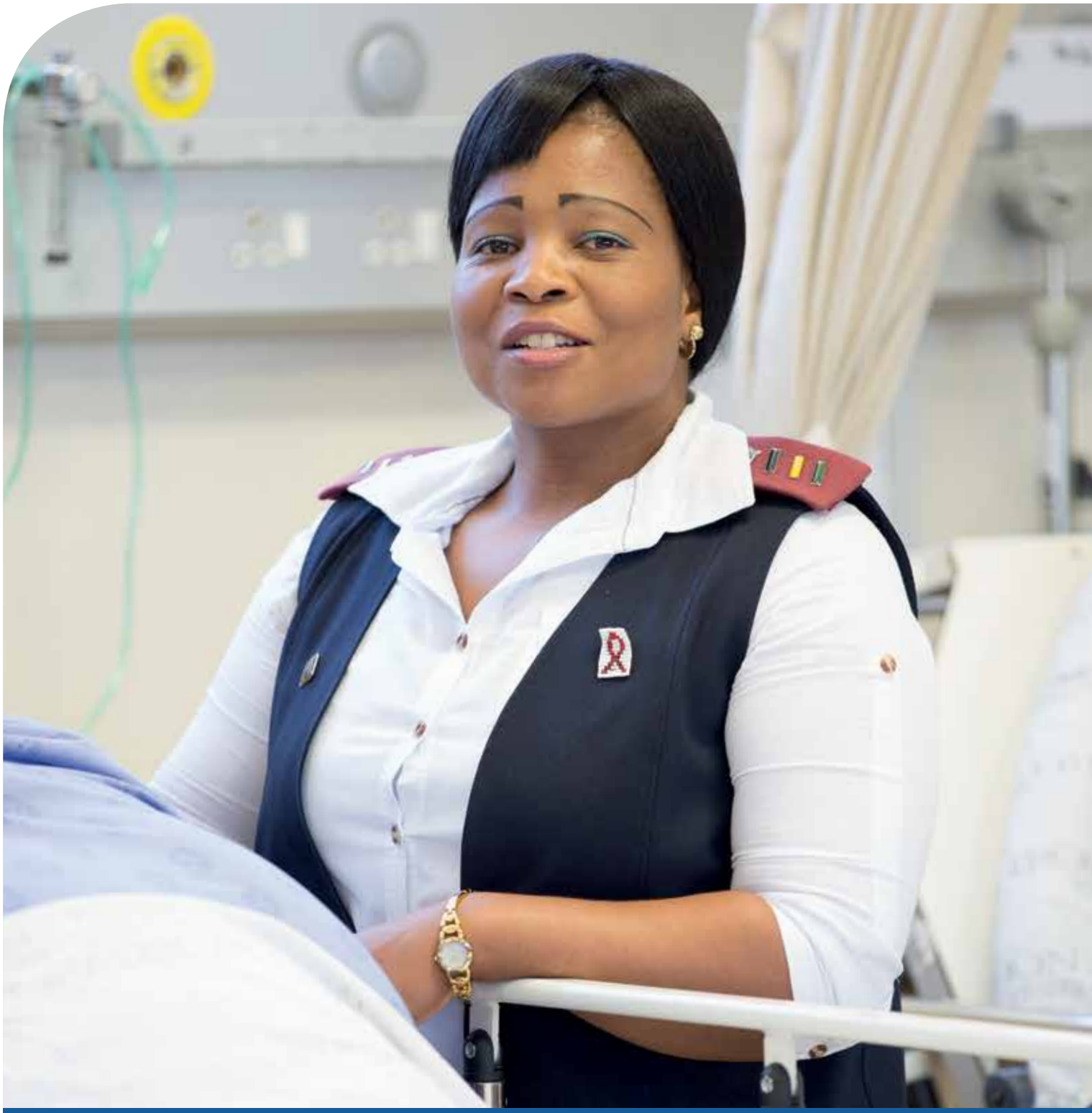
Western Cape Government

Health



Annual Report 2013/2014

Western Cape Government Health

CONTENTS

PART A:
GENERAL INFORMATION

1. DEPARTMENT'S GENERAL INFORMATION

Full name of Department:	Western Cape Government: Health
Physical address of Head Office:	4 Dorp Street Cape Town 8001
Postal address of Head Office:	PO Box 2060 Cape Town 8000
Contact telephone numbers:	+27 21 483 3245 (Directorate: Communications)
Fax number:	+27 21 483 6169
E-mail address:	Marika.Champion@westerncape.gov.za
Website address:	http://www.westerncape.gov.za
ISBN:	978-0-620-62897-6

2. LIST OF ABBREVIATIONS / ACRONYMS

ABET	Adult basic education and training
ACLS	Advanced cardiovascular life support
AFB	Acid-fast bacillus
AFS	Annual financial statements
AGSA	Auditor-General of South Africa
AIDS	Acquired immune deficiency syndrome
ALOS	Average length of stay
AMS	Air Mercy Service
AO	Accounting officer
AOP	Annual operational plan
APL	Approved post list
APP	Annual performance plan
ART	Anti-retroviral treatment / therapy
ARV	Anti-retroviral
ATA	Assistant to artisan
ATLS	Advanced trauma life support
BAS	Basic Accounting System
BBBEE	Broad based black economic empowerment
BMI	Budget management instrument
BUR	Bed utilisation rate
CAD	Computer aided dispatch
CAP	Compliance acceleration plan
CARA	Criminal assets recovery account
CBO	Community-based organisation
CBR	Community-based response
CBS	Community-based services
CCTV	Closed circuit television
CCW	Community care worker
CD	Chief Director

CD4	Cluster of differentiation 4 (lymphocyte)
CDC	Community day centre
CDU	Chronic dispensing unit
Ce-I	Centre for e-Innovation
CEO	Chief executive officer
CFO	Chief financial officer
CGRO	Corporate Governance Review and Outlook
CHC	Community health centre
CISD	Critical incident stress debriefing
CMART	Certificate in the management of patients on anti-retroviral and tuberculosis treatment
CMD	Cape Medical Depot
CMI	Compliance monitoring instrument
CNP	Clinical nurse practitioner
CoCT or CCT	City of Cape Town
CPD	Continuous professional development
CPI	Consumer price index
CPUT	Cape Peninsula University of Technology
CRADLE	Central Reporting of All Delivery Data on Local Establishment
CSIR	Council for Scientific and Industrial Research
CSM	Client service manager
CSP	Comprehensive Service Plan
CSS	Client satisfaction survey
CT	Computerised tomography
CYPR	Couple year protection rate
D or Dir	Director
DB	Database
DDG	Deputy Director-General
DDV	Direct delivery voucher
DEDT	Department of Economic Development and Tourism
DG	Director-General
DHER	District health expenditure review

DHS	District health system / services
DHS & HP	District health services and health programmes
DICU	Devolved internal control unit
DNA	Deoxyribonucleic acid
DoH	Department of Health
DORA	Division of Revenue Act
DOTS	Directly observed treatment, short course
DPC	Disease prevention and control
DPSA	Department of Public Service Administration
DR	Drug resistant
eCare	Electronic care
eGovernment	Electronic government
EAP	Employee assistance programme
EC	Emergency centre
ECD	Early child development
ECM	Enterprise/electronic content management
ECO	Emergency care officer
ECP	Emergency care practitioner
ECT	Emergency care technician
EFAR	Emergency first aid response
EHW	Employee health and wellness
EHWP	Employee health and wellness programme
EMC	Emergency medical care
EML	Essential medicines list
EMS	Emergency medical services
ENT	Ear, nose and throat
EPWP	Expanded public works programme
ERM	Enterprise risk management
ESL	Essential supplies list
ETR.net	Electronic Tuberculosis Register
EU	European Union

FBU	Functional business unit
FIFO	First in, first out
FIU	Forensic investigation unit
FMC	Financial monitoring committee
FOREX	Foreign exchange rate
FPL	Forensic pathology laboratory
FPS	Forensic pathology services
FTE	Full-time equivalent
GAAP	Generally accepted accounting practice
GEMS	Government Employees Medical Scheme
GF	Global Fund
GG	Government garage
GG	Government Gazette
GIAMA	Government Immovable Asset Management Act
GMT	Government motor transport
GN	General notice
GP	General practitioner
GP%	Gross profit percentage
GPSSBC	General Public Service Sector Bargaining Council
GSA	Geographical service area
GSH	Groote Schuur Hospital
HAART	Highly active anti-retroviral therapy
HAST	HIV and AIDS, STI and tuberculosis
HBC	Home-based care
HC	Health care
HCBC	Home community-based care
HCRW	Health care risk waste
HCT	HIV counselling and testing
HDI	Historically disadvantaged individuals
HEI	Higher education institutions
HFRG	Health facility revitalisation grant

HH	Households
HIA	Health impact assessment
HIGC	Health Infrastructure Grant Component
HIS	Hospital Information System
HIV	Human immunodeficiency virus
HO	Head office
HoD	Head of department
HP	Health programmes
HPCSA	Health Professions Council of South Africa
HPTDG	Health professions training and development grant
HR	Human resources
HRD	Human resource development
HRGC	Hospital Revitalisation Grant Component
HRH	Human resources for health strategy
HRM	Human resource management
HRMC	Human resource monitoring committee
HRP	Hospital revitalisation programme
HSRC	Human Sciences Research Council
HST	Health Systems Trust
HTA	High transmission area
HWSETA	Health and Welfare Sector Education and Training Authority
iMMR	Institutional maternal mortality rate
IA	Internal assessment
IAR	Immovable asset register
IAS	International accounting standards
ICAS	Independent Counselling and Advisory Services
ICD-10	International classification of disease (10th revision)
ICT	Information and communication technology
ICU	Intensive care unit
ICU	Information compliance unit
ID	Infectious diseases

IDIP	Infrastructure delivery improvement programme
IDS	Industrial Development Strategy
IDU	Infectious disease unit
IDMS	Infrastructure Delivery Management System
IEC	Information Education and Communication
IHT	Inter-hospital transfers
IM	Information management
IMCI	Integrated management of childhood illness
IMLC	Institutional management labour committees
IMO	International Maritime Organisation
iMOCOMP	Improvement and maintenance of competencies of medical practitioners
IMR	Infant mortality rate
IOD	Injuries on duty
IPC	Infection prevention and control
ISBM	International Standards Book Number
IUSS	Infrastructure unit support system
IYM	In-year monitoring
JAC	Pharmaceutical management system
KDH	Khayelitsha District Hospital
KVA	Kilovolt-ampere
LG	Local government
LGBTI	Lesbian, gay, bisexual, transgender and intersex
LOGIS	Logistic Information Systems
LRA	Labour Relations Act
M	Million
M & E	Monitoring and evaluation
M & M	Morbidity and mortality
MCWH	Maternal, child and women's health
MCWH&N	Maternal, child and women's health and nutrition
MDG	Millennium development goal
MDHS	Metro District Health Services

MDR	Multi-drug resistant
MEC	Member of the executive council
MIMMS	Major incident medical management system
MM	Michael Mapongwana
MMC	Medical male circumcision
MMS	Middle management service
MOU	Midwife obstetric unit
MPSA	Minister of Public Service and Administration
MRC	Medical Research Council of South Africa
MRI	Magnetic resonance imaging
MSAT	Multi-sectorial action teams
MTEF	Medium-term expenditure framework
MTSF	Medium-term strategic framework
N	Number
NACOSA	Networking AIDS Community of South Africa
NCS	National core standards
NDoH	National Department of Health
NDP	National Development Plan
NEMA	National Environmental Management Act
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NHS	National Health Systems
NIDS	National indicator dataset
NIMART	Nurse initiated management of ART
NIMS	Nursing Information Management System
NMS	Non-medical site
NPC	National Planning Commission
NPO	Non-profit organisation
NRF	National Revenue Fund
NQF	National Qualifications Framework
NSDA	Negotiated service delivery agreement

NSRI	National Sea Rescue Institute
NTSG	National tertiary services grant
OD	Organisational Development
OHC	Oral health centre
OHS	Occupational health and safety
OHSC	Office of Health Standards Compliance
OPC	Orthotic and Prosthetic Centre
OPD	Outpatient department
OSD	Occupation specific dispensation
OVC	Orphans and vulnerable children
P1	Priority 1
P2	Priority 2
PAA	Public Audit Act
PACS	Picture archive communication system
PACS/RIS	Picture archive communication system and Radiological imaging system
PALS	Paediatrics advanced life support
PALSA PLUS	Practical approach to lung health and HIV/AIDS and STIs in South Africa
PAY	Premier's advancement of youth (project)
PCR	Polymerase chain reaction
PCV	Pneumococcal conjugate vaccine
PDE	Patient day equivalent
PDP	Public driving permit
PEAP	Provincial employee AIDS programme
PEP	Post exposure prophylaxis
PERMIS	Performance Management Information System
PERSAL	Personnel and Salary Information System
PES	Provincial equitable share
PET	Positron emission tomography
PFMA	Public Finance Management Act
PHC	Primary health care
PHCIS	Primary Health Care Information System

PICT	Provider initiated counselling and testing
PILIR	Policy on incapacity leave and ill-health retirement
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission
PMG	Paymaster General
PMT/Refund & Rem-Act/Grace	Payment made as an act of grace
PN	Practice note
PPE	Property, plant and equipment
PPHC	Personal primary health care
PPP	Public private partnership
PPPFA	Preferential Procurement Policy Framework Act
PPPFA/BBBEE	Preferential Procurement Policy Framework Act / Broad based black economic empowerment
PPT	Planned patient transport
PPTC	Provincial Pharmaceutical and Therapeutic Committee
PSA	Public Service Act
PSA	Public Service Administration
PSI	Palliative / step-down / intermediate care
PSCBC	Public Service Co-ordinating Bargaining Council
PSR	Public service regulations
PTB	Pulmonary tuberculosis
PTMS	Provincial transversal management system
PTI	Provincial Treasury instruction
PTSO	Provincial Technical Support Officer
QA	Quality assurance
RAF	Road Accident Fund
RCAMS	Red Cross Air Mercy Service
RCC	Rolling Continuation Channel
RCWMCH	Red Cross War Memorial Children's Hospital
RDHS	Rural District Health Services
RIS	Radiological imaging system

RTC	Regional training centre
RV	Rotavirus
RWOPS	Remunerative work outside the Public Service
SA	South Africa
SA-NHANES	South African National Health and Nutrition Examination Survey
SABS	South African Bureau of Standards
SAL	Salary
SANC	South African Nursing Council
SAPS	South African Police Service
SBA	Study by assignment
SCM	Supply chain management
SCOA	Standard chart of accounts
SCOPA	Standing Committee on Public Accounts
SDA	Service delivery agreement
SDC	Step-down care
SDF	Step-down facilities
SDIP	Service delivery improvement plan
SETA	State Education and Training Authority
SG	Superintendent General
SHERQ	Safety, health, environment, risk and quality management
SINJANI	Standard Information Jointly Assembled by Networked Infrastructure
SITA	State Information Technology Agency
SLA	Service level agreement
SMME	Small medium and micro enterprises
SMS	Senior management service
SOP	Standard operating procedure
SP	Sub-programme
SPES	Specialised and emergency services
SPMS	Staff performance management system
SSO	Sub-structure office
SSS	Staff satisfaction survey

StatsSA	Statistics South Africa
STI	Sexually transmitted infection
SYSPRO	Software package used by central hospitals for supply chain management and asset management.
TB	Tuberculosis
TBH	Tygerberg Hospital
TR	Treasury regulations
TV	Television
U5MR	Under-five mortality rate
U-AMP	User asset management plan
UCT	University of Cape Town
UNICEF	United Nations International Children's Fund
UPFS	Uniformed Patient Fee Schedule
US	University of Stellenbosch
UV	Ultra-violet
UVGI	Ultra-violet germicidal irradiation
UWC	University of the Western Cape
VHF	Very high frequency
VIR	Vulcanised India Rubber
WC	Western Cape
WC-IDMS	Western Cape infrastructure delivery management system
WCA	Workers compensation assistance
WCBD	Western Cape Bid Documents
WCCN	Western Cape College of Nursing
WCG	Western Cape Government
WCRC	Western Cape Rehabilitation Centre
WCSD	Western Cape Supplier Database
WISN	Workload indicators of staffing needs
WHO	World Health Organisation
WSAR	Wilderness Search & Rescue
XDR	Extreme drug resistant
YLL	Years of potential life lost

3. FOREWORD BY MINISTER

I have been privileged to be the political head of the Western Cape Department of Health over the last five years – since 2009. The year 2013/14 posed its own set of challenges which was largely different because of the culmination of our strategic objective of "Creating Wellness" into tangible and visible projects.

One of the milestones on our road to Wellness certainly was the finalisation of the Healthcare 2030 framework. Healthcare 2030 was developed through a consultative process with inputs from staff, external stakeholders and strategic partners over more than two years. It sets out the vision, values and principles guiding the Department to 2030. Healthcare 2030 has been endorsed by the Western Cape cabinet and forms the compass for the Department over the next two decades in guiding its health service development. I want to congratulate the Department on this major and very important exercise. It will now be converted into sets of priorities that will be incorporated into the annual plans and the new five year term. The thinking and principles of the framework have started to filter through into the dialogues and work of the Department. The journey has begun through the application of the proposed models and approaches in specific services and sections of the Department.

With the increased focus on wellness, Western Cape Government spearheaded the transversal "Walk for Health" initiative in which all government ministries and departments participated.

We have introduced innovative programmes that have leveraged agreements with the private sector and have already started benefiting citizens in the Province.

The need for public and private health services is ever increasing, not only in South Africa, but all over the world, and it is impossible for government funding to cover the growing demand in the public sector. Instead public health systems require funding from everyone who has a stake in the well-being of communities.

The Health Foundation, a non-profit organisation that facilitates donations and partnerships with government, and the strengthening of the business development unit to manage contracts with the private sector will play an important role to "Increase Wellness" and underwrite our government slogan "Better Together". The Department, together with the retail pharmacy sector, launched sixteen wellness centres as a pilot project. We are watching this project with keen interest.

One of the highlights in 2013/14 was certainly the opening of Mitchell's Plain Hospital by premier Helen Zille. This hospital, together with the Khayelitsha Hospital, will make a significant difference to health service provision in the Metro over the forthcoming years.

However, at the same time, the annual report reflects the service pressures that continue to impact on expenditure, and staff capacity, especially in the large district and central hospitals of the Metro.

Strict financial discipline is reflected through the unqualified audit of ten years up to 2012/13 – a sign of solid management practices and systems.

In general, health service outputs and outcomes have steadily improved. Historically the Western Cape HIV programme has set the national trend, and the past year was no exception. The number of patients on ART are now 156 703 and so we surpassed the 150 000 milestone. The mother-to-child transmission rate has been reduced to 1.9 per cent which surpasses the national target of 2 per cent. More than 127 million condoms were distributed which is the best performance in the country.

The Department has embarked on a change management programme involving 38 facilities in District Health Services in the first phase. The objective of the programme is to translate departmental values into actions and behaviours of staff, to provide support to frontline staff and management at facility level, and to encourage innovation in finding solutions to service delivery challenges and to become more person centred.

The credit for the achievements of the Department must go to the hardworking and committed staff at every level of the organisation, the collective leadership of the Department and the range of partners that we collaborate with.

I also thank the Head of the Department, Prof Craig Household, who will retire within the 2014/15 financial year, for his strong and visionary leadership over more than a decade. His contribution has impacted to a large extent in making this Department amongst the best performing departments in the country.

THEUNS BOTHA

WESTERN CAPE MINISTER OF HEALTH

MAY 2014

4. REPORT OF THE ACCOUNTING OFFICER

4.1 OVERVIEW OF THE OPERATIONS OF THE DEPARTMENT

The Department continues to experience escalating service pressures that are fuelled by the quadruple burden of disease i.e. non-communicable diseases, infectious diseases such as HIV and TB, trauma from inter-personal violence and road traffic accidents, and maternal and child health conditions. The non-communicable diseases are of particular concern given that this translates into three out four patients visiting the emergency centres within the Department. There is further evidence that a significant proportion of patients visiting our services have multi-morbidity. These patients are more complex to diagnose and treat, more prone to complications, have a poorer prognosis and are more expensive to manage clinically. This burden is unlikely to decrease in the short term given that the risk factor trends for these diseases are not improving.

The Department runs a 24-hour service, 365 days a year, with a huge service volume. In 2013/14, the Department treated 14 336 969 patients at a primary health care (PHC) level, transported 514 901 patients by ambulances of which 214 172 were priority 1 patients in need of urgent medical care (urban and rural), admitted 529 430 patients across its acute hospitals (district, regional and central hospitals), treated 2 378 520 outpatients in acute hospitals, delivered 95 337 babies in the Province, treated 156 703 patients on ART within the Department, and undertook 7 692 cataract surgery operations. The immunisation coverage rate for under one year olds was 80.4 per cent.

The significant health service outcomes include the mother-to-child transmission rate of 1.9 per cent, a TB smear positive cure rate of 83.7 per cent, and the reduction in child mortality from HIV and diarrhoea. The increase in child mortality from pneumonia is of concern and is being investigated.

The major service development in 2013/14 was the opening of the new Mitchells Plain Hospital and the relocation of services from GF Jooste Hospital. There were initial teething problems but the efforts by clinical staff and management to manage the patient load must be acknowledged. However, these challenges should not undermine the major milestone of opening this hospital and improving the access to health care for the local community. The commissioning of Khayelitsha Hospital in the year before and now Mitchells Plain Hospital are probably the most significant health service developments of the last decade.

The on-going service pressures make the implementation of Healthcare 2030, with its focus on wellness (prevention and health promotion), person-centred care and strengthening of primary health care and district health services, a necessity. The plan has been politically endorsed by the provincial cabinet and will be systematically converted into priorities within the five-year and annual planning processes. The vision, principles and values of Healthcare 2030 should influence every aspect of the Department's operations.

The Department spearheaded the "Walk for Health" campaign led by the Premier within the Western Cape Government. Sixteen wellness centres have been launched in collaboration with the private retail pharmacy sector during the pilot phase. The objective of these wellness centres is to provide improved access for the screening of common chronic diseases.

A key component of person-centred care is listening to the patient and improving the quality of care. In 2013/14 the Department received 9 604 patient complaints and 24 598 patient compliments. The far larger number of compliments is encouraging. The Minister introduced a SMS hotline to provide further means to listen to the concerns of the patients. A total of 1 984 complaints were received through email, SMS, telephone and "Please Call Me" services and 83.2 per cent were resolved.

Legislation to formally establish the Independent Health Complaints Committee has been passed, whereby complaints that have not been satisfactorily addressed within the Department, can be referred by either the Minister or the Head of Health. The Department undertook assessments against the national core standards at 109 facilities during 2013/14 and quality improvement plans to address the shortcomings have been developed.

Effective and efficient service delivery is enabled by support services such as finance and supply chain, human resources, infrastructure, information management and information and communication technology (ICT).

The Department delivered health services in the Western Cape within 0.2 per cent of its equitable share budget for the financial year 2013/14. Areas of under-spending, such as infrastructure, remain a concern and are being addressed together with the Department of Transport and Public Works. The Department is proud of the track record of an unqualified audit for the past ten years. Robust systems, processes and controls have been put in place, together with an on-going vigilance, to ensure this outcome is sustainable.

The Department had 31 017 filled posts as at 31 March 2014, which is an increase of 515 filled posts over the previous year. Significant effort has been put into reducing the turn-around time for the filling of posts which now stands at an average of approximately two to three months. Challenges in recruiting certain categories of skilled staff continue and are being addressed.

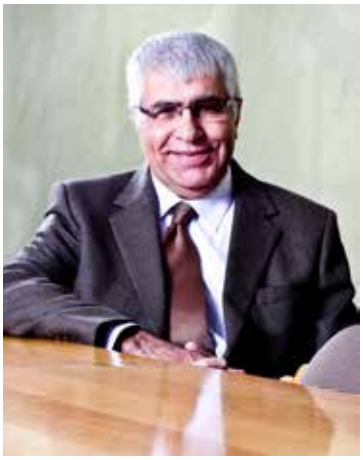
The Department embarked upon a change management project in 38 facilities within the district health service as part of a first phase. The objective of the project is to support staff at the coalface of service delivery, encourage innovation in problem solving and translate the values of the Department into tangible behaviours and actions in the provision of person-centred care during day to day service delivery.

The revitalisation of infrastructure plays an important role in improving the environment for patients as well as staff. The Department completed the following main capital projects in 2013/14: Hermanus Hospital – new ward, outpatients department and administration, Malmesbury Ambulance Station, extensions and alterations to the Swartland Hospital emergency centre, new drug resistant tuberculosis (TB) unit at Brooklyn Chest Hospital, upgrading of Lentegeur Regional Laundry, and Karl Bremer Hospital emergency centre.

ICT has come to play a central role as an enabler of health service delivery. Over and above maintaining the legacy systems, the Department has started to install a new emergency medical services (EMS) software solution for the EMS communication centres, rolled out the Primary Health Care Information System (PHCIS) to 176 facilities with 97 facilities actively using the appointment module, and the pharmaceutical management system (JAC) to 48 sites. The Hospital Information System (HIS) was extended to the Swartland and Lapa Munnik Hospitals in 2013/14. Enterprise Content Management (ECM) was implemented at Mitchells Plain Hospital, George Hospital and the Directorate: Information Management within Head office. The Picture Archiving System/Radiology Information System (PACS/RIS) has been implemented in the central hospitals and a tender has been awarded for the roll-out to regional and certain large district hospitals.

As part of a technology refresh, 926 personal computers older than five years were replaced in 2013/14. Project management capacity will be strengthened to ensure the smooth implementation and sustainable management of ICT projects going forward.

The Department will also encourage innovation that creates viable solutions that offer improved healthcare experiences for patients and care providers in the short to longer-term.



4.2 OVERVIEW OF THE FINANCIAL RESULTS OF THE DEPARTMENT

Departmental receipts

The table below provides a breakdown of the sources of revenue and performance for 2013/14.

Table 4.2.1: Sources of revenue

	2013/14			2012/13		
Departmental receipts	**Estimate**	**Actual amount collected**	**(Over) / under collection**	**Estimate**	**Actual amount collected**	**(Over) / under collection**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**
Sale of goods and services other than capital assets	331 753	419 475	(87 722)	309 208	426 218	(117 010)
Transfers received	146 954	158 839	(11 885)	173 561	161 560	12 001
Fines, penalties and forfeits	-	-	-	-	1	(1)
Interest, dividends and rent on land	932	1 416	(484)	878	1 405	(527)
Sale of capital assets	4	-	4	4	119	(115)
Financial transactions in assets and liabilities	7 330	18 028	(10 698)	7 096	19 101	(12 005)
Total	**486 973**	**597 758**	**(110 785)**	**490 747**	**608 404**	**(117 657)**

The Department ended the 2013/14 financial year with a revenue surplus of R110,785 million.

The surplus is the net effect of the over- and under-recoveries for the year:

- Sales of goods and services:

  The surplus (R87,722 million) is primarily due to the claims paid by the medical aid schemes and the Road Accident Fund in respect of patient fees. The tariffs for patient fees are based on the Uniform Patient Fee Schedule as determined and annually adjusted by the National Department of Health. The tariffs are applied across all provinces accordingly.

- Transfers received:

  The surplus (R11,885 million) is primarily due to the surplus recorded at the Global Fund which was as a result of the prevailing Rand/Dollar exchange rate with the receipt of the latest disbursement.

- Interest:

  The surplus (R484 000) resulted through the levying of interest in respect of patient fee accounts. The surplus is also a result of improved performance in terms of interest collected on staff debt.

- Sales of capital assets:

  The under collection (R4 000) is due to no condemned or obsolete equipment being identified within the Department for sale.

- Financial transactions:

  The surplus (R10,698 million) is mainly due to the recovery of previous years' debtor accounts.

Programme expenditure

Table 4.2.2: Payments made by programme for the period 1 April 2013 to 31 March 2014

	2013/14			2012/13		
Programme name	**Final appropriation** R'000	**Actual expenditure** R'000	**(Over) / under expenditure** R'000	**Final appropriation** R'000	**Actual expenditure** R'000	**(Over) / under expenditure** R'000
Programme 1: Administration	521 704	511 447	10 257	445 509	445 048	461
Programme 2: District Health Services	6 042 255	6 039 262	2 993	5 555 429	5 509 868	45 561
Programme 3: Emergency Medical Services	819 748	819 748	-	695 727	675 514	20 213
Programme 4: Provincial Hospital Services	2 500 139	2 499 888	251	2 300 245	2 299 618	627
Programme 5: Central Hospital Services	4 565 421	4 565 421	-	4 248 545	4 247 459	1 086
Programme 6: Health Sciences and Training	266 262	264 193	2 069	276 553	276 551	2
Programme 7: Health Care Support Services	355 538	339 151	16 387	324 721	324 720	1
Programme 8: Health Facilities Management	958 914	877 852	81 062	897 103	822 079	75 024
Total	**16 029 981**	**15 916 962**	**113 019**	**14 743 832**	**14 600 857**	**142 975**

Virements / roll overs

All virements applied are depicted on pages 309 to 329 of the Annual Financial Statements. All virements were approved by the Accounting Officer.

Roll overs were requested for the conditional grant Health Facilities Revitalisation and the Global Fund.

4.3 UNAUTHORISED, FRUITLESS AND WASTEFUL EXPENDITURE

No unauthorised expenditure has been recorded after the application of virements.

No cases of fruitless and wasteful expenditure were reported for the 2013/14 financial year.

4.4 FUTURE PLANS OF THE DEPARTMENT

The Department has concluded an extensive consultative process that involved two drafts for public comment and each of the inputs being considered before finalising the Healthcare 2030 document. It has been endorsed in principle by the provincial cabinet.

The document has been distributed widely and is also available on the intranet and the internet, see website links below:

[Intranet: http://dws.pgwc.gov.za/dmsv525/download?WEBID+98419]

[Internet: http://www.westerncape.gov.za/assets/departments/health/healthcare2030.pdf]

Healthcare 2030 will provide the strategic direction to health service development over the next two decades. The document allows for flexibility to consider further developments within the health sector environment. The philosophy, vision, values and principles of Healthcare 2030 has been integrated into the language of the Department in the daily operations. It will be more systematically prioritised and form the basis for the next five year plan as well as the annual performance plans of the forthcoming years.

4.5 PUBLIC PRIVATE PARTNERSHIPS

Existing public private partnerships

Western Cape Rehabilitation Centre (WCRC) and Lentegeur Hospital Public Private Partnership

WCRC and Lentegeur Hospital PPP for the period 1 April 2013 to 31 March 2014	
Project name	Western Cape Rehabilitation Centre and Lentegeur Hospital Public Private Partnership
Brief description	Provision of equipment, facilities management and all associated services at the Western Cape Rehabilitation Centre (WCRC) and Lentegeur Hospital.

Date PPP agreement signed	8 December 2006. Full service commencement date was 1 March 2007.
Duration of PPP agreement	12 years
Escalation index for unitary fee	CPI (5.8884298% for 2013/14 increase)
Net present value of all payment obligations discounted at appropriate duration government bond yield	R50 335 737.33 (01 April 2013 to 31 March 2014)
Variations/amendments to PPP agreement	None approved during this period.
Cost implications of variations/amendments	Not applicable as no variations / amendments were approved.
Significant contingent fiscal obligations including termination payments, guarantees, warranties, and indemnities and maximum estimated value of such liabilities	Not applicable.

New public private partnerships

Tygerberg Hospital Redevelopment project

The redevelopment of Tygerberg Hospital has long been envisaged and forms part of Health's strategy to improve infrastructure for the people of the Western Cape. The existing Tygerberg Hospital was commissioned in 1972.

The Tygerberg Hospital Redevelopment project may be procured using a public-private partnership approach. This financial year saw the appointment of transaction advisors for the project and also marked the start of a feasibility study that should be concluded before the end of 2014.

4.6 DISCONTINUED ACTIVITIES / ACTIVITIES TO BE DISCONTINUED

No activities were discontinued during the 2013/14 financial year, nor are there plans to discontinue activities in the 2014/15 financial year.

4.7 NEW OR PROPOSED ACTIVITIES

Introduction of HPV vaccine for Grade 4 girls (9 years old)

The human papilloma virus (HPV) is typically sexually transmitted through intimate contact. HPV is the causative factor in 100 per cent of cervical cancers and 80 per cent of all women will acquire HPV some time in their life. In South Africa 5 743 women develop cervical cancer and 3 027 die annually. The lifetime risk to develop cervical cancer in South Africa is 1:26.

The primary objective of conducting mass immunisation campaigns is to eradicate or eliminate disease. By giving HPV vaccine to as many girls as possible, in a large geographic area, transmission of HPV is interrupted.

The HPV campaign is a national initiative and will be administered as a cohort in two doses. The first round is from 10 March to 11 April 2014, and the second round will start on 29 September 2014. The vaccines for the campaign was procured and paid for by the National Department of Health from a conditional grant. Consumables, donated by Biovac and Glaxco-Smith-Kline, were distributed equitably according to the vaccine orders.

Wellness mobiles for school health services

The Department has entered into a contract with a service provider to supply five vehicles for school health services, two for the Metro District Health Services (MDHS) and three for the Rural District Health Services (RDHS). The service provider will be responsible to drive the vehicles to the schools where they are required, prepare them for service, clean them, and maintain them.

Each vehicle will serve one area with a school nurse, optometrist and a dentist. The optometrist working with state-of-the art equipment will transmit the eye test results to the optometry laboratory. Spectacles will be made and supplied a week later.

The vehicles are designed to provide smart, comfortable accommodation in which the staff can provide excellent quality care to the learners. Each will have air conditioning, a toilet, and kitchenette and was designed ergonomically so that the staff can perform optimally.

These vehicles will be used mainly at schools where the learners are in the greatest socio-economic need, i.e. the quintile 1 and 2 schools especially in the rural or outlying areas. Typically where the parents are unable to take children referred by the school nurse to dentists and optometrists, because of financial and transport challenges. The Department will thus help to remove two barriers to learning, namely toothache and poor vision, in the section of the population most in need of assistance.

It is planned that the service will commence at the beginning of the third school quarter of 2014.

The impact on the services is that the vehicles will provide a comfortable and effective platform from which the staff can function.

The cost of the service is supported by funds transferred from the Department of Education for the three years of the medium term expenditure framework (MTEF). The Department has allocated R10 million per year to fund other costs such as additional staff.

4.8 SUPPLY CHAIN MANAGEMENT (SCM)

Unsolicited bid proposals for the year under review

No unsolicited bids were received during the reporting period.

SCM processes and systems to prevent irregular expenditure

The Department amended the Accounting Officers System in line with the requirements of Provincial Treasury Instruction 16A to ensure procurement compliance. Supply chain management delegations were also amended to ensure that goods and services can be procured at institutions and that processes are approved at the appropriate level.

Furthermore, apart from procurement templates, which were introduced, the Department implemented internal assessment and compliance assessment tools to monitor processes to ensure that irregular expenditure is detected and corrected timeously.

Challenges experienced in SCM

The implementation of Provincial Treasury Instructions 16A was a major challenge. The requirements were addressed in an implementation plan, which led to the amendment of the Accounting Officers System and revised delegations.

The purchase of locally produced products and services as required by National Treasury presented implementation problems. The Department in conjunction with Provincial Treasury drafted a procedure manual, which allows institutions to follow due processes when procuring local produced goods and services.

In order to ensure that the Department only conducts business with tax compliant companies the Western Cape supplier database was introduced by Provincial Treasury. Several hundreds of critical suppliers to the Department were not registered on the Western Cape suppliers' database. Supply Chain Management established a unit to approach these non-compliant suppliers to register. At present less than 100 suppliers are not yet registered.

4.9 GIFTS AND DONATIONS

The Department received gifts and donations to the value of R16 million which is disclosed in the Annual Financial Statements, Annexure 1F, page 385 to 388.

4.10 EXEMPTIONS AND DEVIATIONS RECEIVED FROM THE NATIONAL TREASURY

No exemptions and deviations received from the National Treasury are reported for the year under review.

4.11 EVENTS AFTER THE REPORTING DATE

The Department has no events to report after the reporting date.

4.12 OTHER

Environmental rehabilitation liability

The following activities of the Department have an impact on the environment according to the sustainable development implementation plan of the Department of Environmental Affairs in terms of NEMA.

- Medical waste management.
- Industrial waste management.
- Nuclear waste management.
- Industrial effluent.
- Electricity.
- General.

Medical and industrial waste management

The Department contracted service providers to collect and dispose medical and industrial waste at all institutions.

Nuclear waste management

Nuclear waste is removed from hospitals and shipped to the Nuclear Energy Corporation for further disposal.

Industrial effluent

Municipalities are contracted to process industrial effluent generated by laundries and laboratories to ensure the degradation of the effluent. To curtail the usage of water the Department is, for example, purchasing continuous batch washers for laundries that use as little as six litres of water per kilogram of linen compared to the 24 litres used by the traditional washers. Given the fact that eight million kg of linen is washed, the potential water saving is 144 million litres per year if this technology is applied throughout the laundry service. Over and above the saving of water there is also a saving in steam that reduces carbon emissions and air pollution.

Electricity (Energy efficiency)

The Department is constantly reviewing the use of electricity to minimise usage to reduce the carbon emissions into the atmosphere. Examples are Khayelitsha Hospital, which is an environmentally friendly hospital and the installation of heat pumps to produce hot water at hospitals. These machines consume one third of the electricity required to produce the same amount of hot water.

General

The above examples indicate that the Department is committed to minimise the impact of its activities on the environment. The Department has appointed contractors that are committed to minimise the negative impact on the environment and it is therefore not necessary to provide for a contingent liability in the Annual Financial Statements.

Unauthorised Expenditure 2011/12

Unauthorised expenditure to the value of R53,742 million was incurred during the 2011/12 financial year. The unauthorised expenditure, after consideration by the Standing Committee on Public Accounts on 5 March 2013, was approved to be incurred as a direct charge against the Provincial Revenue Fund. The Provincial Treasury in response compiled the Western Cape Unauthorised Expenditure Bill, 2013 which was approved by Parliament on 27th November 2013.

Medico legal

Medico legal claims lodged against the Department are normally overstated. In terms of the Departmental Financial Reporting Framework Guide (Chapter 8) the "most likely" outcome of the settlement must be determined by a qualified legal person or an expert applying history and trends to determine the amounts to be disclosed.

After consideration of the above, the medico legal expert of the Department determined that certain claims were overstated and reductions to the amount R32,400 million was applied to claims lodged. Annexure 3B refers.

Agency/Principle Activities

The Department is required to report on activities under the control/supervision of another party to collect, hold, administer, manage or pay over funds which the agent is not entitled to keep as its own. This includes public entities, municipalities or private enterprises.

The Department has identified service providers where a commission is paid for the collection of Road Accident Fund (RAF) and Workmen Compensation Act claims on behalf of the Department as agents according to the above-mentioned criteria.

Library material

Feedback from the institutions in the Department other than the central hospitals indicated that no in-house libraries to manage and maintain library material exist.

The three central hospitals have in-house libraries. The library material at these hospitals are procured and paid for by entities such as supportive universities, donors and hospital boards and does not belong to the Department.

Books and educational material are managed as minor assets and accounted for as such in the asset registers of institutions.

Procedure on Incapacity Leave and Ill Health Retirement (PILIR)

The implementation of the Policy and Procedure on Incapacity Leave and Ill Health Retirement (PILIR) was suspended for part of the financial year. PILIR provides for the appointment of a panel of accredited health risk managers, by the Department of Public Service and Administration, as service providers available to a department to investigate and assess the applications made by employees. The appointment of these service providers was delayed due to a legal challenge brought to the High Court against the appointment process. Therefore, for the first half of the financial year no timeous decision could be made on the validity of the incapacity and/or ill health retirement applications received from employees.

Although the Panel was formally established on 1 November 2013 there is a possibility that amounts paid to employees on incapacity and/or ill health retirement may be recoverable if the applications, made in the first part of the financial year, are not subsequently recommended by the service providers.

4.13 ACKNOWLEDGEMENTS

My sincere thanks to each and every one of the staff within the Department, whose hard work and dedication made it possible for the Department to achieve what it has in 2013/14. The collective leadership provided by the senior management of the Department is greatly appreciated. The role of our partners including the higher education institutions, organised labour, other departments and spheres of government, non-profit organisations, the private sector and research agencies is acknowledged.

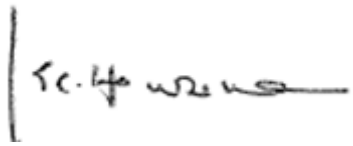
I also use this opportunity to thank Minister Botha for his leadership and unstinting support during my tenure.

4.14 CONCLUSION

I have been the Head: Health Western Cape for just over a decade. I retire from the Department during the 2014/15 financial year and would like to believe that I leave it as the best performing Health Department in the country. It has been a privilege to lead this Department of which I am immensely proud.

4.15 APPROVAL AND SIGN OFF

The Annual Financial Statements set out on pages 309 to 401 have been approved by the Accounting Officer.



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PROFESSOR CRAIG HOUSEHAM
Head: Health Western Cape
30 May 2014

5. STATEMENT OF RESPONSIBILITY AND CONFIRMATION OF THE ACCURACY OF THE ANNUAL REPORT

To the best of my knowledge and belief, I confirm the following:

All information and amounts disclosed throughout the Annual Report are consistent.

The Annual Report is complete, accurate and is free from any omissions.

The Annual Report has been prepared in accordance with the *Guidelines on the Annual Report* as issued by National Treasury.

The annual financial statements (Part E) have been prepared in accordance with the modified cash standard and the relevant frameworks and guidelines issued by the National Treasury.

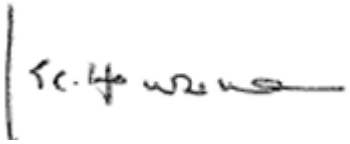
The Accounting Officer is responsible for the preparation of the annual financial statements and for the judgements made in this information.

The Accounting Officer is responsible for establishing, and implementing a system of internal control that has been designed to provide reasonable assurance as to the integrity and reliability of the performance information, the human resources information and the annual financial statements.

The external auditors are engaged to express an independent opinion on the annual financial statements.

In my opinion, the Annual Report fairly reflects the operations, the performance information, the human resources information and the financial affairs of the Department for the financial year ended 31 March 2014.

Yours faithfully



PROFESSOR CRAIG HOUSEHAM
Head: Health Western Cape
30 May 2014

6. STRATEGIC OVERVIEW

6.1 Vision

Quality health for all.

6.2 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.

6.3 Values

The core values of the Department are:

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

7. LEGISLATIVE AND OTHER MANDATES

National legislation

1) Allied Health Professions Act, 63 of 1982
2) Atmospheric Pollution Prevention Act, 45 of 1965
3) Basic Conditions of Employment Act, 75 of 1997
4) Births and Deaths Registration Act, 51 of 1992
5) Broad Based Black Economic Empowerment Act, 53 of 2003
6) Children's Act, 38 of 2005
7) Chiropractors, Homeopaths and Allied Health Service Professions Act, 63 of 1982
8) Choice on Termination of Pregnancy Act, 92 of 1996
9) Compensation for Occupational Injuries and Diseases Act, 130 of 1993
10) Constitution of the Republic of South Africa, 1996
11) Constitution of the Western Cape, 1 of 1998
12) Construction Industry Development Board Act, 38 of 2000
13) Correctional Services Act, 8 of 1959
14) Criminal Procedure Act, 51 of 1977
15) Dental Technicians Act, 19 of 1979

16) Division of Revenue Act (Annually)
17) Domestic Violence Act, 116 of 1998
18) Drugs and Drug Trafficking Act, 140 of 1992
19) Employment Equity Act, 55 of 1998
20) Environment Conservation Act, 73 of 1998
21) Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972
22) Government Immovable Asset Management Act, 19 of 2007
23) Hazardous Substances Act, 15 of 1973
24) Health Professions Act, 56 of 1974
25) Higher Education Act, 101 of 1997
26) Inquests Act, 58 of 1959
27) Intergovernmental Relations Framework, Act 13 of 2005
28) Institution of Legal Proceedings against Certain Organs of State Act, 40 of 2002
29) International Health Regulations Act, 28 of 1974
30) Labour Relations Act, 66 of 1995
31) Local Government: Municipal Demarcation Act, 27 of 1998
32) Local Government: Municipal Systems Act, 32 of 2000
33) Medical Schemes Act, 131 of 1997
34) Medicines and Related Substances Control Amendment Act, 90 of 1997
35) Mental Health Care Act, 17 of 2002
36) Municipal Finance Management Act, 56 of 2003
37) National Health Act, 61 of 2003
38) National Health Laboratories Service Act, 37 of 2000
39) Non Profit Organisations Act, 71 of 1977
40) Nuclear Energy Act, 46 of 1999
41) Nursing Act, 33 of 2005
42) Occupational Health and Safety Act, 85 of 1993
43) Older Persons Act, 13 of 2006
44) Pharmacy Act, 53 of 1974
45) Preferential Procurement Policy Framework Act, 5 of 2000
46) Promotion of Access to Information Act, 2 of 2000
47) Promotion of Administrative Justice Act, 3 of 2000
48) Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000
49) Protected Disclosures Act, 26 of 2000
50) Prevention and Treatment of Drug Dependency Act, 20 of 1992
51) Public Audit Act, 25 of 2005
52) Public Finance Management Act, 1 of 1999
53) Public Service Act, 1994
54) Road Accident Fund Act, 56 of 1996
55) Sexual Offences Act, 23 of 1957
56) State Information Technology Agency Act, 88 of 1998
57) Skills Development Act, 97 of 1998
58) Skills Development Levies Act, 9 of 1999
59) South African Medical Research Council Act, 58 of 1991

60) South African Police Services Act, 68 of 1978
61) Sterilisation Act, 44 of 1998
62) Tobacco Products Control Act, 83 of 1993
63) Traditional Health Practitioners Act, 35 of 2004
64) University of Cape Town (Private) Act, 8 of 1999

Provincial legislation

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

Government policy frameworks that govern the Department

1) Millennium Development Goals
2) Twelve Outcomes of National Government
3) National Development Plan
4) Negotiated Service Delivery Agreement
5) National Health Systems Priorities: The Ten Point Plan
6) National Health Insurance
7) Human Resources for Health
8) Provincial Strategic Objectives
9) Western Cape Infrastructure Delivery Management System (IDMS)
10) 2030 strategic framework (Western Cape Government: Health)
11) National Environmental Health Policy (GN 951 in GG 37112 of 4 December 2013)
12) National Health Act: Publication of Health Infrastructure Norms and Standards Guidelines (No R116 of 17 February 2014)
13) National Health Act: Policy on Management of Public Hospitals (12 August 2011)

8. ORGANISATIONAL STRUCTURE

The organisational structure (organogram) reflects the senior management service (SMS) members as at 31 March 2014. A list of the budget programme managers during 2012/13 is provided after the organogram.

Western Cape Government

BETTER TOGETHER.

Organisational Organogram

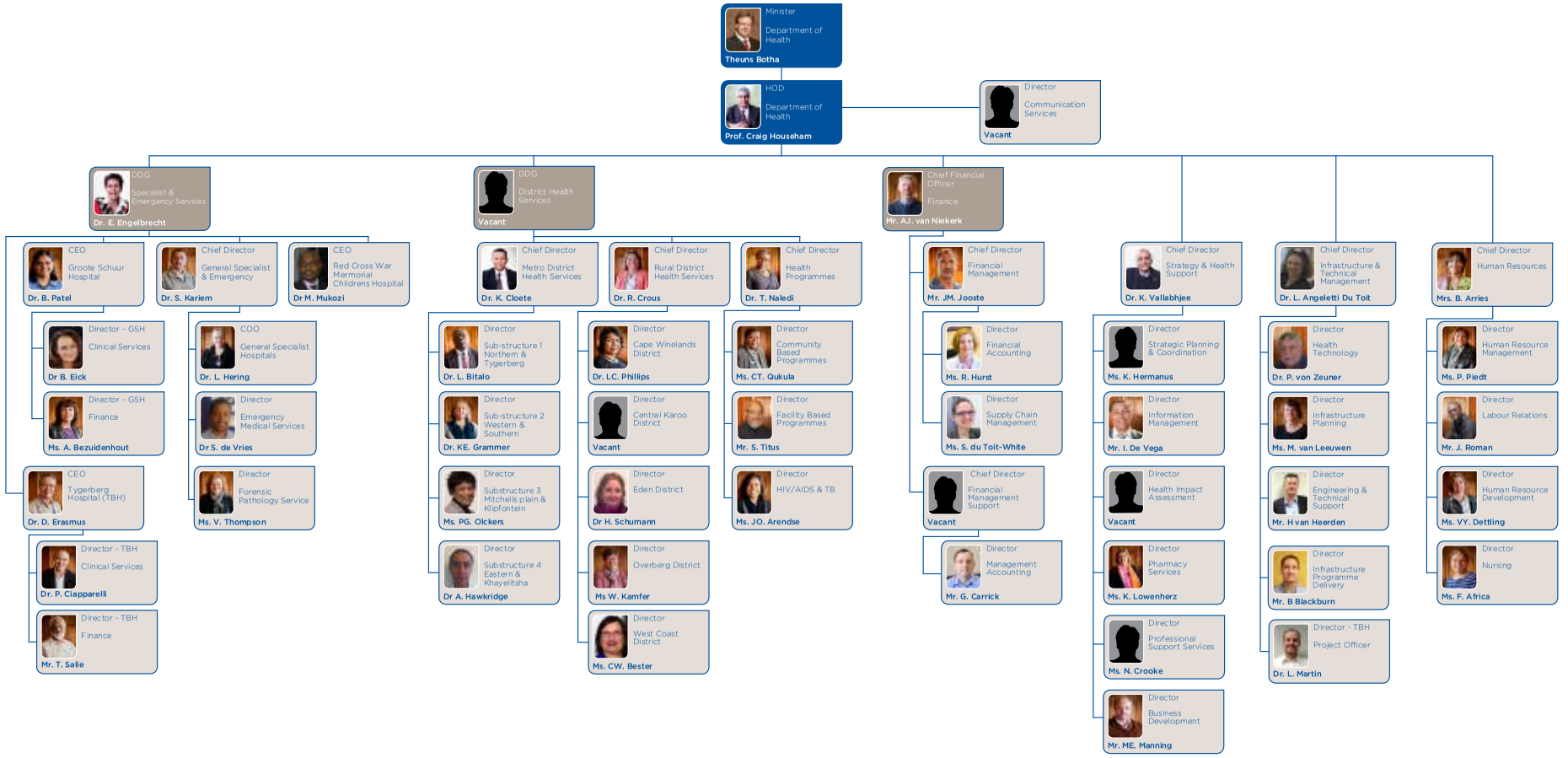


Table 8.1: Budget programme managers during 2013/14

Budget programme manager	Budget programme
(1) Dr K Vallabhjee Chief Director: Strategy and Health Support	• Programme 1: Administration • Programme 7.5: Cape Medical Depot
(2) Dr K Cloete and Dr R Crous Chief Director: Metro District Health Services and Chief Director: Rural District Health Services	• Programme 2: District Health Services • Sub-programme 4.2: Tuberculosis Hospitals
(3) Dr S Kariem Chief Director: General Specialist and Emergency	• Programme 3: Emergency Medical Services • Programme 4: Provincial Hospital Services excluding Sub-programme 4.2 • Sub-programme 7.3: Forensic Pathology Services
(4) Dr D Erasmus CEO: Tygerberg Hospital	• Programme 5: Central Hospital Services
(5) Mrs B Arries Chief Director: Human Resources	• Programme 6: Health Sciences and Training
(6) Dr L Angeletti-du Toit Chief Director: Infrastructure and Technical Management	• Sub-programme 7.1: Laundry Services • Sub-programme 7.2: Engineering Services • Programme 8: Health Facilities Management

PART B:
PERFORMANCE INFORMATION

1. AUDITOR GENERAL'S REPORT: PREDETERMINED OBJECTIVES

The Auditor-General of South Africa (AGSA) currently performs certain audit procedures on the performance information to provide reasonable assurance in the form of an audit conclusion. The audit conclusion on the performance against predetermined objectives is included in the report to management, with material findings being reported under the *Predetermined Objectives* heading in the *Report on other legal and regulatory requirements* section of the auditor's report.

Refer to page 305 of the *Report of the Auditor-General*, published in Part E: Financial Information.

2. OVERVIEW OF DEPARTMENTAL PERFORMANCE

2.1 SERVICE DELIVERY ENVIRONMENT

Services delivered directly to the public

Western Cape Government (WCG): Health provides the following health services to a population of 6.0 million, of which 4.7 million (78 per cent) are uninsured:

(1) Community-based services (CBS) :

Non-acute health services, which include home-based care, preventive and adherence health programmes, mental-health and intermediate care, are rendered at non-health facilities, homes, mental health institutions, early child development (ECD) centres, prisons, old age homes and schools.

The service is currently rendered by lay people who are not registered health professionals but who have been appropriately trained and are employed by non-profit organisations (NPOs), who are in turn sub-contracted by WCG: Health. Some NPOs offer services for tuberculosis (TB) and anti-retroviral treatment (ART) adherence. By the end of March 2014, 3 536 home carers were appointed by NPOs.

(2) Primary health care (PHC) services :

Clinical nurse practitioners (CNPs) provide child and adult curative care, preventive services, antenatal care, postnatal care, family planning, mental health, TB, HIV and AIDS, and chronic disease management at fixed and non-fixed facilities.

The promotion of screening for cervical and breast cancer, strengthening of family planning, earlier antenatal care, and prevention of mother-to-child transmission are focus areas for the Department.

There are 280 PHC facilities across the Province (217 fixed clinics, 54 community day centres and 9 community health centres). Of these facilities, 92 are under the authority of the City of Cape Town (CoCT).

During 2013/14 approximately 14.3 million patients were seen for PHC services of which 9.49 million contacts (66 per cent) occurred in the Metro. About 2.2 million (15 per cent) of the total headcount were children under the age of five years.

(3) Acute district hospital services :

Emergency centres, adult and child inpatient and outpatient care, obstetric care as well as a varying quantum of general specialist services are provided at the Department's 34 district hospitals.

With two new district hospitals having opened in the recent past (Khayelitsha in 2012/13 and Mitchells Plain in 2013/14), and additional beds in Eerste River and other district hospitals, there has been an associated increase in the Metro patient load, as reflected in the patient day equivalents (PDEs) and other district hospital indicators.

In 2013/14 there were 271 963 inpatient separations and 1 297 161 patients were seen in outpatient departments at district hospitals.

(4) Emergency medical services (EMS) and planned patient transport:

Ambulance, rescue and patient transport services are provided from fifty two stations (including three satellite bases) in five rural district EMS services and four Cape Town divisional EMS services with a fleet of 251 ambulances, 1 572 operational personnel, 144 emergency call centre agents and 127 supervisors (officers).

514 901 emergency cases were attended to in 2013/14.

(5) Regional and specialised hospital services:

The full package of general specialist services are rendered by four acute hospitals (New Somerset, Paarl, Worcester and George) whilst Mowbray Maternity Hospital provides a maternal and neonatal health service to the population of the Western Cape. In 2013/14 there were 117 015 inpatient separations and 258 146 patients were seen in outpatient departments at regional hospitals.

There are six specialised TB hospitals in the Province and an infectious disease palliative centre at Nelspoort Hospital. Three of the hospitals (Brewelskloof, Harry Comay and Brooklyn Chest) are designated drug-resistant tuberculosis (DR-TB) units. Brooklyn Chest and DP Marais Hospitals form the Metro TB Complex while Malmesbury ID and Sonstraal Hospitals form the West Coast TB Complex. During 2013/14 some 3 664 inpatients were treated at TB hospitals and a further 7 924 patient contacts were attended to at outpatient departments.

Four psychiatric hospitals (Alexandra, Lentegeur, Stikland and Valkenberg Hospitals) and two sub-acute facilities (New Beginnings and William Slater), all of which are located in the Cape Town Metro District, provide a provincial psychiatric service. These facilities collectively attended to 6 080 inpatient separations and 41 034 patient contacts at outpatient departments.

The Western Cape Rehabilitation Centre (WCRC) provides specialised rehabilitation services including orthotics and prosthetics for people with physical disabilities. In 2013/14 the WCRC had 869 inpatient separations and 10 239 outpatient headcounts.

The oral health centres provides primary, secondary, tertiary and quaternary dental services at Tygerberg Oral Health Centre, Groote Schuur Hospital, Red Cross War Memorial Children's Hospital and the Mitchells Plain Oral Health Centre. There were 114 848 oral health patient visits during 2013/14.

(6) Tertiary and quaternary health services at central hospitals:

Highly specialised tertiary and quaternary services are rendered on a national basis at the Department's two central hospitals, Groote Schuur and Tygerberg and the tertiary hospital, Red Cross War Memorial Children's Hospital.

In 2013/14 there were 140 452 patient separations and 823 213 patients were seen in outpatient departments at central and tertiary hospitals.

(7) Forensic pathology services (FPS):

Specialised forensic pathology services are rendered via eighteen forensic pathology facilities across the Province in order to establish the circumstances and causes surrounding unnatural death.

During the 2013/14 financial year 10 083 medico-legal cases were admitted, resulting in 9 984 post mortem examinations in the Western Cape.

(8) Chronic medication dispensing:

Chronic medicine dispensing services continued to stabilise and no operational penalties were incurred by the service provider in terms of the service level agreement.

The Department continued with an active roll-out of this service to the rural districts. At the end of the reporting period an average of 215 000 prescriptions per month were dispensed using this method of service delivery across the Province. The Department has also begun to set up alternate delivery sites for the dispensing of medicines (600 sites). This has the benefit of improving access for patients but also decongesting busy health facilities.

For more detail on the health services rendered by the Department and the number of patients seen, refer to section 4: *Performance Information by Programme*, of this report.

Problems encountered and corrective steps taken

(1) Community-based services (CBS):

There are discussions taking place at the level of the National Department of Health about introducing significant changes to community-based services. In addition, organisational changes to strengthen community-based services are due to be implemented at a provincial level. New policies are therefore being developed and piloted in preparation for the 2014/15 financial year.

(2) Primary health care (PHC) services:

The entire provincial primary health care platform is in the latter stages of a significant change to a service model based on decentralisation (i.e. a shift from provincial health services to district health services).

The service focus is on addressing the prevailing burden of disease, improving quality of clinical care and improving facility-level management. In addition there is on-going re-organisation of services (e.g. nurse-driven-doctor-supported practices as well as strengthening community-based services) in order to improve patient wellness and education and also ensure that appropriate patients get access to PHC services. Clinical governance and corporate governance systems are being developed and strengthened.

Because there are two health authorities in the Cape Town Metro District, service provision remains fragmented and inefficient. Bilateral management forums have been set up to align priorities and administer the dual authority model. Such meetings do however, of themselves, contribute to on-going inefficiencies and over-use of managerial time. City of Cape Town (CoCT) Municipality reporting continues to improve marginally, but timeliness of data submissions remains a challenge at times. This process is being managed by means of a service level agreement between Metro District Health Services (MDHS) and the CoCT.

(3) Acute service pressures:

Service pressures, especially in the metro hospitals, continue to be a challenge. This is particularly obvious within the emergency centres. Attempts to address the problem have included a streamlining of the EMS services and a new EMS information system which will contribute to on-going efficiencies in this area. Measures to improve patient flow in emergency centres and to facilitate more rapid and appropriate patient placement into hospital beds are also being instituted. A hospital bed bureau has been implemented to enable the EMS communication centre to be able to have oversight of the availability of beds across hospitals. This enables a more efficient directing of ambulances to institutions.

(4) Recruitment and retention of highly skilled medical and nursing staff:

The recruitment and retention of highly skilled medical and nursing staff remained a challenge during 2013/14.

The shortage of professional nurses, in particular those with post basic qualifications in theatre technique, intensive care, paediatrics, mental health and advanced midwifery, impacted on the Department's capacity and ability to provide highly specialised services. The Department incurred additional agency staff expenditure in order to deliver these services.

Furthermore, the shortage of skilled clinical technologists to provide key support services, of nurses specialised in theatre and critical care, and anaesthetists combined with budget constraints and the high costs of consumables limited the reduction of theatre waiting lists for certain procedures.

The Department provided training programmes and opportunities for key staff such as nurses to improve skills and achieve deployment in essential services like critical care, theatres and paediatrics. Strategies leveraging on bursary and training posts were used to improve recruitment of clinical technologists.

Significant service pressures were experienced in burns, emergency medicine, neonatology, as well as orthopaedics services.

(5) Infrastructure requirements:

The infrastructure requirements in the Province, especially in relation to primary health care and district services, remain extensive. The Health Facility Revitalisation Grant (as published in the annual Division of Revenue Act) is utilised to fund these infrastructure requirements through the construction of new facilities and the upgrading and extension of existing facilities. However, given the scale of requirements in relation to available funds, it will take many years before the backlog will be adequately addressed.

Some challenges are still being experienced with the implementation of projects. It is anticipated, however, that with the on-going implementation and institutionalisation of the Western Cape Infrastructure Delivery Management System (WC-IDMS) in both WCG: Health and WCG: Transport and Public Works, these challenges will be addressed.

The process of establishing infrastructure norms and standards for the Province to improve service delivery is being aligned with the Infrastructure Unit Systems Support (IUSS) development of guidelines for health infrastructure, implemented by the National Department of Health. To date three IUSS guidelines have been gazetted whilst 30 guidelines are virtually ready to be gazetted. The remaining 19 should be completed within the next few months. These documents will form the basis of a comprehensive set of provincial infrastructure development guidelines with province specific specifications being added where applicable.

External developments that impacted on the demand for services or service delivery

This paragraph provides more details on any significant developments, external to the Department, that may have impacted either on the demand for the Department's services or on the Department's ability to deliver those services.

(1) Prevalence and multi-morbidity of chronic diseases:

The prevalence of chronic diseases and their risk factor trends continue to fuel the escalating service pressures on the Department. It is now estimated that three out of four patients visiting the emergency centres within the Department do so for chronic diseases and their complications. In a study of ten PHC facilities in the metro, approximately 65 per cent of adult patients had multi-morbidity. These patients are more complex and expensive to treat, have a higher risk of complications, and a poorer prognosis.

(2) Medicine availability:

Medicine availability challenges have decreased during the reporting period, as the contracted medicine suppliers improved the production of procured items and the delivery of items within the contracted lead times.

The percentage of medicine availability increased quarterly in 2013/14 from 86.8 per cent in the first quarter, to 97.5 per cent by the end of the year.

Management continued to employ the following measures to ensure medicine availability and uninterrupted service delivery:

- Tenders close to expiry are identified.
- The National Department of Health and the Provincial Pharmaceutical and Therapeutic Committee (PPTC) are notified of products that will not be available for long periods of time for alternative arrangements to be made. The clinical experts on the PPTC advise on alternate agents where appropriate.
- Bridging orders are placed before tenders expire and where possible staggered delivery is arranged with suppliers.
- The National Department of Health acceded to the request to import certain medication from other sources, meeting both the quality and service needs, in order to ensure a supply of the required medication.
- Mechanisms to redistribute stock between health facilities in the Department have been strengthened.

(3) Upstream determinants of health:

Drugs and alcohol abuse continue to play a significant causative role in many emergency cases and hospital admissions.

(4) Population denominators:

Despite the release of Census 2011 data there remains uncertainty about the accuracy of population information, especially at sub-district and age-group level. This impacts significantly on the Department's ability to set accurate and meaningful targets. An investigation is being planned by the Directorate: Health Impact Assessment's unit to attempt to resolve this problem.

(5) Infrastructure requirements:

The implementation and institutionalisation of the Western Cape Infrastructure Delivery Management System (WC-IDMS), as regulated by Provincial Treasury Instructions Chapters 16A and 16B (PTIs 16A and B), required extensive changes to current infrastructure planning and delivery processes within the Chief Directorate: Infrastructure and Technical Management, as well as the development of entirely new processes. In this regard, a Compliance Acceleration Plan (CAP) was prepared at the beginning of the 2013/14 financial year in order to ensure compliance to PTIs 16A and B by 31 March 2014, and while not all of the detailed deliverables of the CAP were achieved, substantial compliance was realised, and the implementation and institutionalisation of the WC-IDMS is continuing.

2.2 SERVICE DELIVERY IMPROVEMENT PLAN

The Department has completed a service delivery improvement plan. The tables below highlight the service delivery plan and the achievements to date. The feedback provided is in response to the areas identified in the 2013 to 2016 SDIP.

Patient-centred care is identified as a core area of focus in Healthcare 2030. The focus of the SDIP is to improve the patient experience at reception services at Khayelitsha District Hospital, Michael Mapongwana Community Health Centre and Khayelitsha Site B Clinic.

In recent client satisfaction surveys 88 per cent of patients surveyed were generally satisfied with the level of service. However, waiting times, cleanliness of the toilets and the cost to get to health facilities remain challenges. Another measure of departmental performance in this area is that the department in 2013/14 received 9 604 complaints and 24 598 compliments, the number of compliments far exceeding the number of complaints.

The National Department of Health, Office of Health Standards Compliance (OHSC) conducted eighteen mock audits in the period April to August 2013. Some 109 facilities conducted gap-assessments in 2013/14 and developed and implemented quality improvement plans to address areas of non-compliance. In addition to the facility based improvement plans, the Department established three workgroups to assist facilities with achieving compliance namely, a National Core Standards Workgroup, Infection Prevention and Control and Occupational Health and Safety Workgroup and a Data Management Workgroup.

Areas of non-compliance identified by the mock audits conducted by the OHSC are:

(1) Areas of non-compliance per priority area:

- Cleanliness.
- Infection prevention and control.
- Patient safety and security.

(2) Areas of non-compliance per domain:

- Patient rights.
- Operational management.
- Facilities and infrastructure.

The Department piloted a new adverse incident management tool which will be rolled-out to the central, regional, psychiatric and specialised hospitals in 2014/15, and has implemented a strategy to strengthen antibiotic stewardship at health facilities.

Table 2.2.1: Main services and standards

Service Delivery Improvement Plan				
Main services	**Beneficiaries**	**Current / actual standard of service**	**Desired standard of service**	**Actual achievements**
Reception services	1) All current and future clients of Michael Mapongwana (MM) CHC and Khayelitsha Site B Clinic.	Average waiting times at reception not routinely collected.	• Standardised process to measure waiting times developed and piloted successfully at Michael Mapongwana CHC and Khayelitsha Site B Clinic.	• No SOP has been developed and piloted.
			• Training of all staff at Michael Mapongwana CHC and Khayelitsha Site B Clinic (100%).	• No training conducted.
	2) All current and future clients of Khayelitsha District Hospital (KDH).	Average waiting times at reception not routinely collected.	• Standardised process to measure waiting times developed and piloted successfully at Khayelitsha Hospital.	• No process has been developed; No standardised process to measure waiting times has been piloted yet.
			• Training of all staff at Khayelitsha Hospital (100%).	• No specific waiting times training of staff was conducted, however it was briefly highlighted and discussed during two reception manual workshops conducted for admission and ward clerks. Reason for deviation: The current electronic Quematics system was assessed first to understand what waiting times data it revealed. There are currently gaps in the system that prevents comprehensive waiting times information as required by the SDIP. There is a need for further engagements, resources and a service level agreement to be able to utilise the Quematics system as a standardised process to measure waiting times effectively.

Service Delivery Improvement Plan				
Main services	**Beneficiaries**	**Current / actual standard of service**	**Desired standard of service**	**Actual achievements**
				The interim plan is to conduct a manual waiting time survey in June 2014 and to train staff accordingly. Additionally, the TOMSA pilot in the emergency centre has been implemented. It is an initiative to streamline the triage process. A study on the pilot's impact on waiting times is also planned for 2014/15.

Table 2.2.2: Batho Pele arrangements with beneficiaries (Consultation access, etc.)

Service Delivery Improvement Plan		
Current / actual arrangements	**Desired arrangements**	**Actual achievements**
Consultation: • Structured complaints and compliments system.	**Consultation:** • Structured complaints and compliments system.	• A structured complaints and compliments system is in place at Michael Mapongwana CHC and Khayelitsha Site B Clinic. Complaints and compliments boxes are in place in all areas. • A structured complaints and compliments system is in place at Khayelitsha Hospital and the related process of consultation are available in all the reception areas. The patient liaison officer and the quality manager are available for any personal engagements with clients, if required.
• Client satisfaction survey (CSS).	• Client satisfaction survey.	• Michael Mapongwana CHC conducted a client satisfaction survey in 2013. • Khayelitsha Hospital conducted a client satisfaction survey (CSS) from 3 – 7 March 2014 to obtain clients' input and perceptions of the hospital's service delivery. The CSS results reflect a 90% satisfaction rate to the question "The doctor explained to me what was wrong with me" and a 94% satisfaction rate to the question "The nurse who treated me listened to my problems".
• Notice board.	• Up-to-date notice boards with relevant information.	• Notice boards in Michael Mapongwana CHC with Batho Pele principles, patient rights, mission, vision and values. Procedure on how to lodge a complaint explained on posters. • Khayelitsha Hospital procured notice boards which were placed in admissions, reception areas and the main hospital passages. Revised complaints and compliments process posters have been displayed throughout the hospital in two languages: English and Xhosa.

Service Delivery Improvement Plan		
Current / actual arrangements	**Desired arrangements**	**Actual achievements**
	• Designated client service manager (CSM) for reception.	An organogram of the hospital executive and the quality team is visibly displayed. Various posters relating to Batho Pele, patient rights and responsibilities are displayed throughout the hospital. • Michael Mapongwana CHC has a designated quality assurance manager who follows up on all complaints and compliments. Similarly, Khayelitsha Site B Clinic has a designated complaints champion/officer who follows up on complaints to ensure compliance with the 25 day resolution rate. • Currently there is no designated client service manager for the Khayelitsha Hospital reception area due to resource constraints. During 2013/14, partial coverage of the helpdesk was facilitated by allocating two administrative staff (3 hours in the morning and 1 hour during the afternoon visiting times). However, this interim measure will not be continued in 2014/15 due to further resource constraints. A full-time helpdesk clerk is required and critical for the hospital.
Access: • Michael Mapongwana CHC, Steve Biko Road, Harare, Khayelitsha (reception services). • Khayelitsha Site B Clinic, Sulani Drive, Khayelitsha (reception services). • Khayelitsha Hospital, Cnr of Walter Sisulu and Steve Biko Road, Khayelitsha (reception service).	**Access:** • Michael Mapongwana CHC, Steve Biko Road, Harare, Khayelitsha (reception services). • Khayelitsha Site B Clinic, Sulani Drive, Khayelitsha (reception services). • Khayelitsha Hospital, Cnr of Walter Sisulu and Steve Biko Road, Khayelitsha (reception service).	**Access:** • Michael Mapongwana CHC, Steve Biko Road, Harare, Khayelitsha (reception services). • Khayelitsha Site B Clinic, Sulani Drive, Khayelitsha (reception services). • Khayelitsha Hospital, Cnr of Walter Sisulu and Steve Biko Road, Khayelitsha (reception service).
Courtesy: • Structure complaints and compliments system (Provincial Circular H78/2011).	**Courtesy:** • Structure complaints and compliments system (Provincial Circular H78/2011).	**Courtesy:** • Michael Mapongwana CHC and Khayelitsha Site B Clinic have a structured complaints and compliments system in place. • Khayelitsha Hospital has an active and systematic complaints and compliments system and process in place.
• Client satisfaction survey.	• Client satisfaction survey.	• Khayelitsha Site B Clinic conducted a client satisfaction survey in December 2013. • The client satisfaction survey results at Khayelitsha Hospital reflected a 96% satisfaction rate with the question "The doctor who treated me was polite".
• Verbal and written communication (brochures and posters).	• Verbal and written communication (brochures and posters).	• Notice boards with relevant information (patient rights charter, Batho Pele principles) regularly updated at Michael Mapongwana CHC. Notice boards in place and regularly updated at Khayelitsha Site B Clinic. • Two reception manual workshops were conducted with admission and ward clerks at Khayelitsha Hospital to highlight their role in improving the patient experience at reception service areas.

Service Delivery Improvement Plan		
Current / actual arrangements	**Desired arrangements**	**Actual achievements**
• Facility Board meetings (includes community representatives).	• Facility Board meetings (includes community representatives).	• Michael Mapongwana Health Clinic Committee constituted and will commence with monthly meetings from May 2014. Khayelitsha Site B Clinic has a fully functional health committee that meets monthly. • The service delivery improvement plan 2013 to 2016 has been added as a standing agenda items at the facility board meetings at Khayelitsha Hospital.
• Complaints hotline.	• Complaints hotline.	• Complaints hotline information is displayed as required on notice boards in Khayelitsha Site B Clinic. • Details of the complaints hotline are available on posters throughout Khayelitsha Hospital and the reception areas. The complaints and compliments process, inclusive of the complaints hotline, has been communicated with a community non-profit organisation to improve access to information within the community.
• The National Patients' Right Charter, 1999.	• The National Patients' Right Charter, 1999.	• Patient rights charter displayed in all areas of Khayelitsha Site B Clihic. • The national patient rights charter posters are displayed throughout Khayelitsha Hospital, including passages and reception areas.
• Name tags.	• Name tags.	• All staff at Michael Mapongwana CHC and Khayelitsha Site B Clinic wears name badges. • Name badges for all Khayelitsha Hospital staff (permanent and agency) are currently on tender for procurement.
	• Designated client service manager for reception.	• A designated quality assurance manager fulfils the role of client service manager at Michael Mapongwana CHC. • Khayelitsha Hospital does not have a designated client service manager for reception due to resource constraints.
		<u>Additional achievement:</u> • The midwife obstetric unit at Michael Mapongwana is piloting patient-centred care that is looking at patient's interests and staff to improve the patient's experience.
Openness and transparency: • Structure complaints and compliments system.	**Openness and transparency:** • Structure complaints and compliments system.	**Openness and transparency:** • Both Michael Mapongwana CHC and Khayelitsha Site B Clinic have a structured complaints and compliments system. • Khayelitsha Hospital has a structured complaint and compliments system in place and always strives to deal promptly with complaints, involving all relevant stakeholders. Outcomes of complaint investigations are communicated to clients and relevant staff. The patient liaison officer is available as a first line engagement with patients.

Service Delivery Improvement Plan		
Current / actual arrangements	**Desired arrangements**	**Actual achievements**
		The hospital also engages with non-profit organisations e.g. Treatment Action Campaign (TAC) to resolve community complaints and as a resource to facilitate communications and hospital information to the community.
• Client satisfaction survey.	• Client satisfaction survey.	• Both Michael Mapongwana CHC and Khayelitsha Site B Clinic conducted a client satisfaction survey in 2013. • The client satisfaction survey results in Khayelitsha Hospital reflected an 85% satisfaction rate with regard to the question "The staff at the hospital answered all my questions about my illness".
• Direct feedback and notice boards.	• Direct feedback and notice boards.	• Notice boards with relevant information in Michael Mapongwana CHC. Notice boards in place and regularly updated in Khayelitsha Site B Clinic. • Complaints and compliments data are displayed to clients in all the reception and service areas in Khayelitsha Hospital. In addition, actual patient compliments linked to specific wards and areas are also displayed.
• Verbal and written communication (brochures and posters).	• Verbal and written communication (brochures and posters).	• Notice boards with relevant information in Michael Mapongwana CHC. Notice boards in place and regularly updated in Khayelitsha Site B Clinic. • Khayelitsha Hospital clients can at any time lodge a complaint or compliment by following the procedure. Signage posters, forms and complaints / compliments boxes are available in all reception areas.
	• Designated CSM for reception.	• Khayelitsha Hospital does not have a designated client service manager for reception due to resource constraints.
• Facilitate Board meetings (includes community representatives).	• Facilitate Board meetings (includes community representatives).	• Michael Mapongwana Health Clinic Committee constituted and will commence with monthly meetings from May 2014. Khayelitsha Site B Clinic has a fully functional health committee that meets monthly. • Related challenges, data and action plans are discussed at facility board meetings in Khayelitsha Hospital.
Value for money: • Within current approved budget of Michael Mapongwana CHC and Khayelitsha Site B Clinic. • Within current approved budget of Khayelitsha Hospital.	**Value for money:** • Within current approved budget of Michael Mapongwana CHC and Khayelitsha Site B Clinic. • Within current approved budget of Khayelitsha Hospital.	**Value for money:** • Good work attendance. Stock shortages still a challenge at Michael Mapongwana CHC. • Within current approved budget of Khayelitsha Hospital.

Table 2.2.3: Service delivery information tool

Service Delivery Improvement Plan		
Current / actual information tools	**Desired information tools**	**Actual achievements**
Information: • Direct feedback and notice boards.	**Information:** • Direct feedback and notice boards.	**Information:** • Notice boards within Michael Mapongwana CHC regularly update with relevant information (patient rights, Batho Pele). Notice boards in place in Khayelitsha Site B Clinic. • The PALS officer and the quality manager in Khayelitsha Hospital are available to engage with patients. A structured complaints and compliments process is in place and displayed on notice boards in reception areas.
• Verbal and written communication (brochures and posters).	• Verbal and written communication (brochures and posters).	• Complaints and compliments posters detailing complaints and compliments process displayed (in Khayelitsha Site B Clinic. • Awareness posters and information leaflets are available to Khayelitsha Hospital patients linked to awareness campaigns conducted at the time. Triage process posters are displayed in emergency waiting room areas. Information sessions and leaflets are issued to patients in the various outpatients' clinics waiting areas and reception area to raise awareness. A brochure on the services at Khayelitsha Hospital has been formulated and is available to clients. Complaint and compliments data posters are displayed in waiting areas and are updated quarterly.
• Facility Board meetings (includes community representatives).	• Facility Board meetings (includes community representatives).	• Michael Mapongwana Health Clinic Committee constituted and will commence with monthly meetings from May 2014. Khayelitsha Site B Clinic has a fully functional health committee that meets monthly. • The Khayelitsha Hospital Facility Board is updated about SDIP developments and data at meetings.
• Written feedback on complaints.	• Written feedback on complaints.	• The quality assurance manager at Michael Mapongwana CHC investigates and responds to written complaints (in writing) and verbal complaints (directly) with the complainant. • Where indicated, written feedback are provided to clients by Khayelitsha Hospital. Quarterly quality reports are formulated that are available to all relevant stakeholders.
• Service Charter.	• Service Charter.	• Service Charter for Michael Mapongwana CHC and Khayelitsha Site B Clinic still to be printed by the provincial head office. • The Patients' Right Charter, 1999, is displayed in all areas in Khayelitsha Hospital. The service charter will be aligned to the provincial guideline.

Service Delivery Improvement Plan		
Current / actual information tools	**Desired information tools**	**Actual achievements**
• Client satisfaction survey.	• Client satisfaction survey.	• Both Michael Mapongwana CHC and Khayelitsha Site B Clinic conducted a client satisfaction survey in 2013. • Khayelitsha Hospital client satisfaction survey results reflect an average score of 88% satisfaction rate with regard to the following questions relating to information: "The doctor explained what was wrong with me", "The staff at the hospital answered all my questions about my illness", and "The hospital will tell my local health clinic about my future care needs". The client satisfaction survey reflects an overall satisfaction rate of 86% at Khayelitsha Hospital. A summary of the report will be displayed to clients in the reception areas.
	• Designated client service manager for reception.	• A designated quality assurance manager fulfils the role of client service manager at Michael Mapongwana CHC. Khayelitsha Site B Clinic has a designated complaints champion. • Khayelitsha Hospital does not have a designated client service manager for reception due to resource constraints.

Table 2.2.4: Complaints mechanism

Service Delivery Improvement Plan		
Current / actual complaints mechanism	**Desired complaints mechanism**	**Actual achievements**
Redress: • Structured complaints and compliments system.	**Redress:** • Structured complaints and compliments system.	• There is a structured complaints and compliments system at Michael Mapongwana CHC and Khayelitsha Site B Clinic • Khayelitsha Hospital has a structured complaints and compliments system is in place. The PALS officer and the quality manager available to engage with patients who lodge a complaint. Meetings are also co-ordinated with clients and relevant stakeholders to report on complaints, communicate hospital processes, and improve communications.
• Client satisfaction survey.	• Client satisfaction survey.	• Michael Mapongwana CHC conducted a client satisfaction survey in May 2013 and Khayelitsha Site B Clinic in December 2013. • The client satisfaction survey results at Khayelitsha Hospital show a 14% overall dissatisfaction with services at the hospital. The domains that reflected the most dissatisfaction rate were Responsiveness (20%) and Access (33%). Under the Responsiveness domain, the key issue clients were dissatisfied with was: "Visiting hours were not long enough"; and under Access, the dissatisfaction related to: "It takes more than 30 minutes to get to the hospital". This information needs to be further analysed and an appropriate action plan needs to be discussed and formulated with relevant stakeholders.

Service Delivery Improvement Plan		
Current / actual complaints mechanism	**Desired complaints mechanism**	**Actual achievements**
	• Designated client service manager for reception.	• A designated quality assurance manager fulfils the role of client service manager at Michael Mapongwana CHC. Khayelitsha Site B Clinic has a designated complaints champion. • Khayelitsha Hospital does not have a designated client service manager for reception due to resource constraints.

2.3 ORGANISATIONAL ENVIRONMENT

Resignations and/or appointments in Senior Management Service

The following changes occurred in the senior management service (SMS) during 2013/14 as a result of attrition:

Retirements at the end of the previous financial year:

- KLN Linda, CEO: Red Cross Children's War Memorial Hospital, 31 March 2013.
- JRS Cupido, Deputy Director General: District Health Services and Health Programmes, 31 March 2013.

Terminations and transfers out of WCG: Health:

- PTA Carter, CEO: Groote Schuur Hospital, 31 May 2013.
- F Steyn, Director: Communications, 30 November 2013.
- P Peppetta, Director: Financial Administration, 31 December 2013.

New appointments:

- SM Du Toit-White, Director: Supply Chain Management, 22 January 2014.

Promotions and transfers:

- AJ Hawkridge, Director: Infrastructure Planning, 1 April 2013.
- DS Erasmus, CEO: Tygerberg Hospital, 1 April 2013.
- JC Joemat, CEO: Mowbray Maternity Hospital, 1 June 2013.
- LA van der Berg, CEO: Alexandra Hospital, 1 June 2013.
- B Patel: CEO: Groote Schuur Hospital, 1 August 2013.
- MA Mukosi, CEO: Red Cross Children's War Memorial Hospital, 1 September 2013.
- S de Vries, Director: Emergency Medical Services, 1 October 2013.
- NTD Naledi, Chief Director: Health Programmes, 1 January 2014.
- VY Dettling, Director: Human Resource Development, 1 March 2014.

Restructuring

The departmental organisational structure is reviewed on an annual basis with due regard to service delivery needs, operational requirements and the departmental Annual Performance Plan. Where deviations or needs are identified priority projects for the amendment of said structures and new organisational design are investigated and, if approved, implemented through a process of organisation development. Such

interventions then culminate in the restructuring of various organisational structures within the Department.

To address the above, a review of the macro structure of the Department in terms of purpose and function, responsibility, span of control, job description and level was conducted with the view to promote better cohesion in service delivery.

The Directorate: Management Accounting's organisation and post structure became outdated when compared with the services required and it became necessary to redesign the directorate. The directorate's function changed to provide processed financial information to top management and health institutions. This led to increased pressure to improve the quality, method and speed of financial data provision to all health components. The Directorate: Organisation Development proceeded with an investigation into the micro-structure of the directorate (deputy director level and lower) in 2013. This intervention, which also included the relocation and matching and placement of staff, has been finalised and implemented.

The Directorate: Forensic Pathology Services is also being investigated with the purpose to optimise the organisation and post structure. The current structure does not provide for the new responsibilities required in terms of the mandate and growth in service needs. The case load of forensic officers currently far exceeds the available capacity. The case load along with the complexity of forensic medicine inquests and the accompanying legal case load has a negative effect on the well-being of forensic officers and pathologists and is not sustainable in the long run. It is therefore necessary to redesign the service model to effectively address the service needs and pressure in FPS.

The increase in the number of health facilities in the Province over the last decade resulted in an increased workload for maintenance personnel within the Directorate: Engineering and Technical Services. This was mainly due the following changes:

- Primary health clinics were transferred from local government to WCG: Health, excluding the clinics from the City of Cape Town Municipality.
- Forensic pathology laboratories were transferred from the South African Police Services to WCG: Health.
- Emergency medical services were transferred from local government to WCG: Health.
- Expansion of services based on the Comprehensive Services Plan.

The rendering of building maintenance services is a transversal departmental function and its service delivery platform should be aligned with the overall planning and delivery of health services in the Province as outlined in the service delivery model.

Due to the above-mentioned the current organisational structure for engineering and technical services became outdated and ineffective. It was therefore necessary to design a new model for the provisioning of day-to-day, routine and emergency building maintenance services.

Various other organisation development (OD) interventions was conducted during 2013/14 and is listed under the heading "*Ensure and maintain organisational strategic management capacity and synergy*."

The Department also developed and implemented a departmental Human Resource Restructuring Plan which can be used as a guideline to line- and HR managers during the implementation of OD interventions. It also provides a social plan in terms of managing staff that has to be declared redundant due to their post being abolished.

Strike actions

There were no strikes during the reporting period.

Significant system failures

There were no significant system failures during the period under review.

2.4 KEY POLICY DEVELOPMENTS AND LEGISLATIVE CHANGES

Key policy developments

(1) National Development Plan (NDP):

The National Planning Commission published the "National Development Plan: 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. The updated "National Development Plan 2030: Our future – make it work" was published during 2012. 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.

(2) New Medium-term Strategic Framework (MTSF):

A new MTSF, based on the National Development Plan is being developed. This will form the basis of the negotiated service delivery agreement (NSDA) that will be concluded between the National Minister of Health and the President of South Africa after the 2014 general elections. It will form the basis of the 2015/16 to 2019/20 five-year strategic plans that will be developed during 2014.

(3) Geographic service areas (GSAs):

A GSA is defined as a "formally endorsed decentralised unit for planning and management, which 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."

The boundaries of the GSAs and the districts are coterminous, i.e. there are five rural GSAs (managed by the Chief Director: Rural District Health Services [RDHS]) and one metro GSA (managed by the Chief Director: Metro District Health Services [MDHS]).

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

(4) Healthcare 2030: The road to wellness:

WCG: Health has developed a conceptual strategic framework for 2030, building on the achievements and lessons learned in the implementation of the 2010 Comprehensive Service Plan (CSP).

The first draft of the 2030 plan was published for comment in November 2012 and the second draft in October 2013. Comments were considered and where appropriate incorporated into the document. The final 2030 strategy document has been released during the first quarter of 2014/15.

Healthcare 2030 provides a compass to guide the development of health services in the Department over the next two decades.

The technical modelling provides population-based planning tools and uses electoral wards as the smallest planning units. This will enable the Department to develop detailed service platforms in terms of hospital bed numbers, primary health care and home and community-based care.

The modelling tool makes provision to adjust key variables in the event that any of the assumptions change in the future or in the case of other significant developments.

Legislative changes

(1) Western Cape Health Facility Boards Amendment Act, 2012 (Act 7 of 2012):

The Act is being amended to make provision for transitional arrangements pending the appointment of central hospital boards by the National Minister of Health. The amendment will also provide a legal framework for establishing clinic and community health centre committees. Drafting instructions have been submitted to the Department of the Premier.

(2) The Western Cape District Health Councils Amendment Act, 2013 (Act 9 of 2013):

This Act was promulgated on 13 September 2013. It allows representatives of sub-districts in the Cape Town Metro District to be appointed to the District Health Council in the Metro. The composition of the District Health Council in the Metro District will therefore be similar to that of the rural districts.

(3) The Western Cape Independent Health Complaints Committee Act (Act 2 of 2014):

This Act has been assented to by the Premier during April 2014 after which it must be proclaimed before it can be put into operation. The Act makes provision for the establishment of the Independent Health Complaints Committee and the referral of complaints to the committee for consideration.

3. STRATEGIC OUTCOME ORIENTED GOALS

The strategic goals for Western Cape Government: Health for 2010 to 2014 are:

(1) Address the burden of disease.

(2) Improve the quality of health services and the patient experience.

(3) Ensure and maintain organisational strategic management capacity and synergy.

(4) Develop and maintain a capacitated workforce to deliver required health services.

(5) Develop and maintain appropriate health technology, infrastructure and information communication technology (ICT).

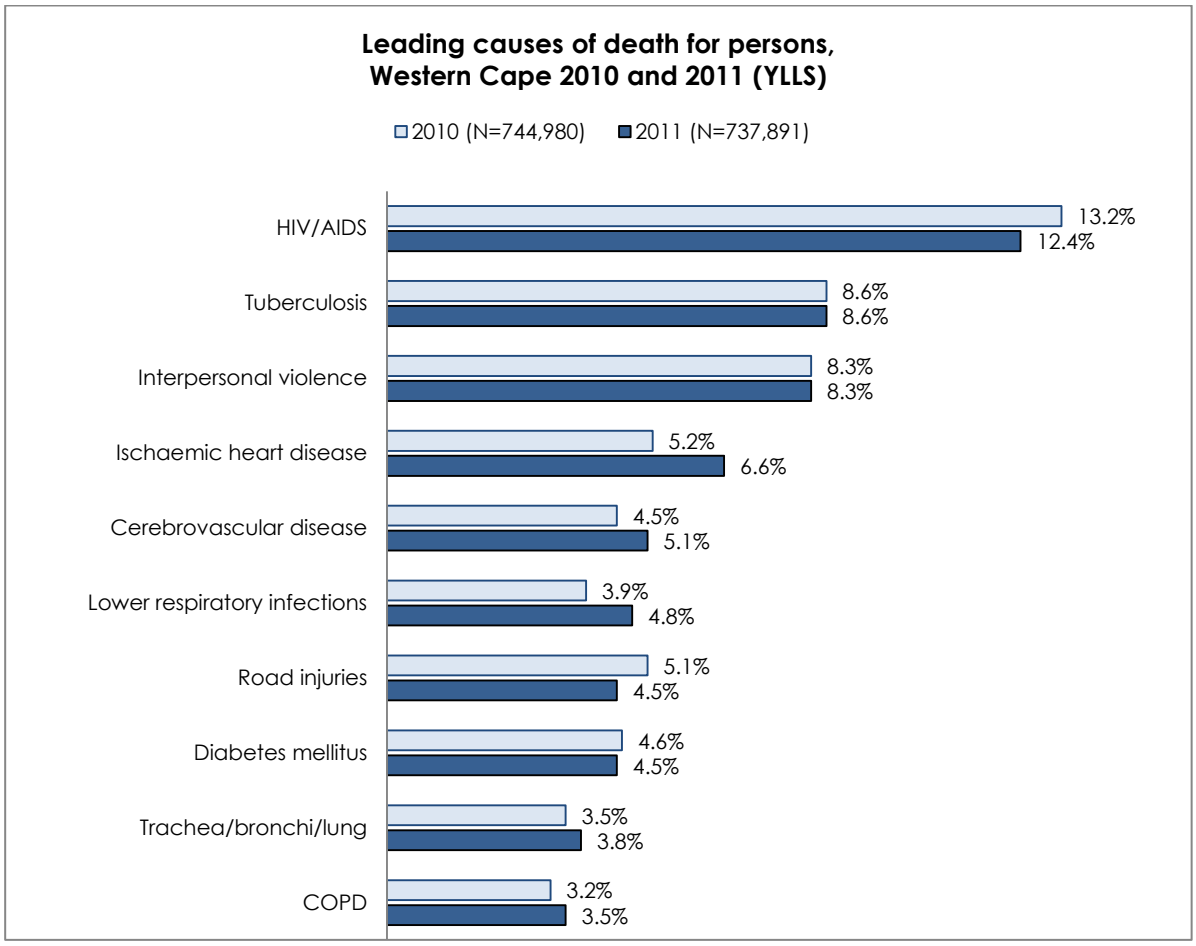
(6) Optimal financial management to maximise health outcomes.

ADDRESS THE BURDEN OF DISEASE

This strategic goal is aligned with the strategic outcome of national government to improve health care and life expectancy among all South Africans and with the provincial strategic objective of increasing wellness.

The Western Cape Province, and South Africa as a country, continues to suffer from the quadruple burden of disease which consists of HIV and TB; child and maternal health; non-communicable diseases; and injuries. The *Western Cape Mortality Surveillance Report* for 2011 shows that HIV and TB remain the leading single causes of premature mortality in the Province, however, premature mortality due to HIV shows a decrease in 2011 compared to 2010. In contrast, premature mortality due to chronic diseases has increased from 2010 to 2011 (Figure 3.1). This is significant as it means people are dying from chronic diseases at a younger age.

Figure 3.1: Leading causes of death, measured in years of potential life lost (YLL), for all persons in Western Cape, 2010 and 2011



[Source: Groenewald P, Berteler M, Bradshaw D, Coetzee D, Cornelius K, Daniels J, Evans J, Neethling I, Msemburi W, Matzopoulos R, Naledi T, Vismer M. Western Cape Mortality Profile 2010. Cape Town: South African Medical Research Council, 2013. ISBN:978-1-920618-11-7 and Western Cape Mortality Profile 2011 preliminary analysis.]

HIV and TB

One of the strategic objectives of the Department is to implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15 - 24 years to 11 per cent in 2014/15. The prevalence of HIV in surveyed pregnant women in this age group reduced from 11.6 per cent in 2011 to 10.4 per cent in 2012. Although this reduction is not statistically significant, the Department is hopeful that as HIV interventions are expanded there will be a continued downward trend of HIV prevalence in this age group.

The HIV prevalence among the reproductive age population (15 - 49 years) in the Western Cape has increased from 5.3 per cent in 2008 to 7.8 per cent in 2012. The failure to observe a decline in prevalence in high HIV burden areas in the Province may be partly due to the declining mortality as a result of improved access to anti-retroviral therapy (ART). Further, according to the Human Sciences Research Council (HSRC) community survey report, condom use has declined from 34 per cent in 2008 to 24.3 per cent in 2012, highlighting the need to better address the behavioural determinants of HIV.
[*Source: Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.*]

The anti-retroviral treatment programme continues to expand rapidly with 156 703 persons on treatment at the end of 2013/14. The roll-out of nurse initiated management of ART (NIMART) has contributed to the expansion of the programme in the Province. A total of 320 professional nurses have been successfully trained through this training programme and are now authorised to prescribe ART in the Western Cape Province.

ART chronic clubs are well established in the Province with 816 clubs now in place. On average 21 per cent of the ART cohort has been moved into chronic clubs and the Province is well on its way with regard to integrated chronic care clubs that provide the client with a "one-stop- shop", thus contributing to an improved person-centred approach.

The prevention of mother-to-child-transmission (PMTCT) rate is continually decreasing in the Western Cape, and remains the lowest in country, with a rate of 1.69 per cent in 2012/13 compared to a national estimate of 2.67 per cent (1.9 per cent in 2013/14). A large part of the success of the PMTCT programme in the Western Cape has been due to progressive provincial policies and successful partnerships with the local authority health services, academic institutions and non-governmental organisations as well as dedicated managers and staff. The Province has opted to place all HIV positive pregnant women on lifelong ART (Option B+) in the antenatal setting and this significantly benefits the pregnant mother, reduces the risk of transmission to the unborn baby and addresses ART as a prevention strategy.

The Western Cape has the third highest number of new TB infections in South Africa (746 cases per 100 000). Although a reduction in TB cases is observed, the proportion of new pulmonary tuberculosis (PTB) cases diagnosed with a high pre-treatment bacillary load is still 53 per cent. This is an indication of the risk of spread of infection due to delayed diagnosis. The TB/HIV co-infection rate remained stable at 38 per cent between 2010 and 2013. Intensified case finding interventions to ensure early diagnosis and initiation of treatment should be emphasised as a priority prevention strategy.

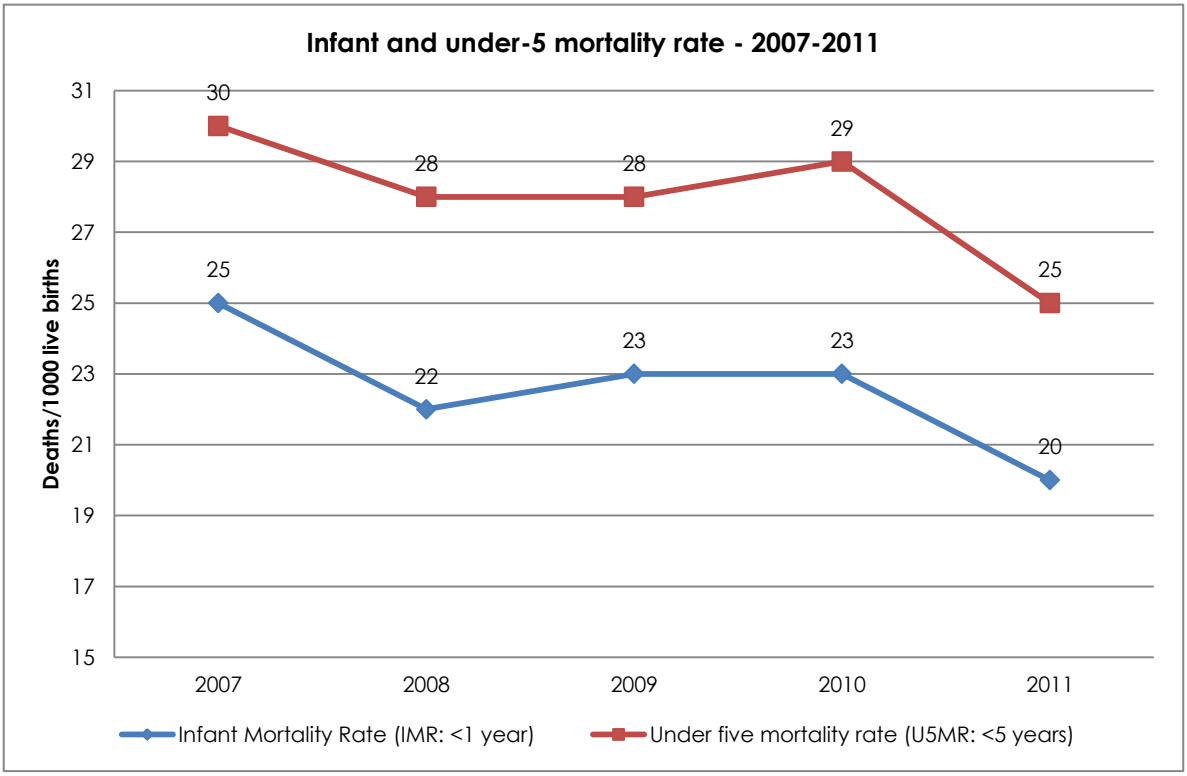
Whilst there has been a reduction in the number of TB cases over time, greater emphasis needs to be placed on strategies for effective prevention, particularly in key populations of higher risk, if we are to bring the number of TB cases down to levels even of other high burden countries. The incidence of multi-drug resistant (MDR) and extreme drug resistant (XDR) TB continues to increase, and despite efforts for earlier diagnosis, there remains a large gap between the number of patients diagnosed with multidrug-resistant TB and those who start treatment.

Child and Maternal/Women's Health

Child health

Infant and child (under 5) mortality rates continue to decrease in the Western Cape as shown in the figure below.

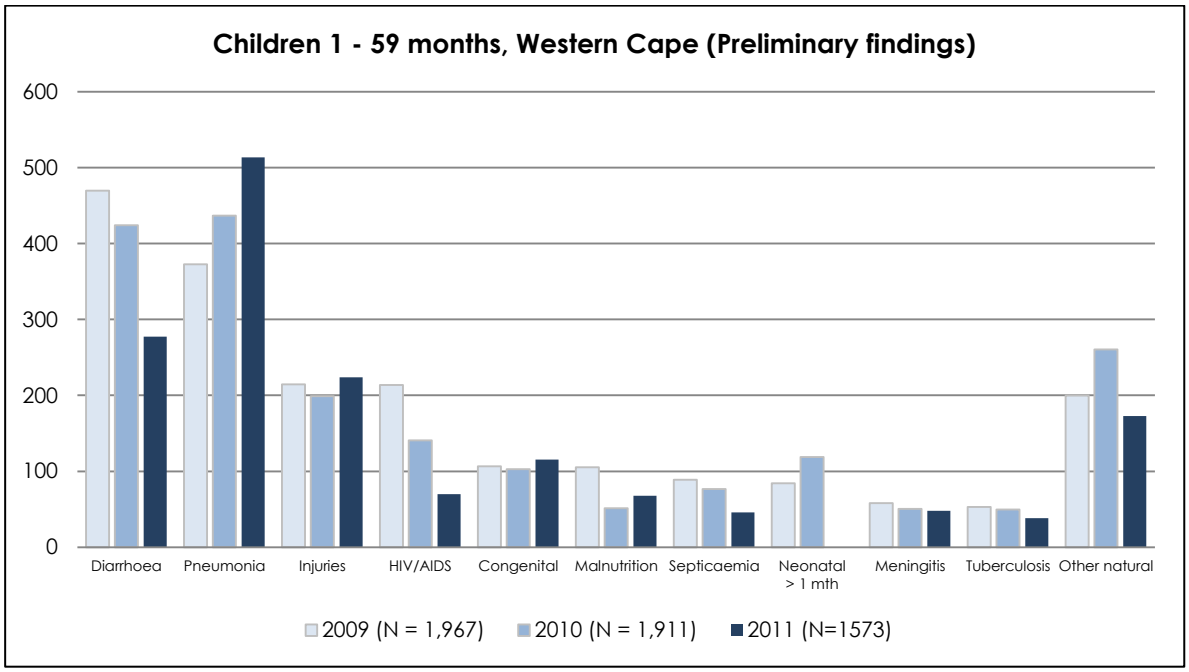
Figure 3.2: Trends in infant and under five mortality rates per 1 000 live births, Western Cape 2007 - 2011



[*Source: Groenewald P, Berteler M, Bradshaw D, Coetzee D, Cornelius K, Daniels J, Evans J, Neethling I, Msemburi W, Matzopoulos R, Naledi T, Vismer M. Western Cape Mortality Profile 2010. Cape Town: South African Medical Research Council, 2013. ISBN:978-1-920618-11-7 and Western Cape Mortality Profile 2011, preliminary analysis*]

The leading causes of death in children under five years of age in 2011 were neonatal causes, diarrhoea, pneumonia, injuries and congenital causes (Figure 3.3). HIV and diarrhoeal deaths have decreased from 2009 to 2011. However, there was a marked increase in pneumonia deaths in 2011. Preliminary analysis has shown that the majority of these deaths occurred outside of public health facilities and in children less than six months of age, with the peak in children aged three to four months.

Figure 3.3: Change in child causes of death, Western Cape 2009 - 2011

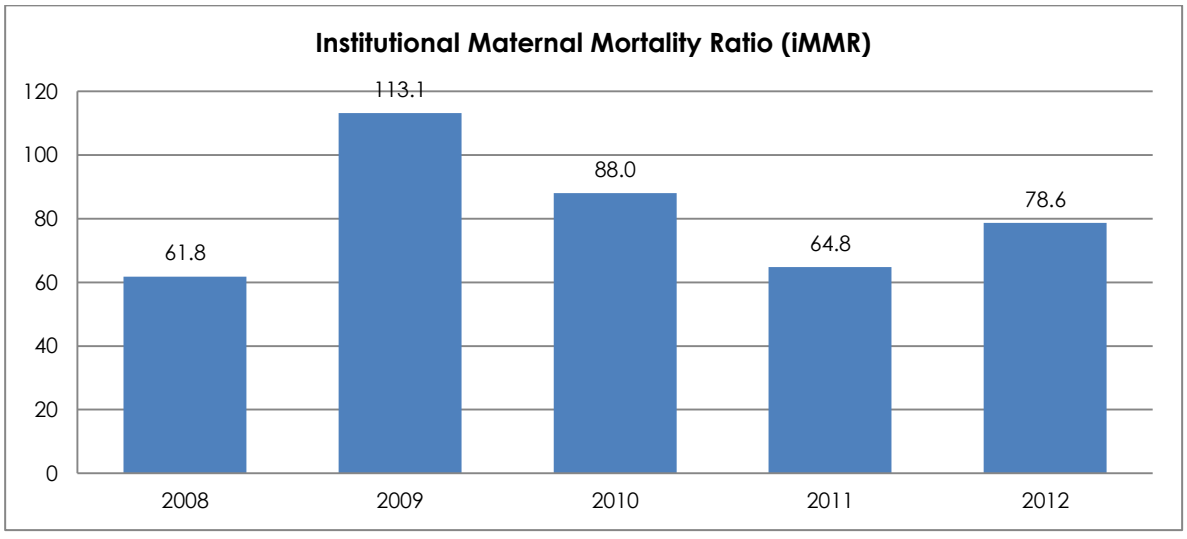


[*Source: Western Cape Mortality Profile 2011, preliminary analysis*]

Maternal and Women's Health

Interim findings from the most recent confidential enquiry into maternal deaths (2011 - 2012) show the institutional maternal mortality rate (iMMR) in the Western Cape was 78.64 per 100 000 live births, significantly lower than the national average of 146.71 per 100 000 live births.

Figure 3.4: Maternal deaths in the Western Cape 2008 - 2012



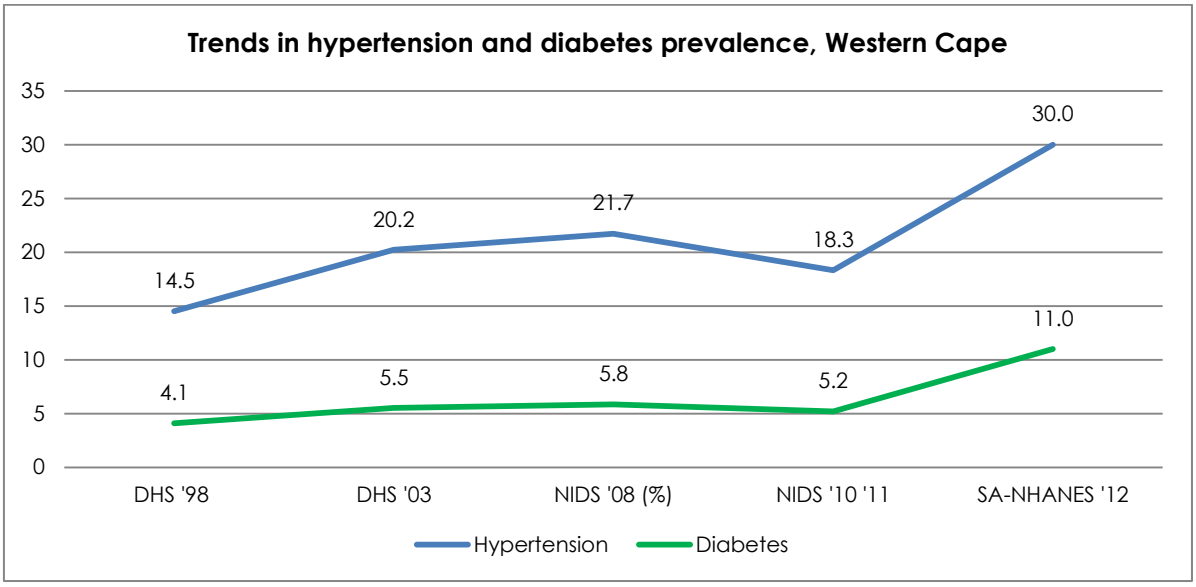
[*Source: Pattinson R, Fawcus S, Moodley J. Tenth interim report on Confidential Enquiries into Maternal Deaths in South Africa 2011 and 2012. National Executive Committee for Confidential Enquiries into Maternal Deaths*]

Leading causes of maternal deaths in the Western Cape were non-pregnancy related infections (35 per cent), medical and surgical disorders (20 per cent), hypertension (14.4 per cent), pregnancy-related sepsis (9.6 per cent) and obstetric haemorrhage (8 per cent). The proportion of deaths due to medical and surgical disorders continue to increase (11 per cent in 2008 to 2010, compared with 20.0 per cent in 2011 to 2012), highlighting the need to improve services that manage pregnant women with pre-existing conditions especially HIV and ART.

Non-communicable disease

Non-communicable or chronic diseases account for the largest proportion of deaths in the Western Cape and are the fourth leading cause of premature years of life lost in the Province. Results from national community based surveys indicate there is an increasing trend in the prevalence of non-communicable diseases in the Western Cape, specifically hypertension and type two diabetes mellitus (Figure 3.5). The burden of non-communicable diseases is likely to worsen given the high prevalence of risk factors in the Province. Results from the South African National Health and Nutrition Examination Survey (SA-NHANES) conducted in 2012 found over half of the Western Cape respondents were overweight or obese (body mass index greater than or equal to 25kg/m2), a third were smokers, and two thirds physically unfit.

Figure 3.5: Hypertension and diabetes prevalence for the Western Cape based on national health surveys



[*Sources:*

DHS '98: *Department of Health. The South African Demographic and Health Survey 1998*

DHS '03: *Department of Health, Medical Research Council, OrcMacro. South Africa Demographic and Health Survey 2003*

NIDS '08: *Southern Africa Labour and Development Research Unit. National Income Dynamics Study 2008*

NIDS '10'11: *Southern Africa Labour and Development Research Unit. National Income Dynamics Study 2010/11*

SA-NHANES: *Shisana, O et al. South African National Health and Nutrition Examination Survey, 2012*]

The co-occurrence of multiple conditions in the same patient (multi-morbidity) is increasingly becoming the norm. A study conducted at ten primary health care facilities in the Province found that 65 per cent of patients presenting with chronic conditions had co-morbidities. [*Source: Isaacs, AA et al. A snapshot of non-communicable disease profiles and their prescription costs at ten primary healthcare facilities in the western half of the Cape Metropole. S.Afr Fam Pract. Volume 56, no 1; 2014*]. This has implications for the complexity of clinical diagnosis and treatment, cost of providing care and the prognosis.

Injuries

Violence is the leading cause of injury in the Western Cape. Interpersonal violence, the third leading cause of death in the Province in 2011, accounts for over half of all violent injuries in the Western Cape. Substance abuse, particularly alcohol abuse, remains one of the most important drivers of the injury burden, accounting for over half of violent injuries and a third of transport related injuries.

IMPROVE THE QUALITY OF HEALTH SERVICES AND THE PATIENT EXPERIENCE

Improving the quality of services and the patient experience are priorities for both the National and Western Cape Provincial Department of Health. In recent client satisfaction surveys 88 per cent of patients surveyed were generally satisfied with the level of service. However, waiting times, cleanliness of toilets and the cost to get to health facilities remain challenges.

Another measure of departmental performance in this area is that the Department in 2013/14 received 9 604 complaints and 24 598 compliments, the number of compliments far exceeding the number of complaints. In terms of staff attitude, the Department received 1 124 complaints and 3 241 compliments.

83.2 per cent of complaints were resolved through the SMS hotline.

In 2013 the Department piloted a new adverse incident management tool which will be rolled out to the central, regional, psychiatric and specialised hospitals in 2014/15, and has implemented a strategy to strengthen antibiotic stewardship at health facilities.

ENSURE AND MAINTAIN ORGANISATIONAL STRATEGIC MANAGEMENT CAPACITY AND SYNERGY

A new organisational component, Organisational Compliance, was established to monitor and evaluate current organisation and post structures on a continuous basis to ensure staff members are functioning according to the purpose and functions of the approved organisational structure and are in possession of job descriptions that reflect said purpose and functions. Should this not be the case interventions should be implemented to rectify the situation.

The component Organisation Compliance must also ensure that the approved structure is in line with the operational requirements and service delivery needs. If this is not the case, projects to address structural deficiencies must be identified to undergo an organisational design process. Such projects are identified annually.

Some of the organisational designs projects that were revised during 2013/14 include:

- Redesign of the Directorate Emergency Medical Services Information Management and Communications.
- The development of a new organisation and post structure for the provision of health technology services by the Department of Health.
- New organisation and post structures for Tygerberg and Lentegeur Laundries.
- Redesign of the emergency centre at Karl Bremer Hospital.
- Creation of a new finance structure for the Central Medical Depot.
- The organisational redesign of Human Resources at Head Office.
- The creation and implementation of a new organisation and post structure for Groote Schuur- and Tygerberg Hospitals.
- Revised organisation and post structure for the provisioning of day-to-day, routine and emergency building maintenance services,

For more detail on restructuring, refer to the paragraph under section 2.3 *Organisational Environment* dealt with earlier in Part B: Performance information of this report.

DEVELOP AND MAINTAIN A CAPACITATED WORKFORCE TO DELIVER THE REQUIRED HEALTH SERVICES

Workforce planning for the health services is challenging and complex. However, it is an important process to deliver optimal health care for all. In line with National Government, Western Cape Government and WCG: Health's strategic goals and priorities, it is required to ensure a capacitated and values-driven workforce to manage the burden of disease and ensure quality of care and improved patient experience. There is a need for a dedicated team to develop and rigorously drive an integrated HR strategy that focuses on the HR priorities for the Department.

The workforce planning framework used by the Department is aligned to the HR planning template provided by the Department of Public Service and Administration. Based on the Department's strategic direction and Annual Performance Plan, an analysis is conducted of the external and internal environment, trends and changes of the macro environment as well as the workforce. A gap analysis is conducted to determine the problem areas. After the gap analysis has been finalised, the areas with the highest impact potential are identified and listed as priorities. Action plans are then developed to address these priority areas. This planning process is done on an annual basis.

More detail on the staff establishment is available in *Part D: Human Resources Management* of this report.

DEVELOP AND MAINTAIN APPROPRIATE HEALTH TECHNOLOGY, INFRASTRUCTURE AND ICT

Health technology and infrastructure

This strategic goal impacts directly on the Chief Directorate: Infrastructure and Technical Management. During 2013/14 various infrastructure, health technology, and maintenance projects were completed, some of which are listed below:

- Brooklyn Chest Hospital MDR and XDR wards.
- Caledon Hospital Disa building upgrade.
- Goodwood Ruyterwacht Clinic.

- Hermanus Hospital emergency centre and general upgrade.
- Karl Bremer Hospital emergency centre and CT (computerised tomography) scan.
- Klaarstroom Clinic.
- Knysna Hospital emergency centre.
- Kuyasa Clinic.
- Lentegeur Regional Laundry upgrade and extension.
- Malmesbury Ambulance Station.
- Mitchell's Plain Hospital.
- Swartland Hospital emergency centre upgrade and extension.
- Tygerberg Hospital emergency centre renovation.

In terms of the 12 outcomes announced by the Department of Performance Monitoring and Evaluation, two outcomes in particular relate to infrastructure, namely:

(1) Revitalisation of primary health care; and

(2) Improved physical infrastructure for healthcare delivery.

Various primary health care projects were in construction during 2013/14, for example:

- Asanda Clinic in Nonzamo, Strand.
- Du Noon Community Health Centre.
- Hermanus Community Day Centre.
- Rawsonville Clinic.
- Symphony Way Community Day Centre in Delft.

Significant achievements in 2013/14 with respect to the National Development Plan are:

- Management significantly improved within the Chief Directorate: Infrastructure and Technical Management with the implementation of the Western Cape Infrastructure Delivery System and associated training for relevant staff members.
- Funding was allocated for the introduction and implementation of Electronic Content Management (ECM), which will improve patient records at various facilities. Some of the facilities that benefited in this regard during 2013/14 are George and Mitchell's Plain Hospitals.

Laundries

Good progress is being made to provide a cost effective and efficient laundry service to all health facilities by 2014/15 with the following as highlights:

- The upgrading, extension and equipping of Lentegeur Regional Laundry was completed during 2013/14 and will enable the rendering of a more cost effective and efficient laundry service from this facility.
- Good progress has been made with the investigation into improving the cost effectiveness and efficiency of the laundry service at George Regional Laundry and it is planned to close the George Regional Laundry during 2014/15.
- Indications are that the 2014/15 strategic plan target for rendering the in-house laundry service, set at an average cost of R4.56 per item laundered in-house, could still be achieved. The average cost per item laundered in-house in 2013/14 is R4.40.

Maintenance

Although the 2013/14 results indicate that 94.1 per cent was achieved with respect to the strategic plan target: "Ensure that 91.8% of all engineering emergency cases reported are attended to within 48 hours by 2014/15", indicating that the 2014/15 target has already been achieved. The Department will strive to maintain this performance.

The Department will also continue to provide an effective and efficient maintenance service to all health facilities maintained by Directorate: Engineering and Technical Support.

In order to improve efficiency and better utilisation of scarce skills, work was begun during the 2011/12 financial year on what is referred to as the "Maintenance Hub Organisation Development Study". This work is part of the Infrastructure Delivery Management System Capacitation Framework initiative and is currently being finalised.

Phased implementation is planned to begin during 2014/15. This will see the establishment of maintenance hubs, located in strategically identified geographical areas across the Province and supported by mobile workshops, which will be centres for the rendering of technical and health technology services.

Expenditure and delivery of projects

Programme 8 (Health Facilities Management) will aim to spend 100 per cent of the annual allocated budgets and achieve 100 per cent of projects planned for completion annually. In spite of various mechanisms that are in place to monitor expenditure, it remains a challenge to achieve 100 per cent spending of the allocated budget.

All attempts are being made to improve delivery of projects, which is key for improving expenditure. Completing 100 per cent of projects planned annually also remains a challenge due to various factors such as longer design periods, construction delays, and change requests submitted close to project completion. The Chief Directorate: Infrastructure and Technical Management is working on establishing norms and standards and developing standard designs that should decrease the project design period.

Information and Communication Technology (ICT)

ICT has come to play a central role as an enabler of health service delivery. Over and above maintaining the legacy systems, the Department has started to install a new emergency medical services (EMS) software solution for its communication centres, rolled out the Primary Health Care Information System (PHCIS) to 176 facilities with 97 facilities actively using the appointment module, and the pharmaceutical management system (JAC) to 48 sites. The Hospital Information System (HIS) was implemented at Swartland and Lapa Munnik Hospitals in 2013/14. The implementation of the Enterprise Content Management (ECM) system at the Mitchells Plain Hospital, George Hospital and the Directorate: Information Management within Head office was undertaken with some challenges. The Picture Archiving System/Radiology Information System (PACS/RIS) has been implemented in the central hospitals and a tender has been awarded for the roll-out to regional and certain large district hospitals.

As part of technology refresh, 926 personal computers older than five years were replaced in 2013/14. Project management capacity will be strengthened to ensure the smooth implementation and sustainable management of ICT projects going forward.

OPTIMAL FINANCIAL MANAGEMENT TO MAXIMISE HEALTH OUTCOMES

The Department continually strives to improve its financial management processes and once again achieved an unqualified audit report for the annual financial statements (2012/13).

In terms of the expenditure per patient day equivalent in 2013/14, the regional hospitals demonstrated strong financial control as they were able to absorb the significant additional patient workload (3.6 per cent increase in patient day equivalents) while still providing an acceptable level of health care. This is a significant improvement on the prior period where the targeted expenditure per patient day equivalent was far exceeded (4.3 per cent).

The central hospitals also improved on this outcome in comparison to the prior period, but were still in excess of the desired target. This was to an extent symptomatic of the service pressures currently experienced by these hospitals, particularly in the emergency medicine and surgical services.

Financial governance in general was improved by the following management tools:

(1) Finance and human resource management work jointly to control personnel expenditure through managing funded posts by means of an approved posts list (APL).
(3) Through internal assessments nearly 80 per cent of all payments (in terms of value) are independently checked for compliance to regulations.
(4) A "compliance assessment" tool has been developed by which internal control staff members use to perform monthly checks on all transactions other than payments.
(5) A hierarchical system of monthly financial monitoring committee (FMC) meetings monitors the expenditure of the Department against the budget and evaluates the results of the internal assessments. The departmental FMC is chaired by the Head of Department whilst FMCs at other levels are chaired by the relevant managers.
(6) The development of the "essential supplies list" (ESL) has made progress. This is the standardisation of the consumables used in clinical settings and the development of transversal contracts to procure the consumables on the ESL.

TWELVE NATIONAL OUTCOMES OF THE NATIONAL GOVERNMENT

The National Government follows an outcomes-based approach and the National Ministers have signed a performance agreement with the President for twelve targeted outcomes. The outcome applicable to health is: "Improve healthcare and life expectancy among all South Africans". This outcome is addressed under the provincial strategic outcome oriented goal "Address the burden of disease".

NATIONAL DEVELOPMENT PLAN: HEALTH CARE FOR ALL

In terms of the National Development Plan (NDP), 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 by 2030. The objectives of the NDP are:

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.

4. PERFORMANCE INFORMATION BY PROGRAMME

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

Programme 1: Administration

Programme 2: District Health Services

Programme 3: Emergency Medical Services

Programme 4: Provincial Hospital Services

Programme 5: Central Hospital Services

Programme 6: Health Sciences and Training

Programme 7: Health Care Support Services

Programme 8: Health Facilities Management

New population estimates, based on the 2011 census information, was distributed by the National Department of Health in January 2014. This information was formally implemented by WCG: Health from 1 April 2014 going forward and all population-based targets in the 2014/15 Annual Performance Plan is based on these new population estimates.

For the purposes of the 2013/14 Annual Report, the previous population estimates were still used since all targets set in the 2013/14 Annual Performance Plan were based on these estimates.

Where indicated expenditure figures were converted to the values of the latest audited year at the time when planned targets were set in the APP, which is the year 2011/12 for the 2013/14 APP. The purpose is to be able to compare the reported costs from year to year.

4.1 PROGRAMME 1: ADMINISTRATION

Purpose of the programme

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

To make limited provision for maintenance and accommodation needs.

Sub-programmes

Sub-programme 1.1: Office of the MEC

Rendering of advisory, secretarial and office support services.

Sub-programme 1.2: Management

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

Strategic objectives

1) Provide sufficient staff with appropriate skills per occupational group by 2014/15.
2) Promote sound financial governance and management to ensure the under/over spending of the annual equitable share is within one per cent of the budget allocation.
3) Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.

Strategic objectives, performance indicators, planned targets and actual achievements

Ensure and maintain organisational strategic management capacity and synergy

All the clinical services have been amalgamated into one division at the provincial level under the leadership of a chief operating officer. The geographic service area has been created as a functional arrangement to co-ordinate services across budget programmes between the district health services and regional, central and specialised hospitals and services. To improve the co-ordination across the support structures, the Head: Health has created an Administrative Executive Committee which he chairs.

The finalisation of Healthcare 2030 through a two to three year process of consultation and engagement with staff and partners has resulted in an important process of developing a shared understanding of the vision, values and principles that will guide the future development of health services over the next two decades.

A new Organisational Compliance component has been established to monitor and evaluate current organisation and post structures on a continuous basis. In addition, this unit confirms that staff members are functioning in accordance with the purpose and functions of the approved organisational structure and are in possession of valid job descriptions.

Support services such as Finance, Human Resources and Information Management were strengthened through the appointment of additional staff in devolved internal control units (DICUs). The function of these units is to improve compliance to the regulatory framework in the respective areas. The compliance monitoring instrument (CMI) continues to be a useful tool in monitoring compliance of priority issues identified by the Department and the Auditor-General of South Africa (AGSA).

Optimal financial management to maximise health outcomes

The Department achieved an unqualified audit of the Annual Financial Statements for the 2012/13 financial year and was acknowledged for significant improvement in overall performance by the AGSA.

Finance and Human Resource Management co-operate to control personnel expenditure through managing funded posts by means of an Approved Post List (APL).

The provision of health services are funded by ensuring the sustained generation of financial resources through:

- Allocating equitable budgets that are aligned with the expected outcomes and provide and optimal service at an appropriate cost per patient.
- Improving systems for procuring medicines to ensure a reliable and uninterrupted supply of medicine.
- Focusing on revenue projects to achieve revenue targets and in the process provide opportunities for institutions to increase expenditure.
- Encouraging funding initiatives by hospital facility boards.

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

Given the importance of human resources, the Department also established a Human Resource Monitoring Committee (HRMC), chaired by the Head of Department, to monitor HR performance on a quarterly basis.

The Department has done well to achieve beyond its targets in reducing the vacancy rates of doctors, medical specialists and pharmacists. This bodes well for ensuring the clinical capability to render a good quality health service.

In certain professional occupational categories the salary structure of the OSD is not competitive enough in comparison with the private sector and this limits the recruitment and retention of staff. These categories include professional nurses in trauma, theatre, maternity, mental health and intensive care, pharmacists, paramedics as well as lecturers in emergency medical services. The failure to achieve the target vacancy rates for professional nurses is largely due to the inability to recruit specialist nurses.

The Department has also put emphasis on reducing the turnaround time for filling posts which is monitored at the highest levels. Given the service pressures, a vacant post could place great pressure on the remaining staff and lead to negative consequences such as burn out and demoralisation.

The Department is placing increasing emphasis on the wellness of employees and supporting staff at the service rendering level. An innovative change management programme has been launched at 38 facilities within the District Health Service to strengthen problem solving capability amongst local staff, encourage innovation, and develop tangible ways to translate the departmental values into positive actions and behaviours to improve person-centred care.

Table 4.1.1: Public health personnel as at 31 March 2014

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

Table 4.1.2: Strategic objectives for human resources 2013/14

Programme 1: Administration								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
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	33.3	33.0	33.1	0.2%	The approved post list (APL) fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for the exact number of medical officers' posts, as it is based on national guidelines and service delivery needs by the respective facilities/hospitals. The Department deems the deviation as minimal and within an acceptable range.
			Numerator:	1 956	1 979	1 984	0.3%	
			Denominator:	58.8	59.98	59.98	0.0%	
			2) Professional nurses per 100 000 people	98.7	99.4	99.7	0.3%	The APL fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for the exact number of professional nurses' posts, as it is based on national guidelines and service delivery needs by the respective facilities/hospitals. The Department deems the deviation as minimal and within an acceptable range.
			Numerator:	5 803	5 962	5 978	0.3%	
			Denominator:	58.8	59.98	59.98	0.0%	
			3) Pharmacists per 100 000 people	6.6	6.5	6.7	2.6%	The APL fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for the exact number of pharmacists' posts, as it is based on national guidelines and service delivery needs by the respective facilities/hospitals. The Department deems the deviation as minimal and within an acceptable range.
			Numerator:	386	389	400	2.8%	
			Denominator:	58.8	59.98	59.98	0.0%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.1.3: Performance indicators for human resources 2013/14

Programme 1: Administration								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
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	33.3	33.0	33.1	0.2%	The approved post list (APL) fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for the exact number of medical officers' posts, as it is based on national guidelines and service delivery needs by the respective facilities/hospitals. The Department deems the deviation as minimal and within an acceptable range.
			Numerator:	1 956	1 979	1 984	0.3%	
			Denominator:	58.8	59.98	59.98	0.0%	
			2) Medical officers per 100 000 people in rural districts	18.1	17.8	18.4	3.3%	The APL fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for the exact number of medical officers' posts (rural), as it is based on national guidelines and service delivery needs by the respective facilities/hospitals. The Department deems the deviation as minimal and within an acceptable range.
			Numerator:	358	359	371	3.3%	
			Denominator:	19.8	20.18	20.18	0.0%	
			3) Professional nurses per 100 000 people	98.7	99.4	99.7	0.3%	The APL fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for the exact number of professional nurses' posts, as it is based on national guidelines and service delivery needs by the respective facilities/hospitals. The Department deems the deviation as minimal and within an acceptable range.
			Numerator:	5 803	5 962	5 978	0.3%	
			Denominator:	58.8	59.98	59.98	0.0%	
			4) Professional nurses per 100 000 people in rural districts	90.1	90.0	89.7	(0.3%)	The APL fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for the exact number of professional nurses' posts (rural), as it is based on national guidelines and service delivery needs by the respective facilities/hospitals. The Department deems the deviation as minimal and within an acceptable range.
			Numerator:	1 786	1 816	1 810	(0.3%)	
			Denominator:	19.8	20.18	20.18	0.0%	
			5) Pharmacists per 100 000 people	6.6	6.5	6.7	2.6%	The APL fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for the exact number of pharmacists' posts, as it is based on national guidelines and service delivery needs by the respective facilities/hospitals. The Department deems the deviation as minimal and within an acceptable range.
			Numerator:	386	389	400	2.8%	
			Denominator:	58.8	59.98	59.98	0.0%	
			6) Pharmacists per 100 000 people in rural districts	6.0	6.1	6.1	(0.0%)	The APL fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for the exact number of pharmacists' posts (rural), as it is based on national guidelines and service delivery needs by the respective facilities/hospitals. The Department deems the deviation as minimal and within an acceptable range.
			Numerator:	119	123	123	0.0%	
			Denominator:	19.8	20.18	20.18	0.0%	

Programme 1: Administration								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
			7) Vacancy rate for professional nurses	3.7%	2.9%	4.5%	54.8%	The APL fluctuates on a monthly/quarterly basis. Although closely monitored, the Department experienced challenges with the filling of professional nurses' posts, especially in the specialist nurse category, due to applicants not meeting the minimum requirements (qualifications and/or work experience). The Department acknowledges the under-performance, and will investigate possible ways to overcome the challenges in the next financial year.
			Numerator:	222	179	281	57.0%	
			Denominator:	6 025	6 141	6 259	1.9%	
			8) Vacancy rate for doctors	2.6%	3.9%	3.4%	(13.9%)	The APL fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for the filling of (medical officers) doctors' posts, as it is based on national guidelines and service delivery needs by the respective facilities/hospitals. The Department managed to fill more posts than anticipated and it resulted in an over-performance, which is deemed acceptable.
			Numerator:	53	80	69	(13.8%)	
			Denominator:	2 010	2 059	2 056	(0.1%)	
			9) Vacancy rate for medical specialists	3.6%	3.1%	2.9%	(5.3%)	The APL fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for medical specialists' post vacancies. The Department managed to create more posts due to service delivery needs and within budget allocation. Furthermore, more posts were filled than anticipated which resulted in an over-performance, which is deemed acceptable.
			Numerator:	23	20	20	0.0%	
			Denominator:	642	649	681	4.9%	
			10) Vacancy rate for pharmacists	6.8%	8.0%	6.3%	(21.0%)	The APL fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan for the filling of pharmacists' posts, as it is based on national guidelines and service delivery needs by the respective facilities/hospitals. The Department managed to fill more posts than anticipated and it resulted in an over-performance, which is deemed acceptable.
			Numerator:	28	34	27	(20.6%)	
			Denominator:	414	423	427	0.9%	

Strategies to overcome areas of under-performance

In addition to other internal control measures, a tracking tool was developed to identify and monitor the movements of vacant funded posts on a monthly basis to curb under expenditure.

Changes to planned targets

No targets were changed during the year.

Table 4.1.4: Strategic objectives for Administration 2013/14

Programme 1: Administration								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
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[1]	99.3%	100.0%	99.8%	(0.2%)	Under expenditure relates to filling of posts as a result of the APL which fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan and manage expenditure for the filling of all posts, as posts are filled on an on-going basis to ensure service delivery needs. The Department deems the deviation as minimal, within an acceptable range and an improvement compared to 2012/13.
			Numerator:	10 654 461 000	11 454 112 000	11 517 782 000	0.6%	
			Denominator:	10 730 229 000	11 454 112 000	11 544 801 000	0.8%	
2. Develop and maintain a capacitated workforce to deliver the required health services.	2.1 Develop and maintain a comprehen-sive Human Resource Plan for the Department.	2.1.1 Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.	2) Amended Human Resource Plan submitted timeously to DPSA	Yes	Yes	Yes	0.0%	Target achieved.

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

[1] Numerator and denominator in APP expressed per R'000.

Table 4.1.5: Performance indicators for Administration 2013/14

Programme 1: Administration								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
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	99.3%	100.0%	99.8%	(0.2%)	Under expenditure relates to filling of posts as a result of the APL which fluctuates on a monthly/quarterly basis. Although closely monitored, it is very difficult to plan and manage expenditure for the filling of all posts, as posts are filled on an on-going basis to ensure service delivery needs. The Department deems the deviation as minimal, within an acceptable range and an improvement compared to 2012/13.
			Numerator:	10 654 461 000	11 454 112 000	11 517 782 000	0.6%	
			Denominator:	10 730 229 000	11 454 112 000	11 544 801 000	0.8%	
2. Develop and maintain a capacitated workforce to deliver the required health services.	2.1 Develop and maintain a comprehen-sive Human Resource Plan for the Department.	2.1.1 Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.	2) Amended Human Resource Plan submitted timeously to DPSA	Yes	Yes	Yes	0.0%	Target achieved.

Strategies to overcome areas of under-performance

No material under-performance identified for Administration.

Changes to planned targets

No targets were changed during the year.

Linking performance with budgets

Table 4.1.6: Summary of expenditure for Administration 2013/14

Expenditure	2013/14			2012/13		
Sub-programme	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000
1.1: Office of the MEC	6 754	6 310	444	6 867	6 421	446
1.2: Management	514 950	505 137	9 813	438 642	438 627	15
Total	**521 704**	**511 447**	**10 257**	**445 509**	**445 048**	**461**

Programme 1 recorded an under expenditure of R10,257 million mainly due to late filling of vacant posts.

Funds were prioritised for the development and strengthening of information technology opportunities, processing of scripts through the chronic dispensing unit (CDU), increased forensic investigation capacity and the settlement of medico-legal claims. These priorities assisted in improving the quality of healthcare services significantly.

4.2 PROGRAMME 2: DISTRICT HEALTH SERVICES

Purpose of the programme

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.

Sub-programmes

Sub-programme 2.1:	District Management
	Management of District Health Services (including facility and community-based services), corporate governance (including financial, human resource management and professional support services e.g. infrastructure and technology planning) and quality assurance (including clinical governance).
Sub-programme 2.2:	Community Health Clinics
	Rendering a nurse-driven primary health care service at clinic level including visiting points and mobile clinics.
Sub-programme 2.3:	Community Health Centres
	Rendering a primary health care service with full-time medical officers, offering services such as: mother and child health, health promotion, geriatrics, chronic disease management, occupational therapy, physiotherapy, psychiatry, speech therapy, communicable disease management, mental health and others.
Sub-programme 2.4:	Community Based Services
	Rendering a community-based health service at non–health facilities in respect of home-based care, community care workers, caring for victims of abuse, mental- and chronic care, school health, etc.
Sub-programme 2.5:	Other Community Services
	Rendering environmental and port health services.
Sub-programme 2.6:	HIV, AIDS, STI and TB
	Rendering a primary health care service for HIV disease, AIDS, sexually transmitted infections and tuberculosis.
Sub-programme 2.7:	Nutrition
	Rendering a nutrition service aimed at specific target groups, combining direct and indirect nutrition interventions to address malnutrition.

Sub-programme 2.8:	Coroner Services
	Rendering forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death.
	These services are reported in Sub-Programme 7.3: Forensic Pathology Services.
Sub-programme 2.9:	District Hospitals
	Rendering of a district hospital service at sub-district level.
Sub-programme 2.10:	Global Fund
	Strengthen and expand the HIV and AIDS prevention, care and treatment programmes.

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 are in Sub-programme 4.2.

DISTRICT HEALTH SERVICES

Strategic objectives

(1) Achieve a PHC utilisation rate of 2.54 visits per person per annum by 2014/15.

(2) Achieve a primary health care (PHC) expenditure of R520 per uninsured person by 2014/15 [2011/12 Rands].

(3) Achieve a 74.0 per cent complaint resolution within 25 working days rate by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

Address the burden of disease

The Department recognises that it is faced with a quadruple burden of disease consisting of:

(1) Infectious diseases (HIV and TB);

(2) Maternal, perinatal and nutritional problems (pregnancy and early childhood-related health challenges);

(3) Non-communicable diseases (diabetes, hypertension, heart disease and others); and

(4) Injuries related to violence, trauma and accidents.

It further recognises that this burden of disease has significant upstream determinants which need to be addressed at the level of primary prevention (for example alcohol misuse is strongly associated with injuries/violence and tuberculosis is associated with poor living conditions). The Department is engaging in multi-sectoral collaborative efforts to address some of these.

The reality however is that most of the health services manage existing disease rather than address primary prevention.

The primary healthcare platform plays a number of roles: primary prevention as through immunisations, cervical screening and prevention of mother-to-child transmission (PMTCT); acute treatment as for minor once-off ailments and sickness events; and secondary prevention by retaining patients with chronic non-communicable diseases (diabetes, etc.) or chronic communicable diseases (HIV) in care and on treatment.

The developing CBS platform will play a large health promotion and adherence support role.

District hospitals saw 271 963 separations in 2013/14, an increase from the previous year, and emergency centres and outpatient departments had 1 296 142 visits (also an increase from the previous year), while the primary health care platform received 14.3 million contacts.

HIV prevalence in women 15 - 24 years reduced to the lowest yet recorded while TB cure rates continued to increase. More people were tested for HIV than targeted and the number of people in ART care was more than 99 per cent of the target.

Immunisation performance was comparable to last year (the challenges posed by immunisation denominators is discussed in the service delivery environment section) and vitamin A coverage (a prevention strategy) was on target. Child and maternal mortality continue to slowly decrease while the PMTCT rate is one of the lowest in the country. Cervical screening and contraception coverage indicate good performance in the area of women's health.

Optimal financial management to maximise health outcomes

The Department has a number of internal tools, such as the budget management instrument (BMI) and the approved post list (APL) as well as processes that are designed to monitor and control expenditure and pursue effectiveness and efficiency. The District Health Expenditure Review (DHER) tool is also used to monitor equity on a district and sub-district level. The fact that Programme 2 spent 99.95 per cent of its allocated budget is indicative of the effectiveness of these tools. Good health outcomes are referred to in the section above.

Improve the quality of health services and the patient experience

Client satisfaction surveys showed a high level of patient satisfaction with health services, as an indication of the patient experience, with measures of 90 per cent general satisfaction recorded for district hospitals. Patient complaints resolution within 25 working days was above 80 per cent for PHC services and district hospitals. There was a commitment to improving the patient experience where deficiencies were highlighted by patients. Health service quality of care performance is reflected in the fact that greater than 90 per cent of district hospitals held the requisite morbidity and mortality meetings. Preparation for, and the conducting of, national core standards gap assessments is still in an early phase and this can be expected to expand in the new financial year.

Table 4.2.1: Strategic objectives for District Health Services 2013/14

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
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	2.5	2.54	2.4	5.9%	An analysis of 10 years of PHC headcount shows a gradual annual increase, to a peak in mid-2011, with a gradual decline subsequently. This is possibly due to an increased focus on the community-based services platform, as well as an increase in the amount of medicines that were dispensed automatically via the chronic dispensing unit. It is also not possible to predict the annual target with great accuracy because it is reliant on patient health-seeking behaviour.
			Numerator:	14 792 882	15 252 132	14 336 969	(6.0%)	
			Denominator:	5 876 887	5 998 164	5 998 164	0.0%	
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].	2) Provincial PHC expenditure per uninsured person	R495	R526	R511	(2.8%)	The expenditure was marginally less than planned for in this sub-component because the chronic dispensing unit (CDU) budget was over-estimated and some PHC posts were unfilled.
			Numerator:	2 270 095 031	2 461 774 793	2 393 395 790	(2.8%)	
			Denominator:	4 585 115	4 679 521	4 679 521	0.0%	
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.	3) Complaints resolution within 25 working days rate (from users of PHC services)	79.2%	73.3%	87.0%	18.6%	Even though more complaints were received than anticipated, the Department managed to resolve a higher percentage of complaints within 25 working days than targeted.
			Numerator:	1 405	660	1 354	105.15%	
			Denominator:	1 775	901	1 557	72.81%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.2.2: Performance indicators for District Health Services 2013/14

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
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	2.5	2.54	2.4	5.9%	See comment below.
			Numerator:	14 792 882	15 252 132	14 336 969	(6.0%)	
			Denominator:	5 876 887	5 998 164	5 998 164	0.0%	
			2) PHC headcount total	14 792 882	15 252 132	14 336 969	6.0%	An analysis of 10 years of PHC headcount shows a gradual annual increase, to a peak in mid-2011, with a gradual decline subsequently. This is possibly due to an increased focus on the community-based services platform, as well as an increase in the amount of medicines that were dispensed automatically via the chronic dispensing unit. It is also not possible to predict the annual target with great accuracy because it is reliant on patient health-seeking behaviour.
			3) PHC utilisation rate – under 5 years	4.0	4.03	3.82	(5.2%)	See comment below.
			Numerator:	2 217 431	2 263 406	2147046	(5.1%)	
			Denominator:	549 832	562 219	562219	0.0%	
			4) PHC headcount under 5 years total	2 217 431	2 263 406	2147046	(5.1%)	Similar to the PHC total headcount comment above, the under-5 headcount has been very gradually declining since about 2011. This is seen across all districts.
			5) PHC supervisor visit rate (fixed clinic / CHC / CDC)	79.2%	93.9%	83.8%	(10.7%)	During the course of the year the scheduling of supervisory visits by the City of Cape Town (CoCT) was different from that of Metro District Health Services (MDHS). For MDHS the expected frequency was monthly while for the City it was three-monthly. Overall the MDHS visit rate is good and the rural supervisor visit rate is above 95%. The situation is slowly improving because of a service level agreement concluded with CoCT.
			Numerator:	225	263	235	(10.7%)	
			Denominator:	284	280	280	0.0%	
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	R153	R161	R167	3.7%	The expenditure was marginally less than planned for in this sub-component because the chronic dispensing unit (CDU) budget was over-estimated and some PHC posts were unfilled.
			Numerator:	2 270 095 031	2 461 774 793	2 393 395 790	(2.8%)	
			Denominator:	14 792 882	15 252 132	14 336 969	(6.0%)	
			7) Provincial PHC expenditure per uninsured person	R495	R526	R511	(2.8%)	As for comment above.
			Numerator:	2 270 095 031	2 461 774 793	2 393 395 790	(2.8%)	
			Denominator:	4 585 115	4 679 521	4 679 521	0.0%	

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
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)	79.2%	73.3%	87.0%	18.6%	Even though more complaints were received than anticipated, the Department managed to resolve a higher percentage of complaints within 25 working days than targeted.
			Numerator:	1 405	660	1 354	105.15%	
			Denominator:	1 775	901	1 557	72.81%	
			9) Percentage of PHC facilities assessed for compliance against the 6 priorities of the core standards (NIDS: Facility core standards self-assessment rate in PHC facilities)	7.0%	9.6%	28.2%	193.9%	Due to the passing of the National Health Amendment Act of 2013, which enabled the establishment of the Office of Health Standards Compliance, all facilities have been encouraged to do national core standards gap assessments. As a result, a much higher than expected number of facilities were assessed against the six priorities in preparation for formal assessments by the Office in future.
			Number of PHC facilities assessed for compliance against the 6 priorities of the core standards					
			Numerator:	20	27	79	192.59%	
			Denominator:	284	280	280	0.0%	

Strategies to overcome areas of under-performance

The ten year assessment of trends in the PHC headcounts for adults and children will be used as a basis for more realistic target setting in future. This will have an impact not only on the PHC headcount total and PHC headcount under 5 years total, but also on the PHC utilisation rate and the PHC utilisation rate under 5 years.

In terms of the PHC supervisor visit rate at fixed clinics, CHCs and CDCs, the service level agreement (SLA) with the City of Cape Town will assist in improving the performance.

Changes to planned targets

No targets were changed during the year.

DISTRICT HOSPITAL SERVICES

Strategic objectives

(1) Establish 2 678 acute district hospital beds in the DHS by 2014/15.

(2) Achieve a district hospital expenditure of R1 422 per PDE by 2014/15 [2011/12 Rands].

(3) Achieve an 87.0 per cent client satisfaction rate by 2014/15.

Table 4.2.3: Strategic objectives for District Hospital Services 2013/14

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
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	2 657	2 678	2 684	(0.2%)	The accuracy of this projection is acceptable given the complexity of the service re-organisation between the decommissioning of GF Jooste Hospital and the opening of the new Mitchells Plain Hospital.
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 [2011/12 Rands].	2) Expenditure per patient day equivalent (PDE) (in district hospitals)	R 1 395	R1 451	R1 506	3.8%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	1 772 606 901	1 851 196 420	1 951 461 161	5.4%	Expenditure was lightly more than expected because of increased busyness at Mitchells Plain and Khayelitsha Hospitals.
			Denominator:	1 270 696	1 276 052	1 296 142	1.6%	
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.	3) Hospital patient satisfaction rate (in district hospitals)	87.0%	86.0%	90.0%	4.7%	Performance here has been above target which is commendable.
			Numerator:	7 173	7 452	8 334	11.8%	
			Denominator:	8 244	8 665	9 260	6.9%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.2.4: Performance indicators for District Hospital Services 2013/14

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
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	2 657	2 678	2 684	(0.2%)	The accuracy of this projection is acceptable given the complexity of the service re-organisation between the decommissioning of GF Jooste Hospital and the opening of the new Mitchells Plain Hospital.
			2) Delivery by caesarean section rate (in district hospitals)	24.1%	24.6%	25.6%	4.2%	The number (and rate) of caesarean sections was more or less as expected, in keeping with a service that is slowly getting busier, especially in the Metro, as district hospitals assume responsibility for maternal services that have previously fallen under regional hospitals.
			Numerator:	7 769	8 855	8 416	(5.0%)	
			Denominator:	32 206	35 979	32 820	(8.8%)	
			3) Inpatient separations - total (in district hospitals)	260 187	264 977	271 963	2.6%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. However, the trend is one of increasing busyness, particularly in the Metro district hospitals.
			4) Patient day equivalents (PDE) total (in district hospitals)	1 270 696	1 276 052	1 296 142	1.6%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			5) OPD headcount total (in district hospitals)	878 760	1 180 584	1 297 161	9.9%	This indicator unfortunately had a target-setting error in the APP. The target and the actual for 2013/14 include the emergency headcount. The OPD only was 852 631. The Department underestimated the busyness of metro district hospitals and the impact of opening two new district hospitals in the last two years. (I.e. Khayelitsha Hospital and Mitchells Plain Hospital.)
			6) Average length of stay (in district hospitals)	3.2 days	3.18 days	3.2 days	(0.7%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	842 491	842 435	863 755	2.5%	
			Denominator:	260 187	264 977	271 963	2.6%	Average length of stay was slightly less than projected because of an increase in the number of patient days and separations. This in turn was a reflection of the increased busyness of the metro district hospitals.
			7) Inpatient bed utilisation rate (based on usable beds in district hospitals)	87.6%	86.7%	88.7%	2.3%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	842 491	842 435	863 755	2.5%	Slightly more than expected because of the afore-mentioned increased number of patient days. A reflection of Metro district hospitals mainly.
			Denominator:	961 941	971 995	973 562	0.2%	

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
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 [2011/12 Rands].	8) Expenditure per patient day equivalent (PDE) (in district hospitals)	R1 395	R1 451	R1 506	3.8%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	1 772 606 901	1 851 196 420	1 951 461 161	5.4%	Expenditure was lightly more than expected because of increased busyness at Mitchells Plain and Khayelitsha Hospitals.
			Denominator:	1 270 696	1 276 052	1 296 142	1.6%	
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)	77.6%	79.2%	85.0%	7.3%	It was difficult to set targets given the opening of Khayelitsha Hospital in 2012/13 and Mitchells Plain Hospital in 2013/14 with the decommissioning of GF Jooste. The state of the art hospitals could also be the reason for the reduction in complaints received compared to the previous year.
			Numerator:	1 652	473	883	86.7%	
			Denominator:	2 128	597	1 039	74.0%	
			10) Hospital patient satisfaction rate (in district hospitals)	87.0%	86.0%	90.0%	4.7%	Performance here has been above target which is commendable.
			Numerator:	7 173	7 452	8 334	11.8%	
			Denominator:	8 244	8 665	9 260	6.9%	
			11) Percentage of district hospitals assessed for compliance against the 6 priorities of the core standards (NIDS: Facility core standards self-assessment rate in district hospitals) Number of hospitals assessed for compliance against the 6 priorities of the core standards (district hospitals)	20.6%	100.0%	47.1%	(52.9%)	An additional ten hospitals completed the survey, but the results were not captured on the system before it closed for the financial year. Given that the Office of Health Standards Compliance has now been legislated and is in the process of being set up, it will be important to ensure full compliance with this target in the next financial year.
			Numerator:	7	34	16	(52.9%)	
			Denominator:	34	34	34	0.0%	
			12) Morbidity and mortality review rate (in district hospitals)	Not required to report	100%	93.8%	(6.2%)	A reasonable compliance with this target has been achieved. Additional effort and support will be put in place to assist especially the smaller district hospitals to have regular morbidity and mortality meetings.
			Numerator:	-	340	319	(6.2%)	
			Denominator:	-	340	340	0.0%	

Strategies to overcome areas of under-performance

Clarity will be provided to all institutions and districts on the definition for OPD headcount total, to ensure consistency in target setting and calculation of actual figures.

Compliance with national core standards is a developmental process. More realistic targets will be set for undertaking assessments. The assessments should take place earlier in the financial year to allow adequate time for data capture onto the system.

Additional clinical and managerial support will be provided to smaller district hospitals in organising their mortality and morbidity review meetings.

Changes to planned targets

No targets were changed during the year.

HIV AND AIDS, STIs AND TB CONTROL (HAST)

Strategic objective

(1) Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15 - 24 years to 11.0 per cent in 2014/15.

Table 4.2.5: Strategic objectives for HIV and AIDS, STIs and TB Control 2013/14

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 MDG Goal 6: Have halted and begun to reverse the spread of HIV and AIDS and TB by 2014/15.	1.1.1 Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15 - 24 years to 11.0% in 2014/15.	1) HIV prevalence in women aged 15 – 24 years	11.6%	11.5%	10.4%	(9.7%)	This is a positive finding, indicating an HIV prevalence in young pregnant females that is slightly lower than projected. It is likely that HIV incidence in the general population is indeed declining but this provincial figure masks some opposing trends in particular districts/sub-districts.
			Numerator:	511	506	392	(22.5%)	
			Denominator:	4 408	4 402	3 776	(14.2%)	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.2.6: Performance indicators for HIV and AIDS, STIs and TB Control 2013/14

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 MDG Goal 6: Have halted and begun to reverse the spread of HIV and AIDS and TB by 2014/15.	1.1.1 Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15 - 24 years to 11.0% in 2014/15.	1) HIV prevalence in women aged 15 – 24 years	11.6%	11.5%	10.4%	(9.7%)	This is a positive finding, indicating an HIV prevalence in young pregnant females that is slightly lower than projected. It is likely that HIV incidence in the general population is indeed declining but this provincial figure masks some opposing trends in particular districts/sub-districts.
			Numerator:	511	506	392	(22.5%)	
			Denominator:	4 408	4 402	3 776	(14.2%)	
			2) Total clients remaining on ART (TROA) at the end of the month	134 212	157 123	156 703	(0.3%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. The ART programme has a successful history of accurate target setting and allied performance.
			3) Male condom distribution rate	54.0	54.13	59.28	9.5%	The supply of condoms has been uncompromised this year and NPO partners have been active participants in increasing coverage amongst hard-to-reach populations. A provincial focus on medical male circumcision and HIV prevention has also contributed to this over-performance.
			Numerator:	113 929 651	116 515 072	127 606 318	9.5%	
			Denominator:	2 108 839	2 152 485	2 152 485	0.0%	
			4) TB (new pulmonary) defaulter rate	7.0%	6.5%	7.5%	15.8%	Over the long term (~10 years) the defaulter rate has declined from ~12% to ~7% which reflects an improvement in the management of the TB programme. But the Department might be at the stage of diminishing returns in terms of its capacity to improve the defaulter rate since these are the defaulters who are very difficult to trace and who default for 'social' reasons – e.g. homelessness, alcoholism, job-seeking. A shift in defaulter management to a very CBS-focus might be required.
			Numerator:	1 025	1 046	1 025	(2.0%)	
			Denominator:	14 722	16 027	13 614	(15.1%)	
			5) TB AFB sputum result turnaround time under 48 hours rate	67.7%	72.2%	72.2%	0.0%	Good support from the National Health Laboratory Services (NHLS) has resulted in the achievement of this target.
			Numerator:	337 976	380 515	211 299	(44.5%)	
			Denominator:	499 310	527 392	292 659	(44.5%)	
			6) HIV testing coverage[2]	28.9%	28.4%	29.9%	5.2%	The assistance of NPOs and the on-going roll-out of the provider-initiated counselling and testing model (whereby nurses test patients themselves, without referring them to counsellors first), has contributed to the success in this indicator.
			Numerator:	934 483	938 107	986 223	5.1%	
			Denominator:	3 233 779	3 300 676	3 300 676	0.0%	

2 Previously the HIV testing rate was monitored (i.e. clients counselled regarding HIV testing / clients tested for HIV). HIV testing coverage refers to the proportion of the population that has been tested for HIV.

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
			7) Percentage of HIV-TB co-infected patients placed on ART (NIDS: Percentage of HIV-TB co-infected patients initiated on ART)	84.0%	69.6%	70.3%	1.0%	Simplifying the criteria for access to ART for TB patients has contributed to the achievement of target for this indicator.
			Numerator:	11 487	12 118	12 564	3.7%	
			Denominator:	13 678	17 414	17 870	2.6%	
			8) TB (new pulmonary) cure rate	81.7%	82.0%	83.7%	2.0%	Performance is 2% better than target which the Department is satisfied with.
			Numerator:	12 023	13 148	11 392	(13.4%)	
			Denominator:	14 722	16 027	13 614	(15.1%)	
			9) PTB two month smear conversion rate	75.5%	76.7%	76.1%	(0.7%)	Performance is within1% of target which the Department is satisfied with.
			Numerator:	10 638	11 297	10 103	(10.6%)	
			Denominator:	14 091	14 728	13 270	(9.9%)	
			10) TB new client treatment success rate	Not required to report	86.6%	87.1%	0.6%	Performance is within 1% of target which the Department is satisfied with.
			Numerator:	-	20 541	11 860	(42.3%)	
			Denominator:	-	23 718	13 614	(42.6%)	

Strategies to overcome areas of under-performance

Strategies have been mentioned in the table with explanations of variances.

Changes to planned targets

No targets were changed during the year.

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

Strategic objectives

(1) Improve the coverage of effective immunisations to 90.0 per cent in children under the age of 5 years by 2014/15.

(2) Reduce the maternal mortality ratio to 58 per 100 000 live births by 2014/15.

Table 4.2.7: Strategic objectives for Maternal, Child and Women's Health (MCWH) and Nutrition 2013/14

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 MDG goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	1.1.1 Improve the coverage of effective immunisations to 90.0% in children under the age of 5 years by 2014/15.	1) Immunisation coverage under 1 year	87.2%	90.4%	80.4%	(11.0%)	Failure to achieve immunisation targets is an issue of some year's standing. Despite the Department's good performance in other health indicators and the Department's specific focus on this indicator, this seemingly poor performance is a cause for concern. It is suspected that a considerable part of the problem might be the use of an incorrect (inflated) denominator for children less than one year of age. The Department is engaging in a multi-pronged study to establish the accuracy of both the numerator and denominator for this indicator - the results will be available in 2014. At a sub-district level, 5 metro sub-districts are responsible for 92% of the observed decrease between 2012/13 and 2013/14. These also happen to be the sub-districts that received the most attention during the immunisation catch-up campaign that occurred early in 2013/14. An unintended consequence of the mass campaign (which achieved very high coverage) was that parents might have felt less motivated to attend facilities for routine immunisations because they thought that the campaign had attended to that. Note that the 2014/15 APP uses an official population figure (for children less than one) that is 5% lower than that used in 2013/14 - instantly improving the performance by the corresponding percentage.
			Numerator:	94 724	100 244	89 202	(11.0%)	
			Denominator:	108 651	110 889	110 889	0.0%	
	1.2 MDG goal 5: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	1.2.1 Reduce the maternal mortality ratio to 58 per 100 000 live births by 2014/15.	2) Maternal mortality in facility ratio (MMR)	60.2 per 100 000	60.00 per 100 000	68.6 per 100 000	14.3%	This is a difficult indicator to collect because of delayed reporting which makes target setting challenging.
			Numerator:	57	60	66	10.0%	
			Denominator:	0.95	1.00	0.96	(3.7%)	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.2.8: Performance indicators for Maternal, Child and Women's Health (MCWH) and Nutrition 2013/14

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 MDG goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	1.1.1 Improve the coverage of effective immunisations to 90.0% in children under the age of 5 years by 2014/15.	1) Immunisation coverage under 1 year	87.2%	90.4%	80.4%	(11.0%)	Failure to achieve immunisation targets is an issue of some year's standing. Despite the Department's good performance in other health indicators and the Department's specific focus on this indicator, this seemingly poor performance is a cause for concern. It is suspected that a considerable part of the problem might be the use of an incorrect (inflated) denominator for children less than one year of age. The Department is engaging in a multi-pronged study to establish the accuracy of both the numerator and denominator for this indicator - the results will be available in 2014. At a sub-district level, 5 metro sub-districts are responsible for 92% of the observed decrease between 2012/13 and 2013/14. These also happen to be the sub-districts that received the most attention during the immunisation catch-up campaign that occurred early in 2013/14. An unintended consequence of the mass campaign (which achieved very high coverage) was that parents might have felt less motivated to attend facilities for routine immunisations because they thought that the campaign had attended to that. Note that the 2014/15 APP uses an official population figure (for children less than one) that is 5% lower than that used in 2013/14 - instantly improving the performance by the corresponding percentage.
			Numerator:	94 724	100 244	89 202	(11.0%)	
			Denominator:	108 651	110 889	110 889	0.0%	
			2) Vitamin A coverage 12 - 59 months (NIDS: Vitamin A coverage 12 - 59 months OR 1 - 4 years)	36.6%	41.0%	42.7%	5.2%	This slight over-performance is because in some sub-districts the immunisation catch-up campaign (conducted in quarter 1) was used as an opportunity to dose children with Vitamin A outside of clinical facilities.
			Numerator:	322 634	360 766	378 972	5.0%	
			Denominator:	882 363	887 562	887 562	0.0%	
			3) Pneumococcal vaccine (PCV) 3rd dose coverage	87.1%	90.1%	82.9%	(8.0%)	See immunisation coverage under 1, above.
			Numerator:	94 604	99 898	91 952	(8.0%)	
			Denominator:	108 651	110 889	110 889	0.0%	
			4) Rotavirus (RV) 2nd dose coverage	84.9%	90.0%	83.6%	(6.7%)	See immunisation coverage under 1, above.
			Numerator:	92 256	99 398	92 665	(6.8%)	
			Denominator:	108 651	110 889	110 889	0.0%	

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
			5) Measles 1st dose under 1 year coverage (NIDS: Measles 1st dose under 1 year coverage annualised)	89.5%	93.1%	83.6%	(10.2%)	See immunisation coverage under 1, above.
			Numerator:	97 217	103 223	92 674	(10.2%)	
			Denominator:	108 651	110 889	110 889	0.0%	
			6) Infant tested PCR positive within 2 months rate	1.7%	1.9%	1.9%	0.9%	The good performance is the result of improved maternal initiation of highly active anti-retroviral therapy due to a change in policy which allows all HIV-infected pregnant women access to life-long ART (i.e. HAART initiation in pregnancy, which is no longer determined by CD4 count).
			Numerator:	216	229	242	5.7%	
			Denominator:	12 748	12 229	12 617	3.2%	
			7) Child under 5 years diarrhoea with dehydration incidence	95.5	79.25	94.9	19.7%	In retrospect, a 15% reduction in diarrhoea cases between what was recorded in 2012/13 and what was set as a target for 2013/14 was overly ambitious. This is most likely due to every individual district overestimating their ability (as a health department) to impact on a problem that has a broad range of determinants that extend into the social and service-delivery spheres. Also note that the APP in previous years measured **ALL** diarrhoea (not just those with dehydration) and this was the basis of the target set for 2013/14. The annual figure of 53 347 cases definitely reflects ALL diarrhoea cases, and not just diarrhoea with dehydration as the name of the performance measure indicates.
			Numerator:	52 493	44 554	53 347	19.7%	
			Denominator:	549.83	562.22	562.2	0.0%	
			8) Child under 5 years pneumonia incidence	59.3	65.79	63.1	(4.1%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. This is an 'over-performance' and is probably attributable to a lower than expected pneumonia 'season' which might possibly reflect the success of pneumococcal vaccine over the last few years.
			Numerator:	32 596	36 988	35 475	(4.1%)	
			Denominator:	549.83	562.22	562.2	0.0%	
			9) Child under 1 year mortality in facility rate	9.16	8.97	9.2	2.4%	There was a slight increase in deaths under one year compared to the target and the previous year. A detailed analysis to better understand the situation is being undertaken.
			Numerator:	1 026	1 025	1 049	2.3%	
			Denominator:	111.91	114.22	114.22	0.0%	

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
			10) Inpatient death under 1 year rate	2.3%	2.5%	1.9%	(24.4%)	This reflects a gradual reduction in provincial childhood death rates. Note the higher than expected number for the denominator (separations under 1). This is because separation data from CDCs and MOUs was recorded on the information system in 2013/14 whereas it had not been in previous years.
			Numerator:	1 026	1 025	1 049	2.3%	
			Denominator:	44 372	41 000	55 513	35.4%	
			11) Inpatient death under 5 years rate	1.5%	1.3%	1.3%	(0.0%)	Target achieved.
			Numerator:	1 168	1 180	1 183	0.3%	
			Denominator:	80 008	89 997	93 908	4.3%	
	1.2 MDG goal 5: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	1.2.1 Reduce the maternal mortality ratio to 58 per 100 000 live births by 2014/15.	12) Maternal mortality in facility ratio (MMR)	60.2 per 100 000	60.00 per 100 000	68.6 per 100 000	14.3%	This is a difficult indicator to collect because of delayed reporting which makes target setting challenging.
			Numerator:	57	60	66	10.0%	
			Denominator:	0.95	1.00	0.96	(3.7%)	
			13) Cervical cancer screening coverage	60.2%	64.1%	63.6%	(0.7%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. There has been a concerted focus on this activity across the Province, with dedicated 'screening drives' occurring in a number of sub-districts. This has allowed for a performance that is close to target.
			Numerator:	81 012	88 066	87 397	(0.8%)	
			Denominator:	134 560	137 341	137 341	0.0%	
			14) Delivery in facility under 18 years rate	6.5%	6.5%	6.3%	(2.8%)	The performance is considered acceptable for the Department, particularly for an indicator which relies, to some degree, on risk-reduction behaviour by the youth.
			Numerator:	6 053	6 185	6 026	(2.6%)	
			Denominator:	93 480	94 858	95 337	0.5%	
			15) Antenatal 1st visit before 20 weeks rate	58.1%	61.0%	61.0%	(0.0%)	Target achieved.
			Numerator:	55 525	59 687	60 384	1.2%	
			Denominator:	95 510	97 851	99 069	1.2%	
			16) Couple year protection rate	42.7%	42.4%	73.0%	72.1%	The target was set using the CYPR definition of 2012/13, in which condoms are multiplied by a factor of 1/500. In the 2014/15 definition of CYPR, condoms were multiplied by a factor of 1/200, effectively giving them 2.5 times the weight they had when the target was set and resulting therefore in an 'over-performance'. If condoms are given the same weight as they had when the target was set, the performance would be within 5% of target.
			Numerator:	615 470	624 064	1 072 570	71.9%	
			Denominator:	1 440 356	1 470 176	1 470 176	0.0%	

Strategies to overcome areas of under-performance

Strategies have been mentioned in the table with explanations of variances.

Changes to planned targets

No targets were changed during the year.

DISEASE PREVENTION AND CONTROL (DPC)

Strategic objectives

(1) Ensure that all districts have plans to deal with outbreaks and epidemics by 2014/15.
(2) Increase the number of cataract surgeries to 1 471 per 1 000 000 by 2014/15.

Table 4.2.9: Strategic objectives for Disease prevention and control (DPC) 2013/14

Programme 2: District Health Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Plan for epidemics and disasters.	1.1.1 Ensure that all districts have plans to deal with outbreaks and epidemics by 2014/15.	1) Malaria case fatality rate	0.0%	0%	1.6%	(100.0%)	Malaria is not endemic to the Western Cape and malaria deaths are by definition imported into the Province and therefore unpredictable.
			Numerator:	0	0	2	(100.0%)	
			Denominator:	68	40	123	(207.5%)	
	1.2 Provide for cataract surgeries.	1.2.1 Increase the number of cataract surgeries to 1 471 per 1 000 000 by 2014/15.	2) Cataract surgery rate	1 212	1 400	1 282	(8.4%)	Despite an 8% increase in number of surgeries performed compared to last year, target was not achieved because of an ambitious target which was set at 18% higher than previous performance. This has been rectified with each participating facility agreeing to their individual target for 2014/15.
			Numerator:	7 122	8 398	7 692	(8.4%)	
			Denominator:	5.88	6.00	6.00	0.0%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.2.10: Performance indicators for Disease prevention and control (DPC) 2013/14

Programme 2: District Health Services							
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Plan for epidemics and disasters.	1.1.1 Ensure that all districts have plans to deal with outbreaks and epidemics by 2014/15.	1) Malaria case fatality rate	0.0%	0.0%	0.8%	(100.0%)	Malaria is not endemic to the Western Cape and malaria deaths are by definition imported into the Province and therefore unpredictable.
			Numerator:	0	0	1	(100.0%)	
			Denominator:	68	40	123	(207.5%)	
			2) Cholera fatality rate	0.0%	0.0%	0.0%	0.0%	No cholera cases detected in 2013/14.
			Numerator:	0	0	0	0.0%	
			Denominator:	0	0	0	100.0%	
	1.2 Provide for cataract surgeries.	1.2.1 Increase the number of cataract surgeries to 1 471 per 1 000 000 by 2014/15.	3) Cataract surgery rate	1 212	1 400	1 282	(8.4%)	Despite an 8% increase in number of surgeries performed compared to last year, target was not achieved because of an ambitious target which was set at 18% higher than previous performance. This has been rectified with each participating facility agreeing to their individual target for 2014/15.
			Numerator:	7 122	8 398	7 692	(8.4%)	
			Denominator:	5.88	6.00	6.00	0.0%	

Strategies to overcome areas of under-performance

Refer to performance table.

Changes to planned targets

No targets were changed during the year.

Linking performance with budgets

Table 4.2.11: Summary of expenditure for District Health Services 2013/14

Expenditure	2013/14			2012/13		
Sub-programme	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000
2.1: District Management	291 569	273 897	17 672	263 034	256 990	6 044
2.2: Community Health Clinics	968 405	958 255	10 150	1 060 714	1 037 606	23 108
2.3: Community Health Centres	1 339 288	1 315 348	23 940	1 128 478	1 126 712	1 766
2.4: Community-Based Services	165 448	163 891	1 557	158 932	163 280	(4 348)
2.5: Other Community Services	1	-	1	1	-	1
2.6: HIV, AIDS, STI and TB	927 547	927 547	-	738 080	738 079	1
2.7: Nutrition	32 376	35 606	(3 230)	26 920	28 693	(1 773)
2.8: Coroner Services	1	-	1	1	-	1
2.9: District Hospitals	2 162 615	2 210 739	(48 124)	1 997 290	2 018 179	(20 889)
2.10: Global Fund	155 005	153 979	1 026	181 979	140 329	41 650
Total	**6 042 255**	**6 039 262**	**2 993**	**5 555 429**	**5 509 868**	**45 561**

District management: The under-expenditure of R17.7 million was mainly due to posts not being filled. There were challenges in finding suitable candidates in certain instances (e.g. a quality assurance manager in the Metro).

Community health clinics: The under-expenditure of R10.2 million was mainly due to less than anticipated claims from the City of Cape Town for vaccines.

Community Health Centres: The under-expenditure of R23.9 million is attributable to two main reasons. The budget for the CDU (chronic dispensing unit) was over-estimated by about R8 million. Secondly, staff turnover and process delays in the filling of posts accounted for most of the other under-expenditure.

District Hospitals: The over-expenditure of R48.1 million was mainly due to the two new hospitals in the Metro – Khayelitsha District Hospital and Mitchells Plain Hospital. The demand for services was more than expected for both these hospitals resulting in this over-expenditure.

4.3 Programme 3: Emergency Medical Services

Purpose of the programme

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

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

Sub-programmes

Sub-programme 3.1:	Emergency Medical Services
	Rendering emergency medical services including ambulance services, special operations, communications and air ambulance services.
	Emergency medicine is reflected as a separate objective within Sub-programme 3.1: Emergency Medical Services.
Sub-programme 3.2:	Planned patient transport (PPP) – HealthNET
	Rendering planned patient transport including local outpatient transport (within the boundaries of a given town or local area) and inter-city/town outpatient transport (into referral centres).

Strategic objectives

(1) Deploying the EMS resources (542 vehicles, 54 bases and 2 366 personnel) necessary to the specified service levels of 176 rostered ambulances per hour in the CSP by 2014/15.

(2) Meet the response time performance of 75.0 per cent for P1 urban and 90.0 per cent for P1 rural clients and ensure the shortest time to definitive care by integrated management of pre-hospital and hospital emergency care resources by 2014/15.

(3) To meet the patient response, transport and inter-hospital transfer needs of the Department in line with the 90:10 CSP model by realigning the configuration of the EMS service by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

Address the burden of disease

Emergency Medical Services (EMS) in the Western Cape faced a number of challenges during the 2013/14 financial year. Ambulance incidents increased by 7.6 per cent, with the majority of the increase occurring in the last two quarters.

This increase placed a significant burden on operations which in turn affects the achievement of annual performance targets. Whilst essentially meeting the targets of all calls within urban and rural areas responded to within 60 minutes, the priority 1 target remained elusive despite a concerted effort to improve performance in this area.

Another significant service pressure was the high volume of inter-facility transfers requested between facilities. These requests affect both priority 1 and priority 2 call volumes significantly, accounting for almost 170 000 cases (or almost a quarter of all EMS cases). EMS together with health facilities need to address this demand innovatively to service the needs of the facilities, whilst maintaining performance to primary calls within communities.

The impact of the introduction of the new EMS Computer Aided Dispatch (CAD) system, as well as additional technology, on EMS performance is difficult to project. Whilst EMS expects an initial performance challenge as staff adapt to the new system, the service is confident that the overall solution will improve the ability of pre-hospital staff to respond to emergencies within the Province as well as provide valuable data in modelling, managing and addressing service needs into the future.

Red Cross Air Mercy Service (RCAMS)

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

The majority of cases are inter-facility transfer and, whether by fixed or rotor-wing programmes, critical patients in remote parts of the Province (and neighbouring provinces) have rapid access to tertiary and specialised services regardless of their financial or insurance status. In addition, the judicious use of an aeromedical platform for the execution of long distance transfers ensures that ambulance resource availability is at an optimum in smaller less well-resourced communities.

During the 2013/14 cycle, this service (fixed wing and aero-medical) performed 1 215 missions transporting 1 388 patients to secondary and tertiary care facilities. The 83 rescue missions resulted in 59 patients being rescued from wilderness areas or the sea. This was achieved by covering 182 943 kilometres by fixed-wing and 1 131 hours of flight by the helicopter programme.

Planned Patient Transport

Planned Patient Transport (PPT) has evolved to become a significant component of EMS and is currently serviced by HealthNET. PPT involves the transport of patients within the Western Cape to and from planned hospital admissions and out-patient services. The service extends throughout the Province and has become an integral component of health service delivery to patients with limited transport availability and access to secondary or tertiary care facilities due to their geographic location.

HealthNET makes use of various types of vehicles depending on the need and volume of transfers and caters to low acuity patients only. Patients are booked from the hospitals and health facilities through an online booking system which has recently been extended to include almost 150 additional facilities, ranging from outpatient clinics at tertiary hospitals to rural health facilities.

With the steady increase in patient volumes using the service, EMS is re-evaluating the design and management of the service to fully address this need including new routes, and alternative and additional vehicles.

Emergency Medicine

Western Cape Emergency Medicine, as a sub-component of EMS, deals with emergencies within a hospital environment, disaster medicine, academic research and specialist training. Emergency medicine leads the clinical governance component of EMS to ensure that patient care is optimal within the operational environment and that the latest evidence is used to guide practice.

Through the Emergency Medicine component, EMS ensures that the patient journey from pre-hospital to the in-hospital environment is as safe and professional as possible and that patient care is always held as the top priority within the service.

Disaster Medicine and Events

Disaster preparedness has once again been a priority for EMS within the Province, and this is demonstrated through regular major incident training (MIMMS) and disaster medicine courses. Close relationships with allied organisations, such as Disaster Management, the South African Police Services (SAPS), private ambulance services and fire services, have further strengthened the ability of EMS to respond should a disaster occur, and this was demonstrated well in the total evacuation of Vergelegen Hospital in 2013 necessitated by flooding of the hospital.

Events management also falls under the Disaster Management component of EMS. Events are managed through the provision of communications, operational and support staff that work months prior to the event to ensure that planning is done to prepare for potential catastrophes that may occur due to the unique nature of mass gatherings within events.

Some noteworthy events during the 2013/14 financial year include:

(1) The Argus Cycle Tour:

EMS led the medical standby and response for this major international event which saw 146 patients seen by EMS paramedics or doctors.

15 of these patients were priority 1 patients, or emergencies with the remainder being priority 2 (124) or non-emergency (7) patients.

(2) The Old Mutual Two Oceans Marathon:

EMS led the medical standby and response for both the trail run and the road marathon event which overall saw 21 patients being transported to hospital by EMS.

(3) CHAN soccer tournament:

Cape Town hosted matches at Cape Town Stadium and Athlone Stadium for this continental event, which saw 60 patients in total being seen at the event.

Of these 60 patients, only 7 were transported to hospital by EMS.

Medical rescue response

Medical rescue services include the medical leadership and control of emergency medical incidents and the provision of access, patient care and extrication to patients entrapped by their physical environment.

EMS is one of the few medical services worldwide that manages its own rescue services, which allows EMS to control the quality, resource allocation and distribution. These services include technical rescue, wilderness search and rescue (WSAR), and maritime rescues amongst others, which are offered in conjunction with RCAMS and volunteers for WSAR.

Rescue services are often displayed prominently in the media due to the nature of the spectacle rescues provide. A notable incident, for which two divers received an international award in 2013/14, was the Miroshga incident in Hout Bay.

Although the incident required displays of courage and bravery from all the emergency service personnel involved, two individuals were singled out for their exceptional actions. Fabian Higgins (EMS recue diver) and Constable Heino Uhde (SAPS rescue diver) risked their own lives under extremely hazardous conditions to rescue three passengers from underneath the upturned hull. These efforts were recognised by the International Maritime Organisation (IMO) at a prestigious award ceremony held in London on the 25th of November 2013.

Internship

The programme yielded positive outcomes for both the interns and the Department. The interns, for their part, have gained valuable skills, knowledge and experience rendering them highly marketable within the public and private sector. In addition, EMS managed to employ 68 interns across the Province whilst simultaneously up-skilling potentially 47 intermediate life-support practitioners.

Emergency First Aid Response (EFAR) programme

An exciting initiative that has gained more traction in 2013/14 is the EFAR programme. The EFAR programme provides basic first aid training to community members and equips them as first responders within their own communities. These first responders are then mobilised to emergencies as a resource from EMS and provide feedback to EMS regarding the patient's condition prior to the ambulance arriving on scene.

Benefits of the system include community participation, relationship building between EMS and communities and patient care through the timely delivery of initial care in these areas.

Various studies are taking place to assess the impact of this system on gangsterism, crime and community upliftment which, whilst not direct goals of the EFAR system, are positive spinoffs of the programme.

Staff safety

EMS staff safety was once again highlighted in 2013/14. Various incidents, including staff assault (physical and verbal), staff caught in crossfire from gang wars, and robbery incidents all occurred during the past year. These incidents are unfortunate as they are committed by the very communities that EMS is serving. EMS has a zero tolerance approach toward violence committed toward staff and work closely with the South African Police Service (SAPS) to both assist EMS to respond to incidents in violent hotspots as well as in the investigation of incidents against team members.

Change in Leadership

The past year saw the departure of Dr Cleeve Robertson after twelve years as EMS director. Dr Robertson accepted an appointment at the NSRI and Dr Shaheem de Vries was appointed as the new director for EMS.

Table 4.3.1: Strategic objectives for EMS and patient transport 2013/14

Programme 3: Emergency Medical Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Fully implement the Comprehen-sive Service Plan (CSP) model for EMS by 2014/15.	1.1.1 Deploying the EMS resources (542 vehicles, 54 bases and 2 366 personnel) necessary to the specified service levels of 176 rostered ambulances per hour in the CSP by 2014/15.	1) Rostered ambulances per 10 000 people	0.28	0.29	0.28	(7.4%)	The challenge around overtime and the operational resources is again noted. Through careful management of the APL and the filling of critical posts, EMS was able to roster more vehicles.
			Numerator:	165	171	166	(5.8%)	
			Denominator:	588	600	600	0.0%	
	1.2 Provide roadside to bedside definitive emergency care with defined emergency time frames within and across geographic and clinical service platforms.	1.2.1 Meet the response time performance of 75.0% for P1 urban and 90.0% for P1 rural clients and ensure the shortest time to definitive care by integrated management of pre-hospital and hospital emergency care resources by 2014/15.	2) EMS P1 urban response under 15 minutes rate	66.8%	75.0%	70.9%	(5.4%)	Notwithstanding the challenges faced by EMS, and recognising that the performance falls short of the target by approximately 5%, it is an improvement on the previous financial year. This remains encouraging given that call volume was increased by almost 20 000 cases during the year.
			Numerator:	109 720	124 759	130 899	4.9%	
			Denominator:	164 131	166 345	184 584	11.0%	
			3) EMS P1 rural response under 40 minutes rate	87.2%	90.0%	85.3%	(5.2%)	Despite rural call volumes increasing more than expected. EMS has managed to maintain a stable performance through strict operational control. Some of the districts exceed the target (Central Karoo and West Coast) but the low performance in other districts brings down the overall performance.
			Numerator:	22 454	21 253	25 234	18.7%	
			Denominator:	25 757	23 615	29 588	25.3%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.3.2: Performance indicators for EMS and patient transport 2013/14

Programme 3: Emergency Medical Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Fully implement the Comprehen-sive Service Plan (CSP) model for EMS by 2014/15.	1.1.1 Deploying the EMS resources (542 vehicles, 54 bases and 2 366 personnel) necessary to the specified service levels of 176 rostered ambulances per hour in the CSP by 2014/15.	1) Rostered ambulances per 10 000 people	0.28	0.29	0.28	(7.4%)	The challenge around overtime and the operational resources is again noted. Through careful management of the APL and the filling of critical posts, EMS was able to roster more vehicles.
			Numerator:	165	171	166	(5.8%)	
			Denominator:	588	600	600	0.0%	
			2) EMS operational ambulance coverage	Not required to report	0.44	0.41	(6.0%)	The nominal decrease in the fleet size follows a departmental decision to hold off on the purchasing of additional ambulances. That said, the value of this indicator is questioned as it does not correlate well with service expansion. It should also be emphasised that the impact of the fleet 'shrinkage' is easily mitigated by the health of the EMS fleet. This is reflected in the > 90% fleet availability during the 2013/14 period.
			Numerator:	-	263	248	(5.7%)	
			Denominator:	-	600	600	0.0%	
			3) Total number of EMS emergency cases	478 365	468 496	514 901	9.9%	Increase in workload is evident and the resources remain a constraint. 10% increase on 2013 financial year.
	1.2 Provide roadside to bedside definitive emergency care with defined emergency time frames within and across geographic and clinical service platforms.	1.2.1 Meet the response time performance of 75.0% for P1 urban and 90.0% for P1 rural clients and ensure the shortest time to definitive care by integrated management of pre-hospital and hospital emergency care resources by 2014/15.	4) EMS P1 urban response under 15 minutes rate	66.8%	75.0%	70.9%	(5.4%)	Notwithstanding the challenges faced by EMS, and recognising that the performance falls short of the target by approximately 5%, it is an improvement on the previous financial year. This remains encouraging given that call volume was increased by almost 20 000 cases during the year.
			Numerator:	109 720	124 759	130 899	4.9%	
			Denominator:	164 131	166 345	184 584	11.0%	
			5) EMS P1 rural response under 40 minutes rate	87.2%	90.0%	85.3%	(5.2%)	Despite rural call volumes increasing more than expected. EMS has managed to maintain a stable performance through strict operational control. Some of the districts exceed the target (Central Karoo and West Coast) but the low performance in other districts brings down the overall performance.
			Numerator:	22 454	21 253	25 234	18.7%	
			Denominator:	25 757	23 615	29 588	25.3%	
			6) EMS P1 call response under 60 minutes rate	Not required to report	97.0%	96.5%	(0.5%)	The performance throughout the year has been stable and is likely to remain so in the foreseeable future. EMS shall endeavour to improve on this throughout the new financial year.
			Numerator:	-	184 262	206 626	12.1%	
			Denominator:	-	189 960	214 172	12.7%	
			7) EMS all calls response under 60 minutes rate	77.3%	80.0%	78.2%	(2.3%)	In Cape Town the proportion of inter-hospital transfers (IHT) calls are greater. This coupled with bed pressures in the city platform continue to impact on this indicator.
			Numerator:	405 580	411 788	482 035	17.1%	
			Denominator:	524 398	514 735	616 645	19.8%	

Programme 3: Emergency Medical Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
	1.3 Manage all patients at the appropriate level of care within the appropriate packages of care.	1.3.1 To meet the patient response, transport and inter-hospital transfer needs of the Department in line with the 90:10 CSP model by realigning the configuration of the EMS service by 2014/15.	8) Percentage of ambulance patients transferred between facilities	21.1%	21.8%	23.0%	5.0%	IHT calls remain above 40% of the overall workload. This has an impact on the Priority 2 response times.
			Numerator:	146 737	140 486	169 450	20.6%	
			Denominator:	694 507	645 457	739 981	14.6%	

Strategies to overcome areas of under-performance

The primary goal of EMS is to deliver quality clinical care to the community within the fastest possible timeframes. Unfortunately, the last financial year saw EMS missing the Priority 1 targets in both urban and rural areas by approximately 5 percentage points in both areas.

EMS has undertaken an aggressive plan to address service needs that include, amongst others, the implementation of advanced technology solutions that will monitor vehicle location and assist in intelligent resource utilisation, staff training programmes to deliver more advanced levels of care (emergency care technician (ECT) and emergency care practitioner (ECP)) to the community.

EMS has also prioritised the filling of vacant posts to ensure that clinical and support functions operate optimally in order to deliver the most efficient service.

The continuation of the learnership programme will also assist to recognise and groom future EMS colleagues and bolster the operational complement within the organisation.

Changes to planned targets

No targets were changed during the year.

Linking performance with budgets

Table 4.3.3: Summary of expenditure for Emergency Medical Services 2013/14

Expenditure	2013/14			2012/13		
Sub-programme	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000
3.1: Emergency Medical Services	756 822	755 571	1 251	633 821	622 802	11 019
3.2: Planned patient transport (PPT) – HealthNET	62 926	64 177	(1 251)	61 906	52 712	9 194
Total	**819 748**	**819 748**	**-**	**695 727**	**675 514**	**20 213**

As noted from the audited financial statement, EMS was able to achieve a zero over/under-expenditure in the 2013/14 financial year – in contrast with the R20 million under-expenditure in the previous financial year.

Targeted expenditure was met in both EMS operations and planned patient transport allowing EMS to focus on service delivery and achieving performance targets.

Key spends in this financial year include:

- The Bid 800 (EMS Evolution) technology system

EMS hopes to achieve similar financial performance in the coming financial year, noting however that costs will increase in the Bid 800 solution due to the exchange rate.

4.4 Programme 4: Provincial Hospital Services

Purpose of the programme

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

Sub-programmes

Sub-programme 4.1: General (Regional) Hospitals

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

Sub-programme 4.2: Tuberculosis Hospitals

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

Sub-programme 4.3: Psychiatric Hospitals

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

Sub-programme 4.4: Rehabilitation Services

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

Sub-programme 4.5: Dental Training Hospitals

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

GENERAL (REGIONAL) HOSPITALS

Strategic objectives

(1) Ensure access to regional hospitals services by providing 1 375 regional hospital beds by 2014/15.

(2) Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies at a target of 39.6 per cent by 2014/15.

(3) Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R2 112 per PDE by 2014/15 [2011/12 Rands].

(4) Efficiently manage the allocated resources of regional hospitals to achieve a target bed utilisation rate of 84.4 per cent and an average length of stay of 3.9 days by 2014/15.

(5) Implement quality assurance measures to minimise patient risk in regional hospitals by monthly mortality and morbidity meetings by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

This sub-programme funds regional hospital services in New Somerset and Mowbray Maternity Hospitals, in the Cape Town Metro District, and Paarl, Worcester and George Hospitals in the rural districts. The reconfiguration and strengthening of these hospitals continued as they focused on the provision of general specialist services with continued outreach and support to district hospitals. Management structures in the geographic service areas have created better service co-ordination and communication between institutions across levels of care.

Address the burden of disease

General specialist services continued to be strengthened within regional hospitals and access to these services were provided with a total of 1 373 beds achieving an overall bed occupancy rate of 87.6 per cent and an average length of stay of 3.7 days.

Anaesthetics, obstetrics and gynaecology, and paediatric district specialist teams, based at New Somerset and the three rural regional hospitals, provided support for the respective geographic service areas. The George Hospital team developed considerable experience with laparoscopic sterilisation marathons in the Eden and Central Karoo Districts. Since 2008 the George Hospital team have performed 750 sterilisations under general anaesthetic during surgical marathons, mostly in district hospitals as part of outreach and support.

Maternal, women's, neonatal and child health was strengthened by outreach specialist services. The caesarean section rate for 2013/14 was 41.1 per cent. While this appears to be high, it must be noted that when all deliveries for the geographic area is factored into the calculation, this dramatically drops. Caesarean sections are usually authorised by a specialist. Significant gains were made in improving perinatal mortality rates at Mowbray Maternity Hospital. Paarl Hospital achieved the baby friendly initiative status.

New Somerset Hospital continued to improve responsiveness to the diarrhoeal season by providing additional support to the service platform in the Cape Town Metro District. The strategy to manage the surge of paediatric patients was prepared by a multi-disciplinary team at New Somerset Hospital. Nine temporary additional paediatric beds were opened for the season. There was no mortality caused by acute diarrhoea at the hospital. Associated malnutrition was common and these cases were referred for community nutritional support and follow up.

Elective surgery backlogs were reduced. Patients previously referred to Tygerberg Hospital, are now treated at the hand surgery clinic at Paarl Hospital. The additional theatre opened at New Somerset Hospital had a significant impact on the general surgical services and

ear, nose and throat surgical services, as this allowed for emergency cases to be attended to without having to cancel elective lists.

The George Hospital team performed 1 127 cataract surgery operations during 2013/14 of which 66 per cent were patients operated on in rural district hospitals, compared to 1 019 during 2012/13.

Infectious disease management was improved by focussing on occupational health risks to staff and other patients through contact with TB patients. A ventilation system was installed at New Somerset Hospital, allowing for additional TB isolation facilities. This was a major step forward in preventing transmission of sensitive TB to other patients and staff.

Long waiting times in the emergency centre at Paarl Hospital remained a challenge as there are no extended hours at primary health care facilities in the Drakenstein Sub-district. Locum clinicians have been appointed to address this challenge.

Optimal financial management to maximise health outcomes

Equitable budgets were allocated that aligned with the expected outcomes to deliver an optimal service at an average cost of R2 046 per patient day equivalent. Regional hospitals demonstrated strong financial control as they were able to absorb the significant additional patient workload of 3.7 per cent while still providing an acceptable level of health care. This is a significant improvement on the previous reporting period where the targeted expenditure per patient day equivalent was exceeded by 4.3 per cent.

Supply chain management processes improved overall within hospitals. Mini contracts, for example patient food, were established to ensure uninterrupted service delivery.

Overall improvement in procurement processes led to a reduction in irregular expenditure as the importance of financial compliance was emphasised with all hospital managers.

Posts were filled in accordance with the approved post list (APL) and the financial year was ended at 96.2 per cent of the APL. The affordable APL was funded at 95.9 per cent.

Cost containment strategies included the monitoring of agency staff expenditure, blood and related products, electricity, laboratory services and medical and surgical supplies. The cost containment strategies were reported on a monthly basis at the Focus Financial Monitoring Committee to ensure the optimal utilisation of allocated budgets and creating savings that could be channelled to other service areas.

The implementation of functional business units (FBU) remained a priority and was monitored by the steering committee as chaired by the accounting officer, emphasising the importance of this priority within the Department of Health. Accountability at cost centre level is a key factor in ensuring the successful implementation of this process. Paarl Hospital was the first hospital to implement the FBU model.

Ensure and maintain organisational strategic management capacity and synergy

All chief executive officer management posts were appropriately filled at regional hospitals, ensuring the improved management competency to facilitate a well-functioning health system. A visit from the Public Protector to Paarl Hospital during 2013 confirmed to the media that Paarl Hospital was one of the well-managed hospitals. [*Cape Argus, Die Burger, 13 September 2013*]

The unified approach towards service delivery within geographical service areas ensured improved co-operation between clinicians and healthcare workers to enable patients experiencing a seamless continuity of care.

Although the concept of functional business units (FBUs) were designed for creating financial accountability, the clinical outputs are monitored within these units to ensure that targets are met, beds are optimally utilised and that average lengths of stay are monitored. Fully operational FBUs will enhance accountability, improve efficiency and improve the quality of care.

Training and development of the workforce continued to improve competencies and allocated budgets were appropriately spent.

Each hospital developed an Annual Operational Plan (AOP), which provided an overview of the expected and achieved deliverables.

Accurate and timeous clinical information provided to managers was meaningfully analysed to improve the quality of care.

Improve the quality of health services and the patient experience

A dedicated drive by management to make healthcare more person-centred, accessible and safe, improved the overall quality of care.

Findings in the annual patient satisfaction survey were analysed and continued efforts were made to improve staff attitudes, reduce waiting times, ensure clean facilities, ensure the safety of patients and staff, avoid transmission of infections and ensure the availability of medical supplies. The overall patient satisfaction rate of 89.2 per cent exceeded the target set.

Quality of services was improved through monthly mortality and morbidity reviews and through acting appropriately on recommendations and findings. The mortality and morbidity review rate was 133.5 per cent, exceeding the target set as more meetings were held than initially planned and contributing to the overall improvement of clinical quality care.

Adverse incidents and patient complaints were investigated and the complaint resolution rate within 25 working days for regional hospitals was 91.57 per cent, an improvement from the previous financial year, reflecting the strategy to enhance the patient experience within health services.

The adherence to the identified priorities extracted from the National Core Standards were assessed and used to improve the overall quality of care. All regional hospitals conducted the compliance assessments. New Somerset Hospital introduced hand washing bottles next to the majority of beds in the medical wards, resulting in a doubling of the frequency of hand washing.

Table 4.4.1: Strategic objectives for General (Regional) Hospitals 2013/14

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Ensure access to general specialist hospital services.	1.1.1 Ensure access to regional hospital services by providing 1 375 regional hospital beds by 2014/15.	1) Number of usable beds (in regional hospitals)	1 375	1 375	1 373	(0.1%)	Target was set prior to final planned bed numbers. The approval for the adjusted bed numbers were not yet obtained from the Accounting Officer at the time the target was set.
	1.2 Reduce facility maternal mortality.	1.2.1 Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies at a target of 39.6% by 2014/15.	2) Delivery by caesarean section rate (in regional hospitals)	39.6%	39.6%	41.1%	3.8%	All caesarean sections are evaluated and authorised by a specialist consultant. A higher proportion of deliveries in regional hospitals than anticipated resulted in increased caesarean sections.
			Numerator:	10 665	10 613	11 347	6.9%	This indicator only includes deliveries at the regional hospitals and excludes the large proportion of deliveries within the geographic area happening at maternity obstetric units (MOUs) and district hospitals. The caesarean section rate for the geographic area is therefore significantly less.
			Denominator:	26 961	26 821	27 613	3.0%	
2. Optimal financial management to maximise health outcomes.	2.1 Allocate sufficient funds to ensure the sustained delivery of the full package of quality regional hospital services.	2.1.1 Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R2 112 per PDE by 2014/15 [2011/12 Rands].	3) Expenditure per patient day equivalent (PDE) (in regional hospitals) [2011/12 Rands]	R 1 922	R2 117	R 2 046	(3.4%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	1 069 760 958	1 175 663 183	1 179 437 376	0.3%	Regional hospitals demonstrated strong financial control as they were able to absorb the significant additional patient workload of 3.8% while still providing an acceptable level of health care. This is a significant improvement on the prior period where the targeted expenditure per patient day equivalent was exceeded by 4.3%.
			Denominator:	556 471	555 272	576 489	3.8%	

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1 Efficiently manage the allocated resources of regional hospitals to achieve a target bed utilisation rate of 84.4% and an average length of stay of 3.9 days by 2014/15.	4) Inpatient bed utilisation rate (based on usable beds in regional hospitals)	84.6%	84.3%	87.6%	4.0%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	423 968	423 056	438 392	3.6%	Performance higher than anticipated due to an increase in workload resulting in an increase in inpatient days and a concomitant higher bed utilisation rate.
			Denominator:	500 957	501 875	500 226	(0.3%)	
			5) Average length of stay (in regional hospitals)	3.9 days	3.9 days	3.7 days	(3.9%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	423 968	423 056	438 392	3.6%	
			Denominator:	108 914	107 943	117 015	8.4%	Due to the increased services pressures, the patients admitted to regional hospitals stayed for a marginally shorter period than anticipated.
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Implement quality assurance measures to minimise patient risk in regional hospitals by monthly mortality and morbidity meetings by 2014/15.	6) Mortality and morbidity review rate (in regional hospitals)	Not required to report	100.0%	133.5%	33.5%	The new definition for morbidity and mortality (M&M) review rate counts all meetings held in the hospital. More meetings were conducted than planned, resulting in improved clinical governance and enhancing the overall quality of patient care.
			Numerator:	-	170	227	33.5%	
			Denominator:	-	170	170	0.0%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.4.2: Performance indicators for General (Regional) Hospitals 2013/14

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Ensure access to general specialist hospital services.	1.1.1 Ensure access to regional hospital services by providing 1 375 regional hospital beds by 2014/15.	1) Number of usable beds (in regional hospitals)	1 375	1 375	1 373	(0.1%)	Target was set prior to final planned bed numbers. The approval for the adjusted bed numbers were not yet obtained from the Accounting Officer at the time the target was set.
			2) Inpatient separations - total (in regional hospitals)	108 914	107 943	117 015	8.4%	The overall increase of 7% compared to 2012-13 in separations is mainly as a result of an increase in separations at Mowbray Maternity Hospital. The reason for the increase was as a result of a correction in patient administration processes. Previously the hospital was not admitting all their sick babies as inpatients, resulting in an undercount. Correction to this process in 2013-14 has had a significant increase (26%) in the number of separations at Mowbray Maternity Hospital.
			3) Patient day equivalents (PDE) - total (in regional hospitals)	556 471	555 272	576 489	3.8%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Increased patient numbers together with increased OPD outputs resulted in a higher PDE than anticipated.
			4) OPD headcount - total (in regional hospitals)	243 365	242 529	258 146	6.4%	The corrections of the Clinicom OPD visit types had a slight impact on the increased patient numbers. The corrections were done after the target was set in the APP. Significant increases in new referred cases at Mowbray Maternity Hospital and follow-up cases at New Somerset Hospital added to the increase in numbers that were not anticipated.
	1.2 Reduce facility maternal mortality.	1.2.1 Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies at a target of 39.6% by 2014/15.	5) Delivery by caesarean section rate (in regional hospitals)	39.6%	39.6%	41.1%	3.8%	All caesarean sections are evaluated and authorised by a specialist consultant. A higher proportion of deliveries in regional hospitals than anticipated resulted in increased caesarean sections.
			Numerator:	10 665	10 613	11 347	6.9%	This indicator only includes deliveries at the regional hospitals and excludes the large proportion of deliveries within the geographic area happening at maternity obstetric units (MOUs) and district hospitals. The caesarean section rate for the geographic area is therefore significantly less.
			Denominator:	26 961	26 821	27 613	3.0%	

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
2. Optimal financial management to maximise health outcomes.	2.1 Allocate sufficient funds to ensure the sustained delivery of the full package of quality regional hospital services.	2.1.1 Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R2 112 per PDE by 2014/15 [2011/12 Rands].	6) Expenditure per patient day equivalent(PDE) (in regional hospitals) [2011/12 Rands]	R 1 922	R 2 117	R 2 046	(3.4%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	1 069 760 958	1 175 663 183	1 179 437 376	0.3%	Regional hospitals demonstrated strong financial control as they were able to absorb the significant additional patient workload of 3.8% while still providing an acceptable level of health care. This is a significant improvement on the prior period where the targeted expenditure per patient day equivalent was exceeded by 4.3%.
			Denominator:	556 471	555 272	576 489	3.8%	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1 Efficiently manage the allocated resources of regional hospitals to achieve a target bed utilisation rate of 84.4% and an average length of stay of 3.9 days by 2014/15.	7) Inpatient bed utilisation rate (based on usable beds in regional hospitals)	84.6%	84.3%	87.6%	4.0%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	423 968	423 056	438 392	3.6%	Performance higher than anticipated due to an increase in workload resulting in an increase in inpatient days and a concomitant higher bed utilisation rate.
			Denominator:	500 957	501 875	500 226	(0.3%)	
			8) Average length of stay (in regional hospitals)	3.9 days	3.9 days	3.7 days	(3.9%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	423 968	423 056	438 392	3.6%	
			Denominator:	108 914	107 943	117 015	8.4%	Due to the increased services pressures, the patients admitted to regional hospitals stayed for a marginally shorter period than anticipated.
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Implement quality assurance measures to minimise patient risk in regional hospitals by monthly mortality and morbidity meetings by 2014/15.	9) Complaint resolution within 25 working days rate (from users of regional hospitals)	87.4%	92.2%	91.57%	(0.7%)	The reporting system has improved as has the health service's focus on improving the person-centred experience, resulting in fewer complaints lodged.
			Numerator:	389	411	380	(7.5%)	
			Denominator:	445	446	415	(7.0%)	
			10) Hospital patient satisfaction rate (in regional hospitals)	84.0%	80.0%	89.2%	11.5%	The performance standards of the hospitals improved as guided by the national core standards, resulting in more patients being satisfied with the treatment received.
			Numerator:	2 434	2 800	3 115	11.3%	
			Denominator:	2 898	3 500	3 491	0.3%	

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
			11) Percentage of regional hospitals assessed for compliance against the 6 priorities of the core standards (NIDS: Facility core standards self-assessment rate in regional hospitals)	100.0%	0.0%	100.0%	100.0%	All hospitals conducted compliance assessments as per the national core standards. Since all five hospitals conducted assessments in the previous year, it was not initially planned for the hospitals to repeat the assessments in 2013/14.
			Number of regional hospitals assessed for compliance against the 6 priorities of the core standards					
			Numerator:	5	0	5	100.0%	
			Denominator:	5	5	5	0.0%	
			12) Morbidity and mortality review rate (in regional hospitals)	Not required to report	100.0%	133.5%	33.5%	The new definition for morbidity and mortality (M&M) review rate counts all meetings held in the hospital. More meetings were conducted than planned, resulting in improved clinical governance and enhancing the overall quality of patient care.
			Numerator:	-	170	227	33.5%	
			Denominator:	-	170	170	0.0%	

Strategies to overcome areas of under-performance

Improving the gaps in quality, safety, equity and access remains a key strategy for this sub-programme. The rising cost of healthcare remains a reality and managers will continue to target the areas of waste and ensure that resources are equitably allocated to improve the overall value in the regional hospitals.

Where necessary, clinical process redesign will be implemented to improve quality health care and limit growth in costs. The role of the functional business units is key to these improvements.

Specifically at Mowbray Maternity Hospital, the level 1 service will be moved out to the Mitchells Plain District Hospital to ensure that the services are rendered at the appropriate level. The Hanover Park MOU level 1 and 2 services will be shifting from New Somerset Hospital to Mowbray Maternity Hospital. The operating hours for a second theatre will be expanded at Mowbray Maternity Hospital to reduce waiting times. These incremental changes will ensure that the health system adjusts at a pace when all levels of care are capacitated to sustain the changes.

The performance standards within the National Core Standards will be used to:

- Create reliable and comparative performance information to make informed decisions.
- Ensure hospital management teams are held accountable for the quality and efficiency of their performance.
- Support quality improvement activities.

Changes to planned targets

No targets were changed during the year.

TUBERCULOSIS HOSPITALS

Strategic objectives

(1) Ensure access to the full package of TB hospital services by providing 1 054 TB hospital beds by 2014/15.

(2) Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R642 per PDE by 2014/15 [2011/12 Rands].

(3) Effectively manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 79.3 per cent and an average length of stay of 78.3 days by 2014/15.

(4) Implement quality assurance measures to minimise patient risk in TB hospitals by monthly mortality and morbidity meetings by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

Address the burden of disease

TB hospitals saw a levelling off of admissions as the Department has embarked on a strategy of decentralising the management of drug-resistant TB cases.

Optimal financial management to maximise health outcomes

The Department has a number of internal tools (such as the budget management instrument and the approved post list) and processes that are designed to monitor and control expenditure and pursue effectiveness and efficiency. The District Health Expenditure Review (DHER) tool is also used to monitor equity on a district and sub-district level.

Ensure and maintain organisational strategic management capacity and synergy

The TB hospitals cannot function in isolation and must work in synergy with PHC services, where the majority of TB patients are managed, acute hospitals, which is their primary source of referrals, and the HIV service, given the dual relationship between TB and HIV.

Improve the quality of health services and the patient experience

Client satisfaction surveys, as an indicator of the patient experience, show a high level of patient satisfaction with health services (approximately 90 per cent general satisfaction for TB hospitals).

Patient complaints resolution within 25 working days was above 80 per cent for TB hospitals. There was a commitment to improving the patient experience where deficiencies were highlighted by patients.

Health service quality of care performance is reflected in the fact that more than 90 per cent of TB hospitals held the requisite morbidity and mortality meetings. Preparation for, and the conducting of, national core standards gap assessments is still in an early phase and this can be expected to expand in the new financial year.

Table 4.4.3: Strategic objectives for Tuberculosis Hospitals 2013/14

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Ensure access to TB hospital services.	1.1.1 Ensure access to the full package of TB hospital services by providing 1 054 TB hospital beds by 2014/15.	1) Number of usable beds (in TB hospitals)	1 021	1 054	1 026	(2.9%)	On the basis of updated PDE and separation information (mentioned below), the Department did not think it prudent to increase the number of TB beds during the course of the year.
2. Optimal financial management to maximise health outcomes.	2.1 Allocate sufficient funds to ensure the sustained delivery of the full package of quality TB hospital services.	2.1.1 Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R642 per PDE by 2014/15. [2011/12 Rands].	2) Expenditure per patient day equivalent (PDE) - total (in TB hospitals) [2011/12 Rands]	R 649	R644	R729	13.2%	Actual expenditure is within 0.8% of target but the indicator creates a more expensive cost per PDE because the PDEs are 11% lower than projected (for reasons explained above). Notwithstanding the reduced PDE, cost per patient is likely to be higher than before because of the increasing costs of MDR treatment.
			Numerator:	187 295 631	197 232 045	198 807 605	0.8%	
			Denominator:	288 559	306 325	272 789	(10.9%)	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1 Effectively manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 79.3% and an average length of stay of 78.3 days by 2014/15.	3) Inpatient bed utilisation rate (based on usable beds in TB hospitals)	76.3%	79.3%	72.3%	(8.8%)	See comment for inpatient separations above.
			Numerator:	286 498	305 184	270 148	(11.5%)	
			Denominator:	375 413	384 710	373 466	(2.9%)	
			4) Average length of stay (in TB hospitals)	76.1 days	78.3 days	73.7 days	5.8%	Less MDR cases were admitted (as a result of the decentralisation policy) and since these cases were contributing to an increased length of stay, the ALOS has declined concomitantly.
			Numerator:	286 498	305 184	270 148	(11.5%)	
			Denominator:	3 764	3 896	3 664	(6.0%)	
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Implement quality assurance measures to minimise patient risk in TB hospitals by monthly mortality and morbidity meetings by 2014/15.	5) Mortality and morbidity review rate (in TB hospitals)	Not required to report	100.0%	132.0%	32.0%	This target was reached but the fact that it was >100% suggests that the proper use of the definition of morbidity and mortality meeting needs to be correctly applied. Each hospital should report only one each month but in certain instances reported more because different departments conducted such reviews.
			Numerator:	-	50	66	32.0%	
			Denominator:	-	50	50	0.0%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.4.4: Performance indicators for Tuberculosis Hospitals 2013/14

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Ensure access to TB hospital services.	1.1.1 Ensure access to the full package of TB hospital services by providing 1 054 TB hospital beds by 2014/15.	1) Number of usable beds (in TB hospitals)	1 021	1 054	1 026	(2.9%)	On the basis of updated PDE and separation information (mentioned below), the Department did not think it prudent to increase the number of TB beds during the course of the year.
			2) Inpatient separations - total (in TB hospitals)	3 764	3 896	3 664	(6.0%)	Two general trends are responsible for a reduction in TB admissions (which reflects in this indicator, as well as PDEs, bed utilisation rate (BUR) and average length of stay (ALOS)). The first is that increasingly widespread ART coverage is likely to be causing a reduction in observed patient acuity (i.e. patients, in general, are less 'sick' from TB since ART has been achieving good population coverage). The second is the policy of decentralised (in-community) TB care for MDR-TB which has freed up TB hospital beds.
			3) Patient day equivalents (PDE) total (in TB hospitals)	288 599	306 325	272 789	(10.9%)	See comment for inpatient separations above.
			4) OPD total headcount (in TB hospitals)	6 302	5 958	7 924	33.0%	The x-ray and audiology departments at the Metro complex hospitals were busier than expected. The x-ray department see referrals from PHC clinics in the vicinity. The numbers referred from these clinics are much higher than the previous year when the arrangement to see these patients was still in the beginning phase. The audiology department get referrals from all over the Metro and from the West Coast and Winelands Districts (Malmesbury ID Hospital and Sonstraal Hospital). All the patients who initiated MDR treatment in-community are referred to the audiology department.
2. Optimal financial management to maximise health outcomes.	2.1 Allocate sufficient funds to ensure the sustained delivery of the full package of quality TB hospital services.	2.1.1 Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R642 per PDE by 2014/15 [2011/12 Rands].	5) Expenditure per patient day equivalent (PDE) - total (in TB hospitals) [2011/12 Rands]	R 649	R644	R729	13.2%	Actual expenditure is within 0.8% of target but the indicator creates a more expensive cost per PDE because the PDEs are 11% lower than projected (for reasons explained above). Notwithstanding the reduced PDE, cost per patient is likely to be higher than before because of the increasing costs of MDR treatment.
			Numerator:	187 295 631	197 232 045	198 807 605	0.8%	
			Denominator:	288 559	306 325	272 789	(10.9%)	

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1 Effectively manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 79.3% and an average length of stay of 78.3 days by 2014/15.	6) Inpatient bed utilisation rate (based on usable beds in TB hospitals)	76.3%	79.3%	72.3%	(8.8%)	See comment for inpatient separations above.
			Numerator:	286 498	305 184	270 148	(11.5%)	
			Denominator:	375 413	384 710	373 466	(2.9%)	
			7) Average length of stay (in TB hospitals)	76.1 days	78.3 days	73.7 days	5.8%	Less MDR cases were admitted (as a result of the decentralisation policy) and since these cases were contributing to an increased length of stay, the ALOS has declined concomitantly.
			Numerator:	286 498	305 184	270 148	(11.5%)	
			Denominator:	3 764	3 896	3 664	(6.0%)	
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Implement quality assurance measures to minimise patient risk in TB hospitals by monthly mortality and morbidity meetings by 2014/15.	8) Complaint resolution within 25 working days rate (from users of TB hospitals)	69.1%	76.5%	100.0%	30.7%	Performance was above expectations.
			Numerator:	47	156	44	(71.8%)	
			Denominator:	68	204	44	(78.4%)	
			9) Hospital patient satisfaction rate (in TB hospitals)	87.8%	85.6%	89.6%	4.7%	Performance was above expectations
			Numerator:	469	518	398	(23.2%)	
			Denominator:	534	605	444	(26.6%)	
			10) Percentage of TB hospitals assessed for compliance against the 6 priorities of the core standards (NIDS: Facility core standards self-assessment rate in TB hospitals)	0.0%	40.0%	16.7%	(58.3%)	Two TB hospitals did complete national core standards gap assessments according the Provincial Quality Assurance office. All TB hospitals should undergo such assessments in the new year given the establishment of the Office of Health Standards Compliance.
			Number of TB hospitals assessed for compliance against the 6 priorities of the core standards					
			Numerator:	0	2	1	(50.0%)	
			Denominator:	5	5	6	20.0%	
			11) Morbidity and mortality review rate (in TB hospitals)	Not required to report	100.0%	132.0%	32.0%	This target was reached but the fact that it was >100% suggests that the proper use of the definition of morbidity and mortality meeting needs to be correctly applied. Each hospital should report only one each month but in certain instances reported more because different departments conducted such reviews.
			Numerator:	-	50	66	32.0%	
			Denominator:	-	50	50	0.0%	

Strategies to overcome areas of under-performance

Refer to performance table.

Changes to planned targets

No targets were changed during the year.

PSYCHIATRIC HOSPITALS

Strategic objectives

(1) Ensure access to the full package of psychiatric hospital services by providing 1 698 psychiatric hospital beds by 2014/15.

(2) Allocate sufficient funds to ensure the delivery of the full package of psychiatric hospital services at a rate of R1 090 per PDE by 2014/15 [2011/12 Rands].

(3) Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 89.0 per cent and an average length of stay of 89.4 days by 2014/15.

(4) Implement quality assurance measures to minimise patient risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

This sub-programme funds four psychiatric hospitals, two sub-acute facilities and the Mental Health Review Board located in the Cape Town Metro District. These facilities support the integration of mental health services into general care settings in line with the Mental Health Care Act 17 of 2002 and provide access to the full package of psychiatric hospital services. The four psychiatric hospitals are Alexandra, Lentegeur, Stikland and Valkenberg. The sub-acute facilities are New Beginnings, supported by Stikland Hospital and William Slater, supported by Valkenberg Hospital.

Acute and chronic intellectual disability services for patients with intellectual disability and mental illness, or severe challenging behaviour, are provided at Lentegeur and Alexandra hospitals.

Acute psychiatric services are provided at Lentegeur, Stikland and Valkenberg hospitals including a range of specialised therapeutic programmes.

Forensic psychiatric services include observation services for awaiting trial prisoners (at Valkenberg Hospital only) and state patient services for people who have been found unfit to stand trial (at Valkenberg and Lentegeur hospitals).

Address the burden of disease

The sub-programme continued to manage the acute burden of disease of mentally ill patients, by providing a total of 1 698 beds in psychiatric hospitals and 145 beds in the two sub-acute facilities.

In order to address the pressure on acute services and facilitate support services for patients discharged early, Stikland Hospital initiated an after discharge support service. Patients are followed up telephonically during the first 90 days after discharge by members of the clinical team. This service is currently offered in Bishop Lavis, Elsies River, Ravensmead and Bellville South and intends to facilitate and support community care for an interim period before handing the patient over to the district health services.

In the period when Mitchells Plain Hospital was commissioned and GF Jooste Hospital was decommissioned, patients were managed by specialist receiving teams. The focus remained on the management of behaviourally disturbed patients.

Community support remained a priority in reducing the re-admission rate of patients to psychiatric hospitals. Data has been collected to monitor the re-admission rate specifically in these hospitals to ensure targeted interventions to reduce the "revolving door syndrome" of patients.

The sub-acute facilities continued to relieve pressure in the acute psychiatric services by providing a continuum of care from acute hospital to community-based residential services. Intensive psycho-social rehabilitation services were provided for patients that required a longer stay in the semi institutional structured environment.

Outreach and support were provided from the psychiatric hospitals to the acute regional and district hospitals.

Optimal financial management to maximise health outcomes

Budgets were equitably allocated to align with the expected deliverables and the average cost per patient day equivalent was R1 106. The budget remained under pressure for this sub-programme as the patient days increased in the acute service areas adding to the increased cost per patient day equivalent.

The National Department of Justice paid an amount of R12 306 028 for the forensic psychiatric observation services rendered at Valkenberg Hospital.

Ensure and maintain organisational strategic management capacity and synergy

Engagement within the geographical service areas ensured the management of the acute psychiatric service pressures across the platform.

The Provincial Clinical Governance Committee ensured the optimal clinical governance of mental health services across the service platform through policies, protocols and guidelines.

The implementation of functional business units (FBU) remained a priority and the implementation of this management model was monitored by the steering committee as chaired by the accounting officer, emphasising the importance of this priority within the Department of Health.

Each hospital developed an annual operational plan (AOP) which provided an overview of the expected and achieved deliverables.

Improve the quality of health services and the patient experience

Monthly mortality and morbidity review meetings (rate achieved was 120 per cent) were held ensuring the monitoring of adverse as well as safety and security incidents to improve the management of clinical risks.

The results from the client satisfaction surveys were assessed and 84.5 per cent of respondents indicated that they were generally satisfied with the way they were treated in psychiatric hospitals.

Staff satisfaction survey results were tabled with management at the end of the financial year, and recommendations will be implemented during 2014/15.

Adherence to the identified priorities extracted from the National Core Standards were assessed and used to improve the overall quality of care. All psychiatric hospitals conducted compliance assessments.

Table 4.4.5: Strategic objectives for Psychiatric Hospitals 2013/14

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Address the burden of disease by ensuring access to psychiatric hospital services.	1.1.1 Ensure access to the full package of psychiatric hospital services by providing 1 698 psychiatric hospital beds by 2014/15.	1) Number of usable beds (in psychiatric hospitals)	1 698	1 698	1 698	0 0%	Target achieved.
2. Optimal financial management to maximise health outcomes.	2.1 Allocate sufficient funds to ensure the sustained delivery of the full package of quality psychiatric hospital services.	2.1.1 Allocate sufficient funds to ensure the delivery of the full package of psychiatric hospital services at a rate of R1 090 per PDE by 2014/15 [2011/12 Rands].	2) Expenditure per patient day equivalent (PDE) total (in psychiatric hospitals) [2011/12 Rands]	R 1 023	R1 090	R1 106	1.5%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	570 926 545	610 395 650	629 874 490	3.2%	On-going acute service pressures and increased OPD outputs resulted in a higher PDE. Overflow beds were opened at Valkenberg Hospital, resulting in increased cost. This sub-programme remained under constant budget pressure the past financial year.
			Denominator:	558 133	560 228	569 423	1.6%	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1 Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 89.0% and an average length of stay of 89.4 days by 2014/15.	3) Inpatient bed utilisation rate (based on usable beds in psychiatric hospitals)	88.5%	88.9%	89.7%	0.9%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	548 596	551 149	555 745	0.8%	The bed utilisation rate in psychiatric hospitals as a result of the acute service pressures was marginally higher than anticipated.
			Denominator:	619 838	619 770	619 838	0.0%	
			4) Average length of stay (in psychiatric hospitals)	90.3 days	89.4 days	91.4 days	2.2%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	548 596	551 149	555 745	0.8%	
			Denominator:	6 079	6 166	6 080	(1.4%)	On average patients stayed longer than anticipated due to the acuity of mental illness.

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services and the patient experience.	4.1.1 Implement quality assurance measures to minimise patient risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014/15.	5) Mortality and morbidity review rate (in psychiatric hospitals)	Not required to report	100.0%	120.0%	20.0%	The new definition for "M&M reviews" counts all meetings held in the hospital. More meetings were conducted than planned, but resulted in improved clinical governance enhancing the overall quality of patient care.
			Numerator:	-	40	48	20.0%	
			Denominator:	-	40	40	0.0%	
Strategic objectives for Step-down beds								
1. Address the burden of disease.	1.1 Address the burden of disease by ensuring access to step-down facilities.	1.1.1 Provide a total of 145 step-down beds and maintain a bed occupancy rate of 82.6% in sub-acute facilities by 2014/15.	1) Number of usable beds (in step-down facilities)	145	145	145	0.0%	Target achieved, zero deviation.
			2) Inpatient bed utilisation rate (in step-down facilities)	83.8%	82.6%	82.2%	(0.5%)	Minimal fluctuation in patient activity. The inpatient bed utilisation rate was lower than anticipated.
			Numerator:	44 365	43 694	43 504	(0.4%)	
			Denominator:	52 931	52 925	52 931	0.0%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.4.6: Performance indicators for Psychiatric Hospitals 2013/14

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Address the burden of disease by ensuring access to psychiatric hospital services.	1.1.1 Ensure access to the full package of psychiatric hospital services by providing 1 698 psychiatric hospital beds by 2014/15.	1) Number of usable beds (in psychiatric hospitals)	1 698	1 698	1 698	0 0%	Target achieved.
			2) Inpatient separations - total (in psychiatric hospitals)	6 079	6 166	6 080	(1.4%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. There were less inpatient separations from psychiatric hospitals than anticipated, due to the increased length of stay.
			3) Patient day equivalents (PDE) total (in psychiatric hospitals)	558 133	560 228	569 423	1.6%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Acute service group increases mainly at Stikland Hospital due to day centre appointments and attendances that were not recorded previously on the system. Valkenberg added an additional 20 overflow beds to the medium secure unit.
			4) OPD headcount total (in psychiatric hospitals)	28 611	27 235	41 034	50.1%	Acute service group increases mainly at Stikland Hospital due to day centre appointments and attendances that were not recorded previously on the system. The day centre caters for patients who receive group therapy and do some activities to develop their skills on a daily basis. These services are rendered by the occupational therapists.
2. Optimal financial management to maximise health outcomes.	2.1 Allocate sufficient funds to ensure the sustained delivery of the full package of quality psychiatric hospital services.	2.1.1 Allocate sufficient funds to ensure the delivery of the full package of psychiatric hospital services at a rate of R1 090 per PDE by 2014/15 [2011/12 Rands].	5) Expenditure per patient day equivalent (PDE) total (in psychiatric hospitals) [2011/12 Rands]	R 1 023	R1 090	R1 106	1.5%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Ongoing acute service pressures and increased OPD outputs resulted in a higher PDE. Overflow beds were opened at Valkenberg Hospital, resulting in increased cost. This sub-programme remained under constant budget pressure the past financial year.
			Numerator:	570 926 545	610 395 650	629 874 490	3.2%	
			Denominator:	558 133	560 228	569 423	1.6%	

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1 Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 89.0% and an average length of stay of 89.4 days by 2014/15.	6) Inpatient bed utilisation rate (based on usable beds in psychiatric hospitals)	88.5%	88.9%	89.7%	0.9%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	548 596	551 149	555 745	0.8%	The bed utilisation rate in psychiatric hospitals as a result of the acute service pressures was marginally higher than anticipated.
			Denominator:	619 838	619 770	619 838	0.0%	
			7) Average length of stay (in psychiatric hospitals)	90.3 days	89.4 days	91.4 days	2.2%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	548 596	551 149	555 745	0.8%	
			Denominator:	6 079	6 166	6 080	(1.4%)	On average patients stayed longer than anticipated due to the acuity of mental illness.
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services and the patient experience.	4.1.1 Implement quality assurance measures to minimise patient risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014/15.	8) Complaint resolution within 25 working days rate (from users of psychiatric hospitals)	87.5%	87.4%	92.1%	5.4%	The reporting system has improved as has the health service's focus on improving the patient-centred experience, resulting in fewer complaints lodged.
			Numerator:	133	148	93	(37.2%)	
			Denominator:	152	170	101	(40.6%)	
			9) Hospital patient satisfaction rate (in psychiatric hospitals)	84.4%	85.0%	84.5%	(0.6%)	More patients participated in survey than planned. Patients satisfied with treatment received.
			Numerator:	573	510	631	23.7%	
			Denominator:	679	600	747	24.5%	
			10) Percentage of psychiatric hospitals assessed for compliance against the 6 priorities of the core standards (NIDS: Facility core standards self-assessment rate in psychiatric hospitals)	100.0%	0.0%	100.0%	100.0%	All hospitals conducted compliance assessments as per the national core standards. . Since all four hospitals conducted assessments in the previous year, it was not initially planned for the hospitals to repeat the assessments in 2013/14.
			Number of psychiatric hospitals assessed for compliance against the 6 priorities of the core standards					
			Numerator:	4	0	4	100.0%	
			Denominator:	4	4	4	0.0%	

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
			11) Morbidity and mortality review rate (in psychiatric hospitals)	Not required to report	100.0%	120.0%	20.0%	The new definition for morbidity and mortality (M&M) review rate counts all meetings held in the hospital. More meetings were conducted than planned, resulting in improved clinical governance and enhancing the overall quality of patient care.
			Numerator:	-	40	48	20.0%	
			Denominator:	-	40	40	0.0%	
Strategic objectives for Step-down beds								
1. Address the burden of disease.	1.1 Address the burden of disease by ensuring access to step-down facilities.	1.1.1 Provide a total of 145 step-down beds and maintain a bed occupancy rate of 82.6% in sub-acute facilities by 2014/15.	1) Number of usable beds (in step-down facilities)	145	145	145	0.0%	Target achieved, zero deviation.
			2) Inpatient bed utilisation rate (in step-down facilities)	83.8%	82.6%	82.2%	(0.5%)	Minimal fluctuation in patient activity. The inpatient bed utilisation rate was lower than anticipated.
			Numerator:	44 365	43 694	43 504	(0.4%)	
			Denominator:	52 931	52 925	52 931	0.0%	
			3) Total number of patient days (in step-down facilities)	44 365	43 694	43 504	(0.4%)	The number of days spent by inpatients in step-down facilities was less than anticipated.

Strategies to overcome areas of under-performance

Psychiatric services continued to remain under pressure, particularly as a result of the high rate of substance abuse, acuity of patients and other social factors.

This sub-programme will continue to focus on the de-institutionalisation of clients and the strengthening of acute, inpatient and outpatient services as well as the district and community-based services.

Changes to planned targets

No targets were changed during the year.

REHABILITATION SERVICES

Strategic objectives

(1) Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014/15.

(2) Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R2 222 per PDE by 2014/15 [2011/12 Rands].

(3) Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilisation rate of 75.8 per cent and an average length of stay of 48.3 days by 2014/15.

(4) Implement quality assurance measures to minimise patient risk in rehabilitation hospitals by monthly mortality and morbidity meetings by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

This sub-programme funds the activities of the Western Cape Rehabilitation Centre (WCRC), which provides specialised rehabilitation services for people with physical disabilities.

The Orthotic and Prosthetic Centre (OPC) resorts under the management of the WCRC.

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

Western Cape Rehabilitation Centre (WCRC)

The WCRC, a 156-bed facility, provides a specialised, comprehensive, multi-disciplinary inpatient and outpatient rehabilitation service to persons with physical disabilities.

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

This service includes the provision of mobility and other assistive devices, such as orthotics and prosthetics where indicated, and serves as a platform for rehabilitation related training.

Specialised outpatient services are provided at urology-, orthopaedics-, plastics- and specialised seating clinics, for referred patients.

Orthotic and Prosthetic Services

On-site, off-site and outreach orthotic and prosthetic services are rendered to all the districts in the Western Cape, with the exception of the Eden and Central Karoo Districts, where services have been outsourced.

Management of the public private partnership (PPP) contract

The public private partnership between Western Cape Government: Health and Mpilisweni Consortium was the first of its kind within the Department. This twelve-year contract concluded its seventh year at the end of this reporting period. The monitoring of the PPP continued through the governance structures ensuring the contractual obligations were met.

Address the burden of disease

Inter-disciplinary outcome-based rehabilitation services were delivered.

Service solutions for the prevention of secondary complications in persons with disabilities, particularly in high risk groups such as the spinal cord injured, were facilitated.

Support was provided to district health services as well as geographical service areas to facilitate the development and provision of quality rehabilitation services for persons with physical disabilities.

An on-site, off-site, and outreach orthotic and prosthetic service was rendered to all the districts in the Western Cape.

Optimal financial management to maximise health outcomes

Sufficient funds were allocated to ensure delivery of specialised rehabilitation services and address the objectives within an affordable cost per patient day equivalent of R1 951. This sub-programme demonstrated strong financial controls, remaining within the allocated cost per patient day equivalent.

The outputs of the PPP were monitored and evaluated through the various governance structures ensuring compliance with contractual obligations, and best value for money. Performance measures, as stipulated in the national core standards, are being developed to measure within the framework of the PPP contract.

Ensure and maintain organisational strategic management capacity and synergy

Continued support was provided to cost centre managers to ensure effective and efficient management of resources in line with the functional business unit model.

As one of six accredited World Health Organisation (WHO) training sites, the WCRC continued to build capacity through the training of health staff from the Western Cape and surrounding provinces in basic- (101 attendees), intermediate- (38 attendees), and advanced seating (24 attendees), and wheelchair repair/maintenance courses (11 attendees).

The WCRC hosted the official launch of the WHO intermediate seating training initiative. Trainers attended from Thailand, the United States of America, Mozambique, the Philippines, Argentina, Kenya, India, the People's Republic of China, Fiji, Romania, Brazil, the United Kingdom, Australia and South Africa.

Improve the quality of health services and the patient experience

The quality of rehabilitation services in terms of the client experience of care was improved.

The sub-programme continued with active participation in task teams in the identified priority areas viz. reducing patient falls, pressure sores, and catheter-acquired urinary tract infections (the latter being a Best Care Always initiative).

Monthly mortality and morbidity meetings (target exceeded) improved management and mitigation of clinical risks.

The results of the annual client and staff satisfaction surveys were assessed and the recommendations will be implemented.

Adherence to the identified priorities extracted from the national core standards was assessed and quality improvement has been planned based on the outcome.

Table 4.4.7: Strategic objectives for Rehabilitation Hospitals 2013/14

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Address the burden of disease by ensuring access to rehabilitation services.	1.1.1 Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014/15.	1) Number of usable beds (in rehabilitation hospitals)	156	156	156	0.0%	Target achieved.
2. Optimal financial management to maximise health outcomes.	2.1 Allocate sufficient funds to ensure the sustained delivery of the full package of quality regional hospital services.	2.1.1 Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R2 222 per PDE by 2014/15 [2011/12 Rands].	2) Expenditure per patient day equivalent (PDE) (in rehabilitation hospitals) [2011/12 Rands]	R 2 064	R2 233	R1 951	(12.6%)	Due to the increased PDE and expenses journalised to other programmes, less than expected was spent per patient day equivalent.
			Numerator:	95 862 488	104 287 932	92 843 113	(11.0%)	
			Denominator:	46 440	46 695	47 589	1.9%	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1 Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilisation rate of 75.8% and an average length of stay of 48.3 days by 2014/15.	3) Inpatient bed utilisation rate (based on usable beds in rehabilitation hospitals)	75.5%	75.8%	77.6%	2.3%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Increased BUR due to the increased demand from acute hospitals to admit patients for rehabilitation, the increased levels of acuity of patients on admission resulted in fewer suspensions as many patients were not yet ready and safe for week-end leave. Social factors also contributed to the increased BUR as some patients are indigent and require placement.
			Numerator:	42 986	43 142	44 176	2.4%	
			Denominator:	56 946	56 940	56 946	0.0%	
			4) Average length of stay (in rehabilitation hospitals)	48.4 days	48.3 days	50.8 days	5.2%	Increased acuity levels and complexity of patients admitted resulted in a longer length of stay. Social factors also contributed as some patients are indigent and require placement.
			Numerator:	42 986	43 142	44 176	2.4%	
			Denominator:	889	893	869	(2.7%)	

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services and the patient experience.	4.1.1 Implement quality assurance measures to minimise patient risk in rehabilitation hospitals by monthly mortality and morbidity meetings by 2014/15.	5) Morbidity and mortality review rate (in rehabilitation hospitals)	Not required to report	100.0%	120.0%	20.0%	The new definition for morbidity and mortality (M&M) review rate counts all meetings held in the hospital. More meetings were conducted than planned, resulting in improved clinical governance and enhancing the overall quality of patient care.
			Numerator:	-	10	12	20.0%	
			Denominator:	-	10	10	0.0%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.4.8: Performance indicators for Rehabilitation Hospitals 2013/14

Programme 4: Provincial Hospital Services							
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Address the burden of disease by ensuring access to rehabilitation services.	1.1.1 Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014/15.	1) Number of usable beds (in rehabilitation hospitals)	156	156	156	0.0%	Target achieved.
			2) Inpatient separations - total (in rehabilitation hospitals)	889	893	869	(2.7%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. The increased acuity levels of patients impacted on the separations. There were fewer discharges as patients were not well enough to be released from their specific rehabilitation programme.
			3) Patient day equivalents (PDE) total (in rehabilitation hospitals)	46 440	46 695	47 589	1.9%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. The increased demand from acute hospitals to admit patients for rehabilitation and the increased levels of acuity of patients on admission, impacted on the average length of stay and consequently the inpatient days.
			4) OPD headcount total (in rehabilitation hospitals)	10 363	10 659	10 239	(3.9%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Due to the limited clinical capacity in the OPD services, fewer patients could be seen than planned. Patient acuity in the wards has increased requiring additional medical cover and they cannot share the OPD load. Due to transport problems experienced by some patients, they do not attend the OPD clinic for their appointments.
2. Optimal financial management to maximise health outcomes.	2.1 Allocate sufficient funds to ensure the sustained delivery of the full package of quality regional hospital services.	2.1.1 Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R2 222 per PDE by 2014/15 [2011/12 Rands].	5) Expenditure per patient day equivalent (PDE) (in rehabilitation hospitals) [2011/12 Rands]	R 2 064	R2 233	R1 951	(12.6%)	Due to the increased PDE and expenses journalised to other programmes, less than expected was spent per patient day equivalent.
			Numerator:	95 862 488	104 287 932	92 843 113	(11.0%)	
			Denominator:	46 440	46 695	47 589	1.9%	

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1 Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilisation rate of 75.8% and an average length of stay of 48.3 days by 2014/15.	6) Inpatient bed utilisation rate (based on usable beds in rehabilitation hospitals)	75.5%	75.8%	77.6%	2.3%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Increased BUR due to the increased demand from acute hospitals to admit patients for rehabilitation, the increased levels of acuity of patients on admission resulted in fewer suspensions as many patients were not yet ready and safe for week-end leave. Social factors also contributed to the increased BUR as some patients are indigent and require placement.
			Numerator:	42 986	43 142	44 176	2.4%	
			Denominator:	56 946	56 940	56 946	0.0%	
			7) Average length of stay (in rehabilitation hospitals)	48.4 days	48.3 days	50.8 days	5.2%	Increased acuity levels and complexity of patients admitted resulted in a longer length of stay. Social factors also contributed as some patients are indigent and require placement.
			Numerator:	42 986	43 142	44 176	2.4%	
			Denominator:	889	893	869	(2.7%)	
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services and the patient experience.	4.1.1 Implement quality assurance measures to minimise patient risk in rehabilitation hospitals by monthly mortality and morbidity meetings by 2014/15.	8) Complaint resolution within 25 working days rate (from users of rehabilitation hospitals)	96.7%	100.0%	100.0%	0.0%	Target achieved. More complaints received than anticipated.
			Numerator:	29	29	43	48.3%	
			Denominator:	30	29	43	48.3%	
			9) Hospital patient satisfaction rate (in rehabilitation hospitals)	92.8%	92.8%	93.1%	0.3%	Target exceeded. More patients satisfied with treatment received.
			Numerator:	220	220	230	4.5%	
			Denominator:	237	237	247	4.2%	

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement** 2012/13	**Planned target** 2013/14	**Actual achievement** 2013/14	**Deviation *** 2013/14	**Comment on deviation**
			10) Percentage of rehabilitation hospitals assessed for compliance against the 6 priorities of the core standards (NIDS: Facility core standards self-assessment rate in rehabilitation hospitals) Number of rehabilitation hospitals assessed for compliance against the 6 priorities of the core standards	100.0%	0.0%	100.0%	(100.0%)	Although it was not planned for the year, a national core standard assessment was conducted.
			Numerator:	1	0	1	100.0%	
			Denominator:	1	1	1	0.0%	
			11) Morbidity and mortality review rate (in rehabilitation hospitals)	Not required to report	100.0%	120.0%	20.0%	The new definition for morbidity and mortality (M&M) review rate counts all meetings held in the hospital. More meetings were conducted than planned, resulting in improved clinical governance and enhancing the overall quality of patient care.
			Numerator:	-	10	12	20.0%	
			Denominator:	-	10	10	0.0%	

Strategies to overcome areas of under-performance

Development of adequate rehabilitation services at primary level within the geographic service areas will continue to ensure the retention of functional gains after discharge of clients back into the community.

Facilitate adherence to the core package of wheelchair and seating services at all levels.

Monitor patients staying longer than the average length of stay through mortality and morbidity meetings. Patients contributing to the longer length of stay due to e.g. placement problems, medical complications and patients from foreign countries requiring repatriation, will be managed through the appropriate structures and other government institutions.

Changes to planned targets

No targets were changed during the year.

DENTAL TRAINING HOSPITALS

Strategic objectives

(1) Ensure access to an integrated oral health service and training platform by providing for 115 150 patient visits per annum by 2014/15.

(2) Provide quality removable prosthetic devices to patients with a target of 4 470 by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

This sub-programme funds oral health services based at the Dental Faculty of the University of the Western Cape (UWC), also referred to as the Oral Health Centre (OHC) and was mostly responsible for the training of certain categories of oral health professionals, namely dentists and oral hygienists. The district oral health services component was managed by Programme 2 (District Health Services).

The OHC also provides dental services to the community of the Western Cape. This service includes primary, secondary, tertiary and quaternary levels of oral health care and is provided on a platform of oral health training complexes which comprises Tygerberg Oral Health Centre, Groote Schuur Hospital, Red Cross War Memorial Children's Hospital and Mitchells Plain Oral Health Centre. The other categories of oral health staff, such as dental technicians, receive their training at the universities of technology.

The package of care provided on the service platform includes consultation and diagnosis, dental x-rays to aid diagnosis, treatment of pain and sepsis, extractions, oral health education, scaling and polishing, fluoride treatment, fissure sealants, fillings, dentures, orthodontics, surgical procedures and maxillofacial procedures.

Address the burden of disease

Due to the burden of disease in the Western Cape, this area has the highest rate of edentulism in the country. The Oral Health Centre is the only provincial facility that provides a comprehensive denture service for state patients. This factor, compounded with the high cost of dentures in the private sector, added to the service pressures experienced at the OHC.

The service is mostly student driven and the student vacations and examination periods impacts on service outputs, reducing the output for dentures, especially over the December and January holiday period.

A special project was launched for six months (October to March) and provided a service totally separate from the teaching and training platform. Clients that have been on the waiting list for dentures for a long period of time were assisted. This was done within the allocated budget of the OHC and 994 devices were delivered, improving the quality of life for those patients.

Table 4.4.9: Strategic objectives for Dental Training Hospitals 2013/14

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Ensure access to dental training hospitals.	1.1.1 Ensure access to an integrated oral health service and training platform by providing for 115 150 patient visits per annum by 2014/15.	1) Number of oral health patient visits per annum	105 439	115 100	114 848	(0.2%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. This is mainly a student driven service, dependent on student availability. Students are not available during exam times and holiday periods. Although the target was marginally underachieved, it is a significant growth of 8.9% from the previous reporting period.
		1.1.2 Provide quality removable prosthetic devices to patients with a target of 4 470 by 2014/15.	2) Number of removable oral health prosthetic devices manufactured (dentures)	4 285	4 460	4 722	5.9%	Increase in denture output due to special project which compensated for student vacation. Funds were made available from the Oral Health Centre's budget to make more dentures and focused on indigent patients who were on the waiting list for an extended period. This is also a significant growth of 10% from the previous reporting period.

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.4.10: Performance indicators for Dental Training Hospitals 2013/14

Programme 4: Provincial Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement** 2012/13	**Planned target** 2013/14	**Actual achievement** 2013/14	**Deviation *** 2013/14	**Comment on deviation**
1. Address the burden of disease.	1.1 Ensure access to dental training hospitals.	1.1.1 Ensure access to an integrated oral health service and training platform by providing for 115 150 patient visits per annum by 2014/15.	1) Number of oral health patient visits per annum	105 439	115 100	114 848	(0.2%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. This is mainly a student driven service, dependent on student availability. Students are not available during exam times and holiday periods. Although the target was marginally underachieved, it is a significant growth of 8.9% from the previous reporting period.
		1.1.2 Provide quality removable prosthetic devices to patients with a target of 4 470 by 2014/15.	2) Number of removable oral health prosthetic devices manufactured (dentures)	4 285	4 460	4 722	5.9%	Increase in denture output due to special project which compensated for student vacation. Funds were made available from the Oral Health Centre's budget to make more dentures and focused on indigent patients who were on the waiting list for an extended period. This is also a significant growth of 10% from the previous reporting period.

Strategies to overcome areas of under-performance

Although this sub-programme did not materially underperform, the mainly student-driven service and the effect of examination and holiday periods will be considered when targets are set and services planned.

Changes to planned targets

No targets were changed during the year.

Linking performance with budgets

Table 4.4.11: Summary of expenditure for Provincial Hospital Services 2013/14

Expenditure	2013/14			2012/13		
Sub-programme	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000
4.1: General (Regional) Hospitals	1 336 786	1 336 141	645	1 216 904	1 217 963	(1 059)
4.2: Tuberculosis Hospitals	223 809	225 222	(1 413)	213 646	213 244	402
4.3: Psychiatric Hospitals	664 819	668 413	(3 594)	621 308	621 038	270
4.4: Rehabilitation Services	150 147	150 328	(181)	139 094	138 125	969
4.5: Dental Training Hospitals	124 578	119 784	4 794	109 293	109 248	45
Total	**2 500 139**	**2 499 888**	**251**	**2 300 245**	**2 299 618**	**627**

The annual expenditure of Programme 4 came within 0.1% of the allocated budget for the reporting period, ensuring that the budget was optimally spent in line with the objectives set for the programme and its entities. Despite the service demand, the programme's ability to apply stringent fiscal control is evident in the balanced budget and financial compliance measures implemented.

The services remained under pressure, which is evident by the growth in patient numbers in hospitals. The programme's overall performance contributed to the Department's objectives where the regional hospitals were pivotal in strengthening the district health system and protected the highly specialised services.

Targeted campaigns include additional cataract surgeries performed in the rural areas and additional dentures in the Metro for clients that have been on the waiting list for long periods.

The growth in the burden of mental illness placed pressure on the acute psychiatric services, but the management strategies and additional spending allowed attempts to address the burden.

Management of Programme 4 was committed to the highest standards of governance, which is fundamental in ensuring that finances and other resources are appropriately managed, achieving the objectives for this programme effectively and efficiently.

4.5 Programme 5: Central Hospital Services

Purpose of the programme

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

Sub-programmes

Sub-programme 5.1:	Central Hospital Services Rendering of general and highly specialised medical health and quaternary services on a national basis and maintaining a platform for the training of health workers and research.
Sub-programme 5.2:	Provincial Tertiary Hospital Services Rendering of general specialist and tertiary health services on a national basis and maintaining a platform for the training of health workers and research.

CENTRAL HOSPITAL SERVICES

Strategic objectives

(1) Perform appropriate 47.7 per cent clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.

(2) Ensure access to central hospital services by providing 2 359 beds by 2014/15.

(3) Efficiently manage resources to achieve the target bed utilisation rate of 84.8 per cent by 2014/15.

(4) Ensure the cost effective management of central hospitals at a target cost of R3 421 per patient day equivalent by 2014/15 [2011/12 Rands].

(5) Effectively manage allocated resources to achieve the target average length of stay of 6.0 days for central hospitals by 2014/15.

(6) Ensure appropriate mechanisms to measure improvement in quality of health services.

Strategic objectives, performance indicators, planned targets and actual achievements

Address the burden of disease

Programme 5 funds the delivery of highly specialised tertiary and quaternary services, as well as a component of general specialist services in the two central hospitals and one

tertiary hospital. The central and tertiary hospitals also serve as an important research and training platform for undergraduate and postgraduate health professionals.

Central and tertiary hospitals provide services for the Province and receive referrals from across the country. The lists of services provided are detailed in Table 4.5.1 below. Tertiary services are partially funded/subsidised through the National Tertiary Services Grant (refer to conditional grant section).

Table 4.5.1: Highly specialised services provided in central and tertiary hospitals

Highly specialised services	
Discipline	**Sub-discipline**
Critical care (intensive care)	Adult critical care
	Paediatric critical care
	Neonatal critical care
Obstetrics and Gynaecology	Maternal-foetal medicine
	Oncology
	Reproductive medicine
	Urogynaecology
Surgery	General Surgery, including hepatobiliary and abdominal surgery
	Cardiothoracic surgery
	Neurosurgery
	Ophthalmology
	Plastic and reconstructive surgery
	Urology
	Ear, nose and throat
	Maxillofacial surgery
	Vascular surgery
	Trauma surgery
Orthopaedics	Hand surgery
	Orthopaedics
	Spinal surgery
	Paediatric orthopaedics
Paediatric Surgery	Paediatric general surgery
	Paediatric neurosurgery
	Paediatric ophthalmology
	Paediatric otolaryngology
	Paediatric urology
Paediatric Medicine	General paediatrics
	Paediatric cardiology
	Paediatric clinical haematology/oncology
	Paediatric gastroenterology
	Paediatric infectious diseases
	Paediatric nephrology
	Paediatric neurology
	Paediatric pulmonology
Medicine	Allergology
	Cardiology
	Clinical haematology/oncology
	Dermatology

Highly specialised services	
Discipline	**Sub-discipline**
	Emergency medicine
	Endocrinology
	Gastroenterology
	General medicine
	Geriatrics
	Hepatology
	Infectious diseases
	Nephrology
	Neurology
	Pulmonology
	Rheumatology
Radiation and Imaging Medicine	Radiation medicine
	Radiology
	Nuclear medicine
	Positron emission tomography (PET) scanning
	Diagnostic radiology
Psychiatry	General psychiatry
	Forensic psychiatry
	Child and adolescent psychiatry

Improved service delivery

Staff played active roles in providing outreach and support within the GSA. Despite strengthening general specialist services and contributions to the GSA service priorities, support was also provided to the newly commissioned Mitchells Plain and Khayelitsha hospitals.

Towards improving the equity of access, the hospitals participated in the pilot arthroplasty waiting list project, applying uniform clinical criteria and reviewing waiting times to prioritise patient requiring elective arthroplasty surgery.

Groote Schuur Hospital, in partnership with the private sector, funded clinical fellowships in spinal surgery, and upper limb and lower limb arthroplasty to improve skill transfer and service provision to the metro areas.

Staff in Groote Schuur Hospital also contributed to establish open source academic resources for ear, nose and throat specialists.

Improved maternal, child and women's health services and health outcomes

High risk multi-disciplinary clinics were established to strengthen service provision for pregnant women with cardiac disease.

All hospitals retained their baby-friendly hospital status and promoted breastfeeding.

The hospitals ensure strict adherence to the PMTCT regime policy to help reduce the transmission of HIV from mothers to babies. Tygerberg Hospital appointed a second dedicated professional nurse to support this service.

Improved management of bottleneck areas such as intensive care units (ICU), theatres and radiology

The hospitals continued to monitor theatre cancellation rates, as well as compliance with completion of the WHO safety check list. Starting times for theatre lists were also monitored to ensure optimal use of available operating time.

Optimal financial management to maximise health outcomes

The hospitals improved decentralised decision making through strengthening implementation of functional business units for each clinical discipline. Reviews were also conducted to assess the mapping of cost centres to the FBU structures.

Ensure and maintain organisational strategic management capacity and synergy

Improved corporate governance

Audit compliance for predetermined objectives, financial management and human resource management was strengthened by conducting regular reviews and completing the compliance monitoring instrument (CMI).

Following completion of the Organisational Development investigations, the hospitals commenced with a matching and placing exercise, which will be completed in 2014/15.

Key high cost equipment purchased for Tygerberg Hospital includes:

- MRI scanner.
- Linear accelerator.
- Updated Hermes system for nuclear medicine.
- A new computerised tomography (CT) scanner for planning of radiation oncology.

Key high cost equipment for Groote Schuur Hospital included:

- Linear accelerator.
- Trauma unit Iodox scan was replaced.
- Critical equipment in cardiology, for example the ultrasound machine, was replaced.

The allocated funding (R39,85 million) for the modernisation of tertiary services was used to improve the medical imaging and diagnostic service. This was done by:

- Funding the clinical engineering capacity at the central hospitals that is essential for the maintenance of equipment and administration of the Picture Archiving and Communication System (PACS) system.
- Implementing the Picture Archiving and Communication System/Radiological Information System (PACS/RIS) solution which is now fully functional in the radiology departments of all three academic hospitals.
- Purchasing high end imaging and radiological equipment, for instance CT scanner, magnetic resonance imaging (MRI) scanner, 3-dimensional ultrasound, upgrading Hermes system etc.

Improve the quality of health services and improve the patient experience

Improved quality of care and clinical governance

Towards improving the person-centred approach and the quality of care, the hospitals participated actively in the best care always initiative. Other strategies included measuring and reducing waiting times.

Morbidity and mortality meetings and regular clinical audits of selected cases were conducted.

The hospitals implemented a system to monitor and improve responsiveness to infections caused by selected organisms.

The hospitals conducted and responded to the findings of the annual patient satisfaction survey.

Measures were put in place to improve compliance with the national core standards.

Table 4.5.2: Strategic objectives for Central Hospitals 2013/14

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate 47.7% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Delivery by caesarean section rate (in central hospitals)	48.3%	47.7%	48.5%	1.7%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	5 041	5 004	5 046	0.8%	More caesarean sections were performed than anticipated and slightly fewer births occurred. Every caesarean section is justified on its own clinical merit and authorised by a specialist consultant.
			Denominator:	10 443	10 500	10 405	(0.9%)	
	1.2 Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to central hospital services by providing 2 359 beds by 2014/15.	2) Number of usable beds (in central hospitals)	2 599	2 359	2 359	0.0%	Target achieved.
	1.3 Ensure the Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed utilisation rate of 84.8% by 2014/15.	3) Inpatient bed utilisation rate (based on usable beds in central hospitals)	82.0%	84.7%	85.1%	0.5%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	781 590	728 894	729 091	0.0%	Inpatient bed utilisation was slightly higher than anticipated. This could be as a result of the increasing complexity of patients as evidenced by the increased average length of stay. It must be noted that this is the global hospital bed utilisation rate and does not necessarily reflect service pressures experienced in individual disciplines.
			Denominator:	953 241	861 035	856 566	(0.5%)	
2. Optimal financial management to maximise health outcomes.	2.1 Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	2.1.1 Ensure the cost effective management of central hospitals at a target cost of R3 421 per patient day equivalent by 2014/15 [2011/12 Rands].	4) Expenditure per patient day equivalent (PDE) (in central hospitals)	R3 390	R3 440	R3 523	2.4%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	3 717 732 848	3 455 078 861	3 511 033 649	1.6%	The patient day equivalents was marginally lower than planned, therefore the cost per PDE was higher. Increased expenditure in surgical and medical supplies as inventory was increased. Also increased costs in oxygen and NHLS were incurred.
			Denominator:	1 096 565	1 004 309	996 506	(0.8%)	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement** 2012/13	**Planned target** 2013/14	**Actual achievement** 2013/14	**Deviation *** 2013/14	**Comment on deviation**
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of sustained health services with well-defined efficiency targets for central hospital services.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 6.0 days for central hospitals by 2014/15.	5) Average length of stay (in central hospitals)	5.8 days	6.0 days	6.2 days	2.7%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Average length of stay was marginally higher than anticipated for both Groote Schuur and Tygerberg Hospitals. This could be a reflection of the increasing complexity of patients being managed within the central hospitals.
			Numerator:	781 590	728 894	729 091	0.0%	
			Denominator:	135 344	121 482	118 351	(2.6%)	
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Ensure appropriate mechanisms to measure improvement in quality of health services.	6) Mortality and morbidity review rate (in central hospitals)	Not required to report	78.6%	94.3%	20.0%	More meetings were conducted than anticipated. This is deemed to be a positive performance. As this was the first year this indicator was reported in the APP, no baseline data was available for target setting. Actual performance for 2013/14 will be used to inform future targets.
			Numerator:	-	55	66	20.0%	
			Denominator:	-	70	70	0.0%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

From 2013/14 onwards, Red Cross War Memorial Children's Hospital, and all the related service outputs, is reported under Programme 5.2 as provincial tertiary hospital services. This should be taken into consideration when the actual achievement for 2012/13 is compared with 2013/14.

Table 4.5.3: Performance indicators for Central Hospitals 2013/14

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/1**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate 47.7% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Delivery by caesarean section rate (in central hospitals)	48.3%	47.7%	48.5%	1.7%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	5 041	5 004	5 046	0.8%	More caesarean sections were performed than anticipated and slightly fewer births occurred. Every caesarean section is justified on its own clinical merit and authorised by a specialist consultant.
			Denominator:	10 443	10 500	10 405	(0.9%)	
	1.2 Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to central hospital services by providing 2 359 beds by 2014/15.	2) Number of usable beds (in central hospitals)	2 599	2 359	2 359	0.0%	Target achieved.
			3) Inpatient separations – total (in central hospitals)	135 344	121 482	118 351	(2.6%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			4) OPD headcount - total (in central hospitals)	810 417	731 245	704 582	(3.6%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			5) Patient day equivalents (PDE) total (in central hospitals)	1 096 565	1 004 309	996 506	(0.8%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Lower than anticipated PDE due to the lower than expected OPD headcount.
	1.3 Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed utilisation rate of 84.8% by 2014/15.	6) Inpatient bed utilisation rate (based on usable beds in central hospitals)	82.0%	84.7%	85.1%	0.5%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	781 590	728 894	729 091	0.0%	Inpatient bed utilisation was slightly higher than anticipated. This could be as a result of the increasing complexity of patients as evidenced by the increased average length of stay. It must be noted that this is the global hospital bed utilisation rate and does not necessarily reflect service pressures experienced in individual disciplines.
			Denominator:	953 241	861 035	856 566	(0.5%)	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/1**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
2. Optimal financial management to maximise health outcomes.	2.1 Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	2.1.1 Ensure the cost effective management of central hospitals at a target cost of R3 421 per patient day equivalent by 2014/15 [2011/12 Rands].	7) Expenditure per patient day equivalent (PDE) (in central hospitals)	R3 390	R3 440	R3 523	2.4%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. The patient day equivalents was marginally lower than planned, therefore the cost per PDE was higher. Increased expenditure in surgical and medical supplies as inventory was increased. Also increased costs in oxygen and NHLS were incurred.
			Numerator:	3 717 732 848	3 455 078 861	3 511 033 649	1.6%	
			Denominator:	1 096 565	1 004 309	996 506	(0.8%)	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of sustained health services with well-defined efficiency targets for central hospital services.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 6.0 days for central hospitals by 2014/15.	8) Average length of stay (in central hospitals)	5.8 days	6.0 days	6.2 days	2.7%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Average length of stay was marginally higher than anticipated for both Groote Schuur and Tygerberg Hospitals. This could be a reflection of the increasing complexity of patients being managed within the central hospitals.
			Numerator:	781 590	728 894	729 091	0.0%	
			Denominator:	135 344	121 482	118 351	(2.6%)	
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Ensure appropriate mechanisms to measure improvement in quality of health services.	9) Complaint resolution within 25 working days rate (in central hospitals)	80.1%	80.0%	84.4%	5.6%	Groote Schuur Hospital complaints resolution was higher than anticipated, which is commendable. The hospital employed focussed strategies to improve performance.
			Numerator:	650	496	760	53.2%	
			Denominator:	811	620	900	45.2%	
			10) Hospital patient satisfaction rate (in central hospitals)	91.0%	90.0%	89.3%	(0.8%)	The less than 1% deviation from target is within acceptable range. However, strategies to improve patient satisfaction are ongoing.
			Numerator:	4 800	7 110	2 791	(60.7%)	
			Denominator:	5 273	7 900	3 127	(60.4%)	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/1**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
			11) Percentage of central hospitals assessed for compliance against the 6 priorities of the core standards (includes external assessment) (NIDS: Facility core standards self-assessment rate in central hospitals)	100.0%	100.0%	100%	0.0%	Target achieved.
			Number of central hospitals assessed for compliance against the 6 priorities of the core standards					
			Numerator:	2	2	2	0.0%	
			Denominator:	2	2	2	0.0%	
			12) Morbidity and mortality review rate (in central hospitals)	Not required to report	78.6%	94.3%	20.0%	More meetings were conducted than anticipated. This is deemed to be a positive performance. As this was the first year this indicator was reported in the APP, no baseline data was available for target setting. Actual performance for 2013/14 will be used to inform future targets.
			Numerator:	-	55	66	20.0%	
			Denominator:	-	70	70	0.0%	

From 2013/14 onwards Red Cross War Memorial Children's Hospital, and all the related service outputs, is reported under Sub-programme 5.2 as provincial tertiary hospital services. This should be taken into consideration when the actual achievement for 2012/13 is compared with 2013/14.

Strategies to overcome areas of under-performance

No material under-performance, i.e. more than 10 per cent, identified for the hospital.

Changes to planned targets

No targets were changed during the year.

GROOTE SCHUUR HOSPITAL

Strategic objectives

(1) Perform appropriate 56.0 per cent clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.

(2) Ensure access to Groote Schuur Hospital services by providing 975 beds by 2014/15.

(3) Efficiently manage resources to achieve the target bed utilisation rate of 86.0 per cent by 2014/15.

(4) Ensure the cost effective management of Groote Schuur Hospital at a target cost of R3 670 per patient day equivalent by 2014/15 [2011/12 Rands].

(5) Effectively manage allocated resources to achieve the target average length of stay of 6.0 days for Groote Schuur Hospital by 2014/15.

(6) Ensure appropriate mechanisms to measure improvement in quality of health services.

Strategic objectives, performance indicators, planned targets and actual achievements

Address the burden of disease

Improving service delivery

Maternal, child and women's health services and health outcomes were improved by:

- Commissioning additional beds to absorb the specialist services from GF Jooste Hospital. These services included medical, surgical, high care and specialist women's health services.
- Appointing a clinical psychologist to strengthen mental health services to women.
- Providing high risk antenatal clinic services with an expanded focus on the management of medical conditions, specifically cardiac conditions, in pregnancy.

- Planning was concluded for a "one stop" clinic for breast and cervical cancer. Patients will receive the comprehensive range of primary screening and diagnostic services. The clinic will be fully operational by the first quarter of 2014/15.
- Providing outreach colposcopy services to Victoria and False Bay hospitals.

Improved management of bottleneck areas such as intensive care units (ICU), theatres and radiology

Additional theatre lists were commissioned for general surgery, orthopaedics and oncological surgery. Operating theatre practitioners were appointed as permanent theatre staff to strengthen capacity. This helps to overcome the shortage of skilled specialist theatre nurses.

Four post-anaesthetic high care beds were in operation in 2013/14. Infrastructure work to allow further expansion will commence in 2014/15.

Increased access to mammograms was achieved through radiology working groups.

Optimal financial management to maximise health outcomes

The hospital improved decentralised decision making through strengthening implementation of functional business units for each clinical discipline. Reviews were also conducted to assess the mapping of cost centres to the FBU structures.

Ensure and maintain organisational strategic management capacity and synergy

Improved corporate governance

Planning commenced for the renovation of the emergency centre. Infrastructure work will commence in the following financial year.

The implementation of a computerised cost-centre requisitioning system was concluded in most areas.

Improve the quality of health services and improve the patient experience

Improved quality of care and clinical governance

The hospital reviewed its quality management and risk for implementation.

Ongoing initiatives, for instance a staff wellness day, were held to improve staff wellness throughout the reporting period.

The Best Care Always programme was implemented in selected areas in the hospital.

Table 4.5.4: Strategic objectives for Groote Schuur Hospital 2013/14

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate 56.0% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Delivery caesarean section rate (in Groote Schuur Hospital)	56.0%	56.0%	56.7%	1.3%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Every caesarean section is justified on its own clinical merit and authorised by a specialist consultant.
			Numerator:	1 749	1 792	1 685	(6.0%)	
			Denominator:	3 111	3 200	2 970	(7.2%)	
	1.2 Ensure the delivery of Groote Schuur Hospital services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to Groote Schuur Hospital services by providing 975 beds by 2014/15.	2) Number of usable beds in Groote Schuur Hospital	945	975	975	0.0%	Target achieved. Thirty more beds were commissioned compared to the previous year to manage the load from the decommissioning of GF Jooste Hospital.
	1.3 Ensure optimal access to Groote Schuur Hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed utilisation rate of 86.0% by 2014/15.	3) Inpatient bed utilisation rate (based on usable beds in Groote Schuur Hospital)	84.0%	87.0%	84.7%	(2.7%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. After commissioning the additional beds to absorb the specialist services from GF Jooste Hospital, the bed utilisation rate were lower than expected.
			Numerator:	289 397	309 611	297 539	(3.9%)	
			Denominator:	344 354	355 875	351 351	(1.3%)	
2. Optimal financial management to maximise health outcomes.	2.1 Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality services in Groote Schuur Hospital.	2.1.1 Ensure the cost effective management of Groote Schuur Hospital at a target cost of R3 670 per patient day equivalent by 2014/15. [2011/12 Rands].	4) Expenditure per patient day equivalent (PDE) (in Groote Schuur Hospital)	R 3 645	R 3 652	R3 860	5.7%	The patient day equivalents decreased, therefore the cost per PDE was higher. A marginal increase in expenditure was incurred for outsourced services, as well as surgical and medical supplies including oxygen and NHLS costs.
			Numerator:	1 537 912 565	1 648 146 376	1 679 680 074	1.9%	
			Denominator:	421 940	451 282	435 121	(3.6%)	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of sustained health services with well-defined efficiency targets for Groote Schuur Hospital.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 6.0 days for Groote Schuur Hospital by 2014/15.	5) Average length of stay (in Groote Schuur Hospital) Numerator: Denominator:	6.1 days 289 397 47 371	6.0 days 309 611 51 602	6.1 days 297 539 49 012	1.2% (3.9%) (5.0%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Average length of stay was higher than anticipated as a result of longer length of stay in dermatology, neurosurgery, orthopaedics and clinical haematology due to higher acuity of patients.
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Ensure appropriate mechanisms to measure improvement in quality of health services.	6) Mortality and morbidity review rate (in Groote Schuur Hospital) Numerator: Denominator:	Not required to report - -	83.3% 25 30	90.0% 27 30	8.0% 8.0% 0.0%	More meetings were conducted than anticipated. This is deemed to be a positive performance. As this was the first year this indicator was reported in the APP, no baseline data was available for target setting. Actual performance for 2013/14 will be used to inform future targets.

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.5.5: Performance indicators for Groote Schuur Hospital 2013/14

Programme 5: Central Hospital Services							
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate 56.0% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Delivery caesarean section rate (in Groote Schuur Hospital)	56.0%	56.0%	56.7%	1.3%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Every caesarean section is justified on its own clinical merit and authorised by a specialist consultant.
			Numerator:	1 749	1 792	1 685	(6.0%)	
			Denominator:	3 111	3 200	2 970	(7.2%)	
	1.2 Ensure the delivery of Groote Schuur Hospital services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to Groote Schuur Hospital services by providing 975 beds by 2014/15.	2) Number of usable beds in Groote Schuur Hospital	945	975	975	0.0%	Target achieved. Thirty more beds were commissioned compared to the previous year to manage the load from the decommissioning of GF Jooste Hospital.
			3) Inpatient separations – total (in Groote Schuur Hospital)	47 371	51 602	49 012	(5.0%)	The de-escalation period that extended into January contributed to the lower than expected service outputs. This is an increase compared to the previous year.
			4) OPD total headcount - total (in Groote Schuur Hospital)	359 998	387 014	372 146	(3.8%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			5) Patient day equivalents (PDE) total (in Groote Schuur Hospital)	421 940	451 282	435 121	(3.6%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
	1.3 Ensure optimal access to Groote Schuur Hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed utilisation rate of 86.0% by 2014/15.	6) Inpatient bed utilisation rate (based on usable beds in Groote Schuur Hospital)	84.0%	87.0%	84.7%	(2.7%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. After commissioning the additional beds to absorb the specialist services from GF Jooste Hospital, the bed utilisation rate were lower than expected.
			Numerator:	289 397	309 611	297 539	(3.9%)	
			Denominator:	344 354	355 875	351 351	(1.3%)	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
2. Optimal financial management to maximise health outcomes.	2.1 Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality services in Groote Schuur Hospital.	2.1.1 Ensure the cost effective management of Groote Schuur Hospital at a target cost of R3 670 per patient day equivalent by 2014/15 [2011/12 Rands].	7) Expenditure per patient day equivalent (PDE) (in Groote Schuur Hospital)	R3 645	R3 652	R3 860	5.7%	The patient day equivalents decreased, therefore the cost per PDE was higher. A marginal increase in expenditure was incurred for outsourced services, as well as surgical and medical supplies including oxygen and NHLS costs.
			Numerator:	1 537 912 565	1 648 146 376	1 679 680 074	1.9%	
			Denominator:	421 940	451 282	435 121	(3.6%)	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of sustained health services with well-defined efficiency targets for Groote Schuur Hospital.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 6.0 days for Groote Schuur Hospital by 2014/15.	8) Average length of stay (in Groote Schuur Hospital)	6.1 days	6.0 days	6.1 days	1.2%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	289 397	309 611	297 539	(3.9%)	
			Denominator:	47 371	51 602	49 012	(5.0%)	Average length of stay was higher than anticipated as a result of longer length of stay in dermatology, neurosurgery, orthopaedics and clinical haematology due to higher acuity of patients.
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Ensure appropriate mechanisms to measure improvement in quality of health services.	9) Complaint resolution within 25 working days rate (from users of Groote Schuur Hospital)	81.0%	80.0%	89.1%	11.3%	Groote Schuur Hospital complaints resolution was higher than anticipated. The hospital employed focussed strategies to improve performance.
			Numerator:	300	280	415	48.2%	
			Denominator:	370	350	466	33.1%	
			10) Hospital patient satisfaction rate (in Groote Schuur Hospital)	88.6%	90.0%	88.2%	(2.0%)	The deviation for target is less than 5% and acceptable to the department. However strategies to improve patient satisfaction are a priority within the Department and will be implemented to improve on this indicator.
			Numerator:	2 715	6 300	2 090	(66.8%)	
			Denominator:	3 063	7 000	2 370	(66.1%)	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
			11) Percentage of assessments for compliance against the 6 priorities of the core standards (includes external assessment) (NIDS: Facility core standards self-assessment rate in central hospitals)	100.0%	100.0%	100%	0.0%	Target achieved.
			Number of assessments at Groote Schuur Hospital for compliance against the 6 priorities of the core standards					
			Numerator:	1	1	1	0.0%	
			Denominator:	1	1	1	0.0%	
			12) Morbidity and mortality review rate (in Groote Schuur Hospital)	Not required to report	83.3%	90.0%	8.0%	More meetings were conducted than anticipated. This is deemed to be a positive performance. As this was the first year this indicator was reported in the APP, no baseline data was available for target setting. Actual performance for 2013/14 will be used to inform future targets.
			Numerator:	-	25	27	8.0%	
			Denominator:	-	30	30	0.0%	

Strategies to overcome areas of under-performance

No material under-performance, i.e. more than 10 per cent, identified for the hospital.

Changes to planned targets

No targets were changed during the year.

TYGERBERG HOSPITAL

Strategic objectives

(1) Perform appropriate 44.0 per cent clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.

(2) Ensure access to Tygerberg Hospital services by providing 1 384 beds by 2014/15.

(3) Efficiently manage resources to achieve the target bed utilisation rate of 84.0 per cent by 2014/15.

(4) Ensure the cost effective management of Tygerberg Hospital at a target cost of R3 221 per patient day equivalent by 2014/15 [2011/12 Rands].

(5) Effectively manage allocated resources to achieve the target average length of stay of 6.0 days for Tygerberg Hospital by 2014/15.

(6) Ensure appropriate mechanisms to measure improvement in quality of health services.

Strategic objectives, performance indicators, planned targets and actual achievements

Address the burden of disease

Improving service delivery

Improved maternal, child and women's health services and health outcomes by:

- Commissioning a dedicated hospital ward for child and adolescent psychiatric services.
- Appointing a dedicated medical officer to the specialist outpatient breast clinic. Specialised equipment (such as a biopsy gun) was purchased to improve the diagnostic services for breast cancer.

Improved management of bottleneck areas such as intensive care units (ICU), theatres and radiology

Two newly-trained operating theatre practitioners were appointed to strengthen theatre service capacity.

An additional theatre list for surgical emergencies was commissioned.

A medical officer driven triage for surgical emergencies was implemented. Hardware was procured to implement a revised triage and prioritisation system for theatre emergencies. Software will be installed to make the system fully operational in 2014/15.

Optimal financial management to maximise health outcomes

The hospital improved decentralised decision making through strengthening implementation of functional business units for each clinical discipline. Reviews were also conducted to assess the mapping of cost centres to the FBU structures.

Ensure and maintain organisational strategic management capacity and synergy

Improved corporate governance

Infrastructure improvement to the paediatric wards commenced, inclusive of dedicated isolation facilities, which will be concluded in 2014/15.

Phase 1 infrastructure upgrade of the emergency centre was concluded to improve patient flow.

Full functionality of the PACS (Picture Archive Communication System) and RIS (Radiological Imaging System) were achieved.

An electronic content management system was implemented to improve the management and availability of clinical records.

Improve the quality of health services and improve the patient experience

Tygerberg Hospital provided a district anaesthetist to assist in strengthening clinical governance and leadership across levels of care within regional and district health services. The anaesthetist also played a key role in the Provincial Clinical Governance Committee, dealing with various matters on clinical governance.

The hospital assigned a clinical lead to support the implementation of the Best Care Always initiative in the selected clinical areas.

Table 4.5.6: Strategic objectives for Tygerberg Hospital 2013/14

Programme 5: Central Hospital Services							
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate 44.0% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Delivery caesarean section rate (in Tygerberg Hospital)	44.9%	44.0%	45.2%	2.7%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	3 292	3 212	3 361	4.6%	
			Denominator:	7 332	7 300	7 435	1.8%	Every caesarean case is justified on its own merit, all cases are evaluated and authorised by a specialist consultant.
	1.2 Ensure the delivery of Tygerberg Hospital services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to Tygerberg Hospital services by providing 1 384 beds by 2014/15.	2) Number of usable beds (in Tygerberg Hospital)	1 384	1 384	1 384	0.0%	Target achieved.
	1.3 Ensure optimal access to Tygerberg Hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed utilisation rate of 84.0% by 2014/15.	3) Inpatient bed utilisation rate (based on usable beds in Tygerberg Hospital)	81.0%	83.0%	85.4%	2.9%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	410 956	419 283	431 552	2.9%	The slight deviation is as a result of the increased service pressures that were experienced specifically in burns, neonatology, medicine, orthopaedics and obstetrics services.
			Denominator:	505 215	505 160	505 215	0.0%	
2. Optimal financial management to maximise health outcomes.	2.1 Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality services in Tygerberg Hospital.	2.1.1 Ensure the cost effective management of Tygerberg Hospital at a target cost of R3 221 per patient day equivalent by 2014/15 [2011/12 Rands].	4) Expenditure per patient day equivalent (PDE) (in Tygerberg Hospital)	R3 150	R3 267	R3 262	(0.1%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	1 704 992 044	1 806 932 485	1 831 353 574	1.4%	Expenditure per patient day equivalent is marginally less than expected, as the PDE was higher than planned.
			Denominator:	541 276	553 027	561 385	1.5%	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement** 2012/13	**Planned target** 2013/14	**Actual achievement** 2013/14	**Deviation *** 2013/14	**Comment on deviation**
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of sustained health services with well-defined efficiency targets for Tygerberg Hospital.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 6.0 days for Tygerberg Hospital by 2014/15.	5) Average length of stay (in Tygerberg Hospital)	6.1 days	6.0 days	6.2 days	2.9%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. There has been an overall increase in complexity and perceived average acuity of cases. It is felt that average case complexity is increasing year on year, especially relating to infectious diseases (HIV and AIDS, and TB), non-communicable diseases (such as diabetes, hypertension and cardiac conditions), and multiple co-morbidities.
			Numerator:	410 956	419 283	431 552	2.9%	
			Denominator:	67 459	69 880	69 339	(0.8%)	
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Ensure appropriate mechanisms to measure improvement in quality of health services.	6) Mortality and morbidity review rate (in Tygerberg Hospital)	Not required to report	75.0%	97.5%	30.0%	More meetings were conducted than anticipated. This is deemed to be a positive performance. As this was the first year this indicator was reported in the APP, no baseline data was available for target setting. Actual performance for 2013/14 will be used to inform future targets.
			Numerator:	-	30	39	30.0%	
			Denominator:	-	40	40	0.0%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.5.7: Performance indicators for Tygerberg Hospital 2013/14

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate 44.0% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Delivery caesarean section rate (in Tygerberg Hospital)	44.9%	44.0%	45.2%	2.7%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	3 292	3 212	3 361	4.6%	
			Denominator:	7 332	7 300	7 435	1.8%	Every caesarean case is justified on its own merit, all cases are evaluated and authorised by a specialist consultant.
	1.2 Ensure the delivery of Tygerberg Hospital services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to Tygerberg Hospital services by providing 1 384 beds by 2014/15.	2) Number of usable beds (in Tygerberg Hospital)	1 384	1 384	1 384	0.0%	Target achieved.
			3) Inpatient separations -total (in Tygerberg Hospital)	67 459	69 880	69 339	(0.8%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Inpatient separations were less than anticipated as a result of a longer length of stay.
			4) OPD headcounts total (in Tygerberg Hospital)	334 384	344 231	332 436	(3.4%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			5) Patient day equivalents (PDE) total (in Tygerberg Hospital)	541 276	553 027	561 385	1.5%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
	1.3 Ensure optimal access to Tygerberg Hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed utilisation rate of 84.0% by 2014/15.	6) Inpatient bed utilisation rate (based on usable beds in Tygerberg Hospital)	81.0%	83.0%	85.4%	2.9%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	410 956	419 283	431 552	2.9%	The slight deviation is as a result of the increased service pressures that were experienced specifically in burns, neonatology, medicine, orthopaedics and obstetrics services.
			Denominator:	505 215	505 160	505 215	0.0%	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
2. Optimal financial management to maximise health outcomes.	2.1 Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality services in Tygerberg Hospital.	2.1.1 Ensure the cost effective management of Tygerberg Hospital at a target cost of R3 221 per patient day equivalent by 2014/15 [2011/12 Rands].	7) Expenditure per patient day equivalent (PDE) (in Tygerberg Hospital)	R3 150	R3 267	R3 262	(0.1%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. Expenditure per patient day equivalent is marginally less than expected, as the PDE was higher than planned.
			Numerator:	1 704 992 044	1 806 932 485	1 831 353 574	1.4%	
			Denominator:	541 276	553 027	561 385	1.5%	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of sustained health services with well-defined efficiency targets for Tygerberg Hospital.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 6.0 days for Tygerberg Hospital by 2014/15.	8) Average length of stay (in Tygerberg Hospital)	6.1 days	6.0 days	6.2 days	2.9%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. There has been an overall increase in complexity and perceived average acuity of cases. It is felt that average case complexity is increasing year on year, especially relating to infectious diseases (HIV and AIDS, and TB), non-communicable diseases (such as diabetes, hypertension and cardiac conditions), and multiple co-morbidities.
			Numerator:	410 956	419 283	431 552	2.9%	
			Denominator:	67 459	69 880	69 339	(0.8%)	
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Ensure appropriate mechanisms to measure improvement in quality of health services.	9) Complaint resolution within 25 working days rate (from users of Tygerberg Hospital)	77.0%	80.0%	79.5%	(0.6%)	Many of the complaints are complex, and require inputs and deliberations between multiple stakeholders from various disciplines. As a result of this some complaints take longer to resolve.
			Numerator:	240	216	345	59.7%	
			Denominator:	313	270	434	60.7%	
			10) Hospital patient satisfaction rate (in Tygerberg Hospital)	95.2%	90.0%	92.6%	2.9%	Patient satisfaction rate was higher than anticipated. This is deemed to be a positive deviation.
			Numerator:	731	810	701	(13.5%)	
			Denominator:	768	900	757	(15.9%)	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
			11) Percentage of assessments for compliance against the 6 priorities of the core standards (includes external assessment) (NIDS: Facility core standards self-assessment rate in central hospitals) Number of assessments at Tygerberg Hospital for compliance against the 6 priorities of the core standards.	100.0%	100.0%	100%	0.0%	Target achieved.
			Numerator:	1	1	1	0.0%	
			Denominator:	1	1	1	0.0%	
			12) Morbidity and mortality review rate (in Tygerberg Hospital)	Not required to report	75.0%	97.5%	30.0%	More meetings were conducted than anticipated. This is deemed to be a positive performance. As this was the first year this indicator was reported in the APP, no baseline data was available for target setting. Actual performance for 2013/14 will be used to inform future targets.
			Numerator:	-	30	39	30.0%	
			Denominator:	-	40	40	0.0%	

Strategies to overcome areas of under-performance

No material under-performance, i.e. more than 10 per cent, identified for the hospital.

Changes to planned targets

No targets were changed during the year.

PROVINCIAL TERTIARY HOSPITALS – RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

Strategic objectives

(1) Ensure access to Red Cross War Memorial Children's Hospital (RCWMCH) services by providing 270 beds by 2014/15.

(2) Efficiently manage resources to achieve the target bed utilisation rate of 85.0 per cent by 2014/15.

(3) Ensure the cost effective management of RCWMCH at a target cost of R3 684 per patient day equivalent by 2014/15 [2011/12 Rands].

(4) Effectively manage allocated resources to achieve the target average length of stay of 4.2 days for RCWMCH by 2014/15.

(5) Ensure appropriate mechanisms to measure improvement in quality of health services.

Strategic objectives, performance indicators, planned targets and actual achievements

Address the burden of disease

There is one provincial tertiary hospital in the Western Cape, namely Red Cross War Memorial Children's Hospital. For a list of highly specialised services provided by central and tertiary hospitals, refer to Table 4.5.1.

The sub-programme provided financial and service support through outreach to Maitland Cottage Home, a provincially aided orthopaedic hospital, which serves as an extension of Red Cross War Memorial Children's Hospital and provide highly specialised paediatric orthopaedic surgery. The facility operates 85 beds, admitting 1 114 patients and performing 575 operations during the 2013/14 financial year.

The following services are provided by Maitland Cottage Home:

- General paediatric orthopaedic elective surgery which include limb reconstruction and pelvic osteotomies as well as soft tissue releases for patients with cerebral palsy.
- Pre- and post-operative management of patients that received spinal surgery at Red Cross War Memorial Children's Hospital.

- Non-operative orthopaedic management of patients for instance splinting of fractures and hosting a specialised outpatient club foot clinic.

The hospital plays a key role in the governance of the facility by means of site visits and regular meetings.

Improving service delivery

Improved acute hospital services by:

- Implementing the ten steps recommended by the WHO to manage malnutrition in children and promoted breastfeeding.
- Establishing dedicated medical doctor and pharmacist posts to sustain a functional poison information centre as a provincial and national resource.
- Appointing a dedicated medical officer to the burns unit and improving skills by means of a focussed training programme for doctors and nurses.

Improved management of bottleneck areas such as intensive care units (ICU), theatres and radiology

Access to twenty ICU beds was sustained. In the fourth quarter, two additional ICU beds were commissioned.

An additional weekly theatre slate was commissioned for maxillofacial surgery.

Optimal financial management to maximise health outcomes

The hospital improved decentralised decision making through strengthening implementation of functional business units for each clinical discipline. Reviews were also conducted to assess the mapping of cost centres to the FBU structures.

Ensure and maintain organisational strategic management capacity and synergy

Improved corporate governance

Infrastructure planning towards improving psychiatric, intensive care and radiology services were concluded. The funded projects will commence in 2014/15.

Key high cost equipment purchased for Red Cross War Memorial Hospital included:

- Retinal imaging system.
- Ultrasound unit.
- Autoclave to sterilise equipment.
- Cardiac output monitoring system.

Improve the quality of health services and improve the patient experience

Improved quality of care and clinical governance

Implemented a queue management system for pharmacy services, as well as measuring and actively responding to waiting times in emergency centres.

Table 4.5.8: Strategic objectives for Tertiary Hospitals – Red Cross War Memorial Children's Hospital 2013/14

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Delivery caesarean section rate (in Red Cross War Memorial Children's Hospital [RCWMCH])	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable.
			Numerator:	-	-	-	-	
			Denominator:	-	-	-	-	
	1.2 Ensure the delivery of RCWMCH services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to RCWMCH services by providing 270 beds by 2014/15.	2) Number of usable beds (in RCWMCH)	270	270	270	0.0%	Target achieved.
	1.3 Ensure optimal access to RCWMCH hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed utilisation rate of 85% by 2014/15.	3) Inpatient bed utilisation rate (based on usable beds in RCWMCH)	78.0%	84.0%	83.6%	(0.5%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	81 238	82 782	82 503	(0.3%)	Bed utilisation rate was less than anticipated as the length of stay was shorter than planned.
			Denominator:	103 671	98 550	98 713	0.2%	
2. Optimal financial management to maximise health outcomes.	2.1 Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality services at RCWMCH.	2.1.1 Ensure the cost effective management of RCWMCH at a target cost of R3 684 per patient day equivalent by 2014/15 [2011/12 Rands].	4) Expenditure per patient day equivalent (PDE) (in RCWMCH)	R3 561	R3 707	R3 760	1.4%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	474 828 239	508 192 700	511 063 961	0.6%	The patient day equivalents decreased, therefore the cost per PDE was higher. Increased expenditure in surgical and medical supplies as inventory was increased, as well as for security services.
			Denominator:	133 349	137 074	135 927	(0.8%)	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement** 2012/13	**Planned target** 2013/14	**Actual achievement** 2013/14	**Deviation *** 2013/14	**Comment on deviation**
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of sustained health services with well-defined efficiency targets for RCWMCH.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 4.2 days for RCWMCH by 2014/15.	5) Average length of stay (in RCWMCH) Numerator: Denominator:	4.0 days 81 238 20 514	4.1 days 82 782 20 191	3.7 days 82 503 22 101	(9.0%) (0.3%) 9.5%	There was a stronger focus on the day patient care model (especially oncology and surgery) which resulted in an increase in the number of separations and subsequent reduction in the ALOS as more separations were recorded. There was a high turnover of patients in the short stay wards as well, which further reduced the average length of stay.
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Ensure appropriate mechanisms to measure improvement in quality of health services.	6) Mortality and morbidity review rate (in RCWMCH) Numerator: Denominator:	Not required to report - -	90.0% 9 10	100.0% 10 10	11.1% 11.1% 0.0%	More meetings were conducted than anticipated. This is deemed to be a positive performance. As this was the first year this indicator was reported in the APP, no baseline data was available for target setting. Actual performance for 2013/14 will be used to inform future targets.

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.5.9: Performance indicators for Tertiary Hospitals – Red Cross War Memorial Children's Hospital 2013/14

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Reduce maternal mortality due to complications during delivery.	1.1.1 Perform appropriate clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Delivery caesarean section rate (in Red Cross War Memorial Children's Hospital (RCWMCH)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable.
			Numerator:	-	-	-	-	
			Denominator:	-	-	-	-	
	1.2 Ensure the delivery of RCWMCH services to manage the burden of disease at the appropriate level of care.	1.2.1 Ensure access to RCWMCH services by providing 270 beds by 2014/15.	2) Number of usable beds (in RCWMCH)	270	270	270	0.0%	Target achieved.
			3) Inpatient separations - total (in RCWMCH)	20 514	20 191	22 101	9.5%	Increase in separations noted mainly in the medical wards and short stay ward. Increase in day patients noted particular in the oncology and day surgery wards due to the commissioning of additional theatre slates.
			4) OPD headcount total (in RCWMCH)	116 035	121 938	118 631	(2.7%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			5) Patient day equivalents (PDE) total (in RCWMCH)	133 349	137 074	135 927	(0.8%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target. PDE was less than the planned target as the OPD headcounts and bed utilisation rate were slightly lower than planned.
	1.3 Ensure optimal access to RCWMCH hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed utilisation rate of 85% by 2014/15.	6) Inpatient bed utilisation rate (based on usable beds in RCWMCH)	78.0%	84.0%	83.6%	(0.5%)	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	81 238	82 782	82 503	(0.3%)	Bed utilisation rate was less than anticipated as the length of stay was shorter than planned.
			Denominator:	103 671	98 550	98 713	0.2%	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
2. Optimal financial management to maximise health outcomes.	2.1 Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality services at RCWMCH.	2.1.1 Ensure the cost effective management of RCWMCH at a target cost of R3 684 per patient day equivalent by 2014/15 [2011/12 Rands].	7) Expenditure per patient day equivalent (PDE) (in RCWMCH)	R3 561	R3 707	R3 760	1.4%	This is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The Department therefore considers a deviation of less than 5% as having achieved the target.
			Numerator:	474 828 239	508 192 700	511 063 961	0.6%	The patient day equivalents decreased, therefore the cost per PDE was higher. Increased expenditure in surgical and medical supplies as inventory was increased, as well as for security services.
			Denominator:	133 349	137 074	135 927	(0.8%)	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1 Management provides sustained strategic direction in the delivery of sustained health services with well-defined efficiency targets for RCWMCH.	3.1.1 Effectively manage allocated resources to achieve the target average length of stay of 4.2 days for RCWMCH by 2014/15.	8) Average length of stay (in RCWMCH)	4.0 days	4.1 days	3.7 days	(9.0%)	There was a stronger focus on the day patient care model (especially oncology and surgery) which resulted in an increase in the number of separations and subsequent reduction in the ALOS as more separations were recorded. There was a high turnover of patients in the short stay wards as well, which further reduced the average length of stay.
			Numerator:	81 238	82 782	82 503	(0.3%)	
			Denominator:	20 514	20 191	22 101	9.5%	
4. Improve the quality of health services and the patient experience.	4.1 Improve the quality of health services.	4.1.1 Ensure appropriate mechanisms to measure improvement in quality of health services.	9) Complaint resolution within 25 working days rate (from users of RCWMCH)	85.9%	80.0%	72.4%	(9.5%)	Complaint resolution is less than anticipated, as some of the complaints were very complex and required multiple stakeholders to participate in the resolution process, which extended the period to resolution beyond the planned target.
			Numerator:	110	96	105	9.4%	
			Denominator:	128	120	145	20.8%	
			10) Hospital patient satisfaction rate (in RCWMCH)	93.9%	90.0%	93.1%	3.5%	Patient satisfaction rate was higher than anticipated. This is deemed to be a positive deviation.
			Numerator:	1 354	2 610	1 411	(45.9%)	
			Denominator:	1 442	2 900	1 515	(47.8%)	

Programme 5: Central Hospital Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
			11) Percentage of assessments for compliance against the 6 priorities of the core standards (includes external assessment) (NIDS: Facility core standards self-assessment rate in central hospitals) Number of assessments at RCWMCH for compliance with the core standards	100.0%	100.0%	100.0%	0.0%	Target achieved.
			Numerator:	1	1	1	0.0%	
			Denominator:	1	1	1	0.0%	
			12) Morbidity and mortality review rate (in RCWMCH)	Not required to report	90.0%	100.0%	11.1%	More meetings were conducted than anticipated. This is deemed to be a positive performance. As this was the first year this indicator was reported in the APP, no baseline data was available for target setting. Actual performance for 2013/14 will be used to inform future targets.
			Numerator:	-	9	10	11.1%	
			Denominator:	-	10	10	0.0%	

Strategies to overcome areas of under-performance

No material under-performance, i.e. more than 10 per cent, identified for the hospital.

Changes to planned targets

No targets were changed during the year.

Linking performance with budgets

Table 4.5.10: Summary of expenditure for Central Hospital Services 2013/14

Expenditure	2013/14			2012/13		
Sub-programme	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000
5.1: Central Hospital Services	3 978 226	3 977 523	703	4 248 545	4 247 459	1 086
5.2: Provincial Tertiary Hospital Services	587 195	587 898	(703)	-	-	-
Total	4 565 421	4 565 421	-	4 248 545	4 247 459	1 086

The programme did not record any material under-performance in any of the planned service targets. There was also no material under- or over-expenditure recorded for the programme.

4.6 Programme 6: Health Sciences and Training

Purpose of the programme

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

Sub-programmes

Sub-programme 6.1: Nurse Training College

(Directorate: Western Cape College of Nursing – WCCN)

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

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

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

Sub-programme 6.3: Bursaries

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

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

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

Sub-programme 6.5: Training (Other)

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

Strategic objectives

(1) Increase the number of basic nurse students graduating (output) to 600 per annum by 2014/15.

(2) Ensure optimum competency levels of 150 health and support professionals per annum through education, training and development by 2014/15.

(3) Expand community-based care services through the optimum training and development of home based carers as part of Expanded Public Works Programme (EPWP) to 1 400 per annum by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

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

The Expanded Public Works Programme (EPWP) is a nationwide programme with the objective of drawing significant numbers of the unemployed into productive work so that learners gain skills while they work and increase their capacity to earn an income. The Western Cape Government is committed to providing and funding internship opportunities in line with Strategic Objective 1 – "Increase opportunities for growth and jobs". The Department contributed to the strategic objective by strengthening the sustainability of community-based services at primary care level through the funding of non-profit institutions to deliver the service and the training of home community based carers (HCBCs) and rehabilitation care workers (RCWs) towards the formal qualifications. In addition, internships were provided for data capturers, pharmacist assistants, basic ambulance assistants, emergency care technicians, human resource and finance interns (PAY project), which contributed towards creating employment opportunities and alleviating poverty through offering stipended work opportunities and training.

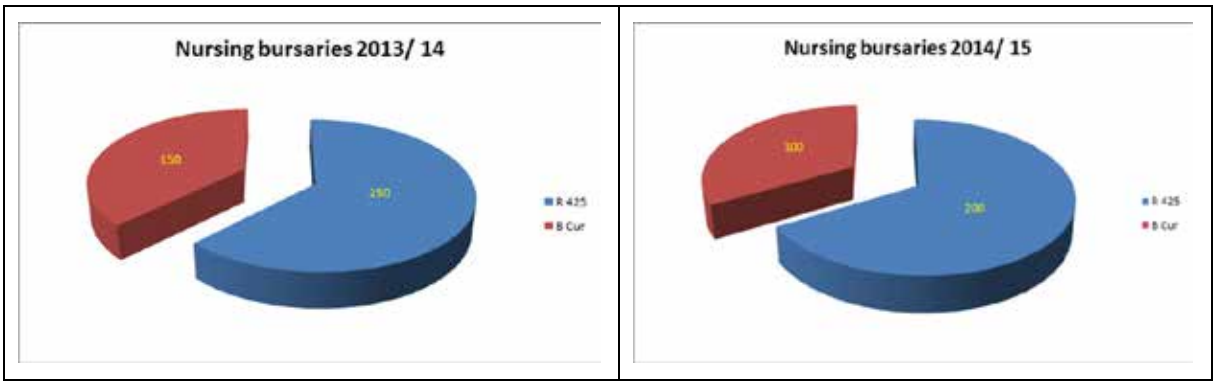
Leadership and management development training programmes were offered during the reporting period. The staff skill development strategy is to ensure appropriate numbers of managers at the various levels, and clinical managers, with the required competencies, are in place to effectively manage human resources and the burden of disease.

To strengthen the Department's ability to retain and recruit scarce skilled staff, bursaries are awarded for higher education to both serving and prospective employees, which is aligned to the Department's Human Resource Plan.

There has been a 25 per cent decrease in nursing bursaries (from 400 to 300 between 2013 and 2014) due to the non-availability of vacant funded posts. Furthermore, the Nursing Plan shows that there will be a large natural attrition due to retirements, an ageing workforce and resignation trends.

Projections for the four year training programme have been based on the anticipated staff losses (and not necessarily the shrinking of services, funding constraints, or the diminishing APL.)

Figure 4.6.1: Nursing bursaries



The skills development strategy addressed the continuous clinical skills and professional development of current health professionals through the identification of skills development needs to enhance critical clinical skills. It also addressed the implementation of evidence-based methodologies/training interventions to build capacity at an individual and team level in support of the evidence-based packages of care required across the service platform in emergency health care, chronic disease management, infectious diseases, women's and child health, and mental health.

Western Cape College of Nursing (WCCN)

Strategies to improve the throughput of students in the basic programme include improved marketing and recruitment with better selection criteria, improved teaching methodologies, increased support in the foundation programmes as well as the straight programmes, and improved services from the learning resource centres at the campus by improving the number of resources and quality of research material. Other areas where improved support was given are the computer training facility and the simulation laboratory. Improving the capacity of the media production unit has an important role to play in terms of learning resource support.

New programmes were introduced at the college. Accreditation had to be obtained from the SA Nursing Council (SANC) for the college teaching sites, the new programmes being introduced and the respective clinical areas for student placement. The programmes are advanced midwifery and neonatology and advanced psychiatry. This had cost implications in terms of staffing and accreditation fees charged by SANC.

Preparation and implementation of the new basic four-year programme, at a higher level than the previous four-year Diploma, has drawn much on the college's human resources.

The above-mentioned introduction of new programmes required significant capacity building/staff development to ensure success. It involved formal studies by academic staff and capacity building on an in-service basis or through workshops/seminars and conferences attended off site.

The mandatory introduction of the new SANC qualifications at a higher education level that will commence in 2016, and its impact on the college as a result of the preparation needed to offer such programmes, is huge in terms of human resources, time, and capacitating and developing the staff. There will be no accreditation requested of SANC and the Council on Higher Education of teaching sites, programmes and clinical areas.

Increased WCCN student numbers in the rural areas is in line with the expansion of the college into such rural areas, allowing improved access for students. With increasing numbers, resources must be increased to ensure a successful programme offering an increased throughput rate.

Adequate clinical accompaniment of students in the clinical areas remains a challenge due to a diminishing teaching role of the unit sister. This has forced the college to increase the lecturer and clinical educator presence in the clinical areas to ensure students get the necessary support to render the quality patient care during training and on qualifying. The increased staff numbers have impacted the budget.

EMS college

During the review period, the EMS college continued to focus on building skills capacity of college and operational employees in alignment with the strategic goals for Health Sciences and Training. This focus was aimed at areas of EMS management, college lecturers and communications.

To address lack of management skills in EMS, training of line managers was increased. Management training was necessary for empowerment of new base managers, appointed from the ranks of operational EMS employees with very little or no prior management training. The expansion of management training aims to streamline adherence to departmental policies, increase efficiency of service delivery and retention of EMS operational employees.

In light of the national education and training migration plan of short course training into NQF qualifications, the college provided formal educational qualification to current college lecturers with the view of improving quality of training, consonant with NQF aligned educational principles and methodology. Improved quality of training aims to reflect in quality of college graduates and ultimately in EMS service delivery.

The Directorate: Human Resource Development (HRD) provided training workshops throughout the period, across all districts, to keep operational EMS employees abreast with best practice, comply with continuous professional development (CPD) requirements and to address issues flagged by quality assurance.

To improve staff motivation and retention in the communications centre, the college supported up-skilling of employees into formal National Qualifications Framework (NQF) qualifications relevant to call taking and dispatching. Moreover, formal training was necessary to enhance staff capacity for implementation of the evolution programme rolled out in 2014.

In line with WCG: Health's strategic objectives, the college has provided employment opportunity to rural communities by selecting a sample of students from rural areas into the emergency care technician (ECT) programme with secured employment within EMS, following completion of their studies. This will improve skills mix in rural areas by providing practitioners with advanced life support scope.

In support of the stipend programme implemented in Western Cape EMS, the college provided up-skilling and refresher training of the stipend holders to improve their employment opportunities and thus address alleviation of poverty and unemployment.

Table 4.6.1: Strategic objectives for Health Sciences and Training 2013/14

Programme 6: Health Sciences and Training								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Develop and maintain a capacitated workforce to deliver the required health services.	1.1 Develop, implement, monitor and evaluate a comprehen-sive Training Plan guided by the Human Resource Plan for health and support professionals in line with the Comprehen-sive Service Plan (CSP).	1.1.1 Increase the number of basic nurse students graduating (output) to 600 per annum by 2014/15.	1) Basic nurse students graduating (at nursing college and HEIs)	336	550	411	(25.3%)	Fewer students graduated from UWC than anticipated. Higher attrition than expected. A 27% attrition rate.
		1.1.2 Ensure optimum competency levels of 150 health and support professionals per annum through education, training and development by 2014/15.	2) EMC intake on accredited HPCSA courses	112	132	159	20.5%	An increase in classroom facilities allowed for the additional intake of students. There were no additional financial implications.
	1.2 Use the Expanded Public Works Programme (EPWP) to create employment opportunities linked to training in line with the Human Resource Plan.	1.2.1 Expand community-based care services through the optimum training and development of home based carers as part of Expanded Public Works Programme (EPWP) to 1 400 per annum by 2014/15.	3) Intake of home community-based carers (HCBCs)	2 000	1 400	1400	0.0%	Target achieved. Note: The target for the HCBC programme was reduced due to a critical mass that was reached in training from 2007 to date. In future, the major focus will be on entry level HCBCs with a further reduction in target.

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.6.2: Performance indicators for Health Sciences and Training 2013/14

Programme 6: Health Sciences and Training							
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Develop and maintain a capacitated workforce to deliver the required health services.	1.1 Develop, implement, monitor and evaluate a comprehen-sive Training Plan guided by the Human Resource Plan for health and support professionals in line with the Comprehen-sive Service Plan (CSP).	1.1.1 Increase the number of basic nurse students graduating (output) to 600 per annum by 2014/15.	1) Intake of nurse students (1st year at nursing college)	326	250	268	7.2%	There was a slight increase in the intake of students including those students on the first year of the extended curriculum programme (ECP).
			2) Intake of nurse students (1st to 4th year at HEIs and nursing college)	2 391	2 200	2 243	2.0%	There was a slight increase in the intake of students in their first year at the nursing college.
			3) Basic nurse students graduating (at nursing college)	209	230	238	3.5%	More students graduated midyear at the college than anticipated.
			4) Basic nurse students graduating (at nursing college and HEIs)	336	550	411	(25.3%)	Fewer students graduated from UWC than anticipated. Higher attrition than expected. A 27% attrition rate.
			5) Students with bursaries from the province	3 153	2 500	2 546	1.8%	There was a slight increase in bursaries allocated to students from the province based on the availability of budget.
		1.1.2 Ensure optimum competency levels of 150 health and support professionals per annum through education, training and development by 2014/15.	6) EMC intake on accredited HPCSA courses	112	132	159	20.5%	An increase in classroom facilities allowed for the additional intake of students. There were no additional financial implications.
	1.2 Use the Expanded Public Works Programme (EPWP) to create employment opportunities linked to training in line with the Human Resource Plan.	1.2.1 Expand community-based care services through the optimum training and development of home based carers as part of Expanded Public Works Programme (EPWP) to 1 400 per annum by 2014/15.	7) Intake of home community-based carers (HCBCs)	2 000	1 400	1400	0.0%	Target achieved. Note: The target for the HCBC programme was reduced due to a critical mass that was reached in training from 2007 to date. In future, the major focus will be on entry level HCBCs with a further reduction in target.
			8) Intake of data-capturer interns	148	120	163	35.8%	Increase in data capturer intake due to service need and availability of budget.
			9) Intake of pharmacy assistants	96	100	96	(4.0%)	Intake reduced in rural districts due to the lack of availability of accredited pharmaceutical training sites
			10) Intake of Assistant to Artisan (ATA) interns	120	120	127	5.8%	Increase in intake due to availability of additional mentor capacity.
			11) Intake of HR and finance interns	186	130	130	0.0%	Target achieved.

Strategies to overcome areas of under-performance

Basic nurse students graduating (at nursing college and HEIs)

Fewer students graduated from UWC than anticipated. Target: 550 Actual: 371

Under-performance: 32%

There was a higher attrition rate at UWC, 27% of final year students, than expected. UWC will have to put measures in place to minimise attrition. The Directorate: Human Resource Development and the Directorate: Nursing will continue to engage with UWC on the measures UWC will implement to minimise attrition.

Changes to planned targets

No targets were changed during the year.

Linking performance with budgets

Table 4.6.3: Summary of expenditure for Health Sciences and Training 2013/14

Expenditure	2013/14			2012/13		
Sub-programme	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000
6.1: Nurse Training College	80 027	79 031	996	73 036	73 034	2
6.2: Emergency Medical Services (EMS) Training College	21 808	23 186	(1 378)	19 649	18 875	774
6.3: Bursaries	53 001	52 716	285	73 674	72 448	1 226
6.4: Primary Health Care (PHC) Training	1	-	1	1	-	1
6.5: Training (Other)	111 425	109 260	2 165	110 193	112 194	(2 001)
Total	**266 262**	**264 193**	**2 069**	**276 553**	**276 551**	**2**

No material under or over-expenditure was reported for Programme 6.

The funding was utilised to provide the services as described under the provincial strategic objective "*Develop and maintain a capacitated workforce to deliver the required health services*" earlier on in this section.

4.7 Programme 7: Health Care Support Services

Purpose of the programme

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

Sub-programmes

Sub-programme 7.1:	Laundry Services
	Rendering a laundry and related technical support service to health facilities.
Sub-programme 7.2:	Engineering Services
	Rendering engineering support services to the Department for the maintenance of health technology, engineering installations and related equipment and infrastructure.
Sub-programme 7.3:	Forensic Pathology Services
	Rendering specialised forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death.
	This function has been transferred from Sub-programme 2.8.
	Providing the Inspector of Anatomy functions in terms of Chapter 8 of the National Health Act and its Regulations.
Sub-programme 7.4:	Orthotic and Prosthetic Services
	Rendering specialised orthotic and prosthetic services.
	This service is reported in Sub-programme 4.4.
Sub-programme 7.5:	Cape Medical Depot
	Managing the supply of pharmaceuticals and medical supplies to health facilities.
	Note that Sub-programme 7.5 has been renamed in line with the incorporation of the trading entity into the Department. Please refer to Sub-programme 7.5 for detail.

LAUNDRY SERVICES

Strategic objective

(1) Provide a cost effective and efficient laundry service to all health facilities by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

Develop and maintain appropriate health technology, infrastructure and ICT

Health technology and infrastructure

Good progress is being made towards achieving the strategic objective to provide a cost effective and efficient laundry service to all health facilities by 2014/15 with the following as highlights:

- The upgrading, extension and equipping of Lentegeur Regional Laundry reached completion during 2013/14 and will ensure the rendering of a more cost effective and efficient laundry service from this facility.
- The reduction of electricity and water consumption by 5 per cent at in-house laundries by 2015/16 has been identified as a priority. This directly links back to the above-mentioned strategic objective.
- Cost-effectiveness should be enhanced when the linen management policy, which is currently being revised, is implemented at facilities.

The strategic objective indicator target of an average cost of R4.37 per item laundered in-house was not achieved in 2013/14 (actual performance was R4.40). Indications are, however, that the 2014/15 strategic plan target of an average cost of R4.56 per item laundered in-house can still be achieved. It is important to note that this indicator only includes the service being rendered by the three regional laundries and thus excludes the service being rendered from the on-premises laundries.

The target for outsourced laundry services, set at R3.03 per item laundered outsourced, was not achieved. The main reasons are: an increase in cost per item laundered for Khayelitsha Hospital due to a new contract, and the outsourcing of the linen service for George Hospital due to the unreliability of the George Laundry equipment.

Table 4.7.1: Strategic objectives for Laundry Services 2013/14

Programme 7: Health Care Support Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Develop and maintain appropriate health technology, infrastructure and ICT.	1.1 Effective and efficient laundry service.	1.1.1 Provide a cost effective and efficient laundry service to all health facilities by 2014/15.	1) Average cost per item laundered in-house	R3.61	R4.37	R4.40	0.7%	The average cost per piece laundered was higher than the annual target mainly due to the following: • Maintenance required at Tygerberg Regional Laundry during the 2nd quarter; and • Less items were laundered, but fixed costs e.g. salaries remain the same – work for George Hospital has been outsourced since December 2013. A reduction in the number of items laundered thus results in an increase in cost per item laundered.
			Numerator:	57 167 185	68 899 022	63 260 438	(8.2%)	
			Denominator:	15 826 075	15 752 478	14 376 272	(8.7%)	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.7.2: Performance indicators for Laundry Services 2013/14

Programme 7: Health Care Support Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Develop and maintain appropriate health technology, infrastructure and ICT.	1.1 Effective and efficient laundry service.	1.1.1 Provide a cost effective and efficient laundry service to all health facilities by 2014/15.	1) Average cost per item laundered in-house	R3.61	R4.37	R4.40	0.7%	The average cost per piece laundered was higher than the annual target mainly due to the following: • Maintenance required at Tygerberg Regional Laundry during the 2nd quarter; and • Less items were laundered, but fixed costs e.g. salaries remain the same – work for George Hospital has been outsourced since December 2013. A reduction in the number of items laundered thus results in an increase in cost per item laundered.
			Numerator:	57 167 185	68 899 022	63 260 438	(8.2%)	
			Denominator:	15 826 075	15 752 478	14 376 272	(8.7%)	
			2) Average cost per item laundered outsourced	R3.02	R3.03	3.19	5.3%	The main reasons for the higher cost per piece are: • The cost per piece for Khayelitsha Hospital increased from December 2013 due to a new contract being entered into. The laundry service for this hospital will be moved to in-house during 2014/15. • George Hospital linen was outsourced from December 2013 due to the unreliability of the George Laundry equipment.
			Numerator:	21 008 525	18 533 999	22 685 064	22.4%	
			Denominator:	6 946 078	6 117 589	7 118 224	16.4%	

Strategies to overcome areas of under-performance

- The cost effectiveness and efficiency of the laundry service in Eden must be improved. Good progress has been made with this process and changes are planned to be implemented during 2014/15.
- The production capacity at the newly upgraded Lentegeur Regional Laundry will be maximised, adding lean management principles.
- Balancing the workload between in-house and outsourced laundry services is being monitored on a continuous basis to ensure the rendering of an uninterrupted laundry service.
- The measurement and reporting of linen losses must be improved.

Changes to planned targets

No targets were changed during the year.

ENGINEERING SERVICES

Strategic objectives

(1) Ensure that 91.8 per cent of all engineering emergency cases reported are attended to within 48 hours by 2014/15.

(2) Provide an effective and efficient maintenance service to all health facilities maintained by Engineering Services by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

Develop and maintain appropriate health technology, infrastructure and ICT

In order to adhere to the strategic objective to ensure the rendering of an effective and efficient maintenance service to all health facilities, work was begun during the 2011/12 financial year on what is referred to as the "Maintenance Hub Organisation Development Study". This work, which includes both health technology and building maintenance, is part of the Infrastructure Delivery Management System Capacitation Framework initiative and is currently in the sign-off process.

Phased implementation is planned to begin during 2014/15. This will see the establishment of maintenance hubs, located in strategically identified geographical areas across the Province and supported by workshops, which will be centres for the rendering of technical and health technology services. This will improve efficiency and better utilisation of scarce technical skills.

Water and electricity consumption will be monitored at selected provincial hospitals from 2014/15 with the aim to reduce consumption by means of implementing technical as well as behavioural change. The introduction of smart metering is one of the means to improve this monitoring. It is further aimed to expand the monitoring to include all provincial hospitals by the end of 2015/16.

In terms of performance, the targets for three of the four strategic objectives were exceeded, namely:

- Percentage of engineering emergency cases attended to within 48 hours, which reflects higher efficiency.
- Percentage of maintenance budget spent as the budget was overspent by 3.8 per cent, which is mainly due to additional preventative maintenance work undertaken on medical life-support equipment.
- Percentage of clinical engineering maintenance jobs completed. The target was exceeded by 22.6 per cent as additional jobs were undertaken whilst the clinical engineering teams visit the facilities. This facilitates the rendering of uninterrupted healthcare services by reducing potential downtime.

Performance on the fourth strategic objective, namely the percentage of engineering maintenance jobs completed, was 9.9 per cent below target and was mainly due to the reduction in maintenance work in order for the servicing of medical life-support equipment to be expedited and to minimise over expenditure.

In line with the strategic goal, the Chief Directorate is committed to continue to provide an effective and efficient maintenance service to all health facilities maintained by Directorate: Engineering and Technical Support by 2014/15.

Table 4.7.3: Strategic objectives for Engineering Services 2013/14

Programme 7: Health Care Support Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Develop and maintain appropriate health technology, infrastructure and ICT.	1.1 Effective and efficient maintenance service to all health facilities.	1.1.1 Ensure that 91.8% of all engineering emergency cases reported are attended to within 48 hours by 2014/15.	1) Percentage of engineering emergency cases addressed within 48 hours	100.0%	90.9%	94.1%	3.5%	The annual target of 90.9% was exceeded, which indicates an improved response time.
			Numerator:	218	189	190	0.5%	
			Denominator:	218	208	202	(2.9%)	
	1.2 Efficiency and effectiveness of Engineering Services.	1.2.1 Provide an effective and efficient maintenance service to all health facilities maintained by Engineering Services by 2014/15.	2) Percentage of maintenance budget spent	91.9%	100.0%	103.8%	3.8%	Performance is slightly above target due to unscheduled work that was undertaken by the Life Support Unit of Clinical Engineering whilst at facilities. This approach is to the advantage of the Department as it minimises downtime.
			Numerator:	87 581	101 221	107 356	6.1%	
			Denominator:	95 259	101 221	103 400	2.2%	
			3) Percentage of clinical engineering maintenance jobs completed	93.0%	77.5%	95.0%	22.6%	Performance is significantly above target and more than 1 300 more jobs were done than the previous year due to unscheduled work that was undertaken by the Life Support Unit of Clinical Engineering whilst at facilities. This approach is to the advantage of the Department as it minimises downtime.
			Numerator:	10 851	8 000	12 182	52.3%	
			Denominator:	11 672	10 320	12 820	24.2%	
			4) Percentage of maintenance jobs (excluding clinical engineering jobs) completed	85.5%	91.0%	82.0%	(9.9%)	Under-performance mainly due to: • Initial delays in finalising day-to-day professional maintenance list (due to late submission from districts), causing a slow start which negatively impacted on overall performance for the year. • Procurement challenges experienced during Quarter 3 caused delays which effect is visible in the 2013/14 annual performance results. • A reduction in maintenance work in order for the servicing of medical life-support equipment to be expedited and to minimise over expenditure.
			Numerator:	12 775	12 387	12 039	(2.8%)	
			Denominator:	14 944	13 612	14 677	7.8%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.7.4: Performance indicators for Engineering Services 2013/14

Programme 7: Health Care Support Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Develop and maintain appropriate health technology, infrastructure and ICT.	1.1 Effective and efficient maintenance service to all health facilities.	1.1.1 Ensure that 91.8% of all engineering emergency cases reported are attended to within 48 hours by 2014/15.	1) Percentage of engineering emergency cases addressed within 48 hours	100.0%	90.9%	94.1%	3.5%	The annual target of 90.9% was exceeded, which indicates an improved response time.
			Numerator:	218	189	190	0.5%	
			Denominator:	218	208	202	(2.9%)	
	1.2 Efficiency and effectiveness of Engineering Services.	1.2.1 Provide an effective and efficient maintenance service to all health facilities maintained by Engineering Services by 2014/15.	2) Percentage of maintenance budget spent	91.9%	100.0%	103.8%	3.8%	Performance is slightly above target due to unscheduled work that was undertaken by the Life Support Unit of Clinical Engineering whilst at facilities. This approach is to the advantage of the Department as it minimises downtime.
			Numerator:	87 581	101 221	107 356	6.1%	
			Denominator:	95 259	101 221	103 400	2.2%	
			3) Percentage of clinical engineering maintenance jobs completed	93.0%	77.5%	95.0%	22.6%	Performance is significantly above target and more than 1 300 more jobs were done than the previous year due to unscheduled work that was undertaken by the Life Support Unit of Clinical Engineering whilst at facilities. This approach is to the advantage of the Department as it minimises downtime.
			Numerator:	10 851	8 000	12 182	52.3%	
			Denominator:	11 672	10 320	12 820	24.2%	
			4) Percentage of maintenance jobs (excluding clinical engineering jobs) completed	85.5%	91.0%	82.0%	(9.9%)	Under-performance mainly due to: • Initial delays in finalising day-to-day professional maintenance list (due to late submission from districts), causing a slow start which negatively impacted on overall performance for the year. • Procurement challenges experienced during Quarter 3 caused delays which effect is visible in the 2013/14 annual performance results. • A reduction in maintenance work in order for the servicing of medical life-support equipment to be expedited and to minimise over expenditure.
			Numerator:	12 775	12 387	12 039	(2.8%)	
			Denominator:	14 944	13 612	14 677	7.8%	

Strategies to overcome areas of under-performance

- Institutionalise the Infrastructure Delivery Management System (IDMS) in accordance with Provincial Treasury Instruction 16B.
- Implement the maintenance hub organisational development study including both building health technology and maintenance as funding is made available.
- Continue to strive to fill all technical posts with qualified and experienced personnel and ensure that adequate succession plans are put in place.
- Preventive maintenance by clinical engineering will be continued which should reduce downtime of medical life support equipment.

Changes to planned targets

No targets were changed during the year.

FORENSIC PATHOLOGY SERVICES

Strategic objective

(1) Provide an efficient Forensic Pathology Service through maintenance of response times to achieve a response of 79.0 per cent within the 40 minutes target by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

Address the burden of disease

The Forensic Pathology Service (FPS) addresses the burden of disease by ensuring access to the service through the management of response times as well as turnaround times of forensic pathology cases.

Percentage of FPS cases responded to within 40 minutes

Despite an increase of 2.9 per cent in scenes attended year-on-year and no additional resources, the overall target for response times were achieved in that 77.8 per cent of scenes were attended within the 40 minute target.

Percentage of cases examined within three days

The target for cases examined within three days was not achieved as only 72.3 per cent of cases were examined within three days against the target of 77.0 per cent. This was largely due to the following:

- The Metro is the biggest contributor towards the provincial caseload and in not achieving the performance during the first two quarters of the year which resulted in the Province not meeting the target. The Metro experienced an increase in case admissions (192 cases, 3 per cent) and also the nature and complexity of the cases.
- There was 4.3 per cent increase in examinations in the Metro (6 180 in 2012/13 to 6 447 in 2013/14), contributing to 65 per cent of the provincial caseload.
- Targets were not reached in some areas due to facilities transporting the decedents to autopsy facilities or doctors travelling to other facilities for examinations.

  This contributed 9 per cent to the provincial total.

Percentage of FPS cases released within five days (excluding unidentified persons)

FPS experienced an increase in caseload and therefore the number of cases released also increased. None of the geographic areas were able to achieve the target of 80 per cent:

- Metro – 75 per cent, attributed to increase in caseload and case complexity (murder shot and procedure related deaths);
- West Coast – 70 per cent, attributed to doctors or cases having to travel;
- Winelands and Overberg – 77 per cent, attributed to cases having to travel;
- Eden and Central Karoo – 73 per cent, attributed to doctors or cases having to travel.

  This impacted on the ability to release the deceased within the expected target.

Operational staff or doctors having to travel for autopsies increases examination times which impacts on the turn-around times for release.

Scientific identification of deceased also impacts on release times.

Table 4.7.5: Strategic objectives for Forensic Pathology Services 2013/14

Programme 7: Health Care Support Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Ensure access to a Forensic Pathology Service.	1.1.1 Provide an efficient Forensic Pathology Service through maintenance of response times to achieve a response of 79.0% within the 40 minutes target by 2014/15.	1) Percentage of FPS cases responded to within 40 minutes	76.6%	78.0%	77.8%	(0.3%)	Despite an increase of 2.9% in scenes attended year-on-year and no additional resources, the overall deviation from target is within acceptable limits to the Department. The challenges are greater within rural districts owing to the longer distances to cover.
			Numerator:	6 940	7 220	7 266	0.6%	
			Denominator:	9 076	9 257	9 340	0.9%	
			2) Percentage of cases examined within 3 days	78.0%	77.0%	72.3%	(6.1%)	The Metro is the biggest contributor towards the caseload and in not achieving the performance target during the first and second quarter it impacted on FPS not meeting the target overall. The Metro experienced a 3% increase in caseload (192 cases).
			Numerator:	7 622	7 754	7 217	(6.9%)	
			Denominator:	9 779	10 070	9 984	(0.9%)	The challenges are greater within rural districts owing to the longer distances to cover.
			3) Percentage of FPS cases released within 5 days (excluding unidentified persons)	78.3%	80.0%	74.4%	(7.0%)	FPS experienced an increase in caseload and therefore the number of cases released also increased. None of the geographic areas were able to achieve the target. Operational staff or doctors having to travel for autopsies increases examination times which impacts on the turnaround times for release.
			Numerator:	7 079	7 324	7 177	(2.0%)	Scientific identification of deceased also impacts on release times.
			Denominator:	9 032	9 155	9 646	5.4%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.7.6: Performance indicators for Forensic Pathology Services 2013/14

Programme 7: Health Care Support Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Address the burden of disease.	1.1 Ensure access to a Forensic Pathology Service.	1.1.1 Provide an efficient Forensic Pathology Service through maintenance of response times to achieve a response of 79.0% within the 40 minutes target by 2014/15.	1) Percentage of FPS cases responded to within 40 minutes	76.6%	78.0%	77.8%	(0.3%)	Despite an increase of 2.9% in scenes attended year-on-year and no additional resources, the overall deviation from target is within acceptable limits to the Department. The challenges are greater within rural districts owing to the longer distances to cover.
			Numerator:	6 940	7 220	7 266	0.6%	
			Denominator:	9 076	9 257	9 340	0.9%	
			2) Percentage of cases examined within 3 days	78.0%	77.0%	72.3%	(6.1%)	The Metro is the biggest contributor towards the caseload and in not achieving the performance target during the first and second quarter it impacted on FPS not meeting the target overall. The Metro experienced a 3% increase in caseload (192 cases).
			Numerator:	7 622	7 754	7 217	(6.9%)	
			Denominator:	9 779	10 070	9 984	(0.9%)	The challenges are greater within rural districts owing to the longer distances to cover.
			3) Percentage of FPS cases released within 5 days (excluding unidentified persons)	78.3%	80.0%	74.4%	(7.0%)	FPS experienced an increase in caseload and therefore the number of cases released also increased. None of the geographic areas were able to achieve the target. Operational staff or doctors having to travel for autopsies increases examination times which impacts on the turnaround times for release.
			Numerator:	7 079	7 324	7 177	(2.0%)	Scientific identification of deceased also impacts on release times.
			Denominator:	9 032	9 155	9 646	5.4%	

Strategies to overcome areas of under-performance

The Approved Post List for 2014/15 has been expanded with the creation and activation of a specialist post in the West Coast area.

An organisational development investigation was concluded during 2013/14 with recommendation on an increase in the staff establishment with a specific focus on medical capacity and support for forensic pathology officers in the Metro.

The Directorate will investigate alternative DNA (deoxyribonucleic acid) analysis options to expedite the scientific identification of deceased.

Changes to planned targets

No targets were changed during the year.

ORTHOTIC AND PROSTHETIC SERVICES

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

CAPE MEDICAL DEPOT

Strategic objective

(1) Ensure pharmaceutical stock levels of 97.0 per cent at the CMD by 2014/15.

Strategic objectives, performance indicators, planned targets and actual achievements

Ensure and maintain organisational strategic management capacity and synergy

The nature and scope of the services provided by the Cape Medical Depot (CMD) is outlined below:

- Supply management information relating to the procurement, availability, warehousing and distribution of products to the Head of Health of the Province, the Directorate: Pharmacy Services, the National Department of Health, demanders, and other relevant stakeholders.
- Procurement, warehousing and distribution of products to facilities and persons registered with the CMD as demanders (pharmaceutical and non-pharmaceutical items).

- Pre-packing bulk into patient ready packs.
- Quality control testing of medication (random batch testing).
- Ensure compliance with the relevant legislative and prescripts as stipulated by the Pharmacy Council of South Africa and Medicines Control Council.
- Monitor provincial performance management of pharmaceutical and non-pharmaceutical suppliers.

Table 4.7.7: Strategic objectives for the Cape Medical Depot 2013/14

Programme 7: Health Care Support Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Ensure and maintain organisational strategic management capacity and synergy.	1.1 To ensure optimum pharma-ceutical stock levels to meet the demand.	1.1.1 Ensure pharmaceutical stock levels of 97% at the CMD by 2014/15.	1) Percentage of pharmaceutical stock available	86.1%	97.0%	94.8%	(2.3%)	Although tenders were in place, stock outages are monitored closely and contingency plans are in place and managed. Poor supplier performance, combined with the last vestiges of the late award of tenders in the previous year, resulted in the target not being achieved. The deviation of 2.3% is however still deemed acceptable.
			Numerator:	640	735	746	1.5%	
			Denominator:	743	758	787	3.8%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.7.8: Performance indicators for the Cape Medical Depot 2013/14

Programme 7: Health Care Support Services								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Ensure and maintain organisational strategic management capacity and synergy.	1.1 To ensure optimum pharmaceuti cal stock levels to meet the demand.	1.1.1 Ensure pharma-ceutical stock levels of 97% at the CMD by 2014/15.	1) Percentage of pharmaceutical stock available	86.1%	97.0%	94.8%	(2.3%)	Although tenders were in place, stock outages are monitored closely and contingency plans are in place and managed. Poor supplier performance, combined with the last vestiges of the late award of tenders in the previous year, resulted in the target not being achieved. The deviation of 2.3% is however still deemed acceptable.
			Numerator:	640	735	746	1.5%	
			Denominator:	743	758	787	3.8%	

Strategies to overcome areas of under-performance

No material under-performance identified for the Cape Medical Depot.

Changes to planned targets

No targets were changed during the year.

Linking performance with budgets

Table 4.7.9: Summary of expenditure for Health Care Support Services 2013/14

Expenditure	2013/14			2012/13		
Sub-programme	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000
7.1: Laundry Services	73 729	69 859	3 870	77 844	84 900	(7 056)
7.2: Engineering Services	103 404	107 355	(3 951)	94 537	87 580	6 957
7.3: Forensic Pathology Services	114 645	114 819	(174)	107 690	107 592	98
7.4: Orthotic and Prosthetic Services	1	-	1	1	-	1
7.5: Cape Medical Depot	63 759	47 118	16 641	44 649	44 648	1
Total	**355 538**	**339 151**	**16 387**	**324 721**	**324 720**	**1**

Expenditure on Laundry Services, including related technical support, has ensured that an uninterrupted service could be rendered to all health facilities in the Province thereby ensuring an ongoing supply of clean disinfected linen (bedding, theatre linen and clothing, dressing linen, etc.).

In terms of Engineering Services, expenditure ensured that the following outputs could be achieved:

- Ongoing maintenance to infrastructure, engineering installations and related equipment at health facilities.
- Ongoing maintenance to health technology including medical life-saving equipment at health facilities.

The under-spending within the Cape Medical Depot is due to:

- A lower than expected stock value at year end due to less stock being maintained as a result of improved stock control.
- A new courier contract with considerable lower rates.

4.8 Programme 8: Health Facilities Management

Purpose of the programme

The provision of new health facilities and the upgrading and maintenance of existing facilities.

Sub-programmes

Sub-programme 8.1: Community Health Facilities

Planning, construction, upgrading, refurbishment, additions, and maintenance of community health centres, community day centres, and clinics.

Sub-programme 8.2: Emergency Medical Services

Planning, construction, upgrading, refurbishment, additions, and maintenance of emergency medical services facilities.

Sub-programme 8.3: District Hospital Services

Planning, construction, upgrading, refurbishment, additions, and maintenance of district hospitals.

Sub-programme 8.4: Provincial Hospital Services

Planning, construction, upgrading, refurbishment, additions, and maintenance of provincial hospitals.

Sub-programme 8.5: Central Hospital Services

Planning, construction, upgrading, refurbishment, additions, and maintenance of central hospitals.

Sub-programme 8.6: Other Facilities

Planning, construction, upgrading, refurbishment, additions, and maintenance of other health facilities, including forensic pathology facilities and nursing colleges.

Strategic objectives

(1) Ensure that 100.0 per cent of the annual allocated budgets are spent.

(2) Ensure 100.0 per cent achievement of projects planned for completion annually.

Strategic objectives, performance indicators, planned targets and actual achievements

Develop and maintain appropriate health technology, infrastructure and ICT

Programme 8 (Health Facilities Management) will continue in its aim to spend the total annual allocated budget and achieve all planned project deliverables. In spite of various mechanisms being in place to monitor expenditure and oversee progress of projects, challenges remain. These challenges include longer design and procurement periods, construction delays, civil unrest and strikes, as well as scope change requests. In collaboration with the implementing department, WCG: Transport and Public Works, numerous attempts are being made to improve delivery of projects. Work is continuing on establishing norms and standards, developing standard designs, enhanced definition of service package and planning that ensures that additional projects are ready for implementation where current projects fail or are stalled.

In terms of performance, none of the targets for the three strategic objectives were met. This is mainly due to challenges as stated above.

With respect to the other five performance targets, four have been achieved and one was exceeded, namely the expenditure on health technology.

Table 4.8.1: Strategic objectives for Health Facilities Management 2013/14

Programme 8: Health Facilities Management								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Develop and maintain appropriate health technology, infrastructure and ICT.	1.1 Effective and efficient management of infrastructure expenditure.	1.1.1 Ensure that 100% of the annual allocated budgets are spent.	1) Percentage of health infrastructure component budget spent	96.3%	100.0%	72.4%	(27.6%)	Main contributors to the under-performance: • Civil unrest and construction industry strike negatively impacted on projects such as Karl Bremer Hospital new emergency centre and new Du Noon CHC. • Design delays on some projects (Prince Alfred Hamlet Clinic, Wolseley Clinic and Napier Clinic). • Slow progress by contractors. • Land availability. • Internal resource constraints – additional resources were appointed in Quarter 4 (recruitment process).
			Numerator:	129 259	122 296	92 131	(24.7%)	
			Denominator:	134 234	122 296	127 271	4.1%	
			2) Percentage of hospital revitalisation component budget spent	88.1%	100.0%	93.5%	(6.5%)	Main contributors to the under- performance are: • Civil unrest and construction industry strike negatively impacted on projects (e.g. Karl Bremer Hospital new emergency centre). • Delays in planning (renovations to existing buildings at Valkenberg Hospital and new psychiatric unit at Paarl Hospital, hybrid theatre at Groote Schuur Hospital). • Design delays on some projects (Paarl Hospital psychiatric ward, District Six CDC, Wolseley Clinic). • Slow progress by contractors (Vredenburg Hospital Phase 2B, Hermanus CDC, Delft CDC, Mitchells Plain Hospital new 72-hour assessment unit, psychiatric ward at George Hospital), • Temporary new emergency centre at Heideveld CDC – completion date delayed, • Delays in the appointment of the transaction advisors on the Tygerberg Hospital redevelopment project.
			Numerator:	444 226	493 526	517 814	4.9%	
			Denominator:	504 414	493 526	553 714	12.2%	
	1.2 Effective and efficient management of infrastructure delivery.	1.2.1 Ensure 100% achievement of projects planned for completion annually.	3) Percentage of capital projects completed	190.0%	100.0%	16.7%	(83.3%)	No deviation – 100% of the budget was spent.
			Numerator:	19	6	1	(83.3%)	
			Denominator:	10	6	6	0.0%	

* This refers to the deviation between the planned target and the actual achievement for 2013/14.

Note: Strategic objective indicators are repeated in the performance indicator table below to maintain consistency with information published in the 2013/14 Annual Performance Plan.

Table 4.8.2: Performance indicators for Health Facilities Management 2013/14

Programme 8: Health Facilities Management								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
1. Develop and maintain appropriate health technology, infrastructure and ICT.	1.1 Effective and efficient management of infrastructure expenditure.	1.1.1 Ensure that 100% of the annual allocated budgets are spent.	1) Percentage of preventive maintenance (Equitable Share) budget spent	89.7%	100.0%	100.0%	0.0%	No deviation – 100% of the budget was spent.
			Numerator:	10 285	20 465	20 465	0.0%	
			Denominator:	11 465	20 465	20 465	0.0%	
			2) Percentage of scheduled maintenance (Equitable Share) budget spent	100.0%	100.0%	100.0%	0.0%	No deviation – 100% of the budget was spent.
			Numerator:	146 918	100 000	100 000	0.0%	
			Denominator:	146 918	100 000	100 000	0.0%	
			3) Percentage of health infrastructure component budget spent	96.3%	100.0%	72.4%	(27.6%)	Main contributors to the under-performance: • Civil unrest and construction industry strike negatively impacted on projects such as Karl Bremer Hospital new emergency centre and new Du Noon CHC. • Design delays on some projects (Prince Alfred Hamlet Clinic, Wolseley Clinic and Napier Clinic). • Slow progress by contractors. • Land availability. • Internal resource constraints – additional resources were appointed in Quarter 4 (recruitment process).
			Numerator:	129 259	122 296	92 131	(24.7%)	
			Denominator:	134 234	122 296	127 271	4.1%	
			4) Percentage of hospital revitalisation component budget spent	88.1%	100.0%	93.5%	(6.5%)	Main contributors to the under- performance are: • Civil unrest and construction industry strike negatively impacted on projects (e.g. Karl Bremer Hospital new emergency centre). • Delays in planning (renovations to existing buildings at Valkenberg Hospital and new psychiatric unit at Paarl Hospital, hybrid theatre at Groote Schuur Hospital). • Design delays on some projects (Paarl Hospital psychiatric ward, District Six CDC, Wolseley Clinic). • Slow progress by contractors (Vredenburg Hospital Phase 2B, Hermanus CDC, Delft CDC, Mitchells Plain Hospital new 72-hour assessment unit, psychiatric ward at George Hospital), • Temporary new emergency centre at Heideveld CDC – completion date delayed, • Delays in the appointment of the transaction advisors on the Tygerberg Hospital redevelopment project.
			Numerator:	444 226	493 526	517 814	4.9%	
			Denominator:	504 414	493 526	553 714	12.2%	

Programme 8: Health Facilities Management								
Strategic goal statement	**Strategic objective title**	**Strategic objective statement**	**Performance indicator**	**Actual achievement 2012/13**	**Planned target 2013/14**	**Actual achievement 2013/14**	**Deviation * 2013/14**	**Comment on deviation**
			5) Percentage of Equitable Share capital budget spent	90.7%	100.0%	100.0%	0.0%	No deviation – 100% of the budget was spent.
			Numerator:	80 500	140 500	140 500	0.0%	
			Denominator:	88 752	140 500	140 500	0.0%	
			6) Percentage of Health Technology budget spent		100.0%	111.8%	11.8%	Health technology forms part of the Health Facility Revitalisation Grant. The over-expenditure was a strategy to compensate for the under expenditure on the infrastructure related projects.
			Numerator:		143 600	245 750	71.1%	
			Denominator:		143 600	219 823	53.1%	
	1.2 Effective and efficient management of infrastructure delivery.	1.2.1 Ensure 100% achievement of projects planned for completion annually.	7) Percentage of strategic briefs completed	Not required to report	100.0%	100.0%	0.0%	No deviation – 100% of the budget was spent.
			Numerator:	-	8	8	0.0%	
			Denominator:	-	8	8	0.0%	
			8) Percentage of capital projects completed	190.0%	100.0%	16.7%	(83.3%)	The deviation can be attributed to: • Scope changes on the new Du Noon CDC. • Projects commencing later than planned i.e. tender dates revised.
			Numerator:	19	6	1	(83.3%)	
			Denominator:	10	6	6	0.0%	

Strategies to overcome areas of under-performance

- Institutionalise the IDMS in accordance with Provincial Treasury Instruction 16B.
- Improve the collegial relationships between the management responsible for health infrastructure in both the Departments of Health and Transport and Public Works.
- Align budget with capacity both within WCG: Health and WCG: Transport and Public Works.
- Planning that ensures that additional projects are ready for implementation where current projects fail or are stalled.
- Enhance definition of service package (clearly defined briefs).
- More efficient and effective procurement and contract management e.g. framework agreements for scheduled maintenance through the implementing department.
- Institutionalise the infrastructure unit support system (IUSS) design guidelines.
- Increased use of standard designs.

Changes to planned targets

No targets were changed during the year.

Linking performance with budgets

Table 4.8.3: Summary of expenditure for Health Facilities Management 2013/14

Expenditure	2013/14			2012/13		
Sub-programme	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000	Final appropriation R'000	Actual expenditure R'000	(Over) / under expenditure R'000
8.1: Community Health Facilities	268 654	176 571	92 083	99 169	100 537	(1 368)
8.2: Emergency Medical Services	23 270	16 481	6 789	24 804	18 615	6 189
8.3: District Hospital Services	314 092	291 238	22 854	452 945	416 211	36 734
8.4: Provincial Hospital Services	122 548	143 984	(21 436)	126 953	123 880	3 073
8.5: Central Hospital Services	169 069	205 925	(36 856)	70 688	71 415	(727)
8.6: Other Facilities	61 281	43 653	17 628	122 544	91 421	31 123
Total	**958 914**	**877 852**	**81 062**	**897 103**	**822 079**	**75 024**

During 2013/14 various infrastructure, health technology, and maintenance projects were completed, some of these are listed below:

- Brooklyn Chest Hospital MDR and XDR wards.
- Caledon Hospital Disa building upgrade.
- Ruyterwacht Clinic.

- Hermanus Hospital emergency centre and general upgrade.
- Karl Bremer Hospital emergency centre and CT scan.
- Knysna Hospital emergency centre.
- Lentegeur Regional Laundry upgrade and extension.
- Malmesbury Ambulance Station.
- Mitchells Plain Hospital.
- Swartland Hospital emergency centre upgrade and extension.
- Tygerberg Hospital emergency centre renovation.

5. TRANSFER PAYMENTS

5.1 TRANSFER PAYMENTS TO ALL ORGANISATIONS OTHER THAN PUBLIC ENTITIES

This section provides information on transfer payments made to provinces, municipalities, departmental agencies (excluding public entities), higher education institutions, public corporations, private enterprises, foreign governments, non-profit institutions and households. It also provides information on where funds were budgeted to be transferred, but transfers were not made and the reasons for not transferring funds.

Table 5.1.1: Transfer payments made for the period 1 April 2013 to 31 March 2014

Transfer payments							
Name of transferee	**Type of organisation**	**Purpose for which the funds were used**	**Did the dept comply with s38(1)(j) of the PFMA**	**Amount transferred (R'000)**	**Amount spent by the entity**	**Reasons for the funds unspent by the entity**	**District / municipality / sub-structure**
Transfers to municipalities							
City of Cape Town	Municipality	Rendering of personal primary health care, including maternal child and infant health care, antenatal care, STI treatment, tuberculosis treatment and basic medical care. Also nutrition, HIV and AIDS and Global Fund.	Yes	353 949	353 949	N/A	City of Cape Town
Central Karoo District	Municipality	Global Fund.	Yes	576	576	N/A	Central Karoo District
Transfers to Departmental Agencies and Accounts							
Health and Welfare SETA	Statutory body	Human resource development.	Yes	4 111	4 111	N/A	City of Cape Town
Radio and Television	Licensing authorities	Licences.	Yes	213	213	N/A	Departmental
Transfers to Universities and technicons							
Cape Peninsula University of Technology	Higher education institution	Nursing training.	Yes	3 480	3 480	N/A	City of Cape Town
Transfers to Non-profit institutions							
Various non-profit institutions	Non-profit institutions	Community health clinics.	Yes	43	43	N/A	Central Karoo District
Various non-profit institutions	Non-profit institutions	Tuberculosis treatment.	Yes	624	624	N/A	Cape Winelands District
			Yes	178	178	N/A	Eden District
			Yes	119	119	N/A	West Coast District
Booth Memorial	Provincially aided hospitals	Intermediate care facility – adult.	Yes	16 857	16 857	N/A	City of Cape Town
Life Esidimeni	Contract hospital	Intermediate care facility – adult.	Yes	36 405	36 405	N/A	City of Cape Town
Sarah Fox	Provincially aided hospitals	Intermediate care facility – child.	Yes	8 432	8 432	N/A	City of Cape Town

Transfer payments							
Name of transferee	**Type of organisation**	**Purpose for which the funds were used**	**Did the dept comply with s38(1)(j) of the PFMA**	**Amount transferred (R'000)**	**Amount spent by the entity**	**Reasons for the funds unspent by the entity**	**District / municipality / sub-structure**
Various non-profit institutions	Non-profit institutions	Health committees, TB adherence, treatment and DOTS.	Yes	1 177	1 177	N/A	Eden District
			Yes	1 619	1 619	N/A	Khayelitsha/Eastern SS
			Yes	1 135	1 135	N/A	Klipfontein/M Plain SS
			Yes	1 485	1 485	N/A	Northern/Tygerberg SS
			Yes	1 853	1 853	N/A	West Coast District
			Yes	456	456	N/A	Western/Southern SS
Various non-profit institutions	Non-profit institutions	Community based response e.g. home-based care.	Yes	2 974	2 974	N/A	Khayelitsha/Eastern SS
			Yes	2 177	2 177	N/A	Klipfontein/M Plain SS
			Yes	69	69	N/A	Northern/Tygerberg SS
			Yes	50	50	N/A	West Coast District
			Yes	2 813	2 813	N/A	Western/Southern SS
Various non-profit institutions	Non-profit institutions	Mental health.	Yes	2 416	2 416	N/A	Cape Winelands District
			Yes	262	262	N/A	Central Karoo District
			Yes	9 097	9 097	N/A	Khayelitsha/Eastern SS
			Yes	6 774	6 774	N/A	Klipfontein/M Plain SS
			Yes	14 958	14 958	N/A	Northern/Tygerberg SS
			Yes	3 335	3 335	N/A	Overberg District
			Yes	5 928	5 928	N/A	Western/Southern SS
Various non-profit institutions	Non-profit institutions	Anti-retroviral treatment, home-based care, step-down care, HIV counselling and testing, etc.	Yes	23 276	23 276	N/A	Cape Winelands District
			Yes	5 169	5 169	N/A	Central Karoo District
			Yes	16 372	16 372	N/A	Eden District
			Yes	2 477	2 477	N/A	HIV and AIDS, and TB
			Yes	8 585	8 585	N/A	Khayelitsha/Eastern SS
			Yes	10 938	10 938	N/A	Klipfontein/M Plain
			Yes	18 519	18 519	N/A	Northern/Tygerberg SS
			Yes	11 205	11 205	N/A	Overberg District
			Yes	16 740	16 740	N/A	West Coast District
			Yes	9 282	9 282	N/A	Western/Southern SS
St Joseph	Provincial aided hospital	Step-down care.	Yes	15 036	15 036	N/A	Northern/Tygerberg SS
Various non-profit institutions	Nutrition	Rendering of a nutrition intervention service to address malnutrition in the Western Cape.	Yes	66	66	N/A	Central Karoo District
			Yes	507	507	N/A	Eden District
			Yes	807	807	N/A	Khayelitsha/Eastern SS
			Yes	236	236	N/A	Klipfontein/M Plain SS
			Yes	202	202	N/A	Northern/Tygerberg SS
			Yes	614	614	N/A	Western/Southern SS
Various non-profit institutions	Global Fund	Providing HIV and AIDS, and tuberculosis treatments, palliative care and community-based response to strengthen the comprehensive HIV and AIDS programme.	Yes	1 938	1 938	N/A	Cape Winelands District
			Yes	715	715	N/A	Central Karoo District
			Yes	9 547	9 547	N/A	Eden District
			Yes	3 889	3 889	N/A	HIV and AIDS, and TB
			Yes	1 716	1 716	N/A	Khayelitsha/Eastern SS
			Yes	2 240	2 240	N/A	Overberg District
			Yes	1 324	1 324	N/A	West Coast District
SA Red Cross Air Mercy	Non-profit institutions	Payment for helicopter and fixed wing flights for rescues and transport of critically ill and injured patients.	Yes	41 728	41 728	N/A	City of Cape Town
Maitland Cottage	Step-down care	Payment for paediatric orthopaedic hospital.	Yes	8 933	8 933	N/A	City of Cape Town
Sunflower Foundation	Non-profit institutions	For funding of the Sunflower Fund for further development of bone marrow register.	Yes	3 000	3 000	N/A	City of Cape Town

Transfer payments							
Name of transferee	**Type of organisation**	**Purpose for which the funds were used**	**Did the dept comply with s38(1)(j) of the PFMA**	**Amount transferred (R'000)**	**Amount spent by the entity**	**Reasons for the funds unspent by the entity**	**District / municipality / sub-structure**
Various non-profit institutions	Non-profit institutions	EPWP funding used for training and home-based care.	Yes	43 970	43 970	N/A	Various
The Children's Hospital Fund	Non-profit institutions	Funds for vital paediatric health care needs like the upgrading of buildings, purchasing of vital equipment.	Yes	26 500	26 500	N/A	City of Cape Town
Health Foundation	Non-profit institutions	Health Foundation fund to raise funds to improve public health care resources.	Yes	2 000	2 000	N/A	City of Cape Town
Transfers to households							
Employee social benefits - cash residents	Various claimants	Injury on duty, leave gratuity, retirement benefit, severance package.	Yes	41 802	41 802	N/A	Departmental
Various claimants	Various claimants	Claims against the state: households.	Yes	23 015	23 015	N/A	Departmental
Various tertiary institutions	Tertiary institutions	Bursaries.	Yes	45 437	45 437	N/A	Various
Various claimants	Various claimants	Payment made as an act of grace.	Yes	29	29	N/A	Departmental
Groote Schuur Hospital Health Facility Board	Facility board	Cash donation.	Yes	84	84	N/A	City of Cape Town
Rape Crisis Cape Town Trust	Rape crisis centre	Cash donation.	Yes	65	65	N/A	City of Cape Town

Table 5.1.2: Transfer payments budgeted for in the period 1 April 2013 to 31 March 2014, but no transfer payments were made

Transfer payments not done						
Name of transferee	**Type of organisation**	**Purpose for which the funds were to be used**	**Amount budgeted for (R'000)**	**Amount transferred (R'000)**	**Reasons why funds were not transferred**	**District / municipality / sub-structure**
Transfers to non-profit institutions						
Non-profit institutions	Tuberculosis	Tuberculosis treatment.	243	-	This surplus was utilised to offset over-expenditure.	Northern/Tygerberg SS
Non-profit institutions	Health committees	Health committees, TB adherence, treatment and DOTS.	62	-	Funding to health forum/committee was discontinued due to the establishment of the District Health Council.	Chief Director: Metro District Health Services

6. CONDITIONAL GRANTS

CONDITIONAL GRANTS AND EARMARKED FUNDS RECEIVED

6.1 HEALTH FACILITY REVITALISATION GRANT (HFRG)

In addition to equitable share funds being allocated to infrastructure projects in 2013/14, funding was also provided through the Health Facility Revitalisation Grant as stipulated in the Division of Revenue Act, Act No. 2 of 2013. This grant comprises of the following three components:

- Hospital Revitalisation Grant Component.
- Health Infrastructure Grant Component.
- Nursing Colleges and Schools Grant Component.

From 1 April 2014 the grant will no longer be divided into the three components mentioned above, but will function as a whole. The strategic goal of the grant is "to enable provinces to plan, manage, maintain and transform health infrastructure in line with national and provincial policy objectives".

The Health Facility Revitalisation Grant was utilised during the 2013/14 financial year in line with Healthcare 2010 and the Comprehensive Service Plan.

Table 6.1.1: Health Facility Revitalisation Grant received during the period 1 April 2013 to 31 March 214

Health Facility Revitalisation Grant (HFRG)	
Department who transferred the grant	National Department of Health
Purpose of the grant	• To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including health technology, organisational design (OD) systems and quality assurance (QA). • Supplement expenditure on health infrastructure delivered through public-private partnerships. • To enhance capacity to deliver health infrastructure. • The Hospital Revitalisation component funds construction, upgrading or replacement of hospitals. • The Nursing Colleges and Schools component funds the upgrading of nursing colleges and schools. • The Health Infrastructure component funds improvements in all health facilities.
Expected outputs of the grant	Refer to table below.
Actual outputs achieved	Refer to table below.
Amount per amended DORA	R694.9 million
Amount received (R'000)	R694.9 million (including roll-over funding of R60.2 million) R219.8 million of this funding was allocated to health technology, R26.6 million to organisational development and quality assurance, and R73.7 million to maintenance.
Reasons if amount as per DORA was not received	Not applicable.

Health Facility Revitalisation Grant (HFRG)	
Amount spent by the department (R'000)	R613.9 million (88.3%) R222.3 million of this amount was spent on health technology, R20.2 million on organisational development and quality assurance, and R43 million on maintenance.
Reasons for the funds unspent by the entity	• Temporary new emergency centre at Heideveld CDC: Completion date delayed. • New 72-hour assessment unit at Mitchell's Plain Hospital: Slow progress by contractor. • Hybrid theatre at Groote Schuur Hospital: Delays in planning. • Renovations to existing buildings at Valkenberg Hospital: Delays in planning. • New psychiatric unit at Paarl Hospital: Delays in planning. • Vredenburg Hospital Phase 2B: Delays due to resolution of contractual issues. Slow progress on site. • Karl Bremer Hospital new emergency centre, Delft Symphony Way CHC and new Du Noon CDC: Civil unrest and construction industry strike. • Hermanus CDC, Delft CDC, Mitchell's Plain Hospital psychiatric ward, George Hospital psychiatric ward: Slow progress by contractors. • Internal resource constraints: Additional resources were appointed in Quarter 4 (slow recruitment process). • Tygerberg Hospital redevelopment: Delays in the appointment of transaction advisors. • Paarl Hospital psychiatric ward, District Six CDC, Prince Alfred Hamlet Clinic, Wolseley Clinic, Napier Clinic, Groote Schuur Hospital Linac phase 2: Design delays. • Hout Bay CDC: No land available.
Reasons for deviations on performance	Refer to table below.
Measures taken to improve performance	• Improve quality of briefs and provide more definitive scope of works through analysis of facility condition assessments. • Improve project monitoring and reporting by ensuring use of the Property Management Information System (PMIS) by implementing department. • Penalty clauses for poor performance by professional service providers to be included in all new appointment documents. • Alignment of budget with capacity both within WCG: Health and WCG: Transport and Public Works. • Ongoing implementation and institutionalisation of the WC-IDMS.
Monitoring mechanism by the receiving department	Monthly infrastructure projects progress review meetings with the implementing department, project meetings and site meetings. The implementing department also records progress and provides project documents on Rational Portfolio Management, which is software that WCG: Health has access to. In addition to this, the Department utilises the Project Management Support Unit (PMSU) system to update project information and progress.

Expected outputs of the grant and the actual outputs achieved

It is important to note that expected output is the project phase as at the beginning of the financial year and the achieved output is the project phase at the end of the financial year. It is thus expected that the achieved outputs would be an advancement of the expected output.

Table 6.1.2: Expected and actual outputs for the Health Facility Revitalisation Grant for the period 1 April 2013 to 31 March 214

Health Facility Revitalisation Grant (HFRG)			
Outputs	**Expected**	**Achieved**	**Reasons for deviation**
Number of health facilities planned (number of projects in identification / feasibility phase).	50	37	More projects were in identification / feasibility phase at the beginning of 2013/14 versus the end of the financial year due to the following: • Delays with some projects moving to design / tender phase during the previous financial year. • More projects progressing to the next phases. • Lack of available land.
Number of health facilities designed (number of projects in design / tender phase)	27	33	More projects progressed to design / tender stage which can be attributed to: • Delays during the previous financial year resulting in projects achieving next phase sooner. • Some projects progressing faster than planned.
Number of health facilities constructed (number of projects in construction / handover phase)	6	17	More projects achieved handover phase by the end of the financial year than anticipated, due to: • Slow progress during the previous financial year which means that projects planned to achieve completion in 2012/13 achieved completion only in 2013/14.
Number of facilities equipped	15	33	More facilities were equipped during the financial year than expected. This is mainly due to: • A substantial portion of the funding was moved to Health Technology to ensure expenditure is achieved. • Moving of funding was required due to slow spending on infrastructure projects.
Number of health facilities operationalised	14	11	Some projects were slightly delayed due to various reasons cited above, which led to not all facilities being able to be operationalised. This information is based on the generally accepted assumption that operationalisation is effected after a period of six months from achieving practical completion.
Number of work opportunities created	Reliable in-formation is not available	Reliable in-formation is not available	Information obtained is questionable and could therefore not be incorporated.

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

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

6.2 EPWP INTEGRATED GRANT FOR PROVINCES

Table 6.2.1: EPWP Integrated Grant for Provinces received during the period 1 April 2013 to 31 March 214

Expanded Public Works Programme (EPWP) Integrated Grant for Provinces		
Department who transferred the grant	National Department of Public Works	
Purpose of the grant	The purpose of the Expanded Public Works Programme Incentive Grant is to incentivise provincial departments to expand work creation efforts through the use of labour intensive delivery methods in the following identified focus areas, in compliance with the EPWP guidelines: • Road maintenance and the maintenance of buildings. • Low traffic volume roads and rural roads. • Other economic and social infrastructure. • Tourism and cultural industries. • Sustainable land based livelihoods.	
Expected outputs of the grant	***Output as per framework***	***Annual target***
	Increase number of people employed and receiving income through the EPWP	232
	• Women	128 (55%)
	• Youth	93 (40%)
	• People with disabilities	5 (2%)
	Increase income per EPWP beneficiary	R75
	Increase average duration of work opportunities created	3 months
Actual outputs achieved	***Output as per framework***	***Outputs achieved by WCG: Transport and Public Works, Branch: Health***
	Increase number of people employed and receiving income through the EPWP	339
	• Women	222 (65%)
	• Youth	148 (44%)
	• People with disabilities	0 (0%)
	Increase income per EPWP beneficiary	R75
	Increase average duration of work opportunities created	6 months
Amount per amended DORA	R3 million	
Amount received (R'000)	R3 million	
Reasons if amount as per DORA was not received	Not applicable.	
Amount spent by the department (R'000)	R3 million	
Reasons for the funds unspent by the entity	Not applicable.	
Reasons for deviations on performance	Not applicable.	
Measures taken to improve performance	Not applicable.	
Monitoring mechanism by the receiving department	Monthly infrastructure projects progress review meetings with the implementing department. The implementing department also records progress and provides project documents on Rational Portfolio Management which is software that WCG: Health has access to.	

No administration costs were incurred by the Department with respect to the EPWP Integrated Grant for Provinces. All administrative costs were borne by WCG: Transport and Public Works.

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

In the management of the EPWP Integrated Grant for Provinces, the Western Cape complied with the Division of Revenue Act requirements and submitted all the required reports as prescribed.

6.3 NATIONAL TERTIARY SERVICES GRANT (NTSG)

Table 6.3.1: National Tertiary Services Grant received during the period 1 April 2013 to 31 March 2014

National Tertiary Services Grant (NTSG)		
Department who transferred the grant	National Department of Health	
Purpose of the grant	Ensure provision of tertiary health services for all South African citizens. To compensate tertiary facilities for the additional costs associated with provision of these services including cross border patients.	
Expected outputs of the grant	***Indicator***	***Annual target***
	Day patient separations - Total	12 418
	Inpatient days - Total	573 256
	Inpatient separations - Total	90 442
	Outpatient first attendance - total	220 874
	Outpatient follow-up attendances	572 186
Actual outputs achieved	***Indicator***	***Actual outputs***
	Day patient separations - Total	13 303
	Inpatient days - Total	578 996
	Inpatient separations - Total	91 204
	Outpatient first attendances	221 516
	Outpatient follow-up attendances - Total	574 064
Amount per amended DORA	R2 400 714	
Amount received (R'000)	R2 400 714	
Reasons if amount as per DORA was not received	Not applicable	
Amount spent by the department (R'000)	R2 400 714	
Reasons for the funds unspent by the entity	Not applicable	
Reasons for deviations on performance	Not applicable	
Measures taken to improve performance	Not applicable	
Monitoring mechanism by the receiving department	Expenditure and service delivery reports provided to National Department of Health and Provincial Treasury. WCG: Health fully complied with the measures and provincial responsibilities as stipulated in the grant framework.	

As a schedule 4 grant the service outputs are subsidised by the NTSG, as the grant funding is insufficient to fully compensate for the service outputs. Deviation from targets therefore does not necessarily reflect an underperformance in terms of the grant funding received. Similarly, when service outputs exceed the expected outputs, it does not mean that funding levels are adequate.

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

In the management of the NTSG, the Western Cape complied with the Division of Revenue Act requirements and submitted all the required reports as prescribed.

6.4 HEALTH PROFESSIONS TRAINING AND DEVELOPMENT GRANT (HPTDG)

Table 6.4.1: Health Professions Training and Development Grant received during the period 1 April 2013 to 31 March 214

Health Professions Training and Development Grant (HPTDG)		
Department who transferred the grant	National Department of Health	
Purpose of the grant	Support Provinces to fund service costs associated with training of health science trainees on the public health service platform.	
Expected outputs of the grant	***Indicator***	***Annual target***
	Number of enrolled medical undergraduate students	2 439
	Number a of enrolled dental undergraduate students	410
	Number of registrars	680
	Number of medical specialists	847
Actual outputs achieved	***Indicator***	***Actual outputs***
	Number of enrolled medical undergraduate students	2 785
	Number a of enrolled dental undergraduate students	422
	Number of registrars	708
	Number of medical specialists	904
Amount per amended DORA	R451 667	
Amount received (R'000)	R451 667	
Reasons if amount as per DORA was not received	Not applicable.	
Amount spent by the department (R'000)	R451 667	
Reasons for the funds unspent by the entity	Not applicable.	
Reasons for deviations on performance	Not applicable.	
Measures taken to improve performance	Not applicable.	
Monitoring mechanism by the receiving department	Quarterly reports (reflecting expenditure and grant outputs) provided to the National Department of Health as well as Provincial Treasury.	

The actual outputs reflect the status at the end of the financial year (31 March 2014). The academic year follows a calendar years while the grant follows a financial year cycle. This results in the financial year spanning two enrolment cycles.

There was an intake of students for the academic year in the fourth quarter of the financial year. Student enrolment is concluded after the submission of the business plan. Students are subjected to a selection process by the higher education institutions before they can enrol. The additional student's enrolments align to national strategic intent but require additional funding to sustain.

All targets were achieved and exceeded. The additional posts/outputs are not necessarily supported by the HPTDG due to the funding deficit estimated at R168.5 million. Other sources of funding are applied to bridge this funding gap.

Some of the specialists reported are part time/ sessional staff and not full time equivalents.

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

In the management of the HPTDG, the Western Cape complied with the Division of Revenue Act requirements and submitted all the required reports as prescribed.

6.5 COMPREHENSIVE HIV AND AIDS GRANT

The HIV and AIDS Conditional Grant was implemented in 2001/02 to address the HIV epidemic in South Africa. Over the past number of years the grant has increased significantly to result in the scale up of anti-retroviral treatment, broad coverage of various HIV preventative interventions and address challenges due to TB co-infection.

In terms of financial compliance, the Western Cape received a 25.67 per cent increase on the amount allocated in the previous year and 100 per cent of the grant allocation was spent.

During the year all programmes were implemented, co-ordinated and maximised as per the approved business plan. The implementation of the programme was monitored and evaluated and reports were submitted quarterly to the National Treasury via the National Department of Health. The National Department of Health also conducted two reviews of the conditional grant performance and expenditure and all districts participated in the process.

Table 6.5.1 below provides detail in terms of the actual activities funded, the budget allocation, actual expenditure and the percentage spent for 2013/14.

Table 6.5.1: Grant budget allocation and expenditure in 2013/14

Comprehensive HIV and AIDS Grant				
Name of project	**Type of project**	**Budget allocation (R'000)**	**Actual expenditure (R'000)**	**% spent**
Anti-retroviral treatment (ART) interventions	Clinical management of HIV positive patients with a CD4 count under 350.	549 144	591 314	107.7%
Home-based care	Community-based care for category 3 clients within home.	47 000	46 565	99.1%

Comprehensive HIV and AIDS Grant				
Name of project	**Type of project**	**Budget allocation (R'000)**	**Actual expenditure (R'000)**	**% spent**
High transmission areas	NPOs contracted to work with vulnerable groups and IEC (information, education and communication) material production.	14 099	10 123	71.8%
Post exposure prophylaxis for victims of sexual assault	Clinical and forensic management of survivors (adults and children) of sexual assault.	880	934	106.1%
Prevention of mother-to-child transmission (PMTCT) of HIV	Management of HIV positive pregnant women and their babies.	42 705	29 193	68.4%
Programme management and strengthening	Personnel within the Western Cape Government: Health who manage and conduct monitoring and evaluation within HAST.	45 842	40 685	88.8%
Regional training centre (RTC)	Training of health care staff in HIV and AIDS.	12 159	10 713	88.1%
Step-down care	Inpatient care at NPO-driven facilities.	42 736	43 917	102.8%
HIV counselling and testing (HCT)	Pre- and post-test counselling and HIV rapid testing.	51 586	48 793	94.6%
Medical male circumcisions (MMC) programme	Provision of medical circumcisions to males over the age of 15 years.	26 600	17 773	66.8%
STI and condoms	Provision of male and female condoms.	44 023	43 655	99.2%
TB and HIV integration	Prevention of new HIV, STI and TB infections, and sustain health and wellness.	50 773	43 882	86.4%
Total		**927 547**	**927 547**	**100.0%**

Table 6.5.2: Comprehensive HIV and AIDS Grant received during the period 1 April 2013 to 31 March 214

Comprehensive HIV and AIDS Grant		
Department who transferred the grant	National Department of Health	
Purpose of the grant	To provide additional and targeted financial resources in order to accelerate the effective implementation of a programme that has been identified as a priority in the 10-point plan of the National Department of Health	
Expected outputs of the grant	***Indicator***	***Annual target***
	ART: Number of facilities accredited as ART service points	248
	ART: Number of registered ART patients	157 123
	PMTCT: Number of antenatal clients tested for HIV	92 000
	PMTCT: Nevirapine dose to baby rate	95%
	PMTCT: Transmission rate	1.9 %

Comprehensive HIV and AIDS Grant		
	RTC: Number of monthly expenditure reports submitted in time	12
	RTC: Number of quarterly output reports submitted in time	4
	HCT: Number of lay counsellors receiving stipend	647
	HCT: Testing rate	98%
	MMC: Number of males > 15 years circumcised	50 000
	HCBC: Number of Home Based Carers receiving stipends	3 500
	Step-down care: Number of step-down care facilities funded	16
Actual outputs achieved	***Indicator***	***Actual outputs***
	ART: Number of facilities accredited as ART service points	236
	ART: Number of registered ART patients	156 703
	PMTCT: Number of antenatal clients tested for HIV	90 348
	PMTCT: Nevirapine dose to baby rate	99%
	PMTCT: Transmission rate	1.9%
	RTC: Number of monthly expenditure reports submitted in time	12
	RTC: Number of quarterly output reports submitted in time	4
	HCT: Number of lay counsellors receiving stipend	667
	HCT: Testing rate	98.6%
	MMC: Number of males > 15 years circumcised	16 596
	HCBC: Number of Home Based Carers receiving stipends	3536
	Step-down care: Number of step-down care facilities funded	18
Amount per amended DORA	R927 547 000	
Amount received (R'000)	R927 547 000	
Reasons if amount as per DORA was not received	Not applicable	
Amount spent by the department (R'000)	R927 546 996	
Reasons for the funds unspent by the entity	Not applicable	
Reasons for deviations on performance	• Number of facilities accredited as ART service points was not reached due to delays in filling posts required to commence new sites. • Number of registered ART patients has not been reached as a result of two rural districts experiencing data challenges which delayed the updating of information at the deadline. • Number of antenatal clients tested for HIV - the target was set against the expected number of antenatal bookings with a previously negative or unknown HIV status (92 000). The true number of antenatal bookings with a previously negative or unknown HIV status was less than anticipated (89 615). In total, 90 106 clients were tested. The data discrepancy of 491 is likely related to terminated pregnancies (TOP) since facilities strictly adhere to testing all antenatal clients, but if after testing, the client decides to terminate and therefore never books, she will not be included in the denominator. Unfortunately the data collection tool and NIDS does not allow for data collection in such a manner to exclude them from the denominator and in the context of universal testing in this group, achievements above 100% can be expected.	

Comprehensive HIV and AIDS Grant	
	• Number of males > 15 years circumcised was not achieved. The NDoH target (70 000) for MMC for the Western Cape was unachievable since MMC was a new intervention within the Province. Although this target has been reduced (50 000) and aligned to the budget allocation, the districts still have challenges in achieving it due to the added challenge w.r.t. cultural practices on traditional circumcision. Finding suitable social mobilisation strategies that have impact in the Province is challenging, as the population is culturally diverse. • Number of home based carers receiving stipends. Target over-achieved by six carers due to more carers being needed and funded through savings due to staff attrition.
Measures taken to improve performance	• Number of facilities accredited as ART service points – target setting will be tabled at district management to gain buy-in for expansion. • Number of registered ART patients - implementation support visits to provide monitoring and evaluation training in accordance with the ART monitoring and evaluation standard operating procedure of 2013 will be conducted. • Number of antenatal clients tested for HIV. There is no improvement required as we are testing all antenatal clients with a previously negative or unknown HIV status. • Number of males > 15 years circumcised. The budget allocation was reduced and the target will not be increased for 2014/15. The staff allocation was also aligned to the district targets that were set. Department of Culture and Sport will be engaged w.r.t. traditional circumcision. The training of the traditional circumcisers and the reporting of the circumcisions that they do will be addressed. A formal partnership with Metropolitan Health ensuring that various general practitioners are trained in MMC will facilitate access for clients who do not necessarily access the public sector facilities. • Number of home-based carers receiving stipends. No intervention is required as this will fluctuate with operational requirements and within the allocated budget.
Monitoring mechanism by the receiving department	Monthly financial reporting. Quarterly programme performance reporting. Bi-annual conditional grant review conducted by the NDoH. Annual HIV conditional grant evaluation report.

The Western Cape Department of Health has successfully implemented the programmes under this grant and met most of the targets. The prevalence of HIV in surveyed pregnant women aged between 15 and 24 years reduced from 11.6 per cent in 2011 to 10.4 per cent in 2012. Although this reduction is not statistically significant, the Department is hopeful that as HIV interventions are expanded there will be a continued downward trend of HIV prevalence in this age group.

The PMTCT transmission rate was 1.9 per cent - less than the national target of 2 per cent. The target for testing antenatal clients with a previously negative or unknown HIV status (initial HIV test at booking visit) was not met since there were fewer eligible clients but 99.7 per cent of eligible clients were tested. A total of 127 626 348 condoms were distributed which was the best performance in the country. The number of clients tested for HIV (including antenatal clients) was 988 760, which provides an important entry into care and treatment. The Department did not achieve the male medical circumcision target and only achieved 33 per cent of the target. However, there was a significant improvement of 138 per cent (from 6 970 to 16 596) in MMCs on the previous year. Social mobilisation efforts will be strengthened for the coming year as well as efforts to support traditional circumcisers. The grant continues to fund ten high HIV transmission intervention projects in all districts with the overall goal of reaching hard-to-reach populations such as sex-workers, truckers, LGBTIs (lesbian, gay, bisexual, transgender, intersex) and refugees.

By the end of 2013/14 there were 236 fully functional ART service points in the Western Cape Province, which was an under-achievement of the target of 248. A total of 156 703 patients were retained in care on ARV treatment which was just below the target of 157 123.

There are 325 professional nurses who have been successfully trained through the Nurse Initiated Management of ART (NIMART) training programme and are now authorised to prescribe ART in the Province. A total of 189 mentors completed the mentors training. This has contributed to the expansion of the programme. There are 894 ART chronic clubs that have been established in the Province to decongest health facilities and make it easier for clients to obtain their medication while also providing adherence support to clients on life-long ART.

The home community-based care policy review was commissioned as a point of reference to inform service re-orientation and related planning for the departmental strategy, Healthcare 2030. There were 18 step-down facilities (SDF) funded by the HIV Conditional Grant in the Western Cape, due to the exit strategy of two of the Global Fund rolling continuation channel funded step-down facilities.

The regional training centre conducted non-clinical training for 945 facility-based counsellors, community health workers and pharmacy assistants. In addition to this, non-formal training was provided to 3 551 nurses, doctors and pharmacists.

6.6 NATIONAL HEALTH INSURANCE GRANT

Table 6.6.1: National Health Insurance Grant received during the period 1 April 2013 to 31 March 214

National Health Insurance (NHI) Grant	
Department who transferred the grant	National Department of Health
Purpose of the grant	• Contribute towards assessing the feasibility and affordability of innovative ways of engaging private sector resources for public purpose. • Test innovations in health service provision for implementing National Health Insurance, allowing for each district to interpret and design innovations relevant to its specific context. • Undertake health system strengthening initiatives. • Support selected pilot districts in implementing identified service delivery interventions.
Expected outputs of the grant	• Appoint a project co-ordinator to manage the NHI projects. • Conduct a workshop with provincial and Eden District health personnel on the outcomes of the 2012/13 NHI projects, and determining the way forward. • Complete the 2012/13 investigation on the "Development and recommendation on the usage of an appropriate model for the strengthening of the current Governance and Critical Support functions of the District Health System", as well as a critical review of the findings, and the development and implementation of an appropriate action plan. • Review the findings and recommendations of the policy framework of the contract management project of 2012/13, develop and implement an appropriate action plan. • Review 2012/13 consumables project that focused on bandages, dressings and sutures, with the development and implementation of an appropriate action plan. Execute an audit on remaining medical consumables at PHC facilities and all hospitals. • Continuation of the school health programme, utilising mobile health care units. • Train CBS co-ordinators on chronic disease management, and roll-out to CCWs to create a long term sustainable training environment, with necessary monitoring and evaluation.

National Health Insurance (NHI) Grant	
	• Complete the 2012/13 review of the provincial policy on Home Community Based Care (HCBC), adherence support, and intellectual disability. Review findings and recommendations of report and develop and implement an appropriate action plan. • Review findings/recommendations of the 2012/13 situational analysis report on the referral processes at the George Regional Hospital specialist clinics; with the development and implementation of an appropriate action plan. • Review of the findings/recommendations of the 2012/13 report on the evaluation study of the current patient folder management processes at PHC facilities, with development and implementation of an appropriate action plan. • Complete the 2012/13 eye-care project and review the findings and recommendations of the rural eye-care model developed for the Eden District (which covers the four main causes of visual impairment or blindness) including the development and implementation of an appropriate phased action plan. • Review the findings and recommendations of the audit on private health care providers in the Eden District (2012/13), which covers the main categories of service providers, and develop and implement an appropriate action plan. • Conduct a situational analysis on women's health, focusing on the whole spectrum of services (including family planning and termination of pregnancies). • Conduct a situational analysis at the six district hospitals focusing on patient referral practices, in view of developing an integrated rational patient referral system. • Implement a patient folder management project at Knysna District Hospital. • Conduct a situational analysis of existing audiology services rendered in the district and develop a sustainable model for rural districts.
Actual outputs achieved	• Project co-ordinator appointed. • Workshop conducted and the way forward determined. • Investigation on the "Development and recommendation on the usage of an appropriate model for the strengthening of the current Governance and Critical Support functions of the District Health System" completed, findings reviewed, and appropriate action plan developed and implemented. • The findings and recommendations of the 2012/13 contract management project were reviewed, and an appropriate action plan was developed and implemented. • The consumables project was reviewed and an appropriate action plan was developed and implemented. An audit was conducted on remaining medical consumables at PHC facilities and all hospitals. Database and report in advanced stage of completion. • School health programme, utilising mobile health care units, implemented. • CBS co-ordinators and 376 CCWs trained on chronic disease management. • 2012/13 review of the provincial policy on home community based care (HCBC), adherence support, and intellectual disability completed. The findings and recommendations of the report were reviewed and an appropriate action plan was developed and implemented. • The findings/recommendations of the 2012/13 situational analysis report on the referral processes at George Regional Hospital specialists clinics was reviewed; and an appropriate action plan was developed and implemented. • The findings/recommendations of the 2012/13 report on the evaluation study of the current patient folder management processes at PHC facilities were reviewed. An appropriate action plan was developed and implemented. • The 2012/13 eye-care project was completed. The findings and recommendations of the rural eye-care model for the Eden District was reviewed. An appropriate phased action plan was developed and implemented. • The findings and recommendations of the audit on private health care providers in the Eden District (2012/13) were reviewed. An appropriate action plan was developed and implemented. • A situational analysis on women's health was conducted, focusing on the whole spectrum of services (including family planning and termination of pregnancies). The project is in an advanced stage of completion.

National Health Insurance (NHI) Grant	
	• A situational analysis was conducted at the three district hospitals focusing on the patient referral practices. The project is in an advanced stage of completion. • A patient folder management system is being implemented at Knysna, Ladismith and Mossel Bay Hospitals. Ladismith and Knysna Hospitals completed. • A situational analysis was conducted of existing audiology services rendered in the district. A sustainable audiology model was developed for the rural districts.
Amount per amended DORA	R4 850 000
Amount received (R'000)	R4 850 000
Reasons if amount as per DORA was not received	Not applicable
Amount spent by the department (R'000)	R4 640 459
Reasons for the funds unspent by the entity	• A number of projects were executed internally, which resulted in lower expenditure when compared with the external quotations received. • The actual costs of some projects which involved personnel salary and wages were lower than budgeted for.
Reasons for deviations on performance	• Supply chain management processes took much longer than expected. The first round of quotations received from TradeWorld on the women's health project was too high in comparison with the allocated budget, forcing a change in the project objectives and specifications. The second round of quotations from TradeWorld was once again much higher than the budgeted allocation, resulting in the project being done internally. • Technical issues, such as the need to file emergency centre cards at Mossel Bay Hospital within the folder management project. The project was initially intended to be done at Knysna Hospital only but was extended to three district hospitals by the final project plan. • Internal human resources constraints with regard to the medical consumables project, impacting on the execution of the project. • Project scopes were broadened. E.g. the situational analysis of patient referrals at district hospitals was broadened to include all PHC staff, resulting in a longer than expected fieldwork period.
Measures taken to improve performance	• The re-appointment of a project co-ordinator to oversee the implementation, monitoring and evaluation of projects / activities. • Internal service providers assisted pro-actively on progress with projects. • All projects monitored on a weekly basis by the project co-ordinator. • Monthly financial reports compiled by the project co-ordinator and discussed at NHI team meetings to determine constraints in budget spending. • When possible weekly NHI management meetings were held and outputs of projects were distributed timeously to all key stakeholders for comments.
Monitoring mechanism by the receiving department	• A project co-ordinator was appointed. • Weekly progress reports are compiled, provided and discussed with the Eden District NHI team. • Bi-weekly progress reports (e-mail or phone) from appointed service providers and monthly project meetings.

Table 6.6.2: General practitioners on contract using the NHI Grant received during the period 1 April 2013 to 31 March 214

Contracting general practitioners using the National Health Insurance (NHI) Grant	
Department who transferred the grant	National Department of Health
Purpose of the grant	To develop and implement innovative models for contracting general practitioners (GPs) within selected NHI pilot districts.

Contracting general practitioners using the National Health Insurance (NHI) Grant	
Expected outputs of the grant	• Source and appoint GPs to provide for 240 sessions per week for six months. • Clinical package of care relevant to health facilities provided by GPs. • GPs trained to ensure compliance with national and provincial guidelines and adherence to the essential medicines list (EML). • GPs attend relevant meetings. • GPs complete administrative duties. • Relevant administration duties of project done by NHI admin clerk.
Actual outputs achieved	Source and appoint GPs to provide for 240 sessions per week for six months: • 9 GPs appointed and signed contracts. • 220 of the 240 GP sessions per week were taken-up (91.6%). Clinical package of care relevant to health facilities provided by GPs: • All GPs complied with specified performance as per signed contracts. • 7 596 PHC patients were seen by the 9 GPs during the period. GPs trained to ensure compliance with national and provincial guidelines and adherence to the EML: • No training of GPs took place. Though GPs commenced with sessions, not enough time was left for centralised training sessions. • At a local level, GPs were given the necessary information. GPs attend relevant meetings: • Not all GPs attended meetings. Though GPs commenced with sessions, not enough time was left for the attendance of meetings. GPs complete administrative duties: • All GPs fulfilled their administrative duties by completing their monthly timesheets and travel claims. Relevant administration duties of project done by NHI admin clerk: • Administrative clerk appointed. • On-the-job-training provided for capturing GP administrative data on a monthly basis. • Filing system has been put in place.
Amount per amended DORA	R 2 452 780
Amount received (R'000)	R 2 452 780
Reasons if amount as per DORA was not received	Not applicable
Amount spent by the department (R'000)	R 724 823
Reasons for the funds unspent by the entity	Severe time limitations and GPs were only able to work for a period of three months of the financial year.
Reasons for deviations on performance	• The 2013/14 business plan was only approved during October 2013, leaving limited time to source, appoint and train GPs on relevant medical courses. • Some of the interviewed GPs were not suitable for the sessions, while others were reluctant to commit to only 3 months. One sub-district (Kannaland) had no applications. • As the GPs only started working during January and February 2014, there was not enough time for training activities, or for all of them to attend relevant meetings. It must however be stated that most of the GPs that were appointed had some prior experience with delivery of PHC services.
Measures taken to improve performance	• The 2014/15 business plan to contract GPs was developed early so that approval by the NDoH will be given in time to allow for the full implementation of the new business plan. • Monthly financial and in-kind reports were compiled by the project co-ordinator and discussed at NHI team meetings to determine constraints in budget spending. • Weekly NHI management meetings took place when possible, and outputs of projects were timeously distributed to all key stakeholders for comments.

Contracting general practitioners using the National Health Insurance (NHI) Grant	
Monitoring mechanism by the receiving department	• A NHI administrative clerk was appointed to check and capture GP timesheets. • Weekly progress reports were compiled, and discussed with the Eden District NHI Team. • Financial and quarterly reports were submitted to NDoH and Treasury.

6.7 SOCIAL SECTOR EPWP INCENTIVE GRANT FOR PROVINCES

Table 6.7.1: Social Sector EPWP Incentive Grant received during the period 1 April 2013 to 31 March 214

Social Sector EPWP Incentive Grant for Provinces	
Department who transferred the grant	Western Cape Government Treasury
Purpose of the grant	To increase work opportunities for home community based carers (HCBCs) engaged through non-profit organisations in the Metro district, and the training of the HCBCs on NQF levels 1 and 2 in ancillary health care and community health work.
Expected outputs of the grant	Improved quality of life of unemployed people through employment creation and increased income, and improved community health based services.
Actual outputs achieved	527 qualified HCBCs (552 full-time equivalents)
Amount per amended DORA	R9 294
Amount received (R'000)	R9 294
Reasons if amount as per DORA was not received	Not applicable
Amount spent by the department (R'000)	R9 294
Reasons for the funds unspent by the entity	Not applicable
Reasons for deviations on performance	Not applicable
Measures taken to improve performance	Not applicable
Monitoring mechanism by the receiving department	Quarterly review meetings. Manage service level agreements with NPOs and training providers.

7. DONOR FUNDS

DONOR FUND RECEIVED

7.1 GLOBAL FUND – ROLLING CONTINUATION CHANNEL

Table 7.1.1: Global Fund Rolling Continuation Channel fund received for the period 1 April 2013 to 31 March 214

Global Fund (GF)	
Name of donor	The Global Fund (GF) – Rolling Continuation Channel (RCC) – Phases I & II
Full amount of the funding	RCC-I: R452 448 638 RCC-II: R296 797 656 (Total budget 1 October 2013 – 31 March 2016)

Global Fund (GF)	
Period of the commitment	RCC-I: 1 July 2010 – 30 June 2013 (extended until 30 September 2013) RCC-II: 1 October 2013 – 31 March 2016 (with a grant close out period: 1 April – 30 Sept 2016)
Purpose of the funding	To strengthen, expand and sustain the Western Cape HIV and AIDS prevention, treatment and care programme through funding the following programmes: • Anti-retroviral treatment (ART) programme: The investment of the GF in the WC ART programme has resulted in an accelerated increase in number of patients started on treatment as well as the development of the three tier reporting system. To ensure sustainability of the GF investment in the ART programme the Department has embarked on a medium term incremental takeover of facilities funded by the GF budget. This has successfully commenced with full services continued to be rendered. • Prevention of mother-to-child transmission (PMTCT): The GF investment in the WC PMTCT programme is focused on bridging the gap between staff able to be funded through existing departmental streams versus staff necessary to ensure that the PMTCT programme is increasingly strengthened and successful. This approach has helped to decrease the vertical transmission between mother and child. • Palliative / step-down / intermediate care programme (PSI care): Through the GF funding the bed availability of PSI care within rural areas has increased. From the 1st July 2012 to date, the incremental takeover of facilities funded by the GF has been successful.
	• HIV and AIDS, and TB community based response (CBR): The objective of this project is to empower communities to address HIV and AIDS, and TB related needs, and to implement projects that mitigate the causes and impact of these diseases within the community. Multi-sectorial action teams (MSATs), operating at a community level, drive these projects and are accountable to the local district health offices.
Expected outputs	Refer table below.
Actual outputs achieved	Refer table below.
Amount received in current period (R'000)	RCC-I: R401 326 529 RCC-II: R55 652 307
Amount spent by the department (R'000)	RCC-I: R399 729 753 RCC-II: R84 930 468
Reasons for the funds unspent	Primary contributing factors to the under /over expenditure (variance): ARV Treatment Programme (ART): • Over expenditure relates to buildings relating to capital works expenditure and budgets only finalised at the end of the financial year. • Over expenditure relates to the significantly higher national tender ART drug multiple price in year addendums. • Accruals awaiting invoices from City of Cape Town relating to drugs and laboratories are pending receipt and payment. Palliative / Step-down / Intermediate care programme (PSI care): • Patient admissions budgeted exceeded number of actual admissions. HIV and AIDS and TB community based response (CBR): • Non-filling of the provincial assistant director post. • Accruals awaiting payment in relation to services rendered from National AIDS convention of South Africa (NACOSA). • Accruals awaiting payment in relation to services rendered by the City of Cape Town.
Monitoring mechanism by the donor	The Global Fund does not have a country-level presence outside of its offices in Geneva, Switzerland. Instead, it hired local fund agents to oversee, verify and report on grant performance. In the case of the Western Cape Global Fund grant, KPMG is contracted by the Global Fund to monitor and evaluate the grant performance from time to time. The Global Fund Grant programme follows the principles of performance-based funding to ensure that the grant funding is managed and spent effectively on programmes stipulated in the grant agreement.

Table 7.1.2: Outputs achieved with the Global Fund programme

Global Fund (GF)							
Strategic objectives	**Actual 2012/13**	**Target RCC-I Apr - Sep 2013**	**Actual outputs achieved**	**Target RCC-II Oct 2013 - Mar 2014**	**Actual outputs achieved 2013/14**	**% achieved**	**Comment on deviation**
1. Number of people living with HIV and AIDS (PLWHAs) receiving ARV treatment	25 438	26 597	25 991	22 387	22 044	98%	The impact of Option B+ has increased the number of patients starting on ART. Community care workers have positively impacted retention in care of clients on ART.
2. % of HIV-infected pregnant women receiving dual PMTCT therapy or HAART	89%	90%	89%	90%	89%	99%	The provincial PMTCT programme is performing well with targets being met within the required range.
3. Number of patients admitted to hospices for palliative/step-down care	1 353	3 332	2 899	262	339	129%	During the initial implementation of intermediate care protocol changes, the number of patients admitted was overachieved.
4. Number of community based organisation (CBO) projects approved for funding	590	579	590	193	124	64%	Grant negotiation delays resulted in the reduction of the number of projects approved for funding.
5. Number of orphans and vulnerable children (OVCs) reached through CBO project	4 924	3 000	4 719	251	1 387	553%	Targets for these two indicators will continue to be exceeded, albeit as a decelerated rate from previous years, until the new financial year where the refined service package and tools will be implemented.
6. Number of people reached through CBO income generation project	2 536	1 500	2 370	125	185	148%	

7.2 EUROPEAN UNION – WORKLOAD INDICATORS STAFFING NEED

Table 7.2.1: European Union Workload Indicators Staffing Need fund received for the period 1 April 2013 to 31 March 214

Workload Indicator Staffing Need (WISN)	
Name of donor	European Union (EU): Workload Indicator Staffing Need (WISN) fund
Full amount of the funding	R4 250 000
Period of the commitment	2014/15 financial year
Purpose of the funding	Appointment of ten provincial technical support officers (PTSOs) in the Western Cape Government: Health for the roll-out of the Workload Indicators Staffing Need (WISN) project. Purchasing of GG vehicles, laptops, printers and the payment of S & T
Expected outputs	N/A
Actual outputs achieved	N/A
Amount received in current period (R'000)	R4 250 000
Amount spent by the department (R'000)	R0

Workload Indicator Staffing Need (WISN)	
Reasons for the funds unspent	The funding was received late in the 2013/14 financial year and was paid into the Department's bank account, however, the spending will only commence in the 2014/15 financial year after the posts, which have recently been advertise, have been filled.
Monitoring mechanism by the donor	N/A

8. CAPITAL INVESTMENT

CAPITAL INVESTMENT, MAINTENANCE AND ASSET MANAGEMENT PLAN

Capital investment

Progress made on implementing capital investment

Good progress was made during 2013/14 with 91.5 per cent of the capital appropriation being spent i.e. R877.9 million of the available R958.9 million. The main reasons for the under-expenditure are:

- Completion date delayed on the temporary new emergency centre at Heideveld CDC.
- Delays in planning of the hybrid theatre at Groote Schuur Hospital.
- Delays in the planning for the renovations to existing buildings at Valkenberg Hospital.
- Delays in the planning of the new psychiatric unit at Paarl Hospital.
- Delays due to poor performance by contractor and the resolution of contractual issues on the Vredenburg Hospital Phase 2B project.
- Civil unrest and the construction industry strike affected progress on various projects such as Karl Bremer Hospital's new emergency centre, Delft Symphony Way CHC and New Du Noon CDC.
- Delays in the appointment of transaction advisors on the Tygerberg Hospital redevelopment project.
- Design delays on some projects including Paarl Hospital psychiatric ward, District Six CDC, Prince Alfred Hamlet Clinic, Wolseley Clinic, Napier Clinic and Groote Schuur Hospital Linac phase 2.
- Difficulty in acquiring a suitable site for the Hout Bay CDC.
- Slow progress by contractors on various projects, including Hermanus CDC, Delft CDC, Mitchell's Plain Hospital psychiatric ward, and George Hospital psychiatric ward.
- Internal resource constraints due to slow recruitment process. Additional resources were appointed in the last quarter of the financial year.
- Delays in finalisation of the new framework agreement for both consultants and contractors.
- Challenges in capturing the appropriate scope of works for each individual project and allocating the budget accordingly.

- Lack of a benchmark for time frames for delivery of design stage documentation and estimates.
- Late appointment of professional service providers by WCG: Transport and Public Works.

The table below reflects the capital expenditure versus the appropriation for both 2013/14 and 2012/13. In comparing the two financial years, it is evident that expenditure for 2012/13 (91.63% spent) was aligned to the expenditure for 2013/14 (91.55% spent).

Table 8.1: Capital expenditure on infrastructure projects 1 April 2013 to 31 March 2014

Expenditure	2013/14			2012/13		
Sub-programme	**Final appropriation R'000**	**Actual expenditure R'000**	**(Over) / under expenditure R'000**	**Final appropriation R'000**	**Actual expenditure R'000**	**(Over) / under expenditure R'000**
New and replacement assets	252 081	200 874	51 207	302 822	291 494	11 328
Existing infrastructure assets	680 513	650 479	30 034	594 281	530 551	63 730
- *Upgrades and additions*	*65 395*	*68 942*	*(3 547)*	*139 148*	*126 303*	*12 485*
- *Rehabilitation, renovations and refurbishments **	*417 921*	*395 010*	*22 911*	*295 750*	*243 284*	*52 466*
- *Maintenance and repairs*	*197 197*	*186 527*	*10 670*	*159 383*	*160 964*	*(1 581)*
Infrastructure transfer	26 320	26 500	180	-	34	(34)
- *Current*	-	-	-	-	*34*	*(34)*
- *Capital*	*26 320*	*26 500*	*(180)*	-	-	-
Total	**958 914**	**877 853**	**81 061**	**897 103**	**822 079**	**75 024**

* Health technology, organisational development and quality assurance are reported as part of rehabilitation, renovations and refurbishments.

Infrastructure projects completed in 2013/14 compared to target

The table below reflects the projects that were planned to achieve completion in 2013/14 and reasons for deviations.

Table 8.2: Infrastructure projects scheduled for completion during 2013/14

Capital investment		
Projects scheduled to achieve practical completion in 2013/14	**Practical completion achieved / not achieved 2013/14**	**Comments / reasons for deviations**
Du Noon CHC (new CDC)	Practical completion not achieved.	Changes required in terms of kitchen and sluicing facilities led to increased scope and subsequent delays.
Manenberg GF Jooste Hospital temporary emergency centre at Klipfontein hub	Practical completion not achieved.	Practical completion expected in July 2014.
Caledon Hospital (upgrade – Disa ward phase 2)	Practical completion achieved.	Target achieved.
Mitchell's Plain Hospital (new district psychiatric evaluation centre)	Practical completion not achieved.	Project under construction.
Observatory Groote Schuur Hospital (master plan)	Practical completion not achieved.	Project could not commence as scope of work for consultants could not be finalised.

Current infrastructure projects

The table below lists the capital projects that are currently in progress (including projects in planning, design, construction and retention) and the expected date of practical completion. Actual completion dates are reflected for projects that have achieved practical completion.

Table 8.3: Performance measures for the Capital Infrastructure Programme

Capital investment						
No	**SP**	**District Municipality**	**Facility**	**Project description / Type of infrastructure**	**Project duration**	
					Date: Start	**Date: Finish**
1	8.1	City of Cape Town	Athlone Dr Abdurahman CDC	CDC replacement	01-Apr-15	31-Mar-19
2	8.1	Central Karoo	Beaufort West CDC	CDC upgrade and additions	01-Apr-17	31-Mar-20
3	8.1	Cape Winelands	Bonnievale Happy Valley Clinic	Clinic upgrade and additions	01-Apr-17	31-Mar-19
4	8.1	Cape Winelands	Ceres CDC	CDC replacement	01-Apr-17	31-Mar-20
5	8.1	Cape Winelands	Ceres: Bella Vista Clinic	Clinic upgrade and additions	01-Apr-17	31-Mar-18
6	8.1	Cape Winelands	De Doorns CDC	CDC upgrade and additions	01-Apr-13	31-Mar-17
7	8.1	Cape Winelands	De Doorns CDC	CDC upgrade and additions	01-Apr-17	31-Mar-20
8	8.1	City of Cape Town	Elsies River CHC	CHC replacement	01-Apr-17	31-Mar-20
9	8.1	Overberg	Gansbaai Clinic	Clinic upgrade and additions	01-Apr-13	31-May-18
10	8.1	Overberg	Genadendal Clinic (mobile clinic)	Clinic upgrade and additions	01-Apr-17	31-Mar-18
11	8.1	Eden	George: Centrum CDC	CDC replacement	01-Apr-17	31-Mar-20
12	8.1	Eden	George: Thembalethu CDC	CDC replacement	01-Apr-15	31-Mar-18
13	8.1	Cape Winelands	Gouda Clinic	Clinic replacement	01-Apr-19	31-Mar-20
14	8.1	City of Cape Town	Gugulethu CHC	CHC replacement	01-Apr-15	31-Mar-18
15	8.1	City of Cape Town	Hanover Park CHC	CHC replacement	01-Apr-17	31-May-21
16	8.1	City of Cape Town	Hout Bay CDC	CDC replacement	01-Apr-17	31-Mar-21
17	8.1	City of Cape Town	Khayelitsha Michael Mapongwana CDC	CDC upgrade and additions	01-Apr-18	31-Mar-20
18	8.1	City of Cape Town	Khayelitsha Site B CHC	CHC upgrade and additions	01-Apr-17	31-Mar-19
19	8.1	Eden	Ladismith Clinic	Clinic replacement	01-Apr-17	31-Mar-19
20	8.1	Central Karoo	Laingsburg Clinic	Clinic upgrade and additions	01-Apr-14	31-Mar-16
21	8.1	Central Karoo	Laingsburg Clinic	Clinic upgrade and additions	01-Apr-17	31-Mar-19
22	8.1	Central Karoo	Laingsburg: Matjiesfontein Satellite Clinic	Clinic replacement	01-Apr-17	31-Mar-18
23	8.1	City of Cape Town	Macassar CDC	CDC upgrade and additions	01-Apr-17	31-Mar-19
24	8.1	City of Cape Town	Maitland Community Day Centre	CDC replacement	01-Apr-17	31-Mar-20
25	8.1	West Coast	Malmesbury: Abbotsdale Satellite Clinic	Clinic replacement	01-Apr-17	31-Mar-18
26	8.1	City of Cape Town	Mfuleni CDC	CDC replacement	01-Apr-17	31-Mar-20
27	8.1	City of Cape Town	Mitchell's Plain: Weltevreden CDC	New community day centre	01-Apr-17	31-Mar-21
28	8.1	Eden	Oudtshoorn: Oudtshoorn New Clinic	New clinic	01-Apr-18	31-Mar-21
29	8.1	Eden	Oudtshoorn: Touwsranten Clinic	Clinic replacement	01-Apr-17	31-Mar-20

Capital investment						
No	SP	District Municipality	Facility	Project description / Type of infrastructure	Project duration	
					Date: Start	Date: Finish
30	8.1	West Coast	Piketberg Clinic	Clinic upgrade and additions	01-Apr-17	31-Mar-19
31	8.1	City of Cape Town	Ravensmead CDC	CDC replacement	01-Mar-14	31-Mar-16
32	8.1	City of Cape Town	Retreat CHC	CHC upgrade and additions	01-Apr-17	31-Mar-19
33	8.1	Cape Winelands	Robertson CDC	New community day centre	01-Apr-17	31-Mar-20
34	8.1	West Coast	Saldanha: Diazville Clinic	Clinic replacement	01-Apr-17	31-Mar-20
35	8.1	West Coast	Saldanha: St Helena Bay Satellite Clinic	Clinic replacement	01-Apr-17	31-Mar-18
36	8.1	Eden	Sedgefield Clinic	Clinic replacement	01-Apr-17	31-Mar-18
37	8.1	Cape Winelands	Stellenbosch: Khayamandi CDC	CDC replacement	01-Apr-17	31-Mar-19
38	8.1	City of Cape Town	Strand CDC	CDC replacement	01-Apr-18	31-Mar-20
39	8.1	Overberg	Villiersdorp Clinic	Clinic replacement	01-Apr-17	31-Mar-20
40	8.1	West Coast	Vredenburg CDC	New community day centre	01-Apr-17	31-Mar-21
41	8.1	West Coast	Vredendal CDC	CDC replacement	01-Apr-17	31-Mar-20
42	8.1	Cape Winelands	Wellington CDC	Pharmacy additions and alterations	01-Apr-13	31-Mar-15
43	8.1	Cape Winelands	Worcester: Avian Park Clinic	New clinic	01-Apr-17	31-Mar-20
44	8.1	Central Karoo	Beaufort West: Hill Side Clinic	Clinic replacement	01-Apr-12	31-Mar-16
45	8.1	City of Cape Town	District Six CDC	CDC replacement	01-Apr-10	31-Mar-17
46	8.1	Overberg	Napier Clinic	Clinic replacement	01-Apr-12	31-Dec-16
47	8.1	Cape Winelands	Prince Alfred Hamlet Clinic	Clinic replacement	01-Apr-11	31-Mar-16
48	8.1	Cape Winelands	Wolseley Clinic	Clinic replacement	01-Apr-11	30-Mar-16
49	8.1	Cape Winelands	Worcester CDC	Dental suite additions and alterations	01-Apr-12	31-Mar-15
50	8.1	City of Cape Town	Delft CHC	ARV consulting rooms and new pharmacy	01-Apr-10	30-Mar-14
51	8.1	City of Cape Town	Delft Symphony Way CDC	New community day centre	01-Apr-10	31-May-14
52	8.1	City of Cape Town	Du Noon CHC	New community health centre	01-Apr-10	30-Apr-14
53	8.1	City of Cape Town	Heideveld CDC - Temporary emergency centre at Klipfontein hub	Enabling work for the GF Jooste Hospital project: new emergency centre at Heideveld CHC	01-Oct-12	31-May-14
54	8.1	Overberg	Hermanus CDC	New community day centre	01-Apr-10	31-Oct-14
55	8.1	City of Cape Town	Phillipi: Inzame Zabantu Clinic	ARV consulting rooms and new pharmacy	01-Apr-10	28-Mar-14
56	8.1	Eden	Plettenberg Bay: New Horizon Clinic	Clinic upgrade and additions	01-Apr-12	31-Aug-14
57	8.1	Cape Winelands	Rawsonville Clinic	Clinic replacement	01-Apr-10	30-Dec-14
58	8.1	City of Cape Town	Strand Nomzamo: Asanda Clinic	New clinic	01-Apr-10	01-May-15
59	8.1	City of Cape Town	Du Noon Clinic	Clinic replacement	01-Apr-12	14-Nov-12
60	8.1	City of Cape Town	Goodwood: Ruyterwacht CDC	CDC replacement	01-Jul-11	31-Aug-13
61	8.1	Overberg	Grabouw CDC	CDC upgrade and additions	10-Sep-09	10-Jun-12
62	8.1	Eden	Knysna CDC	New community day centre	01-Apr-09	28-Feb-13

Capital investment						
No	SP	District Municipality	Facility	Project description / Type of infrastructure	Project duration	
					Date: Start	Date: Finish
63	8.1	West Coast	Malmesbury: Wesbank CDC	New community health centre	30-Apr-08	30-Jun-12
64	8.2	Overberg	Caledon Ambulance Station	Communication centre extension to EMS	01-Apr-17	30-Apr-18
65	8.2	Cape Winelands	De Doorns Ambulance Station	Ambulance station replacement	01-Apr-17	31-Mar-18
66	8.2	City of Cape Town	Du Noon Ambulance Station	New ambulance station	01-Apr-18	31-Mar-20
67	8.2	Overberg	Gansbaai EMS	New ambulance station	01-Apr-16	31-Mar-17
68	8.2	Eden	Great Brak Ambulance Station	Ambulance station upgrade and additions	01-Apr-17	01-Apr-18
69	8.2	City of Cape Town	Hout Bay Ambulance Station	New ambulance station	01-Apr-17	31-Mar-21
70	8.2	Central Karoo	Laingsburg Ambulance Station	Ambulance station upgrade and additions	01-Apr-17	31-Mar-19
71	8.2	West Coast	Lutzville Ambulance Station (MC)	Holding point	01-Apr-18	31-Mar-20
72	8.2	Central Karoo	Murraysburg Ambulance Station	Ambulance station upgrade and additions	01-Apr-18	31-Mar-20
73	8.2	City of Cape Town	Pinelands EMS	EMS renovation	01-Apr-17	31-Mar-20
74	8.2	Eden	Prince Albert Ambulance Station	Ambulance station upgrade and additions	01-Apr-17	31-Mar-18
75	8.2	City of Cape Town	Retreat Ambulance Station	New holding point	01-Apr-18	31-Mar-20
76	8.2	West Coast	Saldanha: Diazville Ambulance Station	New ambulance station	01-Apr-18	31-Mar-20
77	8.2	City of Cape Town	Somerset West: Helderberg Ambulance Station	New ambulance station	01-Apr-18	31-Mar-20
78	8.2	Cape Winelands	Stellenbosch Ambulance Station	Ambulance station replacement	01-Apr-18	31-Mar-20
79	8.2	Cape Winelands	Touwsriver Ambulance station	Wash bay	01-Apr-17	31-Mar-18
80	8.2	Central Karoo	Uniondale Ambulance Station	New ambulance station	01-Apr-18	31-Mar-20
81	8.2	West Coast	Velddrif Ambulance Station	New holding point	01-Apr-18	31-Mar-20
82	8.2	Overberg	Villiersdorp Ambulance Station	Ambulance station replacement	01-Apr-17	31-Mar-20
83	8.2	West Coast	Piketberg Ambulance Station	Ambulance station replacement	01-Apr-10	31-Mar-18
84	8.2	Eden	Heidelberg Ambulance Station	New ambulance station	01-Apr-11	31-Jul-14
85	8.2	Cape Winelands	Robertson Ambulance Station	Ambulance station replacement	01-Apr-11	31-May-14
86	8.3	Central Karoo	Beaufort West Hospital	Extension of waiting area at EC	01-Apr-17	31-Mar-19
87	8.3	City of Cape Town	Bellville: Karl Bremer Hospital	Feasibility study and master plan	01-Apr-17	31-Mar-18
88	8.3	Cape Winelands	Ceres Hospital	Entrance and security upgrade	01-Apr-17	31-Mar-18
89	8.3	City of Cape Town	Eerste River Hospital	Psychiatric evaluation unit	01-Apr-17	31-Mar-20
90	8.3	City of Cape Town	Khayelitsha Hospital	New CT scan infrastructure	01-Apr-15	31-Mar-18
91	8.3	City of Cape Town	Khayelitsha Hospital	Psychiatric evaluation unit	01-Apr-15	31-Mar-18
92	8.3	City of Cape Town	Kraaifontein: Northern Hospital	New district hospital	01-Apr-18	31-Mar-23

Capital investment						
No	SP	District Municipality	Facility	Project description / Type of infrastructure	Project duration	
					Date: Start	Date: Finish
93	8.3	West Coast	Malmesbury: Swartland Hospital	Master plan and feasibility study	01-Apr-17	31-Mar-18
94	8.3	City of Cape Town	Manenberg: New GF Jooste Hospital	Hospital replacement	01-Apr-13	31-Mar-19
95	8.3	Eden	Mossel Bay New Hospital	Hospital replacement	01-Apr-17	31-Mar-21
96	8.3	City of Cape Town	Retreat: Victoria Hospital	Hospital replacement	01-Apr-17	31-Mar-23
97	8.3	Cape Winelands	Robertson Hospital	New emergency centre, reception and pharmacy phase 1	01-Apr-17	31-Mar-20
98	8.3	City of Cape Town	Somerset West: Helderberg Hospital	Hospital replacement	01-Apr-15	31-Mar-21
99	8.3	West Coast	Vredenburg Hospital	Psychiatric evaluation unit	01-Apr-17	31-Mar-19
100	8.3	City of Cape Town	Atlantis: Westfleur Hospital	New emergency centre and paediatric ward	01-Apr-12	31-Mar-16
101	8.3	City of Cape Town	Bellville: Karl Bremer Hospital	Bulk store	01-Apr-15	31-Mar-16
102	8.3	City of Cape Town	Somerset West: Helderberg Hospital	Emergency centre upgrade and additions	01-Apr-13	31-Mar-16
103	8.3	Cape Winelands	Stellenbosch Hospital	Emergency centre upgrade and additions	01-Apr-13	31-Mar-16
104	8.3	City of Cape Town	Wynberg: Victoria Hospital	New emergency centre	01-Apr-12	31-Mar-17
105	8.3	City of Cape Town	Bellville: Karl Bremer Hospital	New emergency centre	01-Apr-09	31-Mar-14
106	8.3	Eden	Knysna Hospital	Hospital and EMS rehabilitation	01-Apr-09	31-Oct-14
107	8.3	Eden	Knysna Hospital	New emergency centre and OPD	01-Apr-09	31-Oct-14
108	8.3	City of Cape Town	Mitchell's Plain Hospital	Psychiatric evaluation unit	01-Mar-13	30-Jun-14
109	8.3	Cape Winelands	Robertson Hospital	New bulk store	01-Apr-11	31-May-14
110	8.3	West Coast	Vredenburg Hospital	Upgrading phase 2B	01-Apr-07	31-Oct-17
111	8.3	Overberg	Caledon Hospital	Upgrade - Disa ward phase 2	01-Apr-09	31-Jul-13
112	8.3	Overberg	Hermanus Hospital	Emergency centre, new wards, OPD and administration	01-Apr-09	31-Mar-13
113	8.3	City of Cape Town	Mitchell's Plain Hospital	New Hospital	01-Apr-05	18-Feb-13
114	8.4	City of Cape Town	Green Point: Somerset Hospital	Psychiatric evaluation unit	01-Apr-17	31-Mar-19
115	8.4	City of Cape Town	Mitchell's Plain: Lentegeur: Western Cape Rehabilitation Centre	Orthotic & Prosthetic Centre replacement	01-Feb-17	31-Mar-20
116	8.4	City of Cape Town	Observatory: Valkenberg Hospital	Relocation of William Slater Step-down	01-Apr-20	31-Mar-23
117	8.4	City of Cape Town	Observatory: Valkenberg Hospital	Acute village redevelopment	01-Apr-10	31-Mar-24
118	8.4	City of Cape Town	Observatory: Valkenberg Hospital	Demolitions and infrastructure bulk service (Forensic and Werf)	01-Apr-15	31-Mar-17
119	8.4	City of Cape Town	Observatory: Valkenberg Hospital	Forensic village (admission, assessment, high secure unit)	01-Apr-10	31-Mar-19
120	8.4	City of Cape Town	Observatory: Valkenberg Hospital	Forensic village: occupational therapy	01-Apr-18	31-Mar-22

Capital investment						
No	SP	District Municipality	Facility	Project description / Type of infrastructure	Project duration	
					Date: Start	Date: Finish
121	8.4	City of Cape Town	Observatory: Valkenberg Hospital	Master plan up to stage 3	01-Apr-08	30-Sep-13
122	8.4	City of Cape Town	Observatory: Valkenberg Hospital	Pharmacy, OPD, Werf (framework agreement)	01-Apr-10	31-Mar-23
123	8.4	City of Cape Town	Observatory: Valkenberg Hospital	Renovations to the historical administration building (phase 1)	01-Apr-10	31-Mar-16
124	8.4	City of Cape Town	Observatory: Valkenberg Hospital	Renovations to the historical administration building (phase 2)	01-Apr-10	31-Mar-18
125	8.4	Cape Winelands	Paarl Hospital	Psychiatric evaluation unit	01-Apr-11	31-Mar-16
126	8.4	Cape Winelands	Worcester Hospital	Hospital upgrade phase 5	01-Apr-12	30-Jun-15
127	8.4	Eden	George Regional Hospital	Psychiatric evaluation unit	12-Aug-12	15-Apr-14
128	8.4	City of Cape Town	Brooklyn: Brooklyn Chest TB Hospital	New MDR and XDR wards	01-Apr-09	31-Mar-13
129	8.4	Cape Winelands	Paarl Hospital	Hospital revitalisation	01-Apr-00	23-Mar-12
130	8.4	Cape Winelands	Worcester Hospital	Hospital upgrade phase 4	01-Apr-08	30-Nov-12
131	8.5	City of Cape Town	Central hospitals	Maintenance (to various facilities to be identified)	01-Apr-13	31-Mar-20
132	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Master plan	01-Apr-13	31-Mar-15
133	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Master plan	01-Apr-17	31-Mar-18
134	8.5	City of Cape Town	Parow: Tygerberg Hospital	Hospital replacement (PPP)	01-Apr-12	31-Mar-21
135	8.5	City of Cape Town	Parow: Tygerberg Hospital	General paediatric outpatient service renovations (in partnership with Children's Hospital Trust)	01-Apr-14	31-Mar-15
136	8.5	City of Cape Town	Rondebosch: Red Cross Children's Hospital	Emergency centre upgrade and additions	01-Apr-16	31-Mar-20
137	8.5	City of Cape Town	Rondebosch: Red Cross Children's Hospital	Master plan	01-Apr-17	31-Mar-18
138	8.5	City of Cape Town	Rondebosch: Red Cross Children's Hospital	New store	01-Apr-17	31-Mar-18
139	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Central kitchen: floor replacement	01-Jun-13	31-Mar-15
140	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Emergency centre upgrade and additions	01-Apr-12	31-Mar-18
141	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	Hybrid theatre	01-Apr-13	31-Mar-15
142	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	New linear accelerator installation new bunker	01-Jun-13	31-Mar-15
143	8.5	City of Cape Town	Rondebosch: Red Cross Children's Hospital	Radiology upgrade and extension (in partnership with trust)	01-Apr-13	01-Mar-15
144	8.5	City of Cape Town	Parow: Tygerberg Hospital	Emergency centre upgrade and additions	01-Apr-09	31-Mar-14
145	8.5	City of Cape Town	Observatory: Groote Schuur Hospital	New linear accelerator installation phase 1	01-Apr-12	01-Mar-13

Capital investment						
No	SP	District Municipality	Facility	Project description / Type of infrastructure	Project duration	
					Date: Start	Date: Finish
146	8.6	Eden	Knysna Forensic Pathology Laboratory	Forensic Pathology Laboratory replacement	01-Apr-17	31-Mar-19
147	8.6	Central Karoo	Laingsburg Forensic Pathology Laboratory	Forensic Pathology Laboratory replacement	01-Apr-17	31-Mar-19
148	8.6	City of Cape Town	Parow: Tygerberg Forensic Pathology Laboratory	Forensic Pathology Laboratory replacement	01-Apr-17	31-Mar-23
149	8.6	Cape Winelands	Stellenbosch Forensic Pathology Laboratory	Forensic Pathology Laboratory replacement	01-Apr-18	31-Mar-21
150	8.6	West Coast	Vredenburg Forensic Pathology Laboratory	Forensic Pathology Laboratory replacement	01-Apr-17	31-Mar-19
151	8.6	Cape Winelands	Worcester: Boland Nurse College	Erica Hostel maintenance	01-Apr-17	31-Mar-19
152	8.6	Eden	George: Eden Nurse College	Nurse hostel upgrade (York Hostel)	01-Apr-13	31-Mar-16
153	8.6	City of Cape Town	Observatory Forensic Pathology Centre	Forensic Pathology Laboratory replacement	01-Apr-12	31-May-18
154	8.6	City of Cape Town	Stikland Nurse College	College renovations	01-Apr-12	31-Mar-18
155	8.6	Cape Winelands	Worcester: Boland Nurse College	Nurses accommodation at Erica Hostel, repairs and renovations.	01-Apr-12	31-May-15
156	8.6	Cape Winelands	Worcester: Boland Nurse College	Training facility at Keerom	01-Apr-12	31-Mar-17
157	8.6	City of Cape Town	Athlone: Western Cape College of Nursing	Security upgrading	01-Apr-12	31-Mar-13
158	8.6	City of Cape Town	Athlone: Western Cape College of Nursing	To convert garages into workshops	01-Apr-12	31-Mar-13
159	8.6	City of Cape Town	Mitchell's Plain: Lentegeur Regional Laundry	Boiler house upgrade including, supply, install, and commission of one coal fired boiler	01-Apr-12	30-Sep-13
160	8.6	City of Cape Town	Mitchell's Plain: Lentegeur Regional Laundry	Regional laundry upgrade and extension	01-Apr-11	30-Jun-13
161	8.6	City of Cape Town	Stikland Nurse College	Air-conditioner in auditorium	01-Apr-12	30-Nov-12

Notes:

Date: Start Starting planning date (i.e. project brief submitted to implementing department).

Date: Finish Construction completion date / take over date (i.e. practical completion date).

Facilities that were closed down or downgraded during 2013/14

No facility was totally closed down or down-graded during 2013/14.

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

Table 8.4: Accommodation identified for disposal

Disposals		
Asset description	**Disposal rationale**	**Disposal year**
Alexandra Hospital	Consolidation of services and future services in specific precinct in order to relinquish land as requested by rationalisation programme of WCG: Transport and Public Works.	2014
Conradie Hospital	First handed back to Property Management in 2005.	
Elsies River CHC	Relocate to newly built facility.	2019
Mossel Bay Hospital	New hospital to be built to replace the current facility. The OPD area will be retained and used as a clinic.	2024
Piketberg EMS	Property exchange with the municipal site for construction of new EMS. The current EMS is not accessible, new facility to be built next to the hospital site.	2017
Robbie Nurock Community Day Centre	New CDC in planning stage (District Six CDC) to replace old facility which is not in the correct position.	2016
Salt River FPL	To be replaced by purpose built new facility which will be conducive to research.	2017
Somerset Hospital including City Precinct	Relinquish for the City Regeneration Project. Helen Bowden Nursing College. CDC on City Hospital Precinct.	2014 Future
Woodstock CDC	New CDC in planning stage (District Six CDC) to replace the current facility.	2015

Maintenance

Progress made on maintenance of infrastructure

The budget allocation for Programme 8 scheduled maintenance in 2013/14 was R100 million (Provincial Equitable Share), of which 100 per cent was spent and R73.7 million (Health Facility Revitalisation Grant) of which 58 per cent was pent. In addition to this, a budget of R20.5 million was allocated to preventive maintenance of which 100 per cent was spent. The preventive maintenance allocation is specifically aimed at maintaining newly completed facilities to the correct maintenance standard.

The maintenance expenditure remains lower than industry norms, which recommends that the maintenance budget for health facilities should be set at 4 per cent of the infrastructure replacement value. The current budget allocation is significantly below this norm.

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

- New facilities currently being constructed, replaced, upgraded or revitalised – see list of projects under the section "Capital investment".
- Projects that are funded by means of the Health Facilities Revitalisation Grant.

Major maintenance projects undertaken during 2013/14

The major scheduled maintenance projects (with a minimum project value of R1 million) that were completed during 2013/14 are listed in the table below.

Table 8.5: Major maintenance projects completed in 2013/14

Major maintenance projects				
No	**SP**	**District**	**Facility**	**Brief description**
1	8.1	Overberg	Bredasdorp: Bredasdorp Clinic	Enlarge existing pharmacy area.
2	8.1	Cape Town	Heideveld: Heideveld CHC	General repairs and painting internal/external including electrical and mechanical.
3	8.1	West Coast	Malmesbury: Riverlands Clinic	Provide new prefab clinic on site of erf no 7840.
4	8.1	Eden	Oudtshoorn: Dysselsdorp CHC	General repairs and renovations including the creation of a reception office for the receptionist.
5	8.1	Overberg	Overberg and Metropole: All medical facilities	Service fire-fighting equipment and smoke detectors.
6	8.1	Cape Winelands	Wellington: House McCrone Clinic	General repairs and painting, including electrical.
7	8.3	Eden	Beaufort West: Beaufort West Hospital	Repair and repaint hospital outside.
8	8.3	Cape Town	Bellville: Karl Bremer Hospital: Hospital and nurses home	General repairs and painting, including electrical and mechanical.
9	8.3	Cape Winelands	Ceres: Ceres Hospital and nurses home	Replace roof cover.
10	8.3	Overberg	Hermanus: Hermanus Hospital	General repairs and painting of wards internally; and repairs to the existing tar roads.
11	8.3	Cape Winelands	Robertson: Robertson Hospital	Road widening and provision of storm water and main water supply, etc.
12	8.4	Cape Town	Bellville: Stikland Hospital: House Miles Bowker	General repairs and renovations to building (internal) and upgrading of bathrooms.
13	8.4	Cape Town	Bellville: Stikland Hospital	New electrical fence.
14	8.4	Cape Town	Bellville: Stikland Hospital	Road rehabilitation.
15	8.4	Cape Town	Brooklyn: Brooklyn Chest TB Hospital	Upgrade pump station and reticulation and replace main water line.
16	8.4	Eden	George: Harry Comay TB Hospital	Repair roads, storm water drainage and upgrade street lights.
17	8.4	Eden	George: Harry Comay TB Hospital	Upgrade of wards; completion of stage 2.
18	8.4	Cape Town	Green Point: New Somerset Hospital	New closed circuit television (CCTV) cameras at all entrances to all wards.
19	8.4	Cape Town	Maitland: Alexandra Hospital	Repairs and renovation including electrical and mechanical works to the OPD and crèche buildings.
20	8.4	Cape Town	Maitland: Alexandra Hospital	Replace current asbestos and cast iron mains with new water reticulation system.
21	8.4	Cape Town	Maitland: Alexandra Hospital	Supply and install high mast lights.
22	8.4	Cape Town	Maitland: Alexandra Hospital	Wards 11 and 12: New perimeter security fence.
23	8.4	Cape Town	Mowbray: Mowbray Maternity Hospital	Installation and upgrading of CCTV cameras.
24	8.4	Eden	Nelspoort: Nelspoort TB Hospital	Emergency storm damage repairs to buildings.
25	8.4	Cape Winelands	Paarl: Sonstraal TB Hospital	General repairs and painting including electrical and mechanical.
26	8.5	Cape Town	Observatory: Groote Schuur Hospital	Upgrade induced draft fans in boiler house.
27	8.5	Cape Town	Observatory: Groote Schuur Hospital	Repair structural cracks in crèche as per recommendation of structural engineer.
28	8.5	Cape Town	Observatory: Groote Schuur Hospital	L Block and old main building: Upgrade air-conditioning.
29	8.5	Cape Town	Parow: Tygerberg Hospital	Supply and install new chiller in A block.

Major maintenance projects				
No	**SP**	**District**	**Facility**	**Brief description**
30	8.5	Cape Town	Parow: Tygerberg Hospital	General repairs and upgrade internally including electrical and mechanical of adult isolation ward D10 and paediatric isolation ward G10.
31	8.5	Cape Town	Rondebosch: Red Cross Hospital and Rondebosch Mowbray Hospital	Painting and repairs to various buildings; repair roof leaks and general repairs to asphalt roads.
32	8.6	Eden	George: George Laundry	Provide new dispatch area and repair internal road.

Major Maintenance Projects that are carried forward to 2014/15

The major maintenance projects (with a minimum project value of R1 million) that are carried forward to 2014/15 are listed in the table below.

Table 8.6: Major maintenance projects carried forward to 2014/15

Major maintenance projects				
No	**SP**	**District**	**Facility**	**Brief description**
1	8.1	Cape Town	Cape Town: Hope Street Dental Clinic	Repairs and renovations: Pharmacy - install new privacy partitions to serving windows, new private consulting room, paint throughout, covered deliveries.
2	8.1	Cape Winelands	Cape Winelands and Metropole	Compulsory servicing of fire-fighting equipment – 2-year contract.
3	8.1	Eden	George: Conville CDC	Repairs and renovations, roof, replace windows, electrical fittings, etc.
4	8.1	Cape Town	Health: Building facilities management and maintenance programme - Metropole North	Cleaning of facilities.
5	8.1	Cape Town	Hout Bay: Hout Bay CDC	Pharmacy: Internal alterations to increase size; new modular shelving; store an office; general repairs and renovation including electrical and mechanical work.
6	8.1	West Coast	Langebaan: Langebaan Clinic	General repairs, painting internal/external and create one disabled toilet within the building, including electrical and mechanical.
7	8.1	West Coast	Leipoldtville: Leipoldtville Clinic	Replace roof covering: general upgrading and repairs to functioning satellite clinic.
8	8.1	Eden	Mossel Bay: Alma Clinic	Repairs and renovations.
9	8.1	Overberg	Overberg and Metropole: All medical facilities	Service of fire-fighting equipment.
10	8.1	Overberg	Villiersdorp: Villiersdorp Clinic	Mobile parking: General upgrade and repairs including electrical and mechanical work.
11	8.2	Cape Town	Parow: Tygerberg Hospital	Communication centre (disaster management centre): General repairs and renovations including electrical and mechanical.
12	8.3	Central Karoo	Beaufort West: Beaufort West Hospital	Paving of internal roads.
13	8.3	Central Karoo	Beaufort West: Beaufort West Hospital	Extension to x-ray.
14	8.3	Cape Town	Health: Building facilities management and maintenance programme - Metropole West	Cleaning of facilities.

Major maintenance projects				
No	**SP**	**District**	**Facility**	**Brief description**
15	8.3	Eden	Montagu: Montagu Hospital and ambulance station	General internal and external repairs including painting, electrical and mechanical.
16	8.3	Eden	Mossel Bay: Mossel Bay Hospital	Repairs and renovations.
17	8.3	Eden	Oudtshoorn: Oudtshoorn Hospital	EMS, nurses home and Toekomsrus: repairs and renovations inclusive of fencing, entrance and upgrade distribution board.
18	8.4	Cape Town	Bellville: Stikland Hospital	General repairs, painting internal including electrical and mechanical works.
19	8.4	Eden	George: Harry Comay TB Hospital	Alterations to existing buildings.
20	8.4	Cape Town	Green Point: Somerset Hospital	Repairs, renovations and upgrading including electrical and mechanical works to 3rd and 6th floors of the New Somerset Hospital, Louis Blumberg nurses home and wards: Barkley, Eden and Lady Lock.
21	8.4	Cape Town	Green Point: Somerset Hospital	Supply of two new 500 KVA generators.
22	8.4	Cape Town	Maitland: Alexandra Hospital	Wards 11 and 12: Upgrading of physiotherapy and rehabilitation centre to accommodate Valkenberg Hospital patients.
23	8.5	Cape Town	Cape Metropole: Various hospitals	Upgrade, modernisation and refurbishment of the complete lift installation of the existing passenger/bed lifts and the supply thereof.
24	8.5	Cape Town	Cape Town: Various hospitals	Maintenance and servicing of lift installations.
25	8.5	Cape Town	Observatory: Groote Schuur Hospital	Various general repairs to roof areas, tiling to various bathrooms, replacement to various carpets and vinyl floor covering, re-painting of identified road markings and parking bays.
26	8.5	Cape Town	Observatory: Groote Schuur Hospital	Examine diesel tanks.
27	8.5	Cape Town	Observatory: Groote Schuur Hospital	Complete electrical upgrade of boiler house.
28	8.5	Cape Town	Parow: Tygerberg Hospital	Upgrade, modernisation and refurbishment of the outstanding lifts at Tygerberg and Mowbray Hospitals.
29	8.5	Cape Town	Parow: Tygerberg Hospital	Supply and install new air handling units.
30	8.5	Cape Town	Parow: Tygerberg Hospital	General repairs and upgrade internally including electrical and mechanical of labour ward phase 2 and occupational therapy department.
31	8.5	Cape Town	Parow: Tygerberg Hospital	Repairs and upgrade existing toilets with new Geberit, vandal proof toilets.
32	8.5	Cape Town	Rondebosch: Red Cross Hospital	Institute of Child Health spalling, OPD internal painting, nurses home retiling bathrooms, road repair and marking, repairs and renovations to ablution and sewers at Maitland Cottage and Johnson & Johnson Building roof and internal gutters maintenance replacement.
33	8.6	Cape Town	Parow: Tygerberg Hospital: Forensic mortuary	Replace roof.
34	8.6	Cape Town	Athlone: Western Cape College of Nursing	Replace steel windows with aluminium.

Preventive Maintenance

The table below provides a list of the preventive maintenance projects undertaken during 2013/14.

Table 8.7: Preventive maintenance projects undertaken during 2013/14

Preventative maintenance projects				
No	**SP**	**District**	**Facility**	**Brief description**
1	8.1	Eden	Melkhoutfontein Clinic	Servicing of air-conditioning and ventilation systems as well as electrical reticulation system.
2	8.1	Eden	Plettenberg Bay Community Day Centre	Servicing of mechanical and electrical systems.
3	8.1	Cape Winelands	Simondium Clinic	Servicing of air-conditioning, water reticulation systems, electrical systems, fire detection system and garden services.
4	8.1	Overberg	Stanford Clinic	Servicing of air-conditioning and fire detection systems.
5	8.1	Cape Winelands	TC Newman Community Day Centre	Servicing of air-conditioning and fire detection systems, electrical infrastructure and maintenance to building envelope.
6	8.1	Cape Winelands	Wellington Community Day Centre	Servicing of air-conditioning, water reticulation systems, electrical systems, fire detection system and garden services.
7	8.1	Cape Winelands	Worcester Community Day Centre	Servicing of air conditioning and ventilation, fire detection and electrical systems.
8	8.2	Overberg	Caledon Ambulance Station	Servicing of air conditioning and ventilation, fire detection and electrical systems as well as painting.
9	8.2	Eden	Leeu-Gamka Ambulance Station	Servicing of air conditioning system.
10	8.3	Eden	Beaufort West Hospital	Servicing of air conditioning and ventilation as well as fire detection systems.
11	8.3	Cape Winelands	Ceres Hospital	Servicing of mechanical and electrical systems.
12	8.3	Cape Town	Eerste River Hospital	Servicing of air-conditioning, mechanical and electrical systems, heat pumps, fire detection and sprinkler systems.
13	8.3	Cape Town	Khayelitsha Hospital	Garden services, stripping and sealing of floors, servicing of plumbing and water reticulation systems as well as air-conditioning systems.
14	8.3	Eden	Oudtshoorn Hospital (bulk pharmacy)	Servicing of air-conditioning and ventilation system as well as fire detection system.
15	8.3	Eden	Riversdale Hospital	Servicing of air-conditioning and fire detection systems as well as servicing of electrical distribution boards.
16	8.3	Cape Winelands	Robertson Hospital	Servicing of air-conditioning system.
17	8.3	West Coast	Vredenburg Hospital	Servicing of mechanical and fire detection systems.
18	8.4	Eden	George Hospital	Servicing of high voltage electrical, electrical, fire detection, air-conditioning and ventilation systems as well as painting.
19	8.4	Cape Town	Mowbray Maternity Hospital	Servicing of mechanical and fire detection systems.
20	8.4	Cape Winelands	Paarl Hospital	Servicing of fire detection, access control and CCTV systems as well as servicing of Building Management System, mechanical systems and electrical systems. Cleaning of roofs and gutters as well as bird-proofing was also undertaken.
21	8.4	Cape Winelands	Worcester Hospital	Servicing of fire detection, access control and CCTV systems as well as mechanical systems and electrical systems.
22	8.5	Cape Town	Groote Schuur Hospital	Servicing of chillers, steam pipe installations, two fire detection systems and access control system. Cleaning of water storage tanks was also undertaken.
23	8.5	Metro	Red Cross War Memorial Children's Hospital	Servicing of mechanical and electrical systems as well as servicing of fire detection system.
24	8.5	Metro	Tygerberg Hospital	Servicing of chillers, cooling towers, air-conditioning systems, electrical distribution boards as well as pest control in plant rooms and roof space.

Preventative maintenance projects				
No	**SP**	**District**	**Facility**	**Brief description**
25	8.6	Eden	Beaufort West Forensic Pathology Laboratory	Servicing of air-conditioning system.
26	8.6	Cape Town	Lentegeur Regional Laundry	Maintenance contract for new equipment.
27	8.6	West Coast	Malmesbury Forensic Pathology Laboratory	Servicing of mechanical and electrical systems as well as fire detection system.
28			George, Khayelitsha, Mitchell's Plain, Paarl, Vredenburg and Worcester Hospitals	Asset Management and Maintenance system.
29			Various facilities	Preventative maintenance to pressure vessels.

Processes in place for the procurement of infrastructure projects

On 1 April 2012, Provincial Treasury published the Standard for a Construction Procurement System the aim of which is to "establish a construction procurement system for an institution to use in fulfilling its obligations in the procurement of goods, services and engineering and construction works within the construction industry". In order to regulate this standard, Provincial Treasury Instructions (PTI) 16A and 16B were issued. In this regard, a Compliance Acceleration Plan (CAP) was prepared at the beginning of the 2013/14 financial year in order to ensure compliance to PTIs 16A and B by 31 March 2014, and while not all of the detailed deliverables of the CAP were achieved, substantive compliance was realised.

Maintenance backlog and planned measures to reduce the maintenance backlog

The total maintenance backlog for all WCG: Health facilities, based on the estimated value of the buildings and allocated budgets, are estimated to be R816.0 million in 2014/15.

Calculations for the total maintenance backlog for all WCG: Health facilities, shown over the following MTEF and based on the estimated value of the buildings and allocated budgets, are reflected in the table below.

Table 8.8: Health facilities maintenance backlog (February 2014)

Major maintenance projects			
Financial year	**2014/15**	**2015/16**	**2016/17**
Estimated value of buildings	36 279 666 000	37 000 000 000	40 700 000 000
Escalated value of buildings escalated @10% p.a.	36 279 666 000	40 700 000 000	44 770 000 000
Estimated value of new buildings and replacements	720 334 000	-	-
Estimated total value of buildings	37 000 000 000	-	-
Maintenance required @ 3.5% p.a.	1 295 000 000	1 424 500 000	1 566 950 000
Cumulative maintenance required	1 566 950 000	1 566 950 000	1 566 950 000
Actual maintenance budget inclusive of scheduled, preventative and day-to-day maintenance at hospitals etc.	478 955 000	533 934 000	441 984 000
Rehabilitation, renovations and refurbishments	-	-	-

Major maintenance projects			
Financial year	**2014/15**	**2015/16**	**2016/17**
Total maintenance, rehabilitation, renovations and refurbishments	478 955 000	533 934 000	441 984 000
Backlog = Maintenance required @ 3.5% p.a. – Total maintenance, rehabilitation, renovations and refurbishments	816 045 000	1 706 611 000	2 831 577 000

Note:

- Actual maintenance budget: Scheduled maintenance, preventive maintenance, engineering, and day to day maintenance at institutions.
- Total maintenance required at health facilities is 3.5 per cent of the replacement cost.
- Engineering and day to day maintenance (at institution) forecast 5 per cent increase per annum.

The sharp increase in the maintenance budget figures as reflected above is more likely to be due to improved available data than to an actual increase in maintenance backlog. Nonetheless, a substantial maintenance backlog does exist and the necessary budget is being sought to address this in order to ensure that all facilities are returned to optimal condition. Such budget is not currently available, and the Chief Directorate is therefore required to analyse the situation on an annual basis versus implementing a more scientific life cycle approach.

The restructuring of the maintenance component of the Directorate: Engineering and Technical Support, being carried out through the Maintenance Hub Organisational Development Study, will be phased in during the 2014/15 financial year. This will result in greatly improved maintenance planning and delivery. In addition to this, a considerable number of primary healthcare facilities in the metro and in the rural districts are due for replacement, which will also contribute to the reduction of the maintenance backlog.

The planned maintenance projects are currently being prioritised by means of facility condition assessments undertaken by WCG: Transport and Public Works and inputs received from the end-user. These assessment reports have cost estimates and priority ratings to determine budget allocation for maintenance needs. The projects are to be prioritised as per the categories below to ensure that critical works are receiving urgent attention.

Facility condition assessments		
Priority number	**Clarification**	**Examples**
CURRENTLY CRITICAL		
1 – Dangerous situation	Life threatening situations, condition which could lead to serious injury. Serious water damage to facades, roofs and finishes.	Sagging columns, beams, walls, unsafe and sagging roof structures, flooring. Loose and broken floor covering. Broken glazing. Bare or unearthed electrical installation. Dangerous building structure. Faulty or dangerous machinery and plant. Leaking gas or fuel pipes and connections etc. Blocked drainage and sewer, seepage. Trees. Paving / walkways.
2 – Health hazards	Drains, water storage, airflow, toilets, sewers etc.	Asbestos removal. Cleaning of storage tanks and reservoirs. Cleaning of air-conditioning ducts. Blocked and defective drainage and sewer systems. Inadequate or no airflow. Seepage.
3 – Occupational Health and Safety Act and regulations	Safety equipment and all regulations.	Fire-fighting equipment. Compliance certificates for electrical installations and lifts. Tests.
POTENTIALLY CRITICAL		
4 – Maintain essential services	To allow occupants to carry out their normal work.	VIR (Vulcanised India Rubber) wiring, overhead lines, service transformers, switch gear, water storage, pumps, generator sets, hot water installations, lifts, fire alarms, fire escapes, gas banks, piping and outlets.

Facility condition assessments		
Priority number	**Clarification**	**Examples**
5 – Prevent costly deterioration	Any part of the building elements, structure, façade, roofs.	Roofs, facia, plaster, brickwork, tree roots, maintain roads.
6 – Prevention of financial loss	Inefficient machinery / plant, installations.	Power factor correction, electricity and water metering, economy of plant, lagging of ducting.
NECESSARY BUT NOT CRITICAL		
7 – Maintain appearance of buildings to acceptable standard	Unsightliness, image of the Western Cape Government.	Painting, cladding, carpets, outside lights, building façades, site works.
8 – Maintain pleasant working environment	Grievances, nice to haves, wish list.	Air-conditioning units, parking, site works.

The Department has implemented the following measures to reduce the backlog over the medium term expenditure framework period:

- By replacing or upgrading existing facilities with the most dilapidated infrastructure first.
- By continuing to improve planning and execution of projects.
- By the simultaneous undertaking of projects located within a specific radius.
- By increasing routine and day-to-day maintenance at facility level.
- By implementing the preventative maintenance programme for all new health facilities completed since 2006.

The importance of ensuring that an accurate and up-to-date immovable asset register (IAR) of all facilities is readily available (including both owned and leased properties) cannot be over-emphasised. Providing such an IAR is the responsibility of WCG: Transport and Public Works which is currently in the process of verifying its own asset register and when this is completed, a more accurate asset register will be available.

Closely aligned to IAR is the need for regular and accurate facility condition assessments of all facilities operated under the auspices of the Department. The Government Immovable Asset Management Act (GIAMA) places the responsibility for the latter with WCG: Transport and Public Works which is currently addressing this issue.

An updated facilities condition assessment is not available, but based on the current information available in the 2014/15 user asset management plan (U-AMP) as well as the maintenance budget allocated to engineering and the health institutions, it is evident that, unless there is an increase in resources in the future, the maintenance backlog will increase.

Development relating to capital investment and maintenance that potentially will impact on expenditure

The following developments relating to capital investment and maintenance will potentially impact on expenditure:

- The Division of Revenue Act stipulates that 25 per cent of the Health Facility Revitalisation Grant allocation must be spent on maintenance.
- Introducing the NHI will have an impact.

Asset Management Plan

All institutions have asset registers for both minor and major assets which are maintained on a daily basis. The Department's assets are housed in the SYSPRO asset management system (for central hospitals) and LOGIS (for all other institutions) and asset purchases on these systems are reconciled with the expenditure through BAS on a monthly basis.

Asset registers maintained complies with the minimum requirements as determined by National Treasury.

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

PART C:
GOVERNANCE

1. INTRODUCTION

Commitment by the Department to maintain the highest standards of governance is fundamental to the management of public finances and resources. Users want assurance that the Department has good governance structures in place to effectively, efficiently and economically utilise the state resources, which is funded by the tax payer.

2. RISK MANAGEMENT

RISK MANAGEMENT POLICY AND STRATEGY

WCG: Health utilises the WCG Enterprise Risk Management (ERM) strategy and policy to guide the departmental risk management processes. These strategy and policy documents constitute the Province's overall intention in respect of ERM and were approved by the Director-General on 7 March 2012, after consultation with Provincial Top Management.

The WCG: Health accounting officer (AO) takes responsibility for ERM in accordance with the National Treasury Public Sector Risk Management Framework.

The Department has a Risk Assessment Monitoring and Management Plan that is approved by the accounting officer. The Chief Director: Strategy and Health Support has been appointed as the risk champion for the Department.

Significant risks to the Department, relevant to objectives in terms of its likelihood and impact, are identified and risk responses are determined. Risk statements, components, mitigating actions and scores are recorded in the risk register at a programme and departmental level and this is monitored at the quarterly Monitoring and Evaluation (M & E) meetings.

RISK ASSESSMENTS

Departmental risks reflected in the risk register were reviewed and scored by the Risk Management Committee on a quarterly basis during the 2013/14 financial year. Risks that had been closed out were removed and newly identified risks were included in the emergent risk register.

RISK MANAGEMENT COMMITTEE

The Department has appointed a Risk Management Committee and the terms of reference for the committee was finalised in August 2013. The committee is chaired by the risk champion for WCG: Health.

The Risk Management Committee consists of representatives from all eight budget programmes as well as the chief financial officer (CFO) so as to ensure good governance and to avoid potential conflicts of interest.

The committee meets once every quarter to review and score departmental risks recorded in the risk register.

ROLE OF THE AUDIT COMMITTEE

The Audit Committee reviews the departmental risk register on a quarterly basis and, through the risk champion, interrogates the effectiveness of mitigation strategies as well as the risk management processes in general. Improvements emanating from these discussions have been incorporated into the departmental 2014/15 Annual Performance Plan and the 2014/15 risk register.

PROGRESS WITH MANAGEMENT OF RISK

There has been significant progress with the management of risks during the 2013/14 financial year, with ten out of twelve departmental risks having residual scores that are lower than the inherent scores at the end of the financial year.

3. FRAUD AND CORRUPTION

The Western Cape Government adopted an anti-corruption strategy which confirms the Province's zero tolerance stance towards fraud and corruption. The Department has an approved Fraud Prevention Plan and a Fraud Prevention Implementation Plan which gives effect to the Fraud Prevention Plan.

Various channels for reporting allegations of fraud and corruption exist and these are described in detail in the Provincial Anti-Corruption Strategy and the departmental Fraud Prevention Plan. Each allegation received by the forensic investigation unit is recorded in a case management system which is used as a management tool to report on progress made with cases relating to the Department and generating statistics for the Province and Department. Employees who blow the whistle on suspicions of fraud, corruption and theft are protected if the disclosure is a protected disclosure (i.e. not malicious). The opportunity to remain anonymous is afforded to any person who would like to report acts of fraud, theft and corruption and should they do so in person, their identities are kept confidential by the person to whom they are reporting.

Once fraud or corruption is confirmed, after completion of an investigation, the relevant employee who participated in these acts is subjected to a disciplinary hearing. In all such instances, the WCG representative initiating the disciplinary proceedings is required to recommend dismissal of the employee concerned. Where prima facie evidence of criminal conduct is detected, a criminal matter is reported to the South African Police Services.

During this financial year, sixty one investigations were completed by the forensic investigation unit whilst twenty eight matters were referred to the Department for an internal investigation. Ten investigations confirmed fraud or corruption, sixteen investigations confirmed irregularities and/or non-compliance, one investigation confirmed theft, three investigations indicated that there was no fraud, corruption or irregularity and in thirty one instances the preliminary investigation did not confirm the allegation of fraud, theft or corruption. At the end of the financial year, twenty nine matters remained on the case list of the Department.

4. MINIMISING CONFLICT OF INTEREST

It will be expected that every official involved in supply chain management (SCM), being it development of specifications or management of a contract, to annually sign:

(1) the code of conduct document as issued by National Treasury; and
(2) the departmental non-disclosure agreement.

In addition to this, it will be expected that every official will declare their interest each and every time they are involved with a procurement related matter, declare any business, commercial interest, and financial interest, or activities undertaken for financial gain that may raise a possible conflict of interest as prescribed by the Accounting Officer.

5. CODE OF CONDUCT

The Code of Conduct is to promote a high standard of professional standards in the workplace, encourage public servants to behave ethically and ensure acceptable behaviour. Formal training workshops were conducted to sensitise employees and raise awareness of the expected standard of behaviour and what behaviour is not acceptable as prescribed by the Public Service Code of Conduct. A total number of 1853 employees attended the code of conduct workshops during 2013/14.

The Directorate: Labour Relations aims to reach all employees, new or existing, to ensure that everyone is in possession of the code of conduct pocket booklet. Attendance at the said workshops is compulsory and proof will exist that the employees were aware of the expected behavioural standards by virtue of the attendance records.

Breach of the code of conduct is immediately addressed in terms of the formal and informal disciplinary code and procedures. A total of 241 employees were disciplined for breach of code of conduct during 2013/14.

6. HEALTH SAFETY AND ENVIRONMENTAL ISSUES

Occupational safety

For many years the focus has been on training health and safety representatives and establishing health and safety committees as prescribed in the Occupational Health and Safety (OHS) Act. Given the wide diversity of specialised work areas in health, the training of persons with specific workplace knowledge has proven to be the best way of ensuring workplace safety. The health and safety committees ensure that problem areas are brought to the attention of the responsible managers. The Employee Health and Wellness (EHW) component annually conducts an audit to ascertain compliance. For the period 2013/14 the overall committee compliance increased from 8 per cent to 76 per cent.

The small number of reportable incidents is an indication that the strategy is working well. Compliance with the general machinery regulations and the "vessels under pressure" regulations is a focus point for engineering personnel. During 2013/14 this initiative was strengthened by the funding provided for preventative maintenance programmes. This work has ensured the safe operation of steam, gas and electrical installations that could have lethal consequences if there were explosions resulting from poor maintenance.

Health

The provision of a healthy workplace is a current focus area. Particular attention is being paid to improving ventilation to help prevent the spread of TB in crowded health care facilities by ensuring the appropriate air flow direction to protect health care workers.

The area of occupational health is being reviewed within the Department including policies, structures, and technical capacity, with a view to providing recommendations for improvement. The Department will enlist the support of experts from the higher education institutions to assist in this process.

Environmental issues

A contract is in place for a specialist company to remove and process health care risk waste (HCRW). New health care risk waste regulations have been promulgated and the contract is in the process of being amended to ensure compliance with these regulations.

7. PORTFOLIO COMMITTEES

Not applicable to the Western Cape Department of Health.

8. SCOPA RESOLUTIONS

Matters from the Report of the Standing Committee on Public Accounts dated 25 March 2014 are as follows:

The Committee noted the Auditor-General's audit opinion regarding the Department's Annual Financial Statements, being financially unqualified with findings of compliance with laws and regulations relating to procurement and contract management, expenditure management, human resources management and compensation, and that this remained unchanged from the 2011/12 unqualified audit opinion with findings.

The Committee noted the Department's commitment of achieving a clean audit in 2014 and beyond. To achieve this commitment and to avoid a regression in the audit outcome, the Department should urgently and sustainably address all matters raised by the Auditor-General, the Audit Committee and this Committee.

Furthermore, the Committee remained concerned that, despite a large number of forensic investigation cases which have been investigated in the Department, few of these cases have had disciplinary outcomes.

The Committee took cognisance of the fact that 43 per cent of high risk areas were covered by Internal Audit, compared to 25 per cent last year, and further noted that of the 15 internal audits approved for auditing during the financial year, 13 were actually completed.

Table 8.1: SCOPA resolutions

SCOPA resolutions				
Resolution no.	**Subject**	**Details**	**Response by the department**	**Resolved (Yes/No)**
Page: 355 of the Annual Report	**Heading:** "Hospital Revitalisation Grant" **Description**: The Committee noted that the Department experienced an under spending as a result of delays with the adjudication of tenders, handing over of sites, slow progress on sites and final accounts being outstanding.	**The Committee agreed that**: 1. A Joint Standing Committee meeting with the relevant Standing Committees should be scheduled where the Departments of Health, Transport and Public Works will brief them on the measures implemented to address the on-going challenges relating to the: 1.1 Infrastructure Demand Management System (IDMS); and 1.2 The Service Level Agreement between the two Departments. (This joint meeting should be held in conjunction with the Auditor-General and Provincial Treasury).	A special committee was established – with representatives from WCG Health, WCG Transport and Public Works, and Provincial Treasury – specifically aimed at monitoring expenditure. Regular meetings are being held in this regard. The Infrastructure Delivery Management Committee was established in October 2011. One of its primary functions is to monitor and facilitate the establishment and institutionalisation of the Western Cape Infrastructure Delivery Management System (IDMS). It has been agreed that the 2013/14 Service Delivery Agreement will remain in place and applicable for 2014/15.	To be scheduled by SCOPA
Page: 368 of the Annual Report	**Heading:** "SCOPA resolutions" **Description:** The Committee thanked the Department for publishing its resolutions, and actions taken in this regard, in its Annual Report, but noted that this was not an accurate reflection of the oversight role exercised by the Committee, in the year under review.	2. The Department should publish the Committee's opening comments specific to this Department, this table of resolutions and the list of information requested by the Committee, in all future Annual Reports.	Noted. The Committee's opening comments specific to this Department, this table of resolutions and the list of information requested by the Committee will be published in all the Annual Reports of this Department starting from the 2013/2014 Annual Report.	On-going, and starting with the publishing of the Departments 2013/14 Annual Report
Page: 378 of the Annual Report	**Heading:** "Infrastructure Matters" **Description**: The Committee noted that the Department was preparing for possible litigation through Legal Services (within the Department of the Premier) for infrastructure matters which related to the Western Cape Nursing College and Valkenberg High Care Unit.	3. The Department should implement mechanisms to recover any funds incurred on the infrastructure projects, namely the Western Cape Nursing College and the Valkenberg High Care Unit.	A legal opinion with respect to the Western Cape College of Nursing and the Valkenberg High Care Admission Unit was requested in November 2013. This legal opinion is still awaited.	To be scheduled by SCOPA
Page: 385 of the Annual Report	**Heading:** "Human resource management and compensation" **Description**: The Committee was concerned that Management did not ensure that sufficient and appropriate monitoring controls were in place to ensure that the verification process for new appointments took place prior to the appointment of the employee and/or did not cover criminal record checks, citizenship verification, financial record checks and reference checks.	4. The Human Resources Unit within the Department should ensure that personnel suitability checks are done prior to appointing new staff within the government departments in order to verify the historic data of individuals.	The Department has put the necessary control measures in place and Circular H134/2013 dated 14 August 2013 has been sent to all institutions to ensure that the verification checks are done as from 1 April 2013. The Advisory Services Component of the Directorate HRM and compliance officers of the regions/districts has conducted pre-audits in this regard to ensure compliance.	To be scheduled by SCOPA

SCOPA resolutions				
Resolution no.	**Subject**	**Details**	**Response by the department**	**Resolved (Yes/No)**
			Verification checks are part of the HR Audit Action Plan that must be completed on a quarterly basis by the various HR Managers as a further control measure. The Department has also taken the matter up with DPSA as there are instances where appointments must be made based on service delivery needs and operational requirements(i.e. doctors and nursing personnel etc.) before the verification process has been finalised. The DPSA has indicated that they are in the process of addressing the challenges experienced by departments in respect of the verification system. The outcome of the review being undertaken will be communicated to departments in due course.	
Page: 385 of the Annual Report	**Heading:** "Achievement of planned targets" **Description:** The Committee noted that of the total number of 196 targets planned for the year, 96 targets were not fully achieved during the year under review. This represented 49% of total planned targets that were not fully achieved during the year under review. This was as a result of the institution not considering relevant systems and evidential requirements during the annual strategic planning process. The indicators being measured by the Department are demand-driven, which makes it difficult to determine accurate targets, other than using prior periods' data as a predictive target.	5. This matter should be referred to the relevant Standing Committee for further monitoring and evaluation, with the Department.	1. The 49% of targets that were not achieved included both under achievement as well as over achievement, and is therefore an overestimation of the size of the challenge. If deviations less than 5% are accepted as achieved, then the Department has not met 27% of its targets; if deviations less than 10% are accepted as achieved, the Department did not meet 15% of its targets. 2. It should be noted that targets for the APP are set before the actual outputs of the previous year are finalised as well as before the budgets are finalised. These constraints are a broader public service challenge. 3. The Department has begun building a target setting process from below. A tool has been created and is being piloted in the metro. In addition to developing more realistic targets, this process will generate better ownership and greater accountability across the system for the achievement of targets. This is therefore more than a numbers exercise. This is a complex exercise in an organisation with 54 hospitals, 284 clinics, six districts and 32 sub districts. This should therefore be seen as developmental work in progress.	On-going, and as scheduled by the relevant Standing Committee

SCOPA resolutions				
Resolution no.	**Subject**	**Details**	**Response by the department**	**Resolved (Yes/No)**
			4. Many of the targets are demand-driven and difficult to predict with absolute accuracy. The Department has made formal representation to national and provincial treasury, the A_G's office and national Health to allow for an acceptable range of deviation as opposed to working with absolute numbers and requesting explanations for every single deviation irrespective of magnitude. We have not formally received a response. However provincial treasury has used a 5% deviation of under achievement as acceptable. 5. We have recommended to national health that the insertion of new indicators annually without having an "informal trial period" to test run the systems of data collection, target setting etc. are problematic.	
Page: 386 of the Annual Report	**Heading:** "Investigations" **Description:** The Committee noted that 67 cases (2011-12) relevant to the Western Cape Department of Health appeared in the Forensic Investigating Unit's register at the end of the financial year under review. The status of these cases were as follows: • 41 cases relating to alleged conflict of interest, corruption, human resource irregularities, theft, financial irregularities, nepotism and procurement fraud that were reported to the Forensic Investigating Unit since June 2011 have not yet been investigated. • 26 cases relating to alleged conflict of interest, corruption, human resource irregularities, theft, financial irregularities and procurement fraud that were reported to the Forensic Investigating Unit since July 2010 are still in progress.	6. The Department and FIU should brief the Committee on progress achieved and/or the outcomes of these investigations.	The Department and the FIU briefed the Committee on progress and outcomes of investigations on 3 March 2014.	To be scheduled by SCOPA

The Department of Health should provide the Committee with:

- A detailed breakdown of all infrastructure projects/matters that are currently underway between the Department and the Department of Transport and Public Works.

- A detailed report which responds to the Auditor-General note which speaks to medical and industrial waste management as indicated on page 377 of the Annual Report[3] of the Department;
- An age-analysis of the income generated in respect of the Road Accident Fund.
- A detailed report explaining and indicating why the basic nurse students at nursing colleges and higher educational institutes are not graduating as projected against the predetermined objectives;
- A detailed report of the costs associated with the unidentified and unclaimed storage of corpses at state mortuaries (exceeding 90 days);
- A detailed report highlighting why the Equitable Share Budget was spent at 89.7% and the Hospital Revitalisation Grant at 88.1 per cent;
- A detailed report highlighting all investigations which were undertaken in the Department as indicated on page 386 of the Annual Report[3] of the Department; and
- A report which highlights the analysis of the current year's fruitless and wasteful expenditure as per page 453 of the Annual Report of the Department.

9. PRIOR MODIFICATIONS TO AUDIT REPORTS

No matters to report.

10. INTERNAL CONTROL UNIT

FINANCE

The Department consists of five rural districts and one metro district, which in turn consists of four sub-structures, a regional office for general and specialised hospital services, three central hospitals and several head office institutions. There are several sub-districts reporting to each district or sub-structure, with several institutions reporting to each of these.

Although it is the responsibility of every institutional manager to ensure compliance with various financial prescripts, including supply chain management (SCM) and accounting, it is the accounting officer's responsibility to monitor the level of compliance to the various prescripts. For this purpose compliance detection units, called devolved internal control units (DICUs), have been established at head office and at district and sub-structure levels. The DICUs evaluate the level of compliance with SCM and accounting prescripts at institutions under the control of a specific district or sub-structure.

The DICUs use two sets of compliance monitoring tools, namely the internal assessment (IA), which is in essence a batch audit, and the compliance assessment (CA), which monitors a range of compliance issues varying from asset and warehouse management, to payments.

The findings are reported via an electronic process to institutional and district managers, and the office of the CFO. The findings are discussed at the district financial control committee (consisting of the district and institutional managers) and the central financial control committee (chaired by the accounting officer).

3 2012/13 Annual Report.

Where necessary an action plan will be compiled, with specific due dates, to improve the level of compliance with financial prescripts.

INFORMATION MANAGEMENT

An internal control unit (ICU) was established in the Directorate: Information Management in March 2013. It consists of twelve senior administrative officers managed by one assistant director within the Sub-directorate: Knowledge Management. The purpose of the unit is to establish and improve the level of compliance to information management (IM) guidelines, policies, standard operating procedures and other departmental prescripts in all public health facilities, IM support offices and systems support offices. This will ensure good data quality and reliable reporting.

The ICU uses an iterative process of assessing, intervening and revisiting. Where there are serious non-compliance findings or lack of action on previous findings, the unit intervenes at district, sub-district and/or facility level by assisting facilities to draft action plans and to implement corrective action to resolve the non-compliance findings. The ICU assessment cycle is aligned with the AGSA annual audit cycle and operational plans of the unit are designed to address non-adherence findings from the AGSA and other audits on performance information and related information systems. It aims to assist the Department in getting an unqualified audit opinion on predetermined objectives.

During 2013/14 the unit was orientated and trained, and developed tools which were used to assess 95 per cent of primary health care facilities and 17 per cent of hospitals. Although there were pockets of excellence, the results of these assessments indicated that compliance in terms of policy, data quality and information management procedures could be improved. The assessment included an opportunity to develop remedial actions with the facility and sub-district which were then approved and handed over to the facility to implement.

In addition, the unit supports health facilities to prepare for internal and external audits and to act as a liaison between the auditor and the entity being audited. The ICU staff play an important role in assisting facilities to reduce non-compliance findings during AGSA audits.

The unit also supports broader IM staff members based in the metro and rural districts with on-the-job training and implementation of tools for data collection, collation and data quality verification. General outcomes of ICU assessments are fed back to the broader departmental structures to assist in, amongst other things, training and performance evaluations, and to inform IM priorities.

HUMAN RESOURCES

The Department intends maintaining its track record of an unqualified audit report in respect of human resource (HR) matters.

The purpose of the Human Resource Management Advisory Services sub-directorate is to render an efficient and effective client/consultancy support service to human resource offices and line managers within the districts and regions, with specific reference to the applications of the Public Service regulatory framework.

In order to achieve the above-mentioned, compliance investigation, informal and formal functional training as well as continuous evaluation of required capacity in terms of the current and newly created organisational structures, are of the utmost importance.

Although there has been significant progress in terms of compliance since the audit conducted by the Auditor-General of South Africa in 2010/11, on-going challenges and gaps still exists as a result of system, individual and institutional weakness. There is a need to improve collaboration with internal clients (outreach) and achieve functional training and relief functions where capacity constraints are experienced.

With specific reference to a lack in human resource capacity, especially pertaining to second level supervisory posts and lack of skills, much emphasis has been placed on the enhancement of capacity through the creation of Devolved Internal Control Units (DICUs) at all district and regional offices and central hospitals.

The core functions of the DICUs are to identify areas of non-compliance as per Quarterly Action Plans (sample testing), to provide informal and functional training, and to provide relief functions where capacity constraints are experienced.

During the period under review the following work was performed by the sub-directorate:

- Compliance investigations: Determine compliance/non-compliance which included informal training – 17 institutions.
- Training: Developed and updated comprehensive user-friendly procedural manuals for HR staff and line managers.
- Functional training:
  - Responsibility of line managers at Klipfontein Mitchell's Plain Sub-Structure Office, Brooklyn Chest Hospital, Victoria Hospital and Beaufort-West Hospital.
  - Basic condition of services at Eden District Office, to SAOs (DICU).
  - Pensions at Beaufort-West Hospital, Western Cape College of Nursing and Directorate: Engineering Services.
  - Utilising management reports in order to ensure compliance at academic/regional offices.
- Ad-hoc investigations:
  - Workload indicators of staffing needs (WISN) project.
  - Grievances at Alexandra Hospital, Khayelitsha District Hospital and Klipfontein Mitchell's Plain Sub-Structure Office.
- Progress in terms of specific aspects of human resource management:
  - Developed management reports that enhance the ability to identify possible non-compliance.
  - Finalise development of user friendly procedural manuals (e.g. people monitoring tool-kit).
  - Annual implementation of control/reporting systems such as the Quarterly Action Plan and Compliance Monitoring Instrument.

11. INTERNAL AUDIT AND AUDIT COMMITTEES

Internal Audit provides management with independent, objective assurance and consulting services designed to add value and to continuously improve the operations of the Department. It should assist the Department to accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. The following key activities are performed in this regard:

- Assess and make appropriate recommendations for improving the governance processes in achieving the department's objectives;
- Evaluate the adequacy and effectiveness and contribute to the improvement of the risk management process; and
- Assist the Accounting Officer in maintaining efficient and effective controls by evaluating those controls to determine their effectiveness and efficiency, and by developing recommendations for enhancement or improvement.

Internal Audit work completed during the year under review for the Department included four assurance engagements, five consulting engagements, nine follow-ups and three engagements from the prior year were concluded. The details of these engagements are included in the Audit Committee report.

The Audit Committees is established as oversight bodies, providing independent oversight over governance, risk management and control processes in the Department, which include oversight and responsibilities relating to:

- Internal audit function.
- External audit function (Auditor-General of South Africa - AGSA).
- Departmental accounting and reporting.
- Departmental accounting policies.
- Review of AGSA management and audit report.
- Review of departmental in-year monitoring.
- Departmental risk management.
- Internal control.
- Pre-determined objectives.
- Ethics and forensic investigations.

The table below discloses relevant information on the audit committee members:

Table 11.1: Audit Committee members during 2013/14

Audit committee meetings						
Name	**Qualifications**	**Internal or external**	**If internal, position in the Department**	**Date appointed**	**Date resigned**	**Number of meetings attended**
Mr Ameen Amod	BCOMPT (HONS), MBA, CIA, CGAP, CRMA	External	N/A	01 Jan 2013	N/A	8
Mr Mervyn Buton	CA (SA), BCOM	External	N/A	01 June 2012	N/A	8
Mr Herman van der Merwe	B Com Maths, B Acc Hons, CA(SA), CIMA, M Acc	External	N/A	01 June 2012	N/A	6
Mr Terence Arendse	CA (SA), CERT IN THE THEORY OF ACCOUNTS	External	N/A	01 Jan 2014	N/A	1
Ms Bonita Petersen	CA (SA)	External	N/A	01 Jan 2014	N/A	1
Mr Lawrence Hyslop	BSC, MSC, MBA, Government certificate of competence	External	N/A	12 Nov 2010 - 31 Dec 2013	N/A	7
Ms Bianca Daries	B Acc, B Compt (Hons), CA(SA)	External	N/A	12 Nov 2010 - 31 Dec 2013	N/A	7

12. Audit committee report

We are pleased to present our report for the financial year ended 31 March 2014.

Audit Committee Responsibility

The Audit Committee reports that it has complied with its responsibilities arising from *Section 38(1)(a)(ii)* of the *Public Finance Management Act (PFMA)* and *National Treasury Regulations 3.1*. The Audit Committee also reports that it has adopted appropriate formal terms of reference as its Audit Committee Charter, has regulated its affairs in compliance with this charter and has discharged all its responsibilities as contained therein.

Effectiveness of Internal Control

In line with the PFMA and the King III Report on Corporate Governance requirements, Internal Audit provides the Audit Committee and Management with reasonable assurance that the internal controls are adequate and effective. This is achieved by a risk-based internal audit plan, Internal Audit assessing the adequacy of controls mitigating the risks and the Audit Committee monitoring implementation of corrective actions.

The following internal audit work was completed during the year under review:

Follow ups:

- False Bay Hospital,
- Hermanus Hospital,
- Citrusdal Hospital,
- Robertson Hospital,
- DP Marais Hospital,
- Valkenberg Hospital,
- Karl Bremer Hospital,
- Western Cape Rehabilitation Centre, and
- Recruitment and Selection.

Assurance Engagements:

- Human Resource Compliance Monitoring Instrument (CMI) (Four Institutions: Tygerberg, Mowbray, Victoria and Eerste River Hospitals);
- Transfer Payments;
- Pharmacy; and
- Human Resource Planning.

Consulting Engagements:

- Human Resource CMI (Overall Head Office];
- Quarterly Management Information;
- CGRO (Irregular Expenditure);
- Corporate Governance (Risk Management), and
- Mid-year stocktake (Cape Medical Depot, Anti-retroviral and Chronic Dispensing Unit).

Completion of prior year Internal Audit reports:

- Equipment Maintenance;
- Finance CMI Overall; and
- Finance CMI Devolved Internal Control Unit (DICU).

The areas of concern by the Audit Committee are:

- Control deficiencies related to monitoring and reporting (CMI, Transfer Payments and Equipment Maintenance).
- Slow progress with regards to the maturity of the Enterprise Risk Management (ERM) environment within the Department.
- The absence of detailed Standard Operating Procedures (SOPs) at institutional and sub-structure/district level, to enable consistent implementation of controls.
- As mentioned in previous Annual Reports, further audit coverage is required to cover a significant percentage of High Risk Areas.

The Centralised Forensic Investigative Unit (FIU) has been outsourced by the Western Cape Government, resulting in improved services to the Department. The FIU presented us with statistics that indicate that, for the year under review, 89 cases were closed, 51 new cases were opened and 29 cases were in progress as at 31 March 2014. The Department, towards meeting its commitment to reduce the Departmental backlog of outstanding cases, has funded 4 additional FIU resources.

The Committee is still concerned with the effectiveness of the system of internal control and the application thereof by the Department based on our review of the Internal Audit reports, the Audit Report on the Annual Financial Statements and the Management Report by the Auditor-General of South Africa (AGSA).

Corrective actions have been agreed upon by Management and are being monitored by the Audit Committee.

In-year management and Monthly/Quarterly Report

The Audit Committee is satisfied with the content and quality of the quarterly in-year management and performance reports issued during the year under review by the

Accounting Officer of the Department in terms of the National Treasury Regulations and the Division of Revenue Act.

Evaluation of Financial Statements

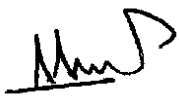
The Audit Committee has:

- reviewed and discussed the Audited Annual Financial Statements to be included in the Annual Report, with the AGSA and the Accounting Officer;
- reviewed the AGSA's Management Report and Management's responses thereto;
- reviewed changes to accounting policies and practices as reported in the Annual Financial Statements;
- reviewed the Department's processes for compliance with legal and regulatory provisions;
- reviewed the information on predetermined objectives as reported in the Annual Report;
- reviewed material adjustments resulting from the audit of the Department;
- reviewed, and where appropriate, recommended changes to the interim financial statements as presented by the Department for the six months ending 30 September 2013.

Report of the Auditor-General South Africa

We have on a quarterly basis reviewed the Department's implementation plan for audit issues raised in the prior year. The Audit Committee has met with the AGSA to ensure that there are no unresolved issues that emanated from the regulatory audit. Corrective actions on the detailed findings raised by the AGSA will continue to be monitored by the Audit Committee on a quarterly basis.

The Audit Committee concurs and accepts the Auditor-General of South Africa's opinion regarding the Annual Financial Statements, and proposes that these Audited Annual Financial Statements be accepted and read together with their report.



Mr Ameen Amod
Chairperson of the Audit Committee
Department of Health
06 August 2014

PART D:
HUMAN RESOURCE MANAGEMENT

1. INTRODUCTION

Human resources (HR) has a pivotal role in ensuring the success of the 2030 strategy to address the requirements for a person-centred quality health service, as staff are the most critical enabler.

HR, through the Human Resources for Health Strategy (HRH, 2011), in terms of the Public Service legislative framework, will significantly influence the strengthening of health systems toward an effective and person-centred health service that will contribute to population outcomes and the achievement of the principles below:

- Person-centred quality of care.
- Outcomes based approach.
- The primary health care (PHC) philosophy.
- Strengthening the district health services model.
- Equity.
- Cost effective and sustainable health service.

2. OVERVIEW OF HUMAN RESOURCES

Status of human resources in the Department

The Department employs 31 017 staff members who are comprised of 64 per cent health professionals and 36 per cent administrative support staff. Ninety-two per cent of staff are employed in a permanent capacity.

Overview of the workforce

- 72 per cent are females and 28 per cent are males.
- 25 per cent are Black; 15 per cent are White, 58 per cent are Coloured and 2 per cent are Indian.
- 51 per cent of senior management positions are held by females.
- 150 persons are classified as disabled.
- 92 per cent of the staff are employed on a full-time permanent basis.
- The length of service ranges from over forty years to newly appointed staff.
- The age profile of the workforce is:
    - 3 per cent under 25 years.
    - 39 per cent aged 25 to 40 years.
    - 46 per cent aged 41 to 55 years.
    - 9 per cent aged 56 to 60 years.
    - 3 per cent aged 61 to 65 years.

Human Resources roles and responsibilities

- Head office (centralised level) provides for policy development, strategic co-ordination, monitoring and evaluation, and provincial oversight of people management.
- Regional/district offices (decentralised level) provides for decentralised oversight and implementation support of HR policies and prescripts.
- Local institutional level (i.e. district, regional, specialised, tertiary and central hospitals) is where the majority of staff are managed and implementation of HR policies occur.

People management in the main is a line function responsibility that is enabled and supported by HR practitioners and policies at various levels.

Human resource priorities for 2013/14 and the impact of these priorities

(1) People management:

WCG: Health has a staff establishment of 31 017 employees that attend to millions of patients annually within a stressful, busy and resource-constrained environment. It is easy to understand how staff working at the coalface can become mechanistic in the way they perform their tasks, slip into a mentality of clearing crowds and treating patients as cases on a daily basis. The biggest unintentional casualty is the human and caring factor in the service.

To effectively address this there needs to be greater alignment between the values of staff and that of the organisation. This requires the involvement of leadership at all levels and the incorporation of a valued based system within all HR practices and processes.

(2) Scarce skills:

The recruitment and retention of scarce skills in approximately all the health related disciplines, from medical doctors, nurses to clinical engineers and forensic pathology staff is still an area that needs to be addressed despite the implementation of various strategies such as the occupational specific dispensations which provided higher salaries and better career-pathing, and the use of bursaries.

In an effort to better understand the reasons why staff leave the service a new electronic exit interview questionnaire has been developed which will be implemented soon(the electronic database implementation was delayed and should become operational during 2014/15

(3) Unqualified HR audit:

The Department achieved an unqualified audit report in 2012/13 in respect of HR matters. The implementation of the HR Compliance Monitoring Instrument (CMI) and Quarterly HR Audit Action Plan has proven to be an effective tool to improve compliance to the HR regulatory framework.

The purpose of the HR-CMI and Audit Action Plan is to ensure compliance with HR practices by HR practitioners, HR managers and line managers.

- The CMI is utilised as a reporting tool by the line manager to the hospital CEO to ensure that line managers at institutions comply with HR responsibilities.

- The Quarterly HR Audit Action Plan is utilised as a reporting tool by all HRM offices at institutional level, district/regional offices and head office.
- The Western Cape Audit Committee is also informed on HR compliance based on the information obtained from the Quarterly HR Audit Action Plans.
- The Quarterly HR Audit Action Plan consists of all matters raised by the Auditor-General over the past years and is updated if necessary on an annual basis.
- The reports are being utilised by the HRM Advisory Services component to determine priority institutions for assistance and training.

(4) Task shifting:

Task shifting is used in various ways to assist health professionals in the employ of WCG: Health. The training of theatre technicians to overcome the shortage of professional nurses employed in theatres has already shown promise. Rehabilitation workers as well as home-based care workers are a further two occupations that will be implemented shortly and will be able to assist with the current work burden placed on health therapists and nursing staff.

(5) Labour relations:

There is an effective provincial public health and social development sectorial bargaining chamber where negotiations and consultation with organised labour were held throughout the reporting period. There were six chamber meetings, six HR task team meetings and two special chamber meetings. A wellbeing agreement for EMS staff and a policy on termination of services due to operational requirements was also concluded in the chamber. Currently there are more than fifty fully functional institutional management labour committees (IMLCs) within the Department which ensure sound interaction with labour at institutional level.

The handling of all fraud related cases of the forensic investigative unit and other serious disciplinary matters have been centralised to head office level to ensure efficiently and consistency.

There has been constant interaction with internal and external stakeholders on various labour related matters and ensure that grievances and disputes are resolved in terms of the relevant prescripts to promote labour peace.

(6) Training:

HR and Human Resource Development (HRD), through workforce/HR planning and the implementation of the Workplace Skills Plan, must deliver competent, well-trained, and caring health professionals and support staff, to deliver a comprehensive package of health services, in order to impact positively on the health of the population of the Western Cape Province. Capacitated health workers in multi-disciplinary teams will provide continuity of care across various levels of care in a coherent health system addressing a quadruple burden of disease.

Education, training and development strategies to ensure a continuous supply of health and support professionals range from bursaries, internships and learnerships to the clinical skills development evidenced-based interventions linked to continuous professional development (CPD) to address critical skills and capacity of existing health and support professionals.

New bursaries were allocated to health professionals as follows during 2013/14:

- Degree: Emergency Medical Care.
- Degree: Dentistry.

- Degree: Dietetics.
- Degree: Medicine.
- Degree: Occupational Therapy.
- Degree: Pharmacy.
- Degree: Physiotherapy.
- Diploma: Security Services.
- Medical Orthotics and Prosthetics.
- National Diploma: Emergency Medical Care.
- National Diploma: Radiography.
- Nursing: B Cur.
- R425 Nursing.

Clinical skills development interventions to address the quadruple burden of disease provided during 2013/14 include:

- HIV and TB training:
  - Manage HIV patients' pre-ARV treatment according to guidelines.
  - Use ARV according to guidelines.
  - Pleural tap.
  - PALSA Plus.
- Chronic diseases:
  - Management of chronic diseases including hypertension, asthma cardiovascular diseases, cancers, respiratory, diseases; diabetes and mental illness.
- Injuries:
  - Paediatrics advanced life support (PALS).
  - Advanced cardiovascular life support (ACLS).
  - Advanced trauma life support (ATLS).
  - Resuscitation skills.
  - Manage clinical forensic cases.
  - Minor surgical skills.
  - Management of psychiatric emergencies.
  - Basic anaesthetics.
- Maternal health:
  - Caesarean section.
  - Perform termination of pregnancy.
  - Obstetric and pelvic ultrasound.
  - Obstetrics.
  - Obstetrics anaesthesia.
  - Pap smear and cervical carcinoma.
  - Drain a Bartholin's abscess or cyst.

- Child health:
  - Neonatology.
  - Integrated management of childhood illness (IMCI).
  - Assess growth and classify malnutrition.

There is also emphasis on leadership and management development to ensure good corporate governance, sound leadership and build transformational leaders in Health. Management training focused on health leadership training, management development programme, lean management and finance management.

The Expanded Public Works Programme (EPWP) skills development focus has traditionally been on community-based services through the training of home community-based carers on four accredited National Qualifications Framework (NQF) levels of training in ancillary health care and community health work.

In addition internship opportunities are available for:

- Data capturer interns.
- Basic and post basic pharmacist's assistants.
- Assistant to artisan (ATA) interns.
- Finance and HR interns (under the Premier's Advancement of Youth (PAY) programme).
- Basic ambulance assistants.
- Emergency care technicians.

(7) Employment equity:

The Employment Equity Plan for 2013 to 2017 was successfully consulted with Organised Labour for implementation. A policy has been developed to implement affirmative action programmes which will be applied in conjunction with the Employment Equity Plan.

To strengthen employment equity targets, funding for R3.6 million was obtained from the Health and Welfare Sector Education and Training Authority (HWSETA) to train and employ fifty persons with disabilities commencing 2011/12 and concluding 2013/14. During the reporting period, the Department recruited thirty-eight people with disabilities.

An internship was conducted for seven deaf persons at the newly commissioned Khayelitsha Hospital in conjunction with the National Institute for the Deaf and Fedics. After internship the seven deaf persons were permanently employed by Fedics which is contracted to render the kitchen function at the hospital. This was part of the Department's social responsibility towards the community of Khayelitsha.

(8) Barret Values Survey:

The Barrett Survey 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.

During July and August 2013 the Department of Health participated in the third Barrett Survey which was available to employees online. The response rate of the Barrett survey was 18 per cent which translates to 244 more employees participating in the survey than in 2011.

The current culture experienced by employees in terms of positive values is accountability, client orientation, accessibility, continuous improvement and team work. The potentially limiting values are red tape, control, hierarchy, cost reduction and confusion. The level of entropy has decreased by 2 per cent which is defined as the energy in an organisation that is consumed by non-productive activities.

Feedback was given to the Top Management Committee. The results were also communicated to all district offices and components within the Department.

(9) Staff Satisfaction Survey:

WCG: Health conducted a staff satisfaction survey (SSS) in mid-July 2013 throughout all districts, institutions and directorates within the Department. This survey was administered in all three official languages. Employees with a disability could complete the survey telephonically. The aim of the SSS was to assess the organisational climate among employees in terms of their thoughts and opinions of the organisation, their job and their work environment. The questionnaire is based on the national core standards as well the DPSA Wellbeing Framework.

There were 9 794 responses to the survey - a 32 per cent response rate which was sufficient to ensure a representative sample. There were 10 649 responses in 2011. There were approximately 15 000 qualitative comments provided on the survey. The most frequently represented employee group were nurses (28 per cent), followed by administrative employees (18 per cent). The largest number of responses was received from the Chief Directorate: General Specialist and EMS. The largest response rate was from the Overberg District. The methodology used was quantitative as well as qualitative. The survey was paper-based and consisted of 77 questions.

The top five shifts in terms of agreement since 2011 has been in the following questions:

- I am able to consult my colleagues when I am faced with an unexpected or challenging situation at work: 6.1 per cent.
- My personal belongings are safe at work, e.g. car, bag, etc.: 5.6 per cent.
- In the last 7 days I have received recognition or praise (for example, a thank you) for doing work: 5.5 per cent.
- The organisation fosters a sense of belonging amongst its employees: 5.4 per cent.
- The organisation values and cares for its employees: 5.3 per cent.

The results of the survey will be used as a planning tool within the Department in order to attain person-centred care and strive towards achieving the outcomes as outlined in Health Care 2030. Feedback was provided to top management as well sub-structure/district management teams within the Province.

(10) Employee health and wellness programme:

The Department recognises that employees play a fundamental role in attaining patient centred care. The employee health and wellness programme (EHWP) evolved, with employees utilising services for different issues and needs.

There has been a shift from more practical concerns to more sensitive personal and work-related issues such as addictive behaviours, organisational issues and stress. This indicates growing trust in the EHWP. This shift also indicates that the programme has increasingly been able to target key risk issues within the organisation and to mitigate the impact of these issues on the Department as a whole. The EHWP has the potential

to improve productivity, morale, motivation and work relationships. The services are available to all employees and their immediate household members and support to managers is available through the use of formal referrals and managerial consultancy services.

The EHWP encompasses the following:

- Individual wellness (physical).
- Individual wellness (psycho-social).
- Organisational wellness.
- Work-life balance.

Individual and organisational wellness is attained by creating an organisational climate and culture that is conducive to wellness and comprehensive identification of psycho-social health risk. Information and education regarding the EHWP was intensified, which resulted in an increased utilisation of the EHWP. The overall engagement rate, which includes uptake of all services provided, amounted to 22.1 per cent during the period under review, which increased from 19.5 per cent in the 2012/13 financial year. Important to note as well is that the problem/case ratio has decreased to 2.12 which indicates that employees are seeking assistance for their problems early. This will be encouraged in the year to come.

Formal referrals are typically made in a context of a threat to the relationship between the employee and the Department. The proportion of Western Cape Government: Health users who were formally referred during the review period was 5.9 per cent (182 cases). This compares to 4.9 per cent (127 cases) during the previous period and 4.8 per cent against the private sector benchmark. This indicates that managers are developing the emotional intelligence to identify troubled employees and are being proactive about their own well-being.

As part of the EHWP, an e-Care programme has been introduced to all employees. The e-Care programme enables employees to manage their well-being online and sends employees a weekly e-mail with information on various health topics to promote physical and emotional well-being. Currently 265 employees profiled themselves on the e-Care service which is 0.9 per cent of the employees. The top three health concerns amongst users are back pain, hay fever/allergic rhinitis and headache/migraine. It is encouraging to note that employees made use of the ask-the-professional service during the year. More awareness of the e-Care service is needed amongst all employees to ensure the enrolment rate reaches the minimum 20 per cent required to draw conclusions about the health wellbeing of WCG: Health as an organisation.

The Department's HIV workplace programme is guided by the Provincial Strategic Plan on HIV and AIDS, STIs and TB 2012 - 2016 and the Transversal Workplace Policy on HIV and AIDS. It is aimed at minimising the impact of HIV and AIDS in the workplace and subsequently minimising the prevalence of HIV and AIDS in the Province. The HIV counselling and testing (HCT) programme in the workplace was strengthened by not only catering for HIV testing, but also testing for other lifestyle diseases such as hypertension and diabetes, and monitoring cholesterol and body mass index. This package of services provided by the HCT programme therefore offers an integrated approach to well-being.

A total of 3 160 employees (10.8 per cent) were tested during 2013/14, compared to a total of 3 594 employees (11.8 per cent) in the previous financial year. Although there has been a slight decrease in the utilisation rate for HCT testing for the review period, results revealed consistency in the number of employees testing positive for

HIV (32 employees tested positive during 2013/14 and 58 employees in 2012/13). The decrease in the utilisation rate could be attributed to testing fatigue as the programme has been in operation for the past seven years.

(11) Diversity management:

The diversity management programme and mainstreaming human rights programmes were strengthened by various training interventions around diversity and capacity training with gender forum members. The simultaneous mainstreaming of gender, youth, disability, and HIV and AIDS strategy has been drafted and will be presented to organised labour during the 2014/15 financial year.

(12) Nursing:

An implementation plan for the Nursing Education and Training Strategy/Framework was developed in collaboration and consultation with relevant stakeholders.

A three-year departmental nurse training plan has been developed and implemented to address the restrictions that have been placed on the appointment of specialty nurses with the introduction of the occupational specific dispensation. Once the qualification has been achieved, professional nurses with the required years of experience will be translated to speciality posts. In addition, the Department is granting bursaries for student nurses towards the nurse (general, psychiatric and community) and midwife (R425) qualification.

Informal training to assist in the maintenance of competencies of nurses was provided which focused on short courses e.g. certificate in the management of patients on anti-retroviral and tuberculosis treatment (CMART). CMART provides the nurse participant with evidence-based clinical management strategies for HIV and AIDS, and TB. The course includes training in adult and paediatric care, treatment guidelines on prevention of mother-to-child transmission (PMTCT), preceptorship course (training professional nurses to enhance the clinical skills of novices and students in the service setting by providing expert guidance and supervision), TB/MDR training and midwifery.

The study by assignment (SBA) process is followed in order to address formal training. The Department annually identifies clinical training needs in respect of nursing staff that are crucial for the effective execution of its core functions. The 50/50 study leave provision is inadequate to cover all the study/training needs of the nurses that need to undertake a minimum of a year training programme that has a theory and practical component of not less than 960 hours of practical. Nurses who embark on non-clinical nurse training programmes and non-nurse training programmes must apply for study leave on the 50/50 basis and examination and preparation leave, subject to operational requirements, as contained in the transversal policy on special leave.

A total number of 383 nursing staff were granted SBA for basic and post basic training in the 2013 academic year and 359 for the 2014 academic year.

The Nursing Information Management System (NIMS) is an automated booking system linking WCG: Health and the currently contracted agencies. NIMS complies with the fair tendering process and allows all nine agencies a fair chance to nominate agency nurses against requests from the services for additional nurses.

To date, seventy one (71) health facilities in the Metro, including regional, psychiatric and tertiary hospitals have been activated and trained on NIMS since its inception over a year ago. On-going support to services is provided by the sub-directorate Nursing Practice. All the nine agencies on the current contract have received training and are activated on NIMS.

An essential feature of teaching practice is the placement of undergraduate and post graduate nursing students in a variety of clinical practice settings where they have the opportunity to develop clinical skills and observe clinical, remedial and training practices. During the 2014 academic year, 5 300 nursing students, attending 23 different under- and post-graduate nurse training programmes, were managed on the clinical placement platform.

The Directorate: Nursing Services supports the standardisation of the patient record system for recording of nursing care activities to comply with the national core standards (checklist on patient records). The new system is being developed in consultation with clinicians.

Placement of community service practitioners is a collaborative process between the National and Provincial Departments of Health and the South African Nursing Council (SANC). Thirty seven (37) placements were allocated for August 2013 and three hundred and forty two (342) for January 2014.

The authorisation of clinical nurse practitioners and the dispensing of medicines by professional nurses are being addressed in order to comply with the legislative requirements and facilitate service delivery.

Workforce planning and key strategies to attract and recruit a skilled and capable workforce

Workforce planning for the health services is challenging and complex, however it is an important process to deliver optimal health care. There is a need for a dedicated team to develop and rigorously drive an integrated HR strategy that focuses on the HR priorities for the Department.

The workforce planning framework used by the Department is aligned to the HR planning template provided by the Department of Public Service and Administration. Based on the Department's strategic direction and Annual Performance Plan, an analysis is conducted of the external and internal environment, trends and changes of the macro environment and the workforce. This is followed by a gap analysis to determine priorities that would have the greatest impact. This planning process is done on an annual basis.

The implementation of the occupational specific dispensations for all health related categories of staff is a successful recruitment strategy. Additional strategies include:

- Promote health occupations at schools to attract talent.
- The allocation of appropriate bursaries and learnerships.
- Focus on training facilities to recruit candidates on completion of their studies.
- Improve the physical working environment and create a more flexible working environment, where possible.
- Provide training in critical and scarce occupations.
- Interventions to attract skilled health professionals working in the private sector and those who have left South Africa.

Employee performance management

A Staff Performance Management System (SPMS) has been operational since 2003. The system is managed on a decentralised basis where each district is responsible for the finalisation of its processes, while the head office component also plays a policy management and oversight role in this regard. Training is consistently provided to promote and ensure the smooth functioning of the system. The moderation phase is strictly managed to ensure that the performance cycle is concluded within the given timeframes.

Employee wellness programmes

Refer to paragraph 10 under "*Human resource priorities for the year under review*" earlier in this section.

Policy development

Policy development has been designated as a transversal function with the Department of the Premier as the custodian. The transversal nature of policy development also means that department-specific inputs are often not included in the final product. Policies therefore need to be accompanied by department-specific guidelines that must be drafted separately and issued in conjunction with the transversal policy. Department-specific guidelines are developed through a process of consultation with role-players in human resources in the Department in order to ensure wide participation and buy-in from managers.

Achievements:

- Departmental policy on the granting of access to consultants for marketing purposes.
- Input to the policy on Remunerative Work Outside the Public Service (RWOPS).
- Input to the policy on the provincial dress code.
- Guiding principles on the performance assessment of employees who are absent for prolonged periods during a performance cycle.

Challenges:

- The centralisation of transversal policy development in the Province means that the development process is time-consuming and that the finalisation of transversal policies is often protracted.

Challenges faced by the Department

- Structural challenges:

  The biggest challenge encountered does not lie with the design of an organisation and post structure itself, but rather the available budget to fund the post structure. The currently designed and approved organisational structures for the Department (based on service needs and workload indicators) compared with the approved staff establishment (based on filled and funded vacancies according to budget) reflects a 30 per cent vacancy rate. However, the vacancy rate between the filled and funded vacancies is currently 4 per cent.

- Competencies:

  A critical need in the Department is a proper skills mix to ensure quality of care and a patient centred experience. An analysis of the current competencies within the Department was conducted and indicates limited and insufficient competencies in a number of occupational groups. A number of training and development interventions have been identified to address scarce skills in consultation with higher education institutions (HEIs), nursing colleges, schools and key stakeholders with regard to training. The Department has also implemented internal and external bursary programmes, internships and learnerships in an effort to attract and retain scarce skills. Levels of qualifications and the number of employees without qualifications cannot be effectively addressed as all employee qualifications have not been captured on PERSAL.

- Training and development:

  According to the analysis on short courses attended by employees in the past three years, a significant number of training interventions took place. Although a number of courses have been presented, sufficient focus was not placed on critical training needs (too much emphasis was placed on soft skills training). The Directorate: Human Resource Development is currently initiating strategies to address training in scarce and critical skills as well as an assessment of the return on investment.

- Managing of grade progression and accelerated pay progression:

  With the implementation of all the occupational specific dispensation (OSD) categories, the management of grade progression and accelerated progression have been identified as a significant challenge. As individuals can be grade progressed on a monthly basis depending on their years of service, hospitals had to develop manual data systems to ensure compliance.

  Currently problems are experienced with the accuracy of this process as the qualifying periods are determined manually and not programmatically. The Department is exploring mechanisms to address the challenge.

- Recruitment of certain health professionals:

  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.

- Age of workforce:

  The average age of the workforce of the Department is between 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.

  The Department is in the process of reviewing its recruitment policy and strategy to address these challenges.

  An analysis indicates that the Department may experience a shortage of skilled staff in the near future due to a relatively high percentage (12 per cent) nearing retirement (65) or early retirement age (55). However, retirees mainly fall in the 60 – 64 age group.

Future human resource plans/goals

The departmental HR plan is drafted on an annual basis in line with the departmental Strategic Plan and the Annual Performance Plan. The next plan will be drafted in 2014/15.

The following are key HR goals:

- Assist in employing the right staff for the right jobs with the right competencies to yield optimal service delivery to health needs in line with the HC 2030 vision and the re-imagined future.
- Working towards the establishing of a competent and skilled workforce with an attitude of service and "patient focus" to yield optimal service delivery.
- Determine scarce skills occupations in terms of the new service model and put strategies in place that will attract and retain an adequate supply of highly skilled and qualified health professionals.
- Delivery of a professional HR service to clients.
- Establish a strategic partnership between HR components and line management for rendering advice and support and the building of a trust relationship between employees and HR components.
- Implement qualitative evaluation of the effect of training on service delivery.
- Training and development to ensure strategic management capacity based on HR needs.
- Strengthen and expand EPWP in areas of need within the Department, i.e. human resources, pharmaceutical services, finance, and emergency medical services.
- Training of rehabilitative care workers.
- Manage the quality and improvement of nursing practice, education and training within the Department.
- 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.
- Develop multi-year human resource plans that are in line with national, provincial and departmental strategic objectives.
- 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.
- Ensure effective consultation with organised labour to ensure full implementation of the organisational restructuring and management of excess staff, where applicable.
- Expeditious resolution of disputes, disciplinary matters and grievances.
- Continuous capacity building of employees in labour relations matters.
- Management of strikes/protest actions and ensuring that contingency plans are in place at all institutions.

3. HUMAN RESOURCES OVERSIGHT STATISTICS

3.1 PERSONNEL RELATED EXPENDITURE

The following tables summarises the final audited personnel related expenditure by programme and by salary bands. In particular, it provides an indication of the following:

- Amount spent on personnel.
- Amount spent on salaries, overtime, homeowner's allowances and medical aid.

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

Table 3.1.1: Personnel costs by programme, 2013/14

Personnel related expenditure							
Programme	**Total expenditure (R'000)**	**Personnel expenditure (R'000)**	**Training expenditure (R'000)**	**Goods and services (R'000)**	**Personnel expenditure as a % of total expenditure**	**Average personnel expenditure per employee (R'000)**	**Number of employees**
Programme 1	511 447	215 664	847	0	42%	351	615
Programme 2	6 039 262	3 294 783	9 349	210 900	55%	289	11 387
Programme 3	819 748	486 359	529	0	59%	237	2 054
Programme 4	2 499 888	1 791 500	3 467	37 909	72%	293	6 106
Programme 5	4 565 421	3 127 750	3 517	59 235	69%	339	9 230
Programme 6	264 193	105 463	264 193	23	40%	331	319
Programme 7	339 151	199 425	617	110	59%	246	810
Programme 8	877 852	16 994	2 494	140	2%	0	49
Total	**15 916 962**	**9 237 938**	**285 013**	**308 717**	**58%**	**302**	**30 570**

Notes:

- Expenditure of sessional, periodical and extra-ordinary appointments are included in the expenditure but not in the personnel totals which will inflate the average personnel cost per employee.
- Personnel expenditure: This excludes standard chart of accounts (SCOA) item *Household (HH)/Employer Social Benefits* on the Basic Accounting System (BAS).
- Goods and services: Consists of the SCOA item *Agency and Outsourced services: Admin and Support Staff, Nursing staff and Professional Staff*.

- The total number of employees is the average of employees that was in service as on 31 March 2013 and 31 March 2014.

Table 3.1.2: Personnel costs by salary band, 2013/14

Personnel related expenditure				
Salary band	**Personnel expenditure (R'000)**	**% of total personnel expenditure**	**Average personnel expenditure per employee (R'000)**	**Number of employees**
Lower skilled (Levels 1 - 2)	274 717	2.99	114	2 409
Skilled (Level 3 - 5)	1 845 158	20.08	163	11 342
Highly skilled production (Levels 6 - 8)	3 277 540	35.67	370	8 848
Highly skilled supervision (Levels 9 - 12)	3 731 093	40.61	472	7 909
Senior and top management (Levels 13 - 16)	59 406	0.65	958	62
Total	**9 187 914**	**100.00**	**301**	**30 570**

Notes:

- Expenditure of sessional, periodical and extraordinary appointments are included in the expenditure but not in the personnel totals which will inflate the average personnel cost per employee.
- The Senior Management cost includes commuted overtime of health professionals which inflates the average personnel cost per employee.
- The total number of employees is the average employees that were in service for 12 months (April 2013 to March 2014).

Table 3.1.3: Salaries, Overtime, Housing Allowance and Medical Aid by programme, 2013/14

Personnel related expenditure								
Programme	**Salaries**		**Overtime**		**Housing allowance**		**Medical assistance**	
	Amount (R'000)	**Salaries as a % of personnel costs**	**Amount (R'000)**	**Overtime as a % of personnel costs**	**Amount (R'000)**	**Housing allowance as a % of personnel costs**	**Amount (R'000)**	**Medical assistance as a % of personnel costs**
Programme 1	198 424	2.16	902	0.01	4 491	0.05	7 414	0.08
Programme 2	2 934 217	31.94	187 635	2.04	86 540	0.94	121 898	1.33
Programme 3	415 699	4.52	27 723	0.30	17 769	0.19	28 971	0.32
Programme 4	1 530 723	16.66	130 606	1.42	49 807	0.54	69 469	0.76
Programme 5	2 547 608	27.73	350 184	3.81	69 432	0.76	94 899	1.03
Programme 6	90 392	0.98	986	0.01	1 938	0.02	3 135	0.03
Programme 7	164 854	1.79	16278	0.18	7 319	0.08	11 316	0.12
Programme 8	16 907	0.18	41	0.00	90	0.00	247	0.00
Total	**7 898 824**	**85.97**	**714 355**	**7.77**	**237 386**	**2.58**	**337 349**	**3.67**

Notes:

- Expenditure of sessional, periodical and abnormal appointments is included in the expenditure.
- Expenditure of the joint establishment (universities conditions of service) is excluded in the above.

Table 3.1.4: Salaries, Overtime, Home Owners Allowance and Medical Aid by salary band, 2013/14

Personnel related expenditure								
Salary band	Salaries		Overtime		Housing allowance		Medical assistance	
	Amount (R'000)	Salaries as a % of personnel costs	Amount (R'000)	Overtime as a % of personnel costs	Amount (R'000)	Housing allowance as a % of personnel costs	Amount (R'000)	Medical assistance as a % of personnel costs
Lower skilled (Levels 1 - 2)	224 037	2.44	5 877	0.06	21 866	0.24	22 937	0.25
Skilled (Level 3 - 5)	1 549 644	16.87	63 344	0.69	103 191	1.12	128 980	1.40
Highly skilled production (Levels 6 - 8)	2 935 720	31.95	98 261	1.07	97 256	1.06	146 303	1.59
Highly skilled supervision (Levels 9 - 12)	3 131 037	34.08	546 482	5.95	15 073	0.16	38 500	0.42
Senior and top management (Levels 13 - 16)	58 386	0.64	391	0.00	0	0.00	629	0.01
Total	**7 898 824**	**85.97**	**714 355**	**7.77**	**237 386**	**2.58**	**337 349**	**3.67**

Notes:

- Expenditure of sessional, periodical and abnormal appointments is included in the expenditure.
- Expenditure of the joint establishment (universities conditions of service) is excluded in the above.
- Commuted overtime is included in salary bands *Highly skilled supervision* (Levels 9 -12) and *Senior Management* (Levels 13 - 16).

3.2 EMPLOYMENT AND VACANCIES

The following tables summarise the number of posts on the establishment, the number of employees, the percentage of vacant posts, and whether there are any staff additional to the establishment. This information is presented in terms of three key variables: programme (Table 3.2.1), salary band (Table 3.2.2) and critical occupation (Table 3.2.3). Departments have identified critical occupations that need to be monitored. Table 3.2.3 provides establishment and vacancy information for key critical occupations of the Department.

Table 3.2.1: Employment and vacancies by programme as on 31 March 2014

Employment and vacancies					
Programme	Number of posts		Number of posts filled	Vacancy rate	Number of posts filled additional to the establishment
	Funded	Unfunded			
Programme 1	778	0	623	19.92	19
Programme 2	12 295	0	11 689	4.93	14
Programme 3	2 088	0	2 032	2.68	0
Programme 4	6 417	0	6 174	3.79	4
Programme 5	9 620	0	9 303	3.30	19
Programme 6	317	0	300	5.36	0
Programme 7	872	0	784	10.09	0
Programme 8	69	0	26	62.32	30
Total	**32 456**	**0**	**30 931**	**4.70**	**86**

Notes:

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

Table 3.2.2: Employment and vacancies by salary band, as at 31 March 2014

Employment and vacancies					
Salary band	**Number of posts**		**Number of posts filled**	**Vacancy rate**	**Number of posts filled additional to the establishment**
	Funded	**Unfunded**			
Lower skilled (Levels 1 - 2)	2 579	0	2 441	5.35	3
Skilled (Level 3 - 5)	12 103	0	11 501	4.97	43
Highly skilled production (Levels 6 - 8)	9 288	0	8 920	3.96	14
Highly skilled supervision (Levels 9 - 12)	8 419	0	8 007	4.89	25
Senior and top management (Levels 13 - 16)	67	0	62	7.46	1
Total	**32 456**	**0**	**30 931**	**4.70**	**86**

Notes:

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

Table 3.2.3: Employment and vacancies by critical occupations, as at 31 March 2014

Employment and vacancies					
Critical occupation	**Number of posts**		**Number of posts filled**	**Vacancy rate**	**Number of posts filled additional to the establishment**
	Funded	**Unfunded**			
Medical orthotist and prosthetist	16	0	14	12.50	0
Medical physicist	12	0	12	0.00	0
Clinical technologist	89	0	82	7.87	0
Pharmacist	427	0	399	6.56	1
Industrial technician	75	0	63	16.00	0
Total	**619**	**0**	**570**	**7.92**	**1**

Notes:

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

3.3 JOB EVALUATION

The Public Service Regulations, 2001as amended, introduced job evaluation as a way of ensuring that work of equal value is remunerated equally. Within a nationally determined framework, executing authorities may evaluate or re-evaluate any job in his or her organisation. In terms of the Regulations, all vacancies on salary levels 9 and higher must be evaluated before they are filled. This was complemented by a decision by the Minister for the Public Service and Administration that all Senior Management Service (SMS) jobs must be evaluated before 31 December 2002.

Table 3.3.1 summarises the number of posts that were evaluated during the year under review. The table also provides statistics on the number of posts that were upgraded or downgraded.

Table 3.3.1: Job Evaluation, 1 April 2013 and 31 March 2014

Job evaluation							
Salary band	Number of posts	Number of jobs evaluated	% of posts evaluated by salary band	Posts upgraded		Posts downgraded	
				Number	% of posts evaluated	Number	% of posts evaluated
Lower skilled (Levels 1 - 2)	2 579	0	0.00	0	0.00	0	0.00
Skilled (Level 3 - 5)	12103	4	0.03	0	0.00	0	0.00
Highly skilled production (Levels 6 - 8)	9288	11	0.12	0	0.00	0	0.00
Highly skilled supervision (Levels 9 - 12)	8 419	17	0.20	0	0.00	0	0.00
Senior Management Service Band A (Level 13)	53	0	0.00	0	0.00	0	0.00
Senior Management Service Band B (Level 14)	9	0	0.00	0	0.00	0	0.00
Senior Management Service Band C (Level 15)	4	0	0.00	0	0.00	0	0.00
Senior Management Service Band D (Level 16)	1	0	0.00	0	0.00	0	0.00
Total	**32 456**	**32**	**0.10**	**0**	**0.00**	**0**	**0.00**

Notes:

- Nature of appointment sessional is excluded.

Table 3.3.2 provides a summary of the number of employees by race, gender and disability whose salary positions were upgraded due to their posts being upgraded.

Table 3.3.2: Profile of employees whose positions were upgraded due to their posts being upgraded, 1 April 2013 and 31 March 2014

Job evaluation					
Gender	African	Indian	Coloured	White	Total
Female	0	0	0	0	0
Male	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**
Employees with disability					None

Notes:

- Nature of appointment sessional is excluded.

Table 3.3.3: Employees who have been granted higher salaries than those determined by job evaluation per race group, 1 April 2013 and 31 March 2014

Job evaluation					
Major occupation	**Number of employees**	**Job evaluation level**	**Remuneration on a higher salary level**	**Remuneration on a higher notch of the same salary level**	**Reason for deviation**
Director	1	13	-	13th of 13	Recruitment
Deputy director	4	11	3	2 x 11th of 12 7th of 11 12th of 12	Recruitment and retention
Assistant director	2	9	2	1st of 10 1st of 11	Recruitment
Facility manager	1	11	-	7th of 11	Recruitment
Quality assurance manager	1	9	-	2nd of 9	Recruitment
Principal personnel officer	1	7	1	2nd of 8	Retention
Administrative officer	1	7	1	3rd of 8	Retention
Senior administrative officer	2	8	1	6th of 8 3rd of 9	Recruitment and retention
Health facility planner	1	9	-	12th of 9	Recruitment
Secretary	1	7	1	8th of 10	Retention
Total number of employees whose salaries exceed the level determined by job evaluation (including awarding of higher notches) in 2013/14					**15**
Percentage of total employed					**0.05%**

The following table summarises the beneficiaries of the above in terms of race, gender, and disability.

Table 3.3.4: Employees who have been granted higher salaries than those determined by job evaluation per race group, 1 April 2013 and 31 March 2014

Job evaluation					
Gender	**African**	**Asian**	**Coloured**	**White**	**Total**
Female	1	1	2	2	6
Male	1	0	6	2	9
Total	**2**	**1**	**8**	**4**	**15**
Employees with disability					None

3.4 EMPLOYMENT CHANGES

Turnover rates provide an indication of trends in the employment profile of the Department during the year under review. The following tables provide a summary of turnover rates by salary band (Table 3.4.1) and by critical occupations (Table 3.4.2).

Table 3.4.1: Annual turnover rates by salary band for the period 1 April 2013 to 31 March 2014

Employment changes							
Salary band	**Number of employees per band as at 31 March 2013**	**Turnover rate 2012/13**	**Appointments into the Department**	**Transfers into the Department**	**Terminations out of the Department**	**Transfers out of the Department**	**Turnover rate 2013/14**
Lower skilled (Levels 1 - 2)	2 422	11.14	400	0	216	5	9.12
Skilled (Level 3 - 5)	11 216	9.06	1 327	13	810	36	7.54
Highly skilled production (Levels 6 - 8)	8 881	14.48	1 155	17	1 204	26	13.85
Highly skilled supervision (Levels 9 - 12)	7 922	18.83	1 361	36	1 409	38	18.27
Senior Management Service Band A (Level 13)	47	16.67	1	0	1	1	4.26
Senior Management Service Band B (Level 14)	10	9.09	0	0	1	1	20.00
Senior Management Service Band C (Level 15)	3	0.00	0	0	1	0	33.33
Senior Management Service Band D (Level 16)	1	0.00	1	0	1	0	100.00
Total	**30 502**	**13.41**	**4 245**	**66**	**3 643**	**107**	**12.29**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Please note that contracts employees are included in the salary bands.

Table 3.4.2: Annual turnover rates by critical occupation for the period 1 April 2013 to 31 March 2014

Employment changes							
Occupation	**Number of employees per occupation at 1 April 2013**	**Turnover rate 2012/13**	**Appointments into the Department**	**Transfers into the Department**	**Terminations out of the Department**	**Transfers out of the Department**	**Turnover rate 2013/14**
Clinical technologist	86	31.43	18	0	19	1	23.26
Industrial technician	64	7.94	4	0	4	0	6.25
Medical orthotist and prosthetist	12	42.86	7	0	5	0	41.67
Medical physicist	11	66.67	2	0	1	0	9.09
Pharmacists	386	31.55	131	1	115	1	30.05
Total	**559**	**29.62**	**162**	**1**	**144**	**2**	**26.12**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Any differences in numbers between 2013 and 2014 are as a result of the rectification of occupational classification and job title codes.
- Turnover rate is based on terminations and transfers out of the Department divided by total number of employees.

Table 3.4.3: Reasons why staff are leaving the employ of the Department, 1 April 2013 to 31 March 2014

Employment changes			
Exit category	**Number**	**% of total exits**	**Number of exits as a % of total number of employees as at 31 March 2014**
Death	85	2.33	0.27
Resignation	1207	33.13	3.89
Expiry of contract	1760	48.31	5.67
Transfer	2	0.05	0.01
Dismissal – operational	2	0.05	0.01
Discharged due to ill-health	73	2.00	0.24
Dismissal – misconduct	121	3.32	0.39
Dismissal – incapacity	2	0.05	0.01
Retirement	391	10.73	1.26
Total	**3 643**	**100.00**	**11.75**
Total number of employees who left as a % of total employment		**11.75**	

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Number of exits as percentage of total number of employees as 31 March 2014 (31 017): Number of terminations divided by 31 017 (filled posts on 31 March 2014) multiplied by100.

Table 3.4.4: Reasons why staff resigned, 1 April 2013 to 31 March 2014

Employment changes		
Termination type	**Number**	**% of total terminations**
No reason	27	2.24%
Age	4	0.33%
Bad health	23	1.91%
Better remuneration	342	28.33%
Breach PDP	3	0.25%
Contract expired	10	0.83%
Domestic problems	17	1.41%
Emigration	1	0.08%
Further studies	54	4.47%

Employment changes		
Termination type	**Number**	**% of total terminations**
Housewife	18	1.49%
Absconded	1	0.08%
Marriage	3	0.25%
Nature of work	106	8.78%
Other occupation	127	10.52%
Operational requirements	4	0.33%
Own business	3	0.25%
Personal grievances	69	5.72%
Resigning of position	389	32.23%
Transfer(spouse)	3	0.25%
Translation permanent	1	0.08%
Transport problem	2	0.17%
Total	**1 207**	**100.00**

Notes:

- Reasons as reflected on PERSAL.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Nature of appointment sessional is excluded.

Table 3.4.5: Different age groups of staff who resigned from the Public Service, 1 April 2013 to 31 March 2014

Employment changes		
Age group	**Number**	**% of total resignations**
Ages <19	0	0.00%
Ages 20 to 24	54	4.47%
Ages 25 to 29	231	19.14%
Ages 30 to 34	234	19.39%
Ages 35 to 39	184	15.24%
Ages 40 to 44	168	13.92%
Ages 45 to 49	147	12.18%
Ages 50 to 54	104	8.62%
Ages 55 to 59	60	4.97%
Ages 60 to 64	21	1.74%
Ages 65 >	4	0.33%
Total	**1 207**	**100%**

Table 3.4.6: Granting of employee initiated severance packages by salary band, 1 April 2013 and 31 March 2014

Utilisation of consultants				
Salary band	**Number of applications received**	**Number of applications referred to the MPSA**	**Number of applications supported by MPSA**	**Number of packages approved by Department**
Lower skilled (Levels 1 - 2)	0	0	0	0
Skilled (Level 3 - 5)	1	1	1	1
Highly skilled production (Levels 6 - 8)	0	0	0	0
Highly skilled supervision (Levels 9 - 12)	0	0	0	0
Senior management (Levels 13 – 16)	0	0	0	0
Total	**1**	**1**	**1**	**1**

Table 3.4.7: Promotions by salary band, 1 April 2013 and 31 March 2014

Employment changes					
Occupation	**Employees 31 March 2013**	**Promotions to another salary level**	**Salary band promotions as a % of employees by salary level**	**Progressions to another notch within a salary level**	**Notch progression as a % of employees by salary bands**
Lower skilled (Levels 1 - 2)	2 422	51	2.11	1 431	59.08
Skilled (Level 3 - 5)	11 216	370	3.30	6 775	60.40
Highly skilled production (Levels 6 - 8)	8 881	413	4.65	4 715	53.09
Highly skilled supervision (Levels 9 - 12)	7 922	377	4.76	4 465	56.36
Senior and top management (Levels 13 - 16)	61	8	13.11	36	59.02
Total	**30 502**	**1 219**	**4.00**	**17 422**	**57.12**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Promotions to another salary level include events 10-Promotion, 52-Promotion: Package MMS, 62-PSR 2001 1.V.C.3, 65-Upgrade Post, 77-Grading OSD, and 81-Grading Progression Non-OSD.
- Progression to another notch within a salary level includes events 61-Pay Progression, 66-Pay Progression SMS, 69-Pay Progression MMS, and 83-Accelerated Pay Progression.

Table 3.4.8: Promotions by critical occupation, 1 April 2013 and 31 March 2014

Employment changes					
Occupation	**Employees as at 1 April 2013**	**Promotions to another salary level**	**Salary level promotions as a % of employees by occupation**	**Progressions to another notch within a salary level**	**Notch progression as a % of employees by occupation**
Clinical technologist	86	5	5.81	45	52
Industrial technician	64	4	6.25	41	64
Medical orthotist and prosthetist	12	0	0.00	7	58
Medical physicist	11	1	9.09	5	45
Pharmacists	386	19	4.92	238	61.66
Total	**559**	**29**	**5.19**	**336**	**60.11**

Notes:

- Nature of appointment sessional is excluded.
- 0Nature of appointments periodical and abnormal is also excluded. No posts.
- Promotions to another salary level include events 10-Promotion, 52-Promotion: Package MMS, 62-PSR 2001 1.V.C.3, 65-Upgrade Post, 77-Grading OSD, and 81-Grading Progression Non-OSD.
- Progression to another notch within a salary level includes events 61-Pay Progression, 69-Pay Progression MMS, and 83-Accelerated Pay Progression.

3.5 EMPLOYMENT EQUITY

Table 3.5.1: Total number of employees (including employees with disabilities) in each of the following occupational bands, as at 31 March 2014

Employment equity											
Occupational levels	**Male**				**Female**				**Foreign nationals**		**Total**
	African	**Coloured**	**Indian**	**White**	**African**	**Coloured**	**Indian**	**White**	**Male**	**Female**	
Top management *(Levels 14-16)*	1	3	1	2	1	1	1	3	0	0	13
Senior management *(Levels 13)*	1	9	1	10	1	11	0	14	0	0	47
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	54	229	74	512	75	325	89	624	27	27	2 036
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8- 10)*	207	652	12	185	646	2 920	77	1 045	6	9	5 759
Semi-skilled and discretionary decision making *(Level 4-7)*	958	2 522	30	312	2 563	7 029	36	968	8	5	14 431
Unskilled and defined decision making *(Levels 1-3)*	807	1 185	6	61	1 908	2 239	3	37	0	2	6 248
Sub-total	**2 028**	**4 600**	**124**	**1 082**	**5 194**	**12 525**	**206**	**2 691**	**41**	**43**	**28 534**

Employment equity											
Occupational levels	Male				Female				Foreign nationals		Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	Male	Female	
Temporary employees	154	235	86	382	330	569	114	507	60	46	2 483
Total	**2 182**	**4 835**	**210**	**1 464**	**5 524**	**13 094**	**320**	**3 198**	**101**	**89**	**31 017**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Total number of employees includes employees additional to the establishment.
- For the number of employees with disabilities, refer to Table 3.5.2.

Table 3.5.2: Total number of employees (with disabilities only) in each of the following occupational bands as on 31 March 2014

Employment equity											
Occupational levels	Male				Female				Foreign nationals		Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	Male	Female	
Top management *(Levels 14-16)*	0	0	0	0	0	0	0	0	0	0	0
Senior management *(Levels 13)*	0	0	0	0	0	0	0	0	0	0	0
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	0	2	0	1	0	2	0	2	0	0	7
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8- 10)*	0	2	0	4	0	2	1	8	0	0	17
Semi-skilled and discretionary decision making *(Level 4-7)*	11	20	0	15	14	22	0	18	0	0	100
Unskilled and defined decision making *(Levels 1-3)*	5	8	0	1	1	6	0	1	0	0	22
Sub-total	**16**	**32**	**0**	**21**	**15**	**32**	**1**	**29**	**0**	**0**	**146**
Temporary employees	0	1	0	1	0	2	0	0	0	0	4
Total	**16**	**33**	**0**	**22**	**15**	**34**	**1**	**29**	**0**	**0**	**150**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Total number of employees includes employees additional to the establishment.

Table 3.5.3: Recruitment, 1 April 2013 to 31 March 2014

Employment equity											
Occupational levels	**Male**				**Female**				**Foreign nationals**		**Total**
	African	**Coloured**	**Indian**	**White**	**African**	**Coloured**	**Indian**	**White**	**Male**	**Female**	
Top management *(Levels 14-16)*	0	0	0	0	0	0	0	0	0	0	0
Senior management *(Levels 13)*	0	0	0	0	0	0	0	1	0	0	1
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	16	35	11	78	26	74	24	106	4	3	377
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8- 10)*	12	19	1	3	31	82	3	37	0	0	188
Semi-skilled and discretionary decision making *(Level 4-7)*	102	125	3	22	357	366	5	74	2	1	1 057
Unskilled and defined decision making *(Levels 1-3)*	79	81	2	6	272	203	1	9	0	0	653
Sub-total	**209**	**260**	**17**	**109**	**686**	**725**	**33**	**227**	**6**	**4**	**2 276**
Temporary employees	125	214	41	169	355	569	80	345	42	29	1 969
Total	**334**	**474**	**58**	**278**	**1 041**	**1 294**	**113**	**572**	**48**	**33**	**4 245**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Total number of employees includes employees additional to the establishment.

Table 3.5.4: Promotions, 1 April 2013 to 31 March 2014

Employment equity											
Occupational levels	**Male**				**Female**				**Foreign nationals**		**Total**
	African	**Coloured**	**Indian**	**White**	**African**	**Coloured**	**Indian**	**White**	**Male**	**Female**	
Top management *(Levels 14-16)*	0	1	0	0	0	0	1	0	0	0	2
Senior management *(Levels 13)*	1	1	0	1	1	2	0	0	0	0	6
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	4	14	0	35	7	15	4	33	2	3	117
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8- 10)*	20	60	0	6	41	177	4	45	0	0	353
Semi-skilled and discretionary decision making *(Level 4-7)*	44	110	0	15	88	243	1	29	1	0	531

Employment equity											
Occupational levels	Male				Female				Foreign nationals		Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	Male	Female	
Unskilled and defined decision making *(Levels 1-3)*	11	33	0	0	27	79	0	0	0	0	150
Sub-total	**80**	**219**	**0**	**57**	**164**	**516**	**10**	**107**	**3**	**3**	**1 159**
Temporary employees	7	7	1	12	2	15	6	8	2	0	60
Total	**87**	**226**	**1**	**69**	**166**	**531**	**16**	**115**	**5**	**3**	**1 219**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Total number of employees includes employees additional to the establishment.

Table 3.5.5: Terminations, 1 April 2013 to 31 March 2014

Employment equity											
Occupational levels	Male				Female				Foreign nationals		Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	Male	Female	
Top management *(Levels 14-16)*	0	1	0	1	0	0	0	0	0	0	2
Senior management *(Levels 13)*	1	0	0	0	1	0	0	0	0	0	2
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	6	19	7	58	14	27	13	77	1	5	227
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8- 10)*	17	32	1	17	49	177	5	70	0	1	369
Semi-skilled and discretionary decision making *(Level 4-7)*	48	124	1	18	118	404	4	88	0	0	805
Unskilled and defined decision making *(Levels 1-3)*	33	67	0	7	57	152	1	6	0	0	323
Sub-total	**105**	**243**	**9**	**101**	**239**	**760**	**23**	**241**	**1**	**6**	**1 728**
Temporary employees	106	213	55	182	340	529	77	351	43	19	1 915
Total	**211**	**456**	**64**	**283**	**579**	**1 289**	**100**	**592**	**44**	**25**	**3 643**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Total number of employees includes employees additional to the establishment.
- Temporary employees reflect all contract appointments (Nature of appointment 05).

Table 3.5.6: Disciplinary actions, 1 April 2013 to 31 March 2014

Employment equity											
Disciplinary actions	Male				Female				Foreign nationals		Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	Male	Female	
Total	267	545	5	45	310	603	1	81	0	0	**1 857**

The disciplinary actions total refers to formal outcomes only and not headcount. For further information on the outcomes of the disciplinary hearings and types of misconduct addressed at disciplinary hearings, please refer to Tables 3.12.2 and Table 3.12.3.

Table 3.5.7: Skills development, 1 April 2013 to 31 March 2014

Employment equity									
Occupational category	Male				Female				Total
	African	Coloured	Indian	White	African	Coloured	Indian	White	
Top management *(Levels 14-16)*	0	0	0	0	0	0	0	0	0
Senior management *(Levels 13)*	0	1	0	2	1	3	0	3	10
Professionally qualified and experienced specialists and mid-management *(Levels 11-12)*	118	251	23	245	538	1 925	100	845	4 045
Skilled technical and academically qualified workers, junior management, supervisors, foremen, and superintendents *(Levels 8- 10)*	617	1481	23	155	1 132	2 314	37	375	6 134
Semi-skilled and discretionary decision making *(Level 4-7)*	22	206	6	36	7	26	0	3	306
Unskilled and defined decision making *(Levels 1-3)*	116	190	1	10	173	287	0	12	789
Sub-total	**873**	**2 129**	**53**	**448**	**1 851**	**4 555**	**137**	**1 238**	**11 284**
Temporary employees	0	0	0	0	0	0	0	0	0
Total	**873**	**2 129**	**53**	**448**	**1 851**	**4 555**	**137**	**1 238**	**11 284**

The above table refers to the total number of personnel who received training, and not the number of training courses attended by individuals. For further information on the actual training provided, please refer to Table 3.13.2.

3.6 SIGNING OF PERFORMANCE AGREEMENTS BY SMS MEMBERS

All members of the SMS must conclude and sign performance agreements within specific timeframes. Information regarding the signing of performance agreements by SMS members, the reasons for not complying within the prescribed timeframes and disciplinary steps taken is presented here.

Table 3.6.1: Signing of Performance Agreements by SMS members as at 31 May 2013

Signing of performance agreements by SMS members				
SMS level	**Number of funded SMS posts per level**	**Number of SMS members per level**	**Number of signed performance agreements per level**	**Signed performance agreements as % of SMS members per level**
Head of Department	1	1	1	100%
Salary Level 16, but not HoD	0	0	0	0.00%
Salary Level 15	4	4	3	75%
Salary Level 14	9	9	8	88.89%
Salary Level 13	53	49	48	97.96%
Total	**67**	**63**	**60**	**95.24%**

The allocation of performance-related rewards (cash bonus) for Senior Management Service members is dealt with later in the report. Please refer to Table 3.8.5.

Table 3.6.2: Reasons for not having concluded Performance Agreements with all SMS members on 31 May 2013

Signing of performance agreements by SMS members
Reasons
Level 15: Official retired
Level 14: Official left Department
Level 13: Official left Department

Table 3.6.3: Disciplinary steps taken against SMS members for not having concluded Performance Agreements on 31 May 2013

Signing of performance agreements by SMS members
Reasons
Not applicable

3.7 FILLING OF SMS POSTS

Table 3.7.1: SMS post information as at 30 September 2013

Filling of SMS posts					
SMS level	**Total number of funded SMS posts**	**Total number of SMS posts filled**	**% of SMS posts filled**	**Total number of SMS posts vacant**	**% of SMS posts vacant**
Head of Department	1	1	100.00%	0	0.00%
Salary Level 16, but not HoD	0	0	0.00%	0	0.00%
Salary Level 15	4	4	100.00%	0	0.00%
Salary Level 14	9	8	88.89%	1	11.11%
Salary Level 13	54	50	92.59%	4	7.41%
Total	**68**	**63**	**92.65%**	**5**	**7.35%**

Notes:

- The number of funded SMS posts per level excludes the de-activated (unfunded) posts.

Table 3.7.2: SMS post information as 31 March 2014

Filling of SMS posts					
SMS level	**Total number of funded SMS posts**	**Total number of SMS posts filled**	**% of SMS posts filled**	**Total number of SMS posts vacant**	**% of SMS posts vacant**
Head of Department	1	1	100.00%	0	0.00%
Salary Level 16, but not HoD	0	0	0.00%	0	0.00%
Salary Level 15	4	4	100.00%	0	0.00%
Salary Level 14	9	9	100.00%	0	0.00%
Salary Level 13	53	49	92.45%	4	7.55%
Total	**67**	**63**	**94.03%**	**4**	**5.97%**

Table 3.7.3: Advertising and filling of SMS posts as at 31 March 2014

Filling of SMS posts			
SMS level	**Advertising**	**Filling of posts**	
	Number of vacancies per level advertised in 6 months of becoming vacant	**Number of vacancies per level filled in 6 months after becoming vacant**	**Number of vacancies per level not filled in 6 months but filled in 12 months**
Head of Department	0	0	0
Salary Level 16, but not HoD	0	0	0
Salary Level 15	1	1	0
Salary Level 14	2	1	1
Salary Level 13	7	7	0
Total	**10**	**9**	**1**

Table 3.7.4: Reasons for not having complied with the filling of funded vacant SMS posts - Advertised within 6 months and filled within 12 months after becoming vacant

Filling of SMS posts	
SMS level	**Reasons for non-compliance**
Head of Department	Not applicable
Salary Level 16, but not HoD	Not applicable
Salary Level 15	Not applicable
Salary Level 14	The ODI report had to be finalised before the post could be advertised.
Salary Level 13	Not applicable

Table 3.7.5: Disciplinary steps taken for not complying with the prescribed timeframes for filling SMS posts within 12 months

Filling of SMS posts
Disciplinary steps taken for not complying with the prescribed timeframes for filling SMS posts within 12 months
Not applicable

3.8 EMPLOYEE PERFORMANCE

Table 3.8.1: Notch progressions by salary band, 1 April 2013 to 31 March 2014

Performance rewards			
Salary band	**Employees as at 31 March 2013**	**Progressions to another notch within a salary level**	**Notch progressions as a % of employees by salary band**
Lower skilled (Levels 1 - 2)	2 422	1 431	59.08
Skilled (Level 3 - 5)	11 216	6 775	60.40
Highly skilled production (Levels 6 - 8)	8 881	4 715	53.09
Highly skilled supervision (Levels 9 - 12)	7 922	4 465	56.36
Senior and top management (Levels 13 - 16)	61	36	59.02
Total	**30 502**	**17 422**	**57.12**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Progression to another notch within a salary level includes events 61-Pay Progression, 66-Pay Progression SMS, 69-Pay Progression MMS and 83-Accelerated Pay Progression.

Table 3.8.2: Notch progressions by critical occupation, 1 April 2013 to 31 March 2014

Performance rewards			
Critical occupation	**Employees as at 31 March 2013**	**Progressions to another notch within a salary level**	**Notch progressions as a % of employees by salary band**
Clinical technologist	86	45	52
Industrial technician	64	42	66
Medical orthotist and prosthetist	12	7	58
Medical physicist	11	5	45
Pharmacists	386	238	61.66
Total	**559**	**337**	**60.29**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Progression to another notch within a salary level includes events 61-Pay Progression, 69-Pay Progression MMS and 83-Accelerated Pay Progression.

To encourage good performance, the Department has granted the following performance rewards allocated to personnel for the performance period 2011/12, but paid in the financial year 2012/13. The information is presented in terms of race, gender, and disability (Table 3.8.3), salary bands (Table 3.8.4 and Table 3.8.5) and critical occupations (Table 3.8.6).

Table 3.8.3: Performance Rewards by race, gender and disability, 1 April 2013 to 31 March 2014

Performance rewards					
Race and Gender	**Beneficiary profile**			**Cost**	
	Number of beneficiaries	**Number of employees in group**	**% of total within group**	**Cost (R'000)**	**Per capita cost (R,000)**
African					
Male	300	2 232	13.44%	1 739	6
Female	707	5 557	12.72%	4 175	6
Asian					
Male	28	219	12.79%	373	13
Female	53	330	16.06%	627	12
Coloured					
Male	1 018	4 839	21.04%	6 501	6
Female	2 958	13 096	22.59%	20 728	7
White					
Male	302	1 502	20.11%	4 278	14
Female	756	3 242	23.32%	8 307	11
Employees with a disability	16	150	10.67%	103	6
Total	**6 122**	**31 017**	**19.74**	**46 728**	**8**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Performance awards include merit awards and allowance 0228.
- Employees with a disability are included in race and gender figures and in "Total".
- Senior Management and Senior Professionals included.

Table 3.8.4: Performance Rewards by salary band for personnel below Senior Management Service, 1 April 2013 to 31 March 2014

Performance rewards						
Salary band	Beneficiary profile			Cost		
	Number of beneficiaries	Total number of employees in group	% of total within salary bands	Cost (R'000)	Average cost per beneficiary	Cost as a % of the total personnel expenditure
Lower skilled (Levels 1 - 2)	456	2 444	18.66	1 335	3	0.01
Skilled (Level 3 - 5)	2 044	11 544	17.71	8 647	4	0.09
Highly skilled production (Levels 6 - 8)	1 899	8 934	21.26	12 987	7	0.14
Highly skilled supervision (Levels 9 - 12)	1 706	8 032	21.24	23 373	14	0.26
Total	**6 105**	**30 954**	**19.72**	**46 342**	**8**	**0.51**

Notes:

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

Table 3.8.5: Performance related rewards (cash bonus), by salary band, for Senior Management Service, 1 April 2013 to 31 March 2014

Performance rewards							
Salary band	Beneficiary profile			Cost			
	Number of beneficiaries	Total number of employees in group	% of total within salary bands	Cost (R'000)	Average cost per beneficiary	Cost as a % of the total personnel expenditure	Personnel expenditure per band (R'000)
Senior Management Service Band A (Level 13)	12	49	24	225	19	0.002	42 261
Senior Management Service Band B (Level 14)	2	9	22	40	20	0.000	9 485
Senior Management Service Band C (Level 15)	2	4	50	42	21	0.000	5 288
Senior Management Service Band D (Level 16)	1	1	100	79	79	0.001	2 372
Total	**17**	**63**	**27**	**386**	**23**	**0.004**	**59 406**

The cost is calculated as a percentage of the total personnel expenditure for salary levels 13 - 16, reflected in Table 3.1.2.

Table 3.8.6: Performance Rewards by critical occupations, 1 April 2013 to 31 March 2014

Performance rewards						
Salary band	Beneficiary profile			Cost		
	Number of beneficiaries	Total number of employees in group	% of total within occupation	Cost (R'000)	Average cost per beneficiary	Cost as a % of the total personnel expenditure
Clinical technologist	23	82	28.05	269	12	0.00%
Industrial technician	15	63	23.81	159	11	0.00%
Medical orthotist and prosthetist	3	14	21.43	25	8	0.00%
Medical physicist	3	12	25.00	38	13	0.00%
Pharmacists	88	400	22.00	1 130	13	0.01%
Total	**132**	**571**	**23.12**	**1 621**	**12**	**0.02%**

Notes:

- Nature of appointment sessional is excluded.
- Nature of appointments periodical and abnormal is also excluded. No posts.
- Performance awards includes merit awards and allowance 0228

3.9 FOREIGN WORKERS

The tables below summarise the employment of foreign nationals in the Department in terms of salary bands and by major occupation. The tables also summarise changes in the total number of foreign workers in each salary band and by each major occupation.

Table 3.9.1: Foreign workers, 1 April 2013 to 31 March 2014, by salary band

Foreign workers						
Salary band	1 April 2013		31 March 2014		Change	
	Number	% of total	Number	% of total	Number	% Change
Lower skilled (Levels 1 - 2)	0	0.00	0	0.00	0	0
Skilled (Level 3 - 5)	9	4.89	9	4.74	0	0
Highly skilled production (Levels 6 - 8)	10	5.43	12	6.32	2	33
Highly skilled supervision (Levels 9 - 12)	164	89.13	168	88.42	4	67
Senior management (Levels 13 – 16)	1	0.54	1	0.53	0	0
Total	**184**	**100.00**	**190**	**100.00**	**6**	**100**

Notes:

- Nature of appointment sessional, periodical and abnormal is not included.

Table 3.9.2: Foreign workers by major occupation, 1 April 2013 to 31 March 2014

Foreign workers						
Major occupation	1 April 2013		31 March 2014		Change	
	Number	% of total	Number	% of total	Number	% Change
Admin office workers	1	0.54	1	0.53	0	0.00
Craft related workers	0	0.00	0	0.00	0	0.00
Elementary occupations	1	0.54	1	0.53	0	0.00
Professionals and managers	152	82.61	155	81.58	3	50.00
Service workers	8	4.35	8	4.21	0	0.00
Senior officials and managers	1	0.54	1	0.53	0	0.00
Technical and associated professionals	21	11.41	24	12.63	3	50.00
Total	**184**	**100.00**	**190**	**100**	**6**	**100.00**

Notes:

- Nature of appointment sessional, periodical and abnormal is not included.

3.10 LEAVE UTILISATION FOR THE PERIOD 1 JANUARY 2013 TO 31 DECEMBER 2013

The Public Service Commission identified the need for careful monitoring of sick leave within the public service. The following tables provide an indication of the use of sick leave (Table 3.10.1) and incapacity leave (Table 3.10.2). In both cases, the estimated cost of the leave is also provided.

Table 3.10.1: Sick leave, 1 January 2013 to 31 December 2013

Leave utilisation							
Salary band	Total days	% days with medical certification	Number of employees using sick leave	Total number of employees 31-12-2013	% of total employees using sick leave	Average days per employee	Estimated cost (R'000)
Lower skilled (Levels 1 - 2)	22 061	87.33%	2 135	2 434	87.72%	9	6
Skilled (Level 3 - 5)	101 952	86.14%	10 231	11 467	89.22%	9	41
Highly skilled production (Levels 6 - 8)	80 212	86.12%	8 085	8 879	91.06%	9	52
Highly skilled supervision (Levels 9 - 12)	49 246	81.98%	5 933	7 961	74.53%	6	65
Senior management (Levels 13 – 16)	205	76.10%	41	64	64.06%	3	1
Total	**253 676**	**85.42%**	**26 425**	**30 805**	**85.78%**	**8**	**165**

Notes:

- Nature of appointment sessional, periodical and abnormal is not included.
- Annual leave cycle is from 1 January - 31 December of each year.
- Sick Leave reported in this table includes all categories of leave of 51, 52 and 53.

Table 3.10.2: Incapacity leave (temporary and permanent), 1 January 2013 to 31 December 2013

Leave utilisation							
Salary band	**Total days**	**% days with medical certification**	**Number of employees using incapacity leave**	**Total number of employees 31-12-2013**	**% of total employees using incapacity leave**	**Average days per employee**	**Estimated cost (R'000)**
Lower skilled (Levels 1 - 2)	1 422	100.00%	22	2 434	0.90%	65	0
Skilled (Level 3 - 5)	4 085	100.00%	88	11 467	0.77%	46	2
Highly skilled production (Levels 6 - 8)	4 402	100.00%	103	8 879	1.16%	43	3
Highly skilled supervision (Levels 9 - 12)	2 101	100.00%	43	7 961	0.54%	49	3
Senior management (Levels 13 – 16)	0	100.00%	0	64	0.00%	0	0
Total	**12 010**	**100.00**	**256**	**30 805**	**0.83%**	**47**	**8**

Notes:

- Nature of appointment sessional, periodical and abnormal is not included.
- Annual leave cycle is from 1 January - 31 December of each year.

The leave dispensation as determined in the "Leave Determination", read with the applicable collective agreements, provides for normal sick leave of 36 working days in a sick leave cycle of three years. If an employee has exhausted his or her normal sick leave, the employer must conduct an investigation into the nature and extent of the employee's incapacity. Such investigations must be carried out in accordance with item 10(1) of Schedule 8 of the Labour Relations Act (LRA).

Incapacity leave is not an unlimited amount of additional sick leave days at an employee's disposal. Incapacity leave is additional sick leave granted conditionally at the employer's discretion, as provided for in the Leave Determination and Policy on Incapacity Leave and Ill-Health Retirement (PILIR).

Table 3.10.3: Annual Leave, 1 January 2013 to 31 December 2013

Leave utilisation			
Salary band	**Total days taken**	**Total number of employees using annual leave**	**Average days per employee**
Lower skilled (Levels 1 - 2)	52 165	2 403	22
Skilled (Level 3 - 5)	263 000	11 490	23
Highly skilled production (Levels 6 - 8)	228 972	9 191	25
Highly skilled supervision (Levels 9 - 12)	193 360	8 273	23
Senior management (Levels 13 – 16)	1 621	70	23
Total	**739 118**	**31427**	**24**

Notes:

- Nature of appointment sessional, periodical and abnormal is not included.
- Annual leave cycle is from 1 January - 31 December of each year.

Table 3.10.4: Capped leave, 1 January 2013 to 31 December 2013

Leave utilisation							
Salary band	**Total days**	**% days with medical certification**	**Number of employees using incapacity leave**	**Total number of employees 31-12-2013**	**% of total employees using incapacity leave**	**Average days per employee**	**Estimated cost (R'000)**
Lower skilled (Levels 1 - 2)	5 403	283	18	16	2	2 434	4 187
Skilled (Level 3 - 5)	61 102	3 494	201	17	5	11 467	56 148
Highly skilled production (Levels 6 - 8)	163 230	9 003	348	26	17	8 879	151 126
Highly skilled supervision (Levels 9 - 12)	114 034	5 450	292	19	13	7 961	106 387
Senior management (Levels 13 – 16)	1 646	102	2	51	24	64	1 526
Total	**345 415**	**18 332**	**861**	**21**	**10**	**30 805**	**319 374**

Notes:

- Nature of appointment sessional, periodical and abnormal is not included.
- Annual leave cycle is from 1 January - 31 December of each year.
- Number of employees as at 31 December 2013 is the total staff compliment and not only those with capped leave.

Table 3.10.5 summarises payments made to employees as a result of leave not taken.

Table 3.10.5: Leave pay-outs for the period 1 April 2013 and 31 March 2014

Leave utilisation			
Reason	**Total amount (R'000)**	**Number of employees**	**Average per employee (R'000)**
Leave pay-outs for 2013/14 due to non-utilisation of leave for the previous cycle	528	46	11
Capped leave pay-outs on termination of service for 2013/14	16 129	309	52
Current leave pay-outs on termination of service 2013/14	37	6	6
Total	**16 694**	**361**	**46**

Notes:

- Capped leave are only paid out in case of normal retirement, termination of services due to ill health and death.

3.11 HIV/AIDS & HEALTH PROMOTION PROGRAMMES

Table 3.11.1: Steps taken to reduce the risk of occupational exposure

HIV/AIDS & Health promotion programmes	
Units/categories of employees identified to be at high risk of contracting HIV & related diseases (if any)	**Key steps taken to reduce the risk**
Employees in clinical areas, i.e. doctors, nurses, medical students, general workers and paramedics are more at risk of contracting HIV and related diseases.	• The HIV and AIDS/STI/TB policy within the Department identified the prevention of occupational exposure to potentially infectious blood and blood products as a key focus area.

HIV/AIDS & Health promotion programmes	
Units/categories of employees identified to be at high risk of contracting HIV & related diseases (if any)	**Key steps taken to reduce the risk**
Young employees, falling into the category of youth, have also been identified to be at high risk. The table below depicts the nature of injuries reported by employees for 2013/14: **Nature of injury on duty** / **Total no. of cases reported** Needle prick: 20 Tuberculosis (TB): 27 Multi-drug resistant TB: 2	• Service providers have been appointed in the districts providing HIV testing as part of a basket of health screenings that also include testing for blood pressure, diabetes, cholesterol, and body mass index. • An infection prevention and control (IPC) strategy for the Department has been drafted to ensure universal infection control measures to be implemented. • Special responsive programmes targeting behavioural risks have been implemented. • Implementation of targeted awareness and education initiatives.

Table 3.11.2: Details of Health Promotion and HIV/AIDS programmes (tick the applicable boxes and provide the required information)

HIV/AIDS & Health promotion programmes			
Question	**Yes**	**No**	**Details, if yes**
(1) Has the Department designated a member of the SMS to implement the provisions contained in Part VI E of Chapter 1 of the Public Service Regulations, 2001? If so, provide her/his name and position.	✓		Mrs Bernadette Arries Chief Director: Human Resources
(2) Does the Department have a dedicated unit or has it designated specific staff members to promote the health and well-being of your employees? If so, indicate the number of employees who are involved in this task and the annual budget that is available for this purpose.	✓		Employee Health and Wellness Component within the Directorate: Transformation at Head Office Level: Deputy Director: Ms Sandra Newman Admin Support: • Ms M Buis • Ms Lisl Mullins • Ms E Abrahams • Ms Caldine Van Willing • Mr Michael Valentine • Mr Nabeel Ismail Institutional and district level: • Groote Schuur Hospital: Ruth Halford • Tygerberg Hospital: Sayeeda Dhansay • Red Cross Hospital: Ntombozuko Ponono • Associated Psychiatric Hospitals: Jessica Minnaar, Anne Marie Basson • Cape Winelands District: BJ Vd Merwe • Overberg District: Dumalisele September • West Coast District: Ester van Ster • Eden/Central Karoo Districts: Nuruh Davids • MDHS: Albertus Oor • EMS: Liesl Meter

HIV/AIDS & Health promotion programmes			
Question	**Yes**	**No**	**Details, if yes**
(3) Has the Department introduced an Employee Assistance or Health Promotion Programme for your employees? If so, indicate the key elements/services of this programme.	✓		The Department makes use of a combined model, i.e. internal and external services. An independent service provider, ICAS, has been appointed to provide this confidential service and three institutions have an internal service in addition to the external service. <u>Programmes and services offered:</u> (1) Counselling and support services: • 24/7/365 telephone counselling • The service is available to all employees and their household members. • Face to face counselling (8 session model) per issue • Case management • Trauma/critical incident management • HIV and AIDS counselling (2) Life management services: • Family care • Money management • Legal information and advice (3) Managerial consultancy and referral services: • Managerial consultancy • Formal referral programme (4) Client management services: • Implementation programme • Promotional material • Account management consultancy • Reporting and review programme • Quality management programme (5) Specialist Services: • Staff satisfaction surveys • Barret Value surveys • Environmental scans • Specialised group interventions • Coaching programme • Regular reporting and feedback sessions with relevant management members occur on a quarterly basis. (6) Training Services: • Targeted training interventions based on identified needs and trends. (7) E - Care • e-Care is an innovative online healthcare service to help improve employee health and wellness.

HIV/AIDS & Health promotion programmes			
Question	**Yes**	**No**	**Details, if yes**
			Key elements – HIV and AIDS/STI programmes: • To ensure that every employee within the Department receives appropriate and accurate HIV and AIDS, and STI risk-reduction education. • To create a non-discriminatory work environment. • To prevent occupational exposure to potentially infectious blood and blood products and to manage occupational exposures that occurred. • To provide HIV counselling and testing services for those employees who wish to determine their own HIV status. • To determine the impact of HIV and AIDS on the Department in order to plan accordingly. • To promote the use of and to provide SABS approved male and female condoms. • Awareness of available services. • Education and training. • Counselling. • Critical incident stress debriefing (CISD). • Reporting and evaluating. In 2013/14, the workplace HIV and AIDS, STI, and TB programme formed part of the provincial and national HIV counselling and testing (HCT) campaign. The HCT campaign follows a more integrated approach to testing and routinely offers HIV testing as part of a basket of health screenings that also include testing for blood pressure, diabetes, cholesterol, and body mass index. These services are provided to employees at no cost, in partnership with GEMS.
(4) Has the Department established (a) committee(s) as contemplated in Part VI E.5 (e) of Chapter 1 of the Public Service Regulations, 2001? If so, please provide the names of the members of the committee and the stakeholder(s) that they represent.	✓		HIV and AIDS, STI, and TB is seen as a transversal issue in the Western Cape Government. The WCG: Health has been appointed as the primary driver of the process and therefore has a dual role to play (i.e. to oversee and manage their departmental programme as well as to manage and co-ordinate the programme within the Province). Health Departmental Committee: Ms S Newman: Head Office Ms R Halford: Groote Schuur Hospital Ms S Dhansay: Tygerberg Hospital Ms N Ponono: Red Cross Hospital Ms A Basson, Ms M Marlie, Ms J Minnar: Associated Psychiatric Hospitals BJ Vd Merwe: Cape Winelands District Mr Dumalisele September: Overberg District Ms E van Ster: West Coast District Ms N Davids: Eden/Central Karoo Districts Mr A Oor: MDHS Ms L Meter: Emergency Medical Services

HIV/AIDS & Health promotion programmes			
Question	**Yes**	**No**	**Details, if yes**
(5) Has the Department reviewed its employment policies and practices to ensure that these do not unfairly discriminate against employees on the basis of their HIV status? If so, list the employment policies/practices so reviewed.	✓		Provincial Employee AIDS Programme (PEAP) committee: Ms S Newman – WCG: Health Ms L Mullins – WCG: Health Ms Mpumi Mxoli – WCG: Education Mr Siviwe Shasha – Department of the Premier Ms Zodwa Norushe – Department of the Premier Ms Fatima Galvaan – Department of the Premier Representatives from the relevant HCT service providers (NPOs)
(6) Has the Department introduced measures to protect HIV-positive employees or those perceived to be HIV-positive from discrimination? If so, list the key elements of these measures.	✓		None of the employment policies and practices discriminates unfairly against employees on the basis of their HIV and AIDS status. The HIV and AIDS, STI, and TB workplace programme is reviewed on an annual basis.
(7) Does the Department encourage its employees to undergo voluntary counselling and testing? If so, list the results that you have you achieved.	✓		One of the objectives of the HIV and AIDS, STI, and TB workplace programme is to "create a working environment that is free of discrimination". In order to meet this objective, the Department: • Includes persons living with AIDS in awareness campaigns. • Develops on-going awareness and communication strategies. • Have programmes and interventions to break social barriers and stigma. • Holds workshops and information sessions. • Promotes openness. • Promotes the need for confidentiality with regards to testing and status. The Department has an annual monitoring and evaluation tool for the Workplace HIV and AIDS Programme. This information is submitted to the HOD, DG and DPSA. Monthly statistics, quarterly reports and annual reports provided by HCT service providers serve as a means to monitor and evaluate the effectiveness of this programme. Quarterly and annual reports provided by the EHWP service provider serves as a means to monitor and evaluate the effectiveness of this programme and also to identify trends and challenges within the Department and develop and implement special interventions to address trends and challenges.
(8) Has the Department developed measures/indicators to monitor and evaluate the impact of its health promotion programme? If so, list these measures/indicators.	✓		The Department of Health has appointed the following non-profit organisations to render an on-site HIV counselling and testing (HCT) service to all employees: • Partners in Sexual Health: Metro East • Wolanani: Metro West • Diakonale Dienste: West Coast District • @Heart: Cape Winelands District • Elgin Learning Foundation: Overberg District • That's It: Eden District • Right to Care: Central Karoo District

<table>
<tr><th colspan="4">HIV/AIDS & Health promotion programmes</th></tr>
<tr><th>Question</th><th>Yes</th><th>No</th><th>Details, if yes</th></tr>
<tr><td></td><td></td><td></td><td>
Results:
<table>
<tr><th rowspan="2">District</th><th colspan="3">No of employees tested</th></tr>
<tr><th>Tested</th><th>Positive</th><th>Negative</th></tr>
<tr><td>Metropole</td><td>1 237</td><td>5</td><td>1 232</td></tr>
<tr><td>West Coast</td><td>901</td><td>18</td><td>883</td></tr>
<tr><td>Overberg</td><td>259</td><td>0</td><td>259</td></tr>
<tr><td>Cape Winelands</td><td>102</td><td>0</td><td>102</td></tr>
<tr><td>Central Karoo</td><td>268</td><td>5</td><td>263</td></tr>
<tr><td>Eden</td><td>393</td><td>4</td><td>389</td></tr>
<tr><td>TOTAL</td><td>3 160</td><td>32</td><td>3 128</td></tr>
</table>
Notes:
Employees who test positive are supported via the Employee Health and Wellness Programme. Employees are also encouraged to join GEMS in cases where they have not already joined a medical aid.
The Programme is currently aligned with national HCT initiative.
</td></tr>
</table>

3.12 LABOUR RELATIONS

The following collective agreements were entered into with trade unions within the Department.

Table 3.12.1: Collective agreements for the period 1 April 2013 and 31 March 2014

Labour relations	
Total number of collective agreements	None

The Department did not enter into collective agreements with any trade unions in the period under review.

Table 3.12.2 summarises the outcome of disciplinary hearings conducted within the Department for the year under review.

Table 3.12.2: Misconduct and disciplinary hearings finalised, 1 April 2013 to 31 March 2014

Labour relations		
Outcomes of disciplinary hearings	**Number**	**% of total**
Correctional counselling	478	26%
Verbal warning	449	24%
Written warning	484	26%
Final written warning	333	18%
Suspended without pay	5	0.3%
Fine	0	0%
Demotion	64	4%
Dismissal	36	2%
Not guilty	8	0.4%
Case withdrawn	0	0%
Total	**1 857**	**0%**
Percentage of total employment		**4.62%**

Notes: Outcomes of disciplinary hearings refer to formal cases only.

Table 3.12.3: Types of misconduct addressed at disciplinary hearings for the period 1 April 2013 and 31 March 2014

Labour relations		
Type of misconduct	**Number**	**% of total**
Absent from work without reason or permission	886	48%
Code of conduct (improper/unacceptable manner)	240	13%
Insubordination	189	10%
Fails to comply with or contravenes acts	289	16%
Negligence	17	1%
Misuse of WCG property	100	5%
Steals, bribes or commits fraud	46	2%
Substance abuse	33	2%
Sexual harassment	9	0.5%
Discrimination	5	0.3%
Assault or threatens to assault	6	0.3%
Desertions	36	2%
Social grant fraud	0	0%
Total	**1 857**	**100%**

Table 3.12.4: Grievances lodged, 1 April 2013 and 31 March 2014

Labour relations		
Grievances	**Number**	**% of total**
Number of grievances resolved	267	88%
Number of grievances not resolved	38	12%
Total number of grievances lodged	**305**	**100%**

Note: Grievances lodged refers to cases that were finalised within the reporting period. Grievances not resolved refers to cases finalised, but where the outcome was not in favour of the aggrieved and found to be unsubstantiated.

Table 3.12.5: Disputes lodged with Councils, 1 April 2013 and 31 March 2014

Labour relations		
Disputes lodged with Councils	**Number**	**% of total**
Conciliations		
Deadlocked	64	93%
Settled	2	3%
Withdrawn	3	4%
Total number of disputes lodged	**69**	**100%**

Labour relations		
Disputes lodged with Councils	**Number**	**% of total**
Arbitrations		
Upheld in favour of employee	17	29%
Dismissed in favour of employer	36	52%
Settled	5	9%
Total number of disputes lodged	**58**	**100%**

Note: Councils refer to the Public Service Coordinating Bargaining Council (PSCBC) and General Public Service Sector Bargaining Council (GPSSBC).

Table 3.12.6: Strike actions, 1 April 2013 and 31 March 2014

Labour relations	
Total number of person working days lost	0
Total cost (R'000) of working days lost	0
Amount (R'000) recovered as a result of no work no pay	**0**

Table 3.12.7 Precautionary suspensions, 1 April 2013 and 31 March 2014

Labour relations	
Number of people suspended	27
Number of people whose suspension exceeded 60 days	9
Average number of days suspended	50
Cost of suspension (R'000)	R756 272.74

Note: Precautionary suspensions refer to staff being suspended with pay whilst the case is being investigated.

3.13 SKILLS DEVELOPMENT

This section highlights the efforts of the Department with regard to skills development. Table 3.13.1 reflect the training needs as at the beginning of the period under review, and Table 3.13.2 the actual training provided.

Table 3.13.1: Training needs identified, 1 April 2013 and 31 March 2014

Skills development						
Occupational category	Gender	Number of employees as at 1 April 2013	Training needs identified at start of the reporting period			
			Learnerships	Skills programmes and other short courses	Other forms of training	Total
Legislators, senior officials and managers	Female	71	0	6	0	6
	Male	145	0	16	0	16
Professionals	Female	8 392	250	7 251	0	7 501
	Male	2 384	0	2 192	0	2 192
Technicians and associate professionals	Female	1 185	27	5 324	0	5 351
	Male	784	78	3 737	0	3 815
Clerks	Female	2 569	0	2 059	0	2 059
	Male	1 343	0	1 548	0	1 548
Service and sales workers	Female	7 236	45	1 357	0	1 402
	Male	1 976	75	730	0	805
Skilled agriculture and fishery workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Craft and related trades workers	Female	3	0	2	0	2
	Male	190	0	272	0	272
Plant and machine operators and assemblers	Female	3	0	8	0	8
	Male	163	0	271	0	271
Elementary occupations	Female	2 370	0	701	0	701
	Male	1 688	0	657	0	657

Skills development						
Occupational category	**Gender**	**Number of employees as at 1 April 2013**	**Training needs identified at start of the reporting period**			
			Learnerships	**Skills programmes and other short courses**	**Other forms of training**	**Total**
Sub-total	Female	**21 829**	**322**	**16 708**	**0**	**17 030**
	Male	**8 673**	**153**	**9 423**	**0**	**9 576**
Total		**30 502**	**475**	**26 131**	***2 440**	**29 046**
Employees with disabilities	Female	64	0	0	0	0
	Male	66	0	0	0	0

Note: Source: Workplace Skills Plan 2012/13

*(Interns, ABET, home-based carers) – M & E report

Table 3.13.2: Training provided, 1 April 2013 and 31 March 2014

Skills development						
Occupational category	**Gender**	**Number of employees as at 1 April 2013**	**Training provided within the reporting period**			
			Learnerships	**Skills programmes and other short courses**	**Other forms of training**	**Total**
Legislators, senior officials and managers	Female	80	0	53	0	53
	Male	151	0	209	0	209
Professionals	Female	9 093	8	7 284	0	7 292
	Male	2 952	4	2 450	0	2 454
Technicians and associate professionals	Female	788	24	2 989	0	3 013
	Male	492	1	1 490	0	1 491
Clerks	Female	2 613	0	2 379	0	2 379
	Male	1 382	0	981	0	981
Service and sales workers	Female	7 296	0	2 335	0	2 335
	Male	1 965	0	1 228	0	1 228
Skilled agriculture and fishery workers	Female	0	0	0	0	0
	Male	0	0	0	0	0
Craft and related trades workers	Female	0	0	6	0	6
	Male	0	0	312	0	312
Plant and machine operators and assemblers	Female	5	0	4	0	4
	Male	162	0	92	0	92
Elementary occupations	Female	2 350	0	958	0	958
	Male	1 688	0	655	0	655
Sub-total	Female	**22 225**	**32**	**16 008**	**0**	**16 040**
	Male	**8 792**	**5**	**7 417**	**0**	**7 422**
Total		**31 017**	**37**	**23 425**	***1 593**	**25 055**

Skills development						
Occupational category	Gender	Number of employees as at 1 April 2013	Training provided within the reporting period			
			Learnerships	Skills programmes and other short courses	Other forms of training	Total
Employees with disabilities	Female	79	0	32	0	32
	Male	71	0	15	0	15

Note: *(Interns, ABET, home-based carers) – M & E report

3.14 INJURY ON DUTY

Table 3.14.1 provides basic information on injury on duty.

Table 3.14.1: Injury on duty for the period 1 April 2013 and 31 March 2014

Injury on duty		
Nature of injury on duty	Number	% of total
Required basic medical attention only	475	80
Temporary total disablement	105	18
Permanent disablement	13	2
Fatal	0	0
Total	**593**	**100%**
Percentage of total employment		**1.9%**

3.15 UTILISATION OF CONSULTANTS

The following tables relate information on the utilisation of consultants in the Department. In terms of the Public Service Regulations "consultant' means a natural or juristic person or a partnership who or which provides in terms of a specific contract on an ad hoc basis any of the following professional services to a Department against remuneration received from any source:

(a) The rendering of expert advice;

(b) The drafting of proposals for the execution of specific tasks; and

(c) The execution of a specific task which is of a technical or intellectual nature, but excludes an employee of a department.

Table 3.15.1: Report on consultant appointments using appropriated funds, 1 April 2013 to 31 March 2014

Utilisation of consultants			
Project title	**Total number of consultants that worked on project**	**Duration (work days)**	**Contract value in Rand**
Auditor-General	Unknown	Unknown	R 568 579.50
Business Connexion (PTY)LTD	3	Unknown	R 3 268 635.55
Cebano Consultants	Unknown	Unknown	R 310 226.30
Datacentrix	Unknown	Unknown	R 3 125 244.77
Department of the Premier and Cultural Affairs	Unknown	Unknown	R 817 357.04
Ernst & Young Advisory Services	Unknown	Unknown	R 5 239 675.48
Evolution Strategies - Client Satisfaction Survey	Unknown	Unknown	R 165 600.00
Fadia Gamieldien: Committee Member for the Mental Health Advisory Committee	1	Unknown	R 4 502.53
Folio Online	Unknown	Unknown	R 261 899.13
Health System Technologies	Unknown	Unknown	R 1 782 492.67
Joan du Plessis Projects	Unknown	Unknown	R 419 779.00
Johan Scoombee	1	Unknown	R 87 210.00
KA Jeens	1	Unknown	R 123 747.00
Lean Sigma consulting CC	Unknown	Unknown	R 400 000.00
Legal cost	Unknown	Unknown	R 6 316 501.00
Liesel v/d Merwe/ A Barnard/ Univ of Cape Town Lung Inst/HST/Univ of Western Cape/PB Schoeman	Unknown	Unknown	R 783 508.26
Litha Lethu Management Solutions, Work dynamics, Lead train assessments	Unknown	Unknown	R 36 903.00
Managed Integrity Evaluation	Unknown	Unknown	R 902 631.16
Mr JA Ireland	1	Unknown	R 350 000.00
NOSA	Unknown	Unknown	R 29 070.00
Patient Satisfaction Survey	Unknown	Unknown	R 180 795.00
Payments in terms of service contracts for members of the Mental Health Review Board: Dr TJ Sutcliffe, Ms M de Goede, Ms C de Cerff, Ms L Ncapayi and Ms SC Matthews.	5	Unknown	R 1 266 590.90
SABS	Unknown	Unknown	R 839 947.63
SSISA, University of Cape Town	Unknown	Unknown	R 102 458.00
Translogic	Unknown	Unknown	R 152 602.27
Turner & Townsend (PTY) LTD + KA Jeenes	Unknown	Unknown	R 212 655.90
University of Cape Town	Unknown	Unknown	R 2 575 689.89
University of Stellenbosch	Unknown	Unknown	R 7 319.10
Verification petty cash	Unknown	Unknown	R 600.00
Waldo Consultants	Unknown	Unknown	R 498 807.00
Work Dynamics (PTY) LTD	Unknown	Unknown	R 35 875.00
ZGM Consulting PTY Ltd T/A PSP	Unknown	Unknown	R 826 741.05

Total number of projects	Total individual consultants	Total duration (work days)	Total contract value in Rand
32	Unknown	Unknown	R 31 693 644.13

Table 3.15.2: Analysis of consultant appointments using appropriated funds, in terms of Historically Disadvantaged Individuals (HDIs), 1 April 2013 to 31 March 2014

Utilisation of consultants			
Project title	**Percentage ownership by HDI groups**	**Percentage management by HDI groups**	**Number of consultants from HDI groups that work on the project**
Auditor-General	*Unknown	*Unknown	*Unknown
Business Connexion (PTY)LTD	*Unknown	*Unknown	*Unknown
Cebano Consultants	*Unknown	*Unknown	*Unknown
Datacentrix	*Unknown	*Unknown	*Unknown
Department of the Premier and Cultural Affairs	*Unknown	*Unknown	*Unknown
Ernst & Young Advisory Services	*Unknown	*Unknown	*Unknown
Evolution Strategies - Client Satisfaction Survey	*Unknown	*Unknown	*Unknown
Fadia Gamieldien: Committee Member for the Mental Health Advisory Committee	*Unknown	*Unknown	*Unknown
Folio Online	*Unknown	*Unknown	*Unknown
Health System Technologies	*Unknown	*Unknown	*Unknown
Joan du Plessis Projects	*Unknown	*Unknown	*Unknown
Johan Scoombee	*Unknown	*Unknown	*Unknown
KA Jeens	*Unknown	*Unknown	*Unknown
Lean Sigma consulting CC	*Unknown	*Unknown	*Unknown
Legal cost	*Unknown	*Unknown	*Unknown
Liesel v/d Merwe/ A Barnard/ Univ of Cape Town Lung Inst/HST/Univ of Western Cape/PB Schoeman	*Unknown	*Unknown	*Unknown
Litha Lethu Management Solutions, Work dynamics, Lead train assessments	*Unknown	*Unknown	*Unknown
Managed Integrity Evaluation	*Unknown	*Unknown	*Unknown
Mr JA Ireland	*Unknown	*Unknown	*Unknown
NOSA	*Unknown	*Unknown	*Unknown
Patient Satisfaction Survey	*Unknown	*Unknown	*Unknown
Payments in terms of service contracts for members of the Mental Health Review Board: Dr TJ Sutcliffe, Ms M de Goede, Ms C de Cerff, Ms L Ncapayi and Ms SC Matthews.	*Unknown	*Unknown	*Unknown
SABS	*Unknown	*Unknown	*Unknown
SSISA, University of Cape Town	*Unknown	*Unknown	*Unknown
Translogic	*Unknown	*Unknown	*Unknown
Turner & Townsend (PTY) LTD + KA Jeenes	*Unknown	*Unknown	*Unknown
University of Cape Town	*Unknown	*Unknown	*Unknown
University of Stellenbosch	*Unknown	*Unknown	*Unknown

Utilisation of consultants			
Project title	**Percentage ownership by HDI groups**	**Percentage management by HDI groups**	**Number of consultants from HDI groups that work on the project**
Verification petty cash	*Unknown	*Unknown	*Unknown
Waldo Consultants	*Unknown	*Unknown	*Unknown
Work Dynamics (PTY) LTD	*Unknown	*Unknown	*Unknown
ZGM Consulting PTY Ltd T/A PSP	*Unknown	*Unknown	*Unknown

*Unknown: The Preferential Procurement Policy Framework Act not longer requires the HDI status of bidders to be recorded when competing for bids and has been replaced with the broad based black economic empowerment (BBBEE) scorecard. The BBEE information on the above consultants is available if needed.

Table 3.15.3: Report on consultant appointments using Donor funds, 1 April 2013 to 31 March 2014

Utilisation of consultants			
Project title	**Total number of consultants that worked on project**	**Duration (work days)**	**Contract value in Rand**
Nil			
Total number of projects	**Total individual consultants**	**Total duration (work days)**	**Total contract value in Rand**
Nil			

Table 3.15.4: Analysis of consultant appointments using Donor funds, in terms of Historically Disadvantaged Individuals (HDIs), 1 April 2013 and 31 March 2014

Utilisation of consultants			
Project title	**Percentage ownership by HDI groups**	**Percentage management by HDI groups**	**Number of consultants from HDI groups that work on the project**
Nil			

PART E:
FINANCIAL INFORMATION

1. REPORT OF THE AUDITOR-GENERAL

REPORT OF THE AUDITOR-GENERAL TO THE WESTERN CAPE PROVINCIAL PARLIAMENT ON VOTE NO. 6: WESTERN CAPE DEPARTMENT OF HEALTH

REPORT ON THE FINANCIAL STATEMENTS

Introduction

1. I have audited the financial statements of the Western Cape Department of Health set out on pages 309 to 378, which comprise the appropriation statement, the statement of financial position as at 31 March 2014, the statement of financial performance, statement of changes in net assets and cash flow statement for the year then ended, as well as the notes, comprising a summary of significant accounting policies and other explanatory information.

Accounting officer's responsibility for the financial statements

2. The accounting officer is responsible for the preparation and fair presentation of these financial statements in accordance with the Modified Cash Standard (MCS) prescribed by the National Treasury and the requirements of the Public Finance Management Act of South Africa, 1999 (Act No. 1 of 1999) (PFMA) and Division of Revenue Act of South Africa, 2013 (Act No. 2 of 2013) (DoRA), and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor-general's responsibility

3. My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA), the general notice issued in terms thereof and International Standards on Auditing. Those standards require that I comply with ethical requirements, and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

4. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

5. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

6. In my opinion, the financial statements present fairly, in all material respects, the financial position of the Western Cape Department of Health as at 31 March 2014 and its financial performance and cash flows for the year then ended, in accordance with the MCS prescribed by the National Treasury and the requirements of the PFMA and DoRA.

Emphasis of matters

7. I draw attention to the matters below. My opinion is not modified in respect of these matters.

Restatement of corresponding figures

8. As disclosed in note 35 to the financial statements, the corresponding figures for 31 March 2013 have been restated as a result of an error discovered during 2014 in the financial statements of the Western Cape Department of Health at, and for the year ended, 31 March 2013.

Material losses/impairments

9. With reference to note 24.2 to the financial statements, material losses to the amount of R189 million (2013: R161 million) were incurred as a result of a write-off of irrecoverable accrued departmental revenue.

10. With reference to note 24.3 to the financial statements, material allowance was made for impairments to the amount of R183 million (2013: R203 million).

Significant uncertainties

11. With reference to note 19.1 to the financial statements, the department has a contingent liability of R181 million. This includes an amount of R179 million, which relates to claims against the department the majority of which are claims for medical negligence. The ultimate outcome of these matters cannot presently be determined and no provision for any liability that may result has been made in the financial statements.

Additional matter

12. I draw attention to the matter below. My opinion is not modified in respect of this matter.

Unaudited supplementary schedules

13. The supplementary information set out on pages 379 to 401 does not form part of the financial statements and is presented as additional information. I have not audited these schedules and, accordingly, I do not express an opinion thereon.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

14. In accordance with the PAA and the general notice issued in terms thereof, I report the following findings on the reported performance information against predetermined objectives for selected programmes presented in the annual performance report, non-compliance with legislation as well as internal control. The objective of my tests was to identify reportable findings as described under each subheading but not to gather evidence to express assurance on these matters. Accordingly, I do not express an opinion or conclusion on these matters.

Predetermined objectives

15. I performed procedures to obtain evidence about the usefulness and reliability of the reported performance information for the following selected programmes presented in the annual performance report of the department for the year ended 31 March 2014:
    - Programme 2: District health services (on pages 76 to 77; 80 to 81; 84 to 85; 88 to 90 and 93)
    - Programme 4: Provincial hospitals (on pages 110 to 112; 116 to 117; 123 to 125; 131 to 133 and 137)
    - Programme 5: Central and tertiary hospitals (on pages 146 to 148; 153 to 155; 160 to 162; and 168 to 170)

16. I evaluated the reported performance information against the overall criteria of usefulness and reliability.

17. I evaluated the usefulness of the reported performance information to determine whether it was presented in accordance with the National Treasury's annual reporting principles and whether the reported performance was consistent with the planned programmes. I further performed tests to determine whether indicators and targets were well defined, verifiable, specific, measurable, time bound and relevant, as required by the National Treasury's *Framework for managing programme performance information*.

18. I assessed the reliability of the reported performance information to determine whether it was valid, accurate and complete.

19. I did not raise any material findings on the usefulness and reliability of the reported performance information for the selected programmes.

Additional matter

20. Although I raised no material findings on the usefulness and reliability of the reported performance information for the selected programmes, I draw attention to the following matter:

Achievement of planned targets

21. Refer to the annual performance report on pages 72 to 94; 104 to 138; and 139 to 171 for information on the achievement of planned targets for the year.

Compliance with legislation

22. I performed procedures to obtain evidence that the department had complied with applicable legislation regarding financial matters, financial management and other related matters. My findings on material non-compliance with specific matters in key legislation, as set out in the general notice issued in terms of the PAA, are as follows:

Annual financial statements

23. The financial statements submitted for auditing were not prepared in accordance with the prescribed financial reporting framework as required by section 40(1)(a) of the PFMA. Material misstatements of some disclosure items identified by the auditors in the submitted financial statements were subsequently corrected, resulting in the financial statements receiving an unqualified audit opinion.

Expenditure management

24. Effective steps were not taken to prevent irregular expenditure, as required by section 38(1)(c)(ii) of the PFMA and Treasury Regulation 9.1.1.

Internal control

25. I considered internal control relevant to my audit of the financial statements, performance report and compliance with legislation. The matters reported below are limited to the significant internal control deficiencies that resulted in the findings on compliance with legislation included in this report.

Leadership

26. The department's action plan to address internal and external audit findings by introducing a compliance monitoring instrument and decentralised internal control units during prior years has assisted the department in reducing the different types of non-compliance and financial findings identified during the audit of the 2013-14 financial year compared to the prior financial year. The challenge for the department remains institutionalisation of the implementation and monitoring of these instruments so that it can contribute to sustainable internal controls and processes and improve audit outcomes.

Financial and performance management

27. Although the compliance monitoring instrument developed by the department placed extensive focus on compliance with laws and regulations, it is evident from the number of repeat instances of irregular expenditure that the intervention of using the compliance monitoring instrument has not yet resulted in the desired impact.

28. Management has not yet obtained an understanding of certain requirements of the MCS, the guidance issued thereon, as well as the specimen financial statements to ensure full compliance with financial reporting requirements.

OTHER REPORTS

Performance audits

29. The report of the Auditor-General of South Africa on a performance audit of the use of consultants at selected departments of the Western Cape provincial government was tabled during the 2013-14 financial year. The Department of Health was one of the departments audited. The department was selected for audit based on our assessment of possible weaknesses in the use of consultants as well as spending trends. The audit covered consultancy payments up to 31 December 2011.

30. The report can be accessed on the website of the Auditor-General of South Africa at http://www.agsa.co.za/Documents/Specialauditreports/Performanceauditreports.aspx

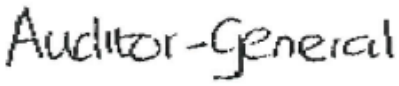
31. The Report of the Auditor-General of South Africa on the readiness of government to report on its performance will be tabled during the 2014 calendar year. The Western Cape Department of Health was one of the 61 institutions/departments audited during this audit. The performance audit focused on the following:

- The systems and processes that government departments have put in place to report on their performance.
- The performance reporting guidance and oversight government departments received.

Investigations

32. Twenty-nine (29) open cases (2012-13: 67) relevant to the Western Cape Department of Health appeared in the forensic investigating unit's register at the end of the financial year under review. The movement of cases is as follows:

- Fifty-one (51) new cases relating to alleged conflict of interest, corruption, human resource irregularities, theft, financial irregularities, nepotism and procurement fraud were reported to the forensic investigating unit during the year.
- Twenty-eight (28) cases relating to alleged human resource irregularities and procurement fraud that were reported to the forensic investigating unit have been referred back to the department for finalisation.
- Sixty-one (61) cases relating to alleged corruption, financial irregularities, procurement fraud, theft and human resources irregularities that were reported to the forensic investigating unit have been closed.



Cape Town

30 July 2014

AUDITOR-GENERAL
SOUTH AFRICA

Auditing to build public confidence

2. ANNUAL FINANCIAL STATEMENTS

Appropriation per Programme									
	2013/14							2012/13	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
1. ADMINISTRATION									
Current payment	486 261	-	(6 820)	479 441	471 493	7 948	98.3%	422 926	422 480
Transfers and subsidies	33 117	-	600	33 717	31 504	2 213	93.4%	11 277	11 263
Payment for capital assets	8 487	-	-	8 487	8 391	96	98.9%	10 424	10 423
Payment for financial assets	-	-	59	59	59	-	100.0%	882	882
	527 865	-	(6 161)	521 704	511 447	10 257		445 509	445 048
2. DISTRICT HEALTH SERVICES									
Current payment	5 314 619	-	(7 399)	5 307 220	5 315 443	(8 223)	100.2%	4 862 841	4 843 181
Transfers and subsidies	661 691	-	(126)	661 565	649 430	12 135	98.2%	611 472	593 165
Payment for capital assets	65 764	-	6 853	72 617	73 536	(919)	101.3%	80 181	72 587
Payment for financial assets	-	-	853	853	853	-	100.0%	935	935
	6 042 074	-	181	6 042 255	6 039 262	2 993		5 555 429	5 509 868
3. EMERGENCY MEDICAL SERVICES									
Current payment	726 680	-	(3 103)	723 577	722 184	1 393	99.8%	594 094	573 883
Transfers and subsidies	38 984	-	3 103	42 087	42 106	(19)	100.0%	46 226	46 226
Payment for capital assets	49 216	-	3 747	52 963	54 337	(1 374)	102.6%	53 953	53 951
Payment for financial assets	-	-	1 121	1 121	1 121	-	100.0%	1 454	1 454
	814 880	-	4 868	819 748	819 748	-		695 727	675 514

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

APPROPRIATION STATEMENT
for the year ended 31 March 2014

Appropriation per Programme									
	2013/14							2012/13	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
4. PROVINCIAL HOSPITAL SERVICES									
Current payment	2 458 053	-	-	2 458 053	2 462 997	(4 944)	100.2%	2 268 886	2 266 642
Transfers and subsidies	6 872	-	10	6 882	7 705	(823)	112.0%	5 437	7 103
Payment for capital assets	35 214	-	(281)	34 933	28 915	6 018	82.8%	25 287	25 239
Payment for financial assets	-	-	271	271	271	-	100.0%	635	634
	2 500 139	-	-	2 500 139	2 499 888	251		2 300 245	2 299 618
5. CENTRAL HOSPITAL SERVICES									
Current payment	4 453 280	-	541	4 453 821	4 488 181	(34 360)	100.8%	4 141 320	4 140 235
Transfers and subsidies	23 443	-	38	23 481	26 568	(3 087)	113.1%	22 731	22 731
Payment for capital assets	87 664	-	(38)	87 626	50 179	37 447	57.3%	83 922	83 921
Payment for financial assets	-	-	493	493	493	-	100.0%	572	572
	4 564 387	-	1 034	4 565 421	4 565 421	-		4 248 545	4 247 459
6. HEALTH SCIENCES AND TRAINING									
Current payment	167 083	-	-	167 083	164 096	2 987	98.2%	162 413	172 269
Transfers and subsidies	97 401	-	-	97 401	97 346	55	99.9%	112 292	102 435
Payment for capital assets	1 700	-	-	1 700	2 673	(973)	157.2%	1 726	1 725
Payment for financial assets	-	-	78	78	78	-	100.0%	122	122
	266 184	-	78	266 262	264 193	2 069		276 553	276 551

APPROPRIATION STATEMENT
for the year ended 31 March 2014

Appropriation per Programme									
	2013/14							2012/13	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
7. HEALTH CARE SUPPORT SERVICES									
Current payment	340 857	-	(1 450)	339 407	322 474	16 933	95.0%	312 079	312 685
Transfers and subsidies	1 234	-	-	1 234	347	887	28.1%	1 154	1 025
Payment for capital assets	13 447	-	-	13 447	14 880	(1 433)	110.7%	11 417	10 939
Payment for financial assets	-	-	1 450	1 450	1 450	-	100.0%	71	71
	355 538	-	-	355 538	339 151	16 387		324 721	324 720
8. HEALTH FACILITIES MANAGEMENT									
Current payment	272 133	-	-	272 133	246 675	25 458	90.6%	208 609	205 169
Transfers and subsidies	26 344	-	180	26 524	26 523	1	100.0%	-	34
Payment for capital assets	660 437	-	(180)	660 257	604 654	55 603	91.6%	688 494	616 876
	958 914	-	-	958 914	877 852	81 062		897 103	822 079
TOTAL	**16 029 981**	**-**	**-**	**16 029 981**	**15 916 962**	**113 019**	**99.3%**	**14 743 832**	**14 600 857**
Reconciliation with Statement of Financial Performance									
Add:									
Departmental receipts				110 785				117 657	
Aid assistance				4 250				7 317	
Actual amounts per Statement of Financial Performance (Total Revenue)				**16 145 016**				**14 868 806**	
Add:									
Aid Assistance					-				7 317
Actual amounts per Statement of Financial Performance (Total Expenditure)					**15 916 962**				**14 608 174**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

APPROPRIATION STATEMENT
for the year ended 31 March 2014

Appropriation per Economic classification									
	2013/14							2012/13	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual Expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
Current payments									
Compensation of employees	9 352 602	-	(63 969)	9 288 633	9 237 938	50 695	99.5%	8 495 046	8 456 868
Goods and services	4 866 364	-	45 738	4 912 102	4 955 604	(43 502)	100.9%	4 478 122	4 479 676
Transfers and subsidies									
Provinces and municipalities	360 319	-	(1 044)	359 275	354 525	4 750	98.7%	334 382	322 613
Departmental agencies and accounts	4 215	-	109	4 324	4 324	-	100.0%	3 656	3 655
Higher education institutions	3 580	-	-	3 580	3 480	100	97.2%	2 988	1 194
Non-profit institutions	413 830	-	2 740	416 570	408 767	7 803	98.1%	362 427	348 080
Households	107 077	-	1 916	108 993	110 283	(1 290)	101.2%	107 136	108 440
Gifts and donations	65	-	84	149	149	-	100.0%	-	-
Payments for capital assets									
Buildings and other fixed structures	498 302	-	6 673	504 975	415 566	89 409	82.3%	599 383	522 567
Machinery and equipment	413 895	-	3 428	417 323	420 399	(3 076)	100.7%	355 143	352 054
Intangible assets	9 732	-	-	9 732	1 602	8 130	16.5%	878	1 040
Payments for financial assets	-	-	4 325	4 325	4 325	-	100.0%	4 671	4 670
Total	**16 029 981**	**-**	**-**	**16 029 981**	**15 916 962**	**113 019**	**99.3%**	**14 743 832**	**14 600 857**

Detail of Programme 1 - ADMINISTRATION
for the year ended 31 March 2014

	2013/14							2012/13	
Programme 1 Per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	234 659	-	(11 622)	223 037	215 664	7 373	96.7%	187 538	187 683
Goods and services	251 602	-	4 802	256 404	255 829	575	99.8%	235 388	234 797
Transfers and subsidies to:									
Departmental agencies and accounts	6	-	-	6	4	2	66.7%	8	7
Non-profit institutions	1 400	-	600	2 000	2 000	-	100.0%	-	-
Households	31 646	-	(84)	31 562	29 351	2 211	93.0%	11 269	11 256
Gifts and donations	65	-	84	149	149	-	100.0%	-	-
Payment for capital assets									
Machinery and equipment	8 324	-	-	8 324	7 669	655	92.1%	10 237	10 236
Intangible assets	163	-	-	163	722	(559)	442.9%	187	187
Payments for financial assets	-	-	59	59	59	-	100.0%	882	882
Total	**527 865**	**-**	**(6 161)**	**521 704**	**511 447**	**10 257**	**98.0%**	**445 509**	**445 048**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

Detail of Programme 1 - ADMINISTRATION
for the year ended 31 March 2014

	2013/14							2012/13	
Detail per sub-programme	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
1.1 OFFICE OF THE PROVINCIAL MINISTER									
Current payment	6 724	-	-	6 724	6 050	674	90.0%	6 026	5 580
Transfers and subsidies	3	-	-	3	-	3		5	5
Payment for capital assets	27	-	-	27	260	(233)	963.0%	836	836
1.2 MANAGEMENT									
Current payment	479 537	-	(6 820)	472 717	465 443	7 274	98.5%	416 900	416 900
Transfers and subsidies	33 114	-	600	33 714	31 504	2 210	93.4%	11 272	11 258
Payment for capital assets	8 460	-	-	8 460	8 131	329	96.1%	9 588	9 587
Payment for financial assets	-	-	59	59	59	-	100.0%	882	882
Total	**527 865**	**-**	**(6 161)**	**521 704**	**511 447**	**10 257**	**98.0%**	**445 509**	**445 048**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

Detail of Programme 2 - DISTRICT HEALTH SERVICES
for the year ended 31 March 2014

	2013/14							2012/13	
Programme 2 Per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	3 350 188	-	(35 244)	3 314 944	3 294 783	20 161	99.4%	3 022 148	2 991 809
Goods and services	1 964 431	-	27 845	1 992 276	2 020 660	(28 384)	101.4%	1 840 693	1 851 372
Transfers and subsidies to:									
Provinces and municipalities	360 319	-	(1 044)	359 275	354 525	4 750	98.7%	334 382	322 613
Departmental agencies and accounts	53	-	49	102	102	-	100.0%	64	64
Non-profit institutions	291 540	-	(1 131)	290 409	282 636	7 773	97.3%	266 185	258 541
Households	9 779	-	2 000	11 779	12 167	(388)	103.3%	10 841	11 947
Payment for capital assets									
Buildings and other fixed structures	9 687	-	6 853	16 540	16 543	(3)	100.0%	13 061	4 881
Machinery and equipment	56 059	-	-	56 059	56 861	(802)	101.4%	67 070	67 706
Intangible assets	18	-	-	18	132	(114)	733.3%	50	-
Payments for financial assets	-	-	853	853	853	-	100.0%	935	935
Total	**6 042 074**	**-**	**181**	**6 042 255**	**6 039 262**	**2 993**	**100.0%**	**5 555 429**	**5 509 868**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

Detail of Programme 2 - DISTRICT HEALTH SERVICES
for the year ended 31 March 2014

	2013/14							2012/13	
Detail per sub-programme	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
2.1 DISTRICT MANAGEMENT									
Current payment	278 192	-	(564)	277 628	260 747	16 881	93.9%	248 516	242 569
Transfers and subsidies	2 470	-	-	2 470	1 339	1 131	54.2%	3 301	3 300
Payment for capital assets	10 907	-	-	10 907	11 247	(340)	103.1%	11 011	10 915
Payment for financial assets	-	-	564	564	564	-	100.0%	206	206
2.2 COMMUNITY HEALTH CLINICS									
Current payment	721 104	-	-	721 104	712 169	8 935	98.8%	820 437	798 420
Transfers and subsidies	234 165	-	-	234 165	230 355	3 810	98.4%	227 375	227 410
Payment for capital assets	13 136	-	-	13 136	15 731	(2 595)	119.8%	12 868	11 742
Payment for financial assets	-	-	-	-	-	-	-	34	34
2.3 COMMUNITY HEALTH CENTRES									
Current payment	1 360 964	-	(31 157)	1 329 807	1 305 473	24 334	98.2%	1 120 888	1 117 883
Transfers and subsidies	2 063	-	3	2 066	2 080	(14)	100.7%	2 701	2 701
Payment for capital assets	7 234	-	-	7 234	7 614	(380)	105.3%	4 482	5 721
Payment for financial assets	-	-	181	181	181	-	100.0%	407	407
2.4 COMMUNITY BASED SERVICES									
Current payment	39 894	-	-	39 894	42 936	(3 042)	107.6%	41 504	39 984
Transfers and subsidies	125 266	-	-	125 266	120 387	4 879	96.1%	117 065	122 964
Payment for capital assets	288	-	-	288	568	(280)	197.2%	325	294
Payment for financial assets	-	-	-	-	-	-	-	38	38
2.5 OTHER COMMUNITY SERVICES									
Current payment	1	-	-	1	-	1	-	1	-

Detail of Programme 2 - DISTRICT HEALTH SERVICES for the year ended 31 March 2014

	2013/14							2012/13	
Detail per sub-programme	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
2.6 HIV AND AIDS									
Current payment	695 795	-	-	695 795	699 481	(3 686)	100.5%	552 136	561 705
Transfers and subsidies	227 972	-	-	227 972	225 530	2 442	98.9%	174 710	170 037
Payment for capital assets	3 780	-	-	3 780	2 536	1 244	67.1%	11 234	6 337
2.7 NUTRITION									
Current payment	25 848	-	-	25 848	28 769	(2 921)	111.3%	20 720	22 584
Transfers and subsidies	6 528	-	-	6 528	6 832	(304)	104.7%	6 200	6 104
Payment for capital assets	-	-	-	-	5	(5)	-	-	5
2.8 CORONER SERVICES									
Current payment	1	-	-	1	-	1	-	1	-
2.9 DISTRICT HOSPITALS									
Current payment	2 106 950	-	29 000	2 135 950	2 184 768	(48 818)	102.3%	1 959 581	1 978 687
Transfers and subsidies	3 816	-	2 046	5 862	6 607	(745)	112.7%	4 282	4 283
Payment for capital assets	20 695	-	-	20 695	19 256	1 439	93.0%	33 177	34 959
Payment for financial assets	-	-	108	108	108	-	100.0%	250	250
2.10 GLOBAL FUND									
Current payment	85 870	-	(4 678)	81 192	81 100	92	99.9%	99 057	81 349
Transfers and subsidies	59 411	-	(2 175)	57 236	56 300	936	98.4%	75 838	56 366
Payment for capital assets	9 724	-	6 853	16 577	16 579	(2)	100.0%	7 084	2 614
Total	**6 042 074**	**-**	**181**	**6 042 255**	**6 039 262**	**2 993**	**100.0%**	**5 555 429**	**5 509 868**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

Detail of Programme 3 - EMERGENCY MEDICAL SERVICES
for the year ended 31 March 2014

	2013/14							2012/13	
Programme 3 Per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	490 315	-	(3 103)	487 212	486 359	853	99.8%	434 223	434 223
Goods and services	236 365	-	-	236 365	235 825	540	99.8%	159 871	139 660
Transfers and subsidies to:									
Departmental agencies and accounts	-	-	12	12	12	-	100.0%	-	-
Non-profit institutions	38 637	-	3 091	41 728	41 728	-	100.0%	45 818	45 818
Households	347	-	-	347	366	(19)	105.5%	408	408
Payment for capital assets									
Machinery and equipment	49 216	-	3 747	52 963	54 337	(1 374)	102.6%	53 953	53 951
Payments for financial assets	-	-	1 121	1 121	1 121	-	100.0%	1 454	1 454
Total	**814 880**	**-**	**4 868**	**819 748**	**819 748**	**-**	**100.0%**	**695 727**	**675 514**

Detail of Programme 3 - EMERGENCY MEDICAL SERVICES for the year ended 31 March 2014

	2013/14							2012/13	
Detail per sub-programme	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
3.1 EMERGENCY TRANSPORT									
Current payment	671 445	-	(3 103)	668 342	665 577	2 765	99.6%	537 375	526 358
Transfers and subsidies	38 941	-	3 103	42 044	42 087	(43)	100.1%	46 184	46 184
Payment for capital assets	41 568	-	3 747	45 315	46 786	(1 471)	103.2%	48 808	48 806
Payment for financial assets	-	-	1 121	1 121	1 121	-	100.0%	1 454	1 454
3.2 PLANNED PATIENT TRANSPORT									
Current payment	55 235	-	-	55 235	56 607	(1 372)	102.5%	56 719	47 525
Transfers and subsidies	43	-	-	43	19	24	44.2%	42	42
Payment for capital assets	7 648	-	-	7 648	7 551	97	98.7%	5 145	5 145
Total	**814 880**	**-**	**4 868**	**819 748**	**819 748**	**-**	**100.0%**	**695 727**	**675 514**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

Detail of Programme 4 - PROVINCIAL HOSPITAL SERVICES
for the year ended 31 March 2014

	2013/14							2012/13	
Programme 4 Per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	1 808 002	-	(14 000)	1 794 002	1 791 500	2 502	99.9%	1 660 850	1 660 315
Goods and services	650 051	-	14 000	664 051	671 497	(7 446)	101.1%	608 036	606 327
Transfers and subsidies to:									
Departmental agencies and accounts	45	-	10	55	55	-	100.0%	43	43
Households	6 827	-	-	6 827	7 650	(823)	112.1%	5 394	7 060
Payment for capital assets									
Machinery and equipment	35 214	-	(281)	34 933	28 884	6 049	82.7%	25 206	25 158
Intangible assets	-	-	-	-	31	(31)	-	81	81
Payments for financial assets	-	-	271	271	271	-	100.0%	635	634
Total	**2 500 139**	**-**	**-**	**2 500 139**	**2 499 888**	**251**	**100.0%**	**2 300 245**	**2 299 618**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

Detail of Programme 4 - PROVINCIAL HOSPITAL SERVICES
for the year ended 31 March 2014

	2013/14							2012/13	
Detail per sub-programme	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
4.1 GENERAL HOSPITALS									
Current payment	1 316 805	-	-	1 316 805	1 320 737	(3 932)	100.3%	1 201 923	1 201 343
Transfers and subsidies	2 866	-	-	2 866	3 325	(459)	116.0%	1 111	2 750
Payment for capital assets	17 247	-	(281)	16 966	11 930	5 036	70.3%	13 594	13 594
Payment for financial assets	-	-	149	149	149	-	100.0%	276	276
4.2 TUBERCULOSIS HOSPITALS									
Current payment	220 267	-	-	220 267	222 027	(1 760)	100.8%	209 123	208 739
Transfers and subsidies	617	-	10	627	527	100	84.1%	464	528
Payment for capital assets	2 914	-	-	2 914	2 667	247	91.5%	4 021	3 939
Payment for financial assets	-	-	1	1	1	-	100.0%	38	38
4.3 PSYCHIATRIC/MENTAL HOSPITALS									
Current payment	653 723	-	-	653 723	656 279	(2 556)	100.4%	613 990	613 758
Transfers and subsidies	2 133	-	-	2 133	3 804	(1 671)	178.3%	2 349	2 312
Payment for capital assets	8 851	-	-	8 851	8 218	633	92.8%	4 669	4 669
Payment for financial assets	-	-	112	112	112	-	100.0%	300	299
4.4 CHRONIC MEDICAL HOSPITALS									
Current payment	147 287	-	-	147 287	148 533	(1 246)	100.8%	137 862	136 858
Transfers and subsidies	844	-	-	844	48	796	5.7%	833	833
Payment for capital assets	2 007	-	-	2 007	1 738	269	86.6%	379	414
Payment for financial assets	-	-	9	9	9	-	100.0%	20	20
4.5 DENTAL TRAINING HOSPITALS									
Current payment	119 971	-	-	119 971	115 421	4 550	96.2%	105 988	105 944
Transfers and subsidies	412	-	-	412	1	411	0.2%	680	680
Payment for capital assets	4 195	-	-	4 195	4 362	(167)	104.0%	2 624	2 623
Payment for financial assets	-	-	-	-	-	-	-	1	1
Total	**2 500 139**	**-**	**-**	**2 500 139**	**2 499 888**	**251**	**100.0%**	**2 300 245**	**2 299 618**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

Detail of Programme 5 - CENTRAL HOSPITAL SERVICES
for the year ended 31 March 2014

	2013/14							2012/13	
Programme 5 Per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	3 137 412	-	-	3 137 412	3 127 750	9 662	99.7%	2 889 415	2 888 986
Goods and services	1 315 868	-	541	1 316 409	1 360 431	(44 022)	103.3%	1 251 905	1 251 249
Transfers and subsidies to:									
Departmental agencies and accounts	-	-	38	38	38	-	100.0%	-	-
Non-profit institutions	11 933	-	-	11 933	11 933	-	100.0%	11 483	11 483
Households	11 510	-	-	11 510	14 597	(3 087)	126.8%	11 248	11 248
Payment for capital assets									
Machinery and equipment	84 066	-	(38)	84 028	49 954	34 074	59.4%	83 362	83 362
Intangible assets	3 598	-	-	3 598	225	3 373	6.3%	560	559
Payments for financial assets	-	-	493	493	493	-	100.0%	572	572
Total	**4 564 387**	**-**	**1 034**	**4 565 421**	**4 565 421**	**-**	**100.0%**	**4 248 545**	**4 247 459**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

Detail of Programme 5 - CENTRAL HOSPITAL SERVICES
for the year ended 31 March 2014

	2013/14							2012/13	
Detail per sub-programme	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
5.1 CENTRAL HOSPITAL SERVICES									
Current payment	3 888 369	-	-	3 888 369	3 918 094	(29 725)	100.8%	4 141 320	4 140 235
Transfers and subsidies	12 331	-	-	12 331	15 767	(3 436)	127.9%	22 731	22 731
Payment for capital assets	77 115	-	-	77 115	43 251	33 864	56.1%	83 922	83 921
Payment for financial assets	-	-	411	411	411	-	100.0%	572	572
5.2 PROVINCIAL HOSPITAL TERTIARY SERVICES									
Current payment	564 911	-	541	565 452	570 087	(4 635)	100.8%	-	-
Transfers and subsidies	11 112	-	38	11 150	10 801	349	96.9%	-	-
Payment for capital assets	10 549	-	(38)	10 511	6 928	3 583	65.9%	-	-
Payment for financial assets	-	-	82	82	82	-	100.0%	-	-
Total	**4 564 387**	**-**	**1 034**	**4 565 421**	**4 565 421**	**-**	**100.0%**	**4 248 545**	**4 247 459**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

Detail of Programme 6 - HEALTH SCIENCES AND TRAINING
for the year ended 31 March 2014

	2013/14							2012/13	
Programme 6 Per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	105 066	-	-	105 066	105 463	(397)	100.4%	99 765	96 636
Goods and services	62 017	-	-	62 017	58 633	3 384	94.5%	62 648	75 633
Transfers and subsidies to:									
Departmental agencies and accounts	4 111	-	-	4 111	4 113	(2)	100.0%	3 541	3 541
Higher education institutions	3 580	-	-	3 580	3 480	100	97.2%	2 988	1 194
Non-profit institutions	44 000	-	-	44 000	43 970	30	99.9%	38 941	32 238
Households	45 710	-	-	45 710	45 782	(72)	100.2%	66 822	65 462
Payment for capital assets									
Machinery and equipment	1 700	-	-	1 700	2 674	(974)	157.3%	1 726	1 725
Payments for financial assets	-	-	78	78	78	-	100.0%	122	122
Total	**266 184**	**-**	**78**	**266 262**	**264 193**	**2 069**	**99.2%**	**276 553**	**276 551**

Detail of Programme 6 - HEALTH SCIENCES AND TRAINING for the year ended 31 March 2014

	2013/14							2012/13	
Detail per sub-programme	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
6.1 NURSING TRAINING COLLEGE									
Current payment	75 805	-	-	75 805	74 451	1 354	98.2%	71 033	72 208
Transfers and subsidies	3 784	-	-	3 784	3 784	-	100.0%	1 388	212
Payment for capital assets	360	-	-	360	718	(358)	199.4%	615	614
Payment for financial assets	-	-	78	78	78	-	100.0%	-	-
6.2 EMS TRAINING COLLEGES									
Current payment	20 455	-	-	20 455	21 214	(759)	103.7%	18 538	17 754
Transfers and subsidies	13	-	-	13	17	(4)	130.8%	-	10
Payment for capital assets	1 340	-	-	1 340	1 955	(615)	145.9%	1 111	1 111
6.3 BURSARIES									
Current payment	7 508	-	-	7 508	7 279	229	96.9%	7 130	7 120
Transfers and subsidies	45 493	-	-	45 493	45 437	56	99.9%	66 422	65 206
Payment for financial assets	-	-	-	-	-	-	-	122	122
6.4 PRIMARY HEALTH CARE TRAINING									
Current payment	1	-	-	1	-	1	-	1	-
6.5 TRAINING OTHER									
Current payment	63 314	-	-	63 314	61 152	2 162	96.6%	65 711	75 187
Transfers and subsidies	48 111	-	-	48 111	48 108	3	100.0%	44 482	37 007
Total	**266 184**	**-**	**78**	**266 262**	**264 193**	**2 069**	**99.2%**	**276 553**	**276 551**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

Detail of Programme 7 - HEALTH CARE SUPPORT SERVICES
for the year ended 31 March 2014

	2013/14							2012/13	
Programme 7 Per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	201 638	-	-	201 638	199 425	2 213	98.9%	187 534	184 165
Goods and services	139 219	-	(1 450)	137 769	123 049	14 720	89.3%	124 545	128 520
Transfers and subsidies to:									
Households	1 234	-	-	1 234	347	887	28.1%	1 154	1 025
Payment for capital assets									
Buildings and other fixed structures	-	-	-	-	140	(140)	-	-	-
Machinery and equipment	13 447	-	-	13 447	14 726	(1 279)	109.5%	11 417	10 939
Intangible assets	-	-	-	-	14	(14)	-	-	-
Payments for financial assets	-	-	1 450	1 450	1 450	-	100.0%	71	71
Total	**355 538**	**-**	**-**	**355 538**	**339 151**	**16 387**	**95.4%**	**324 721**	**324 720**

Detail of Programme 7 - HEALTH CARE SUPPORT SERVICES for the year ended 31 March 2014

Detail per sub-programme	2013/14							2012/13	
	Adjusted Appropriation	Shifting of Funds	Virement	Final Appropriation	Actual Expenditure	Variance	Expenditure as % of final appropriation	Final Appropriation	Actual expenditure
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
7.1 LAUNDRY SERVICES									
Current payment	72 563	-	-	72 563	68 160	4 403	93.9%	77 264	84 302
Transfers and subsidies	34	-	-	34	81	(47)	238.2%	58	76
Payment for capital assets	1 100	-	-	1 100	1 586	(486)	144.2%	511	511
Payment for financial assets	-	-	32	32	32	-	100.0%	11	11
7.2 ENGINEERING SERVICES									
Current payment	99 247	-	-	99 247	102 579	(3 332)	103.4%	91 087	84 570
Transfers and subsidies	1 087	-	-	1 087	125	962	11.5%	1 000	774
Payment for capital assets	3 066	-	-	3 066	4 647	(1 581)	151.6%	2 442	2 228
Payment for financial assets	-	-	4	4	4	-	100.0%	8	8
7.3 FORENSIC PATHOLOGY SERVICES									
Current payment	106 960	-	-	106 960	107 097	(137)	100.1%	100 701	100 595
Transfers and subsidies	18	-	-	18	57	(39)	316.7%	6	13
Payment for capital assets	7 667	-	-	7 667	7 665	2	100.0%	6 931	6 932
Payment for financial assets	-	-	-	-	-	-	-	52	52
7.4 ORTHOTIC AND PROSTHETIC SERVICES									
Current payment	1	-	-	1	-	1	-	1	-
7.5 CAPE MEDICAL DEPOT									
Current payment	62 086	-	(1 450)	60 636	44 638	15 998	73.6%	43 026	43 218
Transfers and subsidies	95	-	-	95	84	11	88.4%	90	162
Payment for capital assets	1 614	-	-	1 614	982	632	60.8%	1 533	1 268
Payment for financial assets	-	-	1 414	1 414	1 414	-	100.0%	-	-
Total	**355 538**	**-**	**-**	**355 538**	**339 151**	**16 387**	**95.4%**	**324 721**	**324 720**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

Detail of Programme 8 - HEALTH FACILITIES MANAGEMENT
for the year ended 31 March 2014

	2013/14							2012/13	
Programme 8 Per Economic classification	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
Current payments									
Compensation of employees	25 322	-	-	25 322	16 994	8 328	67.1%	13 573	13 051
Goods and services	246 811	-	-	246 811	229 680	17 131	93.1%	195 036	192 118
Transfers and subsidies to:									
Non-profit institutions	26 320	-	180	26 500	26 500	-	100.0%	-	-
Households	24	-	-	24	23	1	95.8%	-	34
Payment for capital assets									
Buildings and other fixed structures	488 615	-	(180)	488 435	398 883	89 552	81.7%	586 322	517 686
Machinery and equipment	165 869	-	-	165 869	205 294	(39 425)	123.8%	102 172	98 977
Intangible assets	5 953	-	-	5 953	478	5 475	8.0%	-	213
Total	**958 914**	**-**	**-**	**958 914**	**877 852**	**81 062**	**91.5%**	**897 103**	**822 079**

Detail of Programme 8 - HEALTH FACILITIES MANAGEMENT for the year ended 31 March 2014

	2013/14							2012/13	
Detail per sub-programme	**Adjusted Appropriation**	**Shifting of Funds**	**Virement**	**Final Appropriation**	**Actual Expenditure**	**Variance**	**Expenditure as % of final appropriation**	**Final Appropriation**	**Actual expenditure**
	R'000	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**%**	**R'000**	**R'000**
8.1 COMMUNITY HEALTH FACILITIES									
Current payment	62 290	-	-	62 290	31 328	30 962	50.3%	23 850	31 227
Payment for capital assets	206 364	-	-	206 364	145 243	61 121	70.4%	75 319	69 310
8.2 EMERGENCY MEDICAL RESCUE SERVICES									
Current payment	3 768	-	-	3 768	642	3 126	17.0%	9 512	1 767
Payment for capital assets	19 502	-	-	19 502	15 839	3 663	81.2%	15 292	16 848
8.3 DISTRICT HOSPITAL SERVICES									
Current payment	65 612	-	-	65 612	63 387	2 225	96.6%	54 034	59 172
Transfers and subsidies	1 000	-	180	1 180	1 180	-	100.0%	-	-
Payment for capital assets	247 480	-	(180)	247 300	226 671	20 629	91.7%	398 911	357 039
8.4 PROVINCIAL HOSPITAL SERVICES									
Current payment	48 941	-	-	48 941	61 719	(12 778)	126.1%	40 606	41 815
Payment for capital assets	73 607	-	-	73 607	82 265	(8 658)	111.8%	86 347	82 065
8.5 CENTRAL HOSPITAL SERVICES									
Current payment	63 681	-	-	63 681	71 074	(7 393)	111.6%	51 295	59 213
Transfers and subsidies	25 320	-	-	25 320	25 320	-	100.0%	-	-
Payment for capital assets	80 068	-	-	80 068	109 531	(29 463)	136.8%	19 393	12 202
8.6 OTHER FACILITIES									
Current payment	27 841	-	-	27 841	18 525	9 316	66.5%	29 312	11 975
Transfers and subsidies	24	-	-	24	23	1	95.8%	-	34
Payment for capital assets	33 416	-	-	33 416	25 105	8 311	75.1%	93 232	79 412
Total	**958 914**	**-**	**-**	**958 914**	**877 852**	**81 062**	**91.5%**	**897 103**	**822 079**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2014

1. Detail of transfers and subsidies as per Appropriation Act (after Virement):

Detail of these transactions can be viewed in the note on Transfers and subsidies, disclosure notes and Annexure 1 (A-E) to the Annual Financial Statements.

2. Detail of specifically and exclusively appropriated amounts voted (after Virement):

Detail of these transactions can be viewed in note 1 (Annual Appropriation) to the Annual Financial Statements.

3. Detail on payments for financial assets

Detail of these transactions per programme can be viewed in the note on Payments for financial assets to the Annual Financial Statements.

4. Explanations of material variances from Amounts Voted (after Virement):

4.1 Per Programme

Per programme	Final Appropriation R'000	Actual Expenditure R'000	Variance R'000	Variance as a % of Final Appropriation %
ADMINISTRATION	521 704	511 447	10 257	2%
The under-spending can be attributed to the late filling of posts.				
DISTRICT HEALTH SERVICES	6 042 255	6 039 262	2 993	0%
The under-spending can mainly be attributed to: • Global Fund: Claims in respect of Transfer payments not received for March 2014 from the City of Cape Town relating to drug and laboratory expenditure. • National Health Insurance Grant: Late approval of the 2013/2014 GP Contracting Business Plan, during October 2013, and the tabling of the Additional Adjusted Estimates in February 2014 left limited time to source, appoint and train General Practitioners (GP).				
EMERGENCY MEDICAL SERVICES	819 748	819 748	-	0%
This programme is in budget after application of virements.				
PROVINCIAL HOSPITAL SERVICES	2 500 139	2 499 888	251	0%
This programme is in budget after application of virements.				
CENTRAL HOSPITAL SERVICES	4 565 421	4 565 421	-	0%
This programme is in budget after application of virements.				

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2014

Per programme	Final Appropriation R'000	Actual Expenditure R'000	Variance R'000	Variance as a % of Final Appropriation %
HEALTH SCIENCES AND TRAINING	266 262	264 193	2 069	1%
The under-spending is mainly within EPWP - Training & Development allocation due to the discontinuation of training for data capturers.				

HEALTH CARE AND SUPPORT SERVICES	355 538	339 151	16 387	5%

The under-spending is mainly within the Cape Medical Depot (CMD) and can be attributed to:

- A lower than expected stock value at year end due to less stock being maintained as a result of improved stock control.
- A new courier contract with considerable lower rates.

HEALTH FACILITIES MANAGEMENT	958 914	877 852	81 062	8%

Health Facility Revitalisation Grant:

In the different components of this Grant, the following projects have been mostly affected:

Hospital Revitalisation Component:

The under-spending was mainly due to:

- Slow progress by Contractor:
  - George Hospital Psychiatric Ward
  - New 72 hour Assessment Unit at Mitchell's Plain District Hospital
  - Mitchell's Plain District Hospital Psychiatric Ward
- Delays in design:
  - Groote Schuur Hospital Linac Phase 2
  - Paarl Hospital Psychiatric ward
- Delays due to resolution of contractual issues, slow progress on site:
  - Vredenburg Hospital Phase 2B
- Internal resource constraints:
  - Additional resources were appointed in Quarter 4 (slow recruitment process)
- Civil unrest and construction industry strike:
  - Karl Bremer Hospital New Emergency Centre
- Completion date delayed:
  - Temporary new Emergency Centre at Heideveld Community Day Centre
- Delays in planning:
  - Hybrid theatre at Groote Schuur Hospital,
  - Renovations to existing buildings at Valkenberg Hospital
  - New Psychiatric Unit at Paarl Hospital
- Delays in the appointment of the Transaction Advisors:
  - Tygerberg Hospital Redevelopment

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2014

Per programme	Final Appropriation R'000	Actual Expenditure R'000	Variance R'000	Variance as a % of Final Appropriation %
Health Infrastructure Component: The under-spending was mainly due to: • Delays in design: - Wolseley Clinic - Napier Clinic - Prince Alfred Hamlet Clinic • Civil unrest and construction industry strike: - Delft Symphony Community Health Centre - New Du Noon Community Day Centre **Nursing Colleges & Schools Component:** The under-spending was mainly due to: • Delays in design: - Worcester Nursing College: Nurses Accommodation				

4.2 Per Economic Classification

Per economic classification	Final Appropriation R'000	Actual Expenditure R'000	Variance R'000	Variance as a % of Final Appropriation %
Current payments				
Compensation of employees	9 288 633	9 237 938	50 695	1%
Goods and services	4 912 102	4 955 604	(43 502)	-1%
Transfers and subsidies				
Provinces and municipalities	359 275	354 525	4 750	1%
Departmental agencies and accounts	4 324	4 324	-	0%
Higher education institutions	3 580	3 480	100	3%
Non-profit institutions	416 570	408 767	7 803	2%
Households	108 993	110 283	(1 290)	-1%
Gifts and donations	149	149	-	0%
Payments for capital assets				
Buildings and other fixed structures	504 975	415 566	89 409	18%
Machinery and equipment	417 323	420 399	(3 076)	-1%
Intangible assets	9 732	1 602	8 130	84%
Payments for financial assets	4 325	4 325	-	0%

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2014

4.3 Per Conditional Grant

Per conditional grant	Final Appropriation R'000	Actual Expenditure R'000	Variance R'000	Variance as a % of Final Appropriation %
Health				
National Tertiary Services Grant	2 400 714	2 400 714	-	0%
Health Professions Training and Development Grant	451 667	451 667	-	0%
Comprehensive HIV and Aids Grant	927 547	927 547	-	0%
National Health Insurance Grant	7 303	5 365	1 938	27%
Health Facility Revitalisation Grant: *(Of which the following components)*				
Hospital Revitalisation Component	553 714	517 814	35 900	6%
Health Infrastructure Component	127 271	92 131	35 140	28%
Nursing Colleges & Schools Component	13 964	3 942	10 022	72%
Public Works				
Expanded Public Works Programme Integrated Grant for Provinces	3 000	3 000	-	0%

The under-spending can mainly be attributed to the following:

National Health Insurance Grant:

The under-spending was due to the late approval of the 2013/2014 GP Contracting Business Plan, during October 2013, and the tabling of the Additional Adjusted Estimates in February 2014 left limited time to source, appoint and train General Practitioners (GP).

Health Facility Revitalisation Grant:

In the different components of this Grant, the following projects have been mostly affected:

Hospital Revitalisation Component:

The under-spending was mainly due to:

- Slow progress by Contractor:
  - George Hospital Psychiatric Ward
  - New 72 hour Assessment Unit at Mitchell's Plain District Hospital
  - Mitchell's Plain District Hospital Psychiatric Ward
- Delays in design:
  - Groote Schuur Hospital Linac Phase 2
  - Paarl Hospital Psychiatric ward

WESTERN CAPE GOVERNMENT HEALTH
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NOTES TO THE APPROPRIATION STATEMENT
for the year ended 31 March 2014

Per conditional grant	Final Appropriation R'000	Actual Expenditure R'000	Variance R'000	Variance as a % of Final Appropriation %
• Delays due to resolution of contractual issues, slow progress on site: - Vredenburg Hospital Phase 2B • Internal resource constraints: - Additional resources were appointed in Quarter 4 (slow recruitment process) • Civil unrest and construction industry strike: - Karl Bremer Hospital New Emergency Centre • Completion date delayed: - Temporary new Emergency Centre at Heideveld Community Day Centre • Delays in planning: - Hybrid theatre at Groote Schuur Hospital, - Renovations to existing buildings at Valkenberg Hospital - New Psychiatric Unit at Paarl Hospital • Delays in the appointment of the Transaction Advisors: - Tygerberg Hospital Redevelopment **Health Infrastructure Component:** The under-spending was mainly due to: • Delays in design: - Wolseley Clinic - Napier Clinic - Prince Alfred Hamlet Clinic • Civil unrest and construction industry strike: - Delft Symphony Community Health Centre - New Du Noon Community Day Centre **Nursing Colleges & Schools Component:** The under-spending was mainly due to: • Delays in design: - Worcester Nursing College: Nurses Accommodation				

WESTERN CAPE GOVERNMENT HEALTH
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STATEMENT OF FINANCIAL PERFORMANCE
for the year ended 31 March 2014

	Note	2013/14 R'000	2012/13 R'000
REVENUE			
Annual appropriation	1	16 029 981	14 743 832
Departmental revenue	2	110 785	117 657
Aid assistance	3	4 250	7 317
TOTAL REVENUE		**16 145 016**	**14 868 806**
EXPENDITURE			
Current expenditure			
Compensation of employees	4	9 237 938	8 456 868
Goods and services	5	4 955 604	4 479 676
Total current expenditure		**14 193 542**	**12 936 544**
Transfers and subsidies			
Transfers and subsidies	7	881 528	783 982
Total transfers and subsidies		**881 528**	**783 982**
Expenditure for capital assets			
Tangible assets	8	835 965	881 938
Intangible assets	8	1 602	1 040
Total expenditure for capital assets		**837 567**	**882 978**
Payments for financial assets	6	**4 325**	**4 670**
TOTAL EXPENDITURE		**15 916 962**	**14 608 174**
SURPLUS FOR THE YEAR		**228 054**	**260 632**
Reconciliation of Net Surplus for the year			
Voted funds		**113 019**	**142 975**
Annual appropriation		30 019	75 768
Conditional grants		83 000	67 207
Departmental revenue and NRF Receipts	14	110 785	117 657
Aid assistance	3	4 250	-
SURPLUS FOR THE YEAR		**228 054**	**260 632**

WESTERN CAPE GOVERNMENT HEALTH
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STATEMENT OF FINANCIAL POSITION
as at 31 March 2014

	Note	2013/14 R'000	2012/13 R'000
ASSETS			
Current assets		**329 106**	**421 442**
Unauthorised expenditure	9	-	53 742
Cash and cash equivalents	10	257 464	292 079
Prepayments and advances	11	1 094	1 839
Receivables	12	70 548	73 782
TOTAL ASSETS		**329 106**	**421 442**
LIABILITIES			
Current liabilities		**304 282**	**398 808**
Voted funds to be surrendered to the Revenue Fund	13	113 019	142 975
Departmental revenue and NRF Receipts to be surrendered to the Revenue Fund	14	10 964	11 468
Bank overdraft	15	102 087	82 562
Payables	16	73 962	161 803
Aid assistance unutilised	3	4 250	-
TOTAL LIABILITIES		**304 282**	**398 808**
NET ASSETS		**24 824**	**22 634**
Represented by:			
Recoverable revenue		24 824	22 634
TOTAL		**24 824**	**22 634**

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

STATEMENT OF CHANGES IN NET ASSETS
for the year ended 31 March 2014

	Note	2013/14 R'000	2012/13 R'000
Recoverable revenue			
Opening balance		22 634	17 322
Transfers:		**2 190**	**5 312**
Irrecoverable amounts written off		(1 190)	(2 825)
Debts revised		(193)	(8 538)
Debts recovered (included in departmental receipts)		(526)	1 681
Debts raised		4 099	14 994
Closing balance		**24 824**	**22 634**
TOTAL		**24 824**	**22 634**

WESTERN CAPE GOVERNMENT HEALTH
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CASH FLOW STATEMENT
for the year ended 31 March 2014

	Note	2013/14 R'000	2012/13 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts		**16 631 989**	**15 359 434**
Annual appropriated funds received	1.1	16 029 981	14 743 832
Departmental revenue received	2	596 342	606 880
Interest received	2.3	1 416	1 405
Aid assistance received	3	4 250	7 317
Net (increase)/decrease in working capital		(30 120)	37 961
Surrendered to Revenue Fund		(741 237)	(667 530)
Current payments		(14 193 542)	(12 936 544)
Payments for financial assets		(4 325)	(4 670)
Transfers and subsidies paid		(881 528)	(783 982)
Net cash flow available from operating activities	17	**781 237**	**1 004 669**
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for capital assets	8	(837 567)	(882 978)
Proceeds from sale of capital assets	2.4	-	119
Net cash flows from investing activities		**(837 567)**	**(882 859)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Increase in net assets		2 190	5 312
Net cash flows from financing activities		**2 190**	**5 312**
Net (decrease)/increase in cash and cash equivalents		(54 140)	127 122
Cash and cash equivalents at beginning of period		209 517	82 395
Cash and cash equivalents at end of period	18	**155 377**	**209 517**

WESTERN CAPE GOVERNMENT HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2014

Summary of significant accounting policies

The financial statements have been prepared in accordance with the following policies, which have been applied consistently in all material aspects, unless otherwise indicated.

The historical cost convention has been used, except where otherwise indicated. Management has used assessments and estimates in preparing the annual financial statements. These are based on the best information available at the time of preparation.

Where appropriate and meaningful, additional information has been disclosed to enhance the usefulness of the financial statements and to comply with the statutory requirements of the Public Finance Management Act (PFMA), Act 1 of 1999 (as amended by Act 29 of 1999), and the Treasury Regulations issued in terms of the PFMA and the annual Division of Revenue Act, Act 2 of 2013.

1 Basis of preparation

The financial statements have been prepared in accordance with the Modified Cash Standard.

2 Going concern

The financial statements have been prepared on a going concern basis.

3 Presentation currency

Amounts have been presented in the currency of the South African Rand (R) which is also the functional currency of the department.

4 Rounding

Unless otherwise stated financial figures have been rounded to the nearest one thousand Rand (R'000).

5 Foreign currency translation

Cash flows arising from foreign currency transactions are translated into South African Rands using the exchange rates prevailing at the date of payment / receipt.

6 Current year comparison with budget

A comparison between the approved, final budget and actual amounts for each programme and economic classification is included in the appropriation statement.

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

ACCOUNTING POLICIES
for the year ended 31 March 2014

7 Revenue

7.1 Appropriated funds

Appropriated funds comprises of departmental allocations as well as direct charges against the revenue fund (i.e. statutory appropriation).

Appropriated funds are recognised in the statement of financial performance on the date the appropriation becomes effective. Adjustments made in terms of the adjustments budget process are recognised in the statement of financial performance on the date the adjustments become effective.

The net amount of any appropriated funds due to / from the relevant revenue fund at the reporting date is recognised as a payable / receivable in the statement of financial position.

7.2 Departmental revenue

Departmental revenue is recognised in the statement of financial performance when received and is subsequently paid into the relevant revenue fund, unless stated otherwise.

Any amount owing to the relevant revenue fund at the reporting date is recognised as a payable in the statement of financial position.

7.3 Accrued departmental revenue

Accruals in respect of departmental revenue (excluding tax revenue) are recorded in the notes to the financial statements when:

- it is probable that the economic benefits or service potential associated with the transaction will flow to the department; and
- the amount of revenue can be measured reliably.

The accrued revenue is measured at the fair value of the consideration receivable.

Accrued tax revenue (and related interest and / penalties) is measured at amounts receivable from collecting agents.

8 Expenditure

8.1 Compensation of employees

8.1.1 Salaries and wages

Salaries and wages are recognised in the statement of financial performance on the date of payment.

WESTERN CAPE GOVERNMENT HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2014

8.1.2 Social contributions

Social contributions made by the department in respect of current employees are recognised in the statement of financial performance on the date of payment.

Social contributions made by the department in respect of ex-employees are classified as transfers to households in the statement of financial performance on the date of payment.

8.2 Other expenditure

Other expenditure (such as goods and services, transfers and subsidies and payments for capital assets) is recognised in the statement of financial performance on the date of payment. The expense is classified as a capital expense if the total consideration paid is more than the capitalisation threshold.

8.3 Accrued expenditure payable

Accrued expenditure payable is recorded in the notes to the financial statements when the goods are received or, in the case of services, when they are rendered to the department.

Accrued expenditure payable is measured at cost.

8.4 Leases

8.4.1 Operating leases

Operating lease payments made during the reporting period are recognised as current expenditure in the statement of financial performance on the date of payment.

The operating lease commitments are recorded in the notes to the financial statements.

8.4.2 Finance leases

Finance lease payments made during the reporting period are recognised as capital expenditure in the statement of financial performance on the date of payment.

The finance lease commitments are recorded in the notes to the financial statements and are not apportioned between the capital and interest portions.

Finance lease assets acquired at the end of the lease term are recorded and measured at the lower of:

- cost, being the fair value of the asset; or
- the sum of the minimum lease payments made, including any payments made to acquire ownership at the end of the lease term, excluding interest.

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ACCOUNTING POLICIES
for the year ended 31 March 2014

9 Aid Assistance

9.1 Aid assistance received

Aid assistance received in cash is recognised in the statement of financial performance when received. In-kind aid assistance is recorded in the notes to the financial statements on the date of receipt and is measured at fair value.

Aid assistance not spent for the intended purpose and any unutilised funds from aid assistance that are required to be refunded to the donor are recognised as a payable in the statement of financial position.

9.2 Aid assistance paid

Aid assistance paid is recognised in the statement of financial performance on the date of payment. Aid assistance payments made prior to the receipt of funds are recognised as a receivable in the statement of financial position.

10 Cash and cash equivalents

Cash and cash equivalents are stated at cost in the statement of financial position.

Bank overdrafts are shown separately on the face of the statement of financial position.

For the purposes of the cash flow statement, cash and cash equivalents comprise cash on hand, deposits held, other short-term highly liquid investments and bank overdrafts.

11 Prepayments and advances

Prepayments and advances are recognised in the statement of financial position when the department receives or disburses the cash.

Prepayments and advances are initially and subsequently measured at cost and are expensed once the subsistence and travel claim is processed.

12 Loans and receivables

Loans and receivables are recognised in the statement of financial position at cost plus accrued interest, where interest is charged, less amounts already settled or written-off.

13 Investments

Investments are recognised in the statement of financial position at cost.

WESTERN CAPE GOVERNMENT HEALTH
VOTE 6

ACCOUNTING POLICIES
for the year ended 31 March 2014

14 Impairment of financial assets

Where there is an indication of impairment of a financial asset, an estimation of the reduction in the recorded carrying value, to reflect the best estimate of the amount of the future economic benefits expected to be received from that asset, is recorded in the notes to the financial statements.

15 Payables

Loans and receivables are recognised in the statement of financial position at cost.

16 Capital Assets

16.1 Immovable capital assets

Immovable capital assets are initially recorded in the notes to the financial statements at cost. Immovable capital assets acquired through a non-exchange transaction is measured at fair value as at the date of acquisition.

Where the cost of immovable capital assets cannot be determined accurately, the immovable capital assets are measured at R1 unless the fair value of the asset has been reliably estimated, in which case the fair value is used.

All assets acquired prior to 1 April 2002 (or a later date as approved by the OAG) are recorded at R1.

Immovable capital assets are subsequently carried at cost and are not subject to depreciation or impairment.

Subsequent expenditure that is of a capital nature is added to the cost of the asset at the end of the capital project unless the immovable asset is recorded by another department in which case the completed project costs are transferred to that department.

16.2 Movable capital assets

Movable capital assets are initially recorded in the notes to the financial statements at cost. Movable capital assets acquired through a non-exchange transaction is measured at fair value as at the date of acquisition.

Where the cost of movable capital assets cannot be determined accurately, the movable capital assets are measured at fair value and where fair value cannot be determined; the movable assets are measured at R1.

All assets acquired prior to 1 April 2002 (or a later date as approved by the OAG) are recorded at R1.

WESTERN CAPE GOVERNMENT HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2014

Movable capital assets are subsequently carried at cost and are not subject to depreciation or impairment.

Subsequent expenditure that is of a capital nature is added to the cost of the asset at the end of the capital project unless the movable asset is recorded by another department/entity in which case the completed project costs are transferred to that department.

16.3 Intangible assets

Intangible assets are initially recorded in the notes to the financial statements at cost. Intangible assets acquired through a non-exchange transaction are measured at fair value as at the date of acquisition.

Internally generated intangible assets are recorded in the notes to the financial statements when the department commences the development phase of the project.

Where the cost of intangible assets cannot be determined accurately, the intangible capital assets are measured at fair value and where fair value cannot be determined; the intangible assets are measured at R1.

All assets acquired prior to 1 April 2002 (or a later date as approved by the OAG) are recorded at R1.

Intangible assets are subsequently carried at cost and are not subject to depreciation or impairment.

Subsequent expenditure that is of a capital nature is added to the cost of the asset at the end of the capital project unless the intangible asset is recorded by another department/entity in which case the completed project costs are transferred to that department.

17 Provisions and Contingents

17.1 Provisions

Provisions are recorded in the notes to the financial statements when there is a present legal or constructive obligation to forfeit economic benefits as a result of events in the past and it is probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation and a reliable estimate of the obligation can be made. The provision is measured as the best estimate of the funds required to settle the present obligation at the reporting date.

WESTERN CAPE GOVERNMENT HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2014

17.2 Contingent liabilities

Contingent liabilities are recorded in the notes to the financial statements when there is a possible obligation that arises from past events, and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not within the control of the department or when there is a present obligation that is not recognised because it is not probable that an outflow of resources will be required to settle the obligation or the amount of the obligation cannot be measured reliably

17.3 Contingent assets

Contingent assets are recorded in the notes to the financial statements when a possible asset arises from past events, and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not within the control of the department.

17.4 Commitments

Commitments are recorded at cost in the notes to the financial statements when there is a contractual arrangement or an approval by management in a manner that raises a valid expectation that the department will discharge its responsibilities thereby incurring future expenditure that will result in the outflow of cash.

18 Unauthorised expenditure

Unauthorised expenditure is recognised in the statement of financial position until such time as the expenditure is either:

- approved by Parliament or the Provincial Legislature with funding and the related funds are received; or
- approved by Parliament or the Provincial Legislature without funding and is written off against the appropriation in the statement of financial performance; or
- transferred to receivables for recovery.

Unauthorised expenditure is measured at the amount of the confirmed unauthorised expenditure.

19 Fruitless and wasteful expenditure

Fruitless and wasteful expenditure is recorded in the notes to the financial statements when confirmed. The amount recorded is equal to the total value of the fruitless and/ or wasteful expenditure incurred.

Fruitless and wasteful expenditure is removed from the notes to the financial statements when it is resolved or transferred to receivables for recovery.

WESTERN CAPE GOVERNMENT HEALTH
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ACCOUNTING POLICIES
for the year ended 31 March 2014

Fruitless and wasteful expenditure receivables are measured at the amount that is expected to be recoverable and are de-recognised when settled or subsequently written-off as irrecoverable.

20 Irregular expenditure

Irregular expenditure is recorded in the notes to the financial statements when confirmed. The amount recorded is equal to the total value of the irregularity unless it is impracticable to determine, in which case reasons therefor are provided in the note.

Irregular expenditure is removed from the note when it is either condoned by the relevant authority or transferred to receivables for recovery.

Irregular expenditure receivables are measured at the amount that is expected to be recoverable and are de-recognised when settled or subsequently declared as irrecoverable in the disclosure notes to the annual financial statements.

WESTERN CAPE GOVERNMENT HEALTH
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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2014

1. Appropriation

1.1 Annual Appropriation

	2013/14		2012/13
	Final Appropriation R'000	Actual Funds Received R'000	Appropriation received R'000
Administration	521 704	521 704	445 509
District Health Services	6 042 255	6 042 255	5 555 429
Emergency Medical Services	819 748	819 748	695 727
Provincial Hospital Services	2 500 139	2 500 139	2 300 245
Central Hospital Services	4 565 421	4 565 421	4 248 545
Health Sciences And Training	266 262	266 262	276 553
Health Care Support Services	355 538	355 538	324 721
Health Facilities Management	958 914	958 914	897 103
Total	**16 029 981**	**16 029 981**	**14 743 832**

1.2 Conditional grants

	Note	2013/14 R'000	2012/13 R'000
Total grants received	36	4 485 180	4 013 603
Provincial grants included in Total Grants received		**4 485 180**	**4 013 603**

2. Departmental revenue

	Note		
Sales of goods and services other than capital assets	2.1	419 475	426 218
Fines, penalties and forfeits	2.2	-	1
Interest on debtor accounts (Interest, dividends and rent on land)	2.3	1 416	1 405
Sales of capital assets	2.4	-	119
Transactions in financial assets and liabilities	2.5	18 028	19 101
Transfer received	2.6	158 839	161 560
Total revenue collected		**597 758**	**608 404**
Less: Own revenue included in appropriation	14	486 973	490 747
Departmental revenue collected		**110 785**	**117 657**

WESTERN CAPE GOVERNMENT HEALTH
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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2014

2.1 Sales of goods and services other than capital assets

	Note 2	2013/14 R'000	2012/13 R'000
Sales of goods and services produced by the department		**418 813**	**425 345**
Sales by market establishment (Rental/parking fees)		3 147	6 247
Administrative fees (Commission on insurance)		5 407	5 085
Other sales*		410 259	414 013
Sales of scrap, waste and other used current goods		662	873
Total		**419 475**	**426 218**

*The major contributor to this revenue item is:	
Patient fees	R379 million
Services Rendered, (Boarding fees at Hospital)	R 10 million

2.2 Fines, penalties and forfeits

	Note 2		
Fines (Cashier)		-	1
Total		**-**	**1**

2.3 Interest on debtor accounts

	Note 2		
Interest		1 416	1 405
Total		**1 416**	**1 405**

2.4 Sale of capital assets

	Note 2		
Tangible assets		-	**119**
Machinery and equipment	32.2	-	119
Total		**-**	**119**

2.5 Transactions in financial assets and liabilities

	Note 2		
Receivables		14 946	17 947
Other Receipts including Recoverable Revenue		3 082	1 154
Total		**18 028**	**19 101**

WESTERN CAPE GOVERNMENT HEALTH
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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2014

2.6 Transfers received

	Note 2	2013/14 R'000	2012/13 R'000
Universities and technikons (Joint staff)		22 313	21 583
International organisations (Global Fund)		135 754	133 978
Public corporations and private enterprises*		772	5 999
Total		**158 839**	**161 560**

* Local Donations significantly reduced in this reporting period due to a once off donation received from the City of Cape Town in the previous financial year towards the additional costs for the construction of an entrance at AZ Berman Drive for access to the new Mitchells Plain District Hospital.

3. Aid assistance

3.1 Total Assistance

Aid assistance unutilised*	4 250	-
Other sources	4 250	-
Closing balance	**4 250**	**-**

* The Department received funding from the European Union (EU) Donor Fund for the Workload Indicators Staffing Need (WISN) project. No expenditure has been incurred by the end of the 2013/14 financial year as the Department was in the process of advertising 8 posts and procuring vehicles.

3.2 Aid assistance received in cash from other sources

Foreign

Opening Balance	**-**	**-**
Revenue	4 250	7 317
Expenditure*	**-**	**(7 317)**
Capital	-	(7 317)
Closing Balance	**4 250**	**-**

*The French donor fund was fully utilized by 31 March 2013. No additional funds were received from this fund during the current financial year, as the project was completed.

WESTERN CAPE GOVERNMENT HEALTH
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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2014

4 Compensation of employees

4.1 Salaries and Wages

	2013/14 R'000	2012/13 R'000
Basic salary	6 096 761	5 554 342
Performance award*	46 970	80 988
Service Based	15 118	13 391
Compensative/circumstantial (mainly overtime)**	829 331	733 043
Periodic payments	18 108	11 499
Other non-pensionable allowances***	1 202 410	1 115 923
Total	**8 208 698**	**7 509 186**

*Due to budget constraints the Department took a decision to reduce the % paid for incentive bonuses.

** The comparative figure has been increased with R20 million due to the reclassification of internship stipends from Good & Services to Compensation of employees.

***The major contributor to this expenditure item is:

Housing Allowance:	R239 million
Non Pensionable other (30% in lieu):	R560 million
Service Bonus:	R401 million

4.2 Social contributions

Employer contributions		
Pension	690 076	621 663
Medical	337 994	325 041
Bargaining council	1104	902
Official unions and associations	-	2
Insurance	66	74
Total	**1 029 240**	**947 682**
Total compensation of employees*	**9 237 938**	**8 456 868**
Average number of employees	**30 570**	**30 172**

*Employee cost increased mainly due to:

- Annual cost of living adjustments
- Full commissioning of Mitchells Plain Hospital
- Danger allowance back payments to relevant Emergency Medical Practitioners
- Clinical and nursing service pressures as well as staff shortages within critical areas.

WESTERN CAPE GOVERNMENT HEALTH
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NOTES TO THE ANNUAL FINANCIAL STATEMENTS
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In terms of National Treasury Classification Circular 1, Departments were informed that learnership/ internship cost shall be reported as part of compensation of employees with effect from 1 April 2013. An amount of R 20,179m has therefore been reclassified from Goods & Services - Other operating expenditure (Note 5 & 5.8) to Compensation of Employees - Compensative/ Circumstantial (Note 5) for the 2012/13 financial year.

5 Goods and services

	Note	2013/14 R'000	2012/13 R'000
Administrative fees		957	1 042
Advertising*		32 340	21 537
Minor Assets	5.1	49 105	49 903
Bursaries (employees)		7 279	7 120
Catering		6 341	6 602
Communication		68 836	72 061
Computer services	5.2	81 228	85 873
Consultants, contractors and agency/outsourced services	5.3	1 339 611	1 155 687
Entertainment		223	427
Audit cost – external	5.4	23 660	27 560
Inventory	5.5	2 354 583	2 170 176
Operating leases		20 453	18 469
Property payments	5.6	709 619	621 654
Rental and hiring**		16 732	772
Transport provided as part of the departmental activities		2 340	1 900
Travel and subsistence	5.7	187 977	171 951
Venues and facilities		2 909	3 120
Training and development		34 780	46 209
Other operating expenditure	5.8	16 631	17 613
Total		**4 955 604**	**4 479 676**

* The accrual of R7.1 million, disclosed in 2012/13 financial year was paid in April 2013. To improve the turnaround time in the filling of vacant posts, wider media coverage initiatives were implemented to attract and increase the candidate pool.
** The increase in cost was mainly due to a once-off payment in respect of outstanding utilities at Rocherster House paid to the University of Cape Town.

5.1 Minor Assets

	Note		
Tangible assets	5	**49 083**	**49 871**
Buildings and other fixed structures		-	19
Machinery and equipment		49 083	49 852
Intangible assets		**22**	**32**
Total		**49 105**	**49 903**

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5.2 Computer services

	Note 5	2013/14 R'000	2012/13 R'000
SITA computer services		18 577	24 436
External computer service providers		62 651	61 437
Total		**81 228**	**85 873**

5.3 Consultants, contractors and agency/outsourced services

	Note 5		
Business and advisory services		78 319	72 751
Infrastructure and planning		8 788	13 543
Laboratory services*		528 839	474 973
Legal costs		6 613	5 221
Contractors**		314 024	204 751
Agency and support/outsourced services***		403 028	384 448
Total		**1 339 611**	**1 155 687**

*National Health Laboratory Services (NHLS) increased due to the rollout of GeneXpert laboratory tests in respect of TB.
**Implementation of the new Emergency Medical Services (EMS) Paging System and Computer Aided Dispatch system, as well as the rollout of Picture Archiving and Communication System (PACS) / Radiology Information System (RIS) to additional facilities within the Department.
*** Increase in Agency and support/outsourced services mainly due to:

- price Increase in respect of disposal of Medical Waste;
- increase in catering services in respect of full commissioning of Mitchells Plain Hospital;
- provision of outsourced meals to students at certain rural campuses;
- supplement nursing shortages due to long term illnesses or special leave, and
- the commissioning of new services and facilities.

5.4 Audit cost – External

	Note 5		
Regularity audits*		16 600	24 903
Performance audits		402	780
Investigations **		6 658	1 877
Total		**23 660**	**27 560**

*Reduction in cost due to timing of receipt of invoices during March of the respective years.
**Increase due to the Accounting Officer providing additional funding to address the accumulating backlogs at the Forensic Investigations Unit (FIU).

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5.5 Inventory

	Note 5	2013/14 R'000	2012/13 R'000
Food and food supplies*		123 088	108 237
Fuel, oil and gas**		53 232	41 824
Other consumables		152 762	161 361
Materials and supplies		40 810	40 783
Stationery and printing		68 109	66 484
Medical supplies***		1 026 400	911 550
Medicine		890 182	839 937
Total		**2 354 583**	**2 170 176**

*Increase due to a combination of food inflation and increase in patient workload.
**Increase due to fuel inflation and increase in bulk gas tariff price.
*** Increased services pressures, specifically in emergency medicine and trauma services has increased medical supply usage. This has further been exacerbated by adverse exchange rates which has fuelled price inflation in respect of medical and surgical supplies as well as blood.

5.6 Property payments

	Note 5		
Municipal services*		223 069	201 686
Property management fees**		248 079	198 832
Property maintenance and repairs		238 471	221 136
Total		**709 619**	**621 654**

*Increase mainly due to above inflation utility tariff increases as well as backdated tariff factor adjustments.
**Increase mainly due to the regulatory security wage adjustments the majority of facilities experienced above inflation security cost increases.

5.7 Travel and subsistence

	Note 5		
Local*		187 471	171 101
Foreign		506	850
Total		**187 977**	**171 951**

*Increase mainly due to backdated payments to GMT as well as additional general hired vehicles for the African Cup of Nations (CHAN).

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5.8 Other operating expenditure

	Note 5	2013/14 R'000	2012/13 R'000
Professional bodies, membership and subscription fees		753	482
Resettlement costs		3 700	3 991
Other		12 178	13 140
Total		**16 631**	**17 613**

6 Payments for financial assets

	Note		
Material losses through criminal conduct		**62**	**27**
Theft	6.3	62	27
Other material losses written off	6.1	3 158	1 165
Debts written off	6.2	1 105	3 478
Total		**4 325**	**4 670**

6.1 Other material losses written off

	Note 6		
Nature of losses			
Government vehicle damages and losses*		1 259	1 165
Redundant stock (CMD & HIV Aids)**		1 899	-
Total		**3 158**	**1 165**

*This amount represents write- offs after a thorough investigation to determine whether an official could be held responsible for the loss.
**Redundant stock due to technological advancements.

6.2 Debts written off

	Note 6		
Nature of debts written off			
Salary overpayments		903	1 970
Tax		102	203
Accommodation		2	36
Services rendered		2	759
Other		96	510
Total		**1 105**	**3 478**

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6.3 Details of theft

	Note 6	2013/14 R'000	2012/13 R'000
Nature of theft			
GG Vehicles Accessories		60	14
Other		-	13
Patient Fees		2	-
Total		**62**	**27**

7 Transfers and subsidies

Provinces and municipalities	*Annex 1A*	354 525	322 613
Departmental agencies and accounts	*Annex 1B*	4 324	3 655
Higher education institutions	*Annex 1C*	3 480	1 194
Non-profit institutions	*Annex 1D*	408 767	348 080
Households	*Annex 1E*	110 283	108 440
Gifts, donations and sponsorships made	*Annex 1H*	149	-
Total		**881 528**	**783 982**

8 Expenditure for capital assets

Tangible assets	**835 965**	**881 938**
Buildings and other fixed structures	415 566	529 884
Machinery and equipment	420 399	352 054
Intangible assets	**1 602**	**1 040**
Software	1 602	1 040
Total	**837 567**	**882 978**

During the 2013/14 financial year the Department paid an amount of R2.3 million (Included in machinery and equipment above) to procure motor vehicles. These vehicles was not received in the current financial year therefore represents a prepayment.

8.1 Analysis of funds utilised to acquire capital assets – 2013/14

	Voted funds	Total
Tangible assets	**835 965**	**835 965**
Buildings and other fixed structures	415 566	415 566
Machinery and equipment	420 399	420 399
Intangible assets	**1 602**	**1 602**
Software	1 602	1 602
Total	**837 567**	**837 567**

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8.2 Analysis of funds utilised to acquire capital assets – 2012/13

	Voted funds R'000	Aid assistance R'000	Total R'000
Tangible assets	**874 621**	**7 317**	**881 938**
Buildings and other fixed structures	522 567	7 317	529 884
Machinery and equipment	352 054	-	352 054
Intangible assets	**1 040**	**-**	**1 040**
Software	1 040	-	1 040
Total	**875 661**	**7 317**	**882 978**

8.3 Finance lease expenditure included in Expenditure for capital assets

	2013/14 R'000
Tangible assets	**100 162**
Machinery and equipment	100 162
Total	**100 162**

9 Unauthorised expenditure

9.1 Reconciliation of unauthorised expenditure

	2013/14 R'000	2012/13 R'000
Opening balance	53 742	53 742
Less: Amounts approved by Parliament/Legislature with funding*	(53 742)	-
Unauthorised expenditure awaiting authorisation	**-**	**53 742**

*Unauthorised expenditure incurred in 2011/12 was approved with funding during November 2013

9.2 Analysis of unauthorised expenditure awaiting authorisation per economic classification

Current	-	53 742
Total	**-**	**53 742**

9.3 Analysis of unauthorised expenditure awaiting authorisation per type

Unauthorised expenditure relating to overspending of the vote or a main division within the vote	-	53 742
Total	**-**	**53 742**

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10 Cash and cash equivalents

	2013/14 R'000	2012/13 R'000
Cash on hand	-	26
Investments (Domestic)	257 464	292 053
Total	**257 464**	**292 079**

11 Prepayments and advances

	Note		
Travel and subsistence		334	158
Advances paid	*11.1*	760	1 681
Total		**1 094**	**1 839**

11.1 Advances paid

Non-Profit Organizations	*Annex 6A*	**760**	**1 681**
Total		**760**	**1 681**

12 Receivables

		2013/14				2012/13
	Note	R'000 Less than one year	R'000 One to three years	R'000 Older than three years	R'000 Total	R'000 Total
Claims recoverable	*12.1*	15 909	1 631	-	17 540	13 056
Staff debt	*12.2*	14 069	9 148	13 005	36 222	35 078
Other debtors	*12.3*	12 272	4 150	364	16 786	25 648
Total		**42 250**	**14 929**	**13 369**	**70 548**	**73 782**

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12.1 Claims recoverable

	Note 12	2013/14 R'000	2012/13 R'000
National departments		2 187	2 619
Provincial departments		2 212	2 310
Public entities*		5 792	1 608
Local governments **		7 349	6 519
Total	*Annex 3*	**17 540**	**13 056**

*Outstanding claims not yet refunded by SARS relating to VAT claimed back from the Global Fund. **This balance relates to stock issued by CMD to local entities and entities outside of the Western Cape (e.g. City of Cape Town, Department of Correctional Services).

12.2 Staff debt

	Note 12		
Salary Reversal Control		799	50
Sal: Deductions Disall Account: CA		22	2
Sal: Tax Debt: CA		316	128
Debt Account: CA		35 077	34 898
Sal: Medical Aid		4	-
Sal: Pension Fund		4	-
Total		**36 222**	**35 078**

12.3 Other debtors

	Note 12		
Disallowance Miscellaneous		6 298	9 236
Disallowance damage and losses		132	178
Damage vehicles: CA		1 606	807
Medsas claims recoverable*		-	12 467
Supplier Debtors**		5 819	-
Advances: Public Entities		2 931	2 960
Total		**16 786**	**25 648**

*The trading account of CMD was incorporated in the Department's vote, resulting in this balance that cleared in the current reporting period.
**This balance relates to claims by CMD to suppliers who defaulted on contracts.

12.4 Impairment of Receivables

Estimate of impairment of receivables	529	576
Total	**529**	**576**

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13 Voted funds to be surrendered to the Revenue Fund

	2013/14 R'000	2012/13 R'000
Opening balance	142 975	41 147
Transfer from statement of financial performance	113 019	142 975
Paid during the year	(142 975)	(41 147)
Closing balance	**113 019**	**142 975**

14 Departmental revenue to be surrendered to the Revenue Fund

Opening balance	11 468	29 447
Transfer from Statement of Financial Performance	110 785	117 657
Own revenue included in appropriation	486 973	490 747
Paid during the year	(598 262)	(626 383)
Closing balance	**10 964**	**11 468**

15 Bank Overdraft

Consolidated Paymaster General Account *	102 087	82 562
Total	**102 087**	**82 562**

*This balance relates to payments reflecting in the income statement. However, the cash flow occurred in April 2014.

16 Payables – current

	Note		
Advances received	*16.1*	73 168	105 789
Clearing accounts	*16.2*	794	56 014
Total		**73 962**	**161 803**

16.1 Advances received

	Note 16		
Other institutions	*Annex 6B*	73 168	105 789
Total		**73 168**	**105 789**

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16.2 Clearing accounts

	Note 16	2013/14 R'000	2012/13 R'000
Patient Fee Deposits		321	905
Sal: Pension fund		409	436
Sal: Income tax		63	129
Sal: Bargaining councils		1	1
Unauthorised expenditure 2011/2012		-	53 742
Housing loan guarantee		-	61
Agency services		-	740
Total		**794**	**56 014**

17 Net cash flow available from operating activities

Net surplus as per Statement of Financial Performance	228 054	260 632
Add back non cash/cash movements not deemed operating activities	553 183	744 037
Decrease/(Increase) in receivables – current	3 234	(20 891)
Decrease/(Increase) in prepayments and advances	745	(835)
Decrease in other current assets	53 742	-
(Decrease)/Increase in payables – current	(87 841)	59 687
Proceeds from sale of capital assets	-	(119)
Expenditure on capital assets	837 567	882 978
Surrenders to Revenue Fund	(741 237)	(667 530)
Own revenue included in appropriation	486 973	490 747
Net cash flow generated by operating activities	**781 237**	**1 004 669**

18 Reconciliation of cash and cash equivalents for cash flow purposes

Consolidated Paymaster General account	(102 114)	(82 562)
Cash receipts	1	-
Cash on hand	26	26
Cash with commercial banks (Local)	257 464	292 053
Total	**155 377**	**209 517**

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19 Contingent liabilities and contingent assets

19.1 Contingent liabilities

		Note	2013/14 R'000	2012/13 R'000
Liable to	**Nature**			
Housing loan guarantees	Employees	*Annex 2A*	299	455
Claims against the department		*Annex 2B*	179 230	136 618
Intergovernmental payables (unconfirmed balances)		*Annex 4*	1 166	1 804
Other (OSD) *		*Annex 2B*	-	908
Total			**180 695**	**139 785**

*This matter relates back to July 2007. Due to the fact that the OSD debt prescribed, the Department took a decision to write off this debt. The Department will therefore not pursue this matter any further.

19.2 Contingent assets

Nature of contingent asset		
Occupational specific dispensation (OSD) payments (awaiting approval)*	-	2 177
Total	**-**	**2 177**

* Refer to note 19.1

The implementation of the Policy and Procedure on Incapacity Leave and Ill-health Retirement (PILIR) was suspended for part of the financial year. PILIR provides for the appointment of a Panel of Accredited Health Risk Managers, by the Department of Public Service and Administration, as service providers available to a department to investigate and assess the applications made by employees. The appointment of these service providers was delayed due to a legal challenge brought to the High Court against the appointment process. Therefore for the first half of the financial year no timeous decision could be made on the validity of the incapacity and/or ill-health retirement applications received from employees. Although the Panel was formally established on 1 November 2013 there is a possibility that amounts paid to employees on incapacity and/or ill-health retirement may be recoverable if the applications, made in the first part of the financial year, are not subsequently recommended by the service providers.

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20 Commitments

	2013/14 R'000	2012/13 R'000
Current expenditure	**945 112**	**896 446**
Approved and contracted	817 504	642 110
Approved but not yet contracted	127 608	254 336
Capital expenditure	**1 616 632**	**1 310 088**
Approved and contracted	1 075 460	532 262
Approved but not yet contracted	541 172	777 826
Total Commitments	**2 561 744**	**2 206 534**

21 Accruals

	2013/14 R'000			2012/13 R'000
Listed by economic classification				
	30 Days	**30+ Days**	**Total**	**Total**
Goods and services	215 968	34 589	250 557	223 578
Transfers and subsidies	37 721	12 261	49 982	44 010
Capital assets	7 962	2 795	10 757	16 245
Total	**261 651**	**49 645**	**311 296**	**283 833**

	2013/14	2012/13
Listed by programme level		
Administration	25 762	16 065
District Health Services	93 255	98 459
Emergency Medical Services	16 470	14 743
Provincial Hospital Services	24 181	32 050
Central Hospital Services	126 296	110 052
Health Sciences and Training	3 899	1 770
Health Care Support Service	21 265	7 172
Health Facility Management	168	3 522
Total	**311 296**	**283 833**

Confirmed balances with other departments	*Annex 4*	8 422	7 851
Total		**8 422**	**7 851**

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22 Employee benefits

	2013/14 R'000	2012/13 R'000
Leave entitlement*	276 845	229 081
Service bonus (Thirteenth cheque)	217 285	199 773
Performance awards	46 728	80 291
Capped leave commitments**	268 113	268 339
Other***	22 232	20 849
Total	**831 203**	**798 333**

***Leave Entitlement**

PERSAL Report	226 million
Negative Leave Credits Included	30 million
Leave Captured after 31 March 2014	(21 million)
Leave Captured before 31 March 2014	42 million
Recalculated Leave Entitlement	277 million

Negative balances mostly result from an over-grant of leave which is discovered when leave files are audited.

**Capped Leave Commitments	268 million

***This relates mainly to accruals for overtime and travel and subsistence claims.

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23 Lease commitments

23.1 Operating leases expenditure

2013/14	Machinery and equipment R'000	Total R'000
Not later than 1 year	24 216	24 216
Later than 1 year and not later than 5 years	22 929	22 929
Later than five years	20	20
Total lease commitments	**47 165**	**47 165**

2012/13	Machinery and equipment R'000	Total R'000
Not later than 1 year	20 800	20 800
Later than 1 year and not later than 5 years	28 914	28 914
Total lease commitments	**49 714**	**49 714**

The above operating lease commitments include mainly leases for photocopiers and future lease payments on the GG vehicles. Future operating lease payments on GG vehicles are now reported as part of the Department's operating leases and are reflected in both the current and prior year balances. These figures were excluded from the previous year's financial statements based on guidance provided by the Provincial Treasury.

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23.2 Finance leases expenditure

2013/14	Machinery and equipment R'000	Total R'000
Not later than 1 year	109 659	109 659
Later than 1 year and not later than 5 years	309 660	309 660
Later than five years	36 505	36 505
Total lease commitments	**455 824**	**455 824**
2012/13		
Not later than 1 year	90 250	90 250
Later than 1 year and not later than 5 years	232 019	232 019
Later than five years	39 232	39 232
Total lease commitments	**361 501**	**361 501**

The increase in finance lease commitments relates to future lease payments on GG vehicles that were reported in a separate note during the previous financial year. Future lease payments on GG vehicles are now reported as part of the Department's financial leases.
The Western Cape Department of Health leased 1,575 vehicles from GMT as at 31 March 2014 (March 2013: 1,560). Daily tariffs are payable on a monthly basis, covering the operational costs, capital costs of replacement of vehicles, and the implicit finance costs in this type of arrangement. The implicit Interest is based on Provincial Treasury's approved tariffs for GMT. The department uses the vehicle for most of the useful life of the vehicle. The agreement does not provide for contingent lease payments, and at the end of the useful life as determined by the lessor, the vehicles are returned where it is sold on auction for the benefit of the lessor.

24 Accrued departmental revenue

	Note	2013/14	2012/13
Sales of goods and services other than capital assets (Patient Fees)	*24.1*	515 599	540 113
Total		**515 599**	**540 113**

The Department's debt amounts to R515 million comprising:

Road Accident Fund (RAF):	311 million	370 million
Medical aids, individuals, Compensation of occupation and Injuries (COID) and diseases, etc.	204 million	170 million
Total:	**515 million**	**540 million**

The amount of R515 million must be reduced by the following:
2013/14 RAF & COID payments received, but not credited to billing systems = R 73 million.
Debt older than 3 years and debt to be removed from the system according to departmental policy = R8 million.

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Remaining valid debt = R 435 million.

- Of this amount, R 240 million (55%) consists of RAF debt.
  The Department estimates that a quarter of the RAF debt is irrecoverable due to the rules for shared accountability. The recovery cost of RAF debt is 17% of amounts recovered which is considerably high.
  The Department therefore considers 50% of the RAF debt as recoverable on a net basis. However, despite ongoing payments, it may take years to recover this debt.

The remaining valid debt = R 315 million.

- Of this amount, R114 million relates to debt owed by individuals of which only 55% is deemed recoverable due to the low income of the department's clients.

The remaining valid debt = R 264 million.

- Of this amount, R32 million relates to medical aid debt, of which 90% is estimated to be recoverable since medical aids, on average, pay according to the benefits available. The balance is therefore the individuals' share of the cost, and is more difficult to recover.

The total recoverable debt is therefore estimated at R 261 million.
The above debt includes a credit balance of R 8 million due to the incorrect allocation of payments to invoices within the same account holder, simultaneous write-off and payment, and duplicate payments.
Patient Fees debt written off during the year = R 189 million.
The value of accounts for discharges in March 2014 but raised in April 2014 (due to the Department's 14 days billing rule) amounts to R 14 million.

24.1 Analysis of accrued departmental revenue

	2013/14 R'000	2012/13 R'000
Opening balance	540 113	506 846
Less: amounts received	(379 773)	(386 381)
Add: amounts recognised	544 616	580 610
Less: amounts written-off/reversed as irrecoverable	(189 357)	(160 962)
Closing balance	**515 599**	**540 113**

24.2 Accrued department revenue written off

Nature of losses		
Patient fees	189 357	160 962
Total	**189 357**	**160 962**

24.3 Impairment of accrued departmental revenue

Estimate of impairment of accrued departmental revenue	182 500	202 540
Total	**182 500**	**202 540**

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25 Irregular expenditure

25.1 Reconciliation of irregular expenditure

	2013/14 R'000	2012/13 R'000
Opening balance	168 991	84 974
Add: Irregular expenditure – relating to current year	87 997	86 673
Less: Prior year amounts condoned	(134 267)	(303)
Less: Current year amounts condoned	(34 070)	(205)
Less: Amounts recoverable (not condoned)	-	(2 148)
Less: Amounts not recoverable (not condoned)	(5 282)	-
Irregular expenditure awaiting condonation	**83 369**	**168 991**
Analysis of awaiting condonation per age classification		
Current year	53 927	86 468
Prior years	29 442	82 523
Total	**83 369**	**168 991**

25.2 Details of irregular expenditure – current year

Incident	2013/14 R'000
Contract expanded without approval (Infrastructure project)*	30 558
Contract extended without approval (PILAR)*	15 041
Contract extended without approval	3 129
Incorrect delegations	10 378
Correct bidding process not followed	5 354
Not registered on the WCSDB	4 865
Tradeworld not used (above R10000)	4 057
No formal bidding process followed 500+	3 874
Used invalid contract	3 630
Purchase outside valid contract	3 106
Other	1 655
No valid tax clearance certificate	1 371
Award made to wrong bidder	451
Quantity on invoice more than approved order	227
Item not on this contract	161
Not declared interest on WBSD form or false info provided	111
Prohibited/restricted supplier	29
Total	**87 997**

* Represents R45, 599million (51%) of the current year irregular expenditure and is due to contravention of SCM legislation by other Departments.

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25.3 Details of irregular expenditure condoned

Incident	Condoned by (condoning authority)	2013/14 R'000
Prior Years		
Various	Accounting Officer	133 132
Tax Clearance Certificates	National Treasury	1 135
Current Year		
Award made to wrong bidder	Accounting Officer	194
Contract extended without approval	Accounting Officer	15 971
Incorrect delegations	Accounting Officer	7 433
No formal bidding process followed 500+	Accounting Officer	984
Not declared interest on WBSD form or false info provided	Accounting Officer	1
Not registered on the WCSDB	Accounting Officer	4 277
Other	Accounting Officer	192
Quantity on invoice more than approved order	Accounting Officer	202
Tradeworld not used (above R10000)	Accounting Officer	1 452
Used invalid contract	Accounting Officer	3 364
Total		**168 337**

25.4 Details of irregular expenditure not recoverable (not condoned)

Incident	Not condoned by (condoning authority)	2013/14 R'000
Tax Clearance Certificates	National Treasury	5 282
Total		**5 282**

25.5 Details of irregular expenditures under investigation

Incident	
Exceeding approved contract amount	154
Incorrect use of delegation	4
No tax clearance certificate	83
No valid contract	5 203
No valid tax clearance certificate	3
No WSDB 4	115
Non-compliance with delegations	7 814
Noncompliance with PSR Regulations	11
None compliance with PSR	90
Procurement process not followed	2 626
Restricted supplier	28
Restricted supplier	232
Restricted Suppliers- 08/09	65
Restricted Suppliers- 09/10	3 192
Restricted Suppliers- 10/11	3 858
Restricted Suppliers- 11/12	2 767
Tax clearance certificate	2 195
WCBD 4 interest not declared	1 002
Total	**29 442**

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26 Fruitless and wasteful expenditure

26.1 Reconciliation of fruitless and wasteful expenditure

	2013/14 R'000	2012/13 R'000
Opening balance	316	258
Fruitless and wasteful expenditure – relating to current year	-	58
Fruitless and wasteful expenditure awaiting resolution	**316**	**316**

26.2 Analysis of awaiting resolution per economic classification

Current expenditure	316	316
Total	**316**	**316**

27 Related party transactions

The Department of Health occupies a building free of charge managed by the Department of Transport and Public Works. Parking space is also provided for government officials at an approved fee that is not market related.

The Department of Health received corporate services from the Corporate Services Centre of the Department of the Premier in the Western Cape Province with effect from 1 November 2010 in respect of the following service areas:

- Information and Communication Technology
- Organisation Development
- Provincial Training (transversal)
- Human Resource Management
- Enterprise Risk Management
- Internal Audit
- Forensic investigations
- Legal Services
- Corporate Communication

A related party relationship exists between the Department and Government Motor Transport (GMT) with regard to the management of government motor vehicles of the Departments. This relationship is based on an arm's length transaction in terms of tariffs approved by the Provincial Treasury.

The Department of Health received Security Advisory Services and Security Operations from the Department of Community Safety in the Western Cape.

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28 Key management personnel

	No. of Individuals	2013/14 R'000	2012/13 R'000
Political office bearers (provide detail below)	1	1 657	1 662
Officials:			
Level 15 to 16	6	7 562	5 702
Level 14 (incl. CFO if at a lower level)	11	9 838	10 739
Family members of key management personnel	2	1 009	904
Total		**20 066**	**19 007**

29 Public Private Partnership

Contract fee paid	**50 336**	**46 804**
Fixed component	50 336	46 804
Total	**50 336**	**46 804**

Refer to paragraph 4.5 of the Report of the Accounting Officer for further detail on Public Private Partnerships (PPP's).

30 Debtors written off

Debtors (Actual write-off amount)	190 547	163 787
Total	**190 547**	**163 787**

The amounts disclosed above relates to the actual write-offs of the Department and represents:

Patient fee debtors (Disclosure Note 24.1)	R189,4 million
Staff debtors (Note 6.2)	R 1.1 million

31 Estimated impairments of Debtors

RAF *	120 000	150 000
Individual Debtors *	51 300	42 240
Medical Aid Debt *	3 200	2 300
Debt older than 3 years *	8 000	8 000
Staff Debtors **	529	576
Total	**183 029**	**203 116**

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The amounts disclosed above relates to the total estimated impairments of the Department and represents:	
* Patient fee debtors (Disclosure Note 24.3)	R182,5 million
**Staff debtors (Note 12.4).	R 0.5 million

31.1 Reconciliation of movement in estimated Impairment – 2013/14

	Impairment 1*	Impairment 2**	Impairment 3***&5*****	Impairment 4****	Total Impairment
	R'000	R'000	R'000	R'000	R'000
Opening balance	150 000	42 240	10 300	576	203 116
Increase in impairment	120 000	51 300	11 200	529	183 029
Settlement of impairment	-	-	-	-	-
Unused amount reversed	(150 000)	(42 240)	(10 300)	(576)	(203 116)
Closing balance	**120 000**	**51 300**	**11 200**	**529**	**183 029**

Nature of obligations:

*Debt raised i.t.o. accident victims, submitted to the RAF. Impairments are for claims that will be rejected by the RAF.
**Debt raised i.t.o. individually liable debtors. These are unfunded debtors who do not belong to any medical aid or have a 3rd party responsible for their debt. Impairments made for debtors who experience financial difficulties during the current economic climate that exist in the country.
***Debt raised i.t.o. medical aid beneficiary debtors. Impairments made for debtors who have limited or will deplete their benefits before account is settled.
****Staff debtors with balances under R 2,000.00 encompass the impairment amount of R 529,000 with possibility of full balance recovery of in-service staff.
*****These are debt older than 3 years of individually liable debtors and medical aid accounts that, according to departmental policy, can be written-off.

Description of uncertainties/estimates:

*Based on historical data the department estimates that 50% of outstanding RAF debt will be irrecoverable. The assumption is that the RAF will again reject claims that do not meet their criteria.
**Based on historical data and trends, the department estimates that about 45% of individually liable debt will be written-off. The assumption is that some debtors will continue to experience financial difficulties due to for e.g. Unemployment.
***It is estimated that a total of 10% of medical aid patients treated at our facilities will run out of benefits.
****Due to the high volume of staff turnover within the department it is likely that the balance would increase in the next financial year due to a reviewing of the debt policy.
*****It is estimated that the department will write-off an amount of R 8million debt older than 3 years.

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32 Movable Tangible Capital Assets

MOVEMENT IN MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2014

	Opening balance	Current Year Adjustments to prior year balances	Additions	Disposals	Closing Balance
	R'000	R'000	R'000	R'000	R'000
MACHINERY AND EQUIPMENT	**1 926 930**	**256 268**	**440 949**	**139 750**	**2 484 397**
Transport assets	3 933	313 413	84 158	57 631	343 873
Computer equipment	202 675	934	43 513	11 439	235 683
Furniture and office equipment	66 603	(241)	13 265	2 711	76 916
Other machinery and equipment	1 653 719	(57 838)	300 013	67 969	1 827 925
TOTAL MOVABLE TANGIBLE CAPITAL ASSETS	**1 926 930**	**256 268**	**440 949**	**139 750**	**2 484 397**

32.1 Additions

ADDITIONS TO MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2014

	Cash	Non-cash	(Capital Work in Progress current costs and finance lease payments)	Received current, not paid (Paid current year, received prior year)	Total
	R'000	R'000	R'000	R'000	R'000
MACHINERY AND EQUIPMENT	**420 399**	**110 709**	**(100 125)**	**9 966**	**440 949**
Transport assets	105 153	79 130	(100 125)	-	84 158
Computer equipment	38 192	4 803	-	518	43 513
Furniture and office equipment	11 191	1 929	-	145	13 265
Other machinery and equipment	265 863	24 847	-	9 303	300 013
TOTAL ADDITIONS TO MOVABLE TANGIBLE CAPITAL ASSETS	**420 399**	**110 709**	**(100 125)**	**9 966**	**440 949**

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The increase in transport assets relates to GG vehicles that were reported in a separate note during the previous financial year. GG vehicles are now reported as part of the Department's assets The Western Cape Department of Health leased 1,570 vehicles from GMT as at 31 March 2014 (March 2013: 1,551). Daily tariffs are payable on a monthly basis, covering the operational costs, capital costs of replacement of vehicles, and the implicit finance costs in this type of arrangement. The implicit Interest is based on Provincial Treasury's approved tariffs for GMT. The department uses the vehicle for most of the useful life of the vehicle. The agreement does not provide for contingent lease payments, and at the end of the useful life as determined by the lessor, the vehicles are returned where it is sold on auction for the benefit of the lessor. The amount in work in progress relates to GMT finance leases.

32.2 Disposals

DISPOSALS OF MOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2014

	Sold for cash	Transfer out or destroyed or scrapped	Total disposals	Cash Received Actual
	R'000	R'000	R'000	R'000
MACHINERY AND EQUIPMENT	**-**	**139 750**	**139 750**	**-**
Transport assets	-	57 631	57 631	-
Computer equipment	-	11 439	11 439	-
Furniture and office equipment	-	2 711	2 711	-
Other machinery and equipment	-	67 969	67 969	-
TOTAL DISPOSAL OF MOVABLE TANGIBLE CAPITAL ASSETS	**-**	**139 750**	**139 750**	**-**

32.3 Movement for 2012/13

	Opening balance	Current Year Adjustments to prior year balances	Additions	Disposals	Closing Balance
	R'000	R'000	R'000	R'000	R'000
MACHINERY AND EQUIPMENT	**1 714 230**	**12 623**	**294 054**	**93 977**	**1 926 930**
Transport assets	4 210	(571)	294	-	3 933
Computer equipment	174 040	9 231	32 270	12 866	202 675
Furniture and office equipment	64 482	(5 922)	12 115	4 072	66 603
Other machinery and equipment	1 471 498	9 885	249 375	77 039	1 653 719
TOTAL MOVABLE TANGIBLE CAPITAL ASSETS	**1 714 230**	**12 623**	**294 054**	**93 977**	**1 926 930**

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32.4 Minor assets

MOVEMENT IN MINOR ASSETS PER THE ASSET REGISTER FOR THE YEAR ENDED AS AT 31 MARCH 2014

	Intangible assets	Machinery and equipment	Total
	R'000	R'000	R'000
Opening balance	1 688	471 393	473 081
Current Year Adjustments to Prior Year Balances	(78)	(23 843)	(23 921)
Additions	30	58 789	58 819
Disposals	8	22 853	22 861
TOTAL MINOR ASSETS	**1 632**	**483 486**	**485 118**

	Intangible assets	Machinery and equipment	Total
Number of minor assets at cost	584	420 053	420 637
TOTAL NUMBER OF MINOR ASSETS	**584**	**420 053**	**420 637**

MOVEMENT IN MINOR ASSETS PER THE ASSET REGISTER FOR THE YEAR ENDED AS AT 31 MARCH 2013

	Intangible assets	Machinery and equipment	Total
Opening balance	1 708	444 923	446 631
Curr Year Adjustments to Prior Year balances	(48)	(5 376)	(5 424)
Additions	28	55 648	55 676
Disposals	-	23 802	23 802
TOTAL MINOR ASSETS	**1 688**	**471 393**	**473 081**

	Intangible assets	Machinery and equipment	Total
Number of minor assets at cost	589	433 662	434 251
TOTAL NUMBER OF MINOR ASSETS	**589**	**433 662**	**434 251**

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33 Intangible Capital Assets

MOVEMENT IN INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2014

	Opening balance	Current Year Adjustments to prior year balances	Additions	Disposals	Closing Balance
	R'000	R'000	R'000	R'000	R'000
SOFTWARE	3 235	181	1 602		5 018
TOTAL INTANGIBLE CAPITAL ASSETS	**3 235**	**181**	**1 602**	**-**	**5 018**

33.1 Additions

ADDITIONS TO INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2014

	Cash	Non-Cash	(Development work in progress – current costs)	Received current year, not paid (Paid current year, received prior year)	Total
SOFTWARE	1 602	-	-	-	1 602
TOTAL ADDITIONS TO INTANGIBLE CAPITAL ASSETS	**1 602**	**-**	**-**	**-**	**1 602**

33.2 Movement for 2012/13

MOVEMENT IN INTANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2013

	Opening balance	Current Year Adjustments to prior year balances	Additions	Disposals	Closing Balance
SOFTWARE	2 559	(364)	1 040	-	3 235
TOTAL INTANGIBLE CAPITAL ASSETS	**2 559**	**(364)**	**1 040**	**-**	**3 235**

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34 Immovable Tangible Capital Assets

MOVEMENT IN IMMOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2014

	Opening balance	Current Year Adjustments to prior year balances	Additions	Disposals	Closing Balance
	R'000	R'000	R'000	R'000	R'000
BUILDINGS AND OTHER FIXED STRUCTURES	**11 817**	**752**	**1653**	**552**	**13 670**
Other fixed structures	11 817	752	1 653	552	13 670
TOTAL IMMOVABLE TANGIBLE CAPITAL ASSETS	**11 817**	**752**	**1 653**	**552**	**13 670**

34.1 Additions

ADDITIONS TO IMMOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2014

	Cash	Non-cash	(Capital Work in Progress current costs and finance lease payments)	Received current, not paid (Paid current year, received prior year)	Total
	R'000	R'000	R'000	R'000	R'000
BUILDING AND OTHER FIXED STRUCTURES	**415 566**	**483**	**(414 360)**	**(36)**	**1653**
Non-residential Buildings	414 360	-	(414 360)	-	-
Other fixed structures	1 206	483	-	(36)	1 653
TOTAL ADDITIONS TO IMMOVABLE TANGIBLE CAPITAL ASSETS	**415 566**	**483**	**(414 460)**	**(36)**	**1 653**

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34.2 Disposals

DISPOSALS OF IMMOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2014

	Sold for cash	Transfer out or destroyed or scrapped	Total disposals	Cash Received Actual
	R'000	R'000	R'000	R'000
BUILDINGS AND OTHER FIXED STRUCTURES	**-**	**552**	**552**	**-**
Other fixed structures	-	552	552	-
TOTAL DISPOSALS OF IMMOVABLE TANGIBLE CAPITAL ASSETS	**-**	**552**	**552**	**-**

34.3 Movement for 2012/13

MOVEMENT IN IMMOVABLE TANGIBLE CAPITAL ASSETS PER ASSET REGISTER FOR THE YEAR ENDED 31 MARCH 2013

	Opening balance	Curr Year Adjustments to prior year balances	Additions	Disposals	Closing Balance
	R'000	R'000	R'000	R'000	R'000
BUILDINGS AND OTHER FIXED STRUCTURES	**5 068**	**4 964**	**2 020**	**235**	**11 817**
Other fixed structures	5 068	4 964	2 020	235	11 817
TOTAL IMMOVABLE TANGIBLE CAPITAL ASSETS	**5 068**	**4 964**	**2 020**	**235**	**11 817**

35 Prior period errors

35.1 Correction of prior period error for secondary information

	2013/14 R'000
The comparative amounts for Accrued department revenue written off were restated as follows (Note 24.2):	
Amount reported in Prior Period	(2 825)
Prior Period actual amount	160 962
Net effect on the note	158 137

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36 STATEMENT OF CONDITIONAL GRANTS RECEIVED

NAME OF CONDITIONAL GRANTS RECEIVED	GRANT ALLOCATION					SPENT				2012/13	
	Division of Revenue Act/ Provincial Grants	Roll Overs	DORA Adjustments	Other Adjustments	Total Available	Amount received by department	Amount spent by department	Under / (Over-spending)	% of available funds spent by department	Division of Revenue Act	Amount spent by department
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000
National Tertiary Services Grant	2 400 714	-	-	-	2 400 714	2 400 714	2 400 714	-	100%	2 182 468	2 182 468
Health Professions Training and Development Grant	451 667	-	-	-	451 667	451 667	451 667	-	100%	428 120	428 120
Comprehensive HIV and Aids Grant	927 547	-	-	-	927 547	927 547	927 547	-	100%	738 080	738 079
National Health Insurance Grant	4 850	-	2 453	-	7 303	7 303	5 365	1 938	73%	11 500	9 885
Health Facility Revitalisation Grant: *(Of which the following components)*											
Hospital Revitalisation Component	493 526	60 188	-	-	553 714	553 714	517 814	35 900	94%	504 414	444 226
Health Infrastructure Component	122 296	4 975	-	-	127 271	127 271	92 131	35 140	72%	134 234	129 259
Nursing Colleges & Schools Component	13 964	-	-	-	13 964	13 964	3 942	10 022	28%	10 320	9 892
Expanded Public Works Programme Integrated Grant for Provinces	3 000	-	-	-	3 000	3 000	3 000	-	100%	1 000	1 000
Social Sector Expanded Public Works Programme Incentive Grant for Provinces	-	-	-	-	-	-	-	-		3 467	3 467
Total	**4 417 564**	**65 163**	**2 453**	**-**	**4 485 180**	**4 485 180**	**4 402 180**	**83 000**		**4 013 603**	**3 946 396**

ANNEXURE 1A
STATEMENT OF UNCONDITIONAL GRANTS AND TRANSFERS TO MUNICIPALITIES

NAME OF MUNICIPALITY	GRANT ALLOCATION				TRANSFER		SPENT			2012/13
	Amount	Roll Overs	Adjustments	Total Available	Actual Transfer	% of Available funds Transferred	Amount received by municipality	Amount spent by municipality	% of available funds spent by municipality	Total Available
	R'000	R'000	R'000	R'000	R'000	%	R'000	R'000	%	R'000
City of Cape Town	352 791	5 113	784	358 688	353 949	99%	353 949	353 949	100%	332 423
Central Karoo District	-	898	(311)	587	576	98%	576	576	100%	1 959
Total	**352 791**	**6 011**	**473**	**359 275**	**354 525**		**354 525**	**354 525**		**334 382**

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ANNEXURE 1B
STATEMENT OF TRANSFERS TO DEPARTMENTAL AGENCIES AND ACCOUNTS

DEPARTMENT/ AGENCY/ ACCOUNT	TRANSFER ALLOCATION				TRANSFER		2012/13
	Adjusted Appropriation	Roll Overs	Adjustments	Total Available	Actual Transfer	% of Available funds Transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Health & Welfare SETA	4 111	-	-	4 111	4 111	100%	3 541
Com: Licences (Radio &TV)	104	-	109	213	213	100%	115
Total	**4 215**	**-**	**109**	**4 324**	**4 324**		**3 656**

ANNEXURE 1C
STATEMENT OF TRANSFERS TO HIGHER EDUCATION INSTITUTIONS

NAME OF HIGHER EDUCATION INSTITUTION	TRANSFER ALLOCATION				TRANSFER			2012/13
	Adjusted Appropriation	Roll Overs	Adjustments	Total Available	Actual Transfer	Amount not transferred	% of Available funds Transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	R'000	%	R'000
Cape Peninsula University of Technology	3 580	-	-	3 580	3 480	100	97%	988
University of Cape Town	-	-	-	-	-	-		2 000
Total	**3 580**	**-**	**-**	**3 580**	**3 480**	**100**		**2 988**

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ANNEXURE 1D
STATEMENT OF TRANSFERS TO NON-PROFIT INSTITUTIONS

NON-PROFIT INSTITUTIONS	TRANSFER ALLOCATION				EXPENDITURE		2012/13
	Adjusted Appropriation Act	Roll overs	Adjustments	Total Available	Actual Transfer	% of Available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Transfers							
Community Health Clinics	122	-	-	122	43	35%	116
Tuberculosis	1 190	-	-	1 190	921	77%	1 260
Booth Memorial	16 797	-	-	16 797	16 857	100%	12 578
Life Esidimeni	37 334	-	-	37 334	36 405	98%	34 760
Sarah Fox	7 645	-	-	7 645	8 432	110%	7 133
St Josephs	-	-	-	-	-	-	9 719
Health Committees	13 004	-	-	13 004	7 725	59%	12 450
Home Base Care	10 488	-	-	10 488	8 083	77%	4 216
Mental Health	39 753	-	-	39 753	42 770	108%	36 187
HIV and Aids	140 578	-	-	140 578	137 599	98%	110 465
Nutrition	2 128	-	-	2 128	2 432	114%	2 020
Global Fund Contributions to NPO's	22 501	-	(1 131)	21 370	21 369	100%	35 281
SA Red Cross Air Mercy	38 637	-	3 091	41 728	41 728	100%	45 818
Maitland Cottage	8 933	-	-	8 933	8 933	100%	8 483

ANNEXURE 1D (CONTINUED)
STATEMENT OF TRANSFERS TO NON-PROFIT INSTITUTIONS

NON-PROFIT INSTITUTIONS	TRANSFER ALLOCATION				EXPENDITURE		2012/13
	Adjusted Appropriation Act	Roll overs	Adjustments	Total Available	Actual Transfer	% of Available funds transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Sunflower Foundation	3 000	-	-	3 000	3 000	100%	3 000
EPWP	44 000	-	-	44 000	43 970	100%	38 941
The Children's Hospital Trust	26 320	-	180	26 500	26 500	100%	-
Health Foundation	1 400	-	600	2 000	2 000	100%	-
Total	**413 830**	**-**	**2 740**	**416 570**	**408 767**		**362 427**

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ANNEXURE 1E
STATEMENT OF TRANSFERS TO HOUSEHOLDS

HOUSEHOLDS	TRANSFER ALLOCATION				EXPENDITURE		2012/13
	Adjusted Appropriation Act	Roll Overs	Adjustments	Total Available	Actual Transfer	% of Available funds Transferred	Appropriation Act
	R'000	R'000	R'000	R'000	R'000	%	R'000
Transfers							
Employee social benefits-cash residents	35 462	-	2 246	37 708	41 802	111%	33 746
Claims against the state: households	26 101	-	(339)	25 762	23 015	89%	6 928
Bursaries	45 493	-	-	45 493	45 437	100%	66 422
Payments made as an act of grace	21	-	9	30	29	97%	40
Total	**107 077**	**-**	**1 916**	**108 993**	**110 283**		**107 136**

ANNEXURE 1F
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS RECEIVED

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2013/14	2012/13
		R'000	R'000
Received in cash			
Sports Science Institute South Africa	Cash	1	-
Subtotal		**1**	**-**
Received in kind			
Gifts & Donations and sponsorships received for the year ending 31 March 2013	Various		15 106
Alexandra Hospital	Consumables	29	
Alexandra Hospital	Furniture & Office Equipment	3	
Alexandra Hospital	Other Machinery & Equipment	5	
Brooklyn hospital	Consumables	3	
Brooklyn hospital	Furniture & Office Equipment	37	
CMD	Consumables	326	
CMD	Other Machinery & Equipment	8	
Eerste Rivier Hospital	Computer Equipment	102	
Eerste Rivier Hospital	Furniture & Office Equipment	2	
Eerste Rivier Hospital	Other Machinery & Equipment	1 294	
EMS	Other Machinery & Equipment	1	
False Bay Hospital	Computer Equipment	6	

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ANNEXURE 1F (CONTINUED)
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS RECEIVED

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2013/14	2012/13
		R'000	R'000
False Bay Hospital	Consumables	14	
False Bay Hospital	Furniture & Office Equipment	21	
False Bay Hospital	Other Machinery & Equipment	12	
George Hospital	Consumables	14	
George Hospital	Other Machinery & Equipment	650	
Groote Schuur Hospital	Computer Equipment	3	
Groote Schuur Hospital	Consumables	1 653	
Groote Schuur Hospital	Furniture & Office Equipment	80	
Groote Schuur Hospital	Other Machinery & Equipment	1 720	
Harry Comay	Consumables	1	
Harry Comay	Other Machinery & Equipment	19	
Head Office	Consumables	41	
Head Office	Computer Equipment	1	
Helderberg Hospital	Other Machinery & Equipment	314	
Karl Bremer Hospital	Computer Equipment	17	
Karl Bremer Hospital	Consumables	2	
Karl Bremer Hospital	Other Machinery & Equipment	87	
Khayelitsha District Hospital	Consumables	16	
Khayelitsha District Hospital	Furniture & Office Equipment	8	
Khayelitsha District Hospital	Other Machinery & Equipment	14	
Mitchells Plain Hospital	Computer Equipment	7	
Mitchells Plain Hospital	Consumables	28	
Mitchells Plain Hospital	Furniture & Office Equipment	33	
Mitchells Plain Hospital	Other Machinery & Equipment	249	
Montagu Hospital	Buildings & Other Fixed Structure	150	

ANNEXURE 1F (CONTINUED)
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS RECEIVED

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2013/14	2012/13
		R'000	R'000
Mossel Bay Hospital	Consumables	10	
Mossel Bay Hospital	Furniture & Office Equipment	9	
Mossel Bay Hospital	Other Machinery & Equipment	415	
Mowbray Maternity Hospital	Consumables	42	
Mowbray Maternity Hospital	Other Machinery & Equipment	647	
Oudtshoorn Hospital	Consumables	6	
Oudtshoorn Hospital	Other Machinery & Equipment	24	
Paarl Hospital	Computer Equipment	1	
Paarl Hospital	Other Machinery & Equipment	4	
Red Cross hospital	Consumables	790	
Red Cross hospital	Furniture & Office Equipment	78	
Red Cross hospital	Other Machinery & Equipment	906	
Riversdale Hospital	Consumables	1	
Riversdale Hospital	Furniture & Office Equipment	1	
Riversdale Hospital	Other Machinery & Equipment	19	
Robertson Hospital	Consumables	1	
Robertson Hospital	Transport Assets	500	
Somerset Hospital	Consumables	31	
Somerset Hospital	Furniture & Office Equipment	321	
Stikland Hospital	Furniture & Office Equipment	35	
Stikland Hospital	Other Machinery & Equipment	6	
Swartland Hospital	Furniture & Office Equipment	1	
Tygerberg Hospital	Computer Equipment	1	
Tygerberg Hospital	Consumables	236	
Tygerberg Hospital	Furniture & Office Equipment	3	

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ANNEXURE 1F (CONTINUED)
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS RECEIVED

NAME OF ORGANISATION	NATURE OF GIFT, DONATION OR SPONSORSHIP	2013/14	2012/13
		R'000	R'000
Tygerberg Hospital	Other Machinery & Equipment	2 965	
Tygerberg Oral Health Centre	Consumables	23	
Tygerberg Oral Health Centre	Other Machinery & Equipment	5	
Valkenberg Hospital	Consumables	6	
Valkenberg Hospital	Furniture & Office Equipment	208	
Valkenberg Hospital	Other Machinery & Equipment	57	
Victoria hospital	Computer Equipment	11	
Victoria hospital	Other Machinery & Equipment	5	
Vredenburg Hospital	Computer Equipment	19	
Vredenburg Hospital	Consumables	1	
Vredenburg Hospital	Furniture & Office Equipment	33	
Wesfleur Hospital	Computer Equipment	9	
Wesfleur Hospital	Consumables	2	
Wesfleur Hospital	Other Machinery & Equipment	1 243	
Western Cape Rehab Centre	Consumables	2	
Western Cape Rehab Centre	Other Machinery & Equipment	2	
Worcester Hospital	Other Machinery & Equipment	1	
Subtotal		**15 650**	**15 106**
TOTAL		**15 651**	**15 106**

ANNEXURE 1G
STATEMENT OF AID ASSISTANCE RECEIVED

NAME OF DONOR	PURPOSE	OPENING BALANCE R'000	REVENUE R'000	EXPENDITURE R'000	CLOSING BALANCE R'000
Received in cash					
EU Donor fund	WISN Project	-	4 250	-	4 250
TOTAL		**-**	**4 250**	**-**	**4 250**

* The Department received funding from the European Union (EU) for the Workload Indicators Staffing Need (WISN) project. No expenditure has been incurred by the end of the 2013/14 financial year as the Department was in the process of advertising 8 posts and procuring vehicles.

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ANNEXURE 1H
STATEMENT OF GIFTS, DONATIONS AND SPONSORSHIPS MADE AND REMMISSIONS, REFUNDS AND PAYMENTS MADE AS AN ACT OF GRACE

NATURE OF GIFT, DONATION OR SPONSORSHIP	2013/14	2012/13
	R'000	R'000
Paid in cash		
Donation to Groote Schuur Hospital Health Facility Board	84	-
Donation to Rape Crisis Cape Town Trust	65	-
Subtotal	**149**	**-**
Made in kind		
Eskom (redundant computer equipment donated)	-	559
Grace Tabernacle Ministries	-	22
Healing Ministries	-	5
Huis Boland	-	152
Lindelani Place of Safety	1	-
Subtotal	**1**	**738**
Remissions, refunds, and payments made as an act of grace		
Payment made as an act of grace	29	28
Subtotal	**29**	**28**
TOTAL	**179**	**766**

ANNEXURE 2A
STATEMENT OF FINANCIAL GUARANTEES ISSUED AS AT 31 MARCH 2014 – LOCAL

Guarantor institution	Guarantee in respect of	Original guaranteed capital amount	Opening balance 1 April 2013	Guarantees draw downs during the year	Guarantees released during the year	Revaluations	Closing balance 31 March 2014
		R'000	R'000	R'000	R'000	R'000	R'000
Standard Bank	Housing	-	307	-	76	-	231
First Bank	Housing	-	12	-	-	-	12
Absa	Housing	-	80	-	80	-	-
People Bank FB Fid	Housing	-	31	-	-	-	31
NHFC (MASIKHENI)	Housing	-	25	-	-	-	25
TOTAL		**-**	**455**	**-**	**156**	**-**	**299**

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ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
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ANNEXURE 2B
STATEMENT OF CONTINGENT LIABILITIES AS AT 31 MARCH 2014

Nature of Liability	Opening Balance 1 April 2013	Liabilities incurred during the year	Liabilities paid/cancelled / reduced during the year	Closing Balance 31 March 2014
	R'000	R'000	R'000	R'000
Claims against the department				
Medico Legal	118 010	71 905	32 390	157 525
Civil & Legal claims including Labour Relations claims	18 608	5084	1 987	21 705
Subtotal	**136 618**	**76 989**	**34 377**	**179 230**
Other				
Occupational Specific Dispensation (OSD) for nurses*	908	-	908	-
Subtotal	**908**	**-**	**908**	**-**
TOTAL	**137 526**	**76 989**	**35 285**	**179 230**

*This matter relates back to July 2007. Due to the fact that the OSD debt prescribed, the Department took a decision to write off this debt. The Department will therefore not pursue this matter any further.

ANNEXURE 3
CLAIMS RECOVERABLE

Government Entity	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2014	31/03/2013	31/03/2014	31/03/2013	31/03/2014	31/03/2013
	R'000	R'000	R'000	R'000	R'000	R'000
Department						
WESTERN CAPE PROVINCE						
Department of Transport & Public Works	607	-	743	376	1 350	376
Department of Community Safety	-	-	-	23	-	23
Department of Education	42	-	-	1 766	42	1 766
Department of the Premier	-	21	26	-	26	21
Department of Cultural Affairs	-	-	4	-	4	-
Department of Rural Development	-	-	2	-	2	-
PROVINCE OF THE EASTERN CAPE						
Department of Health	-	30	5	-	5	30
GAUTENG PROVINCE						
Department of Health	-	8	57	-	57	8
NORTHERN CAPE PROVINCE						
Department of Health	-	32	34	-	34	32
FREE-STATE PROVINCE						
Department of Health	-	-	-	24	-	24
PROVINCE OF MPUMALANGA						
Department of Health	691	-	-	9	692	9
LIMPOPO PROVINCE						
Department of Health	-	4	-	-	-	4

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ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
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ANNEXURE 3
CLAIMES RECOVERABLE (CONTINUED)

Government Entity	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2014	31/03/2013	31/03/2014	31/03/2013	31/03/2014	31/03/2013
	R'000	R'000	R'000	R'000	R'000	R'000
NATIONAL DEPARTMENTS						
Department of Environmental Affairs	-	-	28	-	28	-
Defence Force	-	-	-	12	-	12
Department of Communications	-	-	-	38	-	38
Department of Public Protector	2	-	-	-	2	-
Department of Health	22	-	-	78	22	78
Department of Correctional Services	170	-	-	219	170	219
South African Social Security Agency	-	-	1 945	2 220	1 945	2 220
Parliament	-	-	21	40	21	40
Department of Energy	-	-	-	9	-	9
Department of Road and Public Works	-	-	-	20	-	20
South African Revenue services	-	-	5 792	1 608	5 792	1 608
Subtotal	**1 534**	**95**	**8 657**	**6 442**	**10 191**	**6 537**
Other Government Entities						
City of Cape Town (Cape Medical Depot)	-	-	7 349	6 519	7 349	6 519
Subtotal	**-**	**-**	**7 349**	**6 519**	**7 349**	**6 519**
Total	**1 534**	**95**	**16 006**	**12 961**	**17 540**	**13 056**

ANNEXURE 4
INTER-GOVERNMENT PAYABLES

GOVERNMENT ENTITY	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2014	31/03/2013	31/03/2014	31/03/2013	31/03/2014	31/03/2013
	R'000	R'000	R'000	R'000	R'000	R'000
DEPARTMENTS						
Current						
WESTERN CAPE PROVINCE						
Department of Social Development	42	-	-	-	42	-
Department of Education	-	14	644	-	644	14
Government Motor Transport	8 071	7 837	-	-	8 071	7 837
Department of Premier	-	-	307	1	307	1
Provincial Treasury	-	-	-	53	-	53
Department of Transport and Public Works	-	-	135	-	135	-
GAUTENG PROVINCE						
Department of Health	-	-	80	-	80	-
NATIONAL DEPARTMENTS						
Department of Justice & Constitutional Development	309	-	-	583	309	583
Total Departments	**8 422**	**7 851**	**1 166**	**637**	**9 588**	**8 488**

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ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
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ANNEXURE 4
INTER-GOVERNMENT PAYABLES (CONTINUED)

GOVERNMENT ENTITY	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2014	31/03/2013	31/03/2014	31/03/2013	31/03/2014	31/03/2013
	R'000	R'000	R'000	R'000	R'000	R'000
OTHER GOVERNMENT ENTITY						
Current						
Pension Recoverable	-	-	-	427	-	427
Agency Service	-	-	-	740	-	740
Total Other Government Entities	**-**	**-**	**-**	**1 167**	**-**	**1 167**
TOTAL INTERGOVERNMENTAL	**8 422**	**7 851**	**1 166**	**1 804**	**9 588**	**9 655**

ANNEXURE 5
INVENTORY

Inventory	2013/14	
	Quantity	R'000
Opening balance	42 340 874	501 064
Add/(Less): Adjustments to prior year balance	(29 789)	(38)
Add: Additions/Purchases - Cash	290 924 495	2 102 335
Add: Additions - Non-cash	12 872 716	230 632
(Less): Disposals	(1 070 735)	(10 289)
(Less): Issues	(314 946 763)	(2 474 660)
Add/(Less): Adjustments	7 390 979	115 426
Closing balance	**37 481 777**	**464 470**

Inventory	2012/13	
	Quantity	R'000
Opening balance	24 134 314	288 929
Add/(Less): Adjustments to prior year balance	10 633 170	88 208
Add: Additions/Purchases - Cash	263 341 278	2 389 776
Add: Additions - Non-cash	14 550 676	3 964
(Less): Disposals	(54 756)	(5 362)
(Less): Issues	(289 991 977)	(2 370 206)
Add/(Less): Adjustments	19 728 169	105 755
Closing balance	**42 340 874**	**501 064**

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ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
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ANNEXURE 6A
INTER-ENTITY ADVANCES PAID (note 11)

ENTITY	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2014	31/03/2013	31/03/2014	31/03/2013	31/03/2014	31/03/2013
	R'000	R'000	R'000	R'000	R'000	R'000
Acvv Clanwilliam SDC	-	-	1	-	1	-
ACVV Clanwilliam HBC	-	-	8	-	8	-
ACVV Porterville HBC	-	-	7	-	7	-
Afrika Tikkun	-	-	8	23	8	23
Afrika Tikkun TB Dots	-	-	-	15	-	15
Afrika Tikkun TB HIV Integration	-	-	-	44	-	44
Arisen Women	-	-	-	19	-	19
Bergrivier Motivated Women	-	-	-	2	-	2
Call to Serve	-	-	1	-	1	-
Caring Network (Bishop Lavis)	-	-	-	1	-	1
Caring Network (Wallacedene)	-	-	20	61	20	61
Cederberg Matzikama Aids network	-	-	1	-	1	-
Child Resource Centre	-	-	-	3	-	3
Compassion In Action	-	-	-	1	-	1
Compassion In Action: School Health	-	-	-	1	-	1
Darling MSAT	-	-	3	-	3	-
Diakonale Dienste Nuwerus	-	-	-	3	-	3
Etafeni	-	-	-	19	-	19
FMS	-	-	75	75	75	75
Franschoek Hospice, Wellington Society for the Aged	-	-	-	1	-	1
Hospice GF HIV/AIDS &TB	-	-	2	-	2	-
Kheth Impilo - Drug Councellors	-	-	-	2	-	2
Kheth Impilo- HIV Kraaifontein	-	-	69	9	69	9

ANNEXURE 6A
INTER-ENTITY ADVANCES PAID (note 11) (CONTINUED)

ENTITY	Confirmed balance outstanding		Confirmed balance outstanding		Total	
	31/03/2014	31/03/2013	31/03/2014	31/03/2013	31/03/2014	31/03/2013
	R'000	R'000	R'000	R'000	R'000	R'000
Kheth Impilo-TB Enhanced	-	-	2	19	2	19
Kheth Impilo-TB HIV Integrated	-	-	-	37	-	37
Koinonia Welfare	-	-	-	106	-	106
Living Hope: HBC	-	-	-	11	-	11
Living Hope: Integration	-	-	-	1	-	1
Living Hope: Non-Medical Site	-	-	-	6	-	6
Ma Afrika Tikkun	-	-	-	36	-	36
Masincedane	-	-	-	24	-	24
Matzikama Multi Sectorial Action Team	-	-	-	1	-	1
Oasis – Delft	-	-	2	1	2	1
Oasis - Ravensmead	-	-	-	70	-	70
Oikos (Touch)	-	-	21	1	21	1
Ons Huis Farm Health	-	-	6	-	6	-
Ons Huis HBC	-	-	3	-	3	-
Opportunity To Serve Ministries	-	-	-	91	-	91
Partners In Sexual Health HTA	-	-	30	-	30	-
Partners In Sexual Health NMS North	-	-	14	10	14	10
Partners in Sexual Health Truckers NTSS	-	-	35	-	35	-
Sacla	-	-	-	76	-	76
Sonke Gender Justice Prison Project	-	-	-	2	-	2
Spades YDA	-	-	251	173	251	173
St John	-	-	-	13	-	13

WESTERN CAPE GOVERNMENT HEALTH
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ANNEXURES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 March 2014

ANNEXURE 6A
INTER-ENTITY ADVANCES PAID (note 11) (CONTINUED)

ENTITY	Confirmed balance outstanding		Confirmed balance outstanding		Total	
	31/03/2014	31/03/2013	31/03/2014	31/03/2013	31/03/2014	31/03/2013
	R'000	R'000	R'000	R'000	R'000	R'000
St Lukes Hospice	-	-	-	1	-	1
TB/HIV Care	-	-	-	8	-	8
TB/HIV Care: Assoc	-	-	-	58	-	58
TB/HIV Care: Association NMS	-	-	3	48	3	48
TB/HIV Care: TB Clerks & Assistants	-	-	-	2	-	2
Tehilla	-	-	-	6	-	6
The Grail Centre Trust, Thembacare - Village of Hope, Overberg Crisis Centre, Badisa Sorg Sentrum	-	-	-	78	-	78
Touching Nations	-	-	27	430	27	430
Touching Nations - TB Dots	-	-	-	13	-	13
Touching Nations - TB Dots	-	-	-	8	-	8
Touching Nations - Enhanced Response	-	-	-	9	-	9
Triangle NTSS	-	-	1	-	1	-
Tygerberg Hospice - Step Down	-	-	165	17	165	17
Whole World Women NTSS	-	-	5	-	5	-
Wolanani	-	-	-	2	-	2
YMCA Athlone	-	-	-	44	-	44
TOTAL	**-**	**-**	**760**	**1 681**	**760**	**1 681**

ANNEXURE 6B
INTER-ENTITY ADVANCES RECEIVED (note 16.1)

ENTITY	Confirmed balance outstanding		Unconfirmed balance outstanding		Total	
	31/03/2014	31/03/2013	31/03/2014	31/03/2013	31/03/2014	31/03/2013
	R'000	R'000	R'000	R'000	R'000	R'000
OTHER ENTITIES						
Current						
Spectramed	8	8	-	-	8	8
Fishmed	8	8	-	-	8	8
Golden Arrow	12	12	-	-	12	12
Discovery (Control Resp)	-	73	-	-	-	73
Discovery (Management Accounting)	80	-	-	-	80	-
Prosano (Financial Accounting)	-	2	-	-	-	2
Subtotal	**108**	**103**	**-**	**-**	**108**	**103**
Non-Current						
RAF unallocated (Management Accounting)	-	-	70 680	98 622	70 680	98 622
RAF unallocated (Control Responsibility)	-	-	-	386	-	386
Unallocated Medical Aid	-	-	-	8	-	8
COID/WCA unallocated	-	-	2 270	6 670	2 270	6 670
Vericred unallocated	-	-	74	-	74	-
State Departments unallocated	-	-	36	-	36	-
Subtotal	**-**	**-**	**73 060**	**105 686**	**73 060**	**105 686**
TOTAL	**108**	**103**	**73 060**	**105 686**	**73 168**	**105 789**
Current	108	103	-	-	108	103
Non-current	-	-	73 060	105 686	73 060	105 686

Department of Health
P.O. Box 2060, Cape Town, 8000 tel: +27 21 483 3245 fax: +27 21 483 6169
Website: www.westerncape.gov.za

Afrikaans and isiXhosa versions of this publication are available on request.

Western Cape Government
Health