WESTERN CAPE GOVERNMENT:
HEALTH

ANNUAL PERFORMANCE PLAN
2013/14
FEBRUARY 2013

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FOREWORD BY THE MINISTER OF HEALTH
ANNUAL PERFORMANCE PLAN: 2013/2014

Western Cape Government's strategic objective of Increasing Wellness is a vision that encompasses an alternative approach when leading a health department. The wellness concept and the accompanying philosophy of preventing disease rather than providing for the disease burden, is taking root across all spheres of government, and in other countries faced with the challenge of high risk factors for disease. This annual performance plan bears testimony to the foundations that Western Cape Government Health has laid towards this strategic objective.

Western Cape Government Health's core function is to provide a pathway of health care to patients who depend on public health care services, but also requires the implementation of effective interventions to reduce morbidity and mortality. The development and maintenance of support services and infrastructure and the provision of training is an integral part of this function. Furthermore the department's management role in the sector as licensee and regulator of private hospitals, as well as in the provision of emergency medical services and forensic pathology services, are provided for in the 2013/2014 plan, with a view to forward planning for 2015/2016.

The annual performance plan reflects the department's commitment to achieve maximum efficiency within a limited budget. This required the rationalization of available resources and allocating more funds towards core services.

The capital infrastructure health projects in progress are valued at almost R4.5 billion. Of these the commissioning of the Khayelitsha Hospital in 2012/2013 is a milestone in the history of this province. The commissioning of the new Mitchell's Plain Hospital will be a second such milestone that will provide a welcoming and healing space for patients, and staff.

Human resources are our most important asset, and in the past three years 3 106 additional health care staff have been appointed to alleviate staff shortages. The reorganization of the department that is necessary to improve cohesion and deficiencies is a priority, and significant in terms of the rationalization of resources and simultaneous building of capacity to operate efficiently.

Western Cape Government Health has achieved impressive results by focusing on accountability, management and governance structures, despite the province's quadruple burden of disease. I would like to congratulate and thank the Department for this visionary plan which provides for the core functions and outcomes based on a realistic approach.

MR THEUNS BOTHA
WESTERN CAPE MINISTER OF HEALTH

MESSAGE FROM THE HEAD OF DEPARTMENT
PROFESSOR KC HOUSEHAM

The highlight of the 2012/13 financial year was the opening of the Khayelithsha Hospital. The hospital was functioning to full capacity within months of opening, indicating the need for district hospital services in this community. In 2013/14, the Department will open a modern, world class hospital in Mitchells Plain, increasing significantly the access to quality health services for this community. The services from the GF Jooste Hospital will relocate to the Mitchell's Plain Hospital as well as an interim emergency centre service at the Heideveld Community Health Centre while the existing GF Jooste Hospital is rebuilt, to reopen in 2017. The opening and modernising of these three hospitals will significantly improve the health service within the Cape Town Metro District and is one of the most important developments in health service delivery since 1994.

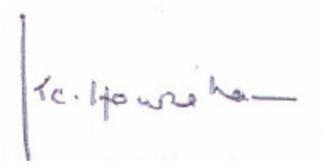
The Department will finalise the 2020 strategic framework after having considered the public comments arising from a second round of public consultation. The vision, principles and values will provide direction to the Department for the next decade.

As part of the 2020 initiative the Department will embark upon a change management programme to improve the quality of health services delivered by departmental employees over a two year period. The project will focus on improving staff engagement and patient satisfaction which are important pre-requisites to improving the patient centred quality health care.

The Department will continue to face budgetary pressure in 2013/14. Over and above the annual inflationary pressures, new or expanded services will be commissioned including, the Mitchells Plain Hospital, Hermanus Hospital and Knysna Community Day Centre, funding for the roll out of IT systems such as the Primary Health Care Information System and the total replacement of the EMS communication system and the extension of the Chronic Dispensing Unit service to the rural districts. The Department will reprioritise within the baseline allocation and increase operational efficiency across the service platform.

Strengthening prevention and promotion both within the health service as well as within the whole of government and society is an important goal. The Department has engaged the private sector to establish wellness centres which will provide basic screening for chronic diseases such as hypertension and diabetes. Pilot projects will be reviewed to assess the cost-effectiveness of these screening services. The recently launched Health Foundation will seek to increase additional funding streams for the Department.

In a year that will require fiscal discipline and efforts will be increased to achieve a "clean" audit, the Department will strive to improve the patient experience and health outcomes for the people of the Western Cape and beyond, who access our services.



PROFESSOR CRAIG HOUSEHAM
HEAD HEALTH: WESTERN CAPE
FEBRUARY 2013

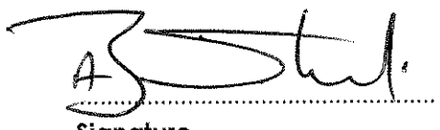
OFFICIAL SIGN-OFF OF THE

ANNUAL PERFORMANCE PLAN: 2013/14

It is hereby certified that this Annual Performance Plan:

- Was developed by the management of the Western Cape Government Health.
- Was prepared in line with the current Strategic Plan of the Western Cape Government Health, under the guidance of Minister Theuns Botha.
- Accurately reflects the targets which the Western Cape Government Health will endeavour to achieve given the resources made available in the budget for 2013/14.

Mr A Van Niekerk
Chief Financial Officer



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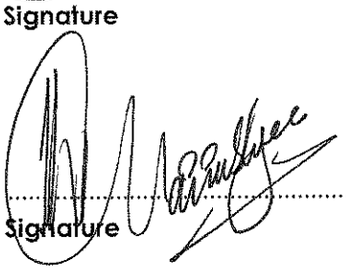
Dr KN Vallabhjee
Chief Director:
Strategy and Health Support



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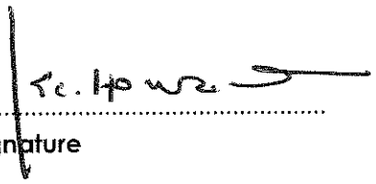
Professor KC Househam
Accounting Officer



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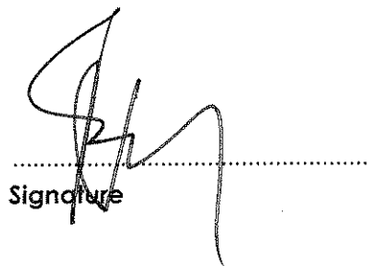
APPROVED BY:

Theuns Botha
Executive Authority



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CONTENTS

PART C: LINKS TO OTHER PLANS

EXECUTIVE SUMMARY

The 2013/14 Annual Performance Plan (APP) outlines the planned performance of the Department in relation to the allocated budget for 2013/14. Following the general election to be held during the course of 2014 a new five-year strategic plan for 2015/16 to 2019/2020 will be developed to give effect to the new five-year election mandate.

Part A of the APP provides a strategic overview of the Department and the environment within which it functions. This includes an overview of the overarching legislative and policy environment that guides the Department's planning such as the international Millennium Development Goals, the National Development Plan and the Negotiated Service Delivery Agreement between the President of the South Africa and the National Minister of Health on the key focus areas for health. In line with national policy the Department is piloting National Health Insurance (NHI) initiatives in the Eden District. At a provincial level the strategic objective for which the Department is the lead department, Increasing Wellness, aims not only to address the burden of disease but also to promote a positive state of wellness. This is a two-pronged approach, to provide an effective and comprehensive health service and to address the upstream issues that contribute to the burden of disease by co-ordinating inter-sectoral collaboration and promoting a whole of society approach.

The Department will finalise the 2020 strategic framework after the second round of public consultation. The 2020 framework will be tabled to the Western Cape Provincial Cabinet for approval. The vision, principles and values will provide direction for the Department during the coming decade. The planning tools contained in the document will be used to ensure the health service meets the needs of communities within the prevailing environment including the availability in funding. An important thrust of the 2020 strategy is to enhance the patient experience of the health service. An external service provider, with proven experience and skills, will facilitate the change management strategy to address staff attitudes in a two year project that will commence during 2013.

Part A provides an overview of the demography and burden of disease in the Province. In view of the lack of finality regarding the outcome of Census 2011, the Department has continued to use the previous projections based on Census 1996, 2001 and the Community Survey 2007. Census 2011 figures will be used for the 2014/15 financial year as required by Treasury.

The Department has recognised that the current organisational structure which consists of two service divisions is not conducive to an integrated approach to delivering patient-centred care Therefore the two service divisions will be amalgamated into a single service component. The building blocks of the service component are the six health districts, where the responsible district managers will ensure that the services are co-ordinated across all levels of service.

The key priorities identified by the Department for 2013/14 are:

1) Transversal imperatives:
    - Patient-centred experience and quality of care should underpin all the activities of the Department.
    - Improvements in efficiency and reduction of wastage.
    - Strengthening of the interaction between clinical staff and management at an operational level.
    - Improvement in communication between staff, patients and their families.
    - Development of a system of priority setting within the Department which is not so complex and time consuming that the Department is paralysed from action.
    - Strengthening and building cohesion within the health system as a whole.

2) Service priorities:

- Mental health including prioritising the management of behaviourally disturbed patients and becoming more responsive to the growing burden of mental ill-health.
- Neonatal and child health with improved and earlier antenatal care and the reduction of neonatal deaths.
- Maternal and women's health to address the causes of maternal deaths, strengthening family planning and improved screening for cervical and breast cancer.
- Reducing the elective surgery backlogs by increasing the number of cataract operations and focusing on surgery where cancer is curable if diagnosed and treated early such as breast, prostate, cervical and colon cancer.
- Prevention, detection and effective management of chronic diseases such as communicable diseases (HIV and TB) and non-communicable diseases (hypertension, diabetes and heart diseases).
- Emergency care and Emergency Medical Services with restructuring and upgrading of emergency centres through reprioritisation of resources from the current infrastructure projects and implementing the EMS communication software solution to modernise call taking and dispatch.

As a result of the downturn in the global and national economy, 2013/14 will be financially challenging. A reprioritisation exercise was undertaken and it is planned to realise savings from shifts of services, reduction in expenditure on goods and services and personnel to provide funding for the operational costs at the new Mitchells Plain Hospital, Du Noon Community Health Centre, Delft Community Day Centre and critical information communication technology projects.

Part B of the APP outlines the eight financial programme budget plans, providing an overview of the respective programmes, their respective challenges, priorities and risks and their performance targets and the related budget allocation.

A significant event for service delivery for 2013/14 will be the relocation of services, currently provided at the GF Jooste Hospital, to the new Mitchell's Plain Hospital around mid-2013. The emergency centre will be relocated temporarily to an enlarged emergency centre at Heideveld Community Health Centre while some of the higher level specialist services will be relocated to Groote Schuur Hospital.

There will be a number of infrastructure projects in the feasibility and planning phases and the following construction projects will be in the construction/ handover phase during 2013/14:

- Community Day Centres at Du Noon, Hermanus and Symphony Way in Delft;
- Robertson Ambulance Station;
- The new emergency centre at Karl Bremer Hospital
- Emergency centre and out-patient department at Knysna Hospital
- Renovation of the emergency centre at Tygerberg Hospital
- Installation of a new linear accelerator at Groote Schuur Hospital
- Upgrading of security at the Western Cape College of Nursing.

During 2013/14 it is projected that 15 252 132 patients will be managed at primary health care facilities, 514 593 patients will be admitted to acute hospitals and 10 955 will be admitted to specialised hospitals. Approximately 468 496 patients will be transported by ambulance, approximately 100 000 babies will be born in maternity services, 8 398 cataract operations will be performed and 157 123 patients will receive antiretroviral therapy. It is aimed to achieve a TB cure rate of 81.8 per cent, immunisation coverage of children under one year of 90.4 per cent and to reduce the mother-to-child transmission of the AIDS virus to 1.87 per cent.

The Chronic Dispensing Unit (CDU) overcame the challenges of the transfer to a new service provider during 2012/13 and is now dispensing and pre-packaging an average of 170 000 prescriptions for chronic medications per month for patients in the Cape Town Metro District and in part of the West Coast and Cape Winelands Districts. Distribution to alternative delivery sites such as local authority health sites has commenced. It is planned that this service will be extended to all five rural districts during 2013/14. The rollout of CDU services in the rural districts will include a two-month supply of medication, reducing the number of patient visits to sites for medicine collection only.

The strengthening of Information Communication Technology (ICT) will include the roll-out and strengthening of a comprehensive health information system service-wide, the implementation of the required ICT for emergency medical services and the development of the business intelligence system.

Quality of care remains a major focus for the Department and some of the specific initiatives include the development of a guideline for the patient-centred approach, continued to implementation of the critical measures of the national core standards and the development of a services charter that publicly commits the Department to a set of service standards.

Part C of the APP provides an overview of links to other plans such as the long-term infrastructure plans, an overview of the conditional grants that the Department receives and to public-private partnerships.

The Annexures provide an update on changes that have been made to the five-year strategic plan, the definitions of each of the performance indicators and also a list of facilities.

In conclusion, the Department remains committed to providing quality health for all by striving for best practice and the optimal utilisation of limited resources.

PART A

STRATEGIC OVERVIEW

PART A: STRATEGIC OVERVIEW

1. VISION

Quality health for all.

The vision statement is in the process of being reviewed as part of the consultation of the 2020 framework.

2. MISSION

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

3. VALUES

The core values of the Department are:

1) Caring
2) Competence
3) Accountability
4) Integrity
5) Responsiveness
6) Respect

4. STRATEGIC GOALS

The strategic goals of the Western Cape Department of Health are aligned with:

- The provincial government's vision to increase wellness in the Province.
- The Millennium Development Goals [MDGs].
- The national government's vision for health: "A long and healthy life for all South Africans", as reflected in the Negotiated Service Delivery Agreement [NSDA] between the President and the National Minister of Health.

The wording of the strategic goal titles and statements has been refined. The changes that have been made are underlined in the table below and included in Annexure A where changes to the 2009/10 Five-year Strategic Plan, are recorded. The strategic goals will be substantially reviewed once the 2020 strategy has been finalised.

Table 1: Strategic goals for Western Cape Government Health for 2010 – 2014 to improve wellness [A1]

STRATEGIC GOAL	GOAL STATEMENT	JUSTIFICATION	LINKS
1. Burden of disease.	1.1. Address the burden of disease.	This strategic goal relates to the core business of the Department, i.e. delivering a health service as well as advocating for interventions to address the upstream factors that generate this burden of disease. All the related strategic objectives are focussed on effective and efficient service delivery in order to maximise health outcomes/increase wellness.	Millennium Development Goals No 4, 5 and 6. Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: Burden of disease report. **Outcomes**: • Increase life expectancy • Decreasing maternal and child mortality • Combating HIV and AIDS and decreasing the burden of disease from tuberculosis • Reduce mortality and morbidity from injuries. Provincial strategic objective 04: Increase wellness.
2. Quality of health services.	2.1. Improve the quality of health services and the patient experience.	The purpose of this goal is to focus on the importance of delivering a quality service.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
3. Strategic management capacity and synergy.	3.1. Ensure and maintain organisational strategic management capacity and synergy.	This goal aims to ensure that: • The Department has a clear plan and targets against which to measure its performance. • Management systems are in place to optimally utilise available resources in a co-ordinated manner.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
4. A capacitated workforce.	4.1. Develop and maintain a capacitated workforce to deliver the required health services.	The purpose of this goal is to ensure that staff is adequately recruited and retained; appropriately trained and skilled to perform the functions for which they are employed.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
5. Health technology, infrastructure and Information Communication Technology (ICT).	5.1. Develop and maintain appropriate health technology, Infrastructure and ICT.	This goal addresses the provision of the appropriate infrastructure to deliver the required service in the most cost effective and efficient manner. It addresses buildings, equipment and information communication technology.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.

STRATEGIC GOAL	GOAL STATEMENT	JUSTIFICATION	LINKS
6. Financial management	6.1. Optimal financial management to maximise health outcomes	Given that the need for health services outstrips the available funding the purpose of this goal is to focus attention on: • The importance of appropriate budgeting and financial control. • The need to explore all appropriate avenues of revenue generation to supplement the budget. • Optimal value for the health rand and maximising efficiencies in all sections of the Department.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.

5. LEGISLATIVE MANDATES AND POLICY INITIATIVES

5.1 LEGISLATIVE MANDATES

5.1.1 The Western Cape Health Facility Boards Act, 2001 (Act 7 of 2001):

The Western Cape Health Facility Boards Amendment Act, 2012 (Act 7 of 2012) which amends the manner in which the Department regulates financial affairs of Health Facility Boards, was assented to on 7 December and published under Provincial Notice 370/2012 in Provincial Gazette No. 7069.

Preparatory work is being done on a further amendment in order to accommodate the changes to this Act as a result of the clauses of the National Health Act, 2003 [Act 61 of 2003] that came into effect from 1 March 2012. This amendment will make provision for transitional arrangements, pending the appointment of central hospital boards by the National Minister of Health, and for the provision of a legal framework for establishing clinic and community health centre committees.

5.1.2 The Western Cape District Health Council's Act, 2012 (Act 5 of 2012):

A Western Cape District Health Councils Amendment Bill has been drafted and published in the Provincial Gazette for public comment. The purpose of this Bill is to allow members of sub-districts in the Cape Town Metro District to be appointed to the District Health Council in order to ensure that the representation in the Metro District is comparable with that of the rural districts.

Section 30 of the National Health Act, 2003 (Act 61 of 2003), makes provision for the Provincial Minister of Health, in concurrence with the Provincial Minister of Local Government, to divide a province into sub-districts and to determine and change the boundaries of these sub-districts. This has been done and is published under Provincial Notice 349/2012 in Provincial Gazette 7063.

6. POLICY INITIATIVES

The policy initiatives that guide the strategy of the Department are outlined below. The Department's progress against the initiatives is reflected in paragraph 7.

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 Objectives:
	Western Cape Infrastructure Delivery Management System (IDMS)
Western Cape Government Health	Provincial Strategic Objective: Increasing wellness
	2020 strategic framework.

6.1 THE MILLENNIUM DEVELOPMENT GOALS [MDGS]

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

Table 2: Millennium development goals

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
1. Eradicate extreme poverty and hunger.	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children under 5 years of age.
		Proportion of the population below minimum level of dietary energy consumption.
2. Achieve universal primary education.	Ensure that by 2015, children everywhere, boys and girls alike, will able to complete a full course of primary schooling.	Net enrolment ratio in primary education.
		Literacy rate of 15 – 24 year-olds.
3. Promote gender equality and empower women.	Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.	Ratio of girls to boys in primary, secondary and tertiary education.
		Ratio of literate females to males of 15 – 24 year-olds.
4. Reduce child mortality.	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.	Under-5 mortality rate (U5MR).
		Infant mortality rate (IMR).
		Proportion of one-year old children immunised against measles.
5. Improve maternal health.	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	Maternal mortality ratio.
		Proportion of births attended by skilled health personnel.

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
6. Combat HIV and AIDS, malaria and other diseases.	Have halted, by 2015, and begun to reverse the spread of HIV and AIDS, malaria and other diseases.	HIV prevalence among 15 – 24 year old pregnant women.
		Condom use rate of the contraceptive prevalence rate.
		Number of children orphaned by HIV and AIDS.
		Proportion of the population in malaria risk areas using effective malaria prevention and treatment measures. (Prevention to be measured by the percentage of under 5 year olds sleeping under insecticide treated bed-nets and treatment to be measured by percentage of under 5 year olds who are appropriately treated.
		Prevalence and death rates associated with Tuberculosis (TB).
		Proportion of TB cases detected and cured under the directly observed treatment short course (DOTS).
7. Ensure environmental sustainability.	Halve, by 2015, the proportion of people without sustainable access to safe drinking water.	Proportion of people with sustainable access to an improved water source.
	By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers.	Proportion of urban population with access to improved sanitation.
8. Develop a global partnership for development.	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.	Official development assistance.
		Proportion of exports admitted free of duties and quotas.
	In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries.	Proportion of population with access to affordable essential drugs on an established basis.

6.2 NATIONAL GOVERNMENT

6.2.1 The Twelve National Outcomes of the National Government

The National Government will continue to follow an outcomes-based approach and the twelve targeted outcomes against which the National Ministers have signed performance agreements with the President are:

1) Improve the quality of basic education.
2) Create decent employment through inclusive economic growth.
3) Develop a skilled and capable workforce.
4) **Improve healthcare and life expectancy among all South Africans.**
5) Build a safer country.
6) Support an efficient, competitive and responsive economic infrastructure network.
7) Develop vibrant, equitable and sustainable rural communities that contribute to adequate food supply.
8) Protect our environment and natural resources.
9) Create sustainable human settlements and improved quality of household life.
10) Build a responsive, accountable, effective local government system.
11) Create a better South Africa, a better Africa and a better world.
12) Generate an efficient, effective and development orientated public services and an empowered, fair and inclusive citizenship.

6.2.2 The National Development Plan

The National Planning Commission (NPC), in the Presidency, released the Diagnostic Report in June 2011, which described South Africa's strategic achievements and challenges since 1994.

The NPC 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 inequality by 2030.

In terms of the plan, by 2030 the health system should provide quality care to all, free at the point of service, or paid for by publicly provided or privately funded insurance.

The NDP identifies the following areas of reform for the public health system:

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

6.2.2.1 Health care for all

Targets:

1) By 2030, life expectancy should reach at least 70 for both men and women.
2) The under-20 age group should largely be an HIV-free generation.
3) The infant mortality rate should decline from 43 to 20 per 1 000 live births and the under-five mortality rate should be less than 30 per 1 000 from 104 today.
4) Maternal mortality should decline from 500 to 100 from 100 000 live births.
5) All HIV-positive people should be on treatment and preventive measures such as condoms and micro-biocides should be widely available, especially to young people.
6) Reduce non-communicable diseases by 28 per cent and deaths from drug abuse, road accidents and violence by 50 per cent.
7) Everyone has access to an equal standard of basic health care regardless of their income.

Actions:

1) Address social determinants of health:
   Promote active lifestyles and balanced diets, control alcohol abuse and health awareness to reduce non-communicable diseases.

2) Reduce burden of disease to manageable levels:
   Broaden coverage of antiretroviral (ARV) treatment to all HIV-positive people, provide ARVs to high-risk HIV negative people and provide effective micro-biocides routinely to all women 16 years and older.

3) Build human resources for the health sector of the future:
   - Accelerate production of community specialists in the five main specialist areas (medicine, surgery, including anaesthetics, obstetrics, paediatrics and psychiatry)
   - Recruit, train and deploy between 700 000 and 1.3 million community health workers to implement community-based health care.

4) Strengthen the national health system:
Determine minimum qualifications for hospital managers and ensure that all managers have the necessary qualifications.

5) Implement national health insurance (NHI):
Implement the scheme in a phased manner, focussing on:
- Improving the quality and care at public facilities.
- Reducing the relative cost of private medical care.
- Increasing the number of medical professionals.
- Introducing a patient record system and supporting information technology systems.

6.2.2.2 **Education**

Another focus area of the NDP is improving education, training and innovation. In order to achieve this, a target has been set to eradicate child under-nutrition and vitamin A deficiency among children by 2030. By 2030 the feeding schemes in schools should cover all children in need and provide food that is high in nutritional content.

6.2.3 **Negotiated Service Delivery Agreement (NSDA)**

The specific national outcome for health is 'Improve healthcare and life expectancy among all South Africans', which is given effect in the Negotiated Service Delivery Agreement between the Minister of Health and the President. The focus areas of this agreement are:

1) Increasing life expectancy
2) Decreasing maternal and child mortality
3) Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis
4) Strengthening health system effectiveness.

Each of these outcomes has identified a number of related activities and indicators to monitor the progress towards achieving the outputs.

6.3 **National Health Systems [NHS] Priorities for 2009 – 2014: The National Department of Health Ten Point Plan**

Table 3: National Health Systems priorities for 2009 – 2014: The Ten Point Plan [A4]

PRIORITY	KEY ACTIVITIES
1. Provision of strategic leadership and creation of social compact for better health outcomes	1) Ensure unified action across the health sector in pursuit of common goals
	2) Mobilise leadership structures of society and communities
	3) Communicate to promote policy and buy in to support government programs
	4) Review of policies to achieve goals
	5) Impact assessment and programme evaluation
	6) Development of a social compact
	7) Grassroots mobilisation campaign
2. Implementation of National Health Insurance (NHI).	8) Finalisation of NHI policies and implementation plan
	9) Immediate implementation of steps to prepare for the introduction of the NHI, e.g. Budgeting, Initiation of the drafting of legislation
3. Improving the quality of health services.	10) Focus on 18 Health districts
	11) Refine and scale up the detailed plan on the improvement of quality of services and directing its immediate implementation

PRIORITY	KEY ACTIVITIES
	12) Consolidate and expand the implementation of the health facilities improvement plans
	13) Establish a national quality management and accreditation body
4. Overhauling the health care system and improving its management.	14) Identify existing constitutional and legal provisions to unify the public health service
	15) Draft proposals for legal and constitutional reform
	16) Development of a decentralised operational model, including new governance arrangements
	17) Training managers in leadership, management and governance
	18) Decentralisation of management
	19) Development of an accountability framework for the public and private sectors
5. Improved human resources planning development and management.	20) Refinement of the HR plan for health
	21) Re-opening of nursing schools and colleges
	22) Recruitment and retention of professionals, including urgent collaboration with countries that have excess of these professionals
	23) Specify staff shortages and training targets for the next 5 years
	24) Make an assessment of and also review the role of the Health Professional Training and Development Grant (HPTDG) and the National Tertiary Services Grant (NTSG)
	25) Manage the coherent integration and standardisation of all categories of community health workers
6. Revitalisation of infrastructure.	26) Urgent implementation of refurbishment and preventative maintenance of all health facilities
	27) Submit a progress report on Revitalization
	28) Assess progress on revitalisation
	29) Review the funding of the revitalization programme and submit proposals to get the participation of the private sector to speed up this programme
7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases.	30) Implementation of prevention of mother-to-child transmission (PMTCT), paediatric treatment guidelines
	31) Implementation of adult treatment guidelines
	32) Urgently strengthen programs against TB, MDR-TB and XDR-TB
8. Mass mobilisation for the better health for the population.	33) Intensify health promotion programmes
	34) Strengthen programmes focusing on maternal, child and women's health
	35) Place more focus on the programmes to attain the Millennium Development Goals (MDGs)
	36) Place more focus on non-communicable diseases and patients' rights, quality and provide accountability
9. Review of drug policy.	37) Complete and submit proposals and a strategy, with the involvement of various stakeholders
	38) Draft plans for the establishment of a state-owned drug manufacturing entity
10. Strengthening Research and Development	39) Commission research to accurately quantify infant mortality
	40) Commission research into the impact of social determinants of health and nutrition
	41) Support research studies to promote indigenous knowledge systems and the use of appropriate traditional medicines

6.3.1 **National Health Insurance**

The National Department of Health has released a Policy Paper on National Health Insurance (NHI) in South Africa for public comment. It is envisaged that the NHI 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 and strengthen district health services in the public sector.

The Department's initiatives which includes: a baseline assessment of compliance with the national core standards in six priority areas at all facilities; building the capacity and systems at the level of district management; the district specialist teams from regional hospitals providing outreach and support and clinical governance oversight; primary health care re-engineering and the strengthening of school health services, which are all in line with the broad direction of the NHI.

6.3.1.1 **District Situational Analysis**

The National Department of Health identified ten pilot sites in South Africa in which to develop frameworks and models to strengthen the performance of the public health system in preparation for the phased implementation of the National Health Insurance (NHI). In the Western Cape, the Eden District, with an estimated population of approximately 586 834 persons of which 85% are uninsured, was identified as a site for piloting innovations related to the District Health Services.

6.3.1.2 **Strategic goal of the pilot:**

Develop frameworks and models that can be used to roll out the National Health Insurance (NHI) pilots in districts and central hospitals critical to achieving the phased implementation of NHI.

6.3.1.3 **Purpose of the NHI Grant:**

- Test innovations necessary for implementing National Health Insurance.
- To establish District Health Authorities (DHA's) that will be the contracting agencies for the delivery and provision of health services within a strengthened district health system.
- To undertake health system strengthening initiatives in selected pilot districts.
- To support selected pilot districts in implementing identified service delivery interventions.
- To strengthen the resource management of primary health care facilities and hospitals.

6.3.1.4 **NHI Grant outcome statements:**

- Strengthened district health services.
- Improved access to quality health services.
- Strengthening efficiencies of the public health sector and improved health systems performance.
- Improved management of health systems and services at a district level.

1) **Summary of the interventions to be piloted**

The focus of all interventions within the NHI pilot is to ensure that South Africans have access to quality health services, experience reduction in the burden of disease, especially that borne by women and children, and to experience improvements in the overall health system performance.

2) **Summary of key outputs and activities**

A range of outputs and activities have been identified, culminating in a number of projects that were finalised in November 2012. The following projects have been identified for the 2012/13 financial year and have been funded by the NHI grant:

- Development of an appropriate HR, Finance and Supply Chain model for strengthening the District Health System;
- Revision of contract management;
- Situational analysis of patient referral system at George Hospital;
- Primary health care patient folder management review and improvements;
- Community health worker training;
- Development of an eye-care model for the Eden District;
- Review and improvement of consumables management;
- Policy review and development of the home and community based care (HCBC), adherence support and counselling, mental health framework, and operational research;
- Appointment of a project co-ordinator and a project administrator;
- Audit and mapping of private health care providers in the Eden District;
- Appointment of general practitioners at PHC facilities on a sessional basis;
- Policy development for facility committees, training of District Health Council members and facility committees;
- Folder management in all PHC facilities in the Eden District;
- Appointment of additional school health staff in the Eden District.

3) **Summary of key deliverables**

A variety of products will be delivered. Each of the projects and activities will be done in a scalable manner and will be thoroughly documented. The deliverables will include reports, databases, GIS products, service delivery models, policy frameworks, operational systems, training of staff, facilitation of changes, and management presentations. The following are the main deliverables per project:

- HR, finance and supply chain management delegation model;
- GIS mapping and profiling of health professionals;
- Standardized contract management procedures;
- Situational analysis and input to referral policy;
- Standardized folder management system, training and change facilitation;
- Training manuals and training on chronic diseases;
- Sustainable eye-care model;
- Review of HCBC and intellectual disability policy, with recommendations;
- Standardised list of medical consumables;
- PHC policy review of PHC facility committees and training;
- Purchasing of medical equipment and computers for PHCs;
- Appointment of general practitioners on sessional bases at PHCs;
- Appointment of school health staff.

6.3.1.5 District specialist teams: George Hospital

Although this is part of the overall strategy, it has not been part of the funding envelope of the first year's approved business plan.

- Additional specialists in obstetrics and gynaecology, paediatrics, anaesthetics, internal medicine and family medicine were appointed to the George Hospital establishment, as part of the Department's established practice of providing specialist outreach and support from regional to district hospitals.
- Additional professional nurses have been appointed in the following areas: paediatrics, obstetrics, theatre, and primary health care.

Currently all of the costs for these appointments are funded through the equitable share component of the George Hospital budget.

6.3.2 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 table below summarises the Western Cape Government Health's contribution to the eleven Provincial strategic objectives:

Table 4: Summary of Western Cape Government Health's contribution to the provincial strategic objectives

Provincial strategic objective	Contribution of the Western Cape Government Health
1. Creating opportunities for growth and jobs (SO1)	The Department is the second largest employer in the provincial government after the Western Cape Government: Education with approximately 29500 staff at the end of March 2012. Furthermore In 2012/13, the following staff were temporarily employed and trained: • 2 100 community health workers • 150 data capturer interns • 130 pharmacist assistants • 120 assistants to artisans interns • 130 human resource and finance interns. • 140 EMS Basic Ambulance Assistant interns
2. Improving education outcomes (SO2)	The Department is collaborating with Western Cape Government Education and Cultural Affairs and Sport in the development of Mass participation, Opportunity and access, Development and Growth (MOD) Centres, an afterschool programme to increase wellbeing of learners by offering physical and cultural activities.
3. Increasing access to safe and efficient transport (SO3)	Emergency Medical Services planned patient transport or HealthNET performs outpatient transfers between levels of care within districts and across districts to regional and tertiary hospitals. Approximately three thousand patients per month are transported to Cape Town hospitals from rural areas. The above excludes the approximately 472 000 patients transported for emergencies by ambulances per year.

Provincial strategic objective	Contribution of the Western Cape Government Health
4. Increasing wellness (SO4)	Refer to paragraph 6.3.3.1
5. Increasing safety (SO5)	The interventions for injury prevention as discussed below would contribute to safety as well. [Refer to paragraph 5.3 below]
6. Developing integrated and sustainable human settlements (SO6)	The Department endeavours to position new health facilities where there is service demand due to population expansion. The Department is part of the workgroup in this Strategic Objective to provide input Into the process of developing integrated and sustainable human settlements. The Department also takes into consideration the spatial planning and other development frameworks of local government when it plans health services.
7. Mainstreaming sustainability and optimising resource use efficiency (SO7)	The primary objective of the infrastructure programme in the Department is to promote and advance the health and well-being of all individuals and populations in the province in an ecologically responsible manner. This objective will be met through the implementation of the "5Ls Agenda" in all new buildings/projects. The "5Ls Agenda is: 1) Long life (sustainability), 2) Loose fit (flexibility and adaptability), 3) Low impact (reduction of carbon footprint), 4) Luminous healing space (enlightened healing environment). 5) Lean design and construction (collaborative and integrated) This aligns to the Provincial Strategic Objective 7: "Mainstreaming sustainability and resource-use efficiency", as well as the National Climate Change Response White Paper of October 2011. The Department has also formed a Climate Change Committee to investigate the adverse effects of climate change on the population and to help the Department build its resilience to respond. The Department has identified Khayelitsha Hospital and the Lentegeur Psychiatric Hospital as part of its commitment to the 110 per cent Green Economy campaign. The Department is also supportive in principle of the Green Procurement Policy and will implement the cost effective recommendations within its available resources.
8. Promoting social inclusion and reducing poverty [SO8 and SO9 are being combined)	The Department aims to deliver quality health services for all and to ensure that wellness is attained through prevention of disease. This contributes to the reduction of poverty because healthy people are more likely to be economically active, attend school and have good education outcomes. The provision of free and accessible PHC services and affordable hospital services provides a safety net and prevents catastrophic expenditure for poor families.
Increasing social cohesion [SO8]	
Poverty reduction and alleviation [SO9]	

Provincial strategic objective	Contribution of the Western Cape Government Health
9. Integrating service delivery for maximum impact (SO10)	The Department has adopted Geographic Service Areas (GSA) to overcome the fragmented service and functional silos associated with historical divisions between institutions and services, working within different budget programmes. The GSA concept provides a functional arrangement to facilitate better cohesion and co-ordination of health services for a defined population within a specified geographic area to ensure the delivery of specific health outcomes. At district level, District Management teams have working relationships with other departments such as Education, Social Development and local municipalities to address in particular social determinants of health e.g. in Cape Winelands District the District Management collaborates with the local Social Development and Education Management teams to understand the root causes of teenage pregnancy and jointly develop an intervention to address this. The Department has collaborated effectively with other departments and spheres of government to co-ordinate and manage the response to the diarrhoeal season which has resulted in a significant reduction in admissions and child deaths. The Department will be working closely with the Department of Education to strengthen school health services. Through the PTMS the Department collaborates with various other departments on the programmes to increase wellness.
10. Increasing opportunities for growth and development in rural areas (SO11)	As reflected in Part B: Programme 8 of the document, most of the infrastructure projects in progress are in the rural areas.
11. Building the best-run provincial government in the world (SO12)	The Department is collaborating with the Department of the Premier and Sports Science Institute of South Africa to develop a pilot workplace programme on employee wellness for the provincial government. The Department is developing a patient-centred approach to health care delivery which is in keeping with the citizen centric policy of the WCG. As part of the service delivery improvement plan, the Department is also developing a Health Services Charter which publicly commits the Department to certain service standards.

6.3.3 Provincial Transversal Management System [PTMS]

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 and improve outcomes.

The strategic objectives are clustered into three sectors:

1) Human development,
2) Economic and infrastructure, and
3) Administration and inter-governmental.

Steering groups co-ordinate the working groups tasked with addressing each of the strategic objectives.

6.3.3.1 **Provincial Strategic Objective 4: Increasing wellness**

The Western Cape Government Health is the lead department for this strategic objective which is described as follows.

1. INTRODUCTION

The Government of the Western Cape is committed to increasing the wellness of the people of the Province. Wellness is defined as not merely the absence of disease but rather the ability to fulfil one's potential in all spheres of life. This will be achieved by co-ordinating measures to address the upstream factors that contribute to the burden of disease and through the provision of comprehensive quality health care services, from primary health care to highly specialised services.

2. PROBLEM STATEMENT

The wellness of the people of the Western Cape is undermined by the growing burden of disease, the root cause of which is socio-economic deprivation.

Comprehensive strategies that address issues such as education, poverty, and housing, together with improved health services, are required to ensure wellness. However the required joint planning across departments, municipalities and sectors to ensure calculated, co-ordinated, targeted interventions to deliver optimal outcomes is lacking. Although many of the provincial health outcomes are superior to the national average and there are many areas of excellence, the health system does not consistently provide quality health care to all patients.

3. THE APPROACH TO INCREASING WELLNESS

The approach to increasing wellness in the Western Cape is based on the framework developed by the WHO Commission on Social Determinants of Health that highlights the following five factors of importance:

1) **Socio-economic context and position**. People's social class, gender, ethnicity, education, occupation and income levels are a critical risk factor in wellness. These issues are often driven by policies outside of the health sector yet are central to ensuring wellness.

2) **Differential exposure.** The exposure to most risk factors (behavioural, societal, and environmental) is inversely related to the socioeconomic position. It is for example more difficult to have a healthy lifestyle if you are from a poor community because healthy foods are more expensive there and less readily available; there is limited access to open and safe open spaces to exercise. Similarly poor communities tend to have unhealthy houses and live in unhealthy environments with poor water and sanitation and are therefore more likely to contract infectious diseases such as diarrhoea and pneumonia.

3) **Differential vulnerability.** The social, cultural and economic environments influence the vulnerability of people in such a way that the same level of exposure could have different outcomes. For example, high access to cheap alcohol has very different consequences if clustered with social exclusion, low income, malnutrition, poor housing and poor access to health services, high levels of mental ill-health as in South Africa, resulting in very high mortality and morbidity compared to some developed countries.

4) **Differential health care outcomes.** The attainment of health outcomes and thus wellness is influenced by the socio-economic context and the resulting differential exposure and vulnerability to disease as discussed above

5) **Differential consequences**. Poor health outcomes may have social and economic consequences such as inability to work and earn a living. The resulting poverty, loss of health insurance or disposable income to pay for transport to access health services and social exclusion may further increase vulnerability to ill-health, loss of earnings, and loss of ability to work and social isolation or exclusion. In addition, sick people often face additional financial burdens that render them less able to pay for health care and medication. Advantaged population groups are better protected from this in terms of job security and health insurance.

4. PLAN TO INCREASE WELLNESS: THE ROLE OF WESTERN CAPE GOVERNMENT HEALTH

4.1 Development of a new strategy towards 2020

The Department has developed the 2020 strategy outlining the long-term strategy of the Western Cape Government Health in its endeavours to increase wellness by improving the quality of health services.

4.2 Principles of 2020

The seven key principles of 2020 with a description of each are listed below:

1) **Patient-centred quality care**:
   - Provide a superior patient experience.
   - Treat patients with dignity, respect, caring and empathy.
   - Provide appropriate clinical treatment.
   - Patient safety is 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.
   - The focus areas are:
     - Increase life expectancy
     - Reduce chronic diseases of lifestyle and their consequences

- Reduce incidence of infectious diseases [HIV/AIDS and TB]
- Reduce child mortality
- Reduce maternal mortality
- Reduce injury-related mortality and morbidity
- Reduce mental health burden
- Superior patient experience.

3) **Primary health care (PHC) philosophy**:

- Provide comprehensive services that include preventive, promotive, curative and rehabilitative care.
- Primary health care is 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 Cape Town Metro District.

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) **Cost effective and sustainable health service**:

- The health service must function within its allocated budget.
- Health services must be planned according to the need for services and quantified in terms of the services that will sustainably be provided within the projected budget.
- There is advocacy to address funding gaps between the projected funding allocation and the projected need for services.
- Alternative sources of funding of health services are pursued.
- Promotion of optimal efficiency at all levels of the service to maximize the value of the health Rand.

7) **Strategic partnerships**:

- Strong relationships are 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.: Western Cape Government Transport and Public Works, Centre for e-Innovation
  - Other spheres of government
  - Private sector

4.3 Immediate action

The Department is working to improve service delivery based on the vision and principles of 2020, whilst continuing to further develop the technical modelling of the strategy.

Extensive technical work has been done on the approach and methodology for determining the requirements for community-based services, primary health care and hospitals. The number and type of hospital beds required and their relative distribution within the geographic areas is being addressed.

The Department is about to finalise the 2020 strategic framework after considering the public comment from a second round of public consultation. The 2020 framework will be tabled to the Western Cape Provincial Cabinet for approval. The vision, principles and values provide direction to the Department for the next decade. Planning tools will be used to match the health service to the local needs of communities as well as changing circumstances.

The Department has secured the services of an external service provider to develop and implement a change management programme to cultivate a positive change in staff attitudes to improve the patient experience within the health service.

A substantially revised version of the 2020 strategy will be made available for comment shortly. In revising the document the comments received on the first draft were taken into consideration and it also includes the technical work done to date. The 2020 framework will be adopted by the provincial cabinet in the first quarter of the 2013/14 financial year.

5. PLAN TO INCREASE WELLNESS: ALL OF GOVERNMENT; WHOLE OF SOCIETY

The social determinants of health often fall outside of the mandate of the Department of Health and can only be effectively addressed through an inter-sectoral approach that includes all of government and the whole of society. The Department strengthens its inter-sectoral influence through advocacy, collaboration and strategic partnerships.

5.1. **Strengthening the advocacy role of the Western Cape Government: Health**:

The advocacy role of the Western Cape Government: Health includes:

- The ability to provide mortality and morbidity information that identifies the communities most affected by the burden of disease and their exposure and vulnerability to associated risk factors;
- Providing the evidence that shows the interventions that have been proven to successfully work elsewhere or in similar contexts;
- Working with other role players to support the design and testing of these interventions locally;
- Establishing early warning systems for important risk factors and surveillance systems for monitoring disease trends;
- Providing a system to monitor and evaluate progress towards addressing health outcomes and providing recommendations on further action to be taken.

To perform this role the Department has invested in the Chief Directorate: Strategy and Health Support that includes Strategic Planning, Health Impact Assessment, Information Management and ICT, and Monitoring and Evaluation to provide the technical support to the Department and other role players. This unit consists of both technocrats and academics and has strategic partnerships with local universities and research institutions such as the Medical Research Council, Human Sciences Research Council and civil society.

Focus areas based on the profile of the burden of disease in the Province:

5.2. **Decreasing the incidence of infectious diseases (HIV and TB)**:

There are five main priority areas to reduce HIV and TB:

1) Promote HIV testing through the HIV counselling and testing campaign (HCT).
2) Promote the use of condoms in males and females.
3) Male medical circumcision.
4) Behaviour change to:
    - Reduce early sexual debut, concurrency, multiple partners, alcohol misuse, drug abuse and increase condom use.
    - Social mobilisation to encourage:
        - Male medical circumcision.
        - HIV testing and counselling.
5) Active TB case finding and promoting adherence to treatment until completion.

The Provincial AIDS Council (PAC) provides strategic leadership and is responsible for monitoring and evaluation for the multi-sectoral response. It has been strengthened through the establishment of a secretariat office. A technical committee of PAC, called the Programme Review Committee, has been established to co-ordinate the evidence-based joint planning, implementation, monitoring and evaluation of the multi-sectoral response including interventions sponsored by big funders like PEPFAR.

5.3. **Preventing violence and road injuries**:

The Department is strongly aligning with area-based interventions in the City of Cape Town such as the Violence Prevention through Urban Upgrade (VPUU) project. This is aimed at uplifting formerly neglected, dysfunctional areas which are rapidly regressing. The goal is to improve safety, quality of life and the socio-economic situation with a particular focus on the shared/public environment.

The following interventions are being implemented more broadly:

A focus on selected high risk areas to deliver inter-sectoral alcohol-related violence reduction interventions which include:

1) Reducing supply of alcohol and creating safer drinking environments through the implementation of the Western Cape Liquor Act, led by the Department of Economic Development and Tourism. The Department will evaluate the impact of the implementation of this Act in Khayelitsha.

2) Reducing alcohol demand through:
   - Booza TV campaign based on Booza TV which is an entertaining and provocative documentary mini-series consisting of six 24-minute episodes, which challenge the misperceptions that South Africans have about alcohol, alcohol abuse and how to reduce alcohol-related harm. This is widely available on the World Wide Web (www.boozatv.com) and is also being used by the civil society, schools, health facilities, traffic department shadow centres.

3) Violence prevention policy
   As the causes and risk factors for violence and injuries are multifactorial, an Integrated Provincial Violence and Injury Prevention Policy, that includes other relevant departments, is being developed, to institutionalise a consistent, long-term commitment to safety promotion and violence and injury prevention. This is consistent with international best practice.

   The aim of the Integrated Provincial Violence and Injury Prevention Policy will be to ensure:
   - Adherence to the key attributes of successful violence and injury prevention approaches, namely:
     - An intervention approach driven by an accessible evidence base and reliable injury surveillance data;
     - The strategic and systematic deployment of prevention resources to target high-risk times, places and groups at-risk;
     - The on-going monitoring of outcomes and risk factors for refinement and improvement;

- Balancing programmatic and policy interventions likely to reduce violence in the short term (such as those that reduce access to lethal means, e.g. firearms, and the use of drugs associated with violence and aggressive behaviour, e.g. alcohol) and interventions that affect sustained long-term change to the social environment and societal norms that support violence (such as infrastructure for improved early childhood development and positive parenting);

- The establishment of a review and consultation process across relevant departments to align existing performance priorities and deliverables;
- On-going consultation with state and non-state actors across the political spectrum as well as community organisations and stakeholders; and
- The institutionalisation of an inter-sectoral framework that supports and sustains multi-dimensional prevention strategies over a long period to protect them from political vicissitudes.

4) Surveillance and evaluation:
The Department has established an injury mortality and morbidity surveillance system using data from trauma units, forensic pathology laboratories and the Department of Home Affairs. The establishment of a surveillance system and the evaluation of interventions will be used to describe the burden of injuries in the communities, inform a prioritisation process and inform targeting of interventions.
The Department will provide the evidence for effective interventions and support the development of a community level observatory to provide outcome data that can support targeting of interventions by government, civil society and communities.

5.4. **Promoting a healthy lifestyle**:

The key priorities in promoting healthy lifestyles that affect cardiovascular diseases in particular includes:

1) Encouraging healthy eating.
2) Increasing physical activity.
3) Reducing smoking.

This will be done using a settings approach, and targeting three key settings:

- The School
  - Screening of all Grade R and 1 pupils.
  - The School Health Programme.
- The Workplace
  - A workplace programme for Western Cape Government staff is being developed in collaboration with the employee wellness sub-group in Strategic Objective 11: Building the best-run provincial government in the world.
  - Workplace wellness programmes in other sectors will also be advocated.

- The Community
  The Department is exploring the establishment of wellness centres aimed at increasing awareness of chronic disease and improving access to screening and behaviour modification services. The key principles for these wellness centres will be:
  - Providing free health checks;
  - Prioritising people living in under-resourced communities;
  - Positioned outside of the health services within communities;
  - Locating in well frequented places in communities such as shopping centres;
  - Strategic partnerships with local pharmacies and other groups;
  - Targeting younger people (25 – 54y);
  - Ensuring strong referral linkages with health sector;
  - Monitoring and evaluation.

5.5 **Improving women's health (WH):**

1) The Department has prioritised an inter-sectoral programme to provide intimate partner violence screening and services.

2) Employment opportunities for women with skills from poor socio-economic areas are provided through the Expanded Public Works Programme, especially through the community health worker programme.

3) Key women's health programmes such as the prevention of breast and cervical cancer, and reproductive health services are provided.

5.6 **Improving maternal and child health:**

The strategy from Western Cape Government: Health to deliver on the targeted outcomes is two pronged. The focus on health sector interventions that include:

- Prioritising perinatal and maternal health within health services;
- Ensuring all health facilities are mother and baby friendly and encourage breastfeeding;
- Strengthening the community health worker programme to move towards geographic coverage;
- Developing and implementing an evidence based breastfeeding restoration policy that takes into account social determinants and provides recommendations for inter-sectoral action;
- Continue to improve the quality and universal coverage of child health services such as immunisation.

The second prong of the strategy is that of advocacy and collaboration. The Department will:

- Continue to collaborate with SO8 and advocate for an approach that strengthens families and promotes an evidence-based "well family concept".
- Continue to collaborate with SO8 on ECD and particular around nutritional support.
- Advocate for particular vulnerable communities with adverse child and maternal health outcomes based on the mortality and morbidity surveillance system.

5.7 **Mental health:**

The Life Course approach needs to be employed to address mental health and to focus on the following four periods:

- The Perinatal Period
  Improving perinatal mental health has been shown to yield very high returns in health outcomes of women and of children. These outcomes are sustainable with long term effects on the child in particular that can be identified even in adulthood. Currently there is reasonable coverage and frequency of contact for the antenatal period. Intervening at this stage is likely to yield very high impact over the medium to long term. A pilot project is being implemented at Mitchell's Plain MOU to address perinatal mental health.
- Childhood
  Early childhood development also yields a very high return on investment and is shown to be effective even up to 27 years post intervention. The Department is collaborating with Western Cape Government Social Development and other partners in the provision of early childhood development services.
- Adolescence
  Mental Health Programme in schools: nearly half of grade 10-12 year olds have mental health problems with substance abuse particularly alcohol being the major problem. The collaboration within MOD Centres will also seek to address the susceptibility to mental ill-health in adolescents.
- Adulthood
  The integration of mental health services in PHC, HIV and chronic disease services, that is being planned as part of the Healthcare 2020 strategy, will make provision for services for approximately half the adults with these co-morbidities.

6.3.3.2 **Provincial strategic objective 12: Building the best run provincial government in the world:**

This is the overarching provincial objective which is led by the Department of the Premier and which is given effect through the following workgroups:

1) Efficient and transparent institutional governance;
2) Financial management;
3) People management;
4) E-government;
5) Citizen-centric service delivery; and
6) Management for results.

The Chief Director: Human Resources Health is responsible for the implementation of the strategic initiative to develop an empowering and enabling people management framework that includes policies, systems and toolkits. A strategic human resources team has been established in the WCG: Health to develop an integrated human resource strategy for the Department. The team has formulated a draft position paper and an action plan to address the initiative and the human resource strategy for the Department.

eGovernment for the Western Cape Government: Health

Electronic Government (eGovernment) is the sustainable use of Information Communication Technology (ICT) to enable improved access to information; improved service delivery and encourage citizen participation in decision making.

Government, through the use of ICT and Internet-based solutions in particular, is able to enhance the access to information and improve service delivery not only to citizens but also to business partners, employees, and government entities.

The WCG: Health aspires to a high level of eGovernment maturity, as interactions between government and citizens are smoother, easier and more efficient in countries where a high level of eGovernment maturity exists. This has resulted in improved relationships between governments and the public in these countries.

6.3.4 Departmental reorganisation: Geographic service areas [GSAs] and departmental priorities

The Department has recognised that the current organisational structure, consisting of two service divisions, and eight budget programmes is not conducive to a holistic and systemic approach to delivering patient centred care.

The current divisions are:

- District Health Services [DHS] which provides community-based services, primary health care, and district and TB hospital services.
- Specialised and Emergency Services [SPES] which includes: regional and psychiatric hospitals, the Western Cape Rehabilitation Centre, dental training hospitals, central hospitals, Emergency Medical Services and the Forensic Pathology Service.

It is recognised that the eight budget programmes are nationally determined and that appropriate steps will have to be taken with Treasury and the National Department of Health in the future planning cycle, in order to make any changes to this structure.

Clients, either patients or those with whom the Department does business, need to experience the Department as a single coherent entity. This is particularly important if patients are to move smoothly along their required care pathway.

It has therefore been decided that the current two service divisions will be combined into a single service component with effect from 1 April 2013. A new organisational structure is in the process of being developed to match this change.

Geographic Service Areas (GSAs)

The GSA mechanism is defined as:
"The GSA mechanism, the formally endorsed decentralised unit for planning, is a functional means to render comprehensive, coherent services to a defined population in a defined geographical area (a district mandated by law) by integrating services that are managed and delivered within a district, with services that are delivered by structures managed outside of the district."

Functions of the GSA:

1) Facilitate transversal local planning of health services within a defined geographic service area.
2) Co-ordinate the implementation of transversal departmental and geographic service area priorities.

3) Monitor the co-ordinated implementation of transversal departmental service delivery priorities within the defined geographic service area.

4) Identify and address transversal service delivery challenges within the defined geographic service area in a co-ordinated manner.

The boundaries of the GSAs and the districts are co-terminous, i.e. there are five rural GSAs and one Cape Town Metro District GSA.

The Chief Director: Metro District Health Services [MDHS] and the Chief Director: Rural District Health Services [RDHS] will take responsibility for the two Metro and three rural GSAs respectively. The relationship between these two chief directors and the respective service managers located within the districts be formalised in terms of 'accountability for GSA deliverables' agreements. The managers involved include:

- The respective DHS district and substructure managers;
- CEOs of central and tertiary hospitals;
- Chief Director: Specialised and Emergency Services;
- Regional and specialised hospital CEOs;
- EMS area managers;
- Forensic Pathology Service managers.

Support function managers, e.g. the Chief Financial Officer [CFO], Human Resources, Strategy and Support, and Infrastructure will provide appropriate technical support to the GSAs via the Chief Directors: MDHS and RDHS.

The GSAs are functional arrangements to enhance service delivery and will not impinge on the statutory structures and powers of the districts and the respective management teams in districts and facilities.

6.3.4.1 **Departmental transversal imperatives:**

Following a two-day planning session in June 2012, the Department identified the following transversal imperatives to be addressed going forward:

1) A focus on the patient-centred experience and quality of care should underpin all the activities of the Department.

2) Improvements in efficiency and reduction of wastage. This ranges from inappropriate tasks undertaken by clinical staff to reducing the number of items prescribed to patients.

3) Strengthening of the interaction between clinical staff and management at an operational level.

4) Improvement in communication between staff, patients and their families, between various categories of staff in an institution and between institutions across the service platform to build improved relationships and improve the quality of services.

5) Development of a system and method of priority setting within the Department.

6) Strengthening and building cohesion within the health system as a whole.

6.3.4.2 **Service priorities:**

The following are the service and therefore funding priorities of the Department:

1) Mental health:
   - Focus on and prioritise the management of behaviorally disturbed patients.

- Reduce the revolving door syndrome of patients with frequent admissions to psychiatric hospitals by increased community support.
- The Department will also investigate other options of becoming more responsive to the unfolding burden of mental ill-health.

2) Neonatal and child health:
   - Improved and earlier antenatal care.
   - Continued focus on prevention of mother-to-child transmission.
   - Focus on particular aspects of neonatal care to reduce neonatal deaths.

3) Maternal and women's health:
   - Addressing the causes of maternal deaths.
   - Widening cancer screening for cervical and breast cancer.
   - Strengthening family planning.

4) Reduce elective surgery backlogs by:
   - Increasing the cataract surgery output.
   - Increase access to non-malignant prostate surgery.
   - Focus on cancer surgery where yields are the greatest, i.e. curable if diagnosed early:
     - Breast cancer
     - Prostate cancer
     - Cervical cancer
     - Colon cancer

5) Prevention, detection and effective management of chronic diseases:
   - Communicable diseases (HIV and TB).
   - Non-communicable diseases (hypertension, diabetes and heart diseases).

6) Emergency care and Emergency Medical Services:
   - Focus on restructuring and upgrading of Emergency Centres with reprioritisation of resources from the current infrastructure projects.
   - Resolve outstanding issues and finalise the procurement of the EMS communication software solution to modernise call taking and dispatch at the minimum.

The Departmental Indicator Workgroup will finalise a list of essential indicators to track the implementation of the service priorities across the GSAs. Quarterly performance reviews will be conducted per GSA/District to monitor performance and facilitate appropriate action.

7. SITUATION ANALYSIS

7.1 POPULATION PROFILE

7.1.1 Major demographic characteristics

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

Based on the outcome of the Community Survey 2007, the Western Cape has a population density of approximately 40.8 persons per square kilometre. The Cape Town Metro District accommodates approximately 66 per cent of the population and displays higher density ratios, which is significant for planning purposes. The remainder of the population is

distributed more sparsely, in approximately equal proportions between the other rural districts, i.e. Cape Winelands, Overberg, Eden, and West Coast, with the exception of the Central Karoo, which is very sparsely populated.

[Note that the population figures will be updated with the Census 2011 figures as soon as all the necessary data is available.]

Table 5: Population estimates

District	Census 2001	Community Survey: 2007	2008 2008/09	2009 2009/10	2010 2010/11	2011 2011/12	2012 2012/13	2013 2013/14	2014 2014/15	2015 2015/16	% Uninsured
City of Cape Town	2 892 243	3 497 097	3 553 571	3 638 959	3 724 347	3 809 735	3 895 123	3 980 511	4 065 899	4 151 287	76%
Cape Winelands	630 492	712 413	726 687	740 556	754 426	768 295	782 165	796 034	809 903	823 773	77%
West Coast	282 672	286 750	299 888	304 901	309 914	314 926	319 939	324 952	329 965	334 978	83%
Overberg	203 519	212 836	223 706	228 499	233 292	238 086	242 879	247 673	252 466	257 259	83%
Eden	454 924	513 308	528 676	540 302	551 937	563 573	575 206	586 834	598 457	610 076	85%
Central Karoo	60 482	56 229	59 238	59 822	60 407	60 991	61 576	62 160	62 744	63 329	86%
Western Cape	**4 524 332**	**5 278 634**	**5 391 765**	**5 513 039**	**5 634 323**	**5 755 607**	**5 876 887**	**5 998 164**	**6 119 435**	**6 240 702**	78%
Uninsured											
City of Cape Town	2 209 674	2 671 782	2 714 928	2 780 164	2 845 401	2 910 637	2 975 874	3 041 110	3 106 346	3 171 583	
Cape Winelands	483 587	546 421	557 369	568 007	578 645	589 282	599 920	610 558	621 196	631 834	
West Coast	235 183	238 576	249 507	253 677	257 848	262 019	266 190	270 360	274 531	278 702	
Overberg	168 310	176 016	185 005	188 969	192 933	196 897	200 861	204 825	208 789	212 753	
Eden	387 140	436 825	449 903	459 797	469 699	479 601	489 500	499 396	509 287	519 175	
Central Karoo	51 833	48 188	50 767	51 268	51 769	52 269	52 770	53 271	53 772	54 273	
Western Cape	**3 535 728**	**4 117 808**	**4 207 479**	**4 301 882**	**4 396 294**	**4 490 706**	**4 585 115**	**4 679 521**	**4 773 922**	**4 868 319**	

Source: Circular H13/2010: Information Management

Table 6 reflects the inconsistent year on year growth rates in the published mid-year estimates. For this reason the Western Cape Government Health has elected to use population projections based on Census 1996 and 2001 and the 2007 Community Survey for planning purposes.

Table 6: Inconsistent year-on-year growth rates in the published mid-year estimates

Year	Mid-Year Estimate Western Cape	Census 2001 & 2007 Community Survey	Mid-Year Estimate RSA	Year on year growth WC	Year on year growth RSA	Stats SA
2001	4 255 743	4 524 332	44 560 644			P03022001
2002	4 321 844		45 454 211	1.55%	2.01%	P03022002
2003	4 740 981		46 429 823	9.70%	2.15%	P03022003
2004	4 570 696		46 586 607	-3.59%	0.34%	P03022004
2005	4 645 600		46 888 200	1.64%	0.65%	P03022005
2006	4 745 500		47 390 900	2.15%	1.07%	P03022006
2007	4 839 800	5 278 584	47 849 800	1.99%	0.97%	P03022007
2008	5 262 000		48 687 300	8.72%	1.75%	P03022008
2009	5 356 900		49 320 500	1.80%	1.30%	P03022009
2010	5 223 900		49 991 300	-2.48%	1.36%	P03022010

7.1.2 Census 2011 vs Projections

The Department of Health used the 2007 Community Survey results in conjunction with the trends displayed in the 1996 and 2001 censuses as a basis for population projections in the Western Cape up to 2015. These projections, which focused specifically on the distribution between districts and sub-districts, were published in subsequent Annual Performance Plans.

Table 7: Comparison of current projections with Census 2011 results

Districts	Projections: 2011	Census 2011	% Variation: Census vs Projections	Population distribution	
				Projections	Census 2011
Cape Winelands District Municipality	768 295	787 490	2.5%	13.3%	13.5%
West Coast District Municipality	314 926	391 767	24.4%	5.5%	6.7%
Overberg District Municipality	238 086	258 176	8.4%	4.1%	4.4%
Eden District Municipality	563 573	574 265	1.9%	9.8%	9.9%
Central Karoo District Municipality	60 991	71 011	16.4%	1.1%	1.2%
City of Cape Town	3 809 735	3 740 025	-1.8%	66.2%	64.2%
Western Cape	**5 757 617**	**5 824 745**	**1.2%**	**100.0%**	**100.0%**

Source for projections: 2013/14 Annual Performance Plan. Source for Census 2011: Statistics South Africa

Notes on the variation between the 2011 Projections and Census 2011:

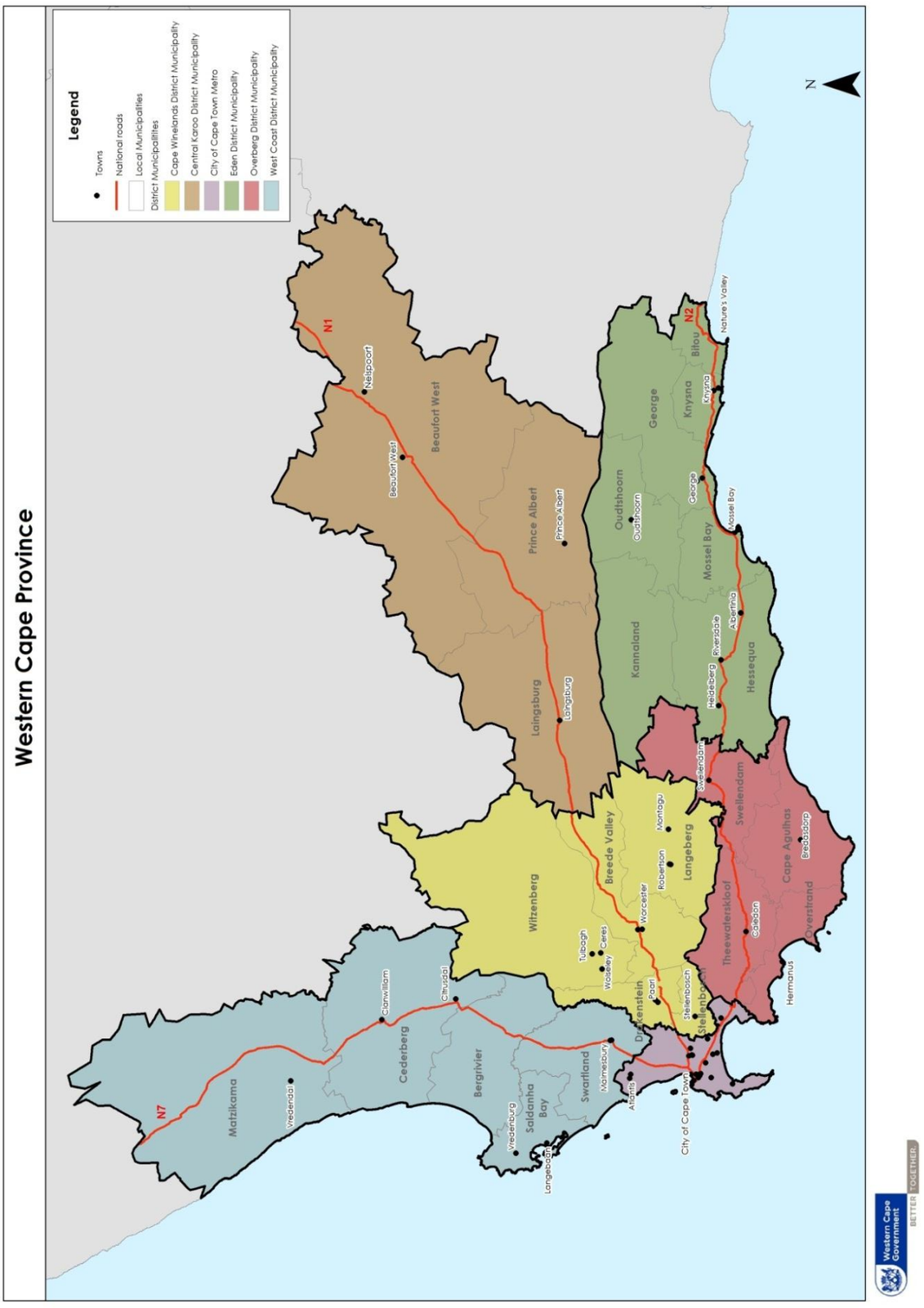
1) The projected population for the Western Cape is 1.2% less than the census results.
2) The variation between the projected figures and the census is the highest for the three smaller districts: West Coast, Overberg and Central Karoo. This does not have a major impact on the overall population distribution.
3) The 2011 census results do not correspond with the previous population growth trends in urban areas. The 2011 census results advocate a decline in urbanisation and significant growth in small rural and deep rural districts.

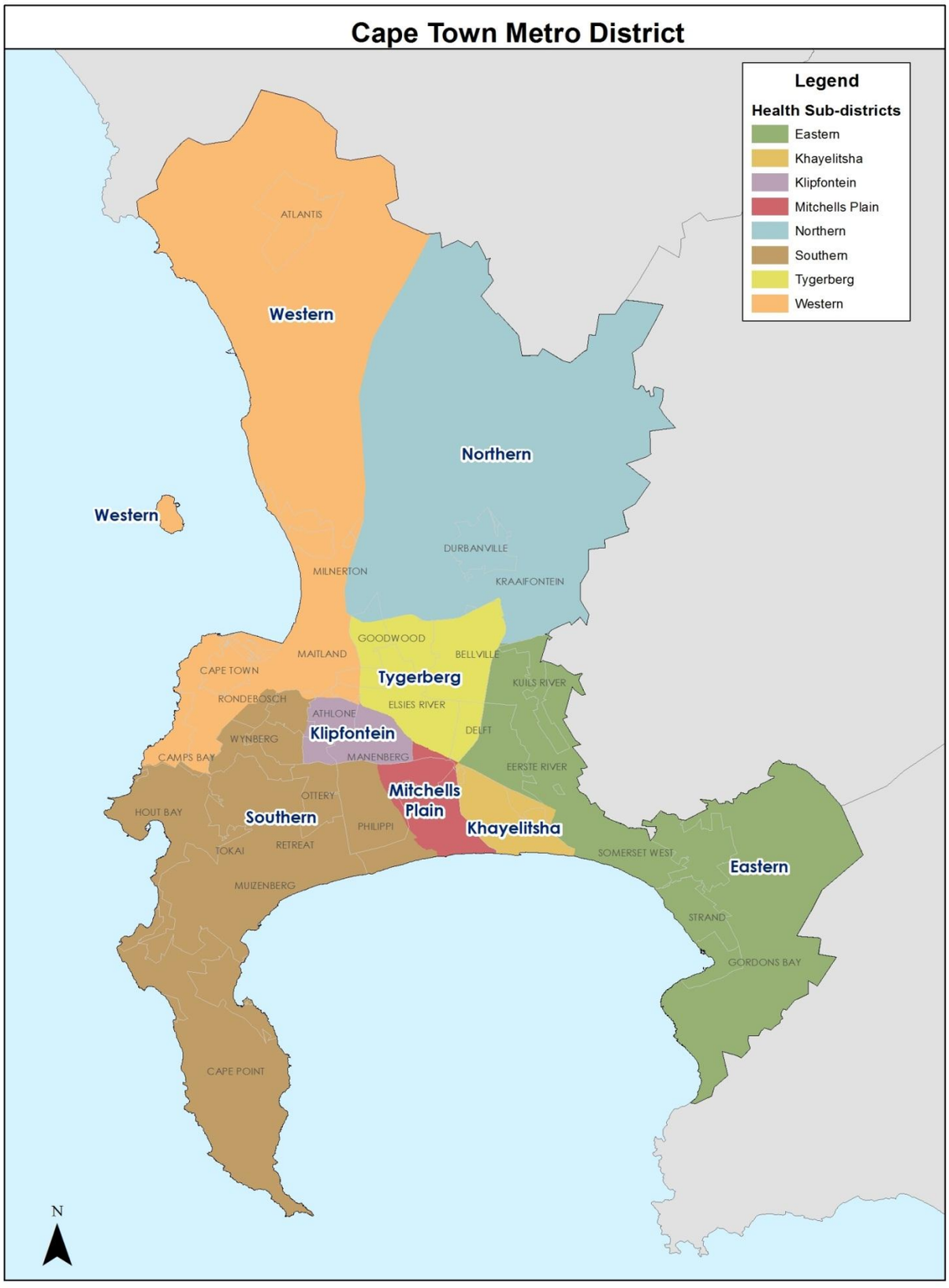
It should be clear that there is significant correlation between the 2011census results and the projections used by the Department. Once all the Census 2011 data are released it can be applied without major challenges regarding target setting and distribution of resources.

It is interesting to note that there is a poor correlation between the 2011 mid-year estimate amounting to 5 287 863 and the 2011 census. The variance is 10.12%. This supports the decision of the Department to use census-based trends for projections and not mid-year estimates.

7.1.3 The impact of population estimates on performance indicators

There is a variation in the population estimates of Census 2011, the mid-year estimates and the projections of academic research. This will be further reviewed during 2013/14. In the interim performance indicators that are based on population, especially specific population groups should be read with caution.


Western Cape Province
Legend
Towns
National roads
Local Municipalities
District Municipalities
Cape Winelands District Municipality
Central Karoo District Municipality
City of Cape Town Metro
Eden District Municipality
Overberg District Municipality
West Coast District Municipality
N
N1
N2
N7
Nelspoort
Beaufort West
Prince Albert
Ladismith
Oudtshoorn
George
Knysna
Plettenberg Bay
Mossel Bay
Riversdale
Albertinia
Heidelberg
Stellenbosch
Somerset West
Paarl
Franschhoek
Worcester
Robertson
Montagu
Tulbagh
Ceres
Wolseley
Clanwilliam
Citrusdal
Vredendal
Malmesbury
Atlantis
City of Cape Town
Vredenburg
Saldanha
Langebaan
Caledon
Bredasdorp
Hermanus
Beaufort West
Prince Albert
Laingsburg
Oudtshoorn
Kannaland
George
Knysna
Bitou
Mossel Bay
Hessequa
Swellendam
Theewaterskloof
Overstrand
Cape Agulhas
Witzenberg
Breede Valley
Langeberg
Stellenbosch
Drakenstein
Cederberg
Matzikama
Bergrivier
Saldanha Bay
Swartland
Nature's Valley
Western Cape Government
BETTER TOGETHER


Cape Town Metro District
Legend
Health Sub-districts
Eastern
Khayelitsha
Klipfontein
Mitchells Plain
Northern
Southern
Tygerberg
Western
ATLANTIS
Western
Northern
Western
DURBANVILLE
MILNERTON
KRAAIFONTEIN
GOODWOOD
MAITLAND
BELLVILLE
CAPE TOWN
Tygerberg
KUILS RIVER
RONDEBOSCH
ELSIES RIVER
ATHLONE
Klipfontein
WYNBERG
DELFT
CAMPS BAY
MANENBERG
EERSTE RIVER
Mitchells Plain
OTTERY
HOUT BAY
Southern
PHILIPPI
Khayelitsha
TOKAI
RETREAT
SOMERSET WEST
Eastern
MUIZENBERG
STRAND
GORDONS BAY
CAPE POINT
N

7.2 SOCIO-ECONOMIC PROFILE/ SOCIAL DETERMINANTS OF DISEASE

According to the South African Index of Multiple Deprivation, 72 per cent (18/25) of the municipalities in the Western Cape are in the fifth quintile of multiple deprivation, i.e. defined as least deprived municipalities in South Africa. Prince Albert and Laingsberg Municipalities are in third quintile and the most deprived of all municipalities in the Western Cape.[1] Province-specific deprivation indices (StatsSA) show that the most deprived wards within the Western Cape are within the City of Cape Town municipality, particularly the townships on the Cape Flats alongside the N2, and in the Karoo. The Central Karoo comprises approximately one per cent of the total population. More detailed analysis also suggests that approximately half of the fifty most deprived wards in the Province are most deprived in four or more of the following domains: income and material deprivation, employment deprivation, health deprivation, education deprivation, and living environment deprivation.

The following table outlines that poverty and socio-demographic data obtained from the General Household Survey with the most recent data from 2011. The downward trend is minimal in some indicators is of concern. Some of the indicators have changed slightly and thus should be interpreted with caution.

Table 8: Poverty and socio-demographic data for the Western Cape

Indicator	2002	2003	2005	2007	2009	2010	2011	National 2011
Education Percentage of persons aged 7 to 24 years who attend educational institutions	67.3%	69.1%	68.7%	69.0%	68.8%	68.1%	68.9%	73.6%-
Housing Percentage of households living in informal dwellings.	14.5%	15.6%	16.5%	19.1%	17.1%	17.0%	15%	12%
Source of energy Percentage of households connected to the mains electricity supply	88.4%	89.2%	92.7%	96.2%	90.0%	87.1%	86.6%	82.7%
Percentage of houses that use paraffin or wood for cooking	14.9%	14.8%	9.1%	6.0%	6.5%	3.9%	3.7%	20.8%
Sanitation[2] Percentage of households that have no toilet facility or were using a bucket toilet	5.7%	8.6%	5.3%	3.8%	4.2%	3.0%	3.4%	5.7%
Refuse removal Percentage of households whose refuse is removed by the municipality	84.0%	85.0%	91.6%	90.8%	73.3%	85.5%	88.1%	61.0%
Water access and use Percentage of households with access to piped or tap water in the dwelling, off-site or on-site	98.8%	98.8%	98.5%	98.0%	99.6%	98.8%	99.5	89.5%

Source: General Household Survey: 2011

7.3 EPIDEMIOLOGICAL PROFILE/ BURDEN OF DISEASE

7.3.1 The mortality profile

The mortality profile for the Western Cape estimated from the district level mortality surveillance shows in Figure 1 below the profile of a quadruple burden of disease that consists of:

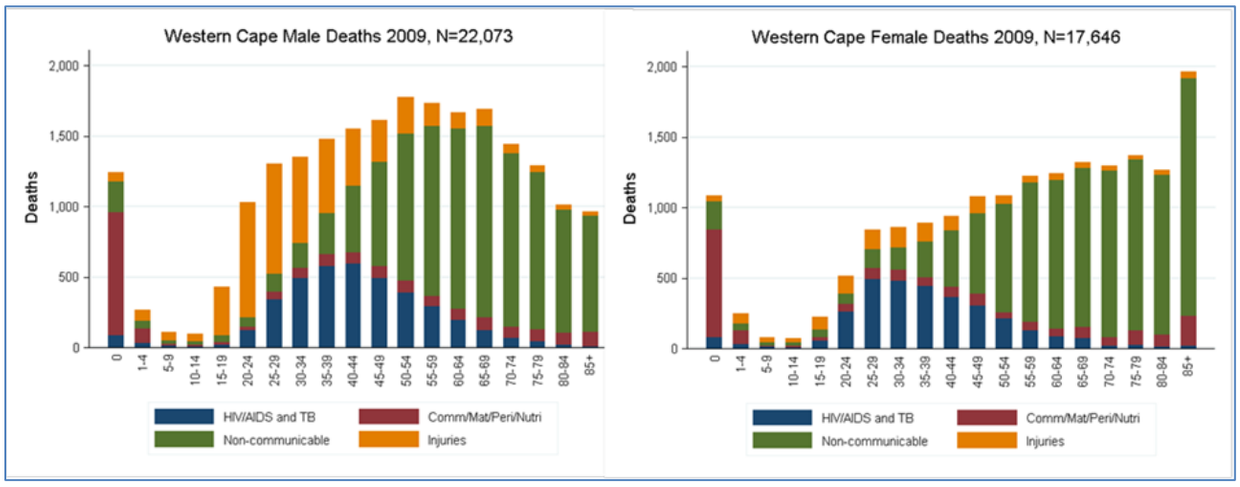
- HIV and TB

[1] Noble, M., Dibben, C. and Wright, G. (2010) The South African Index of Multiple Deprivation 2007 at Datazone Level (modelled), Pretoria: Department of Social Development. Data found at http://www.casasp.ox.ac.uk/imd.html#SAIMD07_mun

[2] The definition of this indicator changed in 2011.

- Child and maternal health: other communicable diseases, maternal, perinatal, nutrition causes
- Non-communicable diseases
- Injuries

Figure 1: **Age specific deaths by broad cause and sex, Western Cape 2009**[3]



In order to effectively estimate the burden of disease, the profile of morbidity also needs to be considered. This system has however, not been institutionalised into the Department and thus such estimation is not yet possible. The burden of mental illness is however one of the key components of the burden of disease that is underestimated by only considering mortality.

7.3.2 HIV and TB

In 2010 the HIV prevalence in the province was 18.5 per cent (95%CI 15.1 – 22.5). Even though this estimate has been increasing for the last three years, it is not statistically significant meaning that in real terms the HIV prevalence in the province has not changed over the last 3 years. Those aged 25-29 and 30-34 years remain the ones mostly affected. The failure to observe a decline in prevalence in high HIV burden in the province may be partly due to the declining mortality as a result of access to antiretroviral therapy (ART).

A third of the sub-districts have HIV prevalence that was greater than the provincial average. These are: Klipfontein, Khayelitsha, Eastern, Western and Northern sub-districts (Metro district), Bitou, Knysna and Mossel Bay sub-districts (Eden district) and Overstrand sub-district (Overberg district). Since 2004, Khayelitsha sub-district in the Cape Town Metro district has had a HIV prevalence estimate consistently higher than the national average.

Apart from mother-to-child transmission (MTCT), the risk of acquiring HIV primarily involves the practice of unsafe sex and is exacerbated by high partner turnover and partner concurrency. Further related issues are gender disparities and the coercive nature of some sexual encounters. Other contributing causes include poor levels of education, transactional sex, mobility, migration and the socio-economic clustering of poverty, unemployment and overcrowding. (Western Cape Burden of Disease reduction study, 2007).

[3] Groenewald P, Bradshaw D, Msemburi W, Neetheling I, Matzopolous R, Naledi T, Daniels J and Dombo M. Western Cape Mortality Profile 2009. Cape Town: South African Medical Research Council, 2012. ISBN: 978-1-920014-84-1

The recently released evaluation of the prevention of mother-to-child-transmission (PMTCT) report shows that the Western Cape had the lowest MTCT rate of 1.98 per cent compared to a national estimate of 2.67 per cent. Even though this is good news, the risk factor for new infections is still prevalent. The HSRC household HIV study reports that in the province less than half of its adults used a condom at their last sex encounter; only about a third of adults have the correct knowledge to prevent HIV and can reject major misconceptions; and less than a quarter had an HIV test in the last 12 months. Much work is thus still required in the arena of behaviour change.

The antiretroviral treatment program continues to expand rapidly with approximately 115 087 persons on antiretroviral in 2011/12. Death due to HIV is showing a decreasing trend.

The concurrent TB infection in patients with HIV is a major challenge. Tuberculosis is described as a social disease as it is closely linked to the upstream issues of poverty, unemployment and overcrowding.

The Western Cape has the third highest number of new TB infections in South Africa (909 cases per 100 000) after Kwazulu-Natal and the Eastern Cape. However, the Department is making significant progress in addressing the epidemic through the implementation of the Enhanced TB Response Strategy. The programme achieved a new smear positive TB cure rate of 81.7 per cent in 2011/12. Two districts (Overberg and Eden) achieved the WHO target of 85 per cent. The provincial TB cure rate is the highest TB cure rate in South Africa. The TB defaulter rate has decreased slowly over the past few years with the implementation of various interventions and stands at 6.8 per cent in 2011/12 in comparison to the 9.4 per cent recorded in 2008/09. Although this is a significant improvement, more effort will be required to reach the national and global 2011 target of a defaulter rate of below 5 per cent. This is required to decrease the size of the infectious pool in the community and prevent the generation of drug resistant TB, which requires longer stays in hospital, is much more costly to treat, and has a very poor prognosis. The incidence of MDR and XDR TB continues to increase and has serious implications for the health service as well as patient outcomes.

7.3.3 **Child health**

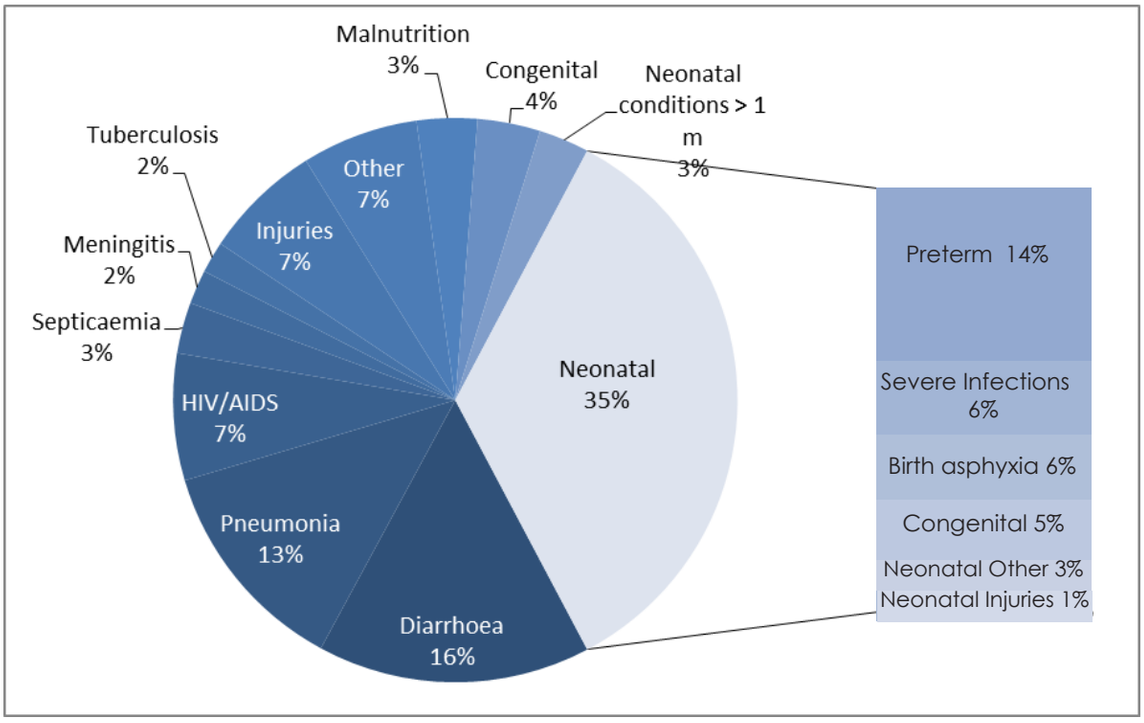
Both infant and child mortality rates are decreasing in all of the Western Cape districts. However, some sub-districts such as Khayelitsha, Witzenberg, Overstrand have rates much higher than the provincial average.

Table 9: Infant and under-five mortality rate (per 1 000 live births)[4]

District	Infant mortality rate IMR (< 1yr)			Under-five mortality rate U5MR (< 5yr)		
	2007	2008	2009	2007	2008	2009
Cape Winelands	28	21	24	33	28	29
Central Karoo	45	43	41	60	58	52
Cape Town metro	20	20	20	25	24	25
Eden	30	21	21	36	27	25
West Coast	36	25	26	45	32	31
Western Cape	**32**	**27**	**22**	**38**	**32**	**25**
WC (Mortality Profile 2009)	*23*	*21*	*21*	*28*	*26*	26

The big five causes of deaths in children under five years are neonatal causes, diarrhoea, pneumonia, HIV and injuries.

Figure 2: **Causes of death in children under 5 years, Western Cape 2009[5]**



The PMTCT programme has been successful and has reduced the HIV in children from above 20 per cent in 2000 to 7 per cent in less than 10 years. [6,7] The pneumococcal and rotavirus vaccine have had a significant impact on reducing the number of pneumonia

[4] Groenewald P, Bradshaw D, Msemburi W, Neethling I, Matzopolous R, Naledi T, Daniels J and Dombo M. Western Cape Mortality Profile 2009. Cape Town: South African Medical Research Council, 2012. ISBN: 978-1-920014-84-1

[5] Groenewald P, Bradshaw D, Msemburi W, Neethling I, Matzopolous R, Naledi T, Daniels J and Dombo M. Western Cape Mortality Profile 2009. Cape Town: South African Medical Research Council, 2012. ISBN: 978-1-920014-84-1

[6] Bradshaw D et al. South African National Burden of Disease Study 2000. Estimates of Provincial Mortality. Cape Town. Medical Research Council. 2004

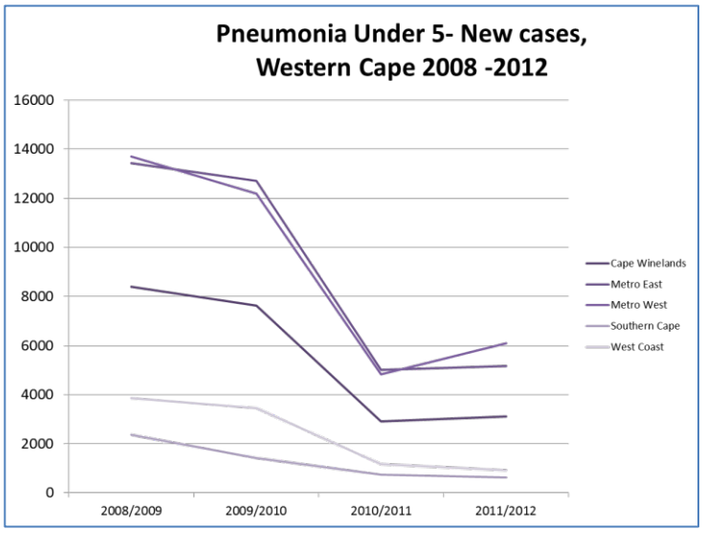
[7] Groenewald P, Bradshaw D, Msemburi W, Neethling I, Matzopolous R, Naledi T, Daniels J and Dombo M. Western Cape Mortality Profile 2009. Cape Town: South African Medical Research Council, 2012. ISBN: 978-1-920014-84-1

cases and reducing the severity of, and mortality of diarrhoea. However, it is recognised that breastfeeding rates in the Western Cape are low and that poor breastfeeding accounts for 45 per cent of the neonatal death burden, 30 per cent of diarrhoea and 18 per cent of pneumonia. Based on studies conducted between 1997 and 2009 it was found that nearly 9 per cent children were acutely malnourished and just 20 per cent chronically malnourished with about 20 per cent of teens overweight.

Social determinants of health influence child health outcomes such as infant mortality rates (IMR). Similarly it is very well documented that downstream interventions such as the provision of quality health services to increase coverage of immunisation, the early diagnosis and management of diarrhoea and pneumonia also have a profound impact in reducing both morbidity and mortality. Pneumococcal and rotavirus vaccines are good examples, as illustrated in the following figures.

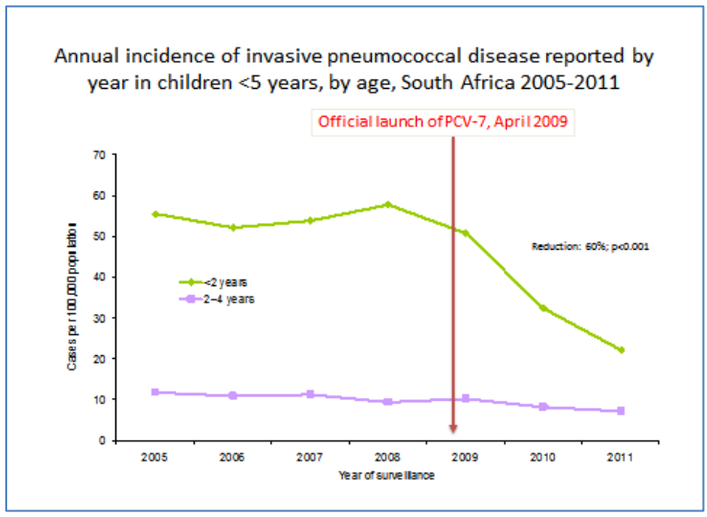
Figure 3 shows data from the routine health information system where the number of new pneumonia cases of those under 5 years decreased sharply after 2009/2010 financial year. Figure 4 shows an evaluation done at a national level where during the same time period there was a 60 per cent decrease in pneumonia cases in the country. This decrease coincides with the introduction of the pneumococcal vaccine suggesting that the introduction of the vaccine has resulted in a reduction in new pneumonia cases.

Figure 3: Pneumonia under 5 years: new cases in the Western Cape: 2008 - 2012[8]



[8] Western Cape Government: Health. Routinely collected health information. Sinjani, 2012

Figure 4: Annual incidence of invasive pneumoccoal disease[9]

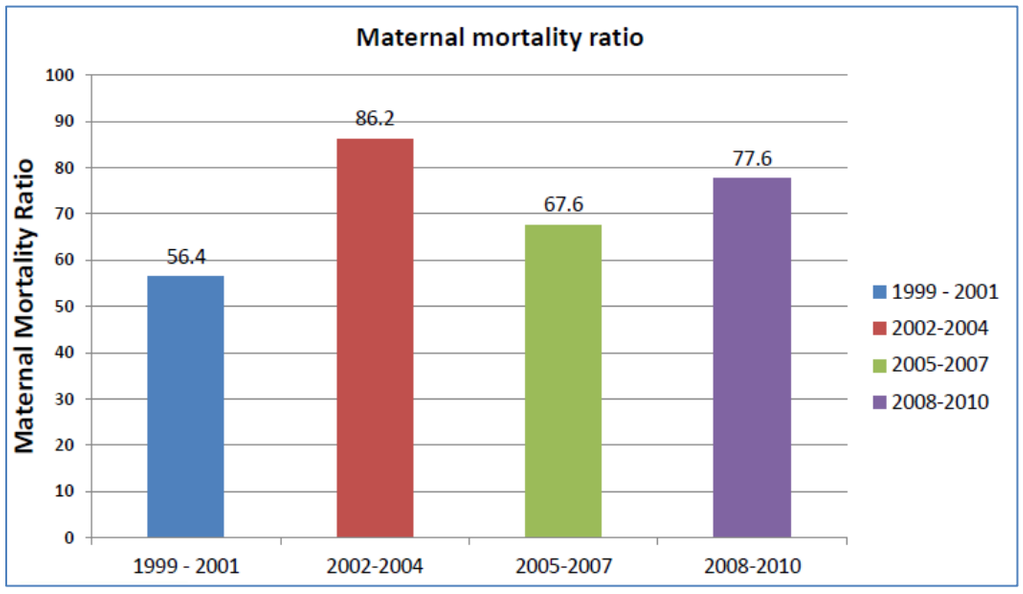


7.3.4 Maternal and Women's Health

The Western Cape enjoys relatively high coverage of antenatal care that is close to 90 per cent. Most pregnant women visit health facilities more than four times during their pregnancy. The key intervention to ensure women present before 20 weeks to health facilities has also been showing some successes. In 2008 just over 40 per cent of women were presenting before 20 weeks for antenatal care and in 2011/12 this has increased to 53 per cent.

Maternal death trends have been erratic over the years but have been on the increase as shown below in figure 5.

Figure 5: Maternal deaths in the Western Cape 2003 – 2010[10]



[9] von Gottberg A, Cohen C, de Gouveia L, Quan V, Meiring S, Madhi SA, Whitney C, Klugman KP, Group for Enteric, Respiratory and Meningeal Disease Surveillance in South Africa (GERMS-SA). Trends in invasive pneumococcal disease after 7-valent pneumococcal conjugate vaccine (PCV7) introduction in South Africa, 2005-2011. Poster presentation. Eighth international symposium on pneumococci and pneumococcal disease, Iguacu Falls, Brazil. 11 – 15 March 2012.

[10] Saving Mothers: Report on Confidential Enquiries into Maternal Deaths in South Africa 1999-2010

The leading causes of maternal death in 2008-2010 were non pregnancy related Infections particularly due to HIV and AIDS (36.1 per cent), Hypertensive disorders (16.3 per cent), pre-existing medical disorders (11.9 per cent), obstetric haemorrhage (8.3 per cent). The peak in 2009 was due to the outbreak of H1N1 influenza.

Deaths from complications of the pregnant state or from interventions, omissions, incorrect treatment, have steadily decreased. However deaths from previous existing disease, or diseases that developed during pregnancy, and which were not due to direct obstetric causes but aggravated by physiological effects of pregnancy increased. This suggests that services to address pregnancy related conditions (antenatal, perinatal, postnatal) are improving but services to manage the pregnant women with pre-existing medical diseases could be improved. It is however, of concern that nearly half the maternal deaths (47.2%) were preventable as different management interventions might have made a difference to the outcome.

Couple year protection rate has been increased slightly from 40.3 per cent in 2008/09 to 42.3 per cent in 2011/12. A Demographic Survey in the West Coast showed the prevalence of family planning in sexually active women has decreased from 73,7 per cent in 1998 to 44.6 per cent in 2006. Thus there is significant room for improvement in access and utilisation of family planning services. Cervical cancer screening has had particular success in the province when it increased in 2007 from 38.6 per cent to 66.5 per cent in 2011.

Globally gender based violence is acknowledged as a public health problem. Research has shown that women who experience violence are more likely to have poor health and to use health services more often. The Western Cape in particular has much higher rates of woman abuse e.g. women abused by a partner in last year were 8.0 per cent in the Western Cape compared to 6.3 per cent in the country.

Intimate partner violence creates vulnerability for women to engage in risky behaviours such as alcohol use, risky sexual behaviours and poor use of health services. It is well documented that the women's position in the home impacts on her ability to access reproductive services. Similarly food security for children depends on the status of the mother in the house. A more gender equitable society will thus impact on women and child wellness across their lifespan and thus interventions with a strong focus on improving gender equity would beneficial.

Community based interventions for both adolescent and adult men and women aiming to improve sexual health and improve psychological wellbeing through building stronger equitable intimate partner relationships are important.

7.3.5 **Non-communicable diseases and mental health**

Non-communicable diseases consist mainly of cardiovascular diseases, neoplasms (cancers), respiratory diseases and diabetes. Diabetes mortality rates are very high in the Western Cape in comparison to developed countries.

Cardiovascular disease includes hypertension, ischaemic heart disease and stroke. It has been well documented that the primary causes of cardiovascular disease, while partly genetic, are largely attributable to environmental factors, specifically an unhealthy lifestyle. The most important risk factors are a lack of regular physical exercise, long-term use of tobacco products and the consumption of an unhealthy diet characterized by a high

intake of fat, salt and sugar, and a low intake of fibre, fruit and vegetables. An unhealthy lifestyle may lead to obesity, hypertension and diabetes.

Compared with the rest of the country, non-communicable or chronic diseases account for a much larger proportion of deaths in the Western Cape (58 per cent) than nationally (38 per cent) and are the third leading cause of premature years of life lost in the Province. The Western Cape has the highest prevalence of smoking of all provinces, i.e. 44.7 per cent of men and 27 per cent of women are smokers.

The National Food Consumption Survey (2005) indicated that 26 per cent of women of child bearing age (16-35years) in the Western Cape were overweight and 32.7 per cent were obese. It is of concern that the prevalence of obesity is 8 per cent more than the national average for women (24.9 per cent). The results of the South African youth behaviour risk survey of 2002 indicated that the prevalence of overweight amongst children is increasing in the Western Cape and confirmed a higher prevalence of overweight adolescents in the Western Cape compared to the national average. Obesity is associated with an increased risk of cardiovascular diseases, hypertension and certain types of cancer of the reproductive system in women and in the rectum, colon and prostate cancers in men

Mental health is also another key component of the burden of disease. Neuropsychiatric conditions such as depression and anxieties are the third highest contributor to burden of disease in SA. The one year prevalence of common mental disorders in SA is 16.5 per cent and lifetime prevalence 30 per cent. Furthermore more than 80 per cent of South Africans with mental health disorders do not receive the care they need.

In South Africa, Cooper et al. (1999) found that 35 per cent of women were diagnosed with postnatal depression in Khayelitsha. Rochat et al. (2011) reported diagnoses of 47 per cent for antenatal depression in rural Kwazulu-Natal. This coheres with preliminary data from the perinatal mental health programme (PMHP) Hanover Park site where 48 per cent of 264 women were diagnosed with depression or anxiety. Of the sample, 12 per cent were at a moderate to high risk of suicide.

There is high co-morbidity of mental illness with chronic diseases. About half of all hypertensive patients, diabetics and cardiorespiratory disease patients in the Eden pilot of PHC 101 had depression.

About 41.4 per cent of Grade 8 -12 Western Cape learners were classified as medium risk and 14.9 per cent as high risk for mental health problems across all the districts.

7.3.6 **Injuries**

According to the Western Cape Burden of Disease project, in 2009 injuries that include homicide, transport injuries, self-inflicted injuries, injuries due to fires accounted for 18.1 per cent of the burden of disease in the Province. This is just less than HIV and TB combined which accounts for 22.5 per cent of the burden. In comparison to the rest of the world violence is a particular problem in the Western Cape where injuries are ten times more prevalent in Western Cape men than the global average for men; and seven times more in Western Cape women than the global average for women. In an analysis of mortuary data in the Province, it was found that 42 per cent of injuries were from homicide and 29 per cent from traffic injuries. Nearly 80 per cent of these deaths were in men aged 20-34 years old.

Substance abuse, particularly alcohol abuse, is one of the most important drivers of the injury burden in the Western Cape as it fuels both violence and road traffic accidents.

Nearly 60 per cent of injuries were alcohol-related and approximately 50 per cent of all alcohol-related violence was found to occur in five areas that correlate with high levels of multiple deprivation and inequity. Alcohol is also a key driver for transport-related deaths. In the same analysis of mortuary deaths, it was found that 66 per cent of pedestrian deaths, 61 per cent of driver deaths and 38 per cent of cyclists' deaths had a positive blood alcohol concentration.

8. PROVINCIAL SERVICE DELIVERY ENVIRONMENT

This paragraph reflects the progress that has been made in the Western Cape against the Millennium Development Goals and the Negotiated Service Delivery Agreement. This is followed by an overview of the successes and challenges in service delivery that the Department has experienced during 2012/13.

8.1 REVIEW THE PROGRESS TOWARDS THE HEALTH RELATED MILLENNIUM DEVELOPMENT GOALS (MDGS)

Table 10: The Western Cape progress on health related Millennium Development Goals 2000-2006 [A3]

Millennium Development Goal	MDG objective	Indicator	Western Cape									South Africa's progress	National Target	Source
			2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2014/15 Target	2004 - 2009	2015	
Eradicate extreme poverty and hunger.	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	1) Prevalence of underweight in children under 5 years of age	2.5%	2.2%	2.2%	2.3%	2.4%	2.5%	2.8%	-	-	9.3%		SINJANI
		Numerator	12 600	11 000	11 024	11 323	12 254	12 858	14 681		-			
		Denominator	502 946	502 584	499 519	493 529	†504 598	515906	527 215	538 524	-			
		2) Incidence of severe malnutrition in children under 5 years of age	3.5/1000	3.1/1000	3.4/1000	4.0/1000	4.5/1000	17.2/1000	22.2/1000	22.1/1000	-			SINJANI
		Numerator	1 767	1 555	1 708	1 951	2 248	8 861	11 678	11 919	-			
		Denominator	502 946	502 584	499 519	493 529	†504 598	515906	527 215	538 524	-			† 2008-2012 population estimates obtained from 2011 projections. 2004-2017 population estimates obtained from DHIS_WC estimates
Reduce Child Mortality.	Reduce by two thirds between 1990 and 2015 the under-five mortality rate	3) Infant mortality rate IMR/1 000 live births	-	-	26	27.3	21†	21	-	-	15	43 per 1 000	14.3 or less per 1 000	SADHS 1998 and 2003 ASSA 2003 StatsSA †WC Mortality Profile 2009
		4) Child (under 5) Mortality Rate/1 000 live births	-	-	39.0	33.0	30.2	38.6	36.6	26.6	30	69 per 1 000	45 per 1 000	SADHS 1998 and 2003 conducted by NDOH StatsSA
		5) Measles coverage under 1 year	91.7%	90.7%	93.7%	102.8%	98.08%	102.8%	89.2%	91.9%	90.3%	85.8% in 2007	100%	Departmental Annual Reports
		Numerator	83 119	87 309	93 117	94 076	97 794	101 154	92 944	97 039	102 147			
		Denominator	90 642	96 262	97 753	91 295	99 700	98 403	104 175	106 413	113 126			
Improve Maternal Health.	Reduce by three quarters between 1990 and 2015, the maternal mortality rate.	6) Maternal Mortality Ratio/100 000 live births	86.2	-	-	67.6	-	-	84.87	-	90	400 - 625 per 100 000	100 or less per 100 000	Saving mothers, Third report on confidential enquiries into maternal deaths in South Africa 2002-2004 and 2005-2007 and 2008-2010

Millennium Development Goal	MDG objective	Indicator	Western Cape									South Africa's progress	National Target	Source
			2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2014/15 Target	2004 - 2009	2015	
		7) Proportion of births attended by skilled health personnel	-	-	-	-	-	-	90%	86%				SINJANI
Combat HIV/AIDS and other diseases.	Have halted by 2015 and begun to reverse the spread of HIV and AIDS.	8) HIV prevalence amongst 15 to 24 year old pregnant women.	-	-	-	12.8%	12.2%	12.4%	13.96%	12.7%	11.0%	21.7% NSDA		Calculated from HIV and Syphilis prevention survey data 2007-2010.
		Numerator				-	-	545	492	516	495			
		Denominator				-	-	4 405	3 527	4 058	4 500			
		9) Contraceptive prevalence rate (Couple year protection rate}	-	-	-	-	40.3%	40.7%	40.6%	42.5%	42.5%			Departmental Annual Reports.
		Numerator					532 161	550 014	560 684	599 310	637 319			
		Denominator					1 321 073	1 350 892	1 380 714	1 410 356	1 499 995			
		10) Condom distribution rate from public sector health facilities (per male >15years)	15.6	20.1	25.7	41.1	33.63	38.8	44.2	49.6	50.42	33.6%		Departmental Annual Reports.
		Numerator												
		Denominator												
		Numerator	25 616 972	33 197 160	57 052 561	71 380 676	65 051 925	74 081 286	89 376 081	102 346 532	110 731 721			
		Denominator	1 642 114	1 651 600	1 675 734	1 734 276	1 934 249	1 909 053	2 021 542	2 065 191	2 196 129			
	Have halted by 2015, and begun to reverse the incidence of malaria and other major diseases.	11) TB (new pulmonary) cure rate	68.6%	69.3%	71.2%	77.4%	77.8%	79.4%	80.5%	81.7%	81.9%	65%	85%	Departmental Annual Reports.
		Numerator	-	-	-	-	12 990	12 853	12 689	12 722	12 700			
		Denominator	-	-	-	-	16 703	16 194	15 761	15 569	15 500			
		12) TB Incidence Rate per 100 000	967	1 041	1 038	1 004	947.8	909	882.9	832.9	-			ETR.net

8.2 PROVINCIAL CONTRIBUTION TO THE HEALTH SECTOR NEGOTIATED SERVICE DELIVERY AGREEMENT [NSDA]

The government agreed to twelve key outcomes as the key indicators for its programme of action for the period 2010 to 2014. The outcome that specifically relates to Health in order to achieve government's vision of "A long and healthy life for all South Africans" is:
Improve healthcare and life expectancy among all South Africans. (Refer paragraph 6.2.4).

Output 1: Increasing life expectancy.

Output 2: Decreasing maternal mortality 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:

1) Revitalisation of primary health care.
2) Health care financing and management.
3) Human resources for health.
4) Quality of health and the accreditation of health establishments.
5) Health infrastructure.
6) Information, communication and technology and health information systems.

Table 11: Provincial contribution towards the achievement of the four NSDA outputs

PROVINCIAL PRIORITIES	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
OUTPUT 1: INCREASING LIFE EXPECTANCY			
1.1. Premier's summit on reducing the burden of disease: 2011.	1.1.1. Review the latest available data on the burden of disease.	Action plan to reduce the burden of disease developed and approved and implementation of priority projects.	Data for 2009 analysed and profiles for all six districts created.
	1.1.2. Convene a summit of all role-players to discuss the burden of disease and the 'whole of society' approach to wellness.		Premier's summit on Wellness held in November 2011.
	1.1.3. Out of the summit develop an action plan to facilitate the collective effort of all role-players to reduce the burden of disease.		Declaration with ten key recommendations for action developed and ratified by the stakeholders at the summit. Action steps being identified for priority focus areas
1.2. Decrease the incidence of injury.	The following strategies are transversal across various departments: 1.2.1. Reduce the burden of disease from intentional and unintentional injury: 1) Increase road safety with the aim of halving fatalities caused by road accidents. 2) Establish a workgroup to develop strategies to reduce the harmful effects of substance abuse, including alcohol.	Inter-sectoral action plan to reduce the harmful effects of alcohol abuse to be developed and approved and implementation of priority projects.	A workgroup on injuries established and alcohol related road traffic and interpersonal injuries prioritised. • Five high prevalence areas identified for intervention. • BoozaTV a six-part health promotion TV series developed to reduce alcohol demand. As at November 2012 near 3 million people had viewed at least one of the episodes on the BoozaTV website. • Brief Motivational Interventions will be piloted in two trauma units. • Injury surveillance is being established in the five priority areas. • Forging partnerships with the City of Cape Town, Violence Prevention through Urban Upgrading to provide outcome information for the effectiveness of alcohol harm reduction interventions.
1.3. Decrease the incidence of non-communicable diseases.	1.3.1. Establish a workgroup to develop strategies to reduce the burden of chronic diseases, e.g. diabetes, hypertension:	Inter-sectoral action plan to promote healthy lifestyles to be developed and approved and implementation of priority projects.	Healthy eating, exercise and smoking cessation has been identified as priorities. Collaboration with the Departments of Cultural Affairs and Sport and Education on Mass participation, Opportunity and access, Development and growth [MOD] centres workplace programmes and wellness centres. Feasibility of wellness centres is being investigated and at least one site will be piloted in 2013/14.
1.4. Provision of an accessible, high quality and comprehensive health care service.	1.4.1. Deliver the full package of primary health care services.	Achieve a PHC utilisation rate of 3.84 visits per person per annum by 2014/15. [Programme 2 strategic objective]	
	1.4.2. Improve response times for ambulances.	Priority 1 calls with a response time <15 minutes in an urban area. Priority 1 calls with a response time <40 minutes in a rural area.	Responses to Priority 1 or life threatening emergencies by ambulances have improved to 69.6%] within 15 minutes in urban areas and 88.2% within 40 minutes in rural (farms) areas. [2011/12]

PROVINCIAL PRIORITIES	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
2. OUTPUT 2: DECREASING MATERNAL AND CHILD MORTALITY			
2.1. Decrease the maternal mortality rate.	2.1.1. Implement the Saving Mothers and Children's Plan to address the recommendations of the National Committee on the Confidential Enquiry into Maternal Deaths that is being implemented. 2.1.2. Prioritisation of emergency transport. 2.1.3. Accelerated staff training programmes.	Reduction in Maternal mortality rate of less than 44 per 100 000 live births by 2014/15. Public health facility maternal mortality rate.	Estimated public health facility maternal mortality rate for 2012/13 is 57 maternal deaths per 100 000 live births. This compares favourably to 62 deaths in the year before and 98 deaths in the year before that
2.2. Decrease the incidence of childhood illness.	2.2.1. Accelerate the roll out of the Road to Health Booklet. 2.2.2. Increased immunization coverage. 2.2.3. Diarrhoeal disease campaign. 2.2.4. Prevention of mother-to-child transmission of HIV. 2.2.5. Expand ART to HIV positive children.	Reduction of mortality in children under the age of 5 years to less than 30 per 1 000 live births by 2014/15.	The estimated public health facility infant mortality rate for 2012/13 is 10.4 deaths under 1 years per 1 000 live births. Rotavirus and pneumococcal vaccines have been introduced in the province in the last two years, and are gaining increasing coverage, with an expected 100,000 doses of each to be delivered in 2013/14. This will no doubt continue to contribute to the reduction in cases of diarrhoea and pneumonia seen. Childhood diarrhoea cases dropped from almost 66 000 in 2009/10 to an estimated 47 000 in 2012/13. Many factors are responsible, but the overarching one is that the DHS took the decision to adopt a "whole system" response to the problem. This meant addressing it from the source (unclean water, maternal education, trained community workers, rotavirus vaccine) to the PHC level (triage systems, "drip corners") to the EMS level ("flying squad" emergency response established for diarrhoea cases). It is expected that gains will continue to be made in addressing diarrhoeal disease over the coming years. In 2009/10 the transmission rate from mother to child of HIV was 3.1%. Steady gains have seen this reduce to an estimated 1.9% in 2012/13. New policies of triple therapy ART for pregnant mothers should see it reduce even further in the future. 7 348 children were receiving ART as of December 2012, representing 5.5% of all people enrolled onto the antiretroviral program. This also represents an almost 80% increase in the number of children on ART since 2008/09.
3. OUTPUT 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS			
3.1. Decrease the incidence of infectious diseases (HIV and TB).	3.1.1. Implementation of combined prevention/promotion strategies. 3.1.2. HIV and AIDS Counselling and Testing [HCT] campaign • Advocacy, communication and social mobilisation (ACSM) • Barrier methods. • PMTCT • HIV treatment • Medical male circumcision	Target: HIV prevalence in the age group 15 – 24 years of 11.5% by 2014/15. Projected 167 256 total registered patients receiving antiretroviral therapy (ART patients) by 2014/15.	Estimated HIV prevalence in women aged 15 – 24 years for 2012/13 is 11.6%. **Barrier methods.** Male condom distribution has increased by 76% over the last 4 years, from 63.8 million condoms in 2008/09 to a projected 112 million in 2012/13. This trend continues to increase and the target for 2013/14 is 116 million condoms. **PMTCT** As above **HIV treatment** 132 000 people were on ART in the Western Cape as of

PROVINCIAL PRIORITIES	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
			December 2012. On average more than 2 000 people have been enrolled onto the program per month and another 30 000 are planned to be enrolled in 2013/14.
3.2. Decrease the incidence of TB and the prevalence of drug resistance TB.	3.2.1. Advocacy, communication and social mobilisation (ACSM) 3.2.2. Integrated TB and IHIV treatment and adherence support.	New smear positive PTB cure rate above 85% by 2014/15.	Estimated new smear positive PTB cure rate for 2012/13 is 80.5%.
4. OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS			
4.1. Revitalisation of Primary Health Care:			
4.1.1. Provincialisation of Personal Primary Health Care in the Metro district.	4.1.1.1. To be addressed at a political level between the province and the City of Cape Town.	An integrated system of personal primary health care service delivery by the provincial sphere of government in the Western Cape.	Provincial cabinet has supported in principle that WCG provides the PPHC for the quantum of funds it provides to the COCT.
	4.1.1.2. Establish the six district health councils.	Implementation of the Western Cape District Health Councils Act and the establishment of the six district health councils.	The Western Cape District Health Councils Act, No 5 of 2010 ("the Act"), was drafted to give effect to section 31 of the National Health Act, No 61 of 2003 and came into effect from 22 August 2011. The inaugural meetings of the six district health councils were convened.
4.2. Health care financing and management:			
4.2.1. Occupation specific dispensation for health professionals to be fully funded.	4.2.1.1. Detailed costing of the required funding for OSD. 4.2.1.2. Secure adequate funding for OSD from Treasury.	Strategic goal: Sustainable income: Ensure a sustainable income to provide the required health services according to the needs. • All mandatory functions and expenses to be fully funded. • Appropriate funding levels to facilitate the required service delivery.	Due to the revised formula for the equitable share the year 2012/13 will be challenging financially. The challenge will be to reduce expenditure in real terms without reducing service delivery. The service delivery platform has been expanded by the commissioning of the Khayelitsha Hospital
4.2.2. Appropriate funding of the conditional grants, in particular 1) National Tertiary Services Grant (NTSG). 2) Health Professions Training and Development Grant (HPTDG).	4.2.2.1. Continue with on-going discussions and submission of motivations to the National Department of Health to demonstrate the funding and policy challenges.		In spite of the Department's continued input and leadership on national forums, the funding for these services are still insufficient due to national government's priority for shifting funds to lesser developed provinces.
4.2.3. Develop and retain appropriate financial management capacity at all levels of the service.	4.2.3.1. Address Auditor-General's (AGs) recommendations to improve financial management. 4.2.3.2. On the basis of the AGs report, develop and implement the Compliance Monitoring Instrument.	Unqualified financial audit reports.	The latest financial statements were not qualified, which means that the Auditor-General found these statements to fairly represent the activities and status of the Department.
4.3. Human resources for Health:			
4.3.1. Implement the provincial Human Resource Plan.	4.3.1.1. Perform a skills audit. 4.3.1.2. Draft action plans to achieve priority elements within the HR Plan: • Organisation development • Competency development	Strategic goal: Attain and maintain a skilled, patient centred workforce of appropriate number to deliver the required health services.	A competency profile (Skills Audit) for prioritized occupational categories completed. Outcomes are used for Workplace Skills Plan, Human Resource Plan and action plans related to training and development. Draft action plans to achieve priority elements were completed and reported to the DPSA in the Department of

PROVINCIAL PRIORITIES	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
	• Employee health and wellness • Employment equity • Recruitment and selection • Systems and information capacity • Training and development		Health's Human Resource Implementation Report dated 30 April 2012 as well as 30 September 2012.
4.3.2. Implement the Provincial Nursing Strategy.	4.3.2.1. Coordinate the quality and improvement of nursing practice. 4.3.2.2. Coordinate nursing related research and development. 4.3.2.3. Market and promote the corporate image of nursing. 4.3.2.4. Implement the integrated nursing education and training framework. 4.3.2.5. Expand nurse education teaching sites, programmes and clinical placement sites of students with relevant coordination thereof. 4.3.2.6. Coordinate formal and informal nurse training programmes and initiatives, in line with the Comprehensive Service Plan, required strategic focus and nursing education legislation. 4.3.2.7. Harmonise and integrate nursing education and training with practice.	An operational plan in place after consulted with stakeholders. Nursing education/training and practice policies and procedures in place to ensure a capacitated nursing workforce to deliver the required health services.	The Operational Plan is in place: **Nursing Practice** • Peer review conducted in the health facilities in all districts. • Collaborative meeting held with the private nursing stakeholders. • Key role-players (National Department of Health) in the development of a "Nursing Compact" for the country. • Pilot of the Nursing Information Management System (NIMS) commenced. As at 30 November 2012, fifteen nursing agencies and 55 health facilities have been activated and trained on NIMS. • Ensure that competent nursing staff is appointed for the new hospital. **Nursing education and training** • Coordinated clinical placement system in place and implemented. • Process regarding Standardised Situational Analysis commenced. • Clinical Nursing Education units - implementation process commenced. • A standardized education and training selection policy developed and implemented. • Three year Departmental Nurse Training Plan developed and implemented based on the outcomes of the OSD for Nurses "Grandfather Clause" analysis and service delivery needs. • Research in nursing enhanced in collaboration with Higher Education Institutions and Services.
4.4. Quality of Health and accreditation of health establishments:			
4.4.1. Develop a patient centred approach.	4.4.1.1. Develop an action plan to address and monitor progress for the six priority focus areas within the national core standards policy document.	Improved patient care and the satisfaction of the users of the health care system.	The baseline audits were completed at the end of March 2012. A patient centred approach has been developed for the Department with manuals and guidelines developed and piloted for roll out in 2013/14. A Provincial Quality Improvement Committee has been established that will align Occupational Health and Safety; Infection Prevention and Control; and Quality Assurance.

PROVINCIAL PRIORITIES	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
4.4.2. Monitoring and evaluation of the quality of clinical care.	4.4.2.1. Monthly mortality and morbidity meetings.		Facilities conduct Morbidity and Mortality Reviews. A M&M SOP has been developed to standardise the practice of M&M in the Department.
	4.4.2.2. Participate in initiatives like Best Care Always [BCA]. The Best Care Always campaign is an initiative, initially co-ordinated by the Institute for Health Improvement, to support healthcare organisations to implement specific, internationally recognised, evidence-based interventions that enhance patient safety and constitute best practice in hospital care. The Department's Quality Assurance component will continue to lead the project. From February 2013 support from BCA will shift to capacitate the Department to run learning collaboratives focussed on current or alternative patient safety issues.		All central and secondary hospitals have implemented a bundle and are submitting monthly reports to the BCA. All hospitals participate in the Best Care Always projects to reduce hospital acquired infections in selected areas. The institutionalisation of Best Care Always is being explored. The following hospitals are participating in the BCA Campaign: • Groote Schuur Hospital • Tygerberg Hospital • Red Cross War Memorial Children's Hospital • Mowbray Maternity Hospital • Western Cape Rehabilitation Centre • George Hospital • Somerset Hospital • Paarl Hospital • Worcester Hospital.
4.5. Effective management and supervision.			
4.5.1. Licensing and inspectorate.	4.5.1.1. The phased rollout of the implementation of the core standards to be the point of departure towards accreditation and certification of facilities.	Establishment of a provincial licensing and inspectorate for all facilities (public and private).	Currently the inspectorate's mandate is for private establishment licensing and accreditation only.
4.5.2 Chronic Dispensing Unit.	4.5.2.1. The expansion of the scope of services, as well as the geographical span, of the Chronic Dispensing Unit service provides chronic medicines to patients from a choice of health facilities and from non-health sites for patients in the Cape Town Metro District.	The expansion of the scope of services, as well as the geographical span, of the Chronic Dispensing Unit (CDU) service provides chronic medicines to patients from a choice of health facilities and from non-health sites for patients in the Cape Town Metro District. This will include spinal and stoma patients in the Metro.	The CDU service expansion to Overberg and Winelands Districts is being planned for 2013/14. The current service includes deliveries for general health and ARVs in the Cape Town Metro District at health sites and increasing the number of non-health sites. Planning CDU services for the stoma and spinal patients is underway.
4.6. Health infrastructure:			
4.6.1. Construction of new district health service facilities (primary health service, and district hospitals).	4.6.1.1. Construction completion of the new Khayelitsha Hospital.	Construction budget spent, projects on time, in budget and required quality.	Construction completed, hospital commissioned and first patients admitted during January 2012.
	4.6.1.2. Construction completion of the new Mitchell's Plain Hospital		This project achieved practical completion in February 2013.
	4.6.1.3. Construction phase for Vredenburg Hospital phase 2B.		Construction in progress with completion planned towards the end of 2014/15.
	4.6.1.4. Upgrade and extension at: • Ceres Hospital		• Ceres Ambulance Station completed, Emergency Department completed in July 2012. • The Emergency Centre at Karl Bremer Hospital is

PROVINCIAL PRIORITIES	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
	• Karl Bremer Hospital • Knysna Hospital • Hermanus Hospital • Malmesbury Hospital • Robertson Hospital		currently under construction and should achieve completion in 2014/15. • The Emergency Centre and Outpatients Department at Knysna Hospital should achieve completion in 2014/15. • Hermanus Hospital project is scheduled to be completed at the end of 2012/13, • Malmesbury Hospital project is scheduled to be completed at the end of 2012/13, • The bulk store at Robertson Hospital should be completed in May 2014,
	4.6.1.5. Construction completion of the new: • Grassy Park Clinic • Knysna Witlokasie Community Day Centre • Malmesbury: Wesbank Community Day Centre • Community Day Centre • Delft: Symphony Way Community Day Centre • Du Noon Community Health Centre		Grassy Park Clinic completed in October 2011. Knysna Witlokasie CDC completed in January 2013. Wesbank Community Day Centre in Malmesbury was completed in April 2012. Delft: Symphony Way Community Day Centre is currently under construction and is planned to achieve completion in May 2014. Du Noon Community Day Centre is currently under construction and is planned to achieve completion in March 2014.
4.6.2. Construction of new EMS and FPL facilities.	4.6.2.1. Construction completion of the new ambulance stations at: • Leeu-Gamka • Vredendal • Malmesbury • Tulbagh	Construction budget spent, projects on time, in budget and required quality	Construction of Ambulance Stations at Leeu-Gamka, Vredendal and Tulbagh completed. Malmesbury Ambulance Station should achieve completion in March 2013. Robertson Ambulance Station is currently under construction.
	4.6.2.2. Construction completion of the new Forensic Pathology Laboratories at: • Beaufort West • Riversdale.		Riversdale Forensic Pathology Laboratory is in the design/tender stage. Construction of Beaufort West Forensic Pathology Laboratory completed.
4.6.3. Hospital Revitalisation projects	4.6.3.1. Revitalisation projects underway at: • George Hospital: Psychiatric Unit • Paarl Hospital: Psychiatric Unit • Worcester Hospital • Valkenberg Hospital • GF Jooste Hospital		• George Hospital Psychiatric Unit at tender stage, tender award imminent. • Paarl Hospital Psychiatric Unit and Worcester Hospital (Phase 5) in design phase, due to go to tender shortly. • Valkenberg Hospital in design phase and should go to tender during 2013/14. • GF Jooste Hospital strategic design phase imminent.
4.6.4. PPP for the new Tygerberg Hospital.	4.6.4.1. Appointment of Transaction Advisors	To conclude the feasibility study	Procurement process for appointment of Transaction Advisors imminent.
4.6.5. Improving maintenance and life cycle costing for all health infrastructure.	4.6.5.1. Maintenance information management system.	Maintenance plan for all new health facilities.	Planning is in progress.

PROVINCIAL PRIORITIES	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
4.7. Information, communication and technology and Health Information Systems:			
4.7.1. Ensure good data quality by implementing the Compliance Management Instrument for predetermined objectives (CMI-PO).	4.7.1.1. Develop and refine the CMI – PO tool. 4.7.1.2. Implement the CMI-PO within all sub-districts.	100% of districts and district, regional and central hospitals implementing the CMI-PO by 2014/15.	The first CMI for predetermined objectives was developed in 2010/11. In response to the Audit Report, an Action Plan is compiled annually to address the audit findings. Based on the Action Plan, the CMI is reviewed annually to ensure all issues are being addressed. The CMI has been implemented at districts and district, regional and central hospitals, but are not necessarily well reported in all facilities. To improve reporting, from 2012/13 onwards, CMIs will be regularly analysed with feedback to Divisional Executive Committees. An Information Compliance Unit is being set up within Directorate IM to monitor and support services.

8.3 OVERVIEW OF SUCCESSES AND CHALLENGES IN SERVICE DELIVERY AND HEALTH OUTCOMES FOR THE PREVIOUS FINANCIAL YEAR

Some of the main successes and challenges experienced by the Department are outlined below:

8.3.1 Service related successes:

1) **Patient Centred Care**:

The Department has a renewed focus on improving the quality of care and adopting a patient-centred care approach as a central pillar of 2020. The Department's vision is to ensure that by 2020 all patients have a superior patient experience when accessing health services in the Western Cape. The focus areas in the framework are the following:

- Reception services and folder registry;
- Clinical services/ clinical governance including pharmacy;
- Discharge, continuity of care and data management;
- Staff wellness;
- Community engagement.

Implementing this approach is new for the Department and will require leadership, respectful partnerships between staff and management, the staff and patients, families and other stakeholders, and the provision of reliable and evidenced based care. Importantly the Department will have to motivate all staff to ensure that the patient is placed at the centre. This is a significant paradigm shift that will require significant changes in the organisation if a patient centred approach is to be sustained over the long term. However, the concept of a patient centred approach is gaining momentum and being embraced in the operating language of the Department. Tools and guidelines to implement this strategy are being developed.

2) **Infrastructure**:

The construction of Khayelitsha Hospital was completed and the first patients were admitted on 16 January 2012. This was the culmination of planning that commenced in 2005 and the construction contract that was awarded in January 2009. The hospital, which is fully operational, 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.

A major achievement for the Department is the completion of the Mitchell's Plain Hospital which was achieved in February 2013. The hospital will be commissioned in phases and the official opening is planned for mid-2013. Mitchell's Plain Hospital will provide a total of 230 district hospital beds with the capacity to expand to 300 beds. This is the culmination of planning that began in 2005 and the construction contract that was awarded on 22 September 2009. The hospital will provide world-class modern infrastructure to render district hospital services to the Mitchell's Plain community.

3) A Picture Archive Communication System (PACS) and Radiological Information System (RIS), integrating and storing digital data, have now been successfully implemented in Tygerberg Hospital, Groote Schuur Hospital and Red Cross War Memorial Children's Hospital, with major achievements in service delivery.

4) The Expanded Public Works Programme (EPWP) initially only provided work opportunities for the home community based care programme (including HIV, AIDS and TB care) and information management through the data capturer internship programme. However, the programme was expanded in 2010/11 to include the Assistant-to-Artisan (ATA) programme to improve maintenance of health facilities, the Pharmacist's Assistant programme, and the Human Resources/Finance Internship programme. The Emergency Medical Services' Basic Ambulance Assistant internship Programme has been an addition to the programme for 2012/13 and 2013/14. The EPWP funding is used to pay training providers and provide a monthly stipend to learners on the programmes.

5) **Corporate governance**:

- The Department achieved an unqualified audit of the Annual Financial Statements for the 2011/12 financial year and was acknowledged for significant improvement in overall performance by the Auditor-General.
- The Auditor-General of South Africa has not expressed an audit opinion on pre-determined objectives to date. However, in the Management Report, the Auditor General indicated that an unqualified report would have been expressed if pre-determined objectives had been formally audited.
- Financial governance was improved by the following management tools:
  - Monthly Financial Monitoring Committee (FMC) meetings, chaired by the Head of Department, monitor the expenditure of the Department against the budget and evaluate the results of the CMI.
  - Internal departmental awards to facilities and others for improved audit performance.
  - A hierarchical system of Monthly Financial Monitoring Committee (FMC) meetings monitor the expenditure of the Department against the budget and evaluate the results of the CMI.
  - Through internal assessments nearly 80 per cent of all payments (in terms of value) are independently checked for compliance to regulations and validity.
- Human resources:
  - The Department constituted a Human Resource Monitoring Committee (HRMC) chaired by the Head of Department to monitor performance of the Department in this area which meets quarterly.
  - Draft action plans to achieve priority elements were completed and reported to the DPSA in the Western Cape Government Health's Human Resources Implementation Report dated 30 April 2012 as well as 30 September 2012.
  - The Department has implemented internal and external bursary programmes and learnerships in an effort to attract and retain scarce skills.
  - The Employee Health and Wellness Programme (EHWP) engaged with 4 270 (15.7 per cent) staff members during 2011/12. The most common problems presented were relationship issues (19.2 per cent), stress (12.1 per cent) and organisational issues (11.4 per cent).
  - The first department-wide staff satisfaction survey, in which 10 649 employees from all facilities and districts participated, was conducted in November 2011.
    - Positively, employees expressed satisfaction with the objectives of the organization and in accomplishing their work, and providing quality care to patients. They indicated that work is interesting and stimulating.

- Negatively employees expressed dissatisfaction with leadership styles, lack of work recognition, ideas that are dismissed and not taken into account and indicated that co-workers have hidden agendas. Employees indicated that there is a lack of staff facilities, such as rest rooms and child care facilities. They also indicated that safety and security is a concern as they do not feel safe at work.

- The Barrett Values process:
  - This process was initiated by the Department of the Premier and aims to establish a set of organisational values that will promote a high-performance organisational culture that will facilitate improved service delivery. Barrett Values Surveys were conducted in 2010 and 2011 and focused on culture shifts and energising core values.
  - The 2010 Barrett Values Survey was open to all employees on salary levels 9 and higher and a total of 622 employees participated in this survey.
  - The 2011 Barrett Values Survey was open to all employees and a total of 1 378 employees participated.
  - Barrett Action Plans are to be implemented prior to the next Barrett Survey which will be conducted in 2013.
  - The Department has adopted the values of care, competence, accountability, integrity, respect and responsiveness [C^2AIR^2]. Adherence to these values by all employees will contribute towards achieving the aim of being the best run regional health department in the world.

- **Information management**:
  - A systematic strategy to improve the quality of data and information in the Department and address the audit findings on predetermined objectives was developed and endorsed by Top Management. An action plan was developed and implementation has begun.
  - The Departmental IT committee has been re-constituted to identify and address the strategic IT issues.
  - The Department for the first time held a strategic planning session for ICT priorities. A revised strategic ICT plan is being developed that will also align itself with the vision of 2020.
  - The Department has supported in principle the roll out Enterprise Content Management (ECM) at all new facilities and beyond within the available resources.
  - A pre-audit process has been done to ensure that the necessary steps have been taken to ensure that the Department is well prepared for the next audit based on the lessons learned.

8.3.2 **Challenges:**

Some of the challenges experienced include:

1) **Patient-centred Care**:

- The second Barrett Values survey results indicate similar limiting values as the first survey. These include amongst others hierarchy, bureaucratic, confusion. This will require management to address the organisational as well as behavioural issues. Complaints that are received from clients about staff attitudes are evidence that this is still an area for improvement.
- The fragmentation of the delivery of PHC services in the Cape Town Metro District between local and provincial government remains a challenge.
- Under-achievement against women's health performance targets in the 2010/11, notably antenatal bookings rate less than 20 weeks and cervical cancer screening.
- Under-achievement in immunisation targets.
- Achieving the target urban response time targets for Emergency Medical Services in the face of an increasing demand for EMS services.
- Managing the acute caseload of patients, including behaviourally disturbed patients, particularly within the Cape Town Metro District.
- The time that patients have to wait for services, e.g. in queues at facilities but also for procedures in theatre, radiology and therapeutic radiation, and emergency centres.

2) **Infrastructure**:

- Addressing the maintenance backlog and ensuring preventative maintenance. There are financial and capacity challenges in this regard.
- Reducing the carbon footprint of the health infrastructure portfolio specifically and health services generally.

3) **Corporate governance**:

- **Finance**:
    - The budget allocated to the department does not allow for real growth. It is therefore a particular challenge to complete the commissioning of Khayelitsha Hospital and to commission the newly built facilities, such as the Mitchells Plain Hospital and the Du Noon CHC, in the coming financial year. There are also other priorities such as the modernisation and roll out of ICT infrastructure and programmes that will improve patient experience and efficiencies. The Department has initiated a re-prioritisation exercise within the allocated budget to investigate options of funding the service and organisational priorities.
    - The Department's financial statements have been unqualified for a number of years, but the Western Cape Government aims to improve on this performance to achieve a "clean audit". This requires the complete compliance with all laws regulations which, given that the Department makes approximately 30 000 payments per month, is a challenge. A plan has been developed to achieve this goal.

- **Human resources:**
    - The recruitment and retention of appropriately qualified and experienced staff is an on-going challenge.
    - A fragmented HR information system continues to adversely impact on management decision making. This is recognised at Cabinet level, and the Department Public Service and Administration (DPSA) is seeking to implement a Public Service Human Resource Information System (HRIS) via the HR Connect project.
    - Attracting suitable applicants in the scarce skills occupational groups is a challenge that impacts negatively on service delivery, particularly in the rural areas. The shortage of skilled staff in certain clinical domains remains a challenge. These areas include clinical and clinical support services such as medical practitioners, paramedics, professional nurses with advanced training in theatre, mental health and midwifery, pharmacists, technologists/technicians, radiographers and dental technicians. These services impact directly on the Department's ability to manage the burden of disease.
    - The shortage of skilled staff within human resources, finance and information management remain challenges which impact on the compliance with regulatory frameworks.
- **Chronic Dispensing Unit (CDU)**:
  There were serious challenges in the transfer of the chronic dispensing unit [CDU] service to the new service provider. This regretfully resulted in prolonged waiting times for patients at several facilities and increased the work load and stress levels for the pharmacist staff within the district health service. These staff members managed the challenges including facing the wrath of angry patients inconvenienced in the process. The Minister and the Department apologised publicly for this inconvenience.

  The Department took remedial steps which included the deployment of a manager to liaise with and support the service provider, and also to institute contractual penalties related to poor performance. The service provider significantly improved its performance in the latter half of the year which has had a positive impact on the patient experience.

9. ORGANISATIONAL ENVIRONMENT

9.1 LINKAGES TO OTHER ORGANISATIONS/ DEPARTMENTS

The Department has a service level agreement with the City of Cape Town (Local Government) for the provision of personal primary health care in the Metro district. These services have been provincialized in the rural districts.

The Department also has a service delivery agreement with the Western Cape Government Transport and Public Works (TPW), as WCG TPW is the implementing department for health infrastructure delivery.

9.2 SUMMARY OF THE ORGANISATIONAL STRUCTURE

The current approved organisation and post structure of the Department is based on the Comprehensive Service Plan (CSP) and reflects the core and support functions required to achieve the strategic objectives of the Department.

Post structures are monitored to ensure that staff members are functioning according to the new organisational design. Priority projects are identified annually to address efficiency, based on service needs and operational requirements.

A review of the macro structure of the Department in terms of purpose and function, responsibility, span of control, job description and level has commenced with the view to promote better cohesion in service delivery. As indicated elsewhere there will be a single "service" division with effect from 1 April 2013 although the approved structure will be amended during the course of the 2013/14 financial year.

Western Cape Government

BETTER TOGETHER.

Organisational Organogram

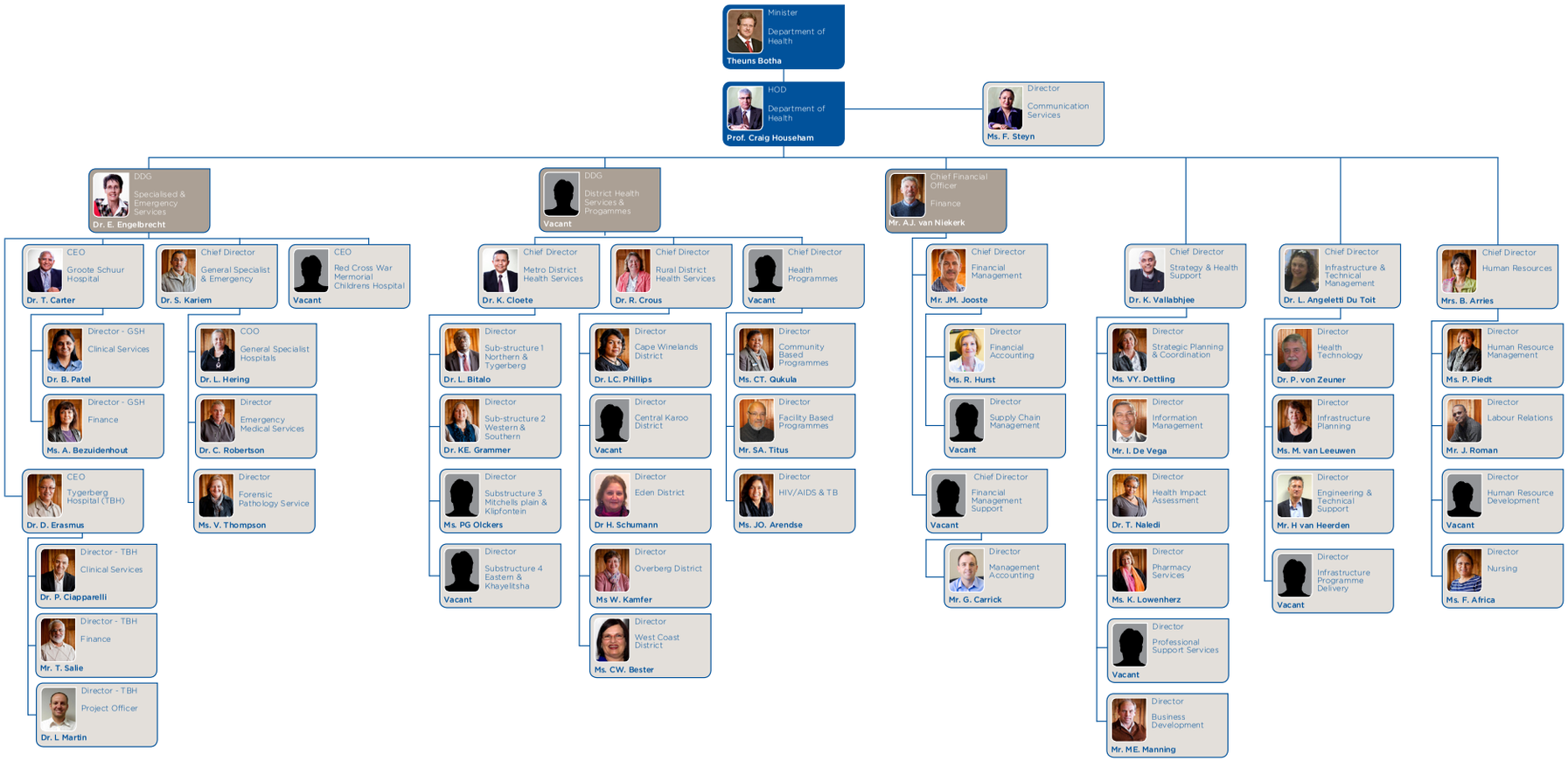


Table 12: Public health personnel as at 31 March 2012 [ADMIN 1]

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	1899	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	5720	19.17%	0.994	1.274	4.56%	23.89%	313 753
Enrolled nurses	2344	7.85%	0.407	0.522	3.62%	5.71%	183 022
Enrolled nursing auxiliaries	4141	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	1707	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	1494	5.01%	0.260	0.333	8.00%	4.48%	225 292
Managers, administrators and all other staff	10603	35.53%	1.842	2.361	4.69%	22.00%	155 901
Grand Total	**29842**	**100.00%**	**5.185**	**6.645**	**4.83%**	**100.00%**	**251 778**

Note:

Student nurses are not employed by the Department.

Students in training receive bursaries and are not appointed on PERSAL.

Table 13: Employment and vacancies by budget programme as at 1 April 2012

Program	Number of funded posts	Number of posts filled	Vacancy rate	Number of posts filled additional to the establishment
1-Administration	821	682	20.4%	37
2-District Health Services	11438	10980	4.00%	49
3-Emergency Medical Services	2107	1826	13.34%	1
4-Provincial Hospital Services	6327	6160	2.64%	16
5-Central Hospitals	9604	9187	4.34%	60
6-Health Science and Training	290	279	3.79%	
7-Health Care Support Services	719	683	5.01%	3
8-Health Facilities Management	51	45	11.76%	24
Grand Total	**31357**	**29842**	**4.83%**	**190**

Table 14: Employment and vacancies by salary bands as at 1 April 2012

Salary Band	Number of funded posts	Number of posts filled	Vacancy rate	Number of posts filled additional to the establishment
Lower Skilled (Levels 1-2)	2 462	2 370	3.74%	1
Skilled (Levels 3-5)	11 382	10 726	5.76%	123
Highly Skilled Production (Levels 6-8)	9 216	8 856	3.91%	24
Highly Skilled Supervision (Levels 9-12)	8 233	7 833	4.86%	41
Senior Management (Levels 13-16)	64	57	10.94%	1
Grand Total	**31 357**	**29 842**	**4.83%**	**190**

9.3 FACTORS IN THE ORGANISATION THAT IMPACT ON THE DELIVERY OF SERVICE

The size and shape of the service platform and related service pressure, impact on the number and skill mix of staff required to deliver the service.

The large service delivery workload creates a stressful working environment that can negatively affect the quality of staff performance and contribute to low morale and high levels of absenteeism.

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

- Nursing in specific specialty areas;
- Family physicians;
- Pharmacists and pharmacists assistants (post basic);
- Clinical psychologists;
- Radiographers in specialty areas;
- Medical orthotists / prosthetists;
- Clinical technologists;
- Clinical engineers;
- Forensic pathology officers;
- Emergency care technicians and paramedics.

9.3.1 Occupational specific dispensations (OSDs):

Occupation specific dispensations have been implemented in the following categories of staff:

Category of staff	Date from which OSD implemented
Nursing staff	1 July 2007
Social workers	1 April 2008
Medical, pharmacy and emergency medical services staff [Phase 1]	1 July 2009
Engineering staff [Phase 1]	1 July 2009
Medical, pharmacy and emergency medical services staff [Phase 2]	1 April 2010
Engineering staff [Phase 2]	1 July 2010
Therapeutic, diagnostic and related allied health professional staff	1 July 2010

- 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 structure of the Department has been aligned in terms of the new occupational specific dispensations.
- The implementation of the occupational specific dispensations has resulted in significantly higher personnel costs.
- A cause for concern is that restrictions have been placed on the appointment of specific professional staff, such as paramedics, forensic pathology officers and certain nursing specialties.
- In certain professional occupational categories, the occupational specific dispensations are not competitive enough in comparison with the private sector and this limits the recruitment of nursing categories, pharmacists, paramedics as well as lecturers.

The shortage of critical competencies within the current workforce is a challenge to the delivery and quality of health services. The following is required to address these challenges:

- Procure funding for the training and development of staff with critical competencies/ skills.
- Develop recruitment and retention strategies that should include the marketing of professions, e.g. at open days at schools as well as institutions of higher education;
- The development, implementation and monitoring of a succession policy.

9.4 IMBALANCES IN SERVICE STRUCTURES AND STAFF MIX

There are imbalances in the staff mix, for example within the community day centres and clinics where there is a shortage of staff nurses and an oversupply of nursing assistants.

Significant progress has been made with the employment of family physicians within the district health services.

9.5 SUMMARY OF PERFORMANCE AGAINST THE PROVINCIAL HUMAN RESOURCE PLAN

The National Department of Health published the Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/13-2016/17, in October 2011, which will provide a framework for further development of the provincial Human Resource Plan.

The eight themes that have been prioritised and which form the framework of the HRH Strategy, and which will also guide the provincial Human Resource Plan are:

1) Leadership, governance and accountability;
2) Health workforce information and health workforce planning;
3) Re-engineering of the workforce to meet service needs;
4) To upscale and revitalise education, training and research;
5) Create the infrastructure for workforce and service development: academic health complexes and nursing colleges;
6) Strengthen and professionalise the management of HR and prioritise workforce needs;
7) Ensure professional quality care through oversight, regulation and continuing professional development; and
8) Improve access to health professionals and health care in rural and remote areas.

9.5.1 Current deployment of staff

Following the reorganisation of the staff establishment, the majority of staff have been matched and placed within the district hospitals (rural and Metro), community day care

centres and clinics in the rural districts; the specialised hospitals, regional and secondary hospitals as well as the Chief Directorate: Health Strategy and Support. Staff members declared in excess will be deployed in terms of the provisions set out in the Departmental Human Resource Restructuring Plan. A policy on the management of excess staff has been developed to assist districts with this exercise.

9.5.2 **Accuracy of staff establishments at all levels against the service requirements**

The organisational structures of all level 1 and 2 services (primary health care CHC's, CDC's and clinics, district hospitals, regional hospitals, secondary hospitals as well as specialised hospitals) are in line with the service requirements. As all of the CSP structures have not been implemented for the central hospitals (Groote Schuur and Tygerberg) the current structures are regularly amended to bridge the staffing gap. The physical implementation of the new organisational development structures commenced with effect from 1 January 2013.

9.5.3 **Staff recruitment, retention and challenges**

The main challenges are to secure sufficient funding for the required organisational structures and to recruit suitably qualified staff.

The attrition rate for medical officers is relatively high as some leave the service within the first three years of appointment. This is attributed mainly to the need for exposure to a particular field of interest prior to entering the registrar training programme and is therefore not necessarily negative. The Department has shown the ability to fill these vacancies on a year-on-year basis from the existing capacity found within the labour market. Capacity issues are rather due to insufficient funding to support all the required health services and not necessarily due to the year-on-year loss of staff. The regular loss of medical officers does however create a challenge for maintaining the continuity of services with an extra burden on on-going training to rebuild capacity.

An analysis of terminations, using the Organising Framework of Occupations (OFO), indicates that the highest number of terminations are professionals (24.81 per cent), followed by technicians and associated professions (14.45 per cent), clerks (13.15 per cent), and craft and related workers (12.64 per cent).

The non-filling of critical vacancies increases the workload of the existing staff members which impacts on staff well-being and contributes to absenteeism and termination of employment.

The recruitment of qualified and competent health professionals poses a challenge due to the scarcity of skills in specialist areas and the restrictive appointment measures that are imposed on certain of the occupations through the various new occupational specific dispensations e.g. pharmacists and emergency medical staff. These issues need to be addressed at a national forum.

The average age of the workforce of the Department is 40 to 49 years. It is therefore necessary to recruit, train and develop younger persons and undertake succession planning. The average age of initial entry into the Department by professionals is 26 years, e.g. medical officers after completing their studies and compulsory in-service duties. The challenge remains to retain these occupational groups in a permanent capacity. The main reasons for resignations are for financial gain and there are instances where employees resign and return on contract in order to receive the monthly 37 per cent service benefit.

The following interventions to address the challenges have been identified to address this issue:

a) Reviewing its recruitment policy and strategy;

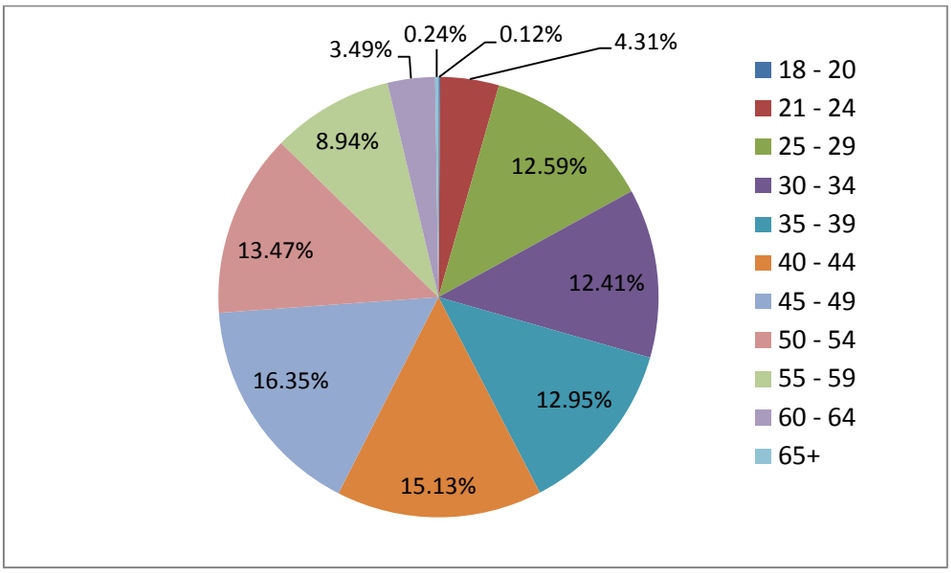
b) Linking career paths to succession planning;

c) Preparing strategies to address the approaching loss of staff due to retirement;

d) Using various marketing tools to promote the new OSD salary structures as well as career paths;

e) Rolling-out of diversity training to all managers to assist younger managers in managing older staff members.

Figure 6: Age profile of the employees of the Department of Health as at 31 March 2012



9.5.4 **Absenteeism and staff turnover**

9.5.4.1 **Absenteeism**

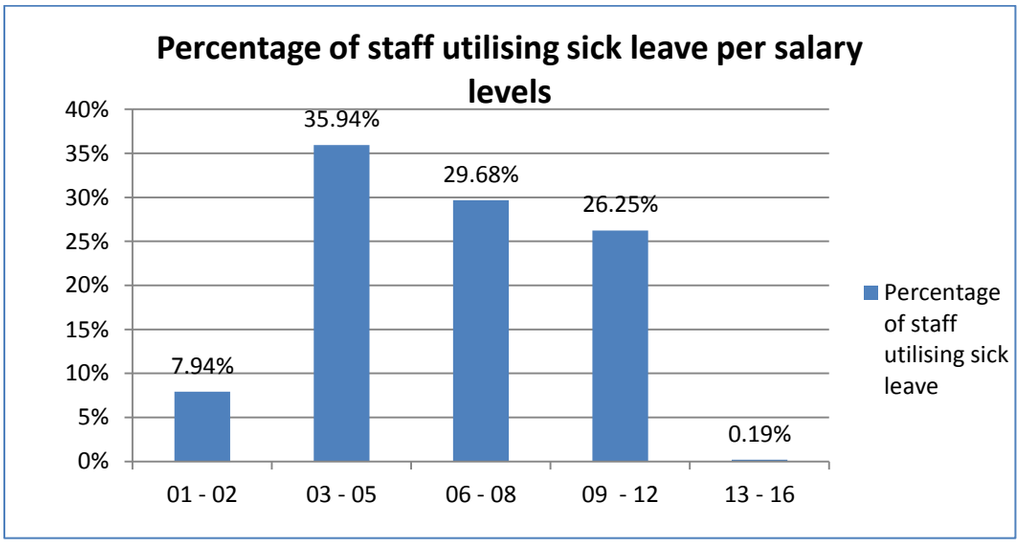
Sick leave:

The management of normal sick leave remains problematic, and impacts on service delivery.

The majority of employees utilising sick leave can be found within levels 3 to 12 of which the highest incidence is found in salary levels 3 to 5 (Figure 7 below). It is assumed that the probable groups are mainly production workers, first-line supervisors and highly skilled supervisors. The workload and operational responsibilities and accountability may play a role in the use of sick leave within these groups.

The loss of man-hours through absenteeism does have a negative impact on service delivery and financial resources.

Figure 7: Total percentage of employees using leave in the 2011



Incapacity leave

The percentages of staff per salary level utilising incapacity leave, has increased in all the salary levels.

The average number of days utilised per employee has, however, decreased in all salary levels with the exception of those in levels 13 – 16, which shows an increase.

In comparison to the total workforce, the amount of employees that have used incapacity leave and ill-health (PILIR) during the 2011 sick leave cycle is below 3 per cent.

The use of sick leave is carefully monitored to prevent abuse and interventions such as the Employee Health and Wellness Programme are used to address problem areas.

9.5.4.2 **Staff turnover**

The average staff turnover rate for the Department in the 2011/2012 was 7.95 per cent (excluding fixed-term contractual appointments such as community service, interns and registrars). This is approximately 50 per cent less than the previous reporting period.

Annual staff losses occur as a result of employees completing their training, competing community service contracts as well as transferring to other departments. This is deemed to be a natural and healthy turnover.

Over and above these losses, unwanted turnover is experienced due to factors not indicated above. This is especially true in specialised nursing, medical, allied health and technological occupations as they provide the core service that the department needs to provide. In addition, there are employees leaving from occupational groups necessary for ensuring compliance with the legal framework applicable to the public service. These are occupations found within finance and human resources.

There are the following challenges in decreasing the turnover rate:

- The lack of recruitment and retention strategies;
- Providing a conducive working environments (e.g. aging equipment);
- Budget constraints;

- Skills development of existing staff;
- Ability to compete with private sector and overseas remuneration rates especially for specialists, dentists, clinical psychologist, pharmacists and pharmacy assistants; and
- Competition with global demand for doctors and nurses and other health professional categories.

The following are some of the initiatives that have been identified to address these challenges:

- Implement recruitment and retention strategies that are applicable to each occupational group;
- Develop, implement and monitor a succession planning policy;
- Conduct an attrition analysis and provide remedial measures;
- Strengthen strategic partnerships with the private sector and health facility boards to enhance improvement of working conditions;
- Implement targeted career path strategies and talent management;
- Establish internships and student training posts for positions such as clinical technologists;
- Continue 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; and
- Post course assessments to determine the impact of training.

9.5.4.3 **Employee Health and Wellness Programme [EHWP]**

The Employee Health and Wellness Programme of the Department contributes to the achievement of Provincial Strategic Objectives 4 and 5 (Increasing Wellness and Increasing Safety) as well as the achievement of Provincial Strategic Objective 11 (Building the best-run provincial government in the world).

The EHWP was first introduced in 2005 and is now well established within the Department. The purpose of the programme is to provide an optimal foundation for the effective management of organisational risk associated with employee personal and work-related problems.

There is an on-going marketing campaign, to ensure that employees are aware of the programme services, that has included briefing sessions to over 6 500 employees and managers, and the distribution of over 130 000 marketing materials such as brochures, wallet cards, fridge magnets, pens and desk-drops.

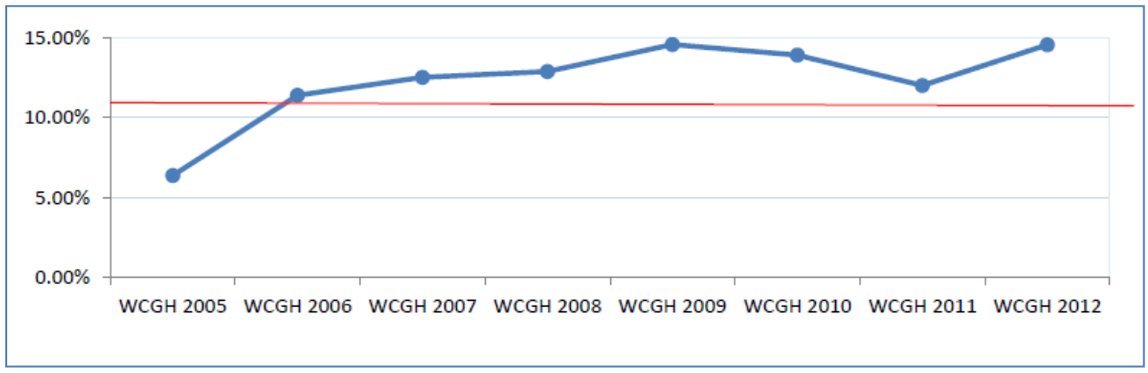
The services are available to all employees and their families, free of charge, 24 hours per day and 365 days per year and are available in all areas of the Province. The services include telephone and face-to-face counselling, as well as access to life management services and management support. Information and guidance is available on the following topics:

- **Financial matters**: money and debt management;
- **Legal matters:** maintenance, child custody, divorce law, consumer right; relationships: family matters, work, partners, friends;
- **Emotional issues**: depression, trauma, substance abuse, stress;
- **Work**: Managerial consultancy, stress management, career matters, maternity harassment, managing others and many more;

- **Health issues**: HIV and AIDS counselling, illness.
- **eCare Online Services:** eCare service is a unique tailored online programme that is provided to all employees within the Department. This service allows employees to access a wellbeing portal that provides health and wellbeing information that spans all relevant topics, providing a number of interactive tools and professional advisory services.

Since the inception of the EHWP in 2005, approximately 83 per cent of the total workforce has engaged with the service. Tracked over time, the engagement rate has consistently remained above the comparable sector benchmark which suggests Employee Health and Wellness Programme is well entrenched in the Department and that the service is responsive to the needs of employees and the Department.

Figure 8: Engagement with the service provider consistently above the benchmark



In addition, the programme has been involved in and provided a number of value-adding and proactive services, such as:

- The Behaviour and Risk Management Audit:
  The Behaviour and Risk Management Audit, conducted in 2007 was a comprehensive analysis of the behavioural risks to which employees are exposed. This survey and personalised feedback assessment reached an additional 5 084 employees and produced both positive and negative outcomes.
  - **Positive outcomes**:
    - Retention of corporate knowledge and memory amongst staff with over ten years' service.
    - The general level of job satisfaction is rated well as employees in health professions find meaning and satisfaction in their work.
    - Employees are clear about what is expected from them at work.
    - There is generally a fair level of work life balance amongst employees.
    - The overall levels of depression amongst employees are lower than the private healthcare sector benchmark.
  - **Negative outcomes**:
    - There are numerous interpersonal workplace factors that negatively impact on employee's experiences of the workplace relationships and environment.

- High stress levels are linked to conflict in the workplace, poor relationships with immediate superiors, poor workplace communication and prevalence of depression.
- There is an increased use of substance abuse, 38 per cent of respondents indicated regular use of a substance. Substance abuse is related to stress and emotional difficulties.
- Perceived inadequacies in the workplace environment include dissatisfaction with the physical work environment, lack of resources and equipment, and concerns regarding personal safety at work.
- In general there is a low level of resilience amongst employees and as result there is a difficulty in coping with changes in the work environment.

An average of approximately 68 per cent of employees has made use of this service annually. The high level of employee engagement with the programme reflects the significant impact of the programme on the staff and the contribution towards the management of people-related risk.

The programme priorities going forward remain:

Workplace HIV and AIDS/STI/TB Programme	• Intensification of workplace HIV Counselling and Testing Campaign • Reduce stigma associated with HIV and TB
Wellness Management	• Coaching programme (individual and group) for managers to strengthen leadership • Physical Wellness (fitness) of EMS Staff • Continued targeted intervention in high risk areas such as Forensic Pathology Services, Emergency Medical Services, TB Hospitals and Trauma Units • Financial planning (managing personal finances and retirement planning)
Safety, Health, Environment, Risk and Quality Management (SHERQ)	• Establishment of Departmental Quality Improvement Committee (OHS, Quality Assurance and Infection Control) • A standard structured OHS Programme and standard measuring tools • Standard contingency plan adaptable to all facilities
Health and Productivity Management	• Analysis of Incapacity Management data (PILIR applications) • Standard reporting procedure for injury on duty
Diversity Management	• Change management processes to create a culture of embracing diversity and values-based service delivery • Development of monitoring and evaluation mechanisms

The achievement of these priorities is dependent, to a large extent, on the creation of a functional and resourced structure at district and institutional level.

9.6 DEPARTMENTAL RISKS

The following have been identified as overarching departmental risks:

Departmental Risk Statement	Three components for the risk statement	Mitigating factors
1) Over-expenditure due to inadequate financial controls and insufficient budget allocation leading to poor quality healthcare services, qualified audits and reputational damage.	Risk: • Over-expenditure Root Cause: • Inadequate budget allocation against rising service pressures and costs of providing services. • Inadequate financial management controls. Impact: • Inability to provide quality healthcare services owing to stringency measures. • Qualified audit. • Reputational damage.	• Monitor expenditure against budget at Programme and departmental levels. • Only funded posts on the APL are filled. • Reduce agency expenditure. • Strengthen financial controls and cost containment strategies. • Use the FBUs to closely monitor the expenditure.
2) Stock-outs of essential goods and services due to supplier challenges, lack of good contract management and inability to secure alternatives resulting in compromised patient centred experience (PCE) and quality of care as well as reputational damage.	Risk: • Stock-outs of essential goods and services. Root cause: • Supplier challenges e.g. global shortages of ingredients. • Lack of timeous and good contract management. • Inability to secure alternatives. Impact: • Compromised PCE and quality of care. • Reputational damage.	• Engage National Department of Health on timeous awarding of national tenders. • Monitor stocks out regularly. • Monitor vaccine supply. • Provide alternatives to especially the essential drugs. • Tighter contract management with suppliers.
3) Fraud due to inadequate internal controls and lack of commitment to organisational values resulting in decreased resources for service delivery and reputational damage.	Risk: • Fraud and theft. Root cause: • Inadequate internal controls. • Lack of commitment to values of the organisation. Impact: • Decreased resources for service delivery. • Reputational damage.	• Monitor the implementation of the fraud prevention plan. • Ensure PERSAL is accurate to prevent ghost employees. • Embark upon change management initiative that emphasises the values of the organisation.
4) Non-compliance with financial, HR and other regulations due to inadequate controls; inadequate training; insufficient capacity; lack of commitment and poor discipline resulting in wasteful expenditure and reputational damage.	Risk: • Non-compliance with financial, HR and other regulations. Root cause: • Multi-factorial – inadequate controls and processes, training, capacity, commitment and discipline. Impact: • Irregular and wasteful expenditure. • Reputational damage.	• To provide formal and informal training to line managers and staff. • Provide relief staff where capacity and skill level constraints are identified. • In the process of developing an HR Toolkit to assist line managers in HR Administration. • Identify high risk institutions by comparing quarterly audit action plans and pre audits conducted. • Engage with managers and CEO's at high risk institutions. • Strengthen the Devolved Internal Control Units (DICU).
5) Shortage of skilled staff across all levels due to emigration; inadequate training; stressful working environments; inadequate remuneration and incentives; which compromises the quality of healthcare.	Risk: • Shortage of skilled staff across all levels. Root cause: • Multi-factorial – brain drain, inadequate training both in term of numbers and skills, stressful working environment, lack of adequate remuneration and incentives. Impact: • Compromised ability to deliver a quality health service.	• Identification of scarce skills per profession. • Allocation of bursaries per profession as a recruitment strategy. • Competency profiling of health professionals per level of care and burden of disease on clinical skills development needs. • Ensure evidenced-based experiential learning for the competency based team. • In the process of developing an on-line exit interview questionnaire to assist in identifying the reasons for exits and to inform future interventions.

Departmental Risk Statement	Three components for the risk statement	Mitigating factors
6) Failure of information technology (IT) networks and computer systems due to inadequate technology infrastructure; resources; and technical capacity within WCG resulting in disrupted service delivery; compromised PCE and low staff morale.	Risk: • Failure of IT networks and computer systems. Root cause: • Inadequate technology infrastructure and resources. • Inadequate technical capacity within WCG. Impact: • Disruption to service delivery and compromised PCE and staff morale. • No communication and collaboration Infrastructure	• Develop a robust ICT disaster recovery plan for the department of health. • Monitor the responsiveness of the Helpdesk and support systems to IT system failure. • Constantly review out-dated infrastructure by conducting regular hardware and ICT infrastructure health check.
7) Inability to fully utilise the allocated budget for the maintenance and upgrading of facilities due to capacity deficiencies in the DTPW resulting in inadequate infrastructure for health service delivery.	Risk: • Inability to fully utilise the allocated budget for the maintenance and upgrading of facilities. Root cause: • Capacity deficiencies in the DTPW. Impact: • Compromised infrastructure to support delivery of health services.	• Implementation of Infrastructure Delivery Management System (IDMS) in both WCG: Health and WCG: Transport and Public Works. • WCG: Transport and Public Works to implement structure as per the capacitation framework for IDMS. • Utilisation of management contractor.
8) Poor quality of care due to insufficient human resources; escalating service pressures; inadequate quality improvement measures; negative staff attitudes leading to poor patient experiences; poor health outcomes and reputational damage.	Risk: Poor quality of health services. Root cause: • Inadequate quantum (numbers) and quality (e.g. skills, values) of human and other resources against background of escalating service pressures. • Inadequate systems, processes and controls to improve quality. • Insufficient measures to address the needs of staff and the working environment. • Lack of commitment and negative staff attitudes. Impact: • Poor patient experience • Poor health outcomes • Reputational damage	• Monitor patient satisfaction and act on the findings at facility level. • Ensure quality improvement plans at facilities to address findings from the baseline audits. • An initial focus on reception services to improve the entry of patients into the health service. • Implement change management exercise to improve the attitudes of staff.
9) Fragmentation and duplication of PPHC services in the Cape Metro District due to dual provision by WCG: Health and the City of Cape Town resulting in compromised quality of health services and inefficient use of government resources.	Risk: • Fragmentation and duplication of the delivery of personal primary health care [PPHC] services in the Cape Town Metro District. Root cause: • Dual responsibility and authority for the provision of PPHC by the Western Cape Government Health and the City of Cape Town. Impact: • Compromised quality of health services. • Inefficient use of resources by government.	• Political decision and additional funding are being sought to provincialize the PPHC services in City of Cape Town Metro.
10) Poor response to outbreaks due to inadequate preparation and surveillance of potential outbreaks resulting in compromised staff and patient safety.	Risk: • Inadequate response to outbreaks. Root cause: • Inadequate preparedness of the Department. • Inadequate surveillance of potential outbreaks. Impact: • Compromised staff and patient safety and health.	• Clearly define roles and responsibilities between HIA, Health programmes and the line function services. • Implement the alert organism initiative through NHLS. • Review the outbreak response plans of the Department.
11) Vandalism and theft due to inadequate security measures and ownership of health facilities by communities resulting in compromised patient care; compromised staff working environment and	Risk: • Compromised staff and patient safety. • Vandalism and theft [fixtures etc.]. Root cause: • Inadequate security measures. • Inadequate ownership of health facilities by communities.	• Review the current security services in DOH and develop a strategic framework with recommendations to top management. • Installation of vandal-proof infrastructure including fixtures and fittings, as far as possible.

Departmental Risk Statement	Three components for the risk statement	Mitigating factors
unnecessary expenditure with repairing damage to property.	Impact: • Compromised quality of care for patients. • Compromised working environment for staff. • Unnecessary costs for maintenance and repair of damage to property.	• Improve security services and contract management at facility level.
12) Fire within health facilities due to inadequate safety measures compromising patient and staff safety and resulting in unnecessary expenditure with repairing damage to property.	Risk: • Fire within health facilities. Root cause: • Inadequate safety measures. • There is the constant trade-off between securing a building from a safety perspective versus maintaining the integrity of fire escapes etc. Impact: • Patient and staff safety compromised which could be life threatening. • Additional costs to repair damage.	• Develop and implement the Provincial Safety, Health, Environment, Risk, and Quality Management (SHERQ) Policy to support and guide facilities. • Ensure that design and construction of infrastructure is compliant with fire regulations. • Monitor and evaluate operational compliance with fire regulations ensuring that disaster plans and fire drills are in place. • Ensure compliance of the physical environment and physical entities such as fire detectors, fire extinguishers, alarms, sprinkler systems, fire doors, and fire exits are in order. • Establish Health & Safety committees, appoint and train emergency representatives (fire, first aid and floor marshals), in accordance with the National Core Standards.

10. DESCRIPTION OF THE STRATEGIC PLANNING PROCESS

A departmental monitoring and evaluation session was held at Lentegeur Hospital on 17 – 18 May 2012. The approach was different from previous years which had focused on budget programme performance. This year the focus was on the priority areas of service delivery such as women's health, child health, HIV and TB, non-communicable diseases, injuries and quality of care. The support services of human resources, finance and infrastructure were also addressed.

A follow-up planning session was held on 21 and 22 June 2012. A key focus area of this session was to understand the challenges of improving the patient centred experience. Various categories of clinical personnel were invited to share their experiences and their ideas for improving the patient experience with management. There was collective support for the vision, values and principles of 2020 and a willingness to embrace the initiatives of the geographic service areas and functional business units. These provide a more co-ordinated and cohesive approach to service delivery through decentralised responsibility and accountability. The transversal imperatives of the Department and service priorities, reflected in paragraph 6.3.3., were adopted at the session.

The GSAs have had planning sessions and discussed how to address the key service priorities described under section 6.3.3

A planning session was held on 19-20 November 2012 where the impact of the budget constraints was discussed and priorities were determined. This information is being factored into the Programme and sub-programme budget allocation by the CFO.

2020:

The Department has developed the 2020 strategy which outlines the long-term strategy of the Department as described earlier. A first draft was published for comment in November 2011. Comments were received and responses incorporated into a second draft with

additional technical work done subsequently. The second draft of the discussion document will be published for comment early in 2013.

ICT strategic Planning:
In parallel with the general strategic planning session, a special session was convened to focus on the strategic ICT issues facing the Department. The relevant partners such as CEI, SITA and the HEIs, e.g. UCT Information System Department, attended the session where it was agreed that the key priorities would inform the revision of the current ICT strategic plan.

The Department welcomes the expansion of broadband connectivity that the WCG has prioritised. The first order priorities are to secure the systems that form the backbone of the service. This includes the roll out of the PHCIS, HIS and ECM and EMS communications. PACS/RIS is also being incrementally rolled out at the central hospitals and the specifications are being finalised for a tender for regional and district hospitals. There are exciting possibilities using M-Health (mobile health technologies) that are being explored and experimented with in the Department.

Climate Change:
The Department has also formed a Climate Change Committee that is trying to better understand and plan for the adverse impacts of climate change. There are several national and provincial policy frameworks that have already been developed that provide a useful guide to the Department. The two main areas of focus are planning for the adverse effects of climate change on the population and the mitigation strategies that the Department should implement to reduce its own carbon footprint.

The Department is putting processes in place to quantify its baselines in terms of water and energy consumption and waste generation. The Department supports the provincial Green Procurement Policy and will implement its recommendations within the available resources and affordable limits.

Khayelithsha and Lentegeur Hospitals are the flagship projects from Health in the 110 per cent Green campaign launched by the Premier.

Technical perspective:
From a technical perspective, there has been a concerted effort to further improve the quality of the performance information, for example through the development of Excel planning templates. The tables of data elements provided in each programme are part of this initiative. The Department also has to prepare District Health Plans which feed into the Annual Performance Plan, particularly of Programme 2. A technical tool has been developed to facilitate the compilation of the performance related data.

11. OVERVIEW OF THE 2013/14 BUDGET AND MTEF ESTIMATES

11.1 ECONOMIC CONTEXT

The key message from the National and Provincial Medium Term Budget Policy Statements 2011 is that there will be a fiscal tightening over the 2012 Medium Term Expenditure Framework (MTEF) period. This means that reprioritization within the current baselines and between institutions is the preferred mechanism to fund priorities more extensively. This means that the focus will be on:

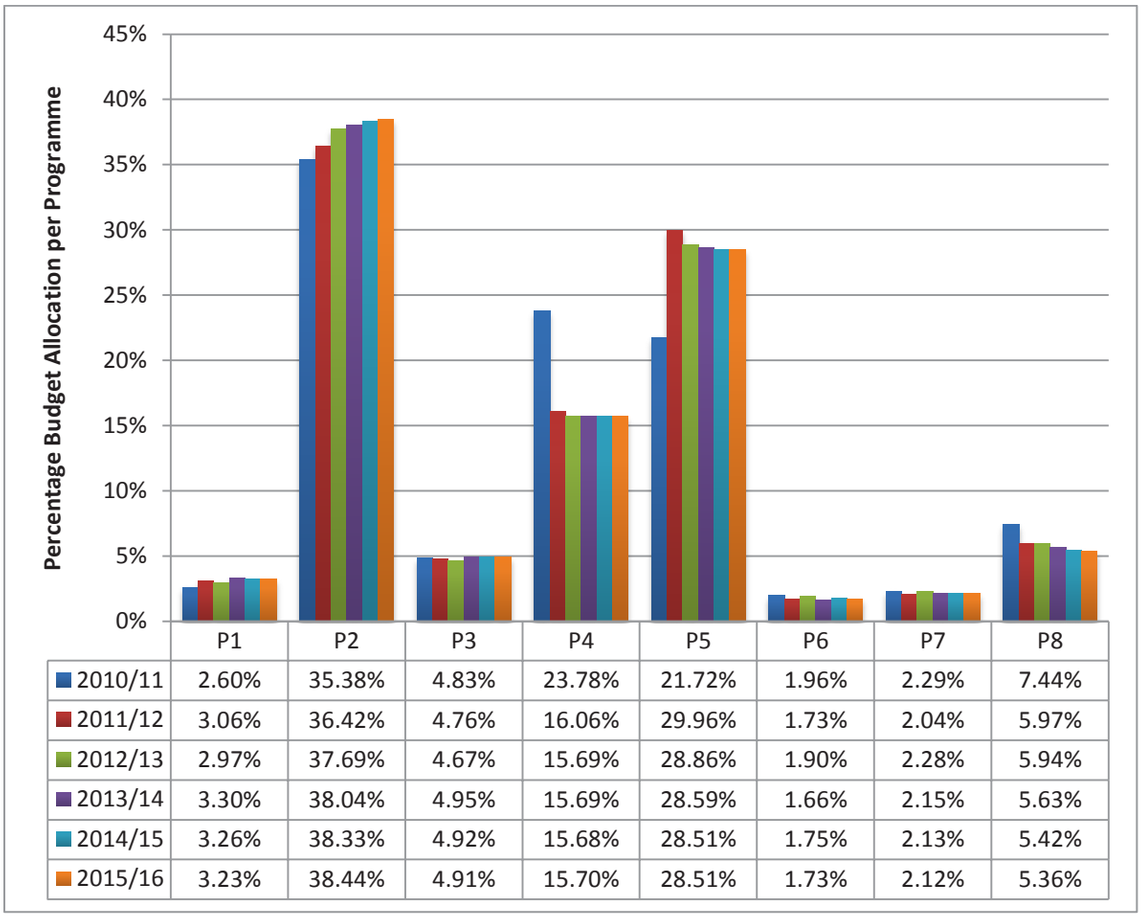
- Efficiency: less inputs for the given outputs;
- Economy: removal of excesses, wastage and unnecessary spending; and
- Effectiveness: attainment of desired outcomes, objectives and results.

[Source: Medium term budget policy statement 2012 – 2015, Provincial Treasury].

11.2 RESOURCE TRENDS OVER THE PAST 3 YEARS

The following graph illustrates the expenditure trend over the reporting period.

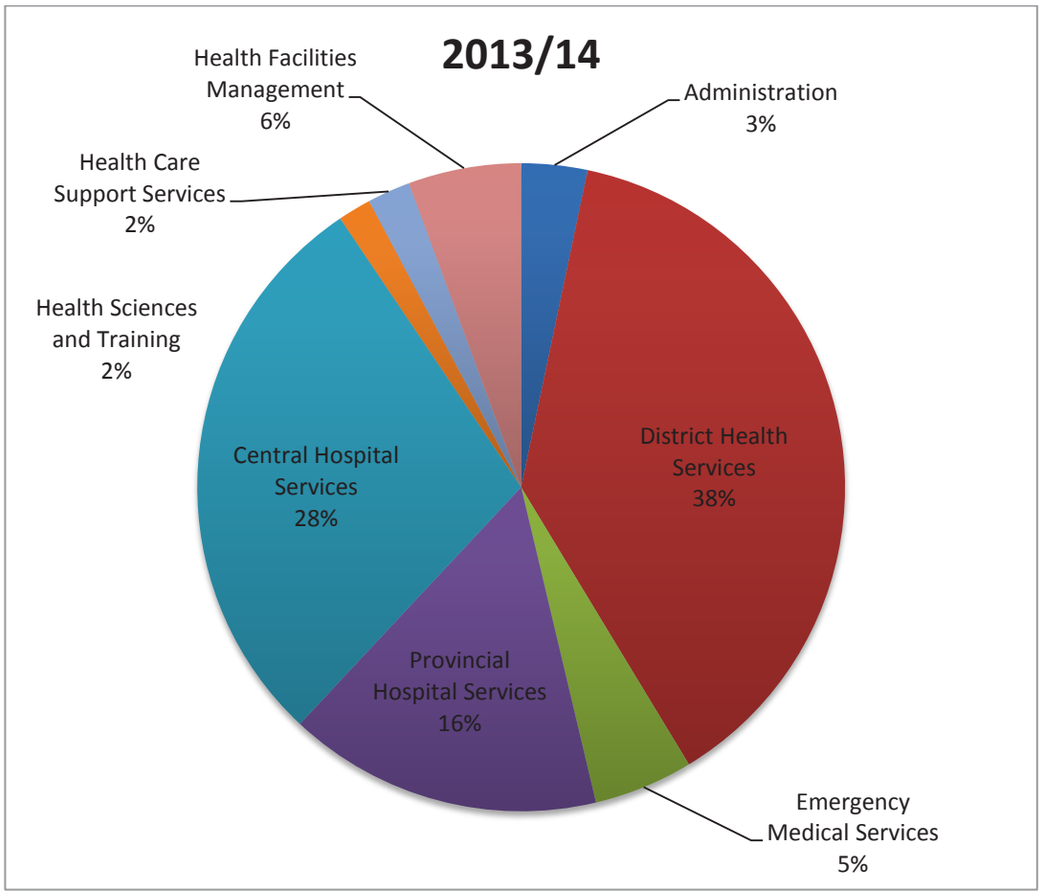
Figure 9: Budget allocation per programme over the reporting period, expressed as a percentage of the departmental budget



	P1	P2	P3	P4	P5	P6	P7	P8
2010/11	2.60%	35.38%	4.83%	23.78%	21.72%	1.96%	2.29%	7.44%
2011/12	3.06%	36.42%	4.76%	16.06%	29.96%	1.73%	2.04%	5.97%
2012/13	2.97%	37.69%	4.67%	15.69%	28.86%	1.90%	2.28%	5.94%
2013/14	3.30%	38.04%	4.95%	15.69%	28.59%	1.66%	2.15%	5.63%
2014/15	3.26%	38.33%	4.92%	15.68%	28.51%	1.75%	2.13%	5.42%
2015/16	3.23%	38.44%	4.91%	15.70%	28.51%	1.73%	2.12%	5.36%

The increases in Programme 2 and changes in Programmes 4 and 5 should be read with caution owing to the change in classification of hospitals over recent years and their re-allocation to budget programmes.

Figure 10: Budget allocation per programme for 2013/14



11.3 FOCUS ON LEVELS OF FUNDING AND SUSTAINABILITY OF HEALTH SERVICES

As a result of the fiscal tightening over the 2013 medium term expenditure framework period the Department's budget does not allow for real growth. The new priorities, such as the full commissioning of Khayelitsha and Mitchell's Plain Hospitals, improved EMS communication centres and the new Delft CHC are funded through reprioritisation.

Limited additional funding has been allocated for the Mitchell's Plain Hospital as GF Jooste Hospital will relocate to the premises of the new Mitchell's Plain Hospital, whilst the current GF Jooste Hospital is redeveloped. Limited funding has been provided for an Emergency Centre at Heideveld CDC to retain access to emergency care in the GF Jooste area after the latter hospital has been relocated.

Over the past years staff numbers have indeed increased. In contrast the budget for personnel expenses for the MTEF period reduces marginally in real terms.

The funding for performance awards (SPMS) was already reduced by 20 per cent in the current (2012/13) financial year. The funding will now be reduced by a further 50 per cent. This reduction will be applicable to all levels of staff. The Department is also limiting overtime payments and will continue to monitor overtime expenses during 2013/14.

The funding for Capital has been maintained at current levels in real terms.

Funding for goods and services is equal to the levels of recent actual expenses plus 5.3 per cent. The percentage was indicated by Provincial Treasury. Medical inflation is normally higher than the average inflation rate. As a result stringency measures with respect to Laboratory tests, Medical and Surgical Supplies, Security, Municipal charges, medicines and Government Motor Transport will have to be strengthened to prevent over-expenditure.

Due to improved "gatekeeping", a control process to ensure that protocols are strictly applied, the Department will contain the funding on Laboratory Services. The growing bill for electricity remains a concern. The Department is initiating a project to monitor and reduce consumption.

Funding for agency services, which forms part of goods and services, has been reduced in real terms in line with the strategic decision of the Department to reduce reliance of agency services. Agency expenditure will be closely monitored.

Funding for Transfer Payments is equal to the Adjusted Budget for 2010/11 plus 5.3 per cent.

Provision is made for an improved emergency communications system.

The conditional grant for AIDS continues to grow in excess of the inflation rate and is supplemented with an allocation from the Global Fund.

In spite of the fiscal pressure the allocation to property maintenance is not reduced compared to current levels in real terms, as this is considered to be a high priority.

The Department increased its revenue targets from own sources over the MTEF period. The Department receives the full benefit of increased revenue.

In conclusion, as a result of the fiscal tightening over the 2013 medium term expenditure framework period the Department's budget does not allow for real growth. The new priorities, such as the full commissioning of Khayelitsha and Mitchells Plain Hospitals, an improved EMS communication centres and the new Delft CHC are funded through reprioritisation. The additional allocation of R25 million for the EMS Communications Centre by the Provincial Treasury is acknowledged.

11.4 FUNDING IMPLICATIONS OF CURRENT TRENDS OF SERVICE VOLUMES

11.4.1 Growth trends in service volumes from 2009/10 to 2012/13

Table 15: Trends in key provincial service volumes [A2]

Indicator	Programme	2009/10 Actual	2010/11 Actual	2011/12 Actual	2012/13 Estimate
PHC headcount total	2	15 848 973	16 206 552	15 535 613	15 201 644
OPD headcount + emergencies in district hospitals	2	844 149	901 798	921 914	894 012
OPD headcount new case not referred	2	Not required to report	Not required to report	Not required to report	192 760
Separations in district hospitals	2	238 085	237 292	246 329	260 684
OPD headcount + emergencies in regional hospitals	4	925 230	863 931	392 206	396 253
OPD headcount new case not referred in regional hospitals	4	Not required to report	Not required to report	Not required to report	16 635
Separations in regional hospitals	4	185 919	174 307	107 713	107 835

Indicator	Programme	2009/10 Actual	2010/11 Actual	2011/12 Actual	2012/13 Estimate
OPD headcount + emergencies in central hospitals	**5**	537 749	541 079	961 433	988 398
OPD headcount new case not referred in central hospitals	**5**	Not required to report	Not required to report	Not required to report	10 855
Separations in central hospitals	**5**	68 231	68 490	134 818	138 184
Total patient volume: Acute Services	**Sub Total**	**18 648 336**	**18 993 449**	**18 300 026**	**17 987 010**
OPD headcount in specialised hospitals	**4**	62 836	69 156	45 961	43 272
Separations in specialised hospitals	**4**	9 882	10 831	10 660	10 666
Total patient volume	**Total**	**18 721 054**	**19 073 436**	**18 356 647**	**18 040 948**

The practice of reporting PHC visits in district hospitals as PHC headcounts rather than hospital OPD visits, as amended at the end of 2010/11, resulted in an increase in the reported PHC headcount with a reduction in OPD visits. From 1 April 2011 all patient visits to hospital outpatient departments have been counted as hospital OPD visits, which resulted in PHC headcounts declining noticeably from 2010/11 to 2011/12, while the hospital OPD counts increased commensurately for the same period. The relatively large decrease in PHC headcounts between 2010/11 and 2011/12 impacts on the total service volumes.

Between 1 April 2008 and 31 March 2011 regional hospital beds in central hospitals were reflected against Programme 4 (regional hospitals). From April 2011 the regional beds in central hospitals were included in programme 5. The result is that regional hospitals (Programme 4) reflect a decline in patient volumes in 2011/12 whereas central hospitals reflect an increase.

The decline in the OPD headcount at specialised hospitals is a result of the successful transfer of patients from the Western Cape Rehabilitation Centre OPD to community-based services.

The Department's efforts to strengthen PHC as the gateway to the health service are finally reaping benefits. The new initiatives via the Provincial Transversal Management System to address the upstream factors in the prevention of disease are still in the early stages and will impact on the patient load in the medium to long term.

11.5 EXPENDITURE ESTIMATES

Table 16: Summary of payments and estimates

Programme R'000	Outcome						Medium-term estimate			
	Audited 2009/10	Audited 2010/11	Audited 2011/12	Main appro-priation 2012/13	Adjusted appro-priation 2012/13	Revised estimate 2012/13	2013/14	% Change from Revised estimate 2012/13	2014/15	2015/16
1. Administration [a,c]	266 710	321 481	410 028	488 548	454 873	448 374	**523 105**	16.67	552 907	580 169
2. District Health Services [b,f,c]	3 722 530	4 367 380	4 875 956	5 498 095	5 533 429	5 549 277	**6 036 795**	8.79	6 504 275	6 896 361
3. Emergency Medical Services [c]	530 130	596 110	637 208	701 392	702 319	704 520	**786 339**	11.61	835 201	880 053
4. Provincial Hospital Services [c]	2 501 088	2 935 241	2 149 535	2 310 951	2 320 145	2 322 082	**2 489 520**	7.21	2 661 297	2 816 088
5. Central Hospital Services [c,d]	2 347 345	2 681 739	4 011 137	4 211 787	4 251 999	4 258 035	**4 538 364**	6.58	4 837 935	5 113 833
6. Health Sciences and Training	194 624	241 374	231 451	254 878	273 099	281 317	**263 184**	(6.45)	297 045	310 525
7. Health Care Support Services [c]	197 605	282 869	272 962	289 629	310 865	320 889	**340 618**	6.15	361 542	380 790
8. Health Facilities Management [e,g]	611 002	918 434	799 486	877 081	897 103	884 546	**893 751**	1.04	919 701	961 717
Total payments and estimates	10 371 034	12 344 628	13 387 763	14 632 361	14 743 832	14 769 040	**15 871 676**	7.47	16 969 903	17 939 536

[a] MEC total remuneration package: R1 652 224 with effect from 1 April 2012.

[b] National Conditional grant: Comprehensive HIV and Aids -R927 547 000 (2013/14), R1 083 286 000 (2014/15) and R1 228 095 (2015/16).

[c] National Conditional grant: Health Professions Training and Development - R451 667 000 (2013/14), R478 767 000 (2014/15) and R500 790 000 (2015/16).

[d] National Conditional grant: National Tertiary Services - R2 400 714 000 (2013/14), R2 537 554 000 (2014/15) and R2 654 281 000 (2015/16).

[e] National Conditional grant: Hospital Facility Revitalisation - R629 786 000(2013/14), R645 200 000 (2014/15) and R674 582 000 (2015/16), of which the following is allocated to:

Health Infrastructure Component - R122 296 000 (2013/14), R143 171 000(2014/15), R150 079 000 (2015/16).

Hospital Revitalisation Component - R493 526 000 (2013/14), R481 079 000(2014/15), R502 589 000 (2015/16)

Nursing Colleges and Schools Component - R13 964 000 (2013/14), R20 950 000(2014/15), R21 914 000 (2015/16).

[f] National Conditional grant: National Health Insurance Grant - R4 850 000 (2013/14), R7 000 000 (2014/15) and R7 396 000 (2015/16).

[g] National Conditional grant: Expanded Public Works Programme Integrated Grant for Provinces - R3 000 000 (2013/14).

Table 17: Summary of payments and estimates by economic classification

Economic classification R'000	Outcome						Medium-term estimate			
	Audited 2009/10	Audited 2010/11	Audited 2011/12	Main appro-priation 2012/13	Adjusted appro-priation 2012/13	Revised estimate 2012/13	2013/14	% Change from Revised estimate 2012/13	2014/15	2015/16
Current payments	9 111 684	10 634 678	11 732 984	12 934 547	13 054 733	13 073 276	**14 194 487**	8.58	15 201 588	16 105 933
Compensation of employees	5 780 151	6 808 175	7 665 447	8 478 408	8 577 603	8 524 048	**9 345 609**	9.64	10 113 868	10 796 608
Salaries and wages	5 145 145	6 066 844	6 814 694	7 530 118	7 620 400	7 567 109	**8 285 344**	9.49	8 965 792	9 570 670
Social contributions	635 006	741 331	850 753	948 290	957 203	956 939	**1 060 265**	10.80	1 148 076	1 225 938
Goods and services	3 331 196	3 826 487	4 067 518	4 456 139	4 477 130	4 549 228	**4 848 878**	6.59	5 087 720	5 309 325
of which										
Administrative fees	836	950	1 002	1 112	1 112	981	**1 034**	5.40	1 074	1 112
Advertising	11 087	17 574	17 762	16 213	16 213	18 076	**20 353**	12.60	23 259	24 264
Assets <R5 000	32 240	43 625	56 733	60 780	81 940	82 457	**85 046**	3.14	62 849	60 317
Audit cost: External	16 907	14 755	21 325	19 551	24 423	24 423	**25 004**	2.38	26 011	26 940
Bursaries (employees)	7 365	8 724	7 782	7 130	7 130	7 130	**7 508**	5.30	7 809	8 085
Catering: Departmental activities	4 735	5 366	4 883	5 015	5 050	5 945	**6 109**	2.76	6 454	6 781
Communication	60 160	66 298	64 599	69 643	70 363	71 740	**75 523**	5.27	78 560	81 335
Computer services	44 114	64 875	76 944	90 408	88 759	87 669	**88 203**	0.61	92 743	96 024
Cons/prof: Business and advisory services	101 619	100 506	71 571	78 728	89 107	86 048	**85 386**	(0.77)	89 777	93 135
Cons/prof: Infrastructure & planning	2 915	990	6							
Cons/prof: Laboratory services	395 711	407 390	422 607	416 657	423 065	455 741	**530 096**	16.32	569 549	599 519
Cons/prof: Legal costs	3 603	4 839	5 945	7 378	7 378	6 121	**6 443**	5.26	6 701	6 939
Contractors	115 450	136 715	198 840	216 070	196 941	200 098	**220 869**	10.38	231 804	240 319
Agency and support/ outsourced services	304 030	288 969	294 459	298 484	321 065	352 257	**316 856**	(10.05)	329 515	341 180
Entertainment	100	217	197	283	294	824	**868**	5.34	905	939
Inventory: Food and food supplies	85 056	96 024	99 605	103 661	104 161	105 404	**110 689**	5.01	120 362	127 100
Inventory: Fuel, oil and gas	26 619	31 833	28 084	34 939	36 642	39 673	**41 776**	5.30	43 459	44 992
Inventory: Materials and supplies	39 782	40 278	38 870	43 227	42 032	38 603	**40 198**	4.13	41 798	43 283
Inventory: Medical supplies	647 736	778 418	865 584	915 164	908 685	889 798	**972 937**	9.34	1 025 405	1 074 916
Inventory: Medicine	661 488	786 569	766 305	898 222	870 919	843 614	**858 244**	1.73	902 160	927 238
Inventory: Other consumables	97 356	111 359	122 075	121 999	127 594	141 825	**148 847**	4.95	154 833	160 348
Inventory: Stationery and printing	41 360	53 232	58 633	60 351	60 921	62 642	**67 024**	7.00	69 800	72 426
Lease payments	15 581	17 880	15 136	103 231	93 607	39 130	**69 864**	78.54	72 665	75 236
Rental and hiring			292	31	31	546	**1 971**	260.99	2 078	2 204
Property payments	357 415	464 130	571 778	616 856	625 074	645 656	**709 684**	9.92	751 346	801 835
Transport provided: Departmental activity	1 297	1 456	986	1 369	1 307	1 387	**1 655**	19.32	1 727	1 797
Travel and subsistence	197 790	226 027	185 605	178 455	190 746	257 992	**269 064**	4.29	281 481	292 704
Training and development	50 391	43 401	49 236	61 059	51 474	43 854	**43 129**	(1.65)	46 524	48 951
Operating expenditure	5 689	10 442	17 599	26 209	27 233	36 894	**41 242**	11.79	43 599	45 730
Venues and facilities	2 764	3 645	3 075	3 914	3 864	2 700	**3 256**	20.59	3 473	3 676
Interest and rent on land	337	16	19							
Interest	337	16	19							
Transfers and subsidies to	550 863	724 559	754 454	817 640	805 795	819 218	**839 419**	2.47	897 814	916 410
Provinces and municipalities	228 424	263 107	302 280	340 354	334 382	334 382	**352 791**	5.51	368 174	377 744
Municipalities	228 424	263 107	302 280	340 354	334 382	334 382	**352 791**	5.51	368 174	377 744
Municipalities	228 424	263 107	302 280	340 354	334 382	334 382	**352 791**	5.51	368 174	377 744
Departmental agencies and accounts	4 712	55 341	15 651	22 071	3 535	3 643	**3 928**	7.82	4 220	4 477
Entities receiving transfers	4 712	55 341	15 651	22 071	3 535	3 643	**3 928**	7.82	4 220	4 477
CMD Capital Augmentation	1 715	52 299	12 535	18 536						
SETA	2 997	3 042	3 116	3 535	3 535	3 541	**3 824**	7.99	4 111	4 366
Other						102	**104**	1.96	109	111
Universities and technikons		1 400	6 025	1 603	3 603	5 400	**3 580**	(33.70)	3 724	3 856
Non-profit institutions	239 925	281 488	313 931	334 945	353 301	355 028	**381 053**	7.33	401 164	416 928
Households	77 802	123 223	116 567	118 667	110 974	120 765	**98 067**	(18.80)	120 532	113 405
Social benefits	18 435	24 400	23 761	22 537	22 627	34 212	**36 102**	5.52	37 563	38 887
Other transfers to households	59 367	98 823	92 806	96 130	88 347	86 553	**61 965**	(28.41)	82 969	74 518

Economic classification R'000	Outcome						Medium-term estimate			
	Audited 2009/10	Audited 2010/11	Audited 2011/12	Main appro-priation 2012/13	Adjusted appro-priation 2012/13	Revised estimate 2012/13	2013/14	% Change from Revised estimate 2012/13	2014/15	2015/16
Payments for capital assets	704 758	973 345	896 801	880 174	883 304	872 078	**837 770**	(3.93)	870 501	917 193
Buildings and other fixed structures	493 617	740 528	551 486	625 049	599 383	586 927	**546 413**	(6.90)	642 360	702 425
Buildings	493 617	740 528	551 486	625 049	599 383	586 927	**546 413**	(6.90)	642 360	702 425
Machinery and equipment	210 361	232 674	345 154	254 316	282 922	284 102	**290 696**	2.32	227 449	214 044
Transport equipment	18 249	13 879	90 651	14 017	10 275	9 837	**19 826**	101.55	20 620	21 355
Other machinery and equipment	192 112	218 795	254 503	240 299	272 647	274 265	**270 870**	(1.24)	206 829	192 689
Software and other intangible assets	780	143	161	809	999	1 049	**661**	(36.99)	692	724
Of which: "Capitalised Compensation" included in Payments for capital assets	141	137								
Of which: "Capitalised Goods and services" included in Payments for capital assets	500 069	739 674	551 634							
Payments for financial assets	3 729	12 046	3 524			4 468		(100.00)		
Total economic classification	10 371 034	12 344 628	13 387 763	14 632 361	14 743 832	14 769 040	**15 871 676**	7.47	16 969 903	17 939 536

11.6 RELATING EXPENDITURE TRENDS TO SPECIFIC GOALS

The impact of the constrained budget is outlined in paragraph 11.3. Focus on levels of funding and sustainability of health services.

The Department must continue to rigorously scrutinise its business processes and ensure that they are appropriately adapted to ensure efficiency to enable optimal health service benefits with the available resources.

The following important initiatives are not funded:

- The provincialisation of Personal Primary Health Care services in the Cape Town Metro District.
- Provision for relief staff to allow full-time staff, particularly nurses, to attend training courses.
- Adequate funding to improve the level of maintenance of health facilities.

Table 18: Trends in provincial health expenditure [A9]

Expenditure	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Current prices							
Total excluding capital	9 760 032	11 426 194	12 588 277	13 884 494	14 977 925	16 050 202	16 977 819
Total Capital	611 002	918 434	799 486	884 546	893 751	919 701	961 717
Grand Total	**10 371 034**	**12 344 628**	**13 387 763**	**14 769 040**	**15 871 676**	**16 969 903**	**17 939 536**
Total per person	1 881	2 191	2 326	2 513	2 646	2 773	2 875
Total per uninsured person	2 411	2 808	2 981	3 221	3 392	3 555	3 685
Constant 2011/12 prices							
Total excluding capital	12 170 760	12 168 897	12 588 277	13 120 847	13 225 508	13 257 467	13 123 854
Total Capital	489 978	862 379	799 486	936 028	1 012 176	1 113 439	1 244 136
Grand Total	**12 660 737**	**13 031 276**	**13 387 763**	**14 056 874**	**14 237 683**	**14 370 906**	**14 367 990**
Total per person	2 297	2 313	2 326	2 392	2 374	2 348	2 302
Total per uninsured person	2 943	2 964	2 981	3 066	3 043	3 010	2 951
% of Total spent on:-							
District Health Services	35.89%	35.38%	36.42%	37.57%	38.04%	38.33%	38.44%
Provincial Hospital Services2	24.12%	23.78%	16.06%	15.72%	15.69%	15.68%	15.70%
Central Hospital Services	22.63%	21.72%	29.96%	28.83%	28.59%	28.51%	28.51%
Other Health Services	11.47%	11.68%	11.59%	11.88%	12.05%	12.06%	11.99%
Capital	5.89%	7.44%	5.97%	5.99%	5.63%	5.42%	5.36%
Health as % of total public expenditure (current prices)	34.9%	33.0%	36.4%	38.6%	38.2%	40.5%	41%

Table 19: CPIX multipliers for adjusting current prices to constant 2011/12 Rands [A10]

2009/10	1.247
2010/11	1.065
2011/12	1.000
2012/13	0.945
2013/14	0.883
2014/15	0.826
2015/16	0.773

Source: Office of the CFO

PART B

BUDGET PROGRAMME PLANS

PROGRAMME 1: ADMINISTRATION

1. PROGRAMME PURPOSE

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

To make limited provision for maintenance and accommodation needs.

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 1.1: OFFICE OF THE MEC

Rendering of advisory, secretarial and office support services.

2.2 SUB-PROGRAMME 1.2: MANAGEMENT

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

3. SITUATION ANALYSIS

There are no changes to the budget programme structure since the compilation of the Strategic Plan 2010 – 2014.

The key management components that provide strategic leadership and support are described below.

3.1. OFFICE OF THE MEC AND THE OFFICE OF THE HEAD OF DEPARTMENT

The Provincial Cabinet and Minister of Health determine provincial policy. The Head of Department implements national and provincial policies to ensure that the Western Cape provincial health service is aligned with national, provincial and departmental strategy, policy and directives.

The communication with stakeholders is managed and co-ordinated both via the provincial Minister and the office of the Head of Department.

The Directorate: Communication resorts under the Office of the Head of Department.

3.2. COMMUNICATIONS

3.2.1. Purpose

To provide a communication platform for the Department's policies and corporate identity, and to promote awareness of service delivery projects and campaigns.

3.2.2. Overview

It is imperative that the marketing of the Department's corporate identity is appropriate and aligned with that of the Provincial Government. This entails ensuring consistency with the logo, typeface and colours, and being "on-brand" with key messages in the manner in

which the Department communicates to portray an organisation that is dynamic and solution-oriented.

The Department makes use of social media, dedicated messaging and interactive discussions on radio as part of its communication strategy. The Department can be accessed via Twitter (WcdeptHealth) or Facebook (search for Western Cape Government: Health). Through Twitter the Department can provide the media with real time information regarding emergency incidents, events and health days. It has also provided a platform to acknowledge staff who received awards for outstanding performance. The Department has been added to the media's Twitter profile and tweets from the Department are being posted regularly.

MXit, a mobile phone application that is free to users, has enabled the Department to communicate with a wider platform in a more relaxed environment (go to Tradepost and search Western Cape Government: Health). The Department uses MXit on an ad-hoc basis during awareness campaigns and more than 50 000 people have previously added the Department's profile as a "friend".

Under the leadership of the provincial Minister of Health, on 1 August 2012, the Directorate initiated a three-month project in which clients were able to telephone, text or e-mail complaints to a call centre and receive responses on the same day. Call centre agents logged each complaint and texted a reference number to complainant. This Complaints Hotline was piloted at Tygerberg Hospital, New Somerset Hospital, Wesfleur Hospital, Helderberg Hospital, Retreat Community Health Centre (CHC), Site B CHC, Mitchells Plain CHC and TC Newman CDC. The initial project was concluded on 30 January 2013. The project has enabled the Department to make informed decisions on the future handling of patient complaints. The service will be implemented at facilities across the Province in a phased approach over the next five years.

The Department has also implemented a telephonic interpretation service which will be rolled out to all health facilities in a phased approach. Health facilities will be able to phone the InterTel service whenever they require an interpreter to communicate with foreign clients or clients who prefer communication in their mother tongue. The number of patients communicating in foreign languages has increased owing to migration to the province.

3.2.3. **Challenges**

The following challenges and mitigating measures have been identified:

Challenges	**Mitigating measures**
1) The appointment of communications officers in all districts to facilitate communication with a wide range of personnel and other stakeholders across the Province.	• Existing staff establishments were amended. • Recruitment and selection of suitable staff has been completed in five out of six districts.
2) Successful marketing of the corporate identity that requires buy-in and support from internal role-players.	• Establish templates and tools to monitor all applications of the new corporate identity. Maintain a database and a closer working relationship with the Directorate: Supply Chain Management to ensure compliance.

Challenges	Mitigating measures
3) Obtain buy-in from facilities to ensure optimal usage of the InterTel service.	• A marketing plan, which will run over a period of six months, is being developed.

3.2.4. **Priorities**

- Support the change management strategy towards 2020.
- Market the new corporate identity of the Province.
- Improve internal communications to staff.
- Implement external and internal communication about programmes, campaigns and employment opportunities.
- Utilise the internet and intranet as a communications vehicle to market the Department.
- Use social media including Facebook, Twitter, YouTube, MXit, Flicker etc. as communication vehicles to market the Department.
- Ensure all stakeholders are aware of improvements in infrastructure and patient experience.
- Expand the interpreter service at various health facilities.

3.3. FINANCE

3.3.1. Purpose

To provide sound budget and financial administration within the Department.

3.3.2. Overview

The division is headed by the Chief Financial Officer and consists of the Chief Directorates Financial Management and Financial Management Support.

3.3.2.1. Financial Management

Financial Management consists of two directorates, namely Financial Accounting and Supply Chain Management.

The Department aims to continue its record of an unqualified audit opinion on financial matters and is striving towards a "clean" audit report. For improved adherence to finance and supply chain management prescripts, a Compliance Monitoring Instrument (CMI) has been introduced, which assists management to ensure compliance with priority issues identified by the Auditor-General of South Africa. The Department also introduced monthly assessments (inspections) for a significant percentage of departmental expenses to prevent; detect and correct errors should they occur.

The key focus areas of the two directorates are:

- Compliance with finance and supply chain management prescripts and procedures.
- Transport management.
- Salary administration.

In co-operation with the line divisions, the Chief Directorate has initiated an Essential Supplies List (ESL) project that will facilitate the standardisation of the medical and surgical supplies that are used and the procurement thereof.

3.3.2.2. **Financial Management Support**

Financial Management Support consists of one directorate, namely Management Accounting.

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 projected against the allocated budget.

A joint initiative with the Directorate: Human Resource Management exists to control personnel expenditure through managing all funded posts in accordance with the Approved Post List (APL).

The vetting, budgeting and reporting of results, per cost centre and/or functional business unit, is 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.

3.3.3. **Challenges**

The following challenges and mitigating measures have been identified:

Challenges	**Mitigating measures**
1) Recruitment and retention of competent and skilled employees.	• Development and implementation of a retention policy and strategy. • Innovative recruitment system.
2) Increased reporting requirements by National and Provincial Treasury.	• Develop specifications and interact with Provincial Treasury.
3) The lack of appropriate transversal financial systems.	• Implementing sound monitoring, evaluation and reporting mechanisms to ensure accountability.

3.3.4. **Priorities**

- Timely resourcing of appropriate supplies and services at the best prices.
- Accurate accounting and reliable reporting to internal and external stakeholders.
- Management of personnel expenditure through a list of affordable posts.
- Operating within allocated budget.
- Working with the CD: Strategy and Health Support and Top Management to set priorities within the limited resources.
- Improving efficiency to get the best value for the health rand.
- Ensuring unqualified annual financial statements without any matters of emphasis through improved internal controls.
- Devolving financial authority and accountability via cost centre accounting (referred to as functional business units).

- Investigating methods to be more supportive of the GSAs as the authority and accountability of these structures increase.

3.4. HUMAN RESOURCES

3.4.1. Purpose

To render an effective human resource service and ensure integration of all human resource services.

3.4.2. Overview

The chief directorate consists of the following directorates/unit:

1) Human Resource Management
2) Human Resource Development
3) Labour Relations
4) Nursing Services
5) Transformation Unit

3.4.2.1. Human Resource Management

1) **Purpose**
To render an effective and efficient human resource management service which includes human resource planning and rendering of an advisory and support service with specific reference to the application of the public service regulatory framework, collective agreements, conditions of service, national and provincial directives as well as organisational change within the Department.

2) **Overview**
Human Resource Management plays a vital role in ensuring the provision of the correct number and skills mix of personnel to render the required health service. The Human Resource Plan addresses the gaps in workforce numbers, competencies and skills.

3) **Challenges**

The following challenges and mitigating measures have been identified:

Challenges	Mitigating measures
1) The successful implementation of the current HR key strategic priorities.	• A dedicated team has been identified to ensure the development, implementation, and monitoring and evaluation of an integrated HR strategy for the Department.
2) The turnaround time taken to fill vacant posts is a significant challenge.	• Monthly monitoring and a multi-pronged strategy to address issues that delay the filling of posts have been implemented.
3) An inadequate HR information system that has resulted in misalignment between the	• Quarterly verification of PERSAL data during which discrepancies are identified and addressed.

Challenges	Mitigating measures
organisational structure and PERSAL.	• HR compliance: Recruitment of additional HR compliance staff and the development and implementation of an HR compliance strategy that includes the conducting of pre-audits at high risk institutions, training and development in HR compliance and monitoring and evaluation of HR compliance. • Investment in the Integrated Financial Management System (IFMS).
4) Recruitment and retention of various staff categories within the Department.	• Development and implementation of a recruitment and retention policy and strategy.
5) Management of employee absenteeism.	• Training of line managers to effectively manage absenteeism.
6) An inadequate service delivery platform to address the burden of disease.	• Strengthening the clinical service to ensure that the burden of disease is effectively addressed once the service platform has been determined.
7) A fragmented training and development plan.	• Development of an integrated training and development system that would include the development of critical clinical, leadership and support staff skills and a rigorous monitoring and evaluation framework to assess the impact of training.
8) Lack of appropriate skills and competencies within clinical and support functions to successfully deliver the package of care and a quality health service.	• Development of health professionals' clinical skills in conjunction with continuous professional development to improve competence and confidence thereby improving the quality of health care.

4) **Priorities**

Key priorities include:

- Effective human resource planning:
    - Workforce planning: The development of detailed staffing plans and organisational structures to support new strategies in healthcare. This will include the scope of practice of healthcare professionals and the development of norms and standards.
    - Ensuring that appropriate numbers of healthcare professionals with the required competencies are in place to effectively manage the burden of disease at various levels of care.
    - Developing multi-year human resource plans that are in line with national, provincial and departmental strategic objectives.

- Effective and efficient management of staff:
  - Facilitating the development and implementation of an HR toolkit for line managers.
- Effective and efficient human resource practices:
  - Facilitating the recruitment and retention of competent and skilled employees (efficient recruitment and selection system, talent management particularly in rural areas) through:
    - Reducing recruitment turnaround times.
    - The development of a recruitment strategy that would include an on-line recruitment system.
    - Ensuring compliance with human resource prescripts and procedures and an unqualified audit from a human resource perspective.
  - Reviewing of the performance management system including leadership training in effective performance management techniques.
  - Develop an integrated training and development plan in partnership with higher education institutions, private sector and Health Councils to ensure that curricula and training address the needs of the Health Department.

3.4.2.2. **Human Resource Development and Western Cape College of Nursing**

Refer to Programme 6.

3.4.2.3. **Labour Relations**

1) **Purpose**

To manage the collective bargaining processes and provide an advisory and support service to enhance service delivery.

2) **Overview**

The directorate consists of the following components:
- Collective Bargaining
- Labour Relations Support Services
- Dispute Management

The function of collective bargaining derives from Part 111 of the Labour Relations Act, 66 of 1995, as amended, regulating collective bargaining processes and the implementation of collective agreements and resolutions. The Department functions under the auspices of the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC). The directorate strives to ensure effective and constructive engagement with organised labour on various matters affecting their members and ensure the full implementation of collective agreements and resolutions.

The directorate renders a support service to senior managers/heads of institutions through various interventions to ensure fair labour relation practices.

The dispute resolution function is regulated in terms of various resolutions and provisions of the Labour Relations Act. The purpose is to ensure that the Department's interest is served and protected without compromising fair labour practices.

3) **Challenges**

The following challenges and mitigating measures have been identified:

Challenges	Mitigating measures
1) Maintaining constructive collective bargaining processes.	• On-going participative consultation with all stakeholders and continuously improve all bargaining and consultation structures.
2) Dispute prevention and prompt resolution of grievances.	• Investigation and action undertaken to address issues promptly.
3) Prompt finalisation of disciplinary cases.	• Capacity building for all line managers and supervisors. • Strengthening the human resource capacity of the directorate to deal with identified serious cases of misconduct.

4) **Priorities**

- Effective consultation with organised labour to ensure full implementation of the organisational structure and management of excess staff.
- Optimal functioning of the provincial chamber and Institutional Management Labour Committees (IMLCs) to deal with matters of mutual interest and to prevent or minimise conflict.
- Prompt and effective management of disciplinary cases/grievances/disputes.
- Development of executive, line managers and employees in labour relations matters through capacity building.
- Management of strikes/protest actions and ensuring that contingency plans are in place at all institutions.
- Capturing and maintaining an internal labour relations information management system to provide accurate statistics and reports to all relevant stakeholders.

3.4.2.4. **Nursing services**

1) **Purpose**

To co-ordinate and provide direction to nursing services, nursing education and nursing governance within the Department.

2) **Overview**

The Directorate Nursing Services comprises of two sub-directorates:

- Clinical Nursing Practice
- Nursing Education and Training

The Directorate is the custodian of the Provincial Nursing Strategy and is responsible for its implementation.

Nurses play a central role in providing and maintaining the health care system through the provision of a comprehensive quality health care service from primary health care (PHC) to highly specialised services.

It is therefore essential that the skills and competency levels of nurses be maintained and developed in order to equip nurses to meet the increasing demands of service delivery and a changing environment.

3) **Challenges**

The following challenges and mitigating measures have been identified:

Challenges	**Mitigating measures**
1) Insufficient funding for relief, community service and graduate bursar posts.	• Steps are being taken to create relief training posts on PERSAL, through shifting of funds currently utilised for agency staff. • Ensuring that funded posts are available for bursars after the satisfactory completion of qualifications.
2) Shortage of nurses in specialty nursing.	• Increasing the number of nursing staff to be released for training in specialty nursing. • Creation of general specialty posts in order to allow the professional nurses to obtain experience before they can be trained and eventually be appointed in a specialty.
3) Limited clinical placement for nursing students.	• Ensuring cluster accreditation of clinical placement facilities, public and private, per district, in consultation with the South African Nursing Council (SANC). • Steps are being taken to engage in joint utilisation of the clinical platform, in both private and public sectors. • Involvement from the NEI's / HEI's to ensure that the health facilities comply with the requirements of SANC for accreditation.
4) Poor public image of nursing impacts on the perception of the public of the nursing profession.	• Improved marketing drives.

4) **Priorities**

- Manage and implement nursing practice, education and training in line with departmental human resource and financial plans.
  - Develop, maintain and implement a training plan for managers based on the outcomes of a skills audit of senior management and facilities management.
  - Effective clinical placement and supervision of students to address the service needs and requirements.

- Manage the quality and improvement of nursing practice, education and training within the Department.
  - Standardisation of policies, standard operating procedures and nursing documentation in line with the national core standards.
  - Provision of continuous professional development (CPD) to ensure that nurses are competent to manage priority conditions such as HIV/AIDS/TB and maternal diseases.
- Co-ordinate nursing related research and development.
- Market and promote the corporate image of nursing.
- Implement and monitor placement systems for community service and graduate bursars for nurses.
- Finalise nursing norms and standards to improve the organisational design system.
- Develop collaborative partnerships with other professional organisations and stakeholders.

3.4.2.5. **Transformation Unit**

1) **Purpose**

To contribute to the achievement of government's national priority areas and the integration of initiatives related to employee wellness, HIV, gender, disability, employment equity and youth.

2) **Overview**

The Transformation Unit consists of two components, namely Wellness and Diversity; and Employment Equity and Disability.

The Employee Health and Wellness Programme (EHWP) of the Department aims to improve productivity, morale, motivation and relationships at work. The services are available to all employees and their household members. Managerial support is available through the use of referrals and managerial consultancy services. A professional referral protocol has been developed for the in-house employee health and wellness services to facilitate co-ordination between the internal and outsourced services.

The Department's HIV Workplace Programme is guided by the Transversal Workplace Policy on HIV and AIDS and is aimed at minimising the impact of HIV and AIDS in the workplace.

Western Cape Government (WCG) Health is the primary driver of the Workplace HIV and AIDS Programmes for all provincial government departments in the Western Cape.

Health and wellness risks are effectively being managed through the incorporation of data on the Policy on Incapacity Leave and Ill-Health Retirements (PILIR), health screenings and HIV counselling and testing.

3) **Challenges**

The following challenges and mitigating measures have been identified:

Challenges	Mitigating measures
1) Lack of uniformity across districts and institutions regarding the human resource structure for transformation programmes.	• District and institutional structures to be aligned with the head office model.
2) Poor understanding of the concept of gender mainstreaming resulting in a lack of support for the implementation of strategies.	• Capacity building for senior and middle managers. • Promotion of awareness, education and popularisation of gender concepts. • Strengthening and capacitating the Departmental Gender Forum. • Developing simultaneous mainstreaming strategies for human rights programmes (HIV, gender, youth and disability).
3) Lack of co-ordination regarding Safety, Health, Environment Risk and Quality (SHERQ).	• Identification of all role-players and stakeholders. • Identification of roles, responsibilities and functions of role-players. • Establishment of SHERQ co-ordinating body within the Department.
4) Deviations from employment equity targets; historically gender-dominated professions, e.g. nursing (female-dominated), engineering (male-dominated) resulted in skewed statistics.	• Strengthening employment equity measures to reach targets.

4) **Priorities**

- Implementation of a programme(s) to communicate the outcomes of the Barrett Values Survey to relevant employees and to address the outcomes of the survey.
- Strengthening the diversity management programme and mainstream human rights programmes (HIV, gender, youth and disability).
- Intensifying information and education regarding the Employee Health and Wellness programme to ensure proactive use of the service to enhance quality of work life management and occupational health and safety.
- Strengthening HIV counselling and testing (HCT) in the workplace to contribute towards meeting provincial HCT targets.
- Establishment of a Safety, Health, Environment Risk and Quality (SHERQ) forum/committee and implementation of a policy as prescribed by the Department of Public Service and Administration (DPSA). The Department is also exploring options to achieve better alignment with infection control and quality assurance initiatives.
- Strengthening employment equity measures.

3.5. STRATEGY AND HEALTH SUPPORT

3.5.1. Purpose

To assist the Head of Department with the prescribed strategic planning framework to ensure alignment between planning and reporting cycles and procedures and to ensure that policy and planning informs the budgetary processes.

3.5.2. Overview

The chief directorate consists of the following directorates:

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

3.5.2.1. Information Management

1) **Purpose**

To enable, facilitate and co-ordinate: the collection, collation, integration, reporting and presentation of data and information in a format that will facilitate the use of data for decision-making.

2) **Overview**

The directorate primarily serves as the central repository for performance information and manages and co-ordinates the collection and dissemination of this information for planning, budgeting, monitoring and evaluation purposes using standardised processes and tools with appropriate governance. Examples of these are data collection systems such as Clinicom and the Primary Health Care Information Systems; and reporting systems such as SINJANI, Geographic Information System and Business Intelligence.

The directorate facilitates the implementation of the information and communications technology (ICT) infrastructure required to support the use of ICT solutions throughout the Department. There will be a revised ICT strategic plan to register the importance, and challenges of ICT and e-Health within the business of rendering health services. ICT needs to be mainstreamed within the generic processes of planning, risk management, implementation, and monitoring and evaluation in the Department.

A further supporting function is records management, which develops; implements and oversees compliance with the Department's records management policies. This function encompasses identifying, classifying, storage and archiving, and providing access to records and the controlled destruction of records. The Promotion of Access to Information Act (PAIA) is administratively managed within this section.

Although the Auditor-General of South Africa (AGSA) has not formally expressed an audit opinion on predetermined objectives in the Audit Report to date, the Department aims to achieve an unqualified audit opinion on predetermined objectives. A

Compliance Monitoring Instrument (CMI) and a supervisory tool have been developed for predetermined objectives to improve adherence to information management prescripts. This tool will, in future, be used by the Information Compliance Unit (ICU) staff, that will be appointed in the latter half of 2012/13 to perform compliance monitoring in the Province across all programmes. The audit action plan adopted by the directorate allows for the revision of these tools on an annual basis, following the publication of the Auditor-General's audit findings.

Information management training is provided on a continuous basis and the directorate has a full-time trainer to further develop and refine the training strategy and the training material in the Province and conduct on-going information management training for staff.

3) **Priorities**

- Establishment of adequate standards, tools, processes and systems to manage performance information.
- Securing adequate resources to strengthen information management capacity at all levels of the health service.
- Ensuring the Department achieves an unqualified audit for predetermined objectives.
- Integrating systems to reduce duplication and create an information system that provides meaningful information.
- Identification, implementation and support for information systems that will support the health strategic principles of the Department.
- Building the skills capacity to undertake high quality technical work and manage projects.
- Identifying the ICT strategic priorities and developing operational plans to address each of them. The Department has identified the following ICT strategic priorities:
- To roll out and strengthen the development of a comprehensive and integrated HIS across the entire health service. This will include the roll out of PHCIS, hospital Information system, JAC PACS/RIS and ECM within the available resources.
    - Development of infrastructure and establishing interoperable systems.
    - Business Intelligence.
- To implement security measures to safeguard the privacy of patient information inherent in electronic health records.
- To facilitate the development of ICT human resource strategy.
- To strengthen the governance and overall management of ICT within Health.
- mHealth - especially as it aligns directly with the key vision of a patient-centred approach and the delivery of quality health care for all.
- Strengthen the relationships with partners such as SITA and CEI to improve the ICT support services.

4) **Challenges**

The following challenges and mitigating measures have been identified:

Challenges	**Mitigating measures**
1) Misalignment between programme requirements and Information management.	• Prioritisation of service needs. • Conducting Joint Information Management Initiative (JIMI) sessions together with programmes. • Interacting at executive committee meetings (DEXCO's) and obtain divisional endorsement.
2) Ensuring performance information is used for management decision-making, is audit compliant and reported timeously by creating a culture of accountability for performance information.	• Implementing control measures for performance data reporting at various levels within the programmes. • Monitoring reporting on a monthly basis by the use of standardised reports available in the SINJANI system. • Conducting annual pre-audit assessments on compliance.
3) Integration of electronic systems.	Continuing to develop a Business Intelligence (BI) solution that will: • Extract the data from various operational systems into a common area. • Perform data validations and verifications and pass the errors to the source system for correction. • Decide on meaningful dimensions and measures. • Use a network friendly presentation layer. • Allow access to a broader end-user community.

Challenges	Mitigating measures
4) Inadequate information management capacity at all levels of the service.	• Filling of critical vacant information management posts throughout the Department. • Training of the information management staff in all aspects of performance data capturing, monitoring and evaluation. • Developing an appropriate and structured capacity for records management. • Investigate the optimal use of administrative capacity within the services in an integrated manner.

3.5.2.2. **Professional Support Services**

To provide professional support services.

1) **Overview**

The directorate provides a support function to the Department with respect to a varied range of professional services.

The directorate's functions include:

- The co-ordination of blood transfusion and pathology services.
- The provision of medico-legal advisory services.
- The regulatory function of private health establishment licensing.
- The co-ordination of radiographic services.
- The co-ordination of security services.

2) **Challenges**

The following challenges and mitigating measures have been identified:

Challenges	Mitigating measures
1) The ICT system for pathology results is not integrated with other information systems which impacts negatively on the ability to make use of technological advancements.	• This will be addressed through the data harmonisation project in Business Intelligence.
2) Ensuring adherence to medical imaging related legislation, which includes compliance with the quality assurance (QA) of the related equipment.	• The provision of QA related training for radiographers by the Department.

Challenges	Mitigating measures
3) Ensure compliance to provincial legislation relating to ambulance services in both the public and private health sectors.	• The inspection and licensing of ambulance services by the Department according to set minimum norms and standards.
4) Developing a strategic framework for the delivery of security services.	• A Deputy director has been appointed centrally to focus on security services and will technically lead this process.

3) **Priorities**

- Supporting the Department to roll out the electronic gatekeeping of laboratory tests as part of a strategy to contain lab costs.
- Engaging the NHLS to develop an alert organism mechanism as an early warning system to infection control.
- Implement the provisions of the Western Cape Ambulance Services Act and related regulations that has been recently passed which applies to both the public and private sector.
- Conducting a review of security services in the Department, developing a strategic security services framework and strengthening the contractual arrangements to get better value for money.
- Establishment of an accredited training programme to meet the quality assurance prescripts of the medical imaging legislation. As of 2012/13 this is a function of the Department of Health as the higher education institutions no longer provide this training.

3.5.2.3. **Strategic Planning and Co-ordination**

1) **Purpose**

To facilitate the strategic planning process, drafting of budget cycle documentation and legal administration for the Department.

2) **Overview**

The directorate's functions include:

- Facilitate the development of long-term strategic plans for the Department by providing the technical analysis required to facilitate the process and compile the necessary documentation.
- Facilitate the compilation of the necessary documentation for the budget cycle, including the Five-year Strategic Plan, Annual Performance Plan, Annual Report, the Estimates of Provincial Revenue and Expenditure and the documentation required for engagement with Provincial Treasury.
- To facilitate and support the audit of predetermined objectives which reflects performance information.
- Legal administration support functions, such as facilitating the drafting of legislation.

3) **Challenges**

The following challenge has been identified:

Challenges	Mitigating measures
1) The recruitment and retention of appropriately skilled staff within the Directorate.	• The recruitment process for vacant post is in progress.

4) **Priorities**

- Recruitment and development of appropriately skilled personnel in order to sustainably provide the required strategic planning and legal administration support to the Department.
- Facilitating the development of the 2020 Strategic Planning Framework for the Department including the development of planning tools to address specific needs.
- Facilitating the development of the budget cycle plans and documentation (Annual Performance Plan, Strategic Plan, Annual Report, the Estimates of Provincial Revenue and Expenditure and the documentation required for engagement with Provincial Treasury).
- Supporting the process of developing District Health Plans.
- Facilitating and providing support to ensure an unqualified audit report on predetermined objectives.
- Facilitating the development and promulgation of provincial health legislation as required.

3.5.2.4. **Health Impact Assessment**

1) **Purpose**

To determine the impact of health programmes and the quality of health services on the burden of disease of the population of the Western Cape and to provide and test recommendations for improvements.

2) **Overview**

The directorate's objective is to improve the quality of public policy decision-making by providing evidence of the effectiveness and impact of current programmes, policies and strategies to enhance health outcomes. The development and implementation of disease surveillance programmes and an early warning system is envisaged to assist in the monitoring of trends in disease burden and risk factors to provide a pointer for resource allocation and appropriate interventions.

Quality of care is a high priority of the Department that is focused on a patient-centred experience. A centralised unit in HIA provides the policy framework, monitors and evaluates the quality of care at sub-provincial level. Complaints and compliments, morbidity and mortality, client satisfaction, and safety risks to patients and staff are regularly monitored. The Department has undertaken baseline self-assessments of the national core standards and is working on meeting these standards in preparation for

the establishment of the National Office of Health Standards that will certify all public and private facilities according to these standards.

The Directorate's functions include:

- Ensuring adequate surveillance of the burden of disease and its associated risk factors affecting the population.
- Co-ordinating all aspects of research taking place within the public health service.
- Evaluating the effectiveness and impact of health services and programmes on the health status of the population.
- Developing interventions to improve the patient experience and overall quality of care.

3) **Challenges**

The following challenges have been identified:

Challenges	**Mitigating measures**
1) Making the changes that would facilitate a paradigm shift in all staff to deliver a patient-centred health service.	• A strategy for PCE has been developed together with a manual on reception services. Other interventions are under development to improve continuity of care in particular.
2) Institutionalising a culture of effective data management, information evaluation and use to improve the effectiveness of services that improve health outcomes.	• Working together with information management to develop key indicators, data collection tools and data management process that include feedback and data use.
3) Ensuring relevant research is done and relevant research findings are translated into policy and practice.	• Improving the co-ordination of research in the department by piloting a web-based information system and having provincial and district research days to receive research results and feedback. Identifying research outputs that can be translated into policy.

4) **Priorities**

- Developing and implementing a comprehensive strategy to ensure renewed focus on improving the patient experience and quality of care.
    - Developing and implementing a departmental framework and guideline for a patient-centred approach.
    - Continuing to implement the critical and vital measures of the national core standards.
    - Ensure the development and implementation of quality improvement plans.
    - Establishing a provincial quality improvement committee that encompasses quality, infection prevention control and occupational health and safety.
    - Develop a services charter that publicly commits the Department to a set of service standards.

- Developing a health services directory of all facilities in the province that will facilitate better referrals in and out of institutions.

- Developing a provincial surveillance system for the measurement of health outcomes utilising both mortality and morbidity indicators.
  - Implementing a web-based mortality surveillance system.
  - Establishing morbidity surveillance through ICD-10 coding.
  - Piloting a community-based surveillance system that could be institutionalised.
  - Undertake a review of all indicators in the Department and provide recommendations on what should be collected. Formally manage the gatekeeping function of adding indicators to the system.

- Strengthen the use of research in policy and practice.
  - Disseminating the provincial research agenda and advocacy through a variety of mechanisms engaging with the key research institutions and stakeholders to buy into the agenda.
  - Establishing the annual research day and research newsletter as a platform for sharing research findings to inform policy and practice.
  - Establishing district level research days.

- Strengthening the advocacy role of the Department in addressing the upstream factors impacting on the burden of disease.
  - Identifying most affected communities and their associated risk factors.
  - Providing early warning systems for important risk factors.
  - Working with other stakeholders to design interventions and provide evidence of effectiveness of interventions. This is part of the "whole of government" and whole of society approach to addressing the social determinants of health.

3.5.2.5. **Pharmacy Services**

1) **Purpose**

To ensure an effective pharmaceutical service.

2) **Overview**

The Department supported the need for dedicated strategic focus on pharmacy services and the delivery of an effective pharmaceutical service in line with 2020. The Directorate: Pharmacy Services was established during 2012/13.

The Department has also made a decision that the Cape Medical Depot (CMD) will no longer function as a separate trading entity but be incorporated into the Department. The CMD function will reside within this Directorate.

The directorate's functions include:

- Pharmaceutical related services including the management of the Chronic Dispensing Unit services to the Department.
- The management of the Cape Medical Depot which is responsible for the procurement and distribution of medicines and supplies to the various health service rendering entities in the Department.
- Provide strategic direction and support the planning, policy development and monitoring of drug management and pharmacy related services.

3) **Challenges**

The following challenges have been identified:

Challenges	Mitigating measures
1) Lack of an integrated information technology (IT) system for the management of medicine and patient medicine records across all levels of care.	• Conducting an options analysis with respect to the Medsas IT system, with the view of enhancement/ replacement of this system. • Investigate the feasibility of accessing and integrating data from various systems such as JAC, CDU and the CMD with patient data through the business intelligence initiative.
2) Retention of competent and skilled pharmacy staff, with particular emphasis on post basic pharmacist assistants.	• Recruitment and retention of competent and skilled employees.
3) Improving the quality of service by ensuring the rational and safe use of medicines.	• Recruitment and retention of competent and skilled employees. • Supporting the strengthening of clinical governance within the Department with a special focus on rational prescribing.

4) **Priorities**

- Support the implementation of medicine management systems across all levels of care.
- Facilitate the training of pharmacy staff in medicines supply management and the completion of the Expanded Public Works Programme (EPWP) pharmacist assistants training programme.
- Expand the scope of the Chronic Dispensing Unit services to patients across different levels of care throughout the province.
- Recruit appropriately skilled staff to meet legislative requirements and implement policy and technology developments.
- Investigate the options to replace the archaic MEDSAS system within the CMD.

3.6. BUSINESS DEVELOPMENT

1) **Purpose**

To strengthen public-private partnerships and initiatives to improve the quality of health care services.

2) **Overview**

The Directorate: Business Development has been re-established to investigate, formally study, report and provide initial impetus for the establishment of viable projects between

third parties and WCG Health including public private partnerships, and intermediary and advisory support to the Health Foundation and Public Private Health Forum.

The unit will also support the activities of the Public Private Health Forum (PPHF) which has been operational for a number of years. The PPHF is increasingly focusing on potential partnerships between the public and private sectors. The Directorate Business Development will investigate, make recommendations, facilitate and implement viable projects.

The key focus areas of the directorate will be to:

- Identify feasible projects.
- Develop business plans and tender specifications and facilitate the implementation of partnerships.
- Facilitate:
  - Interaction between the private sector and the Public Private Health Forum (PPHF).
  - Meeting of managers with interested parties, structured as PPHF task groups.
  - Interaction with other state bodies and organisations such as Economic Development on relevant mutually beneficial matters.
  - The potential partnering of the public and private sectors for the provision of health and related services and for the mutually beneficial sharing of infrastructure and costly equipment.
  - Consultation with the private sector regarding services currently provided and the challenges and successes of partnering with the public sector.
  - Providing initial assistance in respect to the set-up of the Health Foundation.

3) **Challenges**

The following challenge and mitigating measure has been identified:

Challenge	**Mitigating measure**
1) Human resource capacity.	• Recruitment and retention of competent and skilled employees.

4) **Priorities**

- Establish and resource the unit to optimally attend to all projects which would be mutually beneficial to the Department and the private sector.
- Develop a proposal to establish wellness centres across the Province in partnership with the retail pharmacy sector that can provide easy access to screening of chronic diseases risk factors.

3.7. CHIEF DIRECTORATE: INFRASTRUCTURE MANAGEMENT

Refer to Programme 7 and 8.

Table 1.1: Data elements for indicators in Tables 1.2 and 1.3

Source	Data element	Element ID	Audited / Actual performance			Estimated performance	Medium term targets		
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Information Management	Total population	1	5 513 039	5 634 323	5 755 607	5 876 887	5 998 164	6 119 435	6 240 702
Information Management	Total population in rural districts	2	1 874 081	1 909 976	1 945 872	1 981 765	2 017 653	2 053 536	2 089 415
PERSAL	Medical officers	3	1 844	1 881	1 899	1 939	1 979	2 019	2 059
PERSAL	Medical officers in rural districts	4	305	327	345	350	359	365	371
PERSAL	Professional nurses	5	5 201	5 479	5 720	5 841	5 962	6 082	6 203
PERSAL	Professional nurses in rural districts	6	1 584	1 647	1 751	1 783	1 816	1 848	1 880
PERSAL	Pharmacists	7	334	362	374	382	389	397	405
PERSAL	Pharmacists in rural districts	8	109	113	118	121	123	125	127
PERSAL	Funded professional nurse posts	9	5 507	5 652	5 993	6 020	6 141	6 261	6 382
PERSAL	Vacant professional nurse posts	10	306	173	273	179	179	179	179
PERSAL	Funded doctors posts	11	1 956	1 967	1 982	2 019	2 059	2 099	2 139
PERSAL	Vacant doctors posts	12	112	86	83	80	80	80	80
PERSAL	Funded medical specialists posts	13	557	593	618	637	649	662	675
PERSAL	Vacant medical specialists posts	14	37	23	12	20	20	20	20
PERSAL	Funded pharmacists posts	15	381	391	411	416	423	431	439
PERSAL	Vacant pharmacists posts	16	47	29	37	34	34	34	34
BAS	Part of budget spent (Expenditure)	17	7 519 280	8 756 933	9 664 344	10 097 654	11 454 112	12 218 096	12 874 392
Budget Statement	Equitable share budget allocated	18	7 489 777	8 803 710	9 690 810	10 097 564	11 454 112	12 218 096	12 874 392
HR	HR plan timeously submitted to DPSA	19	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Table1.2: Situational analysis and projected performance for Human Resources [ADMIN 1]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets		
					2014/15	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
1. Ensure and maintain organisational strategic management capacity and synergy.	1.1. To have an effective and efficient and skilled workforce.	1.1.1. Provide sufficient staff with appropriate skills per occupational group by 2014/15.	1) Medical officers per 100 000 people	No	33.0	33.4	33.4	33.0	33.0	33.0	33.0	33.0
			Numerator ID3		2 019	1 844	1 881	1 899	1 939	1 979	2 019	2 059
			Denominator ID1 /100 000		61.19	55.13	56.34	57.56	58.77	59.98	61.19	62.41
			2) Medical officers per 100 000 people in rural districts	No		16.3	17.1	17.7	17.7	17.8	17.8	17.8
			Numerator ID4			305	327	345	350	359	365	371
			Denominator ID2 /100 000			18.74	19.10	19.46	19.82	20.18	20.54	20.89
			3) Professional nurses per 100 000 people	No	99.4	94.3	97.2	99.4	99.4	99.4	99.4	99.4
			Numerator ID5		6 082	5 201	5 479	5 720	5 841	5 962	6 082	6 203
			Denominator ID1 /100 000		61.19	55.13	56.34	57.56	58.77	59.98	61.19	62.41
			4) Professional nurses per 100 000 people in rural districts	No		84.5	86.2	90.0	90.0	90.0	90.0	90.0
			Numerator ID6			1 584	1 647	1 751	1 783	1 816	1 848	1 880
			Denominator ID2 /100 000			18.74	19.10	19.46	19.82	20.18	20.54	20.89
			5) Pharmacists per 100 000 people	No	6.5	6.1	6.4	6.5	6.5	6.5	6.5	6.5
			Numerator ID7		397	334	362	374	382	389	397	405
			Denominator ID1 /100 000		61.19	55.13	56.34	57.56	58.77	59.98	61.19	62.41
			6) Pharmacists per 100 000 people in rural districts	No		5.8	5.9	6.1	6.1	6.1	6.1	6.1
			Numerator ID8			109	113	118	121	123	125	127
			Denominator ID2 /100 000			18.74	19.10	19.46	19.82	20.18	20.54	20.89
			7) Vacancy rate for professional nurses	%		5.6%	3.1%	4.6%	3.0%	2.9%	2.9%	2.8%
			Numerator ID10			306	173	273	179	179	179	179
			Denominator ID9			5 507	5 652	5 993	6 020	6 141	6 261	6 382

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets		
					2014/15	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
			8) Vacancy rate for doctors	%		5.7%	4.4%	4.2%	4.0%	3.9%	3.8%	3.7%
			Numerator ID12			112	86	83	80	80	80	80
			Denominator ID11			1 956	1 967	1 982	2 019	2 059	2 099	2 139
			9) Vacancy rate for medical specialists	%		6.6%	3.9%	1.9%	3.1%	3.1%	3.0%	3.0%
			Numerator ID14			37	23	12	20	20	20	20
			Denominator ID13			557	593	618	637	649	662	675
			10) Vacancy rate for pharmacists	%		12.3%	7.4%	9.0%	8.2%	8.0%	7.9%	7.7%
			Numerator ID16			47	29	37	34	34	34	34
			Denominator ID15			381	391	411	416	423	431	439

Note:

Strategic objective performance indicators are highlighted in yellow.

Local Government staff not included.

Table 1.3: Performance indicators for Administration [ADMIN 2]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets		
					2014/15	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
1. Optimal financial management to maximise health outcomes.	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	No	100.0%	100.4%	99.5%	99.7%	100.0%	100.0%	100.0%	100.0%
			Numerator ID17	R'000	11 562 684	7 519 280	8 756 933	9 664 344	10 097 564	11 454 112	12 218 096	12 874 392
			Denominator ID18	R'000	11 562 684	7 489 777	8 803 710	9 690 810	10 097 564	11 454 112	12 218 096	12 874 392
2. Develop and maintain a capacitated workforce to deliver the required health services.	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 Element ID19	Yes / No	Yes	New indicator	Yes	Yes	Yes	Yes	Yes	Yes

Table 1.4: Quarterly targets for 2012/13 [ADMIN 3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2013/14	Q1	Q2	Q3	Q4
1. Optimal financial management to maximise health outcomes.	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	Quarterly	100.0%	100.0%	100.0%	100.0%	100.0%
			Numerator ID17	R'000	11 454 112	11 454 112	11 454 112	11 454 112	11 454 112
			Denominator ID18	R'000	11 454 112	11 454 112	11 454 112	11 454 112	11 454 112
2. Develop and maintain a capacitated workforce to deliver the required health services.	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 Element ID19	Annually	Yes	No	Yes	No	No

Note:

Strategic objective performance indicators are highlighted in yellow.

Provincial indicators are highlighted.

4. RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND THE MTEF

Table 1.5: Summary of payment and estimates – Programme 1: Administration

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2009/10	Audited 2010/11	Audited 2011/12	Main appro-priation 2012/13	Adjusted appro-priation 2012/13	Revised estimate 2012/13	2013/14	% Change from Revised estimate 2012/13	2014/15	2015/16
1. Office of the Provincial Minister [a]	5 844	6 918	8 493	8 298	7 011	7 145	**7 138**	(0.10)	7 615	7 996
2. Management	260 866	314 563	401 535	480 250	447 862	441 229	**515 967**	16.94	545 292	572 173
Central Management [b]	250 010	314 563	401 535	480 250	447 862	441 229	**515 967**	16.94	545 292	572 173
Decentralised Management	10 856									
Total payments and estimates	266 710	321 481	410 028	488 548	454 873	448 374	**523 105**	16.67	552 907	580 169

[a] MEC total remuneration package: R1 652 224 with effect from 1 April 2012.

[b] 2013/14: Conditional grant: Health Professions Training and Development: R4 157 000 (Compensation of employees R3 079 000; Goods and services R1 078 000).

Table 1.6: Payments and estimates by economic classification – Programme 1: Administration

Economic classification R'000	Outcome						Medium-term estimate			
	Audited	Audited	Audited	Main appro-priation	Adjusted appro-priation	Revised estimate	% Change from Revised estimate			
	2009/10	2010/11	2011/12	2012/13	2012/13	2012/13	2013/14	2012/13	2014/15	2015/16
Current payments	247 171	298 717	370 553	438 608	418 758	410 569	**499 334**	21.62	528 182	554 567
Compensation of employees	110 116	123 843	157 965	191 973	191 473	191 013	**244 557**	28.03	263 179	280 179
Salaries and wages	96 644	109 823	140 304	170 731	169 231	170 149	**217 857**	28.04	234 450	249 591
Social contributions	13 472	14 020	17 661	21 242	22 242	20 864	**26 700**	27.97	28 729	30 588
Goods and services	137 055	174 874	212 588	246 635	227 285	219 556	**254 777**	16.04	265 003	274 388
of which										
Administrative fees	817	908	958	1 047	1 047	914	**963**	5.36	1 001	1 037
Advertising	10 366	15 504	12 270	13 863	13 863	15 665	**16 513**	5.41	17 177	17 785
Assets <R5 000	1 066	2 581	1 410	3 018	3 018	2 376	**2 548**	7.24	2 650	2 745
Audit cost: External	16 342	14 063	21 283	18 948	21 748	21 748	**22 901**	5.30	23 818	24 662
Catering: Departmental activities	383	506	800	941	941	972	**1 113**	14.51	1 157	1 197
Communication	5 490	6 055	6 802	7 778	7 778	6 813	**7 337**	7.69	7 632	7 902
Computer services	34 405	52 752	64 463	77 304	72 504	70 063	**75 562**	7.85	78 592	81 375
Cons/prof: Business and advisory services	46 798	42 608	8 687	10 757	10 407	7 643	**13 425**	75.65	13 963	14 458
Cons/prof: Legal costs	3 588	4 828	5 894	7 353	7 353	6 119	**6 443**	5.29	6 701	6 939
Contractors	2 918	20 388	68 488	87 105	70 105	68 130	**87 744**	28.79	91 261	94 495
Agency and support/ outsourced services	1 235	813	91	104	104	176	**273**	55.11	284	295
Entertainment	57	118	106	163	163	174	**196**	12.64	206	215
Inventory: Food and food supplies	2	3	2			2		(100.00)		
Inventory: Materials and supplies	27	22	157	23	23	90	**97**	7.78	99	102
Inventory: Medical supplies	1	7								
Inventory: Other consumables	69	32	39	121	121	110	**126**	14.55	133	137
Inventory: Stationery and printing	2 762	2 485	2 186	2 310	2 310	2 860	**3 081**	7.73	3 208	3 321
Lease payments	742	715	2 812	3 199	3 199	1 310	**1 379**	5.27	1 435	1 486
Rental and hiring			11	2	2	41	**43**	4.88	44	46
Property payments	317	114	5 806	298	298	650	**713**	9.69	742	770
Travel and subsistence	8 135	8 546	7 265	8 541	8 541	11 067	**11 476**	3.70	11 938	12 358
Training and development	779	683	1 532	2 126	2 126	790	**845**	6.96	880	913
Operating expenditure	93	537	833	557	557	1 120	**1 185**	5.80	1 235	1 274
Venues and facilities	663	606	693	1 077	1 077	723	**814**	12.59	847	876
Transfers and subsidies to	10 561	10 929	21 946	35 616	27 833	29 203	**13 666**	(53.20)	14 216	14 719
Departmental agencies and accounts						6	**6**		6	6
Entities receiving transfers						6	**6**		6	6
Other						6	6		6	6
Households	10 561	10 929	21 946	35 616	27 833	29 197	**13 660**	(53.21)	14 210	14 713
Social benefits	3 805	6 947	6 000	6 036	6 036	7 403	**6 540**	(11.66)	6 804	7 045
Other transfers to households	6 756	3 982	15 946	29 580	21 797	21 794	**7 120**	(67.33)	7 406	7 668
Payments for capital assets	8 960	6 102	17 507	14 324	8 282	8 403	**10 105**	20.25	10 509	10 883
Machinery and equipment	8 960	6 084	17 464	13 515	7 473	7 594	**9 942**	30.92	10 340	10 708
Transport equipment	386	360	11 062	1 360	318		**3 289**		3 421	3 543
Other machinery and equipment	8 574	5 724	6 402	12 155	7 155	7 594	**6 653**	(12.39)	6 919	7 165
Software and other intangible assets		18	43	809	809	809	**163**	(79.85)	169	175
Payments for financial assets	18	5 733	22			199		(100.00)		
Total economic classification	266 710	321 481	410 028	488 548	454 873	448 374	**523 105**	16.67	552 907	580 169

5. PERFORMANCE AND EXPENDITURE TRENDS

5.1. Resource considerations

Programme 1 is allocated 3.30 per cent of the vote in 2013/14 in comparison to the 3.04 per cent allocated in the revised estimate of the 2012/13 budget. This amounts to a nominal increase of R74.733 million or 16.67 per cent.

The increase in the budget in Programme 1 is due to the following additional allocations to this Programme, in support of the whole department:

- Implementation of the JAC Pharmacy system in the smaller hospitals;
- The rollout of the Primary Health Information System to rural facilities;
- Enterprise Content Management;
- The accelerated rollout of the Hospital Information System;

- The implementation of the Nursing Information System to manage the cost of agency staff;
- A project to improve the behaviour of front line staff;
- The increase of the volumes of prescripts managed by the central Chronic Dispensing Unit;
- Additional posts for an inspectorate to ensure compliance to rules and regulations.

6. RISK MANAGEMENT

Risk statement	Three components for risk statement	Measures to mitigate impact
1. Non-compliance with financial, HR and other regulations due to inadequate controls; inadequate training; insufficient capacity; lack of commitment and poor discipline.	Risk: • Non-compliance with HR, Finance and information management regulatory framework. Root cause: • Poor governance. • Staff not fully aware of / insufficiently trained on regulatory framework. Impact: • Under / over spending of the annual equitable share is not within 1% of the budget allocation. • Clean audits not being achieved.	**Human Resources and Finance** 1.1. To provide formal and informal training to line managers and staff. 1.2. Provide relief staff where capacity and skill level constraints are identified. 1.3. In the process of developing an HR Toolkit to assist line managers in HR Administration. 1.4. Identify high risk institutions by comparing quarterly audit action plans and pre audits conducted. 1.5. Engage with Managers and CEO's at high risk institutions 1.6. Strengthen the Devolved Internal Control Units (DICU).
2. Shortage of skilled staff across all levels due to poor recruitment and retention of staff with scarce skills; insufficient up-skilling of existing staff resulting in a limited ability to develop a capacitated workforce.	Risk: • Insufficient staff with scarce skills. Root cause: • Poor recruitment and retention of staff with scarce skills. • Insufficient up-skilling and development of existing staff. Impact: • Limited ability to develop a capacitated workforce.	2.1. Identification of scarce skills per profession. 2.2. Allocation of bursaries per profession as a recruitment strategy. 2.3. Competency profiling of health professionals per level of care and burden of disease on clinical skills development needs. 2.4. Ensure evidenced-based experiential learning for the competency based team. 2.5. In the process of developing an on-line exit interview questionnaire to assist in identifying the reasons for exits and to inform future interventions.

Risk statement	Three components for risk statement	Measures to mitigate impact
3. Inadequate IT infrastructure and end-user hardware due to slow SITA procurement process leading to reduced efficiency.	Risk: • Insufficient or inadequate IT infrastructure and end-user hardware Root cause: • Slow SITA procurement process. Impact : • Infrastructure Improvement / Technology consolidation and refresh reduced.	3.1. Continuously improve DITCOM approval process in order to streamline procurement processes to reduce the turnaround times for procurement of computers and other IT hardware. 3.2. Ensure that service level agreements are in place for engagement with SITA to improve efficiency.
4. Poor quality of data and information due to a lack of SOPs, inadequate patient administration systems, non-standardised IT systems, lack of accountability for data quality and excessive collection, which compromises the monitoring and management of services.	Risk: • Poor quality of data and information. Root cause: • Lack of SOPs; • Inadequate patient administration systems in hospitals and PHC facilities; • IT systems not standardised; • Lack of accountability for poor data quality; • Too many indicators and data elements being collected. Impact: • Compromises the monitoring, and management of services.	4.1 Provide training in the implementation of revised policies, standard operating procedures and instruments to improve data quality. 4.2 Roll-out of patient administration systems in hospitals and primary health care facilities. 4.3 Standardisation of IT systems. 4.4 Reduce the number of indicators and data elements being collected. 4.5 Monitor data quality through information compliance unit (ICU), identify high risk areas, develop remedial actions and ensure implementation by following up.

PROGRAMME 2: DISTRICT HEALTH SERVICES

1. PROGRAMME PURPOSE

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

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 2.1: DISTRICT MANAGEMENT

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

2.2 SUB-PROGRAMME 2.2: COMMUNITY HEALTH CLINICS

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

2.3 SUB-PROGRAMME 2.3: COMMUNITY HEALTH CENTRES

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

2.4 SUB-PROGRAMME 2.4: COMMUNITY BASED SERVICES

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

2.5 SUB-PROGRAMME 2.5: OTHER COMMUNITY SERVICES

Rendering environmental and port health services.

2.6 SUB-PROGRAMME 2.6: HIV, AIDS, STI AND TB

Rendering a primary health care service for HIV disease, AIDS, sexually transmitted infections and tuberculosis.

2.7 SUB-PROGRAMME 2.7: NUTRITION

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

2.8 SUB-PROGRAMME 2.8: CORONER SERVICES

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

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

2.9 SUB-PROGRAMME 2.9: DISTRICT HOSPITALS

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

2.10 SUB-PROGRAMME 2.10: GLOBAL FUND

Strengthen and expand the HIV and AIDS 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.

3. DISTRICT HEALTH SERVICES

3.1 SITUATION ANALYSIS

There are no changes to the structure of the budget Programme in comparison to the information provided in the Strategic Plan 2010 – 2014.

3.1.1 Governance of the district health system

3.1.1.1 Legislative

In line with the National Health Act (No. 61 of 2003), six health districts (one metropolitan district: Cape Town Metropolitan District, and five rural districts: West Coast, Cape Winelands, Overberg, Eden and Central Karoo) were formally established during the 2008/09 financial year. Subsequently, on 24th August 2011 the Western Cape District Health Councils Act came into effect. This act formalises community participation and governance oversight within the districts through the establishment of district health councils. The inaugural meetings of the district health councils were convened in all the districts of the Province. This 2013/14 plan marks the first time that the targets in the individual District Health Plans have been collated in order to feed into the provincial Annual Performance Plan.

3.1.1.2 Managerial

The five rural districts are each individually managed by a district director, and together operate under a rural district chief director. The district director is the person responsible for ensuring that District Health Services (DHS) are effectively and efficiently delivered. The Western Cape Government has assumed responsibility for personal primary health care services (PPHC) in all five rural districts since 2006.

As the Cape Metropolitan District, houses approximately 66 per cent of the provincial population, it has been further sub-divided into four sub-structure management units, each of which is run by a district director. The four Metro sub-structure directors are overseen by a Metro chief director. In the Metro District, personal primary health care services are provided jointly by the Western Cape Government Health and the City of Cape Town Municipality and are regulated via a service level agreement, and managed by means of

shared management forums. Environmental health care services are provided by local government authorities across all six health districts.

3.1.1.3 Clinical

Improved clinical governance, with consequent improved health outcomes and improved patient experiences, is a key priority for the division DHS and for the Department as a whole. Clinical governance is currently being functionally defined across four domains: Appropriate assessment, appropriate diagnosis, appropriate clinical intervention/treatment and appropriate outcome, disposal or referral. In the DHS, clinical governance is the responsibility of family physicians, who receive support from designated generalist specialists located at Regional Hospitals. Geographic Service Areas (GSAs) are a co-ordinating management mechanism to facilitate the improvement of clinical governance, allowing for a cohesive group of clinicians to monitor, contribute to, and respond to the care pathway all the way from Primary Health Care (PHC) level to Regional Hospital level. In so doing this will also enhance the development of shared departmental priorities.

3.1.2 The service platform

In the Western Cape the DHS serves as the first point of contact between the patient and the health service. The DHS service platform is divided into Community Based Services (CBS), Primary Health Care (PHC) services and District hospital Services (acute services). Each component of the platform is staffed by different types, and differing proportions, of health care workers (HCWs). Each component offers different packages of care, increasing in range and complexity from CBS up to the hospital services.

3.1.2.1 Community-based services

The Community Based Services (CBS) component (Sub-Programme 2.4) renders services at various institutional facilities and at non-health facilities such as homes, mental health institutions, early child development (ECD) centres, prisons, old age homes and schools. Community-based services are designed to reduce pressure on facility-based care by providing health care directly to the community, by providing beds for non-acute cases and through actively empowering the community to participate in preventive and adherence health Programmes.

The broad areas of work that fall under the CBS component are defined as:

1) Home-based care, which incorporates three service delivery streams:
   - Home-based care
   - Community adherence support
   - Disease prevention/health promotion
2) Intermediate care (beds for the person who does not need the full range of services provided by an acute hospital but is not yet ready for living at home)
3) Life-long care
4) Mental Health Services

Many of the tasks and roles carried out at the CBS level are fulfilled by lay workers overseen by nurses, both categories of worker being employed through partner health organisations. This arrangement requires careful contract management by the Western Cape Government: Health.

A new intermediate care policy, has recently been endorsed, the purpose of which is to decongest acute hospital beds by offering improved rehabilitative skills at an intermediate care level.

3.1.2.2 **Primary health care**

The distribution of PHC facilities across the Province is reflected in Table 2.1.

At fixed and non-fixed facilities, clinical nurse practitioners (CNPs) provide services in accordance with the national PHC package of care, which includes child and adult curative care, preventive and promotive services; antenatal care, postnatal care, family planning and other specialised services; mental health; TB, HIV and AIDS; and chronic disease management.

At community day centres (CDCs) and community health centres (CHCs) services are provided by clinical nurse practitioners (CNPs), with support from full-time medical officers and pharmacists, and patients have access to X-ray services. A CDC normally provides a service between 08:00 and 16:00 during weekdays only, while a CHC provides a 24-hour emergency service. CDCs and CHCs provide a comprehensive package of services that includes: antenatal care, termination of pregnancy, reproductive health, chronic disease management, TB, HIV and AIDS, other curative care, mental health, oral health, rehabilitation and disability services, occupational health, casualty and maternity services.

Ten CDCs in the Cape Town Metro District provide a nurse-based package of services between the hours of 16:00 and 21:00 on weekdays, and between 08:00 and 13:00 over weekends and eleven CHCs also provide 24-hour midwife obstetric services.

3.1.2.3 **District hospitals:**

Thirty-four district hospitals comprise the third component of the DHS service platform in the Western Cape and they are discussed further in the District hospital section of this document.

As of November 2012 the DHS employed 729 doctors, 5107 nurses, 63 dentists, 243 pharmacists, 306 pharmacist assistants and 416 allied health professionals.

3.1.3 **Burden of disease**

As the first point of health contact for the vast majority of the people of the Western Cape, the DHS deals with a large burden of disease which is well documented, and has been described as a quadruple burden of disease, consisting of:

1) The chronic diseases of lifestyle: diabetes, hypertension, heart disease, mental ill health and others;
2) The infectious diseases: HIV and TB;
3) The "pre-transitional" diseases (related to underdevelopment) that cause avoidable infant, child and maternal death; and
4) Injuries and violence.

This quadruple burden, together with a few selected other areas, determines the priority areas of focus for the DHS. Each will be discussed in further detail under the relevant sub-Programme section.

3.1.4 Performance data

3.1.4.1 Headcount and utilisation rate

There was a change in headcount definition halfway through the last 5 years in which OPD headcounts at district hospitals (previously counted as part of PHC headcount) were no longer included in the PHC headcount total. This makes interpretation slightly more difficult. Nevertheless total headcount is more or less static in rural areas, and increasing gradually in the Metro area. Both observations are more or less in line with expected population growth and population movement.

It is noted that PHC utilisation rates in some rural districts and those set as National MTEF targets are diverging. However, this might be an appropriate finding given the divisional policy of pursuing alternative drug dispensing strategies and shifting basic health tasks to the CBS level.

3.1.4.2 Staffing and supervision

Over 90 per cent of CHCs and CDCs have had support from a resident doctor in the recent past. Supervision rates have been lower than hoped for because of difference in management policy between the City of Cape Town (CoCT) and the Provincial Department. The CoCT accounts for about a quarter of all fixed facilities in the Province but does not record supervision visits in the same manner as the Province. This matter has been addressed at a senior management level and should be resolved by 2013/14.

3.1.4.3 Expenditure

At a PHC level, around R500 is spent per annum for every uninsured person in the provincial population. Because the inputs into the numerator of this indicator have changed over time, it is difficult to comment at this stage whether the overall trend is downward or upward. Initially, inputs were from all sub-programs in program 2 (except 2.6 and 2.10), but latterly only include sub-programs 2.1 to 2.5.

3.1.4.4 Quality

The focus on supporting the office of standards compliance resulted in a large number of facilities being assessed against core standards in the 2011/12 financial year, which was a new initiative. Although the Province has performed adequately in terms of resolving user complaints, the system does depend on educated and empowered patients being able to voice their concerns easily. Currently complaints are manually recorded and then captured electronically. The recording of complaints might benefit from a completely computerised system.

Table 2.1 District Health Service facilities by health district in 2011/12 [DHS1]

Health district	Facility type	No.	2011/12 Uninsured Population	Uninsured Population per fixed PHC facility	PHC facilities headcounts	District hospital separations	Per capita (uninsured) utilisation
City of Cape Town Metro District	Non fixed clinics	27	2 910 637	21560	10 348 589	119 514	3.56
	Fixed clinics	88					
	CHCs	9					
	CDCs	38					
	Sub-total clinics + CHCs + CDCs	135					
	District hospitals	9					
CAPE WINELANDS	Non fixed clinics	34	589 282	12 026	1 796 720	25 766	3.05
	Fixed clinics	44					
	CHCs	0					
	CDCs	5					
	Sub-total clinics + CHCs + CDCs	49					
	District hospitals	4					
CENTRAL KAROO (Rural development node)	Non fixed clinics	11	52 269	5 808	199 083	9 515	3.81
	Fixed clinics	8					
	CHCs	0					
	CDCs	1					
	Sub-total clinics + CHCs + CDCs	9					
	District hospitals	4					
EDEN	Non fixed clinics	35	479 601	11 990	1 601 365	37 121	3.34
	Fixed clinics	35					
	CHCs	0					
	CDCs	5					
	Sub-total clinics + CHCs + CDCs	40					
	District hospitals	6					
OVERBERG	Non fixed clinics	21	196 897	8 204	767 539	17 640	3.90
	Fixed clinics	23					
	CHCs	0					
	CDCs	1					
	Sub-total clinics + CHCs + CDCs	24					
	District hospitals	4					
WEST COAST	Non fixed clinics	41	262 019	9 704	822 317	36 773	3.14
	Fixed clinics	27					
	CHCs	0					
	CDCs	0					
	Sub-total clinics + CHCs + CDCs	27					
	District hospitals	7					
PROVINCE	Non fixed clinics	169	4 490 706	15 812	15 535 613	246 329	3.46
	Fixed clinics	225					
	CHCs	9					
	CDCs	50					
	Sub-total clinics + CHCs + CDCs	284					
	District hospitals	34					

Notes:

1. Non-fixed clinics include mobile and satellite clinics. Visiting points have been excluded.
2. Fixed clinics include both provincial and local government facilities. Clinics, CHCs and CDCs make up fixed PHC facilities.
3. PHC facility headcounts and hospital separations are used for per capita utilisation.
4. Number of facilities as at February 2013.

Table 2.2: Data elements for situation analysis indicators in Tables 2.3

Source	Data element	Element ID	Province wide value 2011/12	Cape Town District 2011/12	Cape Winelands District 2011/12	Central Karoo District 2011/12	Eden District 2011/12	Overberg District 2011/12	West Coast District 2011/12
SINJANI	PHC total headcount	1	15 535 613	10 348 589	1 796 720	1 601 365	199 083	767 539	822 317
Information Management	Total population	2	5 755 606	3 809 735	768 295	60 991	563 573	238 085	314 926
SINJANI	PHC total headcount - under 5 years	3	2 427 241	1 463 062	336 307	37 093	288 135	148 876	153 768
Information Management	Population under 5 years old	4	549 832	368 701	70 816	6 507	51 608	23 179	29 021
SINJANI	Fixed facilities with monthly supervisor visits	5	211	77	41	39	8	21	25
SINJANI	Number of fixed PHC facilities	6	284	135	49	40	9	24	27
SINJANI	CHCs and CDCs with a resident doctor	7	54	43	4	1	5	1	-
SINJANI	Number of CDC's and CHC's	8	59	47	5	1	5	1	-
BAS- CFO	Expenditure on PHC by provincial DoH at PHC facilities (in 2011/12 Rands for sub-Programmes 2.1 to 2.5)	9	2 409 695 382	1 514 124 905	312 918 029	54 332 918	264 047 658	120 975 904	143 295 969
Information Management	Uninsured population	10	4 490 706	2 972 475	599 448	47 587	439 718	185 762	245 716
SINJANI	Complaints resolved within 25 working days (from users of PHC services)	11	350	91	190	-	-	69	-
SINJANI	Total complaints (from users of PHC facilities) received	12	495	121	223	-	-	151	-
NDoH assessment tool	PHC facilities assessed for compliance against the 6 priorities of the core standards	13	215	130	44	-	41	-	-

Notes:

Element ID 5: Fixed clinics include both provincial and local government (City of Cape Town in the Metro District) facilities.

Element ID 9 Financial figurers updated to reflect 2011/12 Rands for sub-Programmes 2.1 to 2.5.

Table 2.3 Situation analysis indicators for district health services [DHS3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2011/12	Cape Town District 2011/12	Cape Winelands District 2011/12	Central Karoo District 2011/12	Eden District 2011/12	Overberg District 2011/12	West Coast District 2011/12	National Average 2010/11
1. Address 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 2.54 visits per person per annum by 2014/15.	1) PHC utilisation rate	No	2.70	2.72	2.34	3.26	2.84	3.22	2.61	2.5
			Numerator ID 1		15 535 613	10 348 589	1 796 720	199 083	1 601 365	767 539	822 317	-
			Denominator ID 2		5 755 606	3 809 735	768 295	60 991	563 573	238 085	314 926	-
			2) PHC headcount total	No	15 535 613	10 348 589	1 796 720	199 083	1 601 365	767 539	822 317	-
			Element ID 1									
			3) PHC utilisation rate under 5 years	No	4.41	3.97	4.75	5.70	5.58	6.42	5.30	4.7
			Numerator ID 3		2 427 241	1 463 062	336 307	37 093	288 135	148 876	153 768	-
			Denominator ID 4		549 832	368 701	70 816	6 507	51 608	23 179	29 021	-
			4) PHC headcount - under 5 years total	No	2 427 241	1 463 062	336 307	37 093	288 135	148 876	153 768	-
			Element ID 3									
			5) PHC supervisor visit rate (Fixed clinic/CHC/CDC)	%	74.3%	57.0%	83.7%	20.0%	433.3%	87.5%	92.6%	-
			Numerator ID 5		211	77	41	8	39	21	25	-
			Denominator ID 6		284	135	49	40	9	24	27	-
2. Optimal financial management to maximise health outcomes.	2.1. Allocate sufficient funds to ensure access to and the sustained delivery of the full package of quality PHC services by 2014/15.	2.1.1. Achieve a primary health care (PHC) expenditure of R520 per uninsured person by 2014/15. (2011/12 Rands).	6) Provincial PHC expenditure per headcount	R	R155	R146	R174	R34	R1 326	R158	R174	-
			Numerator ID 9		2 409 695 382	1 514 124 905	312 918 029	54 332 918	264 047 658	120 975 904	143 295 969	-
			Denominator ID 1		15 535 613	10 348 589	1 796 720	199 083	1 601 365	767 539	822 317	-
			7) Provincial PHC expenditure per uninsured person	R	R537	R509	R522	R1 142	R600	R651	R583	-
			Numerator ID 9		2 409 695 382	1 514 124 905	312 918 029	54 332 918	264 047 658	120 975 904	143 295 969	-
			Denominator ID 10		4 490 706	2 972 475	599 448	47 587	439 718	185 762	245 716	-

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2011/12	Cape Town District 2011/12	Cape Winelands District 2011/12	Central Karoo District 2011/12	Eden District 2011/12	Overberg District 2011/12	West Coast District 2011/12	National Average 2010/11
3. Improve the quality of health services and the patient experience.	3.1. Improve the experience of clients utilising the PHC services.	3.1.1. Achieve a 74.0% complaint resolution within 25 working days rate by 2014/15.	8) Complaint resolution within 25 working days rate (from users of PHC services)	%	60.7%	74.8%	25.0%	40.0%	75.9%	43.8%	75.0%	-
			Numerator ID 11		252	83	2	12	85	64	6	-
			Denominator ID 12		415	111	8	30	112	146	8	-
			9) Percentage of PHC facilities assessed for compliance against the 6 priorities of the core standards (NID: Facility core standards self-assessment rate in PHC facilities)	%	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	-
			Number of PHC facilities assessed for compliance against the 6 priorities of the core standards									
			Numerator ID 13									-
			Denominator ID 6									-

Notes:

Indicator 1: Information for 2010/11 still included PHC headcounts at district hospitals.
The definition changed from 1 April 2011 and the PHC headcount at district hospitals is now reflected as part of the OPD headcount.

Indicator 6 & 7: Financial figurers updated to reflect 2011/12 Rands for sub-Programmes 2.1 to 2.5.

Strategic objective performance indicators are highlighted in yellow.

Provincially determined performance indicators are highlighted.

3.2 CHALLENGES

1) The continued provision of health care by two authorities in the Cape Town Metro District (i.e. the Western Cape Government and the City of Cape Town Municipality) fragments the delivery of personal primary health care (PPHC), is inefficient and ultimately compromises quality of care.
2) Less than satisfactory patient experiences in PHC facilities.
3) Reliance on non-profit organisations (NPOs) for services delivered, particularly at CBS level. The related need for careful contract management of NPOs.

3.3 PRIORITIES

1) Given the large burden of chronic disease facing the Province at primary care level there is a need to improve chronic disease management, including cancers. Steps are being taken to delineate a comprehensive chronic disease management plan that will focus on applying clinical governance principles to the primary health care chronic disease burden, such that the appropriately diagnosed chronic disease patient will be managed at the appropriate level (including CBS). The chronic dispensing unit will play a critical role in this re-structuring. Improved cancer management will require improved diagnostics, improved registration capacity and better linkage to appropriate levels of care.
2) Access to intermediate care needs to be enhanced in light of the new policy. Training for intermediate care workers needs to be designed and implemented.
3) Improving the quality of patient care and the patient-centred experience remains an overarching priority of the division. The overall quality of reception services, clinical governance processes and the appropriate use of care pathways have all been identified as focus areas in this regard.

3.4 STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DISTRICT HEALTH SERVICES

Table 2.4: Data elements and related actual and projected performance values for Tables 2.5 – 2.6

Source	Data element	Element ID	Audited / Actual performance			Estimated performance	Medium term targets		
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
SINJANI	PHC total headcount	1	15 848 973	16 206 552	15 535 613	15 201 644	15 252 132	15 543 364	15 851 382
Information Management	Total population	2	5 513 039	5 634 323	5 755 607	5 876 887	5 998 164	6 119 435	6 240 702
SINJANI	PHC total headcount - under 5 years	3	2 527 588	2 453 946	2 427 241	2 307 106	2 263 406	2 308 674	2 354 848
Information Management	Population under 5 years old	4	527 215	538 524	549 832	550 911	562 219	573 526	578 127
SINJANI	Supervisor visit this month (fixed facilities only)	5	198	207	211	220	263	266	272
SINJANI	Number of fixed PHC facilities	6	299	296	292	284	280	280	280
BAS- CFO	Expenditure on PHC by provincial DoH at PHC facilities (in 2011/12 Rands for sub-Programmes 2.1 to 2.5)	9	2 376 191 831	2 335 174 009	2 409 695 382	1 724 353 728	2 461 774 793	2 483 306 641	2 444 898 540
Information Management	Uninsured population	10	4 301 660	4 396 294	4 490 928	4 585 115	4 679 521	4 773 922	4 868 319
SINJANI	Complaints resolved in a 25 working days (from users of PHC facilities)	11	Not required to report	Not required to report	252	587	660	703	754
SINJANI	Total complaints received in PHC facilities	12	Not required to report	Not required to report	415	809	901	950	1 005
NDoH assessment tool	Number of PHC facilities assessed for compliance against the 6 priority areas of the core standards	13	Not required to report	Not required to report	147	0	27	30	33

Notes:

Element ID1: Change to the definition from 1 April 2011: PHC headcount at district hospitals is now reflected as OPD headcount.

Element ID 6: The amalgamation of City of Cape Town and Provincial facilities has led to a gradual decrease in the overall number of facilities in the Province.

Element ID 7 & 8: These elements have been removed from the elements table from April 2013 as they are no longer reporting requirements due to changes in the National Indicator Dataset definitions.

Element ID 9: Financial figurers updated to reflect 2011/12 Rands.

Element ID 11: From 2013/14 due to a change in the National Indicator Dataset definition, the element will reflect complaints resolved within 25 working days, not calendar days.

Element ID13: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

Table 2.5: Strategic objectives, indicators and annual targets for District Health Services [DHS 4 & 5]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2014/15
1. Address 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 2.54 visits per person per annum by 2014/15.	1) PHC utilisation rate	No	2.54	2.87	2.88	2.70	2.59	2.54	2.54	2.54	3.5
			Numerator ID 1		15 543 364	15 848 973	16 206 552	15 535 613	15 201 644	15 252 132	15 543 364	15 851 382	-
			Denominator ID 2		6 119 435	5 513 039	5 634 323	5 755 607	5 876 887	5 998 164	6 119 435	6 240 702	-
			2) PHC headcount total	No	-	15 848 973	16 206 552	15 535 613	15 201 644	15 252 132	15 543 364	15 851 382	-
			Element ID 1										
			3) PHC utilisation rate – under 5 years	No	-	4.79	4.56	4.41	4.19	4.03	4.03	4.07	5.5
			Numerator ID 3		-	2 527 588	2 453 946	2 427 241	2 307 106	2 263 406	2 308 674	2 354 848	-
			Denominator ID 4		-	527 215	538 524	549 832	550 911	562 219	573 526	578 127	-
			4) PHC headcount under 5 years total	No	-	2 527 588	2 453 946	2 427 241	2 307 106	2 263 406	2 308 674	2 354 848	-
			Element ID 3										
			5) PHC supervisor visit rate (fixed clinic/CHC/CDC)	%	-	66.2%	69.9%	72.3%	77.5%	93.9%	95.0%	97.1%	100.0%
			Numerator ID 5		-	198	207	211	220	263	266	272	-
			Denominator ID 6		-	299	296	292	284	280	280	280	-
2. Optimal financial management to maximise health outcomes.	2.1. Allocate sufficient funds to ensure access to and the sustained delivery of the full package of quality PHC services by 2014/15.	2.1.1. Achieve a primary health care (PHC) expenditure of R520 per uninsured person by 2014/15 (2011/12 Rands).	6) Provincial PHC expenditure per headcount	R	-	R150	R144	R155	R113	R161	R160	R154	-
			Numerator ID 9		-	2 376 191 831	2 335 174 009	2 409 695 382	1 724 353 728	2 461 774 793	2 483 306 641	2 444 898 540	-
			Denominator ID 1		-	15 848 973	16 206 552	15 535 613	15 201 644	15 252 132	15 543 364	15 851 382	-
			7) Provincial PHC expenditure per uninsured person	R	R520	R552	R531	R537	R376	R526	R520	R502	-
			Numerator ID 9		2 483 306 641	2 376 191 831	2 335 174 009	2 409 695 382	1 724 353 728	2 461 774 793	2 483 306 641	2 444 898 540	-
			Denominator ID 10		4 773 922	4 301 660	4 396 294	4 490 928	4 585 115	4 679 521	4 773 922	4 868 319	-

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2014/15
3. Improve the quality of health services and the patient experience.	3.1. Improve the experience of clients utilising the PHC services.	3.1.1. Achieve a 74.0% complaint resolution within 25 working days rate by 2014/15.	8) Complaints resolution within 25 working days rate (from users of PHC services)	%	74.0%	Not required to report	Not required to report	60.7%	72.6%	73.3%	74.0%	75.0%	-
			Numerator ID 11		703	-	-	252	587	660	703	754	-
			Denominator ID 12		950	-	-	415	809	901	950	1 005	-
			9) Percentage of PHC facilities assessed for compliance against the 6 priorities of the core standards (NID: Facility core standards self-assessment rate in PHC facilities)	%	-	Not required to report	Not required to report	50.3%	0.0%	9.6%	10.7%	11.8%	-
			Number of PHC facilities assessed for compliance against the 6 priorities of the core standards										
			Numerator ID 13		-			147	0	27	30	33	-
			Denominator ID 6		-			292	284	280	280	280	-

Note:

Indicator 2: Change to the definition from 1 April 2011: PHC headcount at district hospitals is now reflected as OPD headcount. District hospital OPD headcount contributed about 600 000 towards the PHC total headcount.

Indicator 5: Based on a data verification process the historical data for this indicator was updated.
The amalgamation of City of Cape Town and Provincial facilities has led to a gradual decrease in the overall number of facilities in the Province.

Indicator 6 & 7: Financial figurers updated to reflect 2011/12 Rands.

Indicator 8: From 2013/14 due to a change in the National Indicator Dataset definition, the indicator reflects complaints resolved within 25 working days, not calendar days.

Indicator 9: Quality improvement plans to address the findings of the 2011/12 baseline audit have been developed and implemented during 2012/13.

QUARTERLY TARGETS FOR DISTRICT HEALTH SERVICES

Table 2.6: Quarterly targets for District Health Services for 2013/14 [DHS6]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2013/14	Q1	Q2	Q3	Q4
1. Address 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 2.54 visits per person per annum by 2014/15.	1) PHC utilisation rate	Quarterly	2.54	2.54	2.54	2.54	2.54
			Numerator ID 1		15 252 132	3 813 033	3 813 033	3 813 033	3 813 033
			Denominator ID 2		5 998 163	1 499 540	1 499 540	1 499 540	1 499 540
			2) PHC headcount total Element ID 1	Quarterly	15 252 132	3 813 033	3 813 033	3 813 033	3 813 033
			3) PHC utilisation rate –under 5 years	Quarterly	4.03	4.03	4.03	4.03	4.03
			Numerator ID 3		2 263 406	565 852	565 852	565 852	565 852
			Denominator ID 4		562 219	140 555	140 555	140 555	140 555
			4) PHC headcount under 5 years total Element ID 3	Quarterly	2 263 406	565 852	565 852	565 852	565 852
			5) PHC supervisor visit rate (fixed clinic/CHC/CDC)	Quarterly	93.9%	93.9%	93.9%	93.9%	93.9%
			Numerator ID 5		263	263	263	263	263
			Denominator ID 6		280	280	280	280	280
2. Optimal financial management to maximise health outcomes.	2.1. Allocate sufficient funds to ensure access to and the sustained delivery of the full package of quality PHC services by 2014/15.	2.1.1. Achieve a primary health care (PHC) expenditure of R520 per uninsured person by 2014/15 (2011/12 Rands).	6) Provincial PHC expenditure per headcount	Quarterly	R161	R161	R161	R161	R161
			Numerator ID 9		2 461 774 793	615 443 698	615 443 698	615 443 698	615 443 698
			Denominator ID 1		15 252 132	3 813 033	3 813 033	3 813 033	3 813 033
			7) Provincial PHC expenditure per uninsured person	Quarterly	R526	R526	R526	R526	R526
			Numerator ID 9		2 461 774 793	615 443 698	615 443 698	615 443 698	615 443 698
			Denominator ID 10		4 679 521	1 169 880	1 169 880	1 169 880	1 169 880

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2013/14	Q1	Q2	Q3	Q4
3. Improve the quality of health services and the patient experience.	3.1. Improve the experience of clients utilising the PHC services.	3.1.1. Achieve a 74.0% client complaint resolution within 25 working days rate by 2014/15.	8) Complaints resolution within 25 working days rate (from users of PHC services)	Quarterly	73.3%	73.3%	73.3%	73.0%	73.3%
			Numerator ID 11		660	165	165	165	165
			Denominator ID 12		901	225	225	226	225
			9) Percentage of PHC facilities assessed for compliance against the 6 priorities of the core standards (NID: Facility core standards self-assessment rate in PHC facilities)	Annual	9.6%	-	-	-	9.6%
			Number of PHC facilities assessed for compliance against the 6 priorities of the core standards						
			Numerator ID 13		27	-	-	-	27
			Denominator ID 6		280	-	-	-	280

Note:

Indicator 5: In order to comply with the definition of this indicator, all the facilities have to have a supervisory visit each month. Therefore the quarterly targets reflect 263 out of 280 fixed facilities.

Indicator 9: Quality improvement plans to address the findings of the 2011/12 baseline audit have been developed and implemented during 2012/13.

4. DISTRICT HOSPITAL SERVICES

4.1 SITUATION ANALYSIS FOR DISTRICT HOSPITALS

There are no changes to the structure of the budget Programme in comparison to the information provided in the Strategic Plan 2010 – 2014.

4.1.1 District hospital services

There are thirty-four district hospitals in the Province, nine of which are located within the Cape Town Metro District. The recently constructed Khayelitsha Hospital is now fully operational. It is anticipated that the construction of the Mitchell's Plain Hospital will be completed by March 2013 and that the first patients will be admitted from June 2013.

Four hospitals (Karl Bremer, GF Jooste, Helderberg and Victoria Hospitals), previously classified as Regional Hospitals, have been re-classified as district hospitals in the Cape Town Metro District over the last four financial years. Three of these hospitals (Karl Bremer, GF Jooste and Victoria Hospitals) still offer a significant quantum of general specialist services. In 2013, the services at GF Jooste hospital will be decommissioned. This will be done synchronously with the progressive commissioning of the new Mitchells Plain Hospital, and the establishment of an emergency centre with overnight bed capacity on the site of the Heideveld CHC. Once the full staff complement of GF Jooste Hospital has shifted, the re-building of the new GF Jooste Hospital will commence.

Financial sub-Programme 2.9 provides funding for the rendering of District hospital services in the Province. The level 1 hospital package of care provided at a District hospital includes an emergency medical service, adult and child inpatient and outpatient care, and obstetric care. A varying quantum of general specialist services is provided at district hospitals to cost effectively improve both the quality of care and access to these services.

4.1.2 Burden of disease

Hospital in-patients drain from the same population that presents to PHC level; so many beds are occupied by the sequelae of chronic disease (strokes, myocardial infarction, diabetic emergencies, renal disease etc.), complicated HIV and/or TB, diseases associated with pregnancy, and victims of violence and trauma.

The methylamphetamine (tik) and alcohol epidemics that beset the Western Cape result in a large number of acutely psychotic individuals presenting to the emergency services and acute hospitals. This places an enormous burden, in terms of time, stress and personal danger, on staff members who work in areas of first contact with the patient. This load, together with the major burden of trauma, places significant pressure on areas of emergency care work. Both trauma and acute mental illness require strong care pathways to access advanced skills and appropriate tools.

There is a need to improve hospital clinical data so that more is known about hospital outcomes. Data quality and accountability for data management have been identified as key enablers of departmental transversal priorities.

4.1.3 Performance indicators

4.1.3.1 Beds and turnover

Admissions have increased over time, more or less in keeping with the known increase in total population distribution. More District hospital beds have entered the system with the opening of the Khayelitsha Hospital and will continue to do so with the proposed new Mitchells Plain Hospital.

4.1.3.2 Activities

Caesarean sections are the only specific activity per se that is tracked at a hospital level. There is however, a far greater range of activities being performed at district hospitals. The indicator for caesarean sections is somewhat crude since it is not the absolute number or proportion of caesarean sections that matters as much as whether or not the intervention was indicated, competently performed and resulted in a positive health outcome for mother and child. A further limitation of this current, nationally defined, indicator is that the denominator is just the pregnant mothers being admitted to these hospitals and not all the pregnant mothers in the geographic area, which would be a more appropriate way to measure this indicator. Thus the caesarean section rate is over-estimated in the reflected indicator.

4.1.3.3 Expenses

The trend in expenditure per patient day equivalent (PDE) has been varied over the recent past. An increase in total expenditure in this category is foreseen over the 2014/15 MTEF period.

4.1.3.4 Quality

Quality indicators have been recently introduced and will require some refinement.

Table 2.7: Data elements for situation analysis indicators in Table 2.8

Source	Data element	Element ID	Province wide value 2011/12	Cape Town District 2011/12	Cape Winelands District 2011/12	Central Karoo District 2011/12	Eden District 2011/12	Overberg District 2011/12	West Coast District 2011/12
SINJANI	Usable beds in district hospitals	1	2 477	1 172	257	120	396	178	354
SINJANI	Number of caesarean sections in district hospitals	2	6 980	3 478	856	224	1 078	548	796
SINJANI	Deliveries in district hospitals	3	29 486	11 119	4 443	1 102	5 355	2 543	4 924
SINJANI	Inpatient separations in district hospitals (Sum of: Day patients + inpatient deaths + inpatient discharges + inpatient transfers out)	4	246 329	119 512	25 766	9 515	37 121	17 640	36 773
SINJANI	Patient day equivalents (PDE) in district hospitals (Sum of: Inpatient days + ½ day patients + ⅓ OPD headcount + ⅓ emergency headcount)	5	1 182 929	617 462	115 774	41 661	180 664	76 125	151 243
SINJANI	Total OPD and emergency headcount in district hospitals	6	921 914	426 350	103 476	33 573	150 412	55 421	152 682
SINJANI	Emergency headcount in district hospitals	6.1	328 266	209 646	19 110	6 864	45 270	28 069	19 307
SINJANI	OPD headcount in district hospitals	6.2	1 250 180	635 996	122 586	40 437	195 682	83 490	171 989
SINJANI	Patient days in district hospitals (Sum: Inpatient days + ½ day patients)	7	766 201	405 463	74 912	28 182	115 437	48 295	93 914
SINJANI	Total usable beds days in district hospitals	8	904 204	427 879	93 805	43 800	144 540	64 970	129 210
BAS- CFO	Total expenditure in district hospitals (in 2010/11 Rands)	9	1 673 528 610	963 433 982	138 986 165	58 337 180	225 077 571	98 260 636	189 433 075
SINJANI	Complaints resolved within 25 working days (from users of district hospitals)	10	436	229	2	14	151	32	8
SINJANI	Total number of complaints (from users of district hospitals) received	11	620	307	4	25	220	48	16
Facility list	Number of district hospitals	13	34	9	4	4	6	4	7
DHIS	Number of questionnaires with 1 or 2 recorded for pleased with treatment in district hospitals	14	6 863	3 352	710	1 175	87	642	897
DHIS	Number of questionnaires for pleased with treatment in district hospitals	15	8 165	4 007	840	1 547	89	711	971
NDoH assessment tool	District hospitals assessed against the 6 priorities of the core standards	16	24	7	3	4	5	1	4
SINJANI	Number of Mortality and Morbidity review meetings conducted in district hospitals	17	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report
SINJANI	Planned Mortality and Morbidity reviews multiplied by the number of disciplines within the district hospitals	18	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report

Notes:

Element ID 9: Financial figurers updated to reflect 2011/12 Rands.

Element ID 12: This element has been removed from the elements table from April 2013 as it is no longer a reporting requirement due to changes in the National Indicator Dataset definitions.

Table 2.8: Situation analysis indicators for district hospitals [DHS7]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2011/12	Cape Town District 2011/12	Cape Winelands District 2011/12	Central Karoo District 2011/12	Eden District 2011/12	Overberg District 2011/12	West Coast District 2011/12	National Average / Total 2009/10
1. Address the burden of disease.	1.1. Increase access to acute district hospital services in the Western Cape.	1.1.1. Establish 2 678 acute district hospital beds in the DHS by 2014/15.	1) Number of usable district hospital beds Element ID 1	No	2 477	1 172	257	120	396	178	354	-
			2) Delivery by caesarean section rate (in district hospitals)	%	23.67%	31.28%	19.27%	20.33%	20.13%	21.55%	16.17%	18.8%
			Numerator ID 2		6 980	3 478	856	224	1 078	548	796	-
			Denominator ID 3		29 486	11 119	4 443	1 102	5 355	2 543	4 924	-
			3) Inpatient separations - total (in district hospitals) Element ID 4	No	246 327	119 512	25 766	9 515	37 121	17 640	36 773	117 382
			4) Patient day equivalents [PDE] total (in district hospitals) Element ID 5	No	1 182 928	617 462	115 774	41 661	180 664	76 125	151 243	364 854
			5) OPD headcount total (in district hospitals) Element ID 6	No	1 250 180	635 996	122 586	40 437	195 682	83 490	171 989	367 173
			6) Average length of stay (in district hospitals)	Days	3.11	3.39	2.91	2.96	3.11	2.74	2.55	4.3
			Numerator ID 7		766 201	405 463	74 912	28 182	115 437	48 295	93 914	-
			Denominator ID 4		246 327	119 512	25 766	9 515	37 121	17 640	36 773	-
			7) Inpatient bed utilisation rate (based on usable beds in district hospitals)	%	84.74%	94.76%	79.86%	64.34%	79.87%	74.33%	72.68%	65.4%
			Numerator ID 7		766 201	405 463	74 912	28 182	115 437	48 295	93 914	-
			Denominator ID 8		904 204	427 879	93 805	43 800	144 540	64 970	129 210	-
2. Optimal financial management to maximise health outcomes.	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 422 per PDE by 2014/15 (in 2011/12 Rands).	8) Expenditure per patient day equivalent [PDE] (in district hospitals)	R	R1 415	R1 560	R1 200	R1 400	R1 246	R1 291	R1 253	-
			Numerator ID 9		1 673 528 610	963 433 982	138 986 165	58 337 180	225 077 571	98 260 636	189 433 075	-
			Denominator ID 5		1 182 929	617 462	115 774	41 661	180 664	76 125	151 243	-

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value	Cape Town District	Cape Winelands District	Central Karoo District	Eden District	Overberg District	West Coast District	National Average / Total
					2011/12	2011/12	2011/12	2011/12	2011/12	2011/12	2011/12	2009/10
3. Improve the quality of health services and the patient experience.	3.1. Improve the experience of clients utilising district hospital services.	3.1.1. Achieve an 87.0% client satisfaction rate by 2014/15.	9) Complaint resolution within 25 working days rate (from users of district hospitals)	%	70.32%	74.59%	50.00%	56.00%	68.64%	66.67%	50.00%	-
			Numerator ID10		436	229	2	14	151	32	8	-
			Denominator ID 11		620	307	4	25	220	48	16	-
			10) Hospital patient satisfaction rate (in district hospitals)	%	84%	84%	85%	76%	98%	90%	92%	-
			Numerator ID14		6 863	3 352	710	1 175	87	642	897	-
			Denominator ID 15		8 165	4 007	840	1 547	89	711	971	-
			11) Percentage of district hospitals assessed for compliance against the 6 priorities of the core standards (NID: Facility core standards self-assessment rate in district hospitals). Number of district hospitals assessed for compliance against the 6 priorities of the core standards	%	70.6%	77.8%	75.0%	100.0%	83.3%	25.0%	57.1%	-
			Numerator ID 16		24	7	3	4	5	1	4	-
			Denominator ID 13		34	9	4	4	6	4	7	-
			12) Morbidity and mortality review rate (in district hospitals)		Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	-
			Numerator ID 17		-	-	-	-	-	-	-	-
			Numerator ID 18		-	-	-	-	-	-	-	-

Note:

Indicator 8: Financial figures updated to reflect 2011/12 Rands.

Indicator 12: In order to comply with the definition of the indicator every district hospital has to have an M&M every month. Although on average 25 out of the 34 hospitals (74%) had a meeting each month, but only 11 out of 34 managed to hold a meeting every month of the year.

4.2 **CHALLENGES**

1) Adequate funding for newly commissioned district hospitals.

4.3 **PRIORITIES**

1) Managing the acute behaviourally disturbed client.
2) Improving the management of emergency care.
3) Better infrastructure, improved staff skills and clearer polices are necessary in the above two areas.
4) Improved access to elective surgery (as per identified/ prioritised needs). Long surgical waiting lists are a significant source of morbidity and mortality. Improved access to surgical and diagnostic skills is required and will be facilitated by GSA planning.
5) Improving the quality of care at district hospitals.

4.4 STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DISTRICT HOSPITALS [DHS 7 & 8]

Table 2.9 Data elements and related actual and projected performance values for Table 2.10 to 2.11

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
SINJANI	Usable beds in district hospitals	1	2 464	2 482	2 477	2 637	2 678	2 678	2 678
SINJANI	Caesarean sections in district hospitals	2	6 587	6 761	6 980	7 180	8 855	8 860	8 870
SINJANI	Deliveries in district hospitals	3	30 078	29 019	29 486	30 739	35 979	36 000	36 000
SINJANI	Separations in district hospitals (Sum of: Inpatient days + ½ day patients + ⅓ OPD headcount + ⅓ emergency headcount)	4	238 085	237 292	246 329	260 684	264 977	270 000	275 000
SINJANI	Patient day equivalents (PDE) in district hospitals- (Sum of: inpatient days + 1/2 day patients + 1/3 OPD headcount + 1/3 emergency headcount)	5	986 481	999 260	1 182 929	1 264 471	1 276 052	1 300 000	1 325 000
SINJANI	Total OPD and emergency headcount in district hospitals	6	504 673	565 801	921 914	894 012	1 180 584	1 200 000	1 220 000
SINJANI	Patient days in district hospitals (Sum: Inpatient days + ½ day patients)	7	705 098	698 661	766 201	840 080	842 435	864 000	880 000
SINJANI	Total usable beds days in district hospitals	8	899 360	905 959	904 204	962 505	971 995	971 995	971 995
BAS- CFO	Total expenditure in district hospitals (in 2011/12 Rands)	9	1 636 430 813	1 604 251 343	1 673 528 610	1 886 324 433	1 851 196 420	1 849 167 037	1 829 710 556
SINJANI	Complaints resolved within 25 working days in district hospitals	10	498	383	436	648	473	475	488
SINJANI	Complaints lodged in district hospitals	11	679	562	620	871	597	600	600
Facility list	Number of district hospitals	13	34	34	34	34	34	34	34
DHIS	Number of questionnaires with 1 or 2 recorded for pleased with treatment in district hospitals	14	498	383	6 863	7 221	7 452	7 689	7 921
DHIS	Number of questionnaires for pleased with treatment in district hospitals	15	679	562	8 165	8 495	8 665	8 838	8 900
NDoH assessment tool	District hospitals assessed against the core standards	16	Not required to report	Not required to report	24	0	34	15	15
SINJANI	Mortality and morbidity review conducted in district hospitals	17	Not required to report	Not required to report	Not required to report	340	340	340	340
SINJANI	Planned mortality and morbidity meetings multiplied by the number of disciplines within the district hospitals	18	Not required to report	Not required to report	Not required to report	340	340	340	340

Notes:

Element ID 6: Change to the definition from 1 April 2011: PHC headcount at district hospitals is now reflected as OPD headcount.

Element ID 9: Financial figurers updated to reflect 2011/12 Rands.

Element 10: From 2013/14 due to a change in the National Indicator Dataset definition, the element will reflect complaints resolved within 25 working days, not calendar days.

Element ID 12: This element has been removed from the elements table from April 2013 as it is no longer a reporting requirement due to changes in the National Indicator Dataset definitions.

Element ID 16: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.
Element ID 17 and 18: New elements introduced from April 2013 to align with changes in the National Indicator Dataset definition.

Table 2.10: Strategic objectives, indicators and annual targets for district hospitals [DHS 7 & 8]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2014/15
1. Address the burden of disease.	1.1. Increase access to acute district hospital services in the Western Cape.	1.1.1. Establish 2 678 acute district hospital beds in the DHS by 2014/15.	1) Number of usable district hospital beds Element ID 1	No	2 678	2 464	2 482	2 477	2 637	2 678	2 678	2 678	-
			2) Delivery by caesarean section rate (in district hospitals)	%	-	21.9%	23.3%	23.7%	23.4%	24.6%	24.6%	24.6%	15.0%
			Numerator ID 2		-	6 587	6 761	6 980	7 180	8 855	8 860	8 870	-
			Denominator ID 3		-	30 078	29 019	29 486	30 739	35 979	36 000	36 000	-
			3) Inpatient separations - total (in district hospitals) Element ID 4	No	-	238 085	237 292	246 329	260 684	264 977	270 000	275 000	-
			4) Patient day equivalents [PDE] total (in district hospitals) Element ID 5	No	-	986 481	999 260	1 182 929	1 264 471	1 276 052	1 300 000	1 325 000	-
			5) OPD headcount total (in district hospitals) Element ID 6	No	-	504 673	565 801	921 914	894 012	1 180 584	1 200 000	1 220 000	-
			6) Average length of stay (in district hospitals)	Days	-	2.96	2.94	3.11	3.22	3.18	3.20	3.20	3.5 days
			Numerator ID 7		-	705 098	698 661	766 201	840 080	842 435	864 000	880 000	-
			Denominator ID 4		-	238 085	237 292	246 329	260 684	264 977	270 000	275 000	-
			7) Inpatient bed utilisation rate (based on usable beds in district hospitals)	%	-	78.4%	77.1%	84.7%	87.3%	86.7%	88.9%	90.5%	75.0%
			Numerator ID 7		-	705 098	698 661	766 201	840 080	842 435	864 000	880 000	-
			Denominator ID 8		-	899 360	905 959	904 204	962 505	971 995	971 995	971 995	-
2. Optimal financial management to maximise health outcomes.	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 422 per PDE by 2014/15 (in 2011/12 Rands).	8) Expenditure per patient day equivalent [PDE] (in district hospitals)	Rand	1 422	1 659	1 605	1 415	1 492	1 451	1 422	1 381	-
			Numerator ID 9		1 849 167 037	1 636 430 813	1 604 251 343	1 673 528 610	1 886 324 433	1 851 196 420	1 849 167 037	1 829 710 556	-
			Denominator ID 5		1 300 000	986 481	999 260	1 182 929	1 264 471	1 276 052	1 300 000	1 325 000	-

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2014/15
3. Improve the quality of health services and the patient experience.	3.1. Improve the experience of clients utilising district hospital services.	3.1.1. Achieve an 87.0% client satisfaction rate by 2014/15.	9) Complaint resolution within 25 working days rate (from users of district hospitals)	%	-	73.3%	68.1%	70.3%	74.4%	79.2%	79.2%	81.3%	100.0%
			Numerator ID10		-	498	383	436	648	473	475	488	-
			Denominator ID 11		-	679	562	620	871	597	600	600	-
			10) Hospital patient satisfaction rate (in district hospitals)	%	87.0%	73.3%	68.1%	84.1%	85.0%	86.0%	87.0%	89.0%	-
			Numerator ID14		7 689	498	383	6 863	7 221	7 452	7 689	7 921	-
			Denominator ID 15		8 838	679	562	8 165	8 495	8 665	8 838	8 900	-
			11) Percentage of district hospitals assessed for compliance against the 6 priorities of the core standards (NID: Facility core standards self-assessment rate in district hospitals)	%	-	Not required to report	Not required to report	70.6%	0.0%	100.0%	44.1%	44.1%	-
			Number of district hospitals assessed for compliance against the 6 priorities of the core standards										
			Numerator ID 16		-	-	-	24	0	34	15	15	-
			Denominator ID 13		-	-	-	34	34	34	34	34	-
			12) Morbidity and mortality review rate (in district hospitals)	%	-	Not required to report	Not required to report	Not required to report	100%	100%	100%	100%	-
			Numerator ID 17		-	-	-	-	340	340	340	340	-
			Numerator ID 18		-	-	-	-	340	340	340	340	-

Notes:

Indicator 5: Change to the definition from 1 April 2011: PHC headcount at district hospitals is now reflected as OPD headcount.
The projected increase in OPD headcount for 2013/14 is due to Khayelitsha Hospitals becoming fully operational and the opening of Mitchells Plain Hospital.

Indicator 7: The projected decrease in 2013/14 is due to additional hospital beds becoming available with Khayelitsha Hospitals becoming fully operational and the opening of Mitchells Plain Hospital.

Indicator 8: Financial figurers updated to reflect 2011/12 Rands.

Indicator 9: The definition of this indicator has been changed to align with changes in the National Indicator Dataset definition.
The percentage of complaints resolved within 25 working days will be reported instead of those resolved within 25 calendar days with effect from April 2013.

Indicator 12: Quality improvement plans to address the findings of the 2011/12 baseline audit were developed and implemented during 2012/13
Indicator amended from 2013/14 in order to align the definition of the indicator with the changes in the National Indicator Dataset.
The denominator is: Planned mortality and morbidity reviews multiplied by number of disciplines within the facility.
District hospitals are deemed to have one discipline x 10 meetings per year.