Bad debts identified are written off as they occur. The entity does not have any significant credit risk exposure to any single counterparty.

At 31 March 2012 the Depot did not consider there to be any significant concentration of credit risk that had not been adequately provided for.

Financial assets exposed to credit risk at the reporting date were as follows:

	2011/12	**2010/11**
	R'000	**R'000**
Trade and other receivables	27 717	12 490

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Liquidity risk

Liquidity risk is the risk that an entity will encounter difficulty in raising funds to meet commitments associated with financial instruments.

Liquidity risk is managed as follows:

The Department of Health ensures the trading fund is maintained at an adequate level.

Currency risk

The Cape Medical Depot does not transact with any supplier or customer that is not within the South African borders and this risk is therefore not directly applicable. However, this risk becomes applicable as suppliers purchase raw material from international suppliers and is subject to foreign exchange rate fluctuations.

Currency risk is managed as follows:

This is an external factor that cannot be managed by the Cape Medical Depot. Where a price adjustment is identified the additional amounts are paid based on approval and an invoice. This is a journal transaction and must be approved by senior personnel before payment, both on manual documents and electronically. The additional amount paid is expensed and recovered in the year it is paid.

18. Contingencies

	2011/12	2010/11
	R'000	R'000
Contingencies	-	-
	-	**-**

A supplier instituted a claim in the Pretoria High Court against the Cape Medical Depot, arising from monies recovered in terms of State Tender Board regulations during the period 1999/2000. If successful the Depot will be liable for the costs of suit and damages. It is impossible to quantify the claim at this stage. This implies that a contingent liability exists, but has not been raised in the financial statements as the existence of this obligation will only be confirmed pending the outcome of the court case.

19. Material losses through criminal conduct, irregular, fruitless and wasteful expenditure

No material losses through criminal conduct or irregular, fruitless and wasteful expenditure were incurred during the year ended 31 March 2012.

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20. Going concern

The annual financial statements have been prepared on the basis of accounting policies applicable to a going concern. This basis presumes that funds will be available to finance future operations and that the realisation of assets and settlement of liabilities, contingent obligations and commitments will occur in the ordinary course of business. Although the CMD will effectively from 1 April 2012 be incorporated within the Western Cape Department of Health, the functions of the CMD will in future still continue as part of the Western Cape Department of Health, thus supporting the preparation of the annual financial statements on the going concern basis.

21. Events after the reporting date

After statement of financial position date, it was established that the Cape Medical Depot would, backdated from 1 April 2012, be incorporated within the programmes of the Western Cape Department of Health.

22. Key management personnel emoluments

The following staff members do not reside at the CMD and are compensated by the Department of Health. (Their compensation is disclosed in the annual financial statements of the Department of Health):

- Prof KC Household: Accounting Officer (Head: Department of Health)
- Mr A van Niekerk: Chief Financial Officer: Department of Health
- Mr J Jooste: Chief Director: Department of Health
- Mr I Smith: Director: Supply Chain Management
- Ms K Lowenherz: Director: Professional Support Services

Key staff members residing at the Cape Medical Depot:

2011/12	**Salary, bonus and allowance**	**Other allowance**	**Total**
	R'000	**R'000**	**R'000**
Acting depot manager: Mr W Erasmus	384	164	548
	384	**164**	**548**

2010/11	**Salary, bonus and allowance**	**Other allowance**	**Total**
	R'000	**R'000**	**R'000**
Deputy Director: Administration: Mr R Schroeder	242	2	244
Deputy Director: Pharmacy: Mr S Theron	338	-	338
	580	**2**	**582**

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	2011/12	2010/11
	R'000	R'000

23. Related party transactions

Related party relationships

Controlling entity: Western Cape Department of Health

The Cape Medical Depot is a Trading Entity under the control of the Western Cape Department of Health. All transactions with the Department of Health are considered to be related party transactions.

Capital transfers from the Department of Health amounted to R12 535 000 for the year.

All national departments of government and state-controlled entities are regarded as related parties in accordance with Circular 4 of 2005: Guidance on the term "state controlled entities" in context of IAS 24 – Related Parties, issued by the South African Institute of Chartered Accountants. Other related party transactions are also disclosed in terms of the requirements of the accounting standard.

Related party transactions

Goods provided to related parties

The Depot provides medical goods to hospitals and other institutions which form part of the Department of Health.

Sales to Department of Health	606 144	551 855

Other financial liabilities

Amount owing to/ (from) the Western Cape Department of Health	2 436	(9 257)

Other financial liabilities comprise of the balance owed to the Western Cape Department of Health. The carrying amount of this balance is considered to be equal to its fair value.

Services provided by related parties

A related party relationship exists between the Department and Government Motor Transport (GMT) with regard to the management of government motor vehicles of the departments. This relationship is based on an arm's length transaction in terms of tariffs approved by the Provincial Treasury.

Other operating expenses: Government motor transport	22	41

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	2011/12 R'000	2010/11 R'000

Other related party transactions

The building currently occupied by the Depot (16 Chiappini Street, from where its operations are conducted) is owned by the Department of Transport and Public Works. No rent is levied by the Department for the right of use granted to the Depot. Furthermore the Depot received security services provided by the Department of Community Safety in the building being occupied.

The Depot utilises the Human Resources Services and Audit Committee Services provided by the Department of Health free of charge. The Department of Premier provides Internal Audit services to the Depot at no additional charge.

24. Comparatives

Certain comparative figures were adjusted as a result of prior period errors. Also refer to note 15.

25. Irregular expenditure

Reconciliation of irregular expenditure		
Opening balance	2 498	-
Add: Irregular expenditure – relating to the current year	3 160	2 498
Less: Condoned	(5 659)	-
Irregular expenditure awaiting condonement	**-**	**2 498**
Details of irregular expenditure: Current year		
Procurements from sole suppliers without adequate documentation on file to confirm these are sole suppliers.	-	320
Buy-outs without adequate documentation. (Buy-outs are purchases from other suppliers in cases where the contracted suppliers are unable to supply. (2 cases)	3 160	1 801
Insufficient supporting evidence to verify sole supplier classification.	-	377
	3 160	**2 498**

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26. Standards and interpretations in issue not yet effective

At the date of authorisation of these financial statements the following Standards were in issue but not yet effective.

Amendment to IFRS 2	- Clarification of scope of IFRS 2 and IFRS 3 revised (1 July 2009). - Amendments relating to group cash-settled share-based payment transactions – clarity of the definition of the term "Group" and where in a group share based payments must be accounted for (1 January 2010).
IFRS 3 Business combinations	- Amendments to accounting for business combinations (1 July 2009). - Amendments to transition requirements for contingent consideration from a business combination that occurred before the effective date of the revised IFRS (1 January 2011). - Clarification on the measurement of non-controlling interests. - Additional guidance provided on un-replaced and voluntarily replaced share-based payment awards.
IFRS 5 Non-current Assets held for sale and discontinued operations	- Plan to sell the controlling interest in a subsidiary (1 July 2009). - Disclosures of non-current assets (or disposal groups) classified as held for sale or discontinued operations (1 January 2010).
IFRS 7 Financial Instruments: Disclosures	- Amendment clarifies the intended interaction between qualitative and quantitative disclosures of the nature and extent of risks arising from financial instruments and removed some disclosure items which were seen to be superfluous or misleading (1 January 2012). - Amendments require additional disclosure on transfer transactions of financial assets, including the possible effects of any residual risks that the transferring entity retains. The amendments also require additional disclosures if a disproportionate amount of transfer transactions are undertaken around the end of a reporting period (1 July 2012).
IFRS 8 Operating Segments	- Disclosure of information about segment assets (1 January 2010).
IFRS 9 Financial Instruments	- New standard that forms the first part of a three-part project to replace IAS 39 Financial Instruments: Recognition and Measurement (1 January 2013).
IAS 1 Presentation of Financial Statements	- Clarification of statement of changes in equity (1 January 2012).
IAS 7 Statement of Cash Flows	- Classification of expenditures on unrecognised assets (1 January 2010).
IAS 10 Events after the reporting period	- Amendment resulting from the issue of IFRIC 17 (1 July 2009).
IAS 17 Leases	- Classification of leases of land and buildings (1 January 2010).

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IAS 21 The effects of changes in foreign exchange rates	- Consequential amendments from changes to business combinations (1 July 2009). - Consequential amendments from changes to IAS 27 Consolidated and separate financial statements. (Clarification on the transition rules in respect of the disposal or partial disposal of an interest in a foreign operation.) (1 July 2012)
IAS 24 Related party disclosures	- Simplification of the disclosure requirements for government-related entities (1 January 2012). - Clarification of the definition of a related party (1 January 2012).
IAS 27 Consolidated and separate financial statements	- Transition requirements for previous amendments arising from changes to IAS 27 (1 July 2012).
IAS 38 Intangible assets	- Additional consequential amendments arising from revised IFRS 3 (1 July 2009). - Measuring the fair value of an intangible asset acquired in a business combination (1 July 2009).
IAS 39 Financial instruments: recognition and measurement	- Clarifies two hedge accounting issues (1 July 2009): o Inflation in a financial hedged item. o A one-sided risk in a hedged item. - Amendments for embedded derivatives when reclassifying financial instruments (Annual periods ending on or after 30 June 2009). - Treating loan prepayment penalties as closely related embedded derivatives. - Scope exemption for business combination contracts. - Cash flow hedge accounting (1 January 2010).

Management has considered the above standards and interpretations and anticipates that the adoption of these will not have a significant impact on the financial position, financial performance or cash flows of the Depot as the majority of these types of transactions are not currently applicable at the Depot. When adopted, certain disclosures will however need to be amended in accordance with IFRS 7, IFRS 9 and IAS 24. These standards will only be adopted once they become effective.

27. Income Tax Expense

No provision has been made for taxation as the Depot is exempt from income tax in terms of section 10(1) of the Income Tax Act, 1962 (Act No 58 of 1962).

HUMAN RESOURCE MANAGEMENT

4. HUMAN RESOURCE MANAGEMENT (OVERSIGHT REPORT)

4.1 Service delivery

All departments are required to develop a Service Delivery Improvement (SDI) Plan. The following tables reflect the components of the SDI plan as well as progress made in the implementation of these plans.

The reports in the tables below respond to the areas identified in the SDI plan of 2009/10, which is a three year plan.

However, there have been important developments since. Improving the patient experience and quality of care has become central to the strategic direction and vision of 2020. The Department has undertaken a baseline audit of all the facilities in the Province whereby compliance with a set of national care standards has been assessed. The final results from the National Department of Health are still awaited but in the interim institutions are developing quality improvement plans based on preliminary findings.

In parallel to the above mentioned initiative, a framework to improve the patient experience has been developed. The three central pillars of the framework are reception services, clinical governance and continuity of care. Specific interventions are being developed in each of these areas. Regular client satisfaction surveys are conducted in hospitals that also inform the actions plans within institutions.

These initiatives will be included in the new SDI plans for 2013/14.

Table 4.1.1: Main services and service standards provided in terms of the Service Delivery Plan, 1 April 2011 to 31 March 2012

Main services	Actual service beneficiaries	Additional beneficiaries	Standard of service	Actual achievement against standards
To ensure a clean, effective and functional environment in all restrooms and bathroom at George and Helderberg Hospitals.	The public and employees attending George and Helderberg Hospitals.	N/A	Service level agreement (SLA) for cleaning service. Monitoring and evaluation report of the cleaning and servicing of restrooms and bathrooms to adhere to specific standards as indicated in the SLA.	Service level agreement to be implemented in May 2012 at George Hospital and is in place at Helderberg Hospital. Service standards were well adhered to w.r.t bathrooms and restrooms in the clinical areas in both hospitals.

Table 4.1.2: Consultation arrangements with service beneficiaries, 1 April 2011 to 31 March 2012

Type of arrangement	Actual achievements	Comments (possible deviation)
Ensure a clean, effective and functional environment in all restrooms and bathrooms at George and Helderberg Hospitals. Hospital board meetings. Staff meetings.	SEAT project and quality assurance are discussed at the hospital board meetings, which has representation from the staff and community at both hospitals. Quality assurance (QA) is also discussed at staff meetings.	

Table 4.1.3: Service delivery access strategy, 1 April 2011 to 31 March 2012

Access strategy	Actual achievements
Ensure a clean, effective and functional environment in all restrooms and bathrooms (SEAT). George Hospital, Davidson Road, George (all ablution facilities). Helderberg Hospital, Lourensford Road, Somerset West.	Monthly audits and checklists are used to monitor progress at both hospitals.

Table 4.1.4: Service information tool, 1 April 2011 to 31 March 2012

Types of information tool	Actual achievements
a) Feedback on: Complaints and compliments system. Client satisfaction survey.	a) No complaints or compliments received with regard to the ablution facilities and clients are more satisfied at Helderberg Hospital.
b) Direct feedback, regular update of notice boards and press.	b) Direct feedback is given and information displayed on notice board.
c) Staff meetings.	c) Feedback and update given at staff meetings with regard to progress with SEAT.
d) Verbal and written communication.	d) Written feedback contained in the monthly and quarterly QA reports. Verbal communication is taking place on a regular basis.
e) Hospital board meetings.	e) QA progress reports discussed at hospital board meetings.
f) Website.	f) Helderberg Hospital has a website which clients can utilise to lodge complaints.
g) Visual and personal experience of the service.	g) Regular restroom inspections are conducted.

Table 4.1.5: Redress mechanism, 1 April 2011 to 31 March 2012

Redress mechanism	Actual achievements
Ensure a clean, effective and functional environment in all restrooms and bathrooms (SEAT).	
a) Complaints and compliments system at both hospitals.	a) Complaints and compliments received regarding the restrooms and bathrooms are addressed.

4.2 Expenditure

Departments budget in terms of clearly defined programmes. The following tables summarise final audited expenditure by programme (Table 4.2.1) and by salary bands (Table 4.2.2). In particular, it provides an indication of the amount spent on personnel expenditure in terms of each of the programmes or salary bands within the Department.

Table 4.2.1: Personnel expenditure by programme, 2011/12

Programme	Total expenditure (R'000)	Personnel expenditure (R'000)	Training expenditure (R'000)	Goods & services (R'000)	Personnel expenditure as a % of total expenditure	Average personnel expenditure per employee (R'000)	Number of employees
Programme 1	410 028	157 965	1 532	92	39%	315	502
Programme 2	4 875 956	2 685 224	12 346	159 521	55%	250	10 720
Programme 3	637 208	398 136	300	0	62%	223	1 782
Programme 4	2 149 535	1 535 899	4 172	30 017	71%	254	6 058
Programme 5	4 011 137	2 681 706	3 932	49 685	67%	293	9 143
Programme 6	231 451	51 060	231 451	651	22%	218	234
Programme 7	272 962	140 190	433	0	51%	209	672
Programme 8	799 486	15 267	400	9	2%	0	47
Total	**13 387 763**	**7 665 447**	**254 566**	**239 975**	**57%**	**263**	**29 158**

Notes:

- The above expenditure totals and number of employees excludes CMD and European Union (EU) funding.
- Expenditure of sessional, periodical and extraordinary appointments is included in the expenditure but not in the personnel totals which inflate the average personnel cost per employee.
- Personnel expenditure: This excludes SCOA item HH/Employer Social Benefits on BAS.
- Goods and services: Consists of the SCOA item Agency and outsourced services: Admin & Support.
- Staff, nursing staff and professional staff.
- The total number of employees is the average of employees that was in service as on 2011/03/31 and 2012/03/31.

Table 4.2.2: Personnel expenditure by salary bands, 2011/12

Salary bands	Personnel expenditure (R'000)	% of total personnel expenditure	Average personnel expenditure per employee (R'000)	Number of employees
Lower skilled *(Levels 1 – 2)*	217 267	2.86	93	2 336
Skilled *(Levels 3 – 5)*	1 440 767	18.96	135	10 698
Highly skilled production *(Levels 6 – 8)*	1 881 143	24.75	225	8 353
Highly skilled supervision *(Levels 9 – 12)*	4 013 031	52.80	520	7 718
Senior management *(Levels 13 – 16)*	48 674	0.64	918	53
Total	**7 600 882**	**100.00**	**261**	**29 158**

Notes:

- The above expenditure totals excludes CMD and EU funding personnel.
- Expenditure of sessional, periodical and extraordinary appointments is included in the expenditure but not in the personnel totals which inflate the average personnel cost per employee.
- The total number of employees is the average employees that was in service as on 2011/03/31 (28 596) and 2012/03/31 (29 721).

The following tables provide a summary per programme (Table 4.2.3) and salary bands (Table 4.2.4), of expenditure incurred as a result of salaries, overtime, housing allowance and medical assistance. In each case, the table provides an indication of the percentage of the personnel budget that was used for these items.

Table 4.2.3: Salaries, Overtime, Housing Allowance and Medical Assistance by programme, 2011/12

Programme	Salaries		Overtime		Housing allowance		Medical assistance	
	Amount (R'000)	Salaries as a % of personnel expenditure	Amount (R'000)	Overtime as a % of personnel expenditure	Amount (R'000)	Housing allowance as a % of personnel expenditure	Amount (R'000)	Medical assistance as a % of personnel expenditure
Programme 1	148 247	1.95	721	0.01	3 040	0.04	5 838	0.08
Programme 2	2 368 702	31.16	146 396	1.93	68 618	0.90	106 002	1.39
Programme 3	315 223	4.15	45 416	0.60	12 756	0.17	25 716	0.34
Programme 4	1 310 514	17.24	112 433	1.48	42 909	0.56	64 616	0.85
Programme 5	2 163 214	28.46	303 212	3.99	60 315	0.79	85 227	1.12
Programme 6	51 895	0.68	787	0.01	1 512	0.02	2 349	0.03
Programme 7	115 284	1.52	12 852	0.17	5 346	0.07	8 643	0.11
Programme 8	12 299	0.16	589	0.01	52	0.00	159	0.00
Total	**6 485 378**	**85.32**	**622 406**	**8.19**	**194 548**	**2.56**	**298 550**	**3.93**

Notes:

- The above expenditure totals excludes CMD and EU funding personnel.
- Expenditure of sessional, periodical and extraordinary appointments is included.
- Expenditure of the joint establishment (universities conditions of service) is excluded.
- The overtime indicated in programmes 2 to 5 includes commuted overtime.

Table 4.2.4: Salaries, Overtime, Housing Allowance and Medical Assistance by salary bands, 2011/12

Programme	Salaries		Overtime		Housing allowance		Medical assistance	
	Amount (R'000)	Salaries as a % of personnel expenditure	Amount (R'000)	Overtime as a % of personnel expenditure	Amount (R'000)	Housing allowance as a % of personnel expenditure	Amount (R'000)	Medical assistance as a % of personnel expenditure
Lower skilled *(Levels 1 – 2)*	177 726	2.34	4 235	0.06	17 533	0.23	17 773	0.23
Skilled *(Levels 3 – 5)*	1 191 999	15.68	61 989	0.82	80 165	1.05	106 612	1.40
Highly skilled production *(Levels 6 – 8)*	1 637 037	21.54	80 498	1.06	63 757	0.84	99 851	1.31
Highly skilled supervision *(Levels 9 – 12)*	3 430 968	45.14	475 243	6.25	33 093	0.44	73 727	0.97
Senior management *(Levels 13 – 16)*	47 648	0.63	441	0.01	0	0.00	587	0.01
Total	**6 485 378**	**85.32**	**622 406**	**8.19**	**194 548**	**2.56**	**298 550**	**3.93**

Notes:

- The above expenditure totals excludes CMD.
- Expenditure of sessional, periodical and extraordinary appointments is included in the expenditure.
- Expenditure of the joint establishment (universities conditions of service) is excluded in the above.
- Commuted overtime is included in salary bands highly skilled supervision (Levels 9 – 12) and Senior management (Levels 13 – 16).

4.3 Employment and vacancies

The following tables summarise the number of posts on the establishment, the number of employees, the percentage posts vacant, and whether there are any staff that are additional to the establishment. This information is presented in terms of three key variables: programme (Table 4.3.1), salary band (Table 4.3.2) and critical occupations (Table 4.3.3). Departments have identified critical occupations that need to be monitored. Table 4.3.3 provides establishment and vacancy information for the key critical occupations of the Department.

Table 4.3.1: Employment and vacancies by programme, as at 31 March 2012

Programme	Number of funded posts	Number of posts filled	Vacancy rate %	Number of persons additional to the establishment
Programme 1	630	524	16.83	37
Programme 2	11 438	10 931	4.43	49
Programme 3	2 107	1 825	13.38	1
Programme 4	6 327	6 144	2.89	16
Programme 5	9 604	9 127	4.97	60
Programme 6	290	279	3.79	0
Programme 7	719	680	5.42	3
Programme 8	51	21	58.82	24
CMD	191	121	36.65	0
Total	**31 357**	**29 652**	**5.44**	**190**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Vacancy rate is based on funded vacancies.
- Infrastructure management is a newly created component to the establishment and hence the number of vacancies under Programme 8.
- The vacancy rate at the CMD is as a result of the current staff establishment being reviewed. However, a significant number of posts have been advertised in February and March and will be reflected as such in the next reporting period.

Table 4.3.2: Employment and vacancies by salary bands, as at 31 March 2012

Programme	Number of funded posts	Number of posts filled	Vacancy rate %	Number of persons additional to the establishment
Lower skilled *(Levels 1 – 2)*	2 444	2 352	3.76	1
Skilled *(Levels 3 – 5)*	11 284	10 540	6.59	123
Highly skilled production *(Levels 6 – 8)*	9 162	8 803	3.92	24
Highly skilled supervision *(Levels 9 – 12)*	8 212	7 780	5.26	41
Senior management *(Levels 13 – 16)*	64	56	12.50	1
CMD	191	121	36.65	0
Total	**31 357**	**29 652**	**5.44**	**190**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Vacancy rate is based on funded vacancies.
- The vacancy rate at the CMD is as a result of the current staff establishment being reviewed. However, a significant number of posts have been advertised in February and March and will be reflected as such in the next reporting period.

Table 4.3.3: Employment and vacancies by critical occupation, as at 31 March 2012

Programme	Number of funded posts	Number of posts filled	Vacancy rate %	Number of persons additional to the establishment
Clinical technologist	77	70	9.09	0
Industrial technician	77	63	18.18	0
Medical orthotists and prosthetist	14	14	0.00	0
Medical physicist	10	9	10.00	0
Pharmacist	411	372	9.49	2
Total	**589**	**528**	**10.36**	**2**

Notes:

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

4.4 Job evaluation

The Public Service Regulations, 1999 introduced job evaluation as a way of ensuring that work of equal value is remunerated equally. Within a nationally determined framework, executing authorities may evaluate or re-evaluate any job in his or her organisation. In terms of the Regulations all vacancies on salary levels 9 and higher must be evaluated before they are filled. This was complemented by a decision by the Minister for the Public Service and Administration that all senior management service (SMS) jobs must be evaluated before 31 December 2002.

The following table (Table 4.4.1) summarises the number of posts that were evaluated during the year under review. The table also provides statistics on the number of posts that were upgraded or downgraded.

Table 4.4.1: Job Evaluation, 1 April 2011 to 31 March 2012

Salary Band	Total number of posts	Number of posts evaluated	% of posts evaluated	Post upgraded		Posts downgraded	
				Number	% of number of posts	Number	% of number of posts
Lower skilled *(Levels 1-2)*	3 894	0	0.00	0	0.00	0	0.00
Skilled *(Levels 3-5)*	14 530	88	0.61	11	12.50	0	0.00
Highly skilled production *(Levels 6-8)*	11 183	9	0.08	4	44.44	0	0.00
Highly skilled supervision *(Levels 9-12)*	10 437	45	0.43	15	33.33	0	0.00
Senior Management Service Band A *(Level 13)*	58	1	1.72	2	200.00	0	0.00
Senior Management Service Band B *(Level 14)*	13	0	0.00	0	0.00	0	0.00
Senior Management Service Band C *(Level 15)*	3	0	0.00	0	0.00	0	0.00
Senior Management Service Band D *(Level 16)*	1	0	0.00	0	0.00	0	0.00
Total	**40 119**	**143**	**0.36**	**32**	**22.38**	**0**	**0.00**

Notes:

- Nature of appointment sessional is excluded.
- The number of posts of 40119 includes 8762 unfunded posts.

The following table provides a summary of the number of employees whose salary positions were upgraded due to their posts being upgraded.

Table 4.4.2: Profile of employees whose salary positions were upgraded due to their posts being upgraded, 1 April 2011 to 31 March 2012

Beneficiaries	African	Indian	Coloured	White	Total
Female	7	0	15	4	26
Male	5	0	5	0	10
Total	**12**	**0**	**20**	**4**	**36**
Employees with a disability					**0**

The following table summarises the number of cases where remuneration levels exceeded the grade determined by job evaluation (including higher notches awarded). Reasons for the deviation are provided in each case.

Table 4.4.3: Employees whose salary level exceed the grade determined by job evaluation, 1 April 2011 to 31 March 2012 (in terms of PSR 1.V.C.3)

Major occupation	Number of employees	Job evaluation level	Remuneration on a higher salary level	Remuneration on a higher notch of the same salary level	Reason for deviation
Director	2	13	-	5th notch of 13 13th notch of 13	Recruitment Retention
Deputy Director	5	11	12	-	Recruitment and Retention
Assistant Director	1	9	10	-	Retention
Administrative Officer	1	7	8	-	Retention
Chief Artisan	1	Grade A ito OSD	-	10th notch of grade A ito OSD	Recruitment
Chief Engineer	1	Grade B ito OSD	-	31st notch of grade B ito OSD	Recruitment
State Accountant	1	7	9	-	Retention
Head: Info and Communication and Technology Services	1	11	12	-	Retention
Total number of employees whose salaries exceeded the level determined by job evaluation (including awarding of higher notches) in 2011/12					**13**
Percentage of total employment					**0.04%**

Table 4.4.4: Profile of employees whose salary level exceed the grade determined by job evaluation, 1 April 2011 to 31 March 2012 (in terms of PSR 1.V.C.3)

Beneficiaries	African	Indian	Coloured	White	Total
Female	1	0	2	1	4
Male	1	1	4	3	9
Total	**2**	**1**	**6**	**4**	**13**
Employees with a disability					**0**

4.5 Employment changes

Turnover rates provide an indication of trends in the employment profile of the Department. The following tables provide a summary of turnover rates by salary band (Table 4.5.1) and by critical occupations (Table 4.5.2). (These "critical occupations" should be the same as those listed in Table 4.3.3).

Table 4.5.1: Annual turnover rates by salary band, 1 April 2011 to 31 March 2012

Salary band	Number of employees per band as at 31 March 2011	Turnover rate 2010/11	Appoint-ments into the Department	Transfers into the Department	Terminations out of the Department	Transfers out of the Department	Turnover rate 2011/12
Lower skilled *(Levels 1 – 2)*	2 329	15.15	529	3	260	2	11.25
Skilled *(Levels 3 – 5)*	10 807	13.62	1 798	17	1 001	56	9.78
Highly skilled production *(Levels 6 – 8)*	7 909	14.23	1 300	23	1 105	34	14.40
Highly skilled supervision *(Levels 9 – 12)*	7 627	20.63	1 406	27	1 429	35	19.19
Senior Management Service Band A *(Level 13)*	36	17.24	7	0	7	0	19.44
Senior Management Service Band B *(Level 14)*	10	10.00	0	0	0	0	0.00
Senior Management Service Band C *(Level 15)*	3	0.00	0	0	0	0	0.00
Senior Management Service Band D *(Level 16)*	1	0.00	0	0	0	0	0.00
Total	**28 722**	**15.72**	**5 040**	**70**	**3 802**	**127**	**13.68**
			5 110		**3 929**		

Notes:

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

Table 4.5.2: Annual turnover rates by critical occupation, 1 April 2011 to 31 March 2012

Critical occupation	Number of employees per band as at 31 March 2011	Turnover rate 2010/11	Appoint-ments into the Department	Transfers into the Department	Terminations out of the Department	Transfers out of the Department	Turnover rate 2011/12
Clinical technologist	82	21.33	22	1	21	0	25.61
Industrial technician	59	13.56	10	0	4	0	6.78
Medical orthotists and prosthetist	14	33.33	2	0	5	1	42.86
Medical physicist	10	7.14	1	0	0	0	0.00
Pharmacists	362	54.68	129	1	114	1	31.77
Total	**527**	**42.77**	**164**	**2**	**144**	**2**	**27.70**
			166		**146**		

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Any difference in numbers between 2011 and 2012 is a result of the rectification of occupational classification and job title codes.

Table 4.5.3: Staff exiting the employ of the Department, 1 April 2011 to 31 March 2012

Exit category	Number	% of total exits	Number of exits as a % of total number of employees as at 31 March 2011
Death	80	2.10	0.28
Resignation	893	23.49	3.11
Expiry of contract	2 297	60.42	8.00
Dismissal – operational changes	1	0.03	0.00
Dismissal – misconduct	101	2.66	0.35
Dismissal – inefficiency	10	0.26	0.03
Discharged due to ill-health	60	1.58	0.21
Retirement	357	9.39	1.24
Employee initiated severance package	-	-	-
Transfers to other Public Service Departments	3	0.08	0.01
Total	**3 802**	**100.00**	**13.24**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Dismissal (misconduct) in this table is an indication of cases where the terminations were effected on PERSAL within the period 1 April 2011 – 31 March 2012. The number of cases will therefore differ from misconduct cases finalised as indicated in tables 4.6.6 and 4.13.2.

Table 4.5.4: Reasons why staff resigned, 1 April 2011 to 31 March 2012

Reasons for resignation	Number	% of total resignations
Absconded	10	1.12%
Bad health	11	1.23%
Better remuneration	307	34.38%
Contract expired	19	2.13%
Domestic problems	18	2.02%
Emigration	2	0.22%
Further studies	52	5.82%
Housewife	16	1.79%

Reasons for resignation	Number	% of total resignations
Insufficient progression possibilities	2	0.22%
Marriage	5	0.56%
Misconduct	2	0.22%
Nature of work	45	5.04%
Other occupation	79	8.85%
Other reasons not mentioned	48	5.38%
Own business	3	0.34%
Personal grievances	22	2.46%
Pregnancy	2	0.22%
Resigning of position	240	26.88%
Transfer other system	1	0.11%
Transfer(spouse)	6	0.67%
Translation permanent	1	0.11%
Transport problem	2	0.22%
Total	**893**	**100.00**

Notes:

- Reasons as reflected on PERSAL.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Nature of appointment sessional is excluded.

Table 4.5.5: Different age groups of staff who resigned, 1 April 2011 to 31 March 2012

Age group	Number	% of total resignations
Ages <19	0	0.00%
Ages 20 to 24	51	5.71%
Ages 25 to 29	225	25.20%
Ages 30 to 34	183	20.49%
Ages 35 to 39	136	15.23%
Ages 40 to 44	122	13.66%
Ages 45 to 49	82	9.18%
Ages 50 to 54	58	6.49%
Ages 55 to 59	27	3.02%
Ages 60 to 64	8	0.90%
Ages 65 >	1	0.11%
Total	**893**	**100%**

Table 4.5.6: Granting of employee initiated severance packages by salary band, 1 April 2011 to 31 March 2012

Salary band	Number of applications received	Number of applications referred to the MPSA	Number of applications supported by MPSA	Number of packages approved by Department
Lower skilled *(Levels 1 – 2)*	0	0	0	0
Skilled *(Levels 3 – 5)*	0	0	0	0
Highly skilled production *(Levels 6 – 8)*	0	0	0	0
Highly skilled supervision *(Levels 9 – 12)*	2	2	0	0
Senior management *(Levels 13-16)*	0	0	0	0
Total	**2**	**2**	**0**	**0**

Notes:

- The 2 cases are with the executive authority for a final decision.

Table 4.5.7: Promotions by salary band, 1 April 2011 to 31 March 2012

Salary Band	Employees as at 31 March 2011	Promotions to another salary level	Promotions as a % of employees by salary band	Progressions to another notch within a salary level	Notch progressions as a % of employees by salary band
Lower skilled *(Levels 1 – 2)*	2 329	18	0.77	1 450	62.26
Skilled *(Levels 3 – 5)*	10 807	704	6.51	6 332	58.59
Highly skilled production *(Levels 6 – 8)*	7 909	1 384	17.50	4 431	56.02
Highly skilled supervision *(Levels 9 – 12)*	7 627	854	11.20	3 784	49.61
Senior management *(Levels 13 – 14)*	47	5	12.77	25	53.19
Top management *(Levels 15-16)*	3	0	0.00	3	100.00
Total	**28 722**	**2 965**	**10.33**	**16 025**	**55.79**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- The above figures include personnel of CMD.

Table 4.5.8: Promotions by critical occupation, 1 April 2011 to 31 March 2012

Critical Occupation	Employees as at 31 March 2011	Promotions to another salary level	Promotions as a % of employees by occupation	Progressions to another notch within a salary level	Notch progressions as a % of employees by occupation
Clinical technologist	82	18	21.95	67	82
Industrial technician	59	1	1.69	32	54
Medical orthotists and prosthetist	14	11	78.57	8	57
Medical physicist	10	3	30.00	6	60
Pharmacists	362	25	6.91	109	30.11
Total	**527**	**58**	**11.01**	**222**	**42.13**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Promotions to another salary level include events 10 – Promotion and 52 – Promotion: Package MMS (middle management service).
- Progression to another notch within a salary level includes events 61 – Pay Progression and 69 – Pay Progression MMS.

4.6 Employment equity

The following table provides a summary of the total workforce profile per occupational level. Temporary employees provide the total of workers employed for three consecutive months or less. The tables in this section are based on the formats prescribed by the Employment Equity Act, 55 of 1998.

Table 4.6.1: Total number of employees (including employees with disabilities) in each of the following occupational levels, as at 31 March 2012

Occupational levels	Male				Female				Foreign nationals		Total
	A	C	I	W	A	C	I	W	Male	Female	
Top management *(Levels 14-16)*	1	5	1	3	1	1	0	3	0	0	**15**
Senior management *(Level 13)*	3	11	0	8	3	7	0	8	0	0	**40**
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	38	196	68	498	55	253	67	570	34	25	**1 804**

Occupational levels	Male				Female				Foreign nationals		Total
	A	C	I	W	A	C	I	W	Male	Female	
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8-10)*	186	591	13	197	613	2 878	65	1 047	6	11	**5 607**
Semi-skilled and discretionary decision making *(Levels 4-7)*	794	2 380	18	320	1 981	6 876	43	1 029	3	3	**13 447**
Unskilled and defined decision making *(Levels 1-3)*	747	1 190	4	63	1 708	2 346	5	46	3	2	**6 114**
Total	**1 769**	**4 373**	**104**	**1 089**	**4 361**	**12 361**	**180**	**2 703**	**46**	**41**	**27 027**
Temporary employees	166	287	81	405	419	697	125	541	55	39	**2 815**
Grand Total	**1 935**	**4 660**	**185**	**1 494**	**4 780**	**13 058**	**305**	**3 244**	**101**	**80**	**29 842**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- The above figures include personnel of CMD.
- Total number of employees includes employees additional to the establishment.

Table 4.6.2: Total number of employees (with disabilities only) in each of the following occupational levels, as at 31 March 2012

Occupational levels	Male				Female				Foreign nationals		Total
	A	C	I	W	A	C	I	W	Male	Female	
Top management *(Levels 14-16)*	0	0	0	0	0	0	0	0	0	0	**0**
Senior management *(Level 13)*	0	0	0	0	0	0	0	0	0	0	**0**
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	0	2	0	1	0	0	0	1	0	0	**4**

Occupational levels	Male				Female				Foreign nationals		Total
	A	C	I	W	A	C	I	W	Male	Female	
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8-10)*	0	1	0	3	0	1	1	6	0	0	**12**
Semi-skilled and discretionary decision making *(Levels 4-7)*	13	13	0	16	12	18	0	13	0	0	**85**
Unskilled and defined decision making *(Levels 1-3)*	3	8	0	1	1	4	0	1	0	0	**18**
Total	**16**	**24**	**0**	**21**	**13**	**23**	**1**	**21**	**0**	**0**	**119**
Temporary employees	0	0	0	0	0	0	0	1	0	0	**1**
Grand Total	**16**	**24**	**0**	**21**	**13**	**23**	**1**	**22**	**0**	**0**	**120**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- The above figures include the CMD and EU funded personnel.
- Total number of employees includes employees additional to the establishment.

Table 4.6.3: Recruitment, 1 April 2011 to 31 March 2012

Occupational levels	Male				Female				Foreign nationals		Total
	A	C	I	W	A	C	I	W	Male	Female	
Top management *(Levels 14-16)*	0	0	0	0	0	0	0	0	0	0	**0**
Senior management *(Level 13)*	0	0	0	2	1	0	0	1	0	0	**4**
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	4	37	16	88	13	45	21	117	7	8	**356**

Occupational levels	Male				Female				Foreign nationals		Total
	A	C	I	W	A	C	I	W	Male	Female	
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8-10)*	8	16	0	5	21	84	2	33	1	0	**170**
Semi-skilled and discretionary decision making *(Levels 4-7)*	112	160	1	21	331	470	13	96	2	0	**1 206**
Unskilled and defined decision making *(Levels 1-3)*	158	128	0	4	409	218	1	14	1	1	**934**
Total	**282**	**341**	**17**	**120**	**775**	**817**	**37**	**261**	**11**	**9**	**2 670**
Temporary employees	144	296	45	194	398	721	85	413	46	28	**2 370**
Grand Total	**426**	**637**	**62**	**314**	**1 173**	**1 538**	**122**	**674**	**57**	**37**	**5 040**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- The above figures include the CMD personnel.
- Total number of employees includes employees to the establishment.

Table 4.6.4: Promotions, 1 April 2011 to 31 March 2012

Occupational levels	Male				Female				Foreign nationals		Total
	A	C	I	W	A	C	I	W	Male	Female	
Top management *(Levels 14-16)*	0	0	0	0	0	0	0	0	0	0	**0**
Senior management *(Level 13)*	0	2	0	1	0	2	0	0	0	0	**5**
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	4	10	4	18	2	20	4	26	0	0	**88**

Occupational levels	Male				Female				Foreign nationals		Total
	A	C	I	W	A	C	I	W	Male	Female	
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8-10)*	23	117	5	45	59	464	31	282	1	4	**1031**
Semi-skilled and discretionary decision making *(Levels 4-7)*	106	199	1	12	272	997	2	100	0	0	**1689**
Unskilled and defined decision making *(Levels 1-3)*	4	3	0	0	12	11	1	0	0	0	**31**
Total	**137**	**331**	**10**	**76**	**345**	**1494**	**38**	**408**	**1**	**4**	**2844**
Temporary employees	4	8	3	14	4	47	7	32	1	1	**121**
Grand Total	**141**	**339**	**13**	**90**	**349**	**1541**	**45**	**440**	**2**	**5**	**2965**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- The above figures include the CMD personnel.
- Total number of employees includes employees additional to the establishment.

Table 4.6.5: Terminations, 1 April 2011 to 31 March 2012

Occupational levels	Male				Female				Foreign nationals		Total
	A	C	I	W	A	C	I	W	Male	Female	
Top management *(Levels 14-16)*	0	0	0	0	0	0	0	0	0	0	**0**
Senior management *(Level 13)*	1	1	0	2	0	0	1	0	0	0	**5**
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	4	14	5	45	4	17	17	51	3	5	**165**

Occupational levels	Male				Female				Foreign nationals		Total
	A	C	I	W	A	C	I	W	Male	Female	
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8-10)*	5	31	1	10	42	120	2	63	0	0	**274**
Semi-skilled and discretionary decision making *(Levels 4-7)*	36	83	0	27	76	303	1	75	1	0	**602**
Unskilled and defined decision making *(Levels 1-3)*	31	67	0	3	48	104	2	3	0	0	**258**
Total	**77**	**196**	**6**	**87**	**170**	**544**	**23**	**192**	**4**	**5**	**1 304**
Temporary employees	143	308	37	220	365	780	81	496	42	26	**2 498**
Grand Total	**220**	**504**	**43**	**307**	**535**	**1 324**	**104**	**688**	**46**	**31**	**3 802**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- The above figures include the CMD and EU funded personnel.
- Total number of employees includes employees additional to the establishment.
- Temporary employees reflect all contract appointments (Nature of appointments 05).

Table 4.6.6: Disciplinary actions, 1 April 2011 to 31 March 2012

Disciplinary actions total	Male				Female				Foreign nationals		Total
	A	C	I	W	A	C	I	W	Male	Female	
	220	406	0	33	237	452	0	54	0	0	**1 402**

Table 4.6.7: Skills development, 1 April 2011 to 31 March 2012

Occupational levels	Male				Female				Total
	A	C	I	W	A	C	I	W	
Top management *(Levels 14-16)*	0	0	0	0	0	0	0	0	**0**
Senior management *(Level 13)*	6	8	0	4	2	3	0	16	**39**

Occupational levels	Male				Female				Total
	A	C	I	W	A	C	I	W	
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	121	275	40	317	393	2 306	121	1 405	**4 978**
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8-10)*	293	841	7	149	752	2 384	19	457	**4 902**
Semi-skilled and discretionary decision making *(Levels 4-7)*	18	136	4	34	18	38	1	1	**250**
Unskilled and defined decision making *(Levels 1-3)*	122	150	1	12	149	347	1	4	**786**
Total	**1 262**	**2 930**	**88**	**764**	**1 671**	**5 828**	**225**	**2 076**	**14 844**
Temporary employees	4	9	1	1	1	7	0	9	**32**
Grand Total	**1 266**	**2 939**	**89**	**765**	**1 672**	**5 835**	**225**	**2 085**	**14 876**

4.7 Signing of performance agreements by SMS members

Table 4.7.1: Signing of Performance Agreements by SMS members, as at 31 May 2011

SMS level	Number of funded SMS posts per level	Number of SMS members per level	Number of signed performance agreements per level	Signed performance agreements as % of SMS members per level
Director-General/ Head of Department	1	1	1	100%
Salary level 16, but not HOD	0	0	0	N/A
Salary Level 15	3	3	3	100%
Salary Level 14	10	9	9	80%
Salary Level 13	43	37	30	72%
Total	**57**	**50**	**43**	**76%**

Table 4.7.2: Reasons for not having concluded Performance Agreements with all SMS on 31 May 2011

Reasons for not concluding Performance Agreements with all SMS
Promotions and new appointments since 1 April 2011.

Table 4.7.3 Disciplinary steps taken against SMS members for not having concluded Performance Agreements on 31 May 2011

Disciplinary steps taken against SMS members for not having concluded performance agreements
Promotions and new appointments since 1 April 2011.

4.8 Filling of SMS posts

Table 4.8.1: SMS posts information, as at 30 September 2011

SMS level	Number of funded SMS posts per level	Number of SMS posts filled per level	% of SMS posts filled per level	Number of SMS posts vacant per level	% of SMS posts vacant per level
Director-General/ Head of Department	1	1	100.00%	0	0.00%
Salary level 16, but not HOD	0	0	0.00%	0	0.00%
Salary level 15	3	3	100.00%	0	0.00%
Salary level 14	10	10	100.00%	0	0.00%
Salary level 13	46	40	86.96%	6	13.04%
Total	**60**	**54**	**90.00%**	**6**	**10.00%**

Notes:

- The number of funded SMS posts per level excludes the de-activated (unfunded) posts.

Table 4.8.2: SMS posts information, as at 31 March 2012

SMS level	Number of funded SMS posts per level	Number of SMS posts filled per level	% of SMS posts filled per level	Number of SMS posts vacant per level	% of SMS posts vacant per level
Director-General/ Head of Department	1	1	100.00%	0	0.00%
Salary level 16, but not HOD	0	0	0	0	0
Salary level 15	3	3	100.00%	0	0.00%
Salary level 14	11	11	100.00%	0	0.00%
Salary level 13	49	42	85.71%	7	14.29%
Total	**64**	**57**	**89.06%**	**7**	**10.94%**

Table 4.8.3: Advertising and Filling of SMS posts, as on 31 March 2012

SMS level	Advertising	Filling of posts	
	Number of vacancies per level advertised in 6 months of becoming vacant	Number of vacancies per level filled in 6 months after becoming vacant	Number of vacancies per level not filled in 6 months but filled in 12 months
Director-General/ Head of Department	0	0	0
Salary level 16, but not HOD	0	0	0
Salary level 15	0	0	0
Salary level 14	1	1	0
Salary level 13	8	8	0
Total	**9**	**9**	**0**

Table 4.8.4: Reasons for not having complied with the filling of funded vacant SMS posts – Advertised within 6 months and filled within 12 months after becoming vacant

SMS level	Reasons for non-compliance
Director-General/ Head of Department	N/A
Salary level 16, but not HOD	N/A
Salary level 15	N/A
Salary level 14	N/A
Salary level 13	The post of Director: Health Impact Assessment was filled by means of headhunting as no suitable candidate could be attracted via the normal recruitment and selection processes.

Table 4.8.5: Disciplinary steps taken for not complying with the prescribed timeframes for filling SMS posts within 12 months

Disciplinary steps taken
Not applicable.

4.9 Performance rewards

To encourage good performance, the Department has granted the following performance rewards allocated to personnel for the performance period 2009/10, but paid in the financial year 2010/11. The information is presented in terms of race, gender, and disability (Table 4.9.1), salary bands (table 4.9.2) and critical occupations (Table 4.9.3).

Table 4.9.1: Performance Rewards by race, gender, and disability, 1 April 2011 to 31 March 2012

Race and Gender	Beneficiary Profile			Cost	
	Number of beneficiaries	Total number of employees in group	% of total within group	Cost (R'000)	Average cost per employee
African					
Male	239	1 975	12.10%	2 392	10
Female	553	4 805	11.51%	6 353	11
Asian					
Male	23	195	11.79%	1 015	44
Female	48	315	15.24%	1 175	24
Coloured					
Male	929	4 665	19.91%	11 963	13
Female	2 828	13 060	21.65%	37 374	13
White					
Male	272	1 540	17.66%	10 263	38
Female	757	3 287	23.03%	18 123	24
Employees with a disability	11	120	9.17%	307	28
Total	**5 649**	**29 842**	**18.93**	**88 658**	**16**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Performance awards include merit awards and allowance 0228.
- Employees with a disability are included in race and gender figures and in "Total".
- Senior management and senior professionals are included.

Table 4.9.2: Performance Rewards by salary bands for personnel below Senior Management Service, 1 April 2011 to 31 March 2012

Salary bands	Beneficiary profile			Cost		
	Number of beneficiaries	Total number of employees in group	% of total within salary bands	Cost (R'000)	Average cost per beneficiary	Cost as a % of the total personnel expenditure
Lower skilled *(Levels 1 – 2)*	387	2 370	16.33	2 071	5	0.03
Skilled *(Levels 3 – 5)*	1 970	10 726	18.37	15 610	8	0.21
Highly skilled production *(Levels 6 – 8)*	1 674	8 856	18.90	21 841	13	0.29
Highly skilled supervision *(Levels 9 – 12)*	1 586	7 833	20.25	48 967	31	0.65
Total	**5 617**	**29 785**	**18.86**	**88 489**	**16**	**1.17**

Notes:

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

Table 4.9.3: Performance related rewards (cash bonus), by salary band, for Senior Management Service, 01 April 2011 to 31 March 2012

Salary bands	Beneficiary profile			Cost		
	Number of beneficiaries	Total number of employees in group	% of total within salary bands	Cost (R'000)	Average cost per beneficiary	Cost as a % of the total personnel expenditure
Senior Management Service Band A *(Level 13)*	7	42	17	268	38	0.79
Senior Management Service Band B *(Level 14)*	2	11	18	101	51	1.07
Senior Management Service Band C *(Level 15)*	1	3	33	54	54	1.53
Senior Management Service Band D *(Level 16)*	1	1	100	117	117	6.42
Total	**11**	**57**	**19**	**540**	**49**	**1.11**

Table 4.9.4: Performance Rewards by critical occupations, 1 April 2011 to 31 March 2012

Critical occupations	Beneficiary profile			Cost		
	Number of beneficiaries	Total number of employees in group	% of total within salary bands	Cost (R'000)	Average cost per beneficiary	Cost as a % of the total personnel expenditure
Clinical technologist	23	70	32.86	475	21	0.01%
Industrial technician	18	63	28.57	498	28	0.01%
Medical 420rthotists and prosthetist	2	14	14.29	36	0	0.00%
Medical physicist	3	9	33.33	109	36	0.00%
Pharmacists	53	374	14.17	2,125	40	0.03%
Total	**99**	**530**	**18.68**	**3,243**	**33**	**0.04%**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Performance awards include merit awards and allowance 0228.

4.10 Foreign workers

The tables below summarise the employment of foreign nationals in the Department in terms of salary bands and by major occupation. The tables also summarise changes in the total number of foreign workers in each salary band and by each major occupation.

Table 4.10.1: Foreign Workers by salary band, 1 April 2011 to 31 March 2012

Salary bands	1 April 2011		31 March 2012		Change	
	Number	% of total	Number	% of total	Number	% of total
Lower skilled *(Levels 1 – 2)*	1	0.59	2	1.10	1	8
Skilled *(Levels 3 – 5)*	6	3.55	6	3.31	0	0
Highly skilled production *(Levels 6 – 8)*	10	5.92	8	4.42	-2	-17
Highly skilled supervision *(Levels 9 – 12)*	152	89.24	164	90.61	12	100
Senior management *(Levels 13 – 16)*	0	0.00	1	0.55	1	8
Total	**169**	**100.00**	**181**	**100.00**	**12**	**100**

Notes:

- Nature of appointments sessional, periodical and abnormal is not included.

Table 4.10.2: Foreign Workers by major occupation, 1 April 2011 to 31 March 2012

Major Occupation	1 April 2011		31 March 2012		Change	
	Number	% of total	Number	% of total	Number	% of total
Admin office workers	1	0.59	1	0.55	0	0.00
Craft related workers	0	0.00	0	0.00	0	0.00
Elementary occupations	1	0.59	2	1.10	1	8.33
Professionals and managers	141	83.43	150	82.87	9	75.00
Service workers	5	2.96	5	2.76	0	0.00
Plant and machine operators	0	0.00	1	0.55	1	8.33
Technical and associated professionals	21	12.43	22	12.15	1	8.33
Total	**169**	**100.00**	**181**	**100.00**	**12**	**100.00**

Notes:

- Nature of appointments sessional, periodical and abnormal is not included.

4.11 Leave utilisation for the period 1 January 2011 to 31 December 2011

The Public Service Commission identified the need for careful monitoring of sick leave within the public service. The following tables provide an indication of the use of sick leave (Table 4.11.1) and disability leave (Table 4.11.2). In both cases, the estimated cost of the leave is also provided.

Table 4.11.1: Sick leave, 1 January 2011 to 31 December 2011

Salary band	Total days	% days with medical certification	Number of employees using sick leave	Total number of employees	% of total employees using sick leave	Average days per employee	Estimated cost (R'000)
Lower skilled *(Levels 1 – 2)*	18 996	85.75	1 940	2 245	86.41	8	4 695
Skilled *(Levels 3 – 5)*	82 790	84.63	9 060	10 474	86.50	8	28 913
Highly skilled production *(Levels 6 – 8)*	67 969	84.53	7 567	8 601	87.98	8	38 087
Highly skilled supervision *(Levels 9 – 12)*	44 842	81.58	5 512	7 762	71.01	6	55 352
Senior management *(Levels 13 – 16)*	276	86.23	32	57	56.14	5	665
Total	**214 873**	**84.06**	**24 111**	**29 139**	**82.74**	**7**	**127 712**

Notes:

- Nature of appointments sessional, periodical and abnormal is not included.
- Annual leave cycle is from 1 January – 31 December of each year.
- Sick leave reported in this table includes all categories of leave namely sick leave as well as incapacity leave.

Table 4.11.2: Incapacity leave, 1 January 2011 to 31 December 2011

Salary band	Total days	% days with medical certification	Number of employees using incapacity leave	Total number of employees	% of total employees using incapacity leave	Average days per employee	Estimated cost (R'000)
Lower skilled *(Levels 1 – 2)*	2 197	100.00	72	2 245	3.21	31	550
Skilled *(Levels 3 – 5)*	9 485	100.00	303	10 474	2.89	31	3 255
Highly skilled production *(Levels 6 – 8)*	10 114	100.00	279	8 601	3.24	36	5 529
Highly skilled supervision *(Levels 9 – 12)*	6 132	100.00	207	7 762	2.67	30	7 867
Senior management *(Levels 13 – 16)*	58	100.00	2	57	3.51	29	116
Total	**27 986**	**100.00**	**863**	**29 139**	**2.96**	**32**	**17 317**

Notes:

- Nature of appointments sessional, periodical and abnormal is not included.
- Annual leave cycle is from 1 January – 31 December of each year.

Table 4.11.3 summarises the utilisation of annual leave. The wage agreement concluded with trade unions in the PSCBC in 2000 requires management of annual leave to prevent high levels of accrued leave being paid at the time of termination of service.

Table 4.11.3: Annual Leave, 1 January 2011 to 31 December 2011

Salary band	Total days taken	Total number employees using annual leave	Average days per employee
Lower skilled *(Levels 1 – 2)*	45 994	2 221	21
Skilled *(Levels 3 – 5)*	219 947	10 402	21
Highly skilled production *(Levels 6 – 8)*	198 180	8 797	23
Highly skilled supervision *(Levels 9 – 12)*	170 958	7 956	21
Senior management *(Levels 13 – 16)*	1 242	59	21
Total	**636 321**	**29 435**	**22**

Notes:

- Nature of appointments sessional, periodical and abnormal is not included.
- Annual leave cycle is from 1 January – 31 December of each year.

Table 4.11.4: Capped leave, 1 January 2011 to 31 December 2011

Salary band	Total capped leave available as at 31 Dec 2010	Total days of capped leave taken	Number of employees using capped leave	Average number of days taken per employee	Number of employees with capped leave as at 31 Dec 2011	Total capped leave available as at 31 Dec 2011
Lower skilled *(Levels 1 – 2)*	8 157	335	39	9	545	5 987
Skilled *(Levels 3 – 5)*	95 310	4 822	395	12	3 307	69 048
Highly skilled production *(Levels 6 – 8)*	178 300	11 950	805	15	4 332	177 241
Highly skilled supervision *(Levels 9 – 12)*	127 095	6 898	571	12	3 045	122 249
Senior management *(Levels 13 – 16)*	1 736	24	3	8	28	1 495
Total	**410 598**	**24 029**	**1 813**	**13**	**11 257**	**376 020**

Notes:

- Nature of appointments sessional, periodical and abnormal is not included.
- Annual leave cycle is from 1 January – 31 December of each year.

The following table summarises payments made to employees as a result of leave that was not taken.

Table 4.11.5: Leave pay-outs, 1 January 2011 to 31 December 2011

Reason	Total amount (R'000)	Number of employees	Average payment per employee
Leave pay-outs for 2011/12 due to non-utilisation of leave for the previous cycle	293	39	8
Capped leave pay-outs on termination of service for 2011/12	13 186	386	34
Current leave pay-outs on termination of service 2011/12	3 430	681	5
Total	**16 909**	**1 106**	**15**

Notes:

- Capped leave are only paid out in case of normal retirement, termination of services due to ill health and death.

4.12 HIV and AIDS & Health Promotion Programmes

Table 4.12.1: Steps taken to reduce the risk of occupational exposure, 1 April 2011 to 31 March 2012

Units/categories of employees identified to be at high risk of contracting HIV & related diseases (if any)	Key steps taken to reduce the risk
Employees in clinical areas, i.e. doctors, nurses, medical students, general workers and paramedics are more at risk of contracting HIV and related diseases. Young employees, falling into the category of youth, have also been identified to be at high risk. The table below depicts the nature of injuries reported by employees for 2011/12: **Nature of Injury on duty** / **Total number of cases reported** Needle Prick: 112 Tuberculosis (TB): - Multi Drug Resistant TB: - Note: TB statistics were not available at time of going to print.	• The HIV and AIDS / STI / TB policy within the Department identifies the prevention of occupational exposure to potentially infectious blood and blood products as a key focus area. • Service providers have been appointed in the districts providing HIV testing as part of a basket of health screenings that also include testing for blood pressure, diabetes, cholesterol, body mass index and anaemia. • A protocol to ensure universal infection control measures has been implemented. • Special responsive programmes targeting behavioural risks have been implemented. • Implementation of targeted awareness and education initiatives.

Table 4.12.2: Details of Health Promotion and HIV and AIDS Programmes (tick the applicable boxes and provide the required information), 1 April 2011 to 31 March 2012

Question	Yes	No	Details, if yes
1. Has the Department designated a member of the SMS to implement the provisions contained in Part VI E of Chapter 1 of the Public Service Regulations, 2001? If so, provide her/his name and position.	✓		Ms Bernadette Arries Chief Director: Human Resources
2. Does the Department have a dedicated unit or has it designated specific staff members to promote the health and well-being of your employees? If so, indicate the number of employees who are involved in this task and the annual budget that is available for this purpose.	✓		<u>Employee Health and Wellness Programme (EHWP) within the Directorate: Transformation at Head Office Level:</u> Deputy Director: Ms Sandra Newman Admin Support: Ms Nicky van der Walt Ms Lisl Mullins Ms Caldine van Willing Mr Dayithethe Silwanyana Ms Tasneem Jaffer Mr Michael Valentine Mr Nabeel Ismail <u>Institutional / district level:</u> Groote Schuur Hospital: Ruth Halford Tygerberg Hospital: Sayeeda Dhansay Red Cross War Memorial Children's Hospital: Ntombozuko Ponono Associated Psychiatric Hospitals: Soraya Fredericks, Yvonne Swart, Mariam Marlie, Jessica Minnaar Cape Winelands District: Sandra Nieuwoudt Overberg District: Linda Reichert West Coast District: Danie Schoeman Eden / Central Karoo Districts: Nuruh Davids MDHS: Abe Oor EMS: Liz Crossley, Monya-Mika Gerber, Liesl Meter
3. Has the department introduced an Employee Assistance or Health Promotion Programme for your employees? If so, indicate the key elements/services of this programme.	✓		The Department makes use of a combined model, i.e. internal and external services. An independent service provider, ICAS, has been appointed to provide this confidential service and three institutions have an internal service in addition to the external service. **Programmes and services offered**: 1. Counselling and support services: - 24 hours a day, 7 days a week, 365 days of the year telephone counselling. - The service is available to all employees and their household members. - Face to face counselling (8 session model) per issue. - Case management. - Trauma / critical incident management. - HIV and AIDS counselling.

Question	Yes	No	Details, if yes
			2. Life management services: - Family care. - Money management. - Legal information and advice. 3. Managerial consultancy and referral services: - Managerial consultancy. - Formal referral programme. 4. Client management services: - Implementation programme. - Promotional material. - Account management consultancy. - Reporting and review programme. - Quality management programme. 5. Specialist services: - Staff satisfaction surveys. - Climate survey conducted at Khayelitsha Hospital. - Specialised group interventions. - Coaching programme. - Regular reporting and feedback sessions with relevant management members occur on a quarterly basis. 6. Training services: • Targeted training interventions based on identified needs and trends. **Key elements – HIV and AIDS/STI programmes:** • To ensure that every employee within the Department receives appropriate and accurate HIV and AIDS / STI risk reduction education. • To create a non-discriminatory work environment. • To prevent occupational exposure to potentially infectious blood and blood products and to manage occupational exposures that occurred. • To provide HIV counselling and testing services for those employees who wish to determine their own HIV status. • To determine the impact of HIV and AIDS on the Department in order to plan accordingly. • To promote the use of and to provide South African Bureau of Standards(SABS) approved male and female condoms. • Awareness of available services. • Education and training. • Counselling. • Critical incident stress debriefing (CISD). • Reporting and evaluating.

Question	Yes	No	Details, if yes
			In 2011/12, the workplace HIV and AIDS / STI / TB programme formed part of the provincial and national HIV counselling and testing (HCT) campaign. The HCT campaign follows a more integrated approach to testing and routinely offers HIV testing as part of a basket of health screenings that also include testing for blood pressure, diabetes, cholesterol, body mass index and anaemia. These services are provided to employees at no cost, in partnership with GEMS (Government Employees Medical Scheme).
4. Has the Department established (a) committee(s) as contemplated in Part VI E.5 I of Chapter 1 of the Public Service Regulations, 2001? If so, please provide the names of the members of the committee and the stakeholder(s) that they represent.	✓		HIV and AIDS / STI / TB are seen as a transversal issue in the Western Cape Government. The Department of Health has been appointed as the primary driver of the process. The Department of Health therefore has a dual role to play (i.e. to oversee and manage their departmental programme as well as to manage and co-ordinate the programme within the Province). **Health Departmental Committee:** Ms S Newman: Head Office Ms R Halford: Groote Schuur Hospital Ms S Dhansay: Tygerberg Hospital Ms N Ponono: Red Cross War Memorial Children's Hospital Ms S Fredericks, Ms Y Swart, Ms M Marlie, Ms J Minnaar: Associated Psychiatric Hospitals Ms S Nieuwoudt: Cape Winelands District Ms. L Reichert: Overberg District Dr D Schoeman: West Coast District Ms N Davids: Eden / Central Karoo Districts Mr A Oor: MDHS Liesl Meter, Liz Crossley, M Gerber: Emergency Medical Services **Provincial Employee AIDS Programme (PEAP) committee:** Ms S Newman – Department of Health Ms L Mullins – Department of Health Mr M Cronje – Department of Education Ms N Mxoli – Department of Education Mr P Kemp – Department of the Premier Ms N Norushe – Department of the Premier Representatives from the relevant HCT service providers (NPOs).
5. Has the Department reviewed its employment policies and practices to ensure that these do not unfairly discriminate against employees on the basis of their HIV status? If so, list the employment policies/practices so reviewed.	✓		None of the employment policies and practices discriminates unfairly against employees on the basis of their HIV and AIDS status. The HIV and AIDS / STI / TB workplace programme is reviewed on an annual basis.

<table>
<tr><th>Question</th><th>Yes</th><th>No</th><th>Details, if yes</th></tr>
<tr><td>6. Has the Department introduced measures to protect HIV-positive employees or those perceived to be HIV-positive from discrimination? If so, list the key elements of these measures.</td><td>✓</td><td></td><td>One of the objectives of the HIV and AIDS / STI / TB workplace programme is to “create a working environment that is free of discrimination”. In order to meet this objective, the Department:
• Includes persons living with AIDS in awareness campaigns.
• Develops on-going awareness and communication strategies.
• Have programmes and interventions to break social barriers and stigma.
• Holds workshops and information sessions.
• Promotes openness.
• Promotes the need for confidentiality with regards to testing and status.</td></tr>
<tr><td>7. Does the Department encourage its employees to undergo HIV counselling and testing (HCT)? If so, list the results that you have you achieved.</td><td>✓</td><td></td><td>The Department of Health has appointed the following NPOs to render an on-site HIV counselling and testing (HCT) service to all employees:
• LifeLine: Metropole
• Diakonale Dienste: West Coast District
• @Heart: Cape Winelands District
• Elgin Learning Foundation: Overberg District
• That’s It: Eden District
• Right to Care: Central Karoo District
Results:
<table>
<tr><th rowspan="2">District</th><th colspan="3">No of employees tested</th></tr>
<tr><th>Tested</th><th>Positive</th><th>Negative</th></tr>
<tr><td>Metropole</td><td>2 014</td><td>22</td><td>1 992</td></tr>
<tr><td>West Coast</td><td>718</td><td>24</td><td>694</td></tr>
<tr><td>Overberg</td><td>170</td><td>6</td><td>164</td></tr>
<tr><td>Cape Winelands</td><td>284</td><td>1</td><td>283</td></tr>
<tr><td>Central Karoo</td><td>169</td><td>3</td><td>166</td></tr>
<tr><td>Eden</td><td>252</td><td>3</td><td>249</td></tr>
<tr><td>Total</td><td>3 607</td><td>59</td><td>3 548</td></tr>
</table>
Notes:
Employees who test positive are supported via the Employee Health and Wellness Programme. Employees are also encouraged to join GEMS in cases where they have not already joined a medical aid.
The programme is currently aligned with national HCT initiative.</td></tr>
<tr><td>8. Has the Department developed measures / indicators to monitor and evaluate the impact of its health promotion programme? If so, list these measures / indicators.</td><td>✓</td><td></td><td>The Department has an annual monitoring and evaluation tool for the workplace HIV and AIDS programme. This information is submitted to the HOD, DG and DPSA.
Monthly statistics, quarterly reports and annual reports provided by HCT service providers serve as a means to monitor and evaluate the effectiveness of this programme.</td></tr>
</table>

Question	Yes	No	Details, if yes
			Quarterly and annual reports provided by the EHWP service provider serves as a means to monitor and evaluate the effectiveness of this programme and also to identify trends and challenges within the Department and develop and implement special interventions to address trends and challenges.

4.13 Labour relations

The following collective agreements were entered into with trade unions within the Department.

Table 4.13.1: Collective agreements, 1 April 2011 to 31 March 2012

Total collective agreements	None

The following table summarises the outcome of disciplinary hearings conducted within the department for the year under review.

Table 4.13.2: Misconduct and disciplinary hearings finalised, 1 April 2011 to 31 March 2012

Outcomes of disciplinary hearings	Number	% of total
Correctional counselling	248	17.7%
Verbal warning	339	24.2%
Written warning	418	29.8%
Final written warning	299	21.3%
Suspension without pay	4	0.3%
Fine	0	0%
Demotion	2	0.1%
Dismissal/ desertion	89	6.35%
Not guilty	2	0.1%
Case withdrawn	1	0.1%
Total	**1 402**	**100%**
Percentage of total employment		**4.8%**

Table 4.13.3: Types of misconduct addressed at disciplinary hearings, 1 April 2011 to 31 March 2012

Type of misconduct	Number	% of total
Absent from work without reason or permission	723	51.6%
Code of Conduct (improper/unacceptable manner)	158	11.3%
Insubordination	166	11.8%
Fails to comply with or contravenes acts	120	8.6%
Negligence	40	2.9%
Misuse of WCG property	65	4.6%
Steals, bribes or commits fraud	36	2.6%
Substance Abuse	22	1.6%
Sexual Harassment	12	0.9%
Discrimination	6	0.4%
Assault or threatens to assault	14	1.0%
Desertions	29	2.1%
Social grant fraud	11	0.8%
Total	**1 402**	**100%**

Table 4.13.4: Grievances lodged, 1 April 2011 to 31 March 2012

Grievances lodged	Number	% of total
Number of grievances resolved	214	83%
Number of grievances not resolved	44	17%
Total number of grievances lodged	**258**	**100%**

Table 4.13.5: Disputes lodged with Councils, 1 April 2011 to 31 March 2012

Disputes lodged with Councils	Number	% of total
Conciliations		
Deadlocked	94	94%
Settled	4	4%
Withdrawn	2	2%
Total number of disputes lodged	**100**	**100%**

Disputes lodged with Councils	Number	% of total
Arbitrations		
Upheld in favour of Employee	16	24.6%
Dismissed in favour of Employer	46	70.8%
Settled	3	4.6%
Total number of disputes lodged	**65**	**100%**

Table 4.13.6: Strike actions, 1 April 2011 to 31 March 2012

Strike actions	Number
Total number of person working days lost	18.15
Total cost (R'000) of working days lost	R8
Amount (R'000) recovered as a result of no work no pay	Nil

Table 4.13.7: Precautionary suspensions, 1 April 2011 to 31 March 2012

Precautionary suspensions	Number
Number of people suspended	48
Number of people whose suspension exceeded 60 days	19
Average number of days suspended	57
Cost (R'000) of suspensions	R2 285

4.14 Skills development

This section highlights the efforts of the Department with regard to skills development. The tables reflect the training needs as at the beginning of the period under review, and the actual training provided.

Table 4.14.1: Training needs identified, 1 April 2011 to 31 March 2012

Occupational categories	Gender	Number of employees as at 1 April 2011	Training needs identified at start of reporting period			
			Learnerships	Skills programmes & other short courses	Other forms of training	Total
Legislators, senior officials and managers	Female	37	0	30	0	30
	Male	62	0	11	0	11
Professionals	Female	8 557	0	6 362	0	6 362
	Male	2 667	0	4 500	0	4 500

Occupational categories	Gender	Number of employees as at 1 April 2011	Training needs identified at start of reporting period			
			Learnerships	Skills programmes & other short courses	Other forms of training	Total
Technicians and associate professionals	Female	755	70	2 631	0	2 701
	Male	462	40	3 364	0	3 404
Clerks	Female	2 575	0	2 762	0	2 762
	Male	1 341	0	989	0	989
Service and sales workers	Female	7 143	1 450	218	0	1 668
	Male	1 815	150	2 000	0	2 150
Skilled agriculture and fishery workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Craft and related trades workers	Female	2	0	150	0	150
	Male	171	0	246	0	246
Plant and machine operators and assemblers	Female	4	0	215	0	215
	Male	167	0	14	0	14
Elementary occupations	Female	2 394	0	1 910	0	1 910
	Male	1 691	0	277	0	277
Sub-total	Female	21 467	1 520	14 278	0	15 798
	Male	8 376	190	11 401	0	11 591
Total		**29 843**	**1 710**	**25 679**	**6 500**	**33 889**
Employees with disabilities	Female	0	0	0	0	0
	Male	0	0	0	0	0

Table 4.14.2: Training provided, 1 April 2011 to 31 March 2012

Occupational Categories	Gender	Number of employees as at 31 March 2012	Training provided within the reporting period			
			Learnerships	Skills programmes & other short courses	Other forms of training	Total
Legislators, senior officials and managers	Female	37	0	14	0	14
	Male	62	0	18	0	18
Professionals	Female	8 557	0	6 778	0	6 778
	Male	2 667	0	1 206	0	1 206
Technicians and associate professionals	Female	755	0	2 276	0	2 276
	Male	462	0	796	0	796

Occupational Categories	Gender	Number of employees as at 31 March 2012	Training provided within the reporting period			
			Learnerships	Skills programmes & other short courses	Other forms of training	Total
Clerks	Female	2 575	0	1 870	0	1 870
	Male	1 341	0	881	0	881
Service and sales workers	Female	7 143	0	370	0	370
	Male	1 815	0	263	0	263
Skilled agriculture and fishery workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Craft and related trades workers	Female	2	0	1	0	1
	Male	171	0	16	0	16
Plant and machine operators and assemblers	Female	4	0	7	0	7
	Male	167	0	5	0	5
Elementary occupations	Female	2 394	0	104	0	104
	Male	1 691	0	56	0	56
Sub Total	Female	21 467	0	11 420	0	11 420
	Male	8 376	0	3 241	0	3 241
Total		**29 843**	**0**	**14 661**	**11 329**	**25 990**
Employees with disabilities	Female	0	0	0	0	0
	Male	0	0	0	0	0

4.15 Injury on duty

The following tables provide basic information on injury on duty.

Table 4.15.1: Injury on duty, 1 April 2011 to 31 March 2012

Nature of injury on duty	Number	% of total
Required basic medical attention only	43	30
Temporary total disablement	101	70
Permanent disablement	0	0
Fatal	1	1
Total	**145**	**100%**
Percentage of total employment		**0.5%**

4.16 Utilisation of consultants

Table 4.16.1: Report on consultant appointments using appropriated funds, 1 April 2011 to 31 March 2012

Project title	Total number of consultants that worked on the project	Duration: Work days	Contract value in **Rand** (as per BAS reports and information obtained from users/Directorates)
Indigo Holdings – Consultant for Minister on business, marketing and strategy Special advisor – Strategic partnerships – Amanda Brinkman	1	12 months	90 665 per month 1 087 980
Peter Laubscher – Impact of Health on economy – research	1	1	2 550
Business Connexion – Sakkie van Niekerk – PERSAL user support services	1	240	442.89 per hour
Business Connexion – Pottie Potgieter – PERSAL user support services	1	240	286.37 per hour
Business Connexion – Esme van Niekerk – PERSAL user support services	1	240	128.33 per hour
Business Connexion – Total:			*1 672 043*
Management Accounting – Joan Du Plessis – Project manager for Chronic Dispensing Unit	1	240	124 383
IJ Schoombee – Appointment of a contractor to support the PACS/RIS and EMS ICT projects	1	30 – 40 hours per week	475.00 per hour 96 971
Ernst & Young – Internal Audit Services – Commercial Rights – 10 Phases Phase 1: Information gathering and legal opinion Phase 2: Direction around Statutory requirements Phase 3: Research and Market analyses Phase 4: Asset analysis and needs quantification Phase 5:Revenue Assessment, Setting up of foundation Phase 6: Package and option development, legal requirements Phase 7: Preparation of Prospectus Phase 8: Setting up of foundation structures Phase 9: Concluding Key legal agreements Phase 10: Engagement process with key stakeholders	5	118.13	1 627 226
Leadtrain Assessments – Competency Assessment for Human Resource Management	2	2 years	9 598

Project title	**Total number of consultants that worked on the project**	**Duration: Work days**	**Contract value in Rand** (as per BAS reports and information obtained from users/Directorates)
Drake & Scull FM a Division of Tsebo Holdings & Operations (Pty) Ltd Standardised and centralised asset maintenance management system for George, Worcester, Vredenburg and Paarl Hospitals including its satellite institutions	8	240	3 959 959
Comprehensive Health HIV/AIDS – UCT	Unknown	Unknown	339 031
Comprehensive Health HIV/AIDS – V Zweigenthal	1	unknown	59 412
Chief Director: MDHS Ayanda Mbanga Communications – Verification of qualifications	1	Annual	338 535
Chief Director: MDHS – Wilfred Jewell Consultancy cc – Translation and transcription services – Travel safety poster	1	1	912
Work Dynamics (PTY) LTD – SMS competency assessments – posts	1	1.5 per person (depend on number of posts)	99 665
Human Resources Management – Legal advice on various cases	Various advocates	As and when required	6 174 665
Human Resources Management: CD Cebano Consultants – Barrett Assessment	Unknown	Unknown	161 186
Sian Dennis & Associates – SMS competency assessments – Director: Eng. & Tech. post	1	1.5	6 899
Brian Gibson Issue Management – Healthcare 2020	1	December 2011 – April 2012	318 060
University of Cape Town – WCCN – Moderation fees for all exam papers	4 – 5	12 months	339 000
University of Stellenbosch – Health Impact Assessment – Burden of Disease	Unknown	Unknown	50 000
University of Cape Town – Health Impact Assessment – Booza	1	12 months	670 000
South African Medical Research Council – Health Impact Assessment – Burden of Disease	1	12 months	1 513 479
Total number of projects	**Total individual consultants**	**Total duration: Work days**	**Total contract value in Rand**
	>35	2 644 (estimate)	17 592 864 (as per BAS reports)

Table 4.16.2: Analysis of consultant appointments using appropriated funds, in terms of Historically Disadvantaged Individuals (HDIs), 1 April 2011 to 31 March 2012

Project title	Percentage ownership by HDI groups	Percentage management by HDI groups	Number of consultants from HDI groups that work on the project
Indigo Holdings – Consultant for Minister on business, marketing and strategy Special advisor – Strategic partnerships – Amanda Brinkman	Nil	Nil	Nil
Peter Laubscher – Impact of Health on economy – research	Nil	Nil	Nil
Business Connexion – Sakkie van Niekerk – PERSAL user support services	Nil	Nil	Nil
Business Connexion – Pottie Potgieter – PERSAL user support services	Nil	Nil	Nil
Business Connexion – Esme van Niekerk – PERSAL user support services	Ni	Nil	Nil
Management Accounting – Joan Du Plessis – Project manager for Chronic Dispensing Unit	Nil	Nil	Nil
IJ Schoombee – Appointment of a contractor to support the PACS/RIS and EMS ICT projects	Nil	Nil	Nil
Ernst & Young – Internal Audit Services – Commercial Rights (10 phases)	27%	27%	2
Leadtrain Assessments – Competency Assessment for Human Resource Management	Nil	Nil	Nil
Drake & Scull	22.2%	22.2%	3
Comprehensive Health HIV/AIDS – UCT	Unknown	Unknown	Unknown
Comprehensive Health HIV/AIDS – V Zweigenthal	Nil	Nil	Nil
Chief Director: MDHS Ayanda Mbanga Communications – Verification of qualifications	100%	100%	1
Chief Director: MDHS – Wilfred Jewell Consultancy cc – Translation and transcription services – Travel safety poster	100%	100%	1
Work Dynamics (PTY) LTD – SMS competency assessments – posts	Unknown	Unknown	Unknown
Human Resources Management – Legal advice on various cases	N/a	N/a	Unknown
Human Resources Management: CD Cebano Consultants – Barrett Assessment	Unknown	Unknown	Unknown
Sian Dennis & Associates – SMS competency assessments – Director: Eng. & Tech. post	100%	100%	1
Brian Gibson Issue Management – Healthcare 2020	Nil	Nil	Nil
HASS SA	Unknown	Unknown	Unknown

Project title	Percentage ownership by HDI groups	Percentage management by HDI groups	Number of consultants from HDI groups that work on the project
University of Cape Town – WCCN – Moderation fees for all exam papers	N/a	N/a	Unknown
University of Stellenbosch – Health Impact Assessment – Burden of Disease	N/a	N/a	Unknown
University of Cape Town – Health Impact Assessment – Booza	N/a	N/a	Unknown
South African Medical Research Council – Health Impact Assessment – Burden of Disease	Unknown	Unknown	Unknown

Table 4.16.3: Report on consultant appointments using Donor funds, 1 April 2011 to 31 March 2012

Project title	Total Number of consultants that worked on the project	Duration: Work days	Donor and contract value in Rand
	Nil	Nil	Nil
Total number of projects	**Total individual consultants**	**Total duration: Work days**	**Total contract value in Rand**
	Nil	Nil	Nil

Table 4.16.4: Analysis of consultant appointments using Donor funds, in terms of Historically Disadvantaged Individuals (HDIs), 1 April 2011 to 31 March 2012

Project Title	Percentage ownership by HDI groups	Percentage management by HDI groups	Number of Consultants from HDI groups that work on the project
	Nil	Nil	Nil

OTHER INFORMATION

5 OTHER INFORMATION

5.1 List of abbreviations

ACT	Assertive community team
ACTS	Advise, consent, test and support
ACSM	Advocacy, communication and social mobilisation
AGSA	Auditor-General of South Africa
AIDS	Acquired immunodeficiency syndrome
ALOS	Average length of stay
APL	Approved post list
APP	Annual performance plan
ART	Anti-retroviral treatment / therapy
ARV	Anti-retroviral
ASSA	Actuarial Society of South Africa
ATA	Assistant to artisan
BANC	Basic antenatal care
BAS	Basic Accounting System
BAUD	Bar coded asset audit software
BBBEE	Broad based black economic empowerment
BCA	Best care always
BFHI	Baby friendly hospital initiative
BMI	Budget management instrument
CADAC	Communication assistive devices advisory committee
CANSA	Cancer Association of South Africa
CARA	Criminal assets recovery account
CBR	Community based response
CBS	Community based services
CCW	Community care worker
CD	Chief Director
CD4	Cluster of differentiation 4 (lymphocyte)
CDC	Community day centre
CDU	Chronic dispensing unit
Ce-I	Centre for e-Innovation
CEO	Chief executive officer
CFO	Chief financial officer
CHC	Community health centre
CIDB	Construction Industry Development Board

CIMCI	Community integrated management of childhood illness
CISD	Critical incident stress debriefing
CKDO	Central Karoo District Office
CMD	Cape Medical Depot
CME	Continuing medical education
CMI	Compliance monitoring instrument
CMI-PO	Compliance monitoring instrument for predetermined objectives
CoCT	City of Cape Town
COP 17	The 17th Conference of the Parties to the United Nations Framework Convention on Climate Change (UNFCCC)
COSATU	Congress of South African Trade Unions
CPD	Continuous professional development
CPI	Consumer price index
CPS	Construction procurement system
CRADLE	Central Reporting of All Delivery data on Local Establishment
CSIR	Council for Scientific and Industrial Research
CSP	Comprehensive Service Plan
CSS	Client satisfaction survey
CT	Cape Town
CT	Computerised tomography
CTICC	Cape Town International Convention Centre
CWDO	Cape Winelands District Office
D	Director
DBSA	Development Bank of South Africa
DDG	Deputy Director-General
DDV	Direct delivery voucher
DG	Director-General
DHS	District health system / service
DICU	Devolved internal control unit
DMT	District Management Team
DNA	Deoxyribonucleic acid
DO	District office
DoH	Department of Health
DORA	Division of Revenue Act
DPSA	Department of Public Service Administration
DRP	Disaster recovery plan
DTPW	Department of Transport and Public Works
DVD	Digital versatile/video disc

ECC	Emergency control centre
ECM	Enterprise/electronic content management
EDI	Electronic data interchange
EDO	Eden District Office
EHWP	Employee health and wellness programme
EMC	Emergency medical care
EMRS	Emergency medical rescue services
EMS	Emergency medical services
ENT	Ear, nose and throat
EPWP	Expanded public works programme
ERM	Enterprise risk management
ERMCO	Enterprise risk management committee
ESMOE	Essential Steps in the Management of Obstetric Emergencies
ETR.net	Electronic Tuberculoses Register
EU	European Union
FBU	Functional business units
FIFA	Fédération Internationale de Football
FIFO	First in, first out
FIU	Fraud investigative unit
FOREX	Foreign exchange rate
FPS	Forensic pathology services
FTE	Full-time equivalent
GAAP	Generally accepted accounting practice
GEMC 3	Emergency medical services information system
GEMS	Government Employees Medical Scheme
GF	Global Fund
GG	Government garage
GIAMA	Government Immovable Asset Management Act
GMT	Government motor transport
GP%	Gross profit percentage
GSA	Geographical service area
GSH	Groote Schuur Hospital
GVI Oncology	An organisation providing cancer care.
HAST	HIV and AIDS, STI and tuberculosis
HBC	Home based care
HCBC	Home community based carers
HCT	HIV counselling and testing
HDI	Historically disadvantaged individuals

HEI	Higher education institutions
HFA	Healthcare Facility Assessment
HH	Households
HIG	Health infrastructure grant
HIS	Hospital Information System
HIV	Human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
HO	Head office
HoD	Head of department
HPTDG	Health professions training and development grant
HR	Human resources
HRM	Human resource management
HRP	Hospital revitalisation programme
HST	Health Systems Trust
HTA	High transmission area
HWSETA	Health and Welfare Sector Education and Training Authority
IAR	Immovable asset register
IAS	International accounting standards
ICAS	Independent Counselling and Advisory Services
ICD-10	International classification of disease (10th revision)
ICT	Information and communication technologies
ICU	Intensive care unit
ID	Infectious diseases
IDU	Infectious disease unit
IDMS	Infrastructure Delivery Management System
IFRIC	International financial reporting interpretations committee
IFRS	International financial reporting standards
IG	Incentive grant
iMOCOMP	Improvement and maintenance of competencies of medical practitioners
IPC	Infection prevention and control
IT	Information technology
IUCD	Intrauterine contraceptive device
IUSS	Infrastructure unit systems support
IYM	In-year monitoring
JAC	Pharmaceutical management system
JIMI	Joint information management initiative
KVA	Kilovolt-ampere
L1	Level 1 (primary)

L2	Level 2 (secondary)
L3	Level 3 (tertiary)
LG	Local government
LGBTI	Lesbian, gay, bisexual, transgender and intersex
LOGIS	Logistic Information Systems
M	Million
M & E	Monitoring and evaluation
M & M	Morbidity and mortality
MADAC	Mobility and communication assistive devices committee
MCC	Medicine Control Council
MCWH	Maternal, child and women's health
MCWH&N	Maternal, child and women's health and nutrition
MDG	Millennium development goal
MDHS	Metro District Health Services
MDR	Multi-drug resistant
MEC	Member of the executive council
MEDSAS	Medical Stores Administration System
MMC	Medical male circumcision
MMS	Middle management service
MOU	Midwife obstetric unit
MPSA	Minister of Public Service and Administration
MRC	Medical Research Council of South Africa
MRI	Magnetic resonance imaging
MTEF	Medium-term expenditure framework
NACOSA	Networking AIDS Community of South Africa
NCS	National Core standards
NDoH	National Department of Health
NDP	National Development Plan
NEMA	National Environmental Management Act
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NHS	National Health Systems
NIMS	Nursing Information Management System
NPO	Non-profit organisation
NSDA	Negotiated service delivery agreement
NTSG	National tertiary services grant
ODO	Overberg District Office
OPC	Orthotic and Prosthetic Centre

OPD	Outpatient department
OSD	Occupation specific dispensation
P1	Priority 1
P2	Priority 2
PAA	Public Audit Act
PACS	Picture archive communication system
PACS/RIS	Picture archive communication system and Radiological imaging system
PCC	Provincial co-ordinating committee
PCR	Polymerase chain reaction
PCV	Pneumococcal conjugate vaccine
PDE	Patient day equivalent
PEAP	Provincial employee AIDS programme
PEP	Post exposure prophylaxis
PERSAL	Personnel and Salary System
PET	Positron emission tomography
PFMA	Public Finance Management Act
PHC	Primary health care
PHCIS	Primary Health Care Information System
PICT	Provider initiated counselling and testing
PIPP	Perinatal Problem Identification Program
PMTCT	Prevention of mother-to-child transmission
PM	Programme management and strengthening
PN	Practice note
PPE	Property, plant and equipment
PPHC	Personal primary health care
PPP	Public private partnership
PPPFA	Preferential Procurement Policy Framework Act
PPPFA/BBBEE	Preferential Procurement Policy Framework Act / Broad based black economic empowerment
PPT	Planned patient transport
PREHMIS	Primary Health Care Management Information System
PSA	Public Service Administration
PSCBC	Public Service Co-ordinating Bargaining Council
PSR	Public service regulations
PTB	Pulmonary tuberculosis
PTMS	Provincial transversal management system
PTI	Provincial Treasury instruction
QA	Quality assurance

RAF	Road Accident Fund
RCAMS	Red Cross Air Mercy Service
RCC-I	Global Fund Rolling Continuation Channel
RCWMCH	Red Cross War Memorial Children's Hospital
RIS	Radiological imaging system
RTC	Regional training centre
RV	Rotavirus
RWOPS	Remunerative work outside the Public Service
RXH	Red Cross War Memorial Children's Hospital
SA	South Africa
SABS	South African Bureau of Standards
SAL	Salary
SAPS	South African Police Service
SCM	Supply chain management
SCOA	Standard chart of accounts
SCOPA	Standing Committee on Public Accounts
SDA	Service delivery agreement
SDC	Step-down care
SDI	Service delivery improvement
SEAT	Safe environment around toilets
SETA	State Education and Training Authority
SG	Superintendent General
SINJANI	Standard Information Jointly Assembled by Networked Infrastructure
SITA	State Information Technology Agency
SLA	Service level agreement
SMS	Senior management service
SMS	Short message service
SOP	Standard operating procedure
SSO	Sub-structure office
StatsSA	Statistics South Africa
STI	Sexually transmitted infection
SYSPRO	Software package used by central hospitals for supply chain management and asset management.
TB	Tuberculosis
TBH	Tygerberg Hospital
TIK	Methamphetamine (crystal meth)
TV	Television
U-AMP	User asset management plan

UCT	University of Cape Town
UPFS	Uniformed Patient Fee Schedule
US	University of Stellenbosch
UV	Ultra-violet
UVGI	Ultra-violet germicidal irradiation
UWC	University of the Western Cape
VCT	Voluntary counselling and testing
WCBD	Western Cape Bid Documents
WCCN	Western Cape College of Nursing
WCDO	West Coast District Office
WCDoH	Western Cape Department of Health
WCDTPW	Western Cape Department of Transport and Public Works
WCED	Western Cape Education Department
WCG	Western Cape Government
WC IDMS	Western Cape Infrastructure Delivery Management System
WCRC	Western Cape Rehabilitation Centre
WHO	World Health Organisation
XDR	Extreme drug resistant

5.2 List of contact detail

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