Western Cape Government

Health

Annual Performance Plan

2012/2013

WESTERN CAPE GOVERNMENT:
HEALTH

ANNUAL PERFORMANCE PLAN
2012/13

ISBN: 978-0-620-52911-2

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Printed in the Republic of South Africa
For the Government Printers
By Coalition Trading

FOREWORD BY THE MINISTER OF HEALTH

ANNUAL PERFORMANCE PLAN: 2012/13

Western Cape Government's role is to make the vision of an open opportunity society for all an everyday reality. This we cannot achieve alone, but in partnership with each and every citizen, with civil society, with business and with other institutions and spheres of government. We are better together.

The Department of Health leads the way on the road to SO4 – Increasing Wellness with the strategic plan based on patient-centeredness, a move towards an outcomes-based approach, the retention of a primary healthcare philosophy, strengthening the district health services model, and building strategic partnerships.

The key service delivery priorities in this year's annual performance plan include:

- Focusing on quality of care initiatives
- The long-awaited commissioning of the Khayelitsha District Hospital
- Commissioning the Mitchells Plain District Hospital
- Implementing a saving-mothers-and-children plan
- Implementing the integrated TB/HIV plan
- Rolling out key prevention strategies in communities with relevant stakeholders
- Strengthening general specialist service and training

A particular focal point is Healthcare 2020, the Department's strategic vision and comprehensive service plan leading up to 2020, with client-centred quality care at the core. Particularly in the eyes of the patient, the patient experience is as important as the outcome of the treatment, and the respectful treatment of the patient. The Department will put multi-level interventions in place to address staff behaviour and approach towards patients.

It remains a challenge to achieve these performance targets within limited financial constraints. I want to commend all staff members for the exemplary display of discipline on this front.

I endorse this Annual Performance Plan as a detailed framework for this department's targets, within the available budget.

THEUNS BOTHA

WESTERN CAPE MINISTER OF HEALTH

FEBRUARY 2012

MESSAGE FROM THE HEAD OF DEPARTMENT

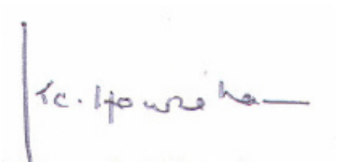
PROFESSOR KC HOUSEHAM

The commissioning of the Khayelithsha Hospital during 2012 is a watershed event in the history of public sector health care in the Western Cape. This is a world class, state of the art, district hospital located in one of the most disadvantaged communities of the Western Cape with some of the poorest health outcomes in the province. It is also the first new hospital to be constructed in the province for several decades. Towards the latter part of this financial year a second hospital, the new Mitchells Plain Hospital will also be commissioned. The opening of these two hospitals will change the landscape of the health service very significantly within the Cape Metro and could be regarded as one of the most important developments in Western Cape health services since 1994.

2012 is in addition a landmark year as the Department will finalise the 2020 strategic framework, which will provide a roadmap for public sector health services in the Western Cape for the next decade. The 2020 framework builds on the Healthcare 2010 Comprehensive Service Plan (CSP) and yet heralds some important policy shifts. 2020 continues to strengthen the Primary Health Care philosophy, the District Health Service model and institutionalises good corporate practices such as operating with the budget and an unqualified audit. However, 2020 places emphasis on improving the quality of care and the patient experience. There is a values-based approach to strengthen commitment of staff towards improving the patient experience and clinical outcomes. There is also a conceptual shift towards wellness, strengthening prevention and promotion both within the health service as well as upstream within broader society.

Finding the additional resources to commission two new hospitals is a significant but welcome challenge. It calls for reprioritisation of the Department's baseline allocation and in addition greater efficiency.

2012 will be year of challenges and opportunities that calls for a united resolve to focus on developing the vision for 2020 and to take the first systematic steps in this direction. I am convinced that the Western Cape Department of Health has the people with skills, dedication and talent to make this vision a reality.



PROFESSOR CRAIG HOUSEHAM
HEAD HEALTH: WESTERN CAPE
FEBRUARY 2012

OFFICIAL SIGN-OFF OF THE

ANNUAL PERFORMANCE PLAN: 2012/13

It is hereby certified that this Annual Performance Plan:

- Was developed by the management of the Western Cape Government: Health.
- Was prepared in line with the current Strategic Plan of the Western Cape Government: Health, under the guidance of Minister Theuns Botha.
- Accurately reflects the targets which the Western Cape Government: Health will endeavour to achieve given the resources made available in the budget for 2012/13.

Mr A Van Niekerk
Chief Financial Officer

Signature: .....

Dr KN Vallabhjee
Chief Director:
Strategy and Health Support

Signature: .....

Professor KC Household
Accounting Officer

Signature: .....

APPROVED BY:

Theuns Botha
Executive Authority

Signature: .....

CONTENTS

PART C: LINKS TO OTHER PLANS

EXECUTIVE SUMMARY

During 2012 the Department will finalize the 2020 strategy. The principles, vision and values and a generic approach to planning for the health service platform embodied in the strategy have been developed and endorsed by a critical mass of senior and middle management within the Department. Following approval of the strategic direction for public health services in the Western Cape by the Provincial Cabinet a discussion document was released in December 2011 for public comment. Staff within the health service as well as external stakeholders such as the universities, organized labor, the private sector and NPOs will be engaged to build consensus around the strategic direction of the Department for the next decade.

The draft strategy for 2020 has two main thrusts, as described in the Strategic Objective: Improving Wellness (SO 4) that forms part of provincial strategic plan.

Firstly, at the heart of the vision of 2020 is a renewed commitment to a caring, quality, patient-centric health service. The district health service, supported by all levels and sections of the service is the key vehicle to deliver this quality health service. The PHC philosophy implies a comprehensive health service across levels of care and the various sectors allowing for meaningful and active participation by communities. The limited resource base compared to the need for health services demands a more focused approach to improve health outcomes in the most efficient and productive manner possible. The Department acknowledges that addressing these challenges requires strong partnerships with a range of role players.

Secondly, there is an important conceptual shift from managing the consequences of the burden of disease to improving wellness. Central to this approach is an increased emphasis on prevention and promotion by addressing the upstream risk factors that impact on health and wellness in the whole of society. The endorsement at the Western Cape Health Summit held in November 2011 of the Cape Town Declaration on Wellness by approximately 250 delegates from all sectors of society in the Western Cape was an important milestone in this regard. There are six focus areas that have been identified and work is underway to identify, plan and implement projects in these areas. A summary of progress has been included in Part A of the APP. These are the promotion of safety and reduction of injuries, women's health, child health, mental health, healthy lifestyles and HIV/TB. These focus areas are aligned with the Millennium Development Goals (MDG) and the quadruple burden of disease that afflicts the provincial population.

The Department will embark upon a structured process to engage staff around creating a heightened values consciousness. The departmental values are caring, competency, accountability, integrity, responsiveness and respect. There is increasing international evidence that a values-based approach impacts positively on the quality of the health service and productivity of the workforce. Annual Baretts values survey results have and will be used as a basis for this dialogue with staff, which will drive a change management process in the Department.

The Department's strategic goals as outlined in the Annual Performance Plan and the 2020 strategy are aligned with the goals of the National Service Delivery Agreement of the National Minister as well as the MDGs. Improvement in the quality of health services and strengthening the district and primary health care services are common to both the 2020 strategy and the discussion document on National Health Insurance. The provincial government while differing with the national government on certain aspects of the NHI proposals supports the general thrust toward improving the quality of health services and as outlined in the APP is strengthening general specialist outreach in health districts and school health services to this end.

An important development within the health service will be the full commissioning of the new Khayelithsha Hospital. This is a state of the art modern 230 bedded hospital located within the Khayelithsha health district that has some of the worst health outcome indicators and greatest burden of disease in the Western Cape. The full impact of the opening of this hospital on health

services in the Cape Metro will only be fully appreciated after the hospital has been fully commissioned.

In 2012/13, it is projected that 16 348 182 patients will be managed at PHC level, 511 367 patients admitted to the department's hospitals, 135 018 patients treated with anti-retroviral therapy, 487 781 patients transported in ambulances, 98 500 babies delivered in the maternity services and 6 909 cataract operations performed. The aim is to achieve a TB cure rate of 82 per cent, immunization coverage of 95 per cent, reduce mother to child transmission of the AIDS virus to 1.8 per cent and reduce maternal mortality within our institutions to 65 per 100 000 live births.

Another important development in 2012 will be the implementation of the new contract for the Chronic Dispensing Unit (CDU). The service from the CDU will be expanded from the Cape Metro to cover all areas of the province in a phased manner and ultimately home delivery of medication to patients who are stable on chronic medication and have a fixed home address.

The overall reduction in real terms of the provincial equitable share of the budget has meant that additional funds could not be allocated specifically to national priority areas such as school health services, district specialist teams and community-based services. However, these priorities will be addressed within the available budget. It is noteworthy that the Western Cape Department of Health has already progressed some way to address these priorities over the last two years.

The need for good quality, auditable data to manage a complex health service requires a further investment of resources. The process to strengthen information management capacity commenced in 2011 will continue. In addition to the appointment of new staff and further in-house training will increase the capacity to address shortcomings in the system.

The Primary Health Care Information System (PHCIS) that was developed by the department will be further rolled out in 2012/13 to cover all the 126 PHC facilities in the province. The increased automation will also reduce the strain that manual processes exert on the staff, improve the quality of the data for better management and reduce the audit risk. The improvement of response times within EMS remains an important priority within the health service and the envisaged new communication system will seek to augment initiatives in this regard. A pharmacy information system is being implemented at hospitals to improve inventory management and controls.

Baseline quality audits were conducted at all facilities to assess compliance with the set of national core quality standards in 2011. These findings will be used as the basis to develop quality improvement plans at institutional level. An initiative to improve the patient experience within PHC and district hospitals will commence with a focus on reception services, clinical governance and continuity of care.

During this financial year two new Primary Health Care facilities in Grassy Park and Malmesbury Wesbank will be completed. The Vrendendal Ambulance Station and the Beaufort West Forensic Pathology Laboratory will also be completed in this period. Adequate maintenance of physical infrastructure remains an on on-going challenge.

The construction of the Mitchells Plain Hospital will be completed at the end of this financial year. The current services from the G F Jooste Hospital will be transferred to the Mitchells Plain Hospital to enable the G F Jooste Hospital to be rebuilt. Ultimately the three new district hospitals in the Cape Metro, viz. Khayelithsha, Mitchells Plain and GF Jooste Hospitals provide much needed relief to the communties of the Cape Flats that for many years have suffered from a lack of adequate hospital facilities in the areas where they live.

In conclusion it can be seen from this executive summary that the Western Cape Department of Health is making significant progress toward its vision of Quality Health for All. The Department has taken seriously the Premier's call for all departments to contribute to the provincial government's efforts to become the best regional government in the world!

PART A
STRATEGIC OVERVIEW

PART A: STRATEGIC OVERVIEW

1. VISION

Quality health for all.

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

2. MISSION

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

3. VALUES

The core values of the Department are:

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

The Western Cape Government conducted a Barrett Survey during 2010 which assessed the personal and organisational values of Departments. Participants in the survey were requested to identify their personal values and the values that they 'desire' and those that they experience in the Department.

This exercise highlighted issues in the actual experienced values of the Department as well as the manner in which staff engage with each other and the organisation.

The Top Management of the Department undertook a 360-degree leadership evaluation to identify areas that can be improved within their specific sphere of influence. Approximately 350 managers have participated in Barrett Survey Values workshops to create awareness of the importance of values and their impact on service delivery. The workshops have orientated senior and middle management to the core values of the Provincial Government and the Department.

The second annual Barrett Survey was undertaken in July 2011 and was broadened to increase the depth of engagement around building a values based approach. This process will be further deepened during the 2012/13 financial year.

4. STRATEGIC GOALS

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

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

The wording of the strategic goal titles and statements has been refined. The changes that have been made are underlined in the table below and included in Annexure A where changes to the 2009/10 Five-year Strategic Plan, are recorded. The strategic goals will be substantially reviewed once the 2020 framework has been adopted in the first half of 2012.

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

STRATEGIC GOAL	GOAL STATEMENT	JUSTIFICATION	LINKS
1. Burden of disease.	1.1. Address the burden of disease.	This strategic goal relates to the core business of the Department, i.e. delivering a health service as well as advocating for interventions to address the upstream factors that generate this burden of disease. All the related strategic objectives are focussed on effective and efficient service delivery in order to maximise health outcomes/increase wellness.	Millennium Development Goals No4, 5 and 6. Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: Burden of disease report. **Outcomes**: • Increase life expectancy • Decreasing maternal and child mortality • Combating HIV and AIDS and decreasing the burden of disease from tuberculosis • Reduce mortality and morbidity from injuries. Provincial strategic objective 04: Increase wellness.
2. Quality of health services.	2.1. Improve the quality of health services and the patient experience.	The purpose of this goal is to focus on the importance of delivering a quality service.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
3. Strategic management capacity and synergy.	3.1. Ensure and maintain organisational strategic management capacity and synergy.	This goal aims to ensure that: • The Department has a clear plan and targets against which to measure its performance. • Management systems are in place to optimally utilise available resources in a co-ordinated manner.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.

STRATEGIC GOAL	GOAL STATEMENT	JUSTIFICATION	LINKS
4. A capacitated workforce.	4.1. Develop and maintain a capacitated workforce to deliver the required health services.	The purpose of this goal is to ensure that staff is adequately recruited and retained; appropriately trained and skilled to perform the functions for which they are employed.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
5. Health technology, infrastructure and Information Communication Technology (ICT).	5.1. Develop and maintain appropriate health technology, Infrastructure and ICT.	This goal addresses the provision of the appropriate infrastructure to deliver the required service in the most cost effective and efficient manner. It addresses buildings, equipment and information communication technology.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
6. Financial management	6.1. Optimal financial management to maximise health outcomes	Given that the need for health services outstrips the available funding the purpose of this goal is to focus attention on: • The importance of appropriate budgeting and financial control. • The need to explore all appropriate avenues of revenue generation to supplement the budget. • Optimal value for the health rand and maximising efficiencies in all sections of the Department.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.

5. LEGISLATIVE MANDATES AND POLICY INITIATIVES

5.1 LEGISLATIVE MANDATES

The Western Cape District Health Councils Act, 5 of 2010 came into operation on 24 August 2011, by proclamation which was signed on 22 August 2011 (Provincial Government Gazette Extraordinary 6901).

According to section 7(8) of the Act, the Minister or his representative must convene the first meeting of a district health council within ninety days of the commencement of the Act.

The inaugural meetings of all the six District Health Councils were convened by 22 November 2011.

6. POLICY INITIATIVES

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

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

6.1 THE MILLENNIUM DEVELOPMENT GOALS [MDGS]

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

Table 2: Millennium development goals

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

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

6.2 NATIONAL GOVERNMENT

6.2.1 The Twelve National Outcomes of the National Government

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

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

6.2.2 **Functional budgeting approach:**

The functional budgeting approach that was developed in the 2011 medium-term expenditure framework (MTEF) will be further embedded in the 2012 MTEF process as the mechanism through which the outcomes-based approach is reflected in the budget.

Functional budgeting entails grouping government activities according to broad policy purposes or types, i.e. functions. All government institutions, i.e. national and provincial departments and their respective entities or local government partners that contribute towards a particular function are grouped together in a functional workgroup. Formal committees are set up within functional workgroups that negotiate among themselves on budgetary matters, such as allocations and priorities, to reach an understanding and agreement around work of the function.

There are eight functional groups at national level:

1) General public services
2) Science and Technology
3) Defence, public order and safety
4) Economic services and environmental protection
5) Economic Infrastructure
6) Local government, housing and community amenities
7) Education, labour and related functions
8) Health and Social Protection.

6.2.3 **The National Planning Commission**

The National Planning Commission (NPC), in the Presidency, released the Diagnostic Report in June 2011, which described the achievements and shortcomings since 1994.

The NPC published the National Development Plan (NDP): Vision for 2030 on 11 November 2011 as a step to charting a new path for South Africa which seeks to eliminate poverty and reduce inequality by 2030.

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

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

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

6.2.3.1 **Health care for all**

Targets:

1) By 2030, life expectancy should reach at least 70 for both men and women.
2) The under-20 age group should largely be an HIV-free generation.
3) The infant mortality rate should decline from 43 to 20 per 1 000 live births and the under-five mortality rate should be less than 30 per 1 000 from 104 today.
4) Maternal mortality should decline from 500 to 100 from 100 000 live births.

5) All HIV-positive people should be on treatment and preventive measures such as condoms and micro-biocides should be widely available, especially to young people.
6) Reduce non-communicable diseases by 28 per cent and deaths from drug abuse, road accidents and violence by 50 per cent.
7) Everyone has access to an equal standard of basic health care regardless of their income.

Actions:

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

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

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

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

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

6.2.3.2 **Education**

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

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

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

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

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

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

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

PRIORITY	KEY ACTIVITIES
1. Provision of strategic leadership and creation of social compact for better health outcomes	1) Ensure unified action across the health sector in pursuit of common goals
	2) Mobilise leadership structures of society and communities
	3) Communicate to promote policy and buy in to support government programs
	4) Review of policies to achieve goals
	5) Impact assessment and programme evaluation
	6) Development of a social compact
	7) Grassroots mobilisation campaign
2. Implementation of National Health Insurance (NHI).	8) Finalisation of NHI policies and implementation plan
	9) Immediate implementation of steps to prepare for the introduction of the NHI, e.g. Budgeting, Initiation of the drafting of legislation
3. Improving the quality of health services.	10) Focus on 18 Health districts
	11) Refine and scale up the detailed plan on the improvement of quality of services and directing its immediate implementation
	12) Consolidate and expand the implementation of the health facilities improvement plans
	13) Establish a national quality management and accreditation body
4. Overhauling the health care system and improving its management.	14) Identify existing constitutional and legal provisions to unify the public health service
	15) Draft proposals for legal and constitutional reform
	16) Development of a decentralised operational model, including new governance arrangements
	17) Training managers in leadership, management and governance
	18) Decentralisation of management
	19) Development of an accountability framework for the public and private sectors
5. Improved human resources planning development and management	20) Refinement of the HR plan for health
	21) Re-opening of nursing schools and colleges
	22) Recruitment and retention of professionals, including urgent collaboration with countries that have excess of these professionals
	23) Specify staff shortages and training targets for the next 5 years
	24) Make an assessment of and also review the role of the Health Professional Training and Development Grant (HPTDG) and the National Tertiary Services Grant (NTSG)
	25) Manage the coherent integration and standardisation of all categories of community health workers
6. Revitalisation of infrastructure.	26) Urgent implementation of refurbishment and preventative maintenance of all health facilities
	27) Submit a progress report on Revitalization
	28) Assess progress on revitalisation
	29) Review the funding of the revitalization programme and submit proposals to get the participation of the private sector to speed up this programme

PRIORITY	KEY ACTIVITIES
7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases.	30) Implementation of prevention of mother-to-child transmission (PMTCT), paediatric treatment guidelines
	31) Implementation of adult treatment guidelines
	32) Urgently strengthen programs against TB, MDR-TB and XDR-TB
8. Mass mobilisation for the better health for the population.	33) Intensify health promotion programmes
	34) Strengthen programmes focusing on maternal, child and women's health
	35) Place more focus on the programmes to attain the Millennium Development Goals (MDGs)
	36) Place more focus on non-communicable diseases and patients' rights, quality and provide accountability
9. Review of drug policy.	37) Complete and submit proposals and a strategy, with the involvement of various stakeholders
	38) Draft plans for the establishment of a state-owned drug manufacturing entity
10. Strengthening Research and Development	39) Commission research to accurately quantify infant mortality
	40) Commission research into the impact of social determinants of health and nutrition
	41) Support research studies to promote indigenous knowledge systems and the use of appropriate traditional medicines

6.3.1 **National Health Insurance:**

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

The Department's focus on strengthening the quality of care includes: a baseline assessment of compliance with the national core standards at all facilities; building the capacity and systems at the level of district management; the district specialist teams from regional hospitals providing outreach and support and clinical governance oversight; primary health care re-engineering and the strengthening of school health services, which are all in line with the broad direction of the NHI. The Western Cape Government is engaging with the national minister regarding its concerns with the NHI.

6.3.2 **Provincial government**

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

The provincial strategic objectives are:

1) Creating opportunities for growth and jobs
2) Improving education outcomes
3) Increasing access to safe and efficient transport

4) **Increasing wellness**
5) Increasing safety
6) Developing integrated and sustainable human settlements
7) Mainstreaming sustainability and optimising resource use efficiency
8) Promoting social inclusion and reducing poverty [SO8 and 9 are being combined)
   Increasing social cohesion [SO8]
   Poverty reduction and alleviation [SO9]
9) Integrating service delivery for maximum impact
10) Increasing opportunities for growth and development in rural areas
11) Building the best-run provincial government in the world.

The Department of Health contribution to the Provincial strategic objectives:

Table 4: Summary of the Department of Health's contribution to the provincial strategic objectives

Provincial strategic objective	Contribution of the Western Cape Department of Health
1. Creating opportunities for growth and jobs	In 2012/13, the following will be temporarily employed and trained: • 2 000 community health workers • 140 data capturer interns • 110 pharmacist assistants • 120 assistants to artisans interns • 120 human resource and finance interns.
2. Improving education outcomes	The Department will be working with the Western Cape Department of Education to strengthen the Health Promoting Schools Programme with a particular emphasis on healthy lifestyles.
3. Increasing access to safe and efficient transport	Emergency Medical Services planned patient transport or HealthNET performs outpatient transfers between levels of care within districts and across districts to regional and tertiary hospitals. Approximately three thousand patients per month are transported to Cape Town hospitals from rural areas.
4. Increasing wellness	Refer to paragraph 6.3.2.2
5. Increasing safety	The interventions for injury prevention as discussed below would contribute to safety as well.
6. Developing integrated and sustainable human settlements	The Department endeavours to position new health facilities where there is service demand due to population expansion. The Department will engage with the Department of Human Settlements to be part of a process of developing integrated and sustainable human settlements.
7. Mainstreaming sustainability and optimising resource use efficiency	The primary objective of the infrastructure programme in the Department of Health is to promote and advance the health and well-being of all individuals and populations in the province in an ecologically responsible manner. This objective will be met through the implementation of the "4Ls Agenda" in all new buildings/projects. The "4Ls Agenda is: 1) Long life (Sustainability), 2) Loose fit (Flexibility),

Provincial strategic objective	Contribution of the Western Cape Department of Health
	3) Low impact (Reduction of carbon footprint), 4) Luminous healing space (Enlightened healing environment). This aligns to the Provincial Strategic Objective 7: "Mainstreaming sustainability and resource-use efficiency", as well as the National Climate Change Response White Paper of October 2011.
8. Promoting social inclusion and reducing poverty [SO8 and 9 are being combined)	The Department's aim to deliver quality health services for all and to ensure that wellness is attained through prevention of disease as discussed above contributes to the reduction of poverty because healthy people are more likely to be economically active, attend school and have good education outcomes.
Increasing social cohesion [SO8]	
Poverty reduction and alleviation [SO9]	
9. Integrating service delivery for maximum impact	Historically the Department has comprised different institutions and services, working within different budget programmes and divisions which have resulted in a fragmented service and the development of functional silos. This lead to the adoption of the concept Geographic Service Areas (GSA), which is a functional arrangement to facilitate better cohesion and co-ordination of health services for a defined population within a specified geographic area to ensure the delivery of specific health outcomes. At district level, District Management teams have working relationships with other departments such as Education, Social department and local municipalities to address in particular social determinants of health e.g. in Cape Winelands District the District Management is collaborating with the local Social Development and Education Management teams to understand the root causes of teenage pregnancy and jointly develop an intervention to address this. The Department has collaborated effectively with other departments and spheres of government to co-ordinate and manage the response to the diarrhoeal season which has resulted in a significant reduction in admissions and child deaths. Through the PTMS the Department collaborates with various other departments on the programmes to increase wellness.
10. Increasing opportunities for growth and development in rural areas	As reflected in Part B: Programme 8 of the document, most of the infrastructure projects in progress are in the rural areas.
11. Building the best-run provincial government in the world.	The Department will be working with the Department of the Premier to develop and pilot a workplace programme on wellness for the employees of the provincial government. This will be done in collaboration with the Sports Science Institute of South Africa.

6.3.2.1 **Provincial Transversal Management System [PTMS]**

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

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

The strategic objectives are clustered into three sectors i.e. human development, economic and infrastructure, and administration and inter-governmental. Each of the strategic objectives has a steering group that co-ordinate the working groups within the strategic objective.

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

1) Violence and road injuries prevention
2) Healthy lifestyles
3) Women's health
4) Maternal and child health
5) Infectious diseases (HIV and TB)
6) Mental Health

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

1. INTRODUCTION

The Government of the Western Cape is committed to increasing the wellness of the people of the Province. This will be achieved by coordinating measures to address the upstream factors that contribute to the burden of disease and through the provision of comprehensive quality health care services, from primary health care to highly specialized services.

The key indicators of wellness are:

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

2. PROBLEM STATEMENT

The health of the people of the Western Cape is undermined by the growing burden of disease of communicable and non-communicable disease and injury.

In order to address this, the causes and effects of the burden of disease need to be addressed in a comprehensive approach to wellness that includes the realisation of an individual's fullest potential (physically, psychologically, socially, spiritually and financially) as well as fulfilment of expectations in the family, community, work, school and other settings.

3. THE APPROACH TO INCREASING WELLNESS

The approach to wellness is one where the whole-of-society resources, knowledge, creativity are mobilized (including from all three spheres of government, civil society, business, and individuals) to contribute meaningfully to the attainment of wellness.

While strengthening collaboration and partnerships, the Department of Health also delivers on its core responsibilities of providing health services that provide for prevention, health promotion, treatment and rehabilitation.

4. PLAN TO INCREASE WELLNESS: THE ROLE OF THE DEPARTMENT OF HEALTH

4.1 Development of a new strategy towards 2020

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

The key components of the strategy include:

1) A change management process to institutionalise a values-driven and client centred approach to patient care and service delivery.
2) A gap analysis to identify the factors that are required to deliver a 'quality patient experience' and the development of appropriate action plans.
3) The technical planning of a financially sustainable service platform to meet the demand for service, in terms of access, equity and type of service.

4.2 Principles of 2020

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

1) Patient centred quality care, will:

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

2) **Health outcomes approach**:

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

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

This means a service that:

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

4) **Strengthening of the district health system model**:

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

5) **Equity**:

- This is an important social justice principle.

- There must be equity in terms of:
  - Access to services
  - Allocation of resources
  - Outcomes
- Patients receive the service that they require according to their need.

6) **Affordable health service**:

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

7) **Strategic partnerships**:

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

4.3 Immediate action

The Department of Health will continue to improve service delivery while developing a 2020 vision and strategy.

A discussion document has been developed on which to base engagements with internal and external stakeholders such as the clients and staff and the faculties of health science at the Western Cape higher education institutions. Feedback will be reviewed and the document finalised and published in the first quarter of the 2012/13 financial year.

Key service delivery priorities for 2012/13 MTEF cycle include:

- Focusing on quality of care initiatives.
- Khayelitsha District Hospital was completed and the first patients were admitted on 16 January 2012.
- Commissioning the Mitchells Plain District Hospital, scheduled for completion of the construction in December 2012.

- Implementing a saving-mothers-and-children plan.
- Implementing the integrated TB/HIV plan contained in the provincial HCT strategy.
- Rolling out key community-based prevention strategies with relevant stakeholders.
- Strengthening general specialist service and training.

The nature of the burden of disease, which is addressed in the strategic objective, is not repeated here as it is addressed in more detail in paragraph 7.3.

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

5.1 The advocacy role of the Department of Health

As discussed the primary role of the Department of Health is to provide a comprehensive package of health services which largely addressed down- and mid-stream risk factors. However, given the Department's understanding of the significant impact that upstream risk factors have on the burden of disease, it must play an effective advocacy role to ensure that upstream issues are appropriately addressed by other departments, sectors and society.

The advocacy role of the Department of Health includes:

- The ability to provide information that identifies the communities most affected by the burden of disease and its associated risk factors.
- Establishing early warning systems for important risk factors.
- Providing the evidence that shows the interventions that have been proven to successfully work elsewhere or in similar contexts.
- Working with other role players to design these interventions locally.
- Providing a system to monitor and evaluate progress towards addressing all (down-, mid- and upstream) risk factors and the associated diseases and providing recommendations on further action to be taken.

5.2 Premier's summit on reducing the burden of disease

On 8 November 2011, Ms Helen Zille, the Premier, hosted a summit on reducing the burden of disease focusing on infectious diseases, child health, woman's health, violence and road injuries, and non-communicable disease. The Summit:

- Reviewed the latest available data on the burden of disease.
- Provided input into the technical strategy to respond to the burden of disease by all levels of government and by role-players outside of government in the private sector and civil society.
- Identified an action agenda for implementation, designed to advance the collective effort of all role-players to reduce the burden of disease.
- Committed a broad range of delegates to the ten undertakings in the Cape Town Declaration on Wellness.

5.3 Decreasing the incidence of infectious diseases (HIV and TB)

The Department, through South African National Aids Council (SANAC) and Provincial Interdepartmental AIDA Committee (PIDAC), has developed a good network of partners to work in the areas of HIV and TB and will continue to use existing structures. There are five main areas:

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

5.4 Preventing violence and road injuries

Alcohol is one of the key risk factors for injuries. The objective is thus to reduce alcohol related injury. The following interventions are thus being implemented.

High Five: A focus on five high risk areas to deliver inter-sectoral alcohol-related violence reduction interventions. This will include:

1) Reducing supply of alcohol and creating safer drinking environments through the implementation of the Western Cape Liquor Act.
2) Reducing alcohol demand through:
   - Booza TV campaign based on Booza TV which is an entertaining and provocative documentary mini-series consisting of six 24-minute episodes, which challenge the misperceptions that South Africans have about alcohol, alcohol abuse and how to reduce alcohol-related harm.
   - Piloting brief motivational interviews in two trauma units aimed to test the feasibility and effectiveness of conducting brief interventions for alcohol and drug abusers at a 'teachable moment' in the trauma wards.
3) Surveillance and evaluation
   This working group is improving its linkages to the Safely Home workgroup that focuses on reducing road traffic injuries. In particular the collaboration between these workgroups is around the reduction of alcohol related harms. The violence and traffic injuries prevention workgroup is also partnering with the violence prevention through urban upgrade project (VPUU) a project aimed at reducing violence in urban areas and in particular Khayelitsha. Similarly that collaboration here is on reducing alcohol related harms
4) Violence prevention policy
   The wellness summit also recommended that a violence prevention policy should be developed because several departments are mandated to address violence in some way and a provincial policy will ensure consistent, long-term commitment to safety promotion and violence and injury prevention.

5.5 **Promoting a healthy lifestyle**

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

1) Encouraging healthy eating.
2) Increasing physical activity.
3) Establishing non-smoking zones to reduce smoking. A School Health Programme is currently under development that will include the following:
   - Advocacy and capacity development of school leadership.
   - Baseline audit of schools.
   - Tuck shop and school lunch guidelines.
   - Review of dietary content of school nutrition programme.
   - Health promotion messages in text books.

A workplace programme for provincial government staff is also being discussed and linked to the employee wellness sub-group in Strategic Objective 11: Building the best-run provincial government in the world. Partnerships with academic institutions to support the design, implementation, monitoring and evaluation of this programme are being explored.

A health brand that recognizes provincial government and private facilities that promote wellness is also being explored.

5.6 **Improving Woman's Health (WH)**

MDG goal 3 aims to promote gender equality and empower women. There is evidence that gender inequality increases the vulnerability of women and children to ill health. Intimate partner violence (IPV) is a proxy indicator for gender inequality and results in high levels of mental health problems, especially depression, anxiety, post-traumatic stress disorder and substance abuse. Teenage pregnancy, school completion, economic empowerment, crime and violence are also aggravated by IPV and rape. The summit recommended the following:

1) Policy on responding to gender based violence (GBV) within health care settings.
2) Incorporate anti- gender based violence programmes into specific women's health services (sexual, reproductive, maternal health, HIV).
3) Provide intimate partner violence screening and services.
4) Training, support and engagement of health care workers to improve the quality of care of birthing practices (address abuse of women in labour, re-ignite caring and compassionate health care workers).
5) Develop effective models of psycho-social counselling to address the huge mental health burden. Improve quality of counselling services (standards, training level).
6) Invest in programmes and projects that work with young boys and young girls to address gender and social norms by working in close collaboration with the Department of Education.

To implement recommendations 2 and 5 the Department is piloting the IPV project in PHC facilities in Cape Winelands and Northern/Tygerberg Sub-structure with a view to wider implementation.

5.7 **Improving maternal and child health**

The Summit recommended that a "life course" approach to child health be taken especially since the social and health status of the mother influences child health. In addition to the wide range of clinical services provided for maternal and child health, the Summit recommended that the following interventions be implemented:

1) Engage parents to promote a "well family" concept.
2) Focus on birthing process (health of child begins from "pre-conception").
3) Promote exclusive breast feeding.
4) Invest in the community health worker (quality and coverage) programme.
5) Invest in early childhood development (SO8).
6) Develop appropriate messages to promote maternal and child health.

5.8 **Mental Health**

This is a new area recommended at the Summit. This workgroup will be established in the 2012/13 financial year and engage with role players to undertake an analysis of the upstream factors impacting on mental health and determine priority interventions. It will work closely with other relevant workgroups and structures such as the substance abuse forum.

The Declaration for the wellness summit is attached as Appendix A.

6.3.3 Geographic service areas [GSAs]

Historically the Department has comprised different institutions and services working within different budget programmes and divisions, which has resulted at times in fragmented service delivery.

The district health service (DHS) includes community based services, primary health care services, district hospital services and more recently the TB hospitals. However, other important services, including the general specialist services, emergency medical services and forensic pathology services, required by people living in the district, lie outside the DHS.

From a patient's perspective the health service is perceived to be a single service regardless of the component parts and management structures. Similarly from the perspective of stakeholders such as suppliers who need to be paid for services rendered, the Department is perceived as a single entity.

A realisation of this challenge lead to the adoption of the concept geographic service areas (GSA), which is a functional arrangement to facilitate better cohesion and co-ordination of health services for a defined population within a specified geographic area.

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

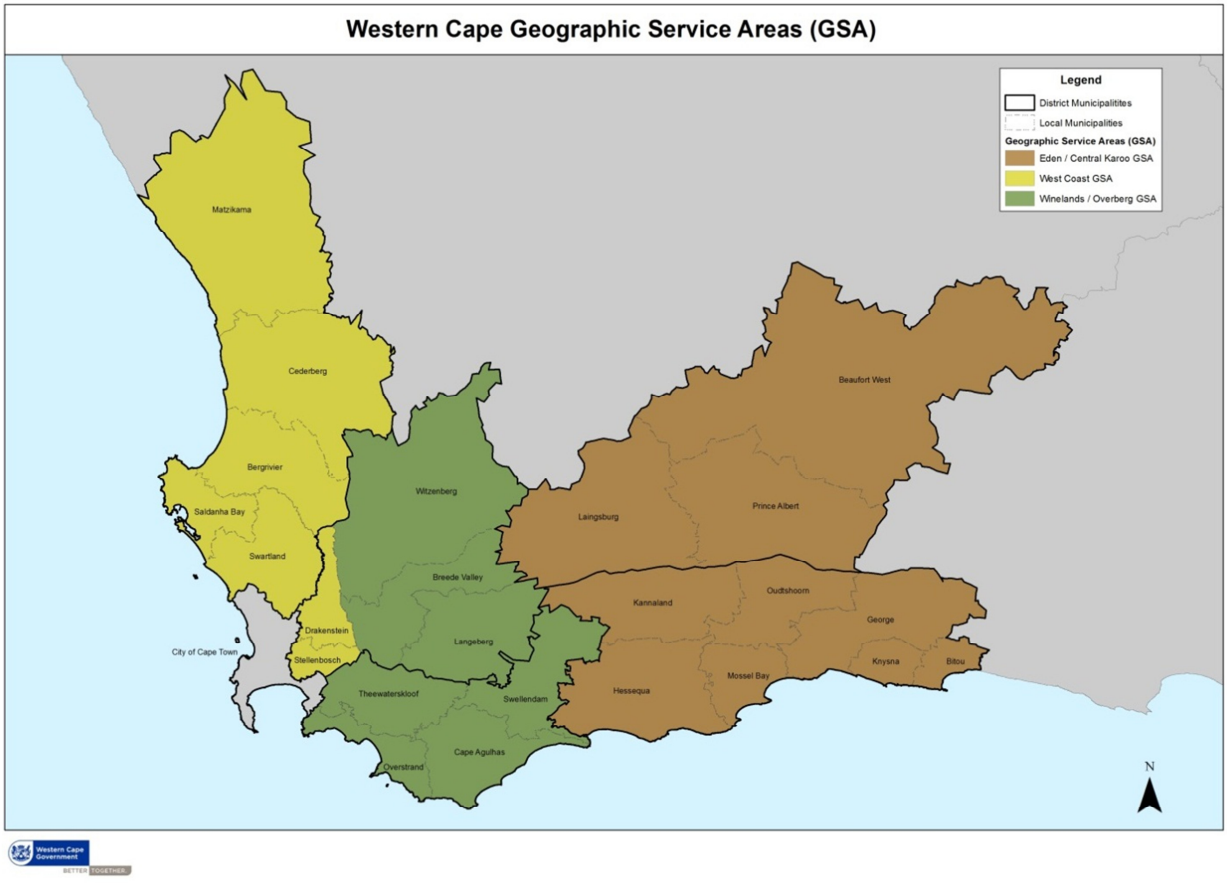
1) The Cape Town Metro District is divided into Metro West and Metro East GSAs.
2) Central Karoo and Eden are combined into the Eden/Central Karoo GSA. This has been done to address the difficulty of recruiting and retaining staff and

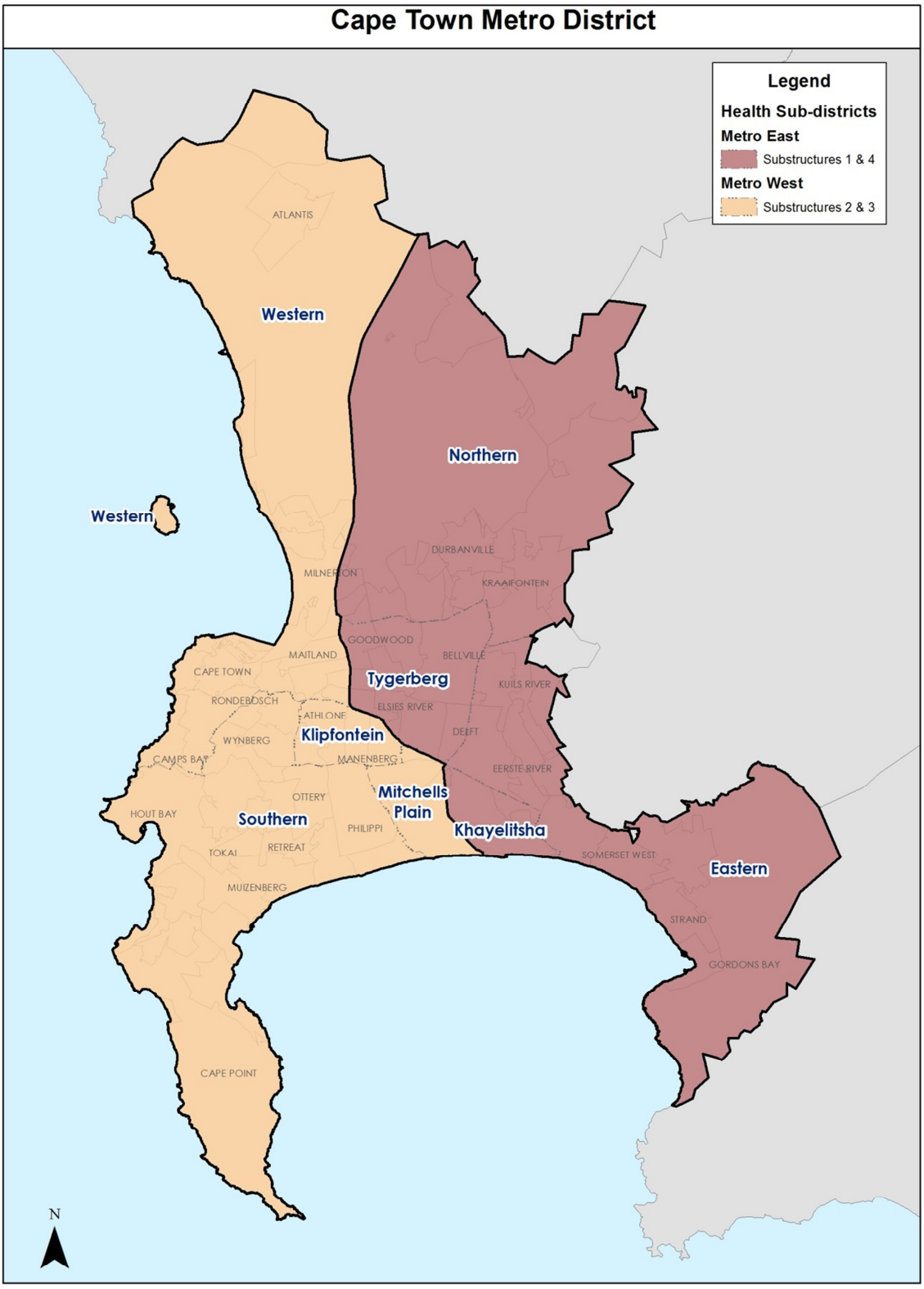
effectively managing the Central Karoo District, which is a geographically large, sparsely populated area, as an independent entity.

3) Winelands and Overberg have been combined into a single GSA for operational and logistical reasons.
4) West Coast:
   The boundaries for the West Coast GSA are co-terminous with the districts except in the Sub-districts of Drakenstein and Stellenbosch which are formally part of the Winelands District and which fall within the West Coast GSA as patients from these communities are referred to Paarl Hospital in the West Coast GSA due to the topography and road links.

District managers co-ordinate the services within the GSA, and working closely with the chief executive officer of the regional hospital, other managers and clinicians within the GSA assume responsibility for service delivery within that area. The GSAs are functional arrangements to enhance service delivery and will not impinge on the statutory structures and powers of the districts and the management teams.

The GSAs began to function during 2011 and the benefits of improved communication and co-ordination with a united focus on service priorities and joint problem solving have been realised.




Cape Town Metro District
Legend
Health Sub-districts
Metro East
Substructures 1 & 4
Metro West
Substructures 2 & 3
Western
Northern
Western
Tygerberg
Klipfontein
Mitchells Plain
Southern
Khayelitsha
Eastern
ATLANTIS
DURBANVILLE
MILNERTON
KRAAIFONTEIN
GOODWOOD
MAITLAND
BELLVILLE
CAPE TOWN
KUILS RIVER
RONDEBOSCH
ELSIES RIVER
ATHLONE
DELFT
WYNBERG
CAMPS BAY
MANENBERG
EERSTE RIVER
OTTERY
HOUT BAY
PHILIPPI
TOKAI
RETREAT
SOMERSET WEST
MUIZENBERG
STRAND
GORDONS BAY
CAPE POINT
N

7. SITUATION ANALYSIS

7.1 POPULATION PROFILE

7.1.1 Major demographic characteristics

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

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

Table 5: Population estimates

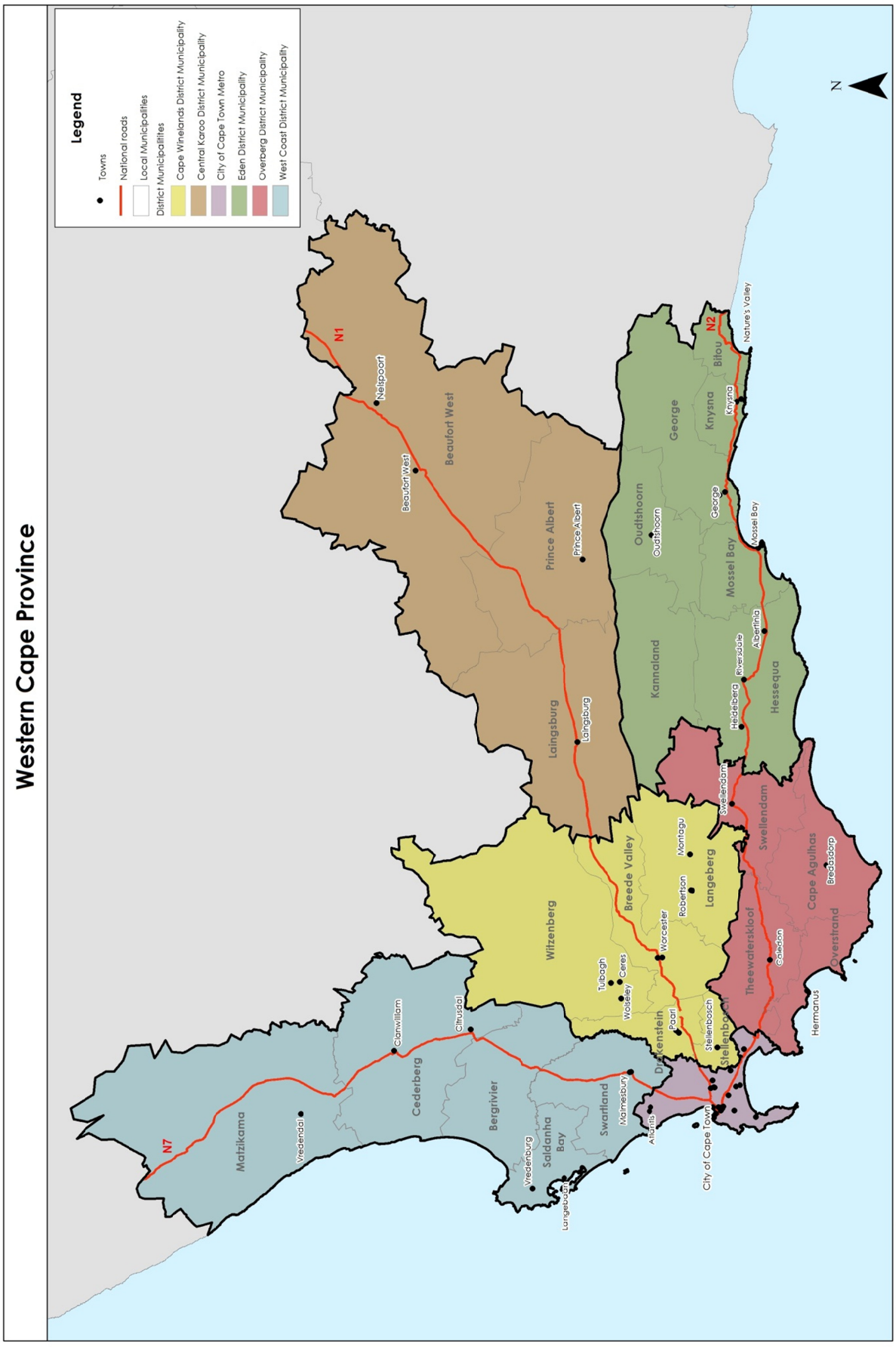
District	Census 2001	Community Survey: 2007	2008 2008/09	2009 2009/10	2010 2010/11	2011 2011/12	2012 2012/13	2013 2013/14	2014 2014/15	2015 2015/16	% Uninsured
City of Cape Town	2 892 243	3 497 097	3 553 571	3 638 959	3 724 347	3 809 735	3 895 123	3 980 511	4 065 899	4 151 287	76%
Cape Winelands	630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

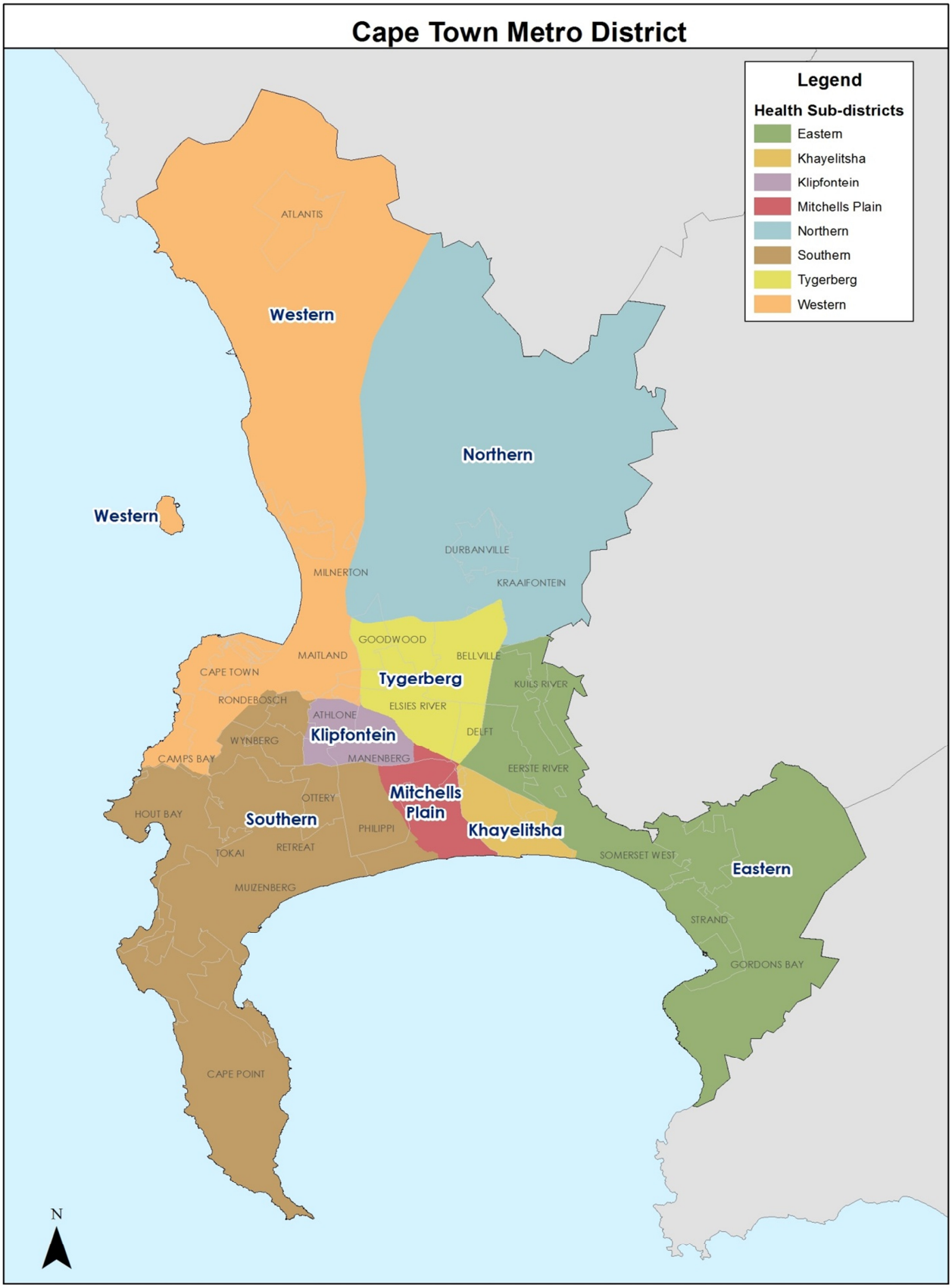
Source: Circular H13/2010: Information Management

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

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

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


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


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

7.2 SOCIO-ECONOMIC PROFILE

Although the South African economy has shown a positive year-on-year growth in real gross domestic product (GDP) since the first quarter of 2010, the labour market shows no real sign of recovery. Nationally the number of unemployed individuals, according to the expanded definition of unemployment, has grown by nearly 7 per cent per annum since 2008.

In the third quarter of 2011/12 the unemployment rate, in terms of the narrow definition of unemployment, which does not take discouraged work seekers into account, was 23.3 per cent in the Western Cape against the national rate of 25.0 per cent. In terms of the broad definition of unemployment the rate in the Western Cape for the same period was 24.3 per cent in comparison to the national rate of 33.3 per cent.

The national patterns of labour market disadvantage are also evident in the provincial labour market where there are biases in terms of youth, gender, race and level of education. (Medium Term Budget Policy Statement 2012-2015).

The deprivation index measures the relative deprivation of populations across districts within South Africa and is derived from a set of demographic and socio-economic variables from the 2007 Community Survey and the 2005 and 2006 General Household Survey. A high value for the deprivation index denotes higher levels of deprivation. Furthermore, districts that fall into socio-economic quintile 5 are the least deprived (best off), whereas those that fall into quintile 1 are most deprived (worst off). All the districts within the Western Cape are ranked amongst the least deprived in the country (District Health Barometer 2008/09).

Province-specific deprivation indices (StatsSA) show that the most deprived wards within the Western Cape are within the City of Cape Town municipality, particularly the townships on the Cape Flats alongside the N2, and in the Karoo. The Central Karoo comprises approximately one per cent of the total population. More detailed analysis also suggests that approximately half of the fifty most deprived wards in the Province are most deprived in four or more of the following domains: income and material deprivation, employment deprivation, health deprivation, education deprivation, and living environment deprivation.

The following Table outlines that poverty and socio-demographic data obtained from the General Household Survey of 2010.

Table 7: Poverty and socio-demographic data for the Western Cape

Indicator	2002	2003	2005	2007	2009	2010	National 2009
Education Percentage of persons aged 7 to 24 years who attend educational institutions	67.3%	69.1%	68.7%	69.0%	68.8	68.1%	-
Housing Percentage of households living in informal dwellings.	14.5%	15.6%	16.5%	19.1%	17.1%	17.0%	13.4%
Source of energy Percentage of households connected to the mains electricity supply	88.4%	89.2%	92.7%	96.2%	90.0%	87.1%	82.6%
Percentage of houses that use paraffin or wood for cooking	14.9%	14.8%	9.1%	6.0%	6.9%	3.9%	24.8%
Sanitation Percentage of households that have no toilet facility or were using a bucket toilet	5.7%	8.3%	5.3%	3.8%	4.2%	3.0%	6.6%
Refuse removal Percentage of households whose refuse is removed by the municipality	84.0%	85.0%	91.6%	90.8%	73.6%	85.5%	53.1%
Water access and use Percentage of households with access to piped or tap water in the dwelling, off-site or on-site	98.8%	98.8%	99.0%	99.5%	99.6%	98.8%	89.3%

Source: General Household Survey: 2010

7.3 EPIDEMIOLOGICAL PROFILE/ BURDEN OF DISEASE

7.3.1 The nature of the burden of disease

Understanding the nature and risk factors or drivers of the causes of mortality and morbidity (the "burden of disease") is the foundation of the provincial strategy to increase wellness in the Western Cape.

The burden of disease in the Western Cape primarily consists of:

- HIV and Aids
- TB
- Injuries (violence and road traffic accidents)
- Non communicable diseases (cardio vascular disease, high blood pressure, asthma, cancers and mental illness)
- Childhood illnesses
- Mental illness

In most instances, diseases are caused and influenced by a range of factors that traverse biological, behavioural, societal and structural domains. Biological factors include age, gender and genetic make-up. Behavioural factors include having multiple sexual partners or smoking. Societal factors include gender inequality and cultural norms. Structural factors include urbanisation and unemployment.

Interventions to reduce and manage the burden of disease are usually grouped into three categories:

1) "downstream" interventions, which target the individual,
2) "midstream" interventions, which target groups of people (institutions or communities, for instance), and
3) "upstream" interventions, which are focused on society as a whole.

Thus the health service usually focuses its work on midstream and downstream interventions while other provincial departments, spheres of government and civil society organisations

need to work together to provide effective midstream and upstream interventions. All levels of intervention need to be rigorously pursued to decrease the burden of disease and enhance wellness.

7.3.2 Mortality rates

According to StatsSA as shown in Table 8 below, both infant and child mortality rates are decreasing in all of the Western Cape districts, although it is noteworthy that districts such as West Coast and Central Karoo have rates that are even higher than the national average. However, the rate in Central Karoo should be interpreted with caution as this district has a very small population.

Although the Cape Town Metro District has more favourable infant and child mortality rates, the inequities within the Metro District are reflected in mortality rates that are higher than the national average in the Khayelitsha and Eastern sub-districts.

Table 8: Infant and under-five mortality rate (per 1 000 live births)

District	Infant mortality rate IMR (< 1yr)		Under-five mortality rate U5MR (< 5yr)	
	2007	2008	2007	2008
Cape Winelands	**26.4**	**20.5**	**31.3**	**27.0**
Central Karoo	**44.4**	**44.3**	**59.3**	**58.8**
Cape Town metro	**25.9**	**24.5**	**31.4**	**30.2**
Eden	**29.0**	**21.9**	**35.1**	**27.4**
West Coast	**35.7**	**30.8**	**41.7**	**36.9**
Western Cape	**27.3**	**24.2**	**33.0**	**30.2**
WC (ASSA 2008)	***25.88***	***23.68***	***34.53***	***30.87***

Trends in maternal mortality should be monitored over a three-year period rather than a year-on-year rate as numbers of maternal deaths are relatively low.

According to the first triennial Saving Mothers report (1999 – 2001) the maternal mortality rate (MMR) for the Western Cape was reported as 56.4 per 100 000 live births, this increased to 86.2/100 000 live births in 2002 – 2004. There was some optimism in the 2005 – 2007 period when MMR decreased to 67.6/100 000 live births but in the period 2008 – 2010 the rate has increased again to 77.6/100 000 live births. The district level estimates are shown below in Table 9.

Table 9: Maternal Mortality Ratio by district 2002-2007 and 2008-2010 (per 1 000 live births)

District	Number of maternal deaths 2008-2010	Number of live births 2008-2010	MMR 2008-2010 Deaths per 100 000 live births	MMR 2002-2007 Deaths per 100 000 live births
Metro	157	194 300	80.8	72.82
Eden	31	29 061	106.7	92.36
Cape Winelands	26	39 986	65.2	46.4
West Coast	11	16 126	68.2	77.67
Central Karoo	7	3 641	192.3	140.45
Overberg	10	9 518	105.6	84.38

Data from Provincial Maternal Death Register and Western Cape Department of Health Information Management data

The leading cause of maternal death in 2008-2010 remains non pregnancy related infections particularly due to HIV and AIDS (36.1%). This was followed hypertensive disorders

(16.3%), pre-existing medical disorders (11.9%), obstetric haemorrhage (8.3%), acute collapse (6%). Death due to embolism increased dramatically from 1.1 per cent in the 2005 - 2007 period to 5.6 per cent in 2008-2010. It is now the sixth most common cause of death, tied with pregnancy related sepsis (5.6.%).

The proportion of direct maternal deaths (i.e. deaths resulting from obstetric complications of the pregnant state or from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above) has steadily decreased from 52.4 per cent in the period 2002-2007 to 46.5 per cent in 2008-2010 whereas the proportion of indirect deaths (i.e. those resulting from previous existing disease, or diseases that developed during pregnancy, and which were not due to direct obstetric causes but aggravated by physiological effects of pregnancy increased from 48 per cent in 2008-2010 compared to 42.8 per cent in 2002-2004. The decreasing direct death rate could suggest that services to address pregnancy related conditions are improving whereas the increasing indirect death rate could suggest that the burden of disease in this group is increasing.

It is however, of concern that nearly half the maternal deaths (47.2%) received suboptimal care. Different management might have made a difference to the outcome or would reasonably have been expected to have made a difference to the outcome.

In order to address these challenges the Department plans to:

- Continue with the prevention of mother-to-child transmission (PMTCT) programme and fast-track eligible women on highly active anti-retroviral therapy (HAART).
- Continue to promote earlier booking for antenatal care through media campaigns, increased basic ante-natal care (BANC) coverage; optimise routine ultrasound.
- Improve postnatal care (integrated 6 week postnatal visit; involve community health workers).
- Improve screening and detection of respiratory infections, especially TB, at clinics and midwife obstetric units (MOUs) with HAST, Palsa Plus.
- Further roll out of the essential steps in the management of obstetric emergencies (ESMOE) and obstetric fire-drills to all district maternity facilities.
- Develop guidelines for thrombo-prophylaxis in pregnancy.

7.3.3 **HIV and AIDS**

According to the 2009 National HIV Survey the estimated HIV prevalence for the Western Cape was 16.9 per cent (confidence interval (CI) 95%: 13.8 -20.5%). The weighted provincial survey estimate from the larger sub-district survey was 16.8 per cent (95% CI 16.0 - 17.7%). The highest HIV prevalence estimates remain amongst the age groups of 25 - 29 and 30 - 34 years.

At sub-district level the 2009 survey estimated that nine of thirty-two sub-districts (32%), compared to six in 2008, have an HIV prevalence that was greater than the provincial prevalence of 16.8 per cent. These are: Klipfontein, Khayelitsha, Eastern, Western and Northern Sub-districts (Metro District), Bitou, Knysna and Mossel Bay Sub-districts (Eden District) and Overstrand Sub-district (Overberg District). Since 2004, Khayelitsha Sub-district in the Cape Town Metro District has had a HIV prevalence estimate consistently higher than the national prevalence of 29.4 per cent. The failure to observe a decline in prevalence in

high HIV burden sub-districts may be partly due to the declining mortality as a result of access to antiretroviral therapy (ART).

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

The anti-retroviral treatment programme continues to expand rapidly despite facing a significant burden of disease and experiencing challenges in staff recruitment and retention. Approximately 2 400 - 2 500 persons were initiated onto anti-retroviral therapy per month during 2009. Assuming no significant in-migration of HIV-infected populations, or change in the national initiation criteria, and despite any possible reduction in new infections, this rate of ART initiation will probably need to be maintained for at least 3 - 5 years. Thereafter it is possible that the demand for new ART initiation might gradually decline. With this large burden of new ART clients accumulating annually, the ART programme needs to expand its capacity to retain long-term ART patients in care.

7.3.4 **Tuberculosis (TB)**

The biggest risk factor for TB is concurrent HIV infection. Tuberculosis is described as a social disease as it is closely linked to the upstream issues of poverty, unemployment and overcrowding.

The Western Cape's incidence (new cases) of TB is 909 cases per 100 000 population. This gives the Western Cape the third highest incidence of TB in South Africa after Kwa-Zulu Natal and the Eastern Cape. However, the Department is making significant progress in addressing the epidemic through the implementation of the Enhanced TB Response Strategy. The programme achieved a new smear positive TB cure rate of 80.5 per cent in 2010/11. Two districts (Overberg and Eden) achieved the World Health Organisation target of 85 per cent. The provincial TB cure rate is the highest TB cure rate in South Africa. The TB defaulter rate has decreased slowly over the past few years with the implementation of various interventions and stands at 7 per cent in 2010/11, whereas approximately three years ago it was 9.2 per cent. Although this is a significant improvement, more effort will be required to reach the national and global 2011 target of a defaulter rate of below 5 per cent. This is required to decrease the size of the infectious pool in the community and prevent the generation of drug resistant TB, which requires longer stays in hospital, is much more costly to treat, and has a very poor prognosis.

7.3.5 **Injuries**

According to the Western Cape Burden of Disease project, in 2009 injuries that include homicide, transport injuries, self-inflicted injuries, injuries due to fires accounted for 18.1 per cent of the burden of disease in the Province. In comparison to the rest of the world violence is a particular problem in the Western Cape where the injury related mortality rate for men is ten times the global average, while for women it is seven times that average. In an analysis of mortuary data in the Province, it was found that 42 per cent of injuries were from homicide and 29 per cent from traffic injuries. Nearly 80 per cent of these deaths were in men aged 20-34years old.

Substance abuse, particularly alcohol abuse, is one of the most important drivers of the injury burden in the Western Cape as it fuels both violence and road traffic accidents. Nearly 60 per cent of injuries were alcohol related and approximately 50 per cent of all alcohol-related violence was found to occur in five areas that correlate with high levels of multiple deprivation and inequity. Alcohol is also a key driver for transport related deaths. In the same analysis of mortuary deaths, it was found that 66 per cent of pedestrian deaths, 61 per cent of driver deaths and 38 per cent of cyclists' deaths had a positive blood alcohol concentration.

7.3.6 **Non Communicable Diseases**

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

Cardiovascular disease includes hypertension, ischaemic heart disease and stroke. It has been well documented that the primary causes of cardiovascular disease, while partly genetic, is largely attributable to environmental factors, specifically an unhealthy lifestyle. The most important risk factors are a lack of regular physical exercise, long-term use of tobacco products and the consumption of an unhealthy diet characterized by a high intake of fat, salt and sugar, and a low intake of fibre, fruit and vegetables. An unhealthy lifestyle may lead to obesity, hypertension and diabetes.

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

The National Food Consumption Survey (2005) indicated that 26 per cent of women of child-bearing age (16 - 35years) in the Western Cape were overweight and 32.7 per cent were obese. It is of concern that the prevalence of obesity is 8 per cent more than the national average for women (24.9%). The results of the South African youth behaviour risk survey of 2002 indicated that the prevalence of overweight amongst children is increasing in the Western Cape and confirmed a higher prevalence of overweight adolescents in the Western Cape compared to the national average. Obesity is associated with an increased risk of cardiovascular diseases, hypertension and certain types of cancer of the reproductive system in women and in the rectum, colon and prostate cancers in men (Willet and Dietz, 1999).

Mental ill health is also included in this category and contributes significantly to the burden of disease through morbidity rather than mortality. The abuse of substances, especially drugs, such as crystal methamphetamine, locally known as TIK, has further exacerbated the burden of mental ill health on the public health service.

7.3.7 **Childhood illnesses**

Childhood illnesses include malnutrition, diarrhoeal diseases and respiratory illnesses. Acutely ill children often present with co-morbidity that involves multiple conditions. This raises the severity of their illness and they often have to be admitted to hospitals.

Diarrhoeal disease is a seasonal phenomenon which peaks between February and May each year and creates enormous pressure on the health services. The critical causative factors are a lack of clean water and sanitation, and feeding practices in informal settlements. Zinc therapy has been added to the management of diarrhoeal disease.

As part of the National Department of Health's initiative, Prevenar, the vaccine to combat the spread of pneumococcal disease in infants, was distributed from primary health care facilities in the Western Cape from July 2009. This was followed by the implementation of the oral Rotarix vaccine against rotavirus from 1 November 2009, which is administered to children at six and fourteen weeks to prevent diarrhoeal disease. DTP-Hib was replaced with Pentaxim (DTaP-IPV/Hib). The province started phasing in Pentaxim from October 2009.

7.3.8 **Mental Health**

The Premier's burden of disease summit recommended that there should be a separate work group focused on improving mental health. A provincial summit will be held during February / March 2012 to focus on reaching inter-sectoral agreement on the interventions that should be implemented to:

- Prevent mental illness before it occurs;
- Ensure that health services for mental illness are of good quality and facilitate patient led recovery; and
- Ensure that all legislative requirements are adhered to.

8. PROVINCIAL SERVICE DELIVERY ENVIRONMENT

This paragraph reflects the progress that has been made in the Western Cape against the Millennium Development Goals and the Negotiated Service Delivery Agreement. This is followed by an overview of the successes and challenges in service delivery that the Department has experienced during 2011/12.

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

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

Millennium Development Goal	MDG objective	Indicator	Western Cape								South Africa's progress	National Target	
			2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2014/15 Target	2004 - 2009	2015	Source
Eradicate extreme poverty and hunger.	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	1) Prevalence of underweight in children under 5 years of age	3.0%	2.4%	2.4%	2.5%	2.4%	2.4%	2.7%	-	9.3%		SINJANI
		Numerator	12 600	11 000	11 024	11 323	12 254	12 858	14 681	-			
		Denominator	424 696	450 900	457 888	462 245	515 906	527 215	538 524	-			
		2) Incidence of severe underweight in children under 5 years of age	4.2/ 1 000	3.4/ 1 000	3.7/ 1 000	4.2/ 1 000	4.4/ 1 000	16.8/ 1 000	21.7/1 000	-			
		Numerator	1 767	1 555	1 708	1 951	2 248	8 861	11 678	-			
		Denominator	424 696	450 900	457 888	462 245	515 905	527 215	538 524	-			
Reduce Child Mortality.	Reduce by two thirds between 1990 and 2015 the under-five mortality rate	3) Infant mortality rate IMR/1000 live births	-	-	26	27.3	24.2	-	-	15	43 per 1 000	14.3 or less per 1 000	SADHS 1998 and 2003 ASSA 2003 StatsSA
		4) Child (under 5) Mortality Rate/ 1000 live births	-	-	39.0	33.0	30.2	-	-	30	69 per 1 000	45 per 1 000	SADHS 1998 and 2003 conducted by NDOH StatsSA
		5) Measles coverage under 1 year	91.7%	90.7%	93.7%	102.8%	98.08%	99.29%	89.2%	95%	85.8% in 2007	100%	Departmental Annual Reports
		Numerator	83 119	87 309	93 117	94 076	97 794	101 223	92 944	107 470			
		Denominator	90 642	96 262	97 753	91 295	99 700	101 937	104 175	113 126			
Improve Maternal Health.	Reduce by three quarters between 1990 and 2015, the maternal mortality rate.	6) Maternal Mortality Ratio/100 000 live births	86.2	-	-	67.6	-	-	77.6	90	400 - 625 per 100 000	100 or less per 100 000	Saving mothers, Third report on confidential enquiries into maternal deaths in South Africa 2002-2004 and 2005-2007 and 2008-2010

Millennium Development Goal	MDG objective	Indicator	Western Cape								South Africa's progress	National Target	
			2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2014/15 Target	2004 - 2009	2015	Source
Combat HIV/AIDS and other diseases.	Have halted by 2015 and begun to reverse the spread of HIV and AIDS.	7) HIV Incidence	-	0.9% /y	-	-	-	-	-	<0.35			SADH 1998 South African National HIV prevalence, incidence behavioural and communication survey 2005 (Empirical data)
		8) HIV prevalence amongst 15 to 24 year old pregnant women.	-	-	-	12.8%	12.2%	12.2%	12.6%	11.5%	21.7% NSDA		Calculated from HIV and Syphilis prevention survey data 2007-2010.
		9) Condom distribution rate from public sector health facilities (per male >15years) Numerator Denominator	15.6	20.1	25.7	41.1	33.63	37.65	44.2	59.2	33.6%		Departmental Annual Reports.
		Numerator	25 616 972	33 197 160	57 052 561	71 380 676	65 051 925	74 465 870	89 376 081	130 000 000			
		Denominator	1 642 114	1 651 600	1 675 734	1 734 276	1 934 249	1 977 894	2 021 542	2 196 129			
		10) Number of maternal HIV and AIDS orphans under 15 years	10 572	14 682	19 648	25 334	-	-	-	-			Dorrington et al, 2003 HIV/AIDS profile in the provinces of South Africa
	Have halted by 2015, and begun to reverse the incidence of malaria and other major diseases.	11) New Smear Positive Cure Rate for TB	68.3%	69.3%	76%	77.7%	79.7	80.5%	81.9%	85%	65%	85%	Departmental Annual Reports.
		12) TB Incidence Rate per 100 000	967	1 041	1 038	1 004	947.8	909	882.9	-			ETR.net

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

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

Output 1: Increasing life expectancy.

Output 2: Decreasing maternal and child mortality.

Output 3: Combating HIV and AIDS and decreasing the burden of disease from tuberculosis.

Output 4: Strengthening health system effectiveness, with a focus on:

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

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

PROVINCIAL PRIORITIES FOR 2011/12	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
OUTPUT 1: INCREASING LIFE EXPECTANCY			
1.1. Premier's summit on reducing the burden of disease: 2011.	1.1.1. Review the latest available data on the burden of disease.	Action plan to reduce the burden of disease developed and approved and implementation of priority projects.	Data for 2009 analysed and profiles for all six districts created.
	1.1.2. Convene a summit of all role-players to discuss the burden of disease and the 'whole of society' approach to wellness.		Premier's summit on Wellness held in November 2011.
	1.1.3. Out of the summit develop an action plan to facilitate the collective effort of all role-players to reduce the burden of disease.		Declaration with ten key recommendations for action developed and ratified by the stakeholders at the summit.
	The following strategies are transversal across various departments:		
1.2. Decrease the incidence of injury.	1.2.1. Reduce the burden of disease from intentional and unintentional injury: 1) Increase road safety with the aim of halving fatalities caused by road accidents. 2) Establish a workgroup to develop strategies to reduce the harmful effects of substance abuse, including alcohol.	Inter-sectoral action plan to reduce the harmful effects of alcohol abuse to be developed and approved and implementation of priority projects.	A workgroup on injuries established and alcohol related road traffic and interpersonal injuries prioritised. • Five high prevalence areas identified for intervention. • BoozaTV a six-part health promotion TV series developed to reduce alcohol demand. • Brief Motivational Interventions will be piloted in two trauma units. • Injury surveillance will be established in the five priority areas.
1.3. Decrease the incidence of non-communicable diseases.	1.3.1. Establish a workgroup to develop strategies to reduce the burden of chronic diseases, e.g. diabetes, hypertension:	Inter-sectoral action plan to promote healthy lifestyles to be developed and approved and implementation of priority projects.	Healthy eating, exercise and smoking cessation has been identified as priorities. Health promoting schools programme in the WCED will be strengthened and a work place programme in the Provincial Government will be piloted in collaboration with the Sports Science Institute of South Africa.
1.4. Provision of an accessible, high quality and comprehensive health care service.	1.4.1. Deliver the full package of primary health care services.	Achieve a PHC utilisation rate of 3.84 visits per person per annum by 2014/15. [Programme 2 strategic objective]	
	1.4.2. Improve response times for ambulances.	Priority 1 calls with a response time <15 minutes in an urban area. Priority 1 calls with a response time <40 minutes in a rural area.	Responses to Priority 1 or life threatening emergencies by ambulances have improved to 70% within 15 minutes in urban areas and 80% within 40 minutes in rural (farms) areas.
2. OUTPUT 2: DECREASING MATERNAL AND CHILD MORTALITY			
2.1. Decrease the maternal mortality rate.	2.1.1. Implement the Saving Mothers and Children's Plan to address the recommendations of the National Committee on the Confidential Enquiry into Maternal Deaths that is being implemented.	Reduction in Maternal mortality rate of less than 44 per 100 000 live births by 2014/15.	Estimated public health facility maternal mortality rate for 2011/12 is 76.3 maternal deaths per 100 000 live births.
	2.1.2. Prioritisation of emergency transport.	Public health facility maternal mortality rate.	
	2.1.3. Accelerated staff training programmes.		

PROVINCIAL PRIORITIES FOR 2011/12	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
2.2. Decrease the incidence of childhood illness.	2.2.1. Accelerate the roll out of the Road to Health Booklet. 2.2.2. Increased immunization coverage. 2.2.3. Diarrhoeal disease campaign. 2.2.4. Prevention of mother-to-child transmission of HIV. 2.2.5. Expand ART to HIV positive children.	Reduction of mortality in children under the age of 5 years to less than 30 per 1 000 live births by 2014/15. Public health facility infant mortality rate.	Estimated public health facility infant mortality rate for 2011/12 is 14.2 deaths under 5 years per 1 000 live births.
3. OUTPUT 3: COMBATING HIV AND AIDS AND DECREASING THE BURDEN OF DISEASE FROM TUBERCULOSIS			
3.1. Decrease the incidence of infectious diseases (HIV and TB).	3.1.1. Implementation of combined prevention/promotion strategies. 3.1.2. HIV and AIDS Counselling and Testing [HCT] campaign • Advocacy, communication and social mobilisation (ACSM) • Barrier methods. • PMTCT • HIV treatment • Medical male circumcision	Target: HIV prevalence in the age group 15 – 24 years of 11.5% by 2014/15. Projected 167 256 total registered patients receiving antiretroviral therapy (ART patients) by 2014/15.	Estimated HIV prevalence in women aged 15 – 24 years for 2011/12 is 12.6%. Estimated number of patients (children and adults) on ART by the end of 2011/12 is 115 237.
3.2. Decrease the incidence of TB and the prevalence of drug resistance TB.	3.2.1. Advocacy, communication and social mobilisation (ACSM) 3.2.2. Integrated TB andIHIV treatment and adherence support.	New smear positive PTB cure rate above 85% by 2014/15.	Estimated new smear positive PTB cure rate for 2011/12 is 81.5%.
4. OUTPUT 4: STRENGTHENING HEALTH SYSTEM EFFECTIVENESS			
4.1. **Revitalisation of Primary Health Care**:			
4.1.1. Provincialisation of Personal Primary Health Care in the Metro district.	4.1.1.1. To be addressed at a political level between the province and the City of Cape Town.	An integrated system of personal primary health care service delivery by the provincial sphere of government in the Western Cape.	A political decision is required nationally and funding needs to be secured.
	4.1.1.2. Establish the six district health councils.	Implementation of the Western Cape District Health Councils Act and the establishment of the six district health councils.	The Western Cape District Health Councils Act, No 5 of 2010 ("the Act"), was drafted to give effect to section 31 of the National Health Act, No 61 of 2003 and came into effect from 22 August 2011. The inaugural meetings of the six district health councils were convened.
4.2. **Health care financing and management:**			
4.2.1. Occupation specific dispensation for health professionals to be fully funded.	4.2.1.1. Detailed costing of the required funding for OSD. 4.2.1.2. Secure adequate funding for OSD from Treasury.	Strategic goal: Sustainable income: Ensure a sustainable income to provide the required health services according to the needs. • All mandatory functions and expenses to be fully funded. • Appropriate funding levels to facilitate the required service delivery.	Due to the revised formula for the equitable share the year 2012/13 will be challenging financially. The challenge will be to reduce expenditure in real terms without reducing service delivery. The service delivery platform will be expanded by the commissioning of the Khayelitsha Hospital Provisionally indicated funding for the later years is sufficient to ensure maintenance of current services.

PROVINCIAL PRIORITIES FOR 2011/12	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
4.2.2. Appropriate funding of the conditional grants, in particular 1) National Tertiary Services Grant (NTSG). 2) Health Professions Training and Development Grant (HPTDG).	4.2.2.1. Continue with ongoing discussions and submission of motivations to the National Department of Health to demonstrate the funding and policy challenges.		In spite of the Department's continued input and leadership on national forums, the funding for these services are still insufficient due to national government's priority for shifting funds to lesser developed provinces.
4.2.3. Develop and retain appropriate financial management capacity at all levels of the service.	4.2.3.1. Address Auditor-General's (AGs) recommendations to improve financial management. 4.2.3.2. On the basis of the AGs report, develop and implement the Compliance Monitoring Instrument.	Unqualified financial audit reports.	The latest financial statements were not qualified, which means that the Auditor-General found these statements to fairly represent the activities and status of the Department.
4.3. **Human resources for Health:**			
4.3.1. Implement the provincial Human Resource Plan.	4.3.1.1. Perform a skills audit. 4.3.1.2. Draft action plans to achieve priority elements within the HR Plan: • Organisation development • Competency development • Employee health and wellness • Employment equity • Recruitment and selection • Systems and information capacity • Training and development	Strategic goal: Attain and maintain a skilled, patient centred workforce of appropriate number to deliver the required health services.	A competency profile (Skills Audit) for prioritized occupational categories completed. Outcomes are used for Workplace Skills Plan, Human Resource Plan and action plans related to training and development. Draft action plans to achieve priority elements were completed and reported to the DPSA in the Department of Health's Human Resource Implementation Plan dated 30th September 2012.
4.3.2. Implement the Provincial Nursing Strategy.	4.3.2.1. Coordinate the quality and improvement of nursing practice. 4.3.2.2. Coordinate nursing related research and development. 4.3.2.3. Market and promote the corporate image of nursing. 4.3.2.4. Implement the integrated nursing education and training framework. 4.3.2.5. Expand nurse education teaching sites, programmes and clinical placement sites of students with relevant coordination thereof. 4.3.2.6. Coordinate formal and informal nurse training programmes and initiatives, in line with the Comprehensive Service Plan, required strategic focus and nursing education legislation. 4.3.2.7. Harmonise and integrate nursing education and training with practice.	An operational plan in place after consulted with stakeholders. Nursing education/training and practice policies and procedures in place to ensure a capacitated nursing workforce to deliver the required health services.	The Operational Plan is in place: **Nursing Practice** • Peer review conducted in the health facilities in all districts. • Collaborative meeting held with the private nursing stakeholders. • Key role-players (National Department of Health) in the development of a "Nursing Compact" for the country. • Pilot of the Nursing Information Management System (NIMS) commenced. • Ensure that competent nursing staff is appointed for the new hospital. **Nursing education and training** • Coordinated clinical placement system in place and implemented. • Process regarding Standardised Situational Analysis commenced. • Clinical Nursing Education units - implementation process commenced. • A standardized education and training selection policy developed and implemented.

PROVINCIAL PRIORITIES FOR 2011/12	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
			• Three year Departmental Nurse Training Plan developed and implemented based on the outcomes of the OSD for Nurses "Grandfather Clause" analysis and service delivery needs. • Research in nursing enhanced in collaboration with Higher Education Institutions and Services.
Quality of Health and accreditation of health establishments:			
4.3.3. Develop a patient centred approach.	4.3.3.1. Develop an action plan to address and monitor progress for the six priority focus areas within the national core standards policy document.	Improved patient care and the satisfaction of the users of the health care system.	The baseline audits will be completed at the end of March 2012 after which, training for all quality assurance managers will be undertaken to develop and monitor facility level quality improvement plans. The provincial Quality Assurance Committee will also review the results of the baseline audit and identify cross cutting areas of concern and develop relevant policies and interventions to address these, oversee their implementation and monitor the implementation thereof.
4.3.4. Monitoring and evaluation of the quality of clinical care.	4.3.4.1. Monthly mortality and morbidity meetings. 4.3.4.2. Participate in initiatives like Best Care Always.		Facilities conduct Morbidity and Mortality Reviews. All facilities central and secondary hospitals have implemented a bundle and are submitting monthly reports to the BCA. Central hospitals participate in the best care always projects to reduce hospital acquired infections in selected areas. A follow-up workshop was held in November 2011 during which feedback on progress and improvements made were provided.
4.3.5. Effective management and supervision. 4.3.5.1. Licensing and inspectorate.	4.3.5.2. The phased rollout of the implementation of the core standards to be the point of departure towards accreditation and licensing of facilities.	Establishment of a provincial licensing and inspectorate for all facilities (public and private).	Currently the inspectorate's mandate is for private establishment licensing and accreditation only.
4.3.5.3. Chronic Dispensing Unit.	4.3.5.4. The expansion of the scope of services, as well as the geographical span, of the Chronic Dispensing Unit service provides chronic medicines to patients from a choice of health facilities and from non-health sites for patients in the Metro district.	Drug supply management system implemented to ensure a stock out rate of <3% of stock items.	Weekly reports are submitted to all facilities with respect to particular line items out of stock, with alternate pack sizes available stated. For each quarter in 2011/12 year, stock out rate was less than 3% of all stock items. The CDU service expansion regarding scope and geography is planned after the new service provider commences full service delivery in latter half of 2012. The current service includes deliveries for general health in the Metro District with ARVs to a limited number of sites, as a pilot phase.

PROVINCIAL PRIORITIES FOR 2011/12	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
4.4. **Health infrastructure**:			
4.4.1. Construction of new district health service facilities (primary health service, and district hospitals).	4.4.1.1. Construction completion of the new Khayelitsha Hospital.	Construction budget spent, projects on time, in budget and required quality.	Construction completed, hospital commissioned and first patients admitted during January 2012.
	4.4.1.2. Construction completion of the new and Mitchell's Plain Hospital		Construction is in progress and scheduled to be completed by December 2012.
	4.4.1.3. Construction phase for Vredenburg Hospital phase 2B.		Tender was awarded on the 23rd of January, 33 months construction period.
	4.4.1.4. Upgrade and extension at: • Ceres Hospital • Karl Bremer Hospital • Knysna Hospital • Hermanus Hospital • Malmesbury Hospital		• Ceres Ambulance Station completed, Emergency Department to be completed by early February 2012. • Hermanus Hospital project to be completed by July 2012, • Malmesbury Hospital project currently under construction, • Karl Bremer Hospital tender to be awarded and Knysna Hospital project to be advertised in March 2012.
	4.4.1.5. Construction completion of the new: • Grassy Park Clinic • Knysna Witlokasie Community Day Centre • Wesbank Community Day Centre • Malmesbury Community Day Centre		Grassy Park Clinic completed. Wesbank Malmesbury to be completed by February 2012 Knysna Witlokasie CDC, under construction, to be completed by April 2013.
	4.4.1.6. Construction phase for Community Day Centres at: • Hermanus • Delft Symphony Way CDCs		Tenders to be advertised by March 2012.
	4.4.1.7. Construction phase for Du Noon Community Health Centre		Planning to go to tender in March 2012.
4.4.2. Construction of new EMS and FPL facilities.	4.4.2.1. Construction completion of the new ambulance stations at: • Leeu-Gamka • Vredendal • Malmesbury • Tulbagh	Construction budget spent, projects on time, in budget and required quality	Construction of Leeu-Gamka and Vredendal Ambulance Stations completed by March 2012.
	4.4.2.2. Construction completion of the new Forensic Pathology Laboratories at: • Beaufort West • Riversdale.		Riversdale Forensic Pathology Laboratory: Is still in the planning phase. Beaufort West Forensic Pathology Laboratory: Construction to be completed at the end of February 2012.
4.4.3. Hospital Revitalisation for Valkenberg and Brooklyn Chest Hospitals.	4.4.3.1. Detailed design completed for the Valkenberg project 4.4.3.2. Completion of the revitalization of the George Hospital	Project budget spent, projects on time, in budget and required quality	George Hospital: scheduled for completion June 2012 Valkenberg Hospital: Complete planning and design documentation and go to construction during 2012

PROVINCIAL PRIORITIES FOR 2011/12	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET BY 2014/15 [REQUIRED PROVINCIAL PERFORMANCE]	PROGRESS TOWARDS TARGET
4.4.4. PPP for the new Tygerberg Hospital.	4.4.4.1. Appointment of Transaction Advisors	To conclude the feasibility study	A project manager has been appointed.
4.4.5. Improving maintenance and life cycle costing for all health infrastructure.	4.4.5.1. Maintenance information management system.	Maintenance plan for all new health facilities.	
4.5. **Information, communication and technology and Health Information Systems:**			
4.5.1. Ensure good data quality by implementing the Compliance Management Instrument for predetermined objectives (CMI-PO).	4.5.1.1. Develop and refine the CMI – PO tool. 4.5.1.2. Implement the CMI-PO within all sub-districts.	100% of districts and district, regional and central hospitals implementing the CMI-PO by 2014/15.	The first CMI for predetermined objectives was developed in 2010/11. In response to the Audit Report, an Action Plan is compiled annually to address the audit findings. Based on the Action Plan, the CMI is reviewed annually to ensure all issues are being addressed. The CMI has been implemented at districts and district, regional and central hospitals, but are not necessarily well reported in all facilities. To improve reporting, from 2012/13 onwards, CMIs will be regularly analysed with feedback to Divisional Executive Committees.

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

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

8.3.1 Service related successes:

1) A major achievement for the Department is the completion and opening of the Khayelitsha District Hospital, where the first patients were admitted on 16 January 2012. The hospital will be commissioned in phases and is to be officially opened by the Premier in April 2012. Khayelitsha District Hospital will provide a total of 230 beds with the capacity to expand to 300 beds. This is the culmination of planning that began in 2005 and the construction contract that was awarded on 6 January 2009. The physical infrastructure was completed on 31 October 2011. The total design and construction cost, including the ambulance station that has been in operation since April 2010 is R530 million. The hospital provides world-class modern infrastructure to render district hospital services to one of the poorest communities in the Province.

2) The Department continued to implement alternative models for the public to access services and medicines through community based services (CBS) and the chronic dispensing unit (CDU).
   - 2 584 community care-givers undertook 4 645 210 home based care client visits in 2010/11. There are 145 NPOs contracted by the Department and of these 100 deliver an integrated home based care service. Alternative funding was made available to appoint additional staff including R2 million that was made available to the Expanded Public Works Programme (EPWP) that funds part of the CBS programme. The increased number of care-givers resulted in an increase in the number of clients that could be seen. The care-givers participated in several prevention and promotion campaigns during the year including the national measles campaign, the national HCT campaign, the women's health season and the infectious disease season.
   - The CDU promotes access by reducing the waiting times for medicines and improving the patient experience at health facilities. The CDU dispensed 1 711 152 prescriptions during 2010/11.

3) HIV prevention and treatment:
   - The PMTCT programme is one of the flagship HIV prevention programmes of the Western Cape and is provided at all facilities, including hospitals and midwife obstetric units (MOUs), that provide antenatal care services.
   - The HIV and AIDS, STI and Tuberculosis (HAST) programme co-ordinated two major national campaigns in 2010/11. An HIV counselling and testing (HCT) campaign and an anti-retroviral therapy (ART) scale-up campaign. A total of 1 042 095 clients were tested, against a target of 1.1 million, during the HCT campaign that lasted from 1 April 2010 until 30 June 2011.
   - Prevention of mother-to-child transmission (PMTCT) services are offered at all facilities which provide antenatal care, maternity services and baby clinics. Transmission rates decreased from 3.6 per cent in 2009/10 to 3.2 per cent during 2010/11 and the target for 2011/12 is 3.2 per cent will be significantly surpassed. This decrease is

attributable to improved monitoring and evaluation of the programme, continued staff training and the integration of the PMTCT and nutrition programmes to address infant feeding challenges.

- Currently there are 132 fully functional ART sites in the Province. By the end of 2010/11 there were 96 284 patients on ARV treatment of which 29 726 started their treatment during the year. The projected number of patients on ART for 2011/12 is 115 237. The Western Cape celebrated the achievement of having 100 000 patients on ART at an event at the New Somerset Hospital which is where the first ART clinic was established ten years ago.
- An electronic client monitoring system for the ART programme was developed and implemented by the Province. The electronic system reduces time spent on manual processes and ensures accurate and reliable data collection and reporting. The system was subsequently endorsed by the National Department of Health for roll out across the country in 2011.
- The STI partner treatment rate increased from 21.7 per cent in 2009/10 to 29.2 per cent in 2010/11.

4) TB programme:

- The enhanced TB response allocates additional resources to high burden TB facilities to support them in achieving their targets. In the Metro, TB enhanced response funding was used to appoint TB assistants (lay community care workers) to support the follow-up of TB defaulters. Additionally each district is given the autonomy to decide which intervention is most suitable for them.
- The new smear positive TB cure rate reached 80.5 per cent in 2010/12 which is the highest in the country and which is projected to increase to 81.5 per cent during 2011/12. Two districts, Overberg and Eden, reached the target of an 85 per cent TB cure rate that is recommended by the World Health Organisation.
- The TB treatment interruption rate decreased further to 7.0 per cent in 2010/11.
- Designated multi-drug resistant TB (MDR-TB) units have been established at Brewelskloof, Harry Comay and Brooklyn Chest Hospitals. Brooklyn Chest and DP Marais Hospitals have been amalgamated into the Metro TB Complex with the appointment of a single management structure.
- A pilot infectious disease palliative centre has been established at Nelspoort Hospital in the Central Karoo District to manage patients with extreme drug resistant TB (XDR-TB) treatment failure.

5) Diarrhoeal season management:

The number of diarrhoeal cases seen over the summer 'diarrhoea season' dropped significantly in 2010/11 due to a comprehensive, multi-sectoral and multi-level approach to prevention and treatment. In terms of prevention, community workers in the most affected areas participated in community awareness drives with respect to basic hygiene principles and hand-washing, and education sessions were provided in waiting rooms advising mothers of the signs and symptoms of severe diarrhoea. Immunisation with rotarix, effective against rotavirus, one of the principal pathogens responsible for childhood diarrhoea, was scaled up in the period preceding the summer months.

Staff was re-trained in detecting severely dehydrated cases and were instructed to triage waiting queues regularly for children with diarrhoea. Oral and naso-gastric

rehydration stations ("OHS corners") were set up in all high-burdened primary health care facilities and lines of communication and referral were improved between PHC level and secondary and tertiary level hospitals.

6) Quality of care:

The Department has a renewed focus on improving the quality of care within its health services. The National Department of Health has developed a set of comprehensive core standards within seven domains as shown in the diagram below. The national minister identified six priority areas on which to focus in the first phase to improve quality. These are values and attitudes of staff, cleanliness, waiting times, patient safety, infection control and availability of medicines.

The Department, in partnership with Health Systems Trust has conducted a baseline assessment at all the facilities in the Province that will be completed by the end of March 2012, using a set of nationally developed instruments. The information from the audits will provide a baseline for the development and implementation of quality improvement plans.

Although areas of non-compliance have been identified there are many areas where a facility failed by very small margin. The response to both the audit process and the outcomes has been positive and staff have started to vigorously address the areas of non-compliance.

Seven Domains of the National Core Standards

7) The roll out of a new Road-to-Health Booklet (RTHB):.

The Road-to-Health Booklet replaces the Road-to-Health Card, with updated and additional health related information. The RTHB is issued to parents and guardians and is used world-wide by health personnel to monitor and record the health status of children. The aim of the booklet is to provide an accurate record of a child's health and development that will assist health professionals to identify the children that need extra care as regular growth monitoring is the easiest and quickest method for the early detection of disease, developmental and nutritional problems.

After an official launch by the Western Cape Minister of Health at Mowbray Maternity Hospital on 31 May 2011, the Road-to-Health Booklet was released for use in the Department.

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

9) Improvement in response time for emergency medical services:
   - In urban areas the Priority 1 response time improved to 68.5 per cent in the third quarter of 2011/12 (52.6% for 2010/11) due to significant changes to the dispatch model and additional resources made available through the 2010 FIFA World Cup.
   - In rural (farms) areas the Priority 1 response time has improved to 87.3 per cent within 40 minutes.

10) Infrastructure:
   - The construction of Khayelitsha Hospital was completed.
   - The construction of Mitchells Plain Hospital is in progress and will be completed by December 2012.
   - The Western Cape Minister of Health, Minister Theuns Botha officially opened the new Kwanokuthula Community Day Centre in Pletttenberg Bay on18 April 2011. This facility will render primary healthcare services to more than 46 000 people in Bitou Sub-district.
   - The Paarl Forensic Pathology Laboratory was officially opened on 10 June 2011. The facility is on the premises of TC Newman Community Day Centre in Paarl East. The new purpose-built Malmesbury and Worcester Forensic Pathology Laboratories that were officially opened by Minister Botha on 23 and 27 September 2011, respectively.

11) The Western Cape College of Nursing (WCCN):
   - The Boland campus of the WCCN, in Worcester, expanded its teaching facilities and office space for another intake of students and the appointment of more academic staff.
   - The second intake of students was admitted to the WCCN for the post-basic Critical Care: Trauma Programme (R212).
   - The post-registration Diploma in Midwifery was approved by the South African Nursing Council and commenced during the 2010 academic year, with an intake of thirty-five students.
   - The WCCN undertook a province-wide road-show to market and recruit candidates for the basic four-year training programme, which resulted in improved quality of applications and increased interest of males in the profession.
   - The attrition of nursing students has dropped from 15 per cent in 2006 to 3.5 per cent in 2010.

12) The Cape Medical Depot maintained a stock availability rate of approximately 97 per cent.

13) A Picture Archiving and Communication system, which provides all medical images through a digital system, was successfully implemented at Tygerberg Hospital and the first phase at Groote Schuur Hospital has been initiated.

14) Improvement in Clinical Governance

- Eighteen family physicians and sixty-four family medicine registrars have been appointed in the District Health System.
- Heads of general specialist services have been appointed in all GSAs for the major disciplines. They will work together with the family physicians to strengthen clinical governance.

15) Corporate governance :

- The Department achieved an unqualified audit of the Annual Financial Statements for the 2010/11 financial year.
- The Auditor-General of South Africa has not expressed an audit opinion on pre-determined objectives to date. However, in the Management Report, the Auditor General indicated that an unqualified report would have been expressed if pre-determined objectives had been formally audited.
- Financial governance was improved by the following management tools:
  - The Budget Management Instrument (BMI), whereby all expenditure is measured and monitored against budgets within respective economic classification throughout the programmes and entities of the Department on a monthly basis;
  - A joint initiative with human resources to manage all funded posts as listed on the Approved Post List (APL);
  - Vetting, budgeting and reporting of results, per cost centre and/or functional business unit, are implemented at different stages of maturity throughout the Department; and
  - Monthly reporting and monitoring of compliance to financial and supply chain prescripts and procedures by means of a Compliance Monitoring Instrument (CMI) that monitors departmental compliance to said prescripts.
  - Monthly Financial Monitoring Committee (FMC) meetings, chaired by the Head of Department, are used to monitor expenditure of the Department against budget and programme managers are asked to account for any variances.
- Human resources:
  - Ninety-four of the 147 organisational and post structures have been aligned to the CSP.
  - The Department has implemented internal and external bursary programmes and learnerships in an effort to attract and retain scarce skills.
  - Together with an accredited service provider appointed by the Department of Public Administration (DPSA), namely HR Connect, incomplete information regarding employee qualifications/skills/competencies captured on PERSAL are being addressed through specialised interventions. By the end of 2010/11 61.2 per cent were completed.
  - The Employee Health and Wellness Programme (EHWP) engaged with 4 939 (18.2%) staff members during 2010/11.
- Information management :
  - A systematic strategy to improve the quality of data and information in the Department and address the audit findings on predetermined objectives was

developed and endorsed by Top Management. An action plan was developed and implementation has begun.

- The Departmental IT committee has been re-constituted to identify and address the strategic IT issues.
- A pre-audit process has been done to ensure that the necessary steps have been taken to ensure that the Department is well prepared for the next audit based on the lessons learned previously.

16) The second Barret Survey of values was conducted amongst staff. These surveys contributed to increase awareness of the importance and impact of values on service delivery. A focus on staff is central to the objective of improving patient experience.

8.3.2 **Challenges**

Some of the challenges experienced include:

1) To change the hearts and minds of staff so that they express the desired values of the organisation through their actions and behaviour. Complaints that are received from clients about staff attitudes are evidence that this is still an area for improvement.
2) An appropriate budget allocation in order to provide the required services.
3) The National Tertiary Services Grant (NTSG) and the Health Professions Training and Development Grant (HPTDG) are insufficient to appropriately fund the cost of providing the required tertiary services and the costs associated with the training of health professionals. These grants are therefore supplemented with allocations from the Provincial Equitable Share.
4) The recruitment and retention of appropriately qualified and experienced staff is an on-going challenge.
5) The fragmentation of the delivery of PHC services in the Metro between local and provincial government remains a challenge.
6) Securing the operational budget to commission a full package of clinical services at Khayelitsha Hospital during the 2012/13 financial year.
7) Under-achievement against women's health performance targets in the 2010/11, notably antenatal bookings rate < 20 weeks and cervical cancer screening.
8) Under-achievement in immunisation targets
9) Achieving the target urban response time targets for Emergency Medical Services in the face of an increasing demand for EMS services.
10) Managing the acute caseload of patients, particularly within the Cape Town Metro District.
11) The time that patients have to wait for services, e.g. in queues at facilities but also for procedures in theatre, radiology and therapeutic radiation, and emergency centres.
12) Addressing the maintenance backlog and ensuring preventative maintenance which is both a financial and a capacity issue.
13) Reducing the carbon footprint of the health infrastructure portfolio.

14) The attrition and failure rate of undergraduate nurse students remains an issue. Measures to improve the selection and support of students on the programme are in place to address this issue.

15) A fragmented HR information system continues to adversely impact on management decision making. This is recognised at Cabinet level, and the Department Public Service and Administration (DPSA) is seeking to implement a Public Service Human Resource Information System (HRIS) via the HR Connect project.

16) Attracting suitable applicants in the scarce skills occupational groups is a challenge that impacts negatively on service delivery, particularly in the rural areas.

17) The shortage of skilled staff within human resources, finance and information management remain challenges which impact on the compliance with regulatory frameworks.

9. ORGANISATIONAL ENVIRONMENT

9.1 LINKAGES TO OTHER ORGANISATIONS/ DEPARTMENTS

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

The Department has a service delivery agreement with the Department of Transport and Public Works (DTPW), as DTPW is the implementing agent for health infrastructure delivery.

9.2 SUMMARY OF THE ORGANISATIONAL STRUCTURE

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

The Healthcare 2010 and CSP organisational and post structures have been implemented in the Metro District Health Services, psychiatric hospitals and TB hospitals; and the Chief Directorates: Infrastructure Management and Health Strategy and Support.

In addition, it was necessary to realign certain sections of the approved organisational structure of the Chief Directorate: Regional Hospitals, Mental Health, Emergency Medical Services (EMS) and Forensic Pathology Services (FPS).

The development of the organisational and post structures for the rural secondary hospitals at Worcester, George, Paarl and the central hospitals (Groote Schuur, Tygerberg and Red Cross War Memorial Children's Hospital) has been completed. Implementation, matching and placement of staff and related exercises will span over a two-year period, which commenced in 2011/12.

The following organisational development projects have been identified for the period 2011/12 to 2012/13:

1) Forensic Pathology Services: investigate the need for an adequate support structure, new categories of staff and career path opportunities.
2) Emergency Medical Services: investigate all aspects of creating sub-directorate managers.
3) Directorate: Management Accounting.

4) Revisit the responsibility of the manager of the Cape Winelands District for sub-districts with no district hospitals.
5) Investigate and review the engineering and hospital maintenance workshops.
6) Radiography services: focus on regional and district hospitals, recognizing the need for adequate support structures, new categories of staff and career path opportunities.
7) Conduct a needs analysis to determine appropriate competencies and salary levels attached to the positions of facility manager at various levels of institutions.
8) Revitalisation of Primary Health Care Services: re-organisation into geographical areas.

Figure 1: Organogram of the senior management of the Department

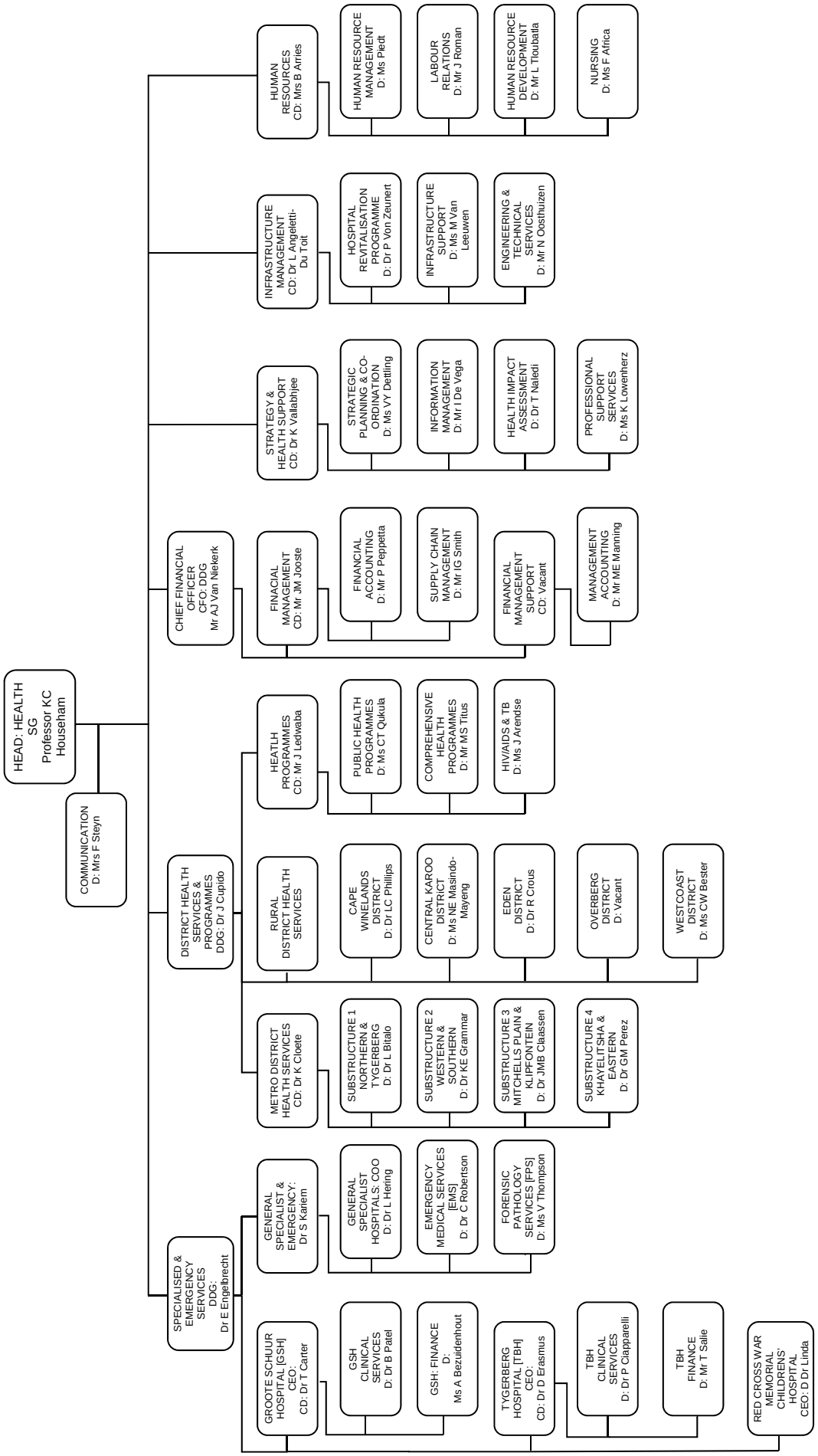


Table 12: Public health personnel in 2010/11, as at 31 March 2011 [ADMIN 1]

Categories	Number employed	% of total employed	Number per 1 000 people	Number per 1 000 uninsured people	Vacancy rate	% of total personnel budget	Annual cost per staff member
Medical Officers	1 881	6.55%	0.33	0.43	4.37%	15.97%	573 407
Medical Specialists	570	1.98%	0.10	0.13	3.88%	8.82%	1 044 408
Dental Specialists	28	0.10%	0.00	0.01	3.45%	0.26%	620 830
Dentists	66	0.23%	0.01	0.02	5.71%	0.64%	650 649
Professional Nurse	5 479	19.08%	0.97	1.25	3.06%	23.86%	293 991
Enrolled Nurses	2 275	7.92%	0.40	0.52	2.11%	5.79%	171 830
Enrolled Nursing Auxilliaries	4 058	14.13%	0.72	0.92	1.60%	8.62%	143 486
Student Nurses	-	-	-	-	-	-	-
Pharmacists	362	1.26%	0.06	0.08	7.42%	2.06%	384 799
Physiotherapists	126	0.44%	0.02	0.03	3.08%	0.45%	239 313
Occupational Therapists	130	0.45%	0.02	0.03	2.26%	0.46%	238 190
Clinical Psychologists	69	0.24%	0.01	0.02	6.76%	0.34%	334 428
Radiographers	417	1.45%	0.07	0.09	2.34%	1.68%	271 412
Emergency Medical Staff	1619	5.64%	0.29	0.37	3.86%	5.01%	209 091
Dieticians	80	0.28%	0.01	0.02	10.11%	0.31%	259 519
Other allied health professionals & technicians	1246	4.34%	0.22	0.28	8.38%	3.96%	214 372
Managers, administrators & all other staff	10317	35.92%	1.83	2.35	5.38%	21.78%	142 554
Grand Total	**28723**	**100%**	**5.10**	**6.53**	**4.10%**	**100.00%**	**235 072**

Note:
Student nurses are not employed by the Department.
Students in training receive bursaries and are not appointed on PERSAL.

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

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

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

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

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

9.3.1 **Occupational specific dispensations (OSDs):**

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

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

- The implementation of the various occupational specific dispensations has resulted in specific occupational streams, within occupations, having new job titles and remuneration packages. This includes a new competency mix (scope of practice) of positions providing health services at ward/unit/clinic level.
- As a result, the entire organisational and post structure of the Department has been aligned in terms of the new occupational specific dispensations.
- Over the past two years the implementation of the occupational specific dispensations has resulted in significantly higher personnel costs.
- A cause for concern is that restrictions have been placed on the appointment of specific professional staff, such as paramedics, forensic pathology officers and certain nursing specialties.
- In certain professional occupational categories, the occupational specific dispensations are not competitive enough in comparison with the private sector and this limits the recruitment of nursing categories, pharmacists, paramedics as well as lecturers.

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

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

9.4 **IMBALANCES IN SERVICE STRUCTURES AND STAFF MIX**

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

Significant progress has been made with the employment of family physicians within the Metro district health services. The recruitment of family physicians in the rural districts must still be addressed.

9.5 SUMMARY OF PERFORMANCE AGAINST THE PROVINCIAL HUMAN RESOURCE PLAN

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

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

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

9.5.1 Current deployment of staff

Following the reorganisation of the staff establishment the majority of staff have been matched and placed within the district hospitals, community day care centres and clinics in the rural districts; and the psychiatric and TB hospitals. Thirty-five staff members have been officially declared in excess and will be deployed in terms of the provisions set out in the Departmental Human Resource Restructuring Plan. A policy on the management of excess staff has been developed to assist districts with this exercise. The individual profiles of these staff are captured on a central database and vacancies will be advertised to specifically target the possible absorption of excess staff.

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

The staff establishment of the district hospitals, community day centres and clinics within the rural districts as well as psychiatric and TB hospitals are in line with the service requirements. As all of the CSP structures have not been implemented the current structures are regularly amended to bridge the staffing gap.

9.5.3 Staff recruitment, retention and challenges

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

The attrition rate for medical officers is relatively high as they leave the service soon after the first three years of appointment. This is attributed mainly to the need for exposure to a particular field of interest prior to entering the registrar training programme and is therefore not necessarily negative.

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

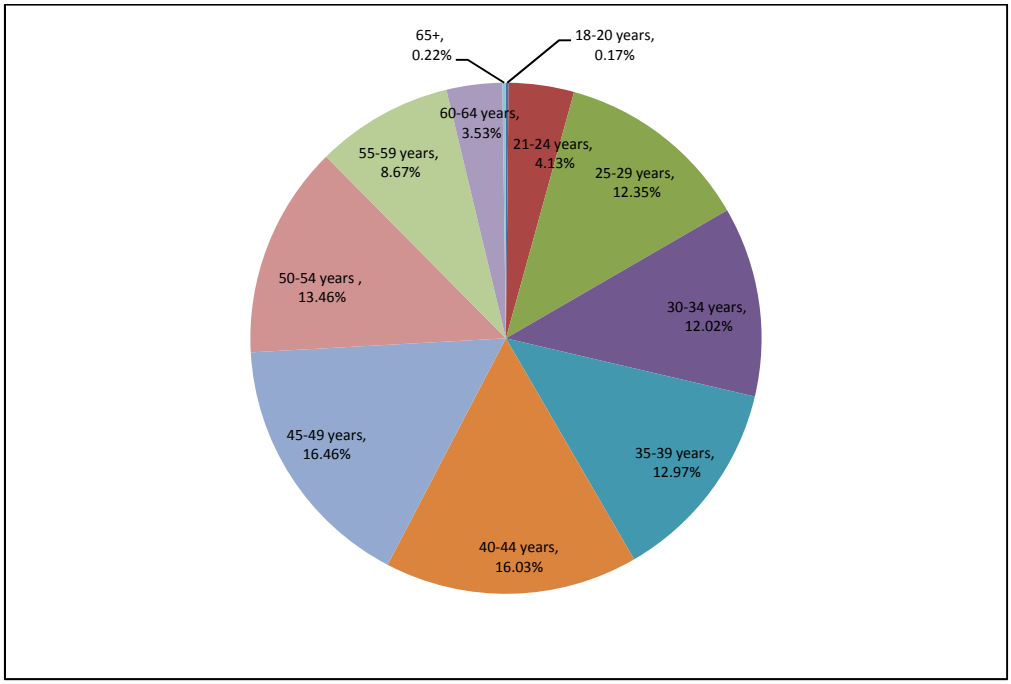
The recruitment of qualified and competent health professionals poses a challenge due to the scarcity of skills, the restrictive appointment measures that are imposed on some of the

occupations through the various new occupational specific dispensations e.g. pharmacists and emergency medical staff. These issues need to be addressed at a national forum.

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

The Department is in the process of reviewing its recruitment policy and strategy to address the above mentioned challenges.

Figure 2: Age profile of the employees of the Department of Health as at 31 March 2011



9.5.4 Absenteeism and staff turnover

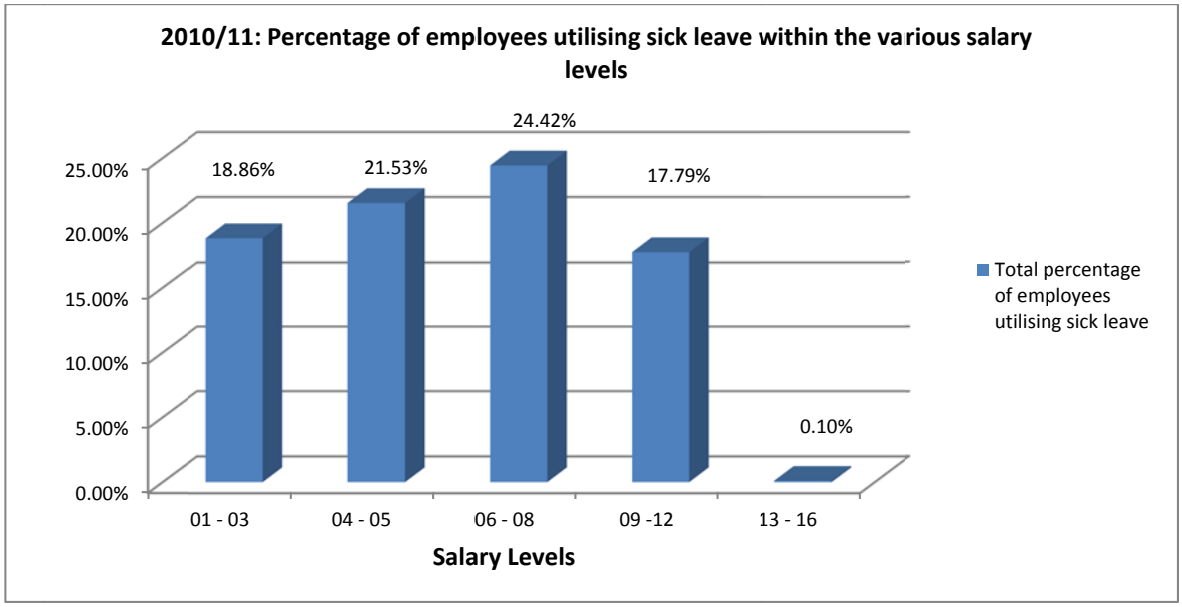
9.5.4.1 Absenteeism

The management of annual and sick leave remains problematic, and impacts on service delivery. A recent sick leave profile indicated that the highest instance in the use of sick leave is captured against employees within the salary levels 4 – 8, which are mainly production workers and frontline supervisors.

Sick leave usage by staff has increased by 4 per cent from 2009/10 to 2010/11. Although the sick leave percentages are not abnormally high, the loss of man-hours through absenteeism does have a negative impact on service delivery and financial resources.

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

Figure 3: Total percentage of employees using sick leave during 2010/11



9.5.4.2 **Staff turnover**

The average staff turnover rate for the Department in 2010/11 was 14.95 per cent. The turnover for contractual appointments is not included in this figure but fixed-term contractual appointments such as community service, interns and registrars are included. The termination of fixed-term contractual staff contributes 0.84 per cent to the average departmental staff turnover rate. Occupational categories identified with above average turnover rates were dieticians, physiotherapists, pharmacists (production and managers, pharmacist assistants, professional nurses (particularly within general), technologists, clinical psychologists, radiography (production), occupational therapy (production), speech therapy (production) dentists, medical officers, specialists (especially heads of departments), medical officer (production), artisans and administrative officer (supervisors).

The following challenges exist in decreasing the turnover rate:

- The lack of recruitment and retention strategies;
- Providing a conducive working environments (aging equipment);
- Budget constraints;
- Skills development of existing staff;
- Ability to compete with private sector remuneration especially specialists, dentists, clinical psychologist, pharmacists and pharmacy assistants; and
- Competition with global demand for doctors and nurses.

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

- Implement recruitment and retention strategies that are applicable to each occupational group;
- Develop, implement and monitor a succession planning policy;
- Conduct an attrition analysis and provide remedial measures;
- Strengthen strategic partnerships with the private sector and health facility boards to enhance improvement of working conditions;
- Implement targeted career path strategies and talent management;

- Establish internships and student training posts for positions such as clinical technologists;
- Continue to align individual performance plans/competency gaps with training plans;
- Mentoring should be formalised as a key strategy to improve and develop the skills within management, technical or clinical categories; and
- Post course assessments to determine the impact of training.

9.6 DEPARTMENTAL RISKS

The following have been identified as overarching departmental risks:

1) Insufficient funds, for example for the operational costs of Khayelitsha and Mitchells Plain Hospitals, and over-expenditure.
2) Failure of supply chain management regarding the procurement of medicines and goods and services, resulting in items being out of stock. This includes contractual obligations that are not met as a result of poor contract management.
3) Fraud, theft of money and other assets and fraudulent (ghost) appointments.
4) Non-compliance with financial, human resource and other regulations, resulting in irregular expenditure.
5) Inadequate performance management of human resources.
6) Shortage of skilled staff at all levels.
7) Inadequate information, which compromises planning, monitoring and the management of the service.
8) Failure of information technology networks and computer systems.
9) Inadequate health technology and infrastructure to support health services, including capacity deficiencies in the Department of Transport and Public Works.
10) Poor quality of care.
11) The continued dual authority responsibility of provincial and local government for the provision of Personal Primary Health Care services in the Cape Town Metro District.
12) Disasters and outbreaks, for example H1N1 or similar unpredictable outbreaks.

10. DESCRIPTION OF THE STRATEGIC PLANNING PROCESS

A strategic planning session was held on 19 – 20 April 2011 with members of senior management to focus on developing a more client-centred approach and to the implementation of priorities for 2011/12.

This was followed by a two-day workshop on 20 -21 June 2011 where the Department's performance during the 2010/12 financial year was reviewed and evaluated against the pre-determined targets for that year.

A strategic planning was held on 8 - 9 September 2011 where over 100 senior managers in the Department and from various stakeholder groups, gathered to debate the factors that impact on the 2012/13 Annual Performance Plan and the planning for 2020.

There is a reciprocal relationship between the strategic planning/monitoring and evaluation sessions that are held at Departmental level and those that are held within the component divisions and chief directorates where there is engagement with a broader range of stakeholders.

From a technical perspective, there has been a concerted effort to further improve the quality of the performance information, for example through the development of Excel planning templates. The tables of data elements provided in each programme are part of this initiative.

11. OVERVIEW OF THE 2010/11 BUDGET AND MTEF ESTIMATES

11.1 ECONOMIC CONTEXT

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

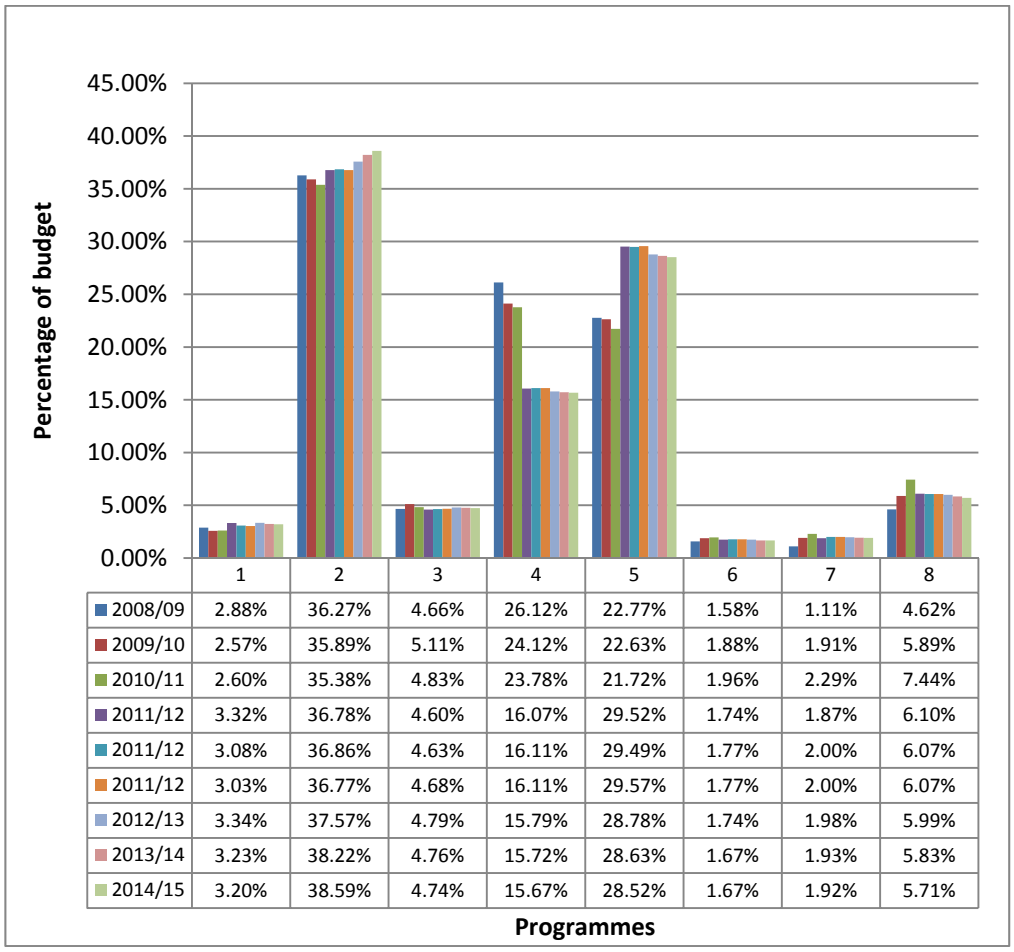
- Efficiency: less inputs for the given outputs;
- Economy: removal of excesses, wastage and unnecessary spending; and
- Effectiveness: attainment of desired outcomes, objectives and results.

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

11.2 RESOURCE TRENDS OVER THE PAST 3 YEARS

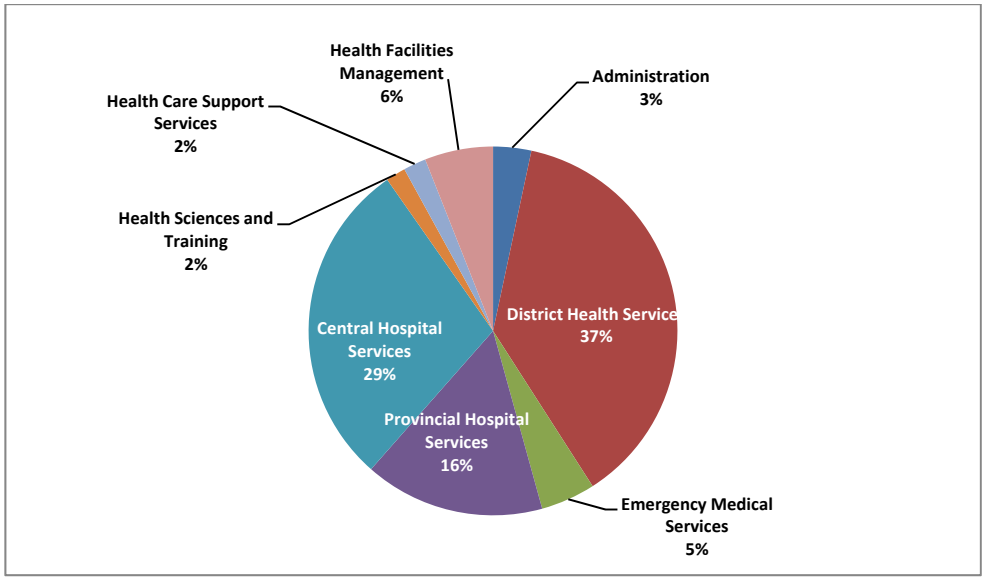
The following graph illustrates the expenditure trend over the reporting period.

Figure 4: Budget allocation per programme over the reporting period



	1	2	3	4	5	6	7	8
2008/09	2.88%	36.27%	4.66%	26.12%	22.77%	1.58%	1.11%	4.62%
2009/10	2.57%	35.89%	5.11%	24.12%	22.63%	1.88%	1.91%	5.89%
2010/11	2.60%	35.38%	4.83%	23.78%	21.72%	1.96%	2.29%	7.44%
2011/12	3.32%	36.78%	4.60%	16.07%	29.52%	1.74%	1.87%	6.10%
2011/12	3.08%	36.86%	4.63%	16.11%	29.49%	1.77%	2.00%	6.07%
2011/12	3.03%	36.77%	4.68%	16.11%	29.57%	1.77%	2.00%	6.07%
2012/13	3.34%	37.57%	4.79%	15.79%	28.78%	1.74%	1.98%	5.99%
2013/14	3.23%	38.22%	4.76%	15.72%	28.63%	1.67%	1.93%	5.83%
2014/15	3.20%	38.59%	4.74%	15.67%	28.52%	1.67%	1.92%	5.71%

Figure 5: Budget allocation per programme for 2012/13



11.3 FOCUS ON LEVELS OF FUNDING AND SUSTAINABILITY OF HEALTH SERVICES

As a result of the fiscal tightening over the 2012 medium term expenditure framework period the Department's budget does not allow for real growth. The new Khayelitsha Hospital, the increased capacity of the Chronic Dispensing Unit, the strengthened control to prevent and detect fraud and irregular expenses and other priorities are funded through reprioritisation.

Additional funding has not been allocated for the Mitchell's Plain Hospital as GF Jooste Hospital will relocate to the premises of the new Mitchell's Plain Hospital, whilst the current GF Jooste Hospital is redeveloped.

Due to funding pressures, many of the priority allocations listed in the Provincial Treasury's allocation letter are not separately funded in the 2012/13 MTEF budget as additional expenditure. As the allocation to the Department in 2012/13 is marginally less, in real terms, than the Adjusted Budget of 2011/12, these priority allocations did not effectively result in real additional funding. The affected priority allocations include:

- Nursing college recapitalisation
- Maternal and child health
- HIV and ADIS CD4 350 treatment threshold
- Registrars (especially paediatricians and obstetricians) and other critical posts
- Family health teams and PHC re-engineering and hospital norms and standards

However, the goals of these priority allocations are being achieved by reprioritised operational priorities.

Over the past years staff numbers have indeed increased. In contrast the budget for personnel expenses for 2012/13 has been provided using the average actual expenses for November and December 2011 as the basis, to which the salary increases, as indicated by Treasury were added. Firstly, this means that staff numbers must remain at current levels during 2012/13. Secondly, as many posts were vacant during those months, the current approved post list (APL) will not be fully funded in 2012/13. The APL will be marginally reduced across the platform to fund Khayeltisha Hospital and related shifts in services.

The funding for performance awards will be reduced by 20 per cent and is applicable to all levels of staff. The Department is also limiting overtime payments and will continue to monitor overtime expenses during 2012/13.

Funding for Capital in 2012/13 has been provided at a lower level than in the 2011/12 Adjusted Budget. However, over the full MTEF period the funding for Capital has been maintained at current levels in real terms.

Funding for goods and services is equal to the levels of recent actual expenses plus 5 per cent. This is lower than the 5.2 per cent indicated by Provincial Treasury. Medical inflation is normally higher than the average inflation rate which implies an even higher differential between the allocated and anticipated rates of inflation. As a result stringency measures will have to be strengthened to prevent over-expenditure during 2012/13.

Funding for agency services, which forms part of goods and services, has been reduced in real terms in line with the strategic decision of the Department to reduce reliance of agency services. Agency costs will be closely monitored. Some of the agency funds will be directed towards the filling of full-time posts.

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

Funding for Transfer Payments is equal to the Adjusted Budget for 2010/11 plus 4 per cent. However, the provision for medico legal claims, which forms part of Transfer Payments, is increased due to a number of large claims that are expected to be finalised in 2012/13.

Funding is provided for personnel expenses in Emergency Medical Services to ensure that the current acceptable response times are maintained. Limited provision is made for an improved emergency communications system.

The conditional grant for AIDS continues to grow in excess of the inflation rate. However, the number of patients is growing at a higher level than the real increase in the conditional grant. The cost per patient is therefore reducing. The conditional grant for AIDS is supplemented with a substantial allocation from the Global Fund.

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

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

A process has been initiated to incorporate the Cape Medical Depot, which is currently managed as a trading entity separate from the department, into the Department, without altering any of the operations of the Depot. This will result in adjustments to the budget. However, the initial step in the process will be the repeal of Provincial Ordinance 3 of 1962, which it is anticipated will occur by either the 2012 Adjusted Estimate or from 1 April 2013.

In conclusion, 2012/13 will be financially challenging, allowing for no growth in services, in spite of the increasing patient load. Reductions in service levels can only be prevented or mitigated by further improvement in service efficiency and through a focus on preventive medicine. It is well documented that preventive measures in public health usually tend to pay dividends in the medium to long term.

11.4 FUNDING IMPLICATIONS OF CURRENT TRENDS OF SERVICE VOLUMES

11.4.1 Growth trends in service volumes from 2008/08 to 2011/12

Table 13: Trends in key provincial service volumes [A2]

Indicator	Programme	2008/09	2009/10	2010/11	2011/12
		Actual	Actual	Actual	Estimate
PHC total headcount	2	15 051 210	15 848 973	16 206 552	15 764 882
OPD headcount + emergencies in district hospitals	2	508 504	504 673	901 798	1 191 908
Separations in district hospitals	2	221 365	238 085	237 292	244 001
OPD headcount + emergencies in regional hospitals	4	1 026 319	925 232	863 931	414 834
Separations in regional hospitals	4	196 668	185 919	174 307	108 257
OPD headcount + emergencies in central hospitals	5	543 461	537 749	541 079	989 401
Separations in central hospitals	5	62 555	68 231	68 490	136 883
Total patient volume: Acute Services	**Sub Total**	**17 610 082**	**18 308 862**	**18 993 449**	**18 850 165**
OPD headcount in specialised hospitals	4	56 409	84 735	92 776	53 377
Separations in specialised hospitals	4	9 720	9 882	10 831	10 898
Total patient volume	**Total**	**17 676 211**	**18 403 479**	**19 097 056**	**18 914 440**

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

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

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

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

11.4.2 Growth projections

Table 14: Output growth projections

	2012/13	2013/14	2014/15	Cumulative	% of Cost
PHC total headcount	3.7%	3.7%	3.7%	11.1%	24%
District hospitals	0.4%	3.5%	0.7%	4.5%	18%
Regional hospitals	1.0%	1.0%	1.0%	3.0%	11%
TB hospitals	10.4%	3.5%	0.0%	13.9%	2%
Psychiatric hospitals	1.0%	1.0%	1.0%	3.0%	6%
Rehabilitation hospitals	0.1%	0.0%	0.0%	0.1%	1%
Central hospitals	2.0%	-2.3%	0.2%	0.0%	38%
Weighted average	**2.1%**	**0.8%**	**1.3%**	**4.2%**	

The table above indicates the projected percentage growth in patient day equivalents (PDEs) and headcounts per sector of the Department as well as the weighted average growth. Sectors are for instance Primary Health Care services as reflected by the total headcount and the various categories of hospitals as reflected by the PDE's. The weighted average reflects the overall average of all the sectors.

The percentage cost column reflects the percentage of the departmental operational budget absorbed by each sector and thus indicates the relative impact that each sector has on the weighted average increase in outputs.

Central hospitals will receive 38 per cent of the operational budget of the services, reflected in Table 14, while there is a projected reduction in PDEs in 2013/14. This results in a low overall projected growth in output of the Department for that financial year.

The sectors of the Department with the highest growth are PHC headcounts and TB hospitals. However, TB hospitals consume only 2% of the budget and therefore PHC is the sector of the Department that contributes most to the overall growth in departmental output.

These growth projections are made against the background of a departmental budget that remains constant in real terms implying increased efficiency with respect to departmental activities over the MTEF period.

11.5 EXPENDITURE ESTIMATES

Table 15: Summary of payments and estimates

Programme R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
1. Administration [a,c]	249 104	266 710	321 481	445 222	413 705	406 775	488 548	20.10	508 531	535 885
2. District Health Services [b,c,h]	3 139 800	3 722 530	4 367 380	4 926 594	4 949 312	4 938 747	5 498 095	11.33	6 015 110	6 463 672
3. Emergency Medical Services [c]	403 118	530 130	596 110	616 047	622 416	627 895	701 392	11.71	749 757	793 917
4. Provincial Hospital Services [c,h]	2 260 650	2 501 088	2 935 241	2 152 471	2 163 298	2 164 091	2 310 951	6.79	2 474 309	2 624 694
5. Central Hospital Services [c,d,h]	1 970 686	2 347 345	2 681 739	3 953 753	3 959 727	3 971 758	4 211 787	6.04	4 507 020	4 776 767
6. Health Sciences and Training	136 629	194 624	241 374	233 466	237 455	237 389	254 878	7.37	263 138	279 083
7. Health Care Support Services	96 150	197 605	282 869	251 027	268 167	268 167	289 629	8.00	303 694	320 860
8. Health Facilities Management [e,f,g,i]	399 708	611 002	918 434	816 480	814 830	814 830	877 081	7.64	918 423	956 354
Total payments and estimates	8 655 845	10 371 034	12 344 628	13 395 060	13 428 910	13 429 652	14 632 361	8.96	15 739 982	16 751 232

[a] MEC total remuneration package: R1 566 089 with effect from 1 April 2011.

[b] National Conditional grant: Comprehensive HIV and Aids - R738 080 000 (2012/13) , R927 547 000 (2013/14) and R1 074 487 000 (2014/15).

[c] National Conditional grant: Health Professions Training and Development - R428 120 000 (2012/13), R451 667 000 (2013/14) and R478 767 000 (2014/15).

[d] National Conditional grant: National Tertiary Services - R2 182 468 000 (2012/13), R2 400 714 000 (2013/14) and R 2 537 554 000 (2014/15).

[e] National Conditional grant: Hospital Revitalisation - R496 085 000 (2012/13), R503 526 000 (2013/14) and R 511 079 000 (2014/15).

[f] National Conditional grant: Health Infrastructure Grant - R131 411 000 (2012/13), R139 296 000 (2013/14) and 150 171 000 (2014/15).

[g] National Conditional grant: Nursing Colleges and School Grant - R10 320 000 (2012/13), R14 964 000 (2013/14) and R20 950 000 (2014/15).

[h] National Conditional grant: National Health Insurance Grant - R11 500 000 (2012/13), R26 833 000 (2013/14) and R38 333 000 (2014/15).

[i] National Conditional grant: Expanded Public Works Programme Integrated Grant for Provinces - R1 000 000 (2012/13).

Table 16: Summary of payments and estimates by economic classification

Economic classification R'000	Outcome			Main appro-priation	Adjusted appro-priation	Revised estimate	Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	2011/12	2011/12	2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
Current payments	7 756 666	9 111 684	10 634 678	11 781 235	11 789 298	11 781 462	12 934 547	9.79	13 956 994	14 866 619
Compensation of employees	4 876 271	5 780 151	6 808 175	7 637 201	7 698 894	7 715 021	8 478 408	9.89	9 158 861	9 831 726
Salaries and wages	4 328 659	5 145 145	6 066 844	6 802 826	6 861 499	6 861 029	7 530 118	9.75	8 133 761	8 730 854
Social contributions	547 612	635 006	741 331	834 375	837 395	853 992	948 290	11.04	1 025 100	1 100 872
Goods and services	2 879 999	3 331 196	3 826 487	4 144 034	4 090 404	4 066 441	4 456 139	9.58	4 798 133	5 034 893
of which										
Administrative fees	640	836	950	974	973	1 014	1 112	9.66	1 177	1 217
Advertising	21 625	11 087	17 574	34 254	24 961	24 327	16 213	(33.35)	18 577	20 126
Assets <R5 000	36 590	32 240	43 625	55 908	64 715	61 839	60 780	(1.71)	55 559	55 421
Audit cost: External	12 282	16 907	14 755	20 998	18 998	18 563	19 551	5.32	20 693	21 467
Bursaries (employees)	4 581	7 365	8 724	7 723	7 723	9 973	7 130	(28.51)	7 553	7 821
Catering: Departmental activities	5 241	4 735	5 366	5 861	6 038	5 087	5 015	(1.42)	5 337	5 635
Communication	47 942	60 160	66 298	69 065	68 509	66 758	69 643	4.32	73 873	76 520
Computer services	42 134	44 114	64 875	83 418	79 621	81 004	90 408	11.61	95 744	99 237
Cons/prof: Business and advisory services	85 723	101 619	100 506	149 624	82 874	77 623	78 728	1.42	83 526	87 917
Cons/prof: Infrastructure & planning	4 425	2 915	990							
Cons/prof: Laboratory services	349 059	395 711	407 390	433 091	435 413	411 985	416 657	1.13	460 995	485 202
Cons/prof: Legal costs	3 987	3 603	4 839	5 954	5 954	6 246	7 378	18.12	7 815	8 092
Contractors	92 800	115 450	136 715	146 906	189 402	196 098	216 070	10.18	228 875	236 988
Agency and support/ outsourced services	277 506	304 030	288 969	262 367	249 216	281 537	298 484	6.02	316 743	327 965
Entertainment	125	100	217	246	242	259	283	9.27	293	296
Inventory: Food and food supplies	69 478	85 056	96 024	110 925	111 730	104 687	103 661	(0.98)	112 235	116 872
Inventory: Fuel, oil and gas	21 258	26 619	31 833	31 621	30 817	32 861	34 939	6.32	37 013	38 320
Inventory: Materials and supplies	30 542	39 782	40 278	44 856	39 211	39 041	43 227	10.72	45 799	47 428
Inventory: Medical supplies	551 395	647 736	778 418	785 061	814 622	826 503	915 164	10.73	987 760	1 034 000
Inventory: Medicine	549 909	661 488	786 569	883 603	841 132	765 236	898 222	17.38	990 684	1 062 487
Inventory: Other consumables	67 149	97 356	111 359	118 347	114 952	119 984	121 999	1.68	129 484	134 264
Inventory: Stationery and printing	40 416	41 360	53 232	54 625	56 111	58 744	60 351	2.74	64 553	68 099
Lease payments	30 850	15 581	17 880	17 775	63 180	67 351	103 231	53.27	109 363	113 245
Rental and hiring						117	31	(73.50)	32	32
Property payments	315 055	357 415	464 130	505 579	513 891	544 006	616 856	13.39	661 990	688 769
Transport provided: Departmental activity	2 111	1 297	1 456	2 748	2 798	1 209	1 369	13.23	1 488	1 580
Travel and subsistence	151 548	197 790	226 027	225 703	178 824	181 473	178 455	(1.66)	190 203	197 599
Training and development	36 560	50 391	43 401	71 093	65 467	59 265	61 059	3.03	66 676	71 269
Operating expenditure	24 513	5 689	10 442	6 877	15 659	18 254	26 209	43.58	19 274	20 242
Venues and facilities	4 555	2 764	3 645	8 832	7 371	5 397	3 914	(27.48)	4 819	6 783
Interest and rent on land	396	337	16							
Interest	396	337	16							
Transfers and subsidies to	427 489	550 863	724 559	772 512	786 587	789 708	817 640	3.54	872 840	927 873
Provinces and municipalities	165 186	228 424	263 107	315 436	322 763	321 941	340 354	5.72	365 261	385 922
Municipalities	165 186	228 424	263 107	315 436	322 763	321 941	340 354	5.72	365 261	385 922
Municipalities	165 186	228 424	263 107	315 436	322 763	321 941	340 354	5.72	365 261	385 922
Departmental agencies and accounts	4 368	4 712	55 341	16 415	16 415	15 651	22 071	41.02	17 767	18 731
Entities receiving transfers	4 368	4 712	55 341	16 415	16 415	15 651	22 071	41.02	17 767	18 731
CMD Capital Augmentation	1 573	1 715	52 299	12 535	12 535	12 535	18 536	47.87	13 963	14 661
SETA	2 795	2 997	3 042	3 880	3 880	3 116	3 535	13.45	3 804	4 070
Universities and technikons			1 400	1 926	1 926	470	1 603	241.06	1 683	1 767
Non-profit institutions	211 455	239 925	281 488	334 487	336 613	336 641	334 945	(0.50)	356 530	384 876
Households	46 480	77 802	123 223	104 248	108 870	115 005	118 667	3.18	131 599	136 577
Social benefits	15 988	18 435	24 400	18 045	18 204	21 240	22 537	6.11	23 662	24 843
Other transfers to households	30 492	59 367	98 823	86 203	90 666	93 765	96 130	2.52	107 937	111 734

Economic classification R'000	Outcome			Main appro-priation	Adjusted appro-priation	Revised estimate	Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	2011/12	2011/12	2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
Payments for capital assets	469 518	704 758	973 345	841 313	853 025	855 219	880 174	2.92	910 148	956 740
Buildings and other fixed structures	328 119	493 617	740 528	535 235	551 807	551 807	625 049	13.27	676 581	719 573
Buildings	328 119	493 617	740 528	535 235	551 807	551 807	625 049	13.27	676 581	719 573
Machinery and equipment	141 302	210 361	232 674	303 981	296 089	298 349	254 316	(14.76)	232 701	236 240
Transport equipment	6 625	18 249	13 879	9 615	14 810	14 795	14 017	(5.26)	14 990	16 034
Other machinery and equipment	134 677	192 112	218 795	294 366	281 279	283 554	240 299	(15.25)	217 711	220 206
Software and other intangible assets	97	780	143	2 097	5 129	5 063	809	(84.02)	866	927
Of which: "Capitalised Compensation" included in Payments for capital assets		141	137							
Of which: "Capitalised Goods and services" included in Payments for capital assets	326 951	500 069	739 674	539 033	553 723	553 698	625 197	12.91	676 738	719 740
Payments for financial assets	2 172	3 729	12 046			3 263		(100.00)		
Total economic classification	8 655 845	10 371 034	12 344 628	13 395 060	13 428 910	13 429 652	14 632 361	8.96	15 739 982	16 751 232

11.6 RELATING EXPENDITURE TRENDS TO SPECIFIC GOALS

The impact of the constrained budget is outlined in paragraphs 11.3. Focus on levels of funding and sustainability of health services, and 11.4 Funding implications of current trends of service volumes.

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

The following important initiatives are not funded

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

Table 17: Trends in provincial health expenditure [A9]

	Audited/Actual			Estimate	Medium term projection		
Expenditure	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Current prices							
Total excluding capital	8 256 137	9 760 032	11 426 194	12 614 822	13 755 280	14 821 559	15 794 878
Total Capital	399 708	611 002	918 434	814 830	877 081	918 423	956 354
Grand Total	**8 655 845**	**10 371 034**	**12 344 628**	**13 429 652**	**14 632 361**	**15 739 982**	**16 751 232**
Total per person	1 605	1 881	2 191	2 333	2 490	2 624	2 737
Total per uninsured person	2 057	2 411	2 808	2 991	3 191	3 364	3 509
Constant 2009/10 prices							
Total excluding capital	11 145 785	11 419 237	11 426 194	11 731 784	12 104 646	12 301 894	12 320 005
Total Capital	296 080	522 224	918 434	876 161	996 683	1 106 534	1 226 095
Grand Total	**11 441 865**	**11 941 461**	**12 344 628**	**12 607 946**	**13 101 329**	**13 408 428**	**13 546 100**
Total per person	2 122	2 166	2 191	2 191	2 229	2 235	2 214
Total per uninsured person	2 719	2 776	2 808	2 808	2 857	2 865	2 838
% of Total spent on:-							
District Health Services	36.27%	35.89%	35.38%	36.77%	37.57%	38.22%	38.59%
Provincial Hospital Services[2]	26.12%	24.12%	23.78%	16.11%	15.79%	15.72%	15.67%
Central Hospital Services	22.77%	22.63%	21.72%	29.57%	28.78%	28.64%	28.52%
Other Health Services	10.22%	11.47%	11.68%	11.47%	11.85%	11.59%	11.51%
Capital	4.62%	5.89%	7.44%	6.07%	5.99%	5.83%	5.71%
Health as % of total public expenditure (current prices)	34.9%	33.0%	36.4%	38.6%	38.2%	40.5%	41%

Table 18: CPIX multipliers for adjusting current prices to constant 2010/11 prices [A10]

2008/09	1.32	
2009/10	1.15	
2010/11	1.00	Real terms= 2010/11 prices
2011/12	0.93	
2012/13	0.88	
2013/14	0.82	
2014/15	0.77	

Source: Office of the CFO

PART B
BUDGET PROGRAMME PLANS

PROGRAMME 1: ADMINISTRATION

1. PROGRAMME PURPOSE

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

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 1.1: OFFICE OF THE MEC

Rendering of advisory, secretarial and office support services.

2.2 SUB-PROGRAMME 1.2: MANAGEMENT

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

2.3 SUB-PROGRAMME 1.2.1: CENTRAL MANAGEMENT

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

3. SITUATION ANALYSIS

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

The key management components that provide strategic leadership and support include the following:

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

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

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

The following directorates resort under the Office of the Head of Department:

- Directorate: Communication
- Directorate: Business Development

3.2. COMMUNICATIONS

3.2.1. Purpose

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

3.2.2. Overview

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

The Department makes use of social media, dedicated messaging and interactive discussions on radio as part of its communication strategy. The Department can be accessed via Twitter (WcdeptHealth), Facebook (search for Western Cape Government: Health) or MXit (go to Tradepost and search Western Cape Government: Health).

This has enabled the Department to provide the media with real time information via Twitter regarding emergency incidents, events and health days. It has also provided a platform to acknowledge staff who received awards for outstanding performance. The Department has been added to the media's Twitter profile and tweets from the Department are being posted regularly. MXit, a mobile phone application that is free to users, has enabled the Department to communicate with a wider platform in a more relaxed environment and more than 45 000 people have added the Department's profile as a "friend".

3.2.3. Challenges

The following challenges and mitigating measures have been identified:

- The appointment of communications officers in all districts to facilitate communication with a wide range of personnel and other stakeholders across the Province.
  - Amend existing staff establishment and recruit and select suitable staff for the different districts.
- Successful marketing of the corporate identity that requires buy-in and support from internal role-players.
  - Establish templates and tools to monitor all applications of the new corporate identity. Maintain a database and a closer working relationship with the Directorate: Supply Chain Management to ensure compliance.

3.2.4. Priorities

- Support the change management strategy towards 2020.
- Market the new corporate identity of the Province.
- Improve internal communications to staff.
- Implement external and internal communication about programmes, campaigns and employment opportunities.
- Utilise the internet and intranet as a communications vehicle to market the Department.

- Use social media including Facebook, Twitter, U-tube, MXit, Flicker etc. as communication vehicles to market the Department.
- Ensure all stakeholders are aware of improvements in infrastructure and patient experience.
- Expand the interpreter service at various health facilities.

3.3. BUSINESS DEVELOPMENT

3.3.1. Purpose

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

3.3.2. Overview

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

The key focus areas of the directorate will be to:

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

3.3.3. Challenges

The following challenges and mitigating measures have been identified:

- Human resource capacity.
  - Recruitment and retention of competent and skilled employees.

3.3.4. Priorities

- Establish and resource the unit to optimally attend to all projects which would be mutually beneficial to the Department and the private sector.

3.4. FINANCE

3.4.1. Purpose

To provide sound budget and financial administration within the Department.

3.4.2. Overview

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

3.4.2.1. Financial Management

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

The Department aims to continue its record of an unqualified audit opinion on financial matters and is striving towards a "clean" audit report. For improved adherence to finance and supply chain management prescripts, a Compliance Monitoring Instrument (CMI) has been introduced, which assists management to ensure compliance with priority issues identified by the Auditor-General of South Africa.

The key focus areas of the two directorates are:

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

3.4.2.2. Financial Management Support

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

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

To control personnel expenditure, a joint initiative with the Directorate: Human Resource Management exists to manage all funded posts in accordance with the Approved Post List (APL).

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

3.4.3. Challenges

The following challenges and mitigating measures have been identified:

- Recruitment and retention of competent and skilled employees.
  - Development and implementation of a retention policy and strategy.
  - Innovative recruitment system.
- Increased reporting requirements by National and Provincial Treasury.
  - Develop specifications and interact with Provincial Treasury.
- The lack of appropriate transversal financial systems.

- Implementing sound monitoring, evaluation and reporting mechanisms, which ensures accountability.

3.4.4. **Priorities**

- Timely resourcing of appropriate supplies and services at the best prices.
- Accurate accounting and reliable reporting to internal and external stakeholders.
- Manage personnel expenditure through a list of affordable posts.
- Operate within allocated budget.
- Set priorities within the limited resources.
- Improve efficiency to get the best value for the health rand.
- Ensure unqualified Annual Financial Statements without any matters of emphasis through improved internal controls.
- Devolve financial authority and accountability via cost centre accounting (referred to as functional business units).

3.5. **HUMAN RESOURCES**

3.5.1. **Purpose**

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

3.5.2. **Overview**

The chief directorate consists of the following directorates/unit:

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

3.5.2.1. **Human Resource Management**

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

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

To ensure alignment to the Department's strategic objectives, the strategies and action plans identified through the human resource planning process will focus on employing the right number of people with the appropriate competencies and skills to be able to deliver maximum health outcomes to the people of the Western Cape.

3) **Challenges**

The following challenges and mitigating measures have been identified:

- The turnaround time taken to fill vacant posts is a significant challenge.
  - Monitored monthly with a multi-pronged strategy to address issues that delay the filling of posts has been implemented.
- Unsatisfactory application of the Staff Performance Management System.
  - Policy review, audit and training in performance management.
- Misalignment between the organisational structure and PERSAL.
  - Quarterly PERSAL data verification exercises and discrepancies addressed.
- Retention of human resource and other staff categories within the Department.
  - Develop and implement a retention policy and strategy.
- Management of employee absenteeism.
  - Training of line managers to effectively manage absenteeism.

4) **Priorities**

Key priorities include:

- Effective human resource planning:
  - Workforce analysis.
  - Develop multi-year human resource plans that are in line with national, provincial and departmental strategic objectives.
- Effective and efficient human resource practices:
  - Facilitate the recruitment and retention of competent and skilled employees (efficient recruitment and selection system, talent management).
  - Reduce the recruitment turnaround time.
  - Ensure compliance with human resource prescripts and procedures and an unqualified audit from a human resource perspective.
- Develop and implement a balanced scorecard for human resources:
  - Become the employer of choice.
  - Internal state of the people.
  - People growth and innovation.

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

Refer to Programme 6.

3.5.2.3. **Labour Relations**

1) **Purpose**

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

2) **Overview**

The directorate consists of the following components:

- Collective Bargaining
- Labour Relations Support Services
- Dispute Management

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

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

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

3) **Challenges**

The following challenges and mitigating measures have been identified:

- Maintaining constructive collective bargaining processes.
  - On-going participative consultation with all stakeholders and continuously improve all bargaining and consultation structures.
- Dispute prevention and prompt resolution of grievances.
  - Investigate and address issues promptly.
- Prompt finalisation of disciplinary cases.
  - Capacity building for all line managers and supervisors and strengthening the human resource capacity of the directorate to deal with identified serious cases of misconduct.

4) **Priorities**

- Ensure effective consultation with organised labour to ensure full implementation of the organisational structure and management of excess staff.
- Facilitate the optimal functioning of the provincial chamber and Institutional Management Labour Committees (IMLCs) to deal with matters of mutual interest and to prevent or minimise conflict.
- Manage disciplinary cases/grievances/disputes promptly and effectively.
- Continue to develop executive, line managers and employees in labour relations matters through capacity building.
- Manage strikes and ensure that contingency plans are in place at all institutions.
- Capture and maintain an internal labour relations information management system to provide accurate statistics and reports to all the relevant stakeholders.

3.5.2.4. **Nursing Services**

1) **Purpose**

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

2) **Overview**

The Directorate Nursing Services comprises of two sub-directorates:

- Clinical Nursing Practice
- Nursing Education and Training

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

Nurses play a central role in providing and maintaining the health care system through the provision of a comprehensive quality health care service from primary health care (PHC) to highly specialised services. The Nursing Strategy for South Africa (2008) indicates that "*the change in the mode of delivery of health services from a hospital centred approach to a PHC approach requires a modification in the practice of nursing and consequent change in emphasis in the education and training of health professionals*".

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

3) **Challenges**

- Insufficient funding for relief posts, community service posts and graduate bursar posts.
  - Steps are being taken to create relief training posts on PERSAL, through shifting of funds currently utilised for agency staff.
  - Ensure that funded posts are available for bursars after the satisfactory completion of qualifications.
- Shortage of nurses in specialty nursing.
  - Increase the number of nursing staff to be released for training in specialty nursing.
- Limited clinical placement for nursing students.
  - Ensure cluster accreditation of clinical placement facilities, public and private, per district, in consultation with the South African Nursing Council.
- Poor public image of nursing impacts on the perception of the public of the nursing profession.
  - Improved marketing drives.

4) **Priorities**

- Manage and implement nursing practice, education and training in line with departmental human resource and financial plans.
- 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.
- Finalise nursing norms and standards to improve the organisational design system.

3.5.2.5. **Transformation Unit**

1) **Purpose**

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

2) **Overview**

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

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

Specialised interventions are implemented to address organisational conflict and the management of cultural diversity in the workplace.

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

The Department of Health is the primary driver of the Workplace HIV and AIDS Programmes for all provincial government departments in the Western Cape.

Health and wellness risks are effectively being managed through the incorporation of data on policy on incapacity leave and ill-health retirements (PILIR), health screenings and HIV counselling and testing.

3) **Challenges**

The following challenges and mitigating measures have been identified:

- Lack of uniformity across districts and institutions regarding the human resource structure for transformation programmes.
  - District and institutional structures to be aligned with the head office model.
- Poor understanding of the concept of gender mainstreaming resulting in a lack of support for the implementation of strategies.
  - Capacity building for senior and middle managers.
  - Promote awareness of, educate and popularise gender concepts.
  - Strengthen and capacitate the Departmental Gender Forum.

  - Develop simultaneous mainstreaming strategies for human rights programmes (HIV, gender, youth and disability).

- Lack of co-ordination regarding Safety, Health, Environment Risk and Quality (SHERQ).
  - Identification of all role-players and stakeholders.
  - Roles, responsibilities and functions of role-players to be identified.
  - Establish SHERQ co-ordinating body within the Department.
- Deviations from employment equity targets; historically gender-dominated professions, e.g. nursing (female-dominated), engineering (male-dominated) resulted in skewed statistics.
  - Strengthen employment equity targets.

4) **Priorities**

- Implement a programme(s) to communicate the outcomes of the Barrett Values Survey to relevant employees and to address the outcomes of the survey.
- Strengthen the diversity management programme and mainstream human rights programmes (HIV, gender, youth and disability).
- Intensify information and education regarding the Employee Health and Wellness programme to ensure proactive use of the service to enhance quality of work life management and occupational health and safety.
- Strengthen HIV counselling and testing (HCT) in the workplace to contribute towards meeting provincial HCT targets.
- Establish a Safety, Health, Environment Risk and Quality forum/committee and implement policy as prescribed by the Department of Public Service and Administration (DPSA).
- Strengthen employment equity measures.

3.6. STRATEGY AND HEALTH SUPPORT

3.6.1. Purpose

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

3.6.2. Overview

The chief directorate consists of the following directorates:

1) Information Management
2) Professional Support Services
3) Strategic Planning and Co-ordination
4) Health Impact Assessment

3.6.2.1. **Information Management**

1) **Purpose**

To co-ordinate, integrate and provide information in a format, which will enhance management decision-making.

2) **Overview**

The directorate serves as the central repository for performance information and manages and co-ordinates the collection and dissemination of this information for planning, budgeting, monitoring and evaluation purposes.

Although the Auditor-General of South Africa (AGSA) has not formally expressed an audit opinion on predetermined objectives in the Audit Report to date, the Department aims to achieve an unqualified "clean" audit opinion on predetermined objectives when this is implemented. A Compliance Monitoring Instrument (CMI) has been developed for predetermined objectives (similar to the instrument developed for finance and supply chain prescripts) to improve adherence to information management policies and standard operating procedures.

In addition Information Management training is provided on a continuous basis and the directorate has appointed a full-time trainer to further develop and refine the training strategy and training material in the Province.

The directorate facilitates the implementation of the information and communications technology (ICT) infrastructure required to implement information systems throughout the Department.

A further function is records management, which encompasses identifying, classifying, archiving, and the controlled destruction of records. The Promotion of Access to Information Act (PAIA) is administratively managed within this section.

3) **Priorities**

- Build the skills capacity to undertake high quality technical work and manage projects.
- Establish adequate tools, processes and systems to manage performance information.
- Secure adequate resources to strengthen information management capacity at all levels of the health service.
- Ensure the Department achieves an unqualified "clean" audit for predetermined objectives.

4) **Challenges**

- Ensuring performance information is used for management decision-making, is audit compliant and reported timeously by creating a culture of accountability for performance information.
  - Implement control measures for performance data reporting at various levels within the programmes.
  - Monitor reporting on a monthly basis by the use of standardised reports available in the SINJANI system.

- Annual pre-audit assessments on compliance.

- Inadequate information management capacity at all levels of service.
  - Filling of critical vacant Information Management posts throughout the Department.
  - Training of the Information Management staff in all aspects of performance data capturing, monitoring and evaluation.

3.6.2.2. **Professional Support Services**

1) **Purpose**

To provide professional support services.

2) **Overview**

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

The directorate's functions include:

- Pharmaceutical related services including the management of the Chronic Dispensing Unit services to the Department.
- The management of the Cape Medical Depot and Pharmacy Services, relating to policy development for all pharmacy related service delivery.
- The co-ordination of blood transfusion and pathology services.
- The provision of medico-legal advisory services.
- The regulatory function of private health establishment licensing.

3) **Challenges**

The following challenges and mitigating measures have been identified:

- Lack of an integrated information technology (IT) system for the management of medicine and patient medicine records across all levels of care.
- Retention of competent and skilled pharmacy staff, with particular emphasis on post basic pharmacist assistants.
- The ICT system for pathology results is not integrated with other information systems which impacts negatively on the ability to make use of technological advancements.
- Ensuring adherence to medical imaging related legislation, which includes compliance with the quality assurance (QA) of the related equipment.
- Ensure compliance to provincial legislation relating to ambulance services in both the public and private health sectors.
- Improve the quality of service by ensuring the rational and safe use of medicines.

4) **Priorities**

- Support the implementation of medicine management systems across all levels of care.

- Facilitate the training of pharmacy staff in medicines supply management and the completion of Expanded Public Works Programme (EPWP) pharmacist assistant learner project.
- Continued and continuous developments of IT monitoring and evaluation (M and E) of service provision using standard reporting mechanisms at all levels of care.
- Establish an accredited training programme to meet the quality assurance prescripts of the medical imaging legislation. As of 2012/13 this is a function of the Department of Health as the higher education institutions no longer provide this training.
- Recruit appropriately skilled staff to meet legislative requirements and implement policy and technology developments.
- Expand the scope of the Chronic Dispensing Unit services to all patients across different levels of care.

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

1) **Purpose**

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

2) **Overview**

The directorate's functions include:

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

3) **Challenges**

- The recruitment and retention of appropriately skilled staff within the Directorate.

4) **Priorities**

- Recruit and develop appropriately skilled personnel in order to sustainably provide the required strategic planning support to the Department.
- Facilitate the development of the 2020 Strategic Planning Framework for the Department including the development of planning tools to address specific needs.
- Facilitate the development of the budget cycle plans and documentation (Annual Performance Plan, Strategic Plan, Annual Report, the Estimates of Provincial

Revenue and Expenditure and the documentation required for engagement with Provincial Treasury).

- Support the process of developing district health plans.
- Facilitate and provide support to ensure an unqualified audit report will be obtained by the Department on predetermined objectives.

3.6.2.4. **Health Impact Assessment**

1) **Purpose**

To determine the impact of the health programmes and services on the population of the Western Cape as well as its effect on the burden of disease of its population.

2) **Overview**

The Directorate's objective is to improve the quality of public policy decision-making through recommendations to enhance health outcomes. The development and implementation of disease surveillance programmes assists in overcoming challenges brought about by the burden of disease and resource constraints.

Quality of care is a high priority of the Department and a centralised unit supports and co-ordinates the activities of the quality assurance managers at sub-provincial level. Complaints and compliments, morbidity and mortality, client satisfaction surveys and evaluation of safety and security risks to patients and staff are regularly monitored. The Department is currently undertaking baseline self-assessments using the national core standards in preparation for the establishment of the National Office of Health Standards that will certify all public and private facilities according to these standards.

The Directorate's functions include:

- Ensure adequate surveillance of the burden of disease affecting the population.
- Co-ordinate all aspects of research taking place within the public health service.
- Monitor the impact of health services and programmes on the health status of the population.
- Develop interventions to improve the patient experience and overall quality of care.

3) **Challenges**

- Ensure that quality is "everyone's business".
- Institutionalise a culture of effective data management, information evaluation and use.
- Ensure relevant research is performed and feedback on the findings is translated into policy, practice and advocacy.

4) **Priorities**

- Develop and implement a comprehensive strategy to ensure renewed focus on improving the patient experience and quality of care.
  - o Baseline audits for national core standards included training for all managers and direct feedback with regard to the facility or district performance.

  - Train quality assurance managers on the development of quality improvement plans to be conducted, who in turn will train other managers and staff to oversee and monitor implementation.
  - The Provincial Quality Assurance Committee will identify transversal areas of weakness and develop appropriate policies and interventions, support implementation and interventions with evaluation of the impact.

- Develop a provincial surveillance system for the measurement of health outcomes utilising both mortality and morbidity indicators.
  - Develop a programme evaluation strategy.
  - Provide feedback on the evaluation results with recommended actions to health facilities, managers and communities.
  - Monitor and report on the implementation of actions and the impact thereof.
  - Showcase good practices at internal and external workshops and conferences.
- Strengthen the use of research in Policy and Practice
  - Disseminate the provincial research agenda and advocacy through a variety of mechanisms engaging with the key research institutions and stakeholders to buy into the agenda.
- Strengthen the advocacy role of the Department in addressing the upstream factors impacting on the burden of disease.
  - Identify most affected communities and their associated risk factors.
  - Provide early warning systems for important risk factors.
  - Evidence of effectiveness of interventions.
  - Work with other stakeholders to design interventions.

3.7. **Chief Directorate Infrastructure Management**

Refer to Programme 7 and 8.

Table 1.1: Data elements for situation analysis indicators in Tables 1.2

Source	Data element	Element ID	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Information Management	Total population	1	5 391 765	5 513 039	5 634 323	5 755 607	5 876 887	5 998 164	6 119 435
Information Management	Total population in rural districts	2	1 838 195	1 874 081	1 909 976	1 945 872	1 981 765	2 017 653	2 053 536
PERSAL	Medical officers	3	1 808	1 844	1 881	1 918	1 918	1 918	1 918
PERSAL	Medical officers in rural districts	4	286	305	327	352	352	352	352
PERSAL	Professional nurses	5	5 098	5 201	5 479	5 635	5 635	5 635	5 635
PERSAL	Professional nurses in rural districts	6	1 577	1 584	1 647	1 726	1 726	1 726	1 726
PERSAL	Pharmacists	7	343	334	362	368	368	368	368
PERSAL	Pharmacists in rural districts	8	110	109	113	115	115	115	115
PERSAL	Funded professional nurse posts	9	-	5 507	5 652	5 752	5 752	5 752	5 752
PERSAL	Vacant professional nurse posts	10	-	306	173	117	117	117	117
PERSAL	Funded doctors posts	11	-	1 956	1 967	1 979	1 979	1 979	1 979
PERSAL	Vacant doctors posts	12	-	112	86	61	61	61	61
PERSAL	Funded medical specialists posts	13	-	557	593	616	616	616	616
PERSAL	Vacant medical specialists posts	14	-	37	23	27	27	27	27
PERSAL	Funded pharmacists posts	15	-	381	391	406	406	406	406
PERSAL	Vacant pharmacists posts	16	-	47	29	38	38	38	38
BAS	Part of budget spent (Expenditure)	17	6 188 127 000	7 519 280 000	8 756 933 000	9 653 622 000	10 097 564 000	10 733 243 000	11 376 773 000
Budget Statement	Equitable share budget allocated	18	6 163 668 000	7 489 777 000	8 803 710 000	9 690 810 000	10 097 564 000	10 733 243 000	11 376 773 000
HR	HR plan timeously submitted to DPSA	19	New indicator	Yes	Yes	Yes	Yes	Yes	Yes

Notes:

The staff numbers per category are kept constant at the level of November/December 2011, over the MTEF period due to funding constraints.

It is not a mandatory requirement to include the above table. However, the purpose is to provide an easy reference to raw data from which values for indicators are determined and to facilitate the audit trail.

The purpose of the column ‘Element ID’ is purely to facilitate cross referencing between the tables.

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

Strategic goal:	Strategic objective: Title	Strategic objective: Statement	Performance Measure/Indicator	Type	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Ensure and maintain organisational strategic management capacity and synergy.	1.1. To have an effective and efficient and skilled workforce.	1.1.1. Provide sufficient staff with appropriate skills per occupational group by 2014/15.	1) Medical officers per 100 000 people	No	33.5	33.4	33.4	33.32	32.64	31.98	31.34
			Numerator ID3		1 808	1 844	1 881	1 918	1 918	1 918	1 918
			Denominator ID1 /100 000		53.92	55.13	56.34	57.56	58.77	59.98	61.19
			2) Medical officers per 100 000 people in rural districts	No	15.6	16.3	17.1	18.09	17.76	17.45	17.14
			Numerator ID4		286	305	327	352	352	352	352
			Denominator ID2 /100 000		18.38	18.74	19.10	19.46	19.82	20.18	20.54
			3) Professional nurses per 100 000 people	No	94.6	94.3	97.2	97.90	95.88	93.95	92.08
			Numerator ID5		5 098	5 201	5 479	5 635	5 635	5 635	5 635
			Denominator ID1 /100 000		53.92	55.13	56.34	57.56	58.77	59.98	61.19
			4) Professional nurses per 100 000 people in rural districts	No	85.8	84.5	86.2	88.70	87.09	85.54	84.05
			Numerator ID6		1 577	1 584	1 647	1 726	1 726	1 726	1 726
			Denominator ID2 /100 000		18.38	18.74	19.10	19.46	19.82	20.18	20.54
			5) Pharmacists per 100 000 people	No	6.4	6.1	6.4	6.39	6.26	6.14	6.01
			Numerator ID7		343	334	362	368	368	368	368
			Denominator ID1 /100 000		53.92	55.13	56.34	57.56	58.77	59.98	61.19
			6) Pharmacists per 100 000 people in rural districts	No	6.0	5.8	5.9	5.91	5.80	5.70	5.60
			Numerator ID8		110	109	113	115	115	115	115
			Denominator ID2 /100 000		18.38	18.74	19.10	19.46	19.82	20.18	20.54
			7) Vacancy rate for professional nurses	%	25%	5.6%	3.1%	2.03%	2.03%	2.03%	2.03%
			Numerator ID10		-	306	173	117	117	117	117
			Denominator ID9		-	5 507	5 652	5 752	5 752	5 752	5 752

Strategic goal:	Strategic objective: Title	Strategic objective: Statement	Performance Measure/Indicator	Type	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
			8) Vacancy rate for doctors	%	16%	5.7%	4.4%	3.08%	3.08%	3.08%	3.08%
			Numerator ID12		-	112	86	61	61	61	61
			Denominator ID11		-	1,956	1,967	1 979	1 979	1 979	1 979
			9) Vacancy rate for medical specialists	%	22%	6.6%	3.9%	4.38%	4.38%	4.38%	4.38%
			Numerator ID14		-	37	23	27	27	27	27
			Denominator ID13		-	557	593	616	616	616	616
			10) Vacancy rate for pharmacists	%	28%	12.3%	7.4%	9.36%	9.36%	9.36%	9.36%
			Numerator ID16		-	47	29	38	38	38	38
			Denominator ID15		-	381	391	406	406	406	406

Note:

1. The number of employees per category of staff for 2010/11 is shown in Table 1.1
2. Vacancy rates indicated for the period:
   - 2008/09 is based on vacant funded and unfunded posts.
   - 2009/10 until 2014/15 is based on vacant funded posts only.
3. Strategic objective performance indicators are highlighted in yellow.

Table 1.3: Performance indicators for Administration [ADMIN 2]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets		
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Optimal financial management to maximise health outcomes	1.1. Promote efficient financial resource use.	1.1.1. Promote sound financial governance and management to ensure the under/over spending of the annual equitable share is within 1% of the budget allocation.	1) Percentage expenditure of the annual equitable share budget allocation	No	100.0%	100.4%	100.4%	99.5%	99.6%	100.0%	100.0%	100.0%
			Numerator ID17		11 376 773 000	6 188 127 000	7 519 280 000	8 756 933 000	9 653 622 000	10 097 564 000	10 733 243 000	11 376 773 000
			Denominator ID18		11 376 773 000	6 163 668 000	7 489 777 000	8 803 710 000	9 690 810 000	10 097 564 000	10 733 243 000	11 376 773 000
2. Develop and maintain a capacitated workforce to deliver the required health services..	2.1. Develop and maintain a comprehensive Human Resource Plan for the Department.	2.1.1. Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.	2) Amended Human Resource Plan submitted timeously to DPSA	Yes / No	Yes	New indicator	Yes	Yes	Yes	Yes	Yes	Yes
			Element ID19									

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

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
1. Optimal financial management to maximise health outcomes.	1.1. Promote efficient financial resource use.	1.1.1. Promote sound financial governance and management to ensure the under/over spending of the annual equitable share is within 1% of the budget allocation.	1) Percentage expenditure of the annual equitable share budget allocation	Annually	100.0%	-	-	-	100.0%
			Numerator ID17		10 097 564 000	-	-	-	10 097 564 000
			Denominator ID18		10 097 564 000	-	-	-	10 097 564 000
2. Develop and maintain a capacitated workforce to deliver the required health services.	2.1. Develop and maintain a comprehensive Human Resource Plan for the Department.	2.1.1. Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.	2) Amended Human Resource Plan submitted timeously to DPSA	Annually	Yes	No	Yes	No	No
			Element ID19						

3 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND THE MTEF

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

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
1. Office of the Provincial Minister [a]	5 855	5 844	6 918	8 171	8 871	8 309	8 298	(0.13)	8 863	9 359
2. Management	243 249	260 866	314 563	437 051	404 834	398 466	480 250	20.52	499 668	526 526
Central Management [b]	233 528	250 010	314 563	437 051	404 834	398 466	480 250	20.52	499 668	526 526
Decentralised Management	9 721	10 856								
Total payments and estimates	249 104	266 710	321 481	445 222	413 705	406 775	488 548	20.10	508 531	535 885

[a] MEC total remuneration package: R1 566 089 with effect from 1 April 2011.

[b] 2012/13: Conditional grant: Health Professions Training and Development: R3 490 000 (Compensation of employees R2 585 000; Goods and services R905 000).

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

Economic classification R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
Current payments	228 741	247 171	298 717	412 517	381 000	370 975	438 608	18.23	465 809	490 819
Compensation of employees	96 213	110 116	123 843	175 032	165 615	158 156	191 973	21.38	204 567	220 329
Salaries and wages	84 683	96 644	109 823	155 840	146 245	140 266	170 731	21.72	181 949	196 038
Social contributions	11 530	13 472	14 020	19 192	19 370	17 890	21 242	18.74	22 618	24 291
Goods and services	132 528	137 055	174 874	237 485	215 385	212 819	246 635	15.89	261 242	270 490
of which										
Administrative fees	639	817	908	965	965	978	1 047	7.06	1 109	1 148
Advertising	20 747	10 366	15 504	15 815	15 649	15 103	13 863	(8.21)	14 684	15 204
Assets <R5 000	1 128	1 066	2 581	1 994	1 994	1 269	3 018	137.83	3 197	3 308
Audit cost: External	11 344	16 342	14 063	20 435	18 435	18 000	18 948	5.27	20 071	20 783
Catering: Departmental activities	384	383	506	508	544	648	941	45.22	996	1 030
Communication	4 803	5 490	6 055	6 348	5 748	5 645	7 778	37.79	8 237	8 530
Computer services	35 637	34 405	52 752	73 925	68 877	68 854	77 304	12.27	81 886	84 790
Cons/prof: Business and advisory services	34 765	46 798	42 608	64 666	9 842	10 632	10 757	1.18	11 396	11 799
Cons/prof: Laboratory services	6									
Cons/prof: Legal costs	3 982	3 588	4 828	5 937	5 937	6 228	7 353	18.06	7 789	8 065
Contractors	5 150	2 918	20 388	29 213	70 213	70 221	87 105	24.04	92 266	95 536
Agency and support/ outsourced services	739	1 235	813	478	3		104		110	114
Entertainment	76	57	118	93	93	130	163	25.38	169	171
Inventory: Food and food supplies	2	2	3	5	5					
Inventory: Fuel, oil and gas	3									
Inventory: Materials and supplies	10	27	22	14	14	25	23	(8.00)	24	25
Inventory: Medical supplies	3	1	7	3	3					
Inventory: Other consumables	22	69	32	63	63	49	121	146.94	127	131
Inventory: Stationery and printing	2 822	2 762	2 485	3 000	3 000	2 658	2 310	(13.09)	2 446	2 532
Lease payments	757	742	715	1 002	2 802	1 953	3 199	63.80	3 389	3 509
Rental and hiring						1	2	100.00	2	2
Property payments	411	317	114	175	175	267	298	11.61	316	327
Transport provided: Departmental activity	1									
Travel and subsistence	6 546	8 135	8 546	9 372	7 899	7 140	8 541	19.62	9 047	9 366
Training and development	1 088	779	683	1 714	1 714	1 582	2 126	34.39	2 252	2 332
Operating expenditure	277	93	537	153	153	543	557	2.58	588	607
Venues and facilities	1 186	663	606	1 607	1 257	893	1 077	20.60	1 141	1 181
Transfers and subsidies to	9 028	10 561	10 929	21 948	21 948	25 263	35 616	40.98	32 397	34 016
Households	9 028	10 561	10 929	21 948	21 948	25 263	35 616	40.98	32 397	34 016
Social benefits	4 966	3 805	6 947	5 044	5 044	5 260	6 036	14.75	6 338	6 654
Other transfers to households	4 062	6 756	3 982	16 904	16 904	20 003	29 580	47.88	26 059	27 362
Payments for capital assets	11 192	8 960	6 102	10 757	10 757	10 529	14 324	36.04	10 325	11 050
Machinery and equipment	11 138	8 960	6 084	9 702	9 702	9 490	13 515	42.41	9 459	10 123
Transport equipment		386	360	720	720	707	1 360	92.36	1 454	1 556
Other machinery and equipment	11 138	8 574	5 724	8 982	8 982	8 783	12 155	38.39	8 005	8 567
Software and other intangible assets	54		18	1 055	1 055	1 039	809	(22.14)	866	927
Payments for financial assets	143	18	5 733			8		(100.00)		
Total economic classification	249 104	266 710	321 481	445 222	413 705	406 775	488 548	20.10	508 531	535 885

4 PERFORMANCE AND EXPENDITURE TRENDS

4.1. Resource considerations

Programme 1 is allocated 3.34 per cent of the vote in 2012/13 in comparison to the 3.03 per cent allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R81.773 million or 20.10 per cent.

R19 million provincial equitable share (PES) is allocated to the Chronic Dispensing Unit for the cost of the new agreement with the service provider and for the processing of an increased number of prescriptions and service delivery points.

R3 million (PES) is allocated for the Pharmacy Inventory Management System:
From 2012/13 National Treasury requires the Department to report on the number and value of the pharmaceutical inventories as a Disclosure in the Financial Statements, but does not currently have the system to do so. The tenders are in the process of being adjudicated.

R12 million (PES): is allocated for the increased number of medico-legal claims being received by the Department.

R11 million (PES) is allocated for posts that are required to facilitate the reporting on financial, human resources and performance management regularity.

4.2. Risk management

Risks	Measures to mitigate impact
1. Lack of compliance to regulatory framework in respect of HR, finance and information management.	1.1. **Finance** 1.1.1. Devolve internal control units at district level. 1.1.2. Implement the compliance monitoring instrument. 1.1.3. Implement standardised procurement templates. 1.2. **Human Resources** 1.2.1. Implement the HR Audit Action Plan. 1.2.2. Implement the HR compliance monitoring instrument. 1.2.3. On-going formal and informal training. 1.2.4. Regular forum meetings on various HR fields. 1.2.5. On-going HR compliance audits. 1.2.6. On-going reporting and engagements on HR compliance with chief executive officers (CEOs) and top management. 1.3. **Information Management** 1.3.1. Develop standard operating procedures for filing, movement and tracking of patient folders. 1.3.2. Central storing and reporting of performance information. 1.3.3. Joint Information Management Initiative (JIMI) with all programmes to develop and implement standard operating procedures and data collection tools. 1.3.4. Implement a supervisory visit tool to monitor compliance with information management policies and procedures. 1.3.5. Implement a compliance monitoring instrument for predetermined objectives.

Risks	Measures to mitigate impact
	1.3.6. Stringently monitor data quality through data status reports that have been developed on SINJANI (software application). 1.3.7. On-going training on data collection, collation, validation and processing.
2. Lack of human resource capacity and skilled workforce.	2.1. Develop and implement the Comprehensive Human Resource Plan. 2.1.1 Recruit and retain staff with scarce skills. 2.1.2 Education, training and development of current workforce.
3 Slow procurement process of IT infrastructure and end-user hardware.	3.1. Standardise specifications and streamline procurement processes to reduce the turnaround times for procurement of computers and other IT hardware.
4 Poor quality of data and information.	4.1 Facilitate implementation of revised policies, standard operating procedures and instruments to improve data quality. 4.2 Roll-out of patient administration systems in hospitals and primary health care facilities. 4.3 Standardisation of IT systems. 4.4 Strengthen end-user ownership and responsibility for improving quality of data. 4.5 Reduce the number of indicators and data elements being collected.

PROGRAMME 2: DISTRICT HEALTH SERVICES

1. PROGRAMME PURPOSE

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

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 2.1: DISTRICT MANAGEMENT

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

2.2 SUB-PROGRAMME 2.2: COMMUNITY HEALTH CLINICS

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

2.3 SUB-PROGRAMME 2.3: COMMUNITY HEALTH CENTRES

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

2.4 SUB-PROGRAMME 2.4: COMMUNITY BASED SERVICES

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

2.5 SUB-PROGRAMME 2.5: OTHER COMMUNITY SERVICES

Rendering environmental and port health services.

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

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

2.7 SUB-PROGRAMME 2.7: NUTRITION

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

2.8 SUB-PROGRAMME 2.8: CORONER SERVICES

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

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

2.9 SUB-PROGRAMME 2.9: DISTRICT HOSPITALS

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

2.10 SUB-PROGRAMME 2.10: GLOBAL FUND

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

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

3. DISTRICT HEALTH SERVICES

3.1 SITUATION ANALYSIS

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

3.1.1 Structure of the District Health System

In line with the National Health Act (No. 61 of 2003), six health districts (Cape Town Metropolitan District, West Coast, Cape Winelands, Overberg, Eden and Central Karoo) were formally established during the 2008/09 financial year. The Cape Town Metro District has been further sub-divided into four management sub-structures, each consisting of two adjoining sub-districts. Each of the five rural districts and the four sub-structures in the Metro are managed by a director, who is responsible for ensuring that district health services are effectively and efficiently delivered.

The Provincial Government of the Western Cape has assumed responsibility for personal primary health care services (PPHC) in the five rural districts. In the Cape Town Metropolitan District, personal primary health care services are provided jointly by the Provincial Department of Health and the City of Cape Town Municipality and are regulated via a service level agreement. Environmental health care services are provided by the local government authorities across all six health districts.

The Western Cape District Health Councils Act that came into effect on 24 August 2011, and gives effect to the requirements of the National Health Act, formalises community participation and governance oversight within the districts through the establishment of district health councils. The inaugural meetings of the district health councils were convened in all the districts of the Province and district health plans will be tabled to the councils before the start of the 2012/13 financial year.

3.1.2 Primary Health Care (PHC) facility-based services

Community health clinics include fixed and non-fixed clinics (satellite clinics and mobiles). Clinical nurse practitioners (CNPs) provide services in accordance with the national PHC

package of care, which includes child and adult curative care, preventive and promotive services; antenatal care, postnatal care, family planning and other specialised services; mental health; TB, HIV and AIDS; and chronic disease management. There are 460 clinics (including local government clinics) in the Province, of which 285 (62%) are fixed clinics and 175 are non-fixed clinics. The distribution of PHC facilities across the Province is reflected in Table 2.1.

At community day centres (CDCs) and community health centres (CHCs) services are provided by clinical nurse practitioners (CNPs), with support from full-time medical officers and pharmacists, and patients have access to X-ray services. A CDC normally provides a service between 08:00 and 16:00 during weekdays only, while a CHC provides a 24-hour emergency service. CDCs and CHCs provide a comprehensive package of services that includes: antenatal care; termination of pregnancy; reproductive health; chronic disease management; TB, HIV and AIDS; other curative care; mental health; oral health, rehabilitation and disability services; occupational health; casualty and maternity services. Ten CDCs in the Cape Town Metro District provide a nurse-based package of services between the hours of 16:00 and 21:00 on weekdays, and between 08:00 and 13:00 over weekends and eleven CHCs also provide 24-hour midwife obstetric services.

3.1.3 **Community-based Services**

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

The Western Cape Government: Health is committed to progressively realising the vision of community based services and school health services functioning as two central pillars of primary health care within the district health system. The Department will work actively with the National Department of Health and interested partners to achieve this.

Non-profit organisations (NPOs) are formally contracted to render services on behalf of the Department of Health primarily via community care workers (CCWs).

The University of the Western Cape, in conjunction with the University of Cape Town, has been contracted to review the current departmental CBS policy framework. In the current draft policy, community-based services will be re-organised into four main components:

1) Home-based care - with three service delivery streams:
    - Home-based care;
    - Community adherence support; and
    - Prevention/health promotion.
2) Intermediate care:
    - Post-acute care for users convalescing after a hospital stay, with mild, moderate and severe impairment in body structure and function.
    - Restorative or rehabilitative care for users with significant activity limitations and participation restrictions.

- End of life or palliative care for users with a terminal illness requiring pain and other symptom relief and with progressive to complete impairment in body structure and function.
- Psycho-social services which is a cross-cutting component of all of the above and includes family involvement, counselling, grants, placements, and ensuring a fit between the patient and their home or long term care environment.

3) Lifelong care:

For lifelong/long-term clients i.e. greater than six months, offered in one consolidated facility.

4) Mental health services:

To assist mental health clients to live more independently in the community and to provide services to de-hospitalised mental health clients in order to prevent hospitalisation.

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

Health district	Facility type	No.	2010/11 Uninsured Population	Uninsured Population per fixed PHC facility	PHC facilities headcounts	District hospital separations	Per capita (uninsured) utilisation
City of Cape Town Metro District	Non fixed clinics	27	2 845 400	21 077	10 415 052	115 443	3.66
	Fixed clinics	88					
	CHCs	9					
	CDCs	38					
	Sub-total clinics + CHCs + CDCs	135					
	District hospitals	9					
CAPE WINELANDS	Non fixed clinics	34	578 645	11 809	1 978 282	24 027	3.42
	Fixed clinics	44					
	CHCs	0					
	CDCs	5					
	Sub-total clinics + CHCs + CDCs	49					
	District hospitals	4					
CENTRAL KAROO (Rural development node)	Non fixed clinics	11	51 769	5 752	235 003	10 501	4.54
	Fixed clinics	8					
	CHCs	0					
	CDCs	1					
	Sub-total clinics + CHCs + CDCs	9					
	District hospitals	4					
EDEN	Non fixed clinics	35	469 699	11 742	1 803 475	36 366	3.84
	Fixed clinics	35					
	CHCs	0					
	CDCs	5					
	Sub-total clinics + CHCs + CDCs	40					
	District hospitals	6					
OVERBERG	Non fixed clinics	21	192 933	8 039	826 899	16 645	4.29
	Fixed clinics	23					
	CHCs	0					
	CDCs	1					
	Sub-total clinics + CHCs + CDCs	24					
	District hospitals	4					
WEST COAST	Non fixed clinics	41	257 848	9 550	947 841	34 310	3.68
	Fixed clinics	27					
	CHCs	0					
	CDCs	0					
	Sub-total clinics + CHCs + CDCs	27					
	District hospitals	7					
PROVINCE	Non fixed clinics	169	4 396 294	15 480	16 206 552	237 292	3.69
	Fixed clinics	225					
	CHCs	9					
	CDCs	50					
	Sub-total clinics + CHCs + CDCs	284					
	District hospitals	34					

Notes:

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

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

Source	Data element	Element ID	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11
SINJANI	PHC total headcount	1	16 206 552	10 415 052	1 978 282	235 003	1 803 475	826 899	947 841
Information Management	Total population	2	5 634 323	3 724 347	754 426	60 407	551 937	233 292	309 914
SINJANI	PHC total headcount - under 5 years	3	2 453 946	1 451 568	351 140	41 534	302 274	145 525	161 906
Information Management	Population under 5 years old	4	527 215	352 536	68 321	6 385	49 568	22 296	28 108
SINJANI	Supervisor visit this month (fixed facilities only)	5	207	76	43	7	37	22	22
SINJANI	Fixed PHC facilities ÷ number of months in the reporting period	6	296	148	49	9	40	24	26
SINJANI	CHCs and CDCs with a resident doctor	7	50	40	5	1	4	-	-
SINJANI	CDC's/CHC's	8	53	42	5	1	4	1	-
NPO home carer database	NPO appointed home carers	9	2 584	1 494	247	77	311	193	262
BAS- CFO	Expenditure on PHC by provincial DoH at PHC facilities (in 2010/11 rands for sub-programmes 2.1 to 2.5)	10	2 193 568 000	1 362 063 000	289 617 000	51 817 000	243 909 000	114 474 000	131 689 000
Information Management	Uninsured population	11	4 396 294	2 845 400	578 645	51 769	469 699	192 933	257 848
SINJANI	Complaints resolved in a 25 day cycle	12	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report
SINJANI	Complaints received/lodged in a 25 day cycle	13	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report
NDoH assessment tool	PHC facilities assessed for compliance against the 6 priorities of the core standards	14	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report

Notes:

Element ID10: Financial figurers updated to reflect 2010/11 rands for sub-programmes 2.1 to 2.5.

It is not a mandatory requirement to include the above table. However, the purpose is to provide an easy reference to raw data from which values for indicators are determined and to facilitate the audit trail. The purpose of the column 'Element ID' is purely to facilitate cross referencing between the tables.

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

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11	National Average 2010/11
1. Address the burden of disease.	1.1. Increase access to PHC services in the DHS in the Western Cape.	1.1.1. Achieve a PHC utilisation rate of 2.9 visits per person per annum by 2014/15.	1) Utilisation rate – PHC (total population)	No	2.9	2.8	2.6	3.9	3.3	3.5	3.1	2.5
			Numerator ID 1		16 206 552	10 415 052	1 978 282	235 003	1 803 475	826 899	947 841	
			Denominator ID 2		5 634 323	3 724 347	754 426	60 407	551 937	233 292	309 914	
			2) PHC total headcount Element ID 1	No	16 206 552	10 415 052	1 978 282	235 003	1 803 475	826 899	947 841	
			3) Utilisation rate – PHC under 5 years	No	4.7	4.1	5.1	6.5	6.1	6.5	5.8	4.7
			Numerator ID 3		2 453 946	1 451 568	351 140	41 534	302 274	145 525	161 905	
			Denominator ID 4		527 215	352 536	68 321	6 385	49 568	22 296	28 109	
			4) PHC total headcount - under 5 years Element ID 3	No	2 453 946	1 451 568	351 140	41 534	302 274	145 525	161 905	
			5) Fixed PHC facilities with a monthly supervisory visit rate	%	70%	51%	88%	78%	93%	92%	85%	
			Numerator ID 5		207	76	43	7	37	22	22	
			Denominator ID 6		296	148	49	9	40	24	26	
			6) Percentage of CHCs and CDCs with a resident doctor	%	94%	95%	100%	100%	100%	0%	0%	70.6%
			Numerator ID 7		50	40	5	1	4	-	-	
			Denominator ID 8		53	42	5	1	4	1	-	
			7) Number of NPO appointed home carers Element ID 9	%	2 584	1494	247	77	311	193	262	
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 R472 per uninsured person by 2014/15 (2010/11 rands).	8) Provincial expenditure per PHC headcount	R	135	131	146	220	135	138	139	
			Numerator ID 10		2 193 568 000	1 362 062 000	289 617 000	51 817 000	243 909 000	114 474 000	131 689 000	
			Denominator ID 1		16 206 552	10 415 052	1 978 282	235 003	1 803 475	826 899	947 841	
			9) Provincial PHC expenditure per uninsured person	R	499	479	501	1 001	519	593	511	
			Numerator ID 10		2 193 568 000	1 362 062 000	289 617 000	51 817 000	243 909 000	114 474 000	131 689 000	
			Denominator ID 11		4 396 294	2 845 400	578 645	51 769	469 699	192 933	257 848	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11	National Average 2010/11
3. Improve the quality of health services and the patient experience.	3.1. Improve the experience of clients utilising the PHC services.	3.1.1. Achieve a 70% client satisfaction rate by 2014/15.	10) Percentage of complaints of users of PHC services resolved within 25 days	%	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	
			Numerator ID 12		-	-	-	-	-	-	-	
			Denominator ID 13		-	-	-	-	-	-	-	
			11) Number of PHC facilities assessed for compliance against the core standards Element ID 14	%	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	

Notes:

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

Indicator 8 & 9: Financial figurers updated to reflect 2010/11 rands for sub-programmes 2.1 to 2.5.

Strategic objective performance indicators are highlighted in yellow.

Provincially determined performance indicators are highlighted.

3.1.4 DHS performance indicators

1) A total PHC headcount of 16 206 552 was recorded (against a target of 17 466 401) in 2010/11. This was an increase of 2.3 per cent from the 2009/10 financial year. The Cape Town Metro District accounted for 64 per cent of the headcount, while the five rural districts accounted for 36 per cent.

2) The PHC utilisation rate per capita (total population) of 2.88 in 2010/11 was lower than the target of 3.1. The PHC utilisation rate for the population under five decreased from 4.9 in 2009/10 to 4.7 in 2010/11. The lower utilisation rates have been ascribed to a higher rate of utilisation on the community-based services platform.

3.2 CHALLENGES

1) The continued provision of health care by two authorities in the Cape Town Metro District (i.e. the Western Cape Government and the City of Cape Town Municipality) fragments the delivery of personal primary health care (PPHC), is inefficient and ultimately compromises quality of care.

2) Less than satisfactory patient experiences in PHC facilities.

3) A need to revise the departmental policy framework for the community-based services (CBS) platform.

4) The need to manage health services in an integrated manner, across different levels of care, within specific geographic service areas (GSAs).

3.3 PRIORITIES

The overall DHS priorities for the 2012/13 year are:

1) Improve the patient's experience of the quality of care by responding to complaints timeously and implementing the national core standards wherever feasible.

2) Improve the efficiency of community-based services by implementing a re-designed CBS model and improving the monitoring of such services.

3) Co-ordinate services within and across the five geographic service areas (GSAs).

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

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

Source	Data element	Element ID	Audited / Actual performance			Estimated performance	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	PHC total headcount	1	15 051 210	15 848 973	16 206 552	15 764 882	16 348 182	16 953 065	17 580 328
Information Management	Total population	2	5 391 765	5 513 039	5 634 323	5 755 607	5 876 887	5 998 164	6 119 435
SINJANI	PHC total headcount - under 5 years	3	2 436 479	2 527 588	2 453 946	2 424 091	2 639 194	2 749 586	2 749 586
Information Management	Population under 5 years old	4	504 598	515 906	527 215	538 524	549 832	561 140	572 448
SINJANI	Supervisor visit this month (fixed facilities only)	5	162	198	207	239	257	260	263
SINJANI	Fixed PHC facilities ÷ number of months in the reporting period	6	290	299	296	292	284	284	284
SINJANI	CHCs and CDCs with a resident doctor	7	Not required to report	Not required to report	50	55	55	56	57
SINJANI	CDC's/CHC's	8	Not required to report	Not required to report	53	58	59	59	59
NPO home carer database	NPO appointed home carers	9	2 455	2 491	2 584	2 957	3 050	3 100	3 100
BAS- CFO	Expenditure on PHC by provincial DoH at PHC facilities (in 2010/11 rands for sub-programmes 2.1 to 2.5)	10	2 152 168 856	2 184 491 224	2 193 568 189	2 283 977 110	2 268 861 658	2 268 920 678	2 253 115 426
Information Management	Uninsured population	11	4 207 479	4 301 882	4 396 294	4 490 706	4 585 115	4 679 521	4 773 922
SINJANI	Complaints resolved in a 25 day cycle	12	Not required to report	Not required to report	Not required to report	136	151	171	194
SINJANI	Complaints received/lodged in a 25 day cycle	13	Not required to report	Not required to report	Not required to report	239	251	263	277
NDoH assessment tool	PHC facilities assessed for compliance against the 6 priorities of the core standards	14	Not required to report	Not required to report	Not required to report	359	0	359	0

Notes:

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

Element ID 6: The actual number of facilities in the Province has not decreased. An incorrect figure was reported in previous years.

Element ID10: Financial figurers updated to reflect 2010/11 rands.

Element ID14: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

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

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Address the burden of disease.	1.1. Increase access to PHC services in the DHS in the Western Cape.	1.1.1. Achieve a PHC utilisation rate of 2.9 visits per person per annum by 2014/15.	1) Utilisation rate – PHC (total population)	No	2.9	2.8	2.9	2.9	2.7	2.8	2.8	2.9	3.5
			Numerator ID 1		17 580 328	15 051 210	15 848 973	16 206 552	15 764 882	16 348 182	16 953 065	17 580 328	
			Denominator ID 2		6 119 435	5 391 765	5 513 039	5 634 323	5 755 607	5 876 887	5 998 164	6 119 435	
			2) PHC total headcount	No		15 051 210	15 848 973	16 206 552	15 764 882	16 348 182	16 953 065	17 580 328	
			Element ID 1										
			3) Utilisation rate – PHC under 5 years	No		4.8	4.9	4.7	4.5	4.8	4.9	4.8	5.5
			Numerator ID 3			2 436 479	2 527 588	2 453 946	2 424 091	2 639 194	2 749 586	2 749 586	
			Denominator ID 4			504 598	515 906	527 215	538 524	549 832	561 140	572 448	
			4) PHC total headcount - under 5 years	No		2 436 479	2 527 588	2 453 946	2 424 091	2 639 194	2 749 586	2 749 586	
			Element ID 3										
			5) Fixed PHC facilities with a monthly supervisory visit rate	%		56%	66%	70%	82%	91%	92%	93%	100%
			Numerator ID 5			162	198	207	239	257	260	263	
			Denominator ID 6			290	299	296	292	284	284	284	
			6) Percentage of CHCs and CDCs with a resident doctor	%		Not required to report	Not required to report	94%	95%	93%	95%	97%	100%
			Numerator ID 7			-	-	50	55	55	56	57	
			Denominator ID 8			-	-	53	58	59	59	59	
			7) Number of NPO appointed home carers	No	3 100	2 455	2 491	2 584	2 957	3 050	3 100	3 100	
			Element ID 9										

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 R472 per uninsured person by 2014/15 (2010/11 rands).	8) Provincial expenditure per PHC headcount	R		143	138	135	145	139	134	128	
			Numerator ID 10			2 152 168 856	2 184 491 224	2 193 568 189	2 283 977 110	2 268 861 658	2 268 920 678	2 253 115 426	
			Denominator ID 1			15 051 210	15 848 973	16 206 552	15 764 882	16 348 182	16 953 065	17 580 328	
			9) Provincial PHC expenditure per uninsured person	R	472	512	508	499	509	495	485	472	
			Numerator ID 10		2 253 115 426	2 152 168 856	2 184 491 224	2 193 568 189	2 283 977 110	2 268 861 658	2 268 920 678	2 253 115 426	
			Denominator ID 11		4 773 922	4 207 479	4 301 882	4 396 294	4 490 706	4 585 115	4 679 521	4 773 922	
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 70% client satisfaction rate by 2014/15.	10) Percentage of complaints of users of PHC services resolved within 25 days	%		Not required to report	Not required to report	Not required to report	57%	60%	65%	70%	
			Numerator ID 12			-	-	-	136	151	171	194	
			Denominator ID 13			-	-	-	239	251	263	277	
			11) Number of PHC facilities assessed for compliance against the core standards	No		Not required to report	Not required to report	Not required to report	359	0	359	0	
			Element ID 14										

Note:

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

Indicator 5: Based on a data verification process the historical data for this indicator was updated. The actual number of facilities in the Province has not decreased. An incorrect figure was reported in previous years.

Indicator 6: Vacant posts in smaller facilities in rural areas lead to a performance of less than 100%.

Indicator 8 & 9: Financial figurers updated to reflect 2010/11 rands.

Indicator 11: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

3.5 QUARTERLY TARGETS FOR DISTRICT HEALTH SERVICES

Table 2.6: Quarterly targets for District Health Services for 2012/13 [DHS6]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
1. Address the burden of disease.	1.1. Increase access to PHC services in the DHS in the Western Cape.	1.1.1. Achieve a PHC utilisation rate of 2.9 visits per person per annum by 2014/15.	1) Utilisation rate – PHC (total population)	Quarterly	2.78	2.78	2.78	2.78	2.78
			Numerator ID 1		16 348 182	4 087 046	4 087 046	4 087 046	4 087 044
			Denominator ID 2		5 876 887	1 469 222	1 469 222	1 469 222	1 469 221
			2) PHC total headcount ID 1	Quarterly	16 348 182	4 087 046	4 087 046	4 087 046	4 087 044
			3) Utilisation rate – PHC under 5 years	Quarterly	4.8	4.8	4.8	4.8	4.8
			Numerator ID 3		2 639 194	659 799	659 799	659 799	659 797
			Denominator ID 4		549 832	137 458	137 458	137 458	137 458
			4) PHC total headcount - under 5 years ID 3	Quarterly	2 639 194	659 799	659 799	659 799	659 797
			5) Fixed PHC facilities with a monthly supervisory visit rate	Quarterly	91%	91%	91%	91%	91%
			Numerator ID 5		257	257	257	257	257
			Denominator ID 6		284	284	284	284	284
			6) Percentage of CHCs and CDCs with a resident doctor	Quarterly	93%	93%	93%	93%	93%
			Numerator ID 7		55	55	55	55	55
			Denominator ID 8		59	59	59	59	59
			7) Number of NPO appointed home carers ID 9	Annually	3 050	-	-	-	3 050
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 R472 per uninsured person by 2014/15 (2010/11 rands).	8) Provincial expenditure per PHC headcount	Quarterly	139	139	139	139	139
			Numerator ID 10		2 268 861 658	567 215 414	567 215 414	567 215 414	567 215 414
			Denominator ID 1		16 348 182	4 087 046	4 087 046	4 087 046	4 087 044

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
			9) Provincial PHC expenditure per uninsured person	Quarterly	495	495	495	495	495
			Numerator ID 10		2 268 861 658	567 215 414	567 215 414	567 215 414	567 215 414
			Denominator ID 11		4 585 115	1 146 279	1 146 279	1 146 279	1 146 278
3. Improve the quality of health services and the patient experience.	2.1. Improve the experience of clients utilising the PHC services.	2.1.1. Achieve a 70% client satisfaction rate by 2014/15.	10) Percentage of complaints of users of PHC services resolved within 25 days	Quarterly	60%	60%	60%	60%	60%
			Numerator ID 12		151	37	38	38	38
			Denominator ID 11		251	62	63	63	63
			11) Number of PHC facilities assessed for compliance against the core standards	Annual	0	-	-	-	-

Note:

Indicator 5: In order to comply with the definition of this indicator, all the facilities have to have a supervisory visit each month. Therefore the quarterly targets reflect 257 out of 285 fixed facilities and not 64 (257 divided by 4) out of 71 (285 divided by 4).

Indicator 11: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

4. DISTRICT HOSPITAL SERVICES

4.1 SITUATION ANALYSIS FOR DISTRICT HOSPITALS

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

4.1.1 District hospital services

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

There are thirty-four district hospitals in the Province, nine of which are located within the Cape Town Metro Health District. The construction of the Khayelitsha Hospital has been completed and patients have been admitted from January 2012. The Mitchell's Plain Hospital is still under construction.

Three of the Cape Town Metro District hospitals (Karl Bremer, GF Jooste and Victoria Hospitals) offer a significant quantum of general specialist services reflecting their transition from regional to district hospitals. At the Helderberg Hospital a more limited general specialist service is provided.

Cape Winelands, Overberg and Central Karoo Districts have four district hospitals each, while Eden has six and West Coast seven. The population living in the George, Breede Valley (Worcester surrounds) and Drakenstein (Paarl surrounds) Sub-districts access the three rural regional hospitals, i.e. George, Worcester and Paarl Hospitals, for level 1 acute hospital services, as there are no district hospitals in these sub-districts.

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

Source	Data element	Element ID	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11
SINJANI	Usable beds in district hospitals	1	2 482	1 161	261	120	401	185	354
SINJANI	Caesarean sections in district hospitals	2	6 761	3 366	897	215	1 085	537	661
SINJANI	Deliveries in district hospitals	3	29 019	10 516	4 395	1 059	5 479	2 656	4 914
SINJANI	Separations	4	237 292	115 443	24 027	10 501	36 366	16 645	34 310
SINJANI	PDE- Sum of: inpatient days + 1/2 day patients + 1/3 OPD headcount + 1/3 emergency headcount	5	999 260	537 843	89 912	37 365	151 370	64 449	118 321
SINJANI	Total OPD and emergency headcount	6	901 798	561 800	50 565	25 693	127 739	57 725	78 276
SINJANI	OPD headcount	6.1	565 801	359 422	30 168	10 205	77 004	33 366	55 636
SINJANI	Emergency headcount	6.2	335 997	202 378	20 397	15 488	50 735	24 359	22 640
SINJANI	Patient days	7	698 661	350 577	73 056	28 801	108 790	45 207	92 230
SINJANI	Total usable beds days	8	905 930	423 765	95 265	43 800	146 365	67 525	129 210
BAS- CFO	Total expenditure in district hospitals (in 2010/11 rands)	9	1 506 969 000	853 520 000	128 901 000	55 628 000	206 032 000	89 501 000	173 387 000
SINJANI	Complaints resolved within 25 days	10	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report
SINJANI	Complaints lodged	11	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report
SINJANI	District hospitals with M & M meetings every month	12	20	9	4	-	2	2	3
Facility list	District hospitals	13	34	9	4	4	6	4	7
DHIS	Number of questionnaires with 1 or 2 recorded for pleased with treatment	14	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report
DHIS	Number of questionnaires for pleased with treatment	15	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report
NDoH assessment tool	District hospitals assessed against the core standards	16	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report

Notes:

Element ID 9: Financial figurers updated to reflect 2010/11 rands.

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

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11	National Average / Total 2009/10
1. Address the burden of disease.	1.1. Increase access to acute district hospital services in the Western Cape.	1.1.1. Establish 2 705 acute district hospital beds in the DHS by 2014/15.	1) Number of district hospital beds Element ID 1	No	2 482	1 161	261	120	401	185	354	
			2) Caesarean section rate in district hospitals	%	23%	32%	20%	20%	20%	20%	13%	18.8%
			Numerator ID 2		6 761	3 366	897	215	1 085	537	661	
			Denominator ID 3		29 019	10 516	4 395	1 059	5 479	2 656	4 914	
			3) Total separations in district hospitals Element ID 4	No	237 292	115 443	24 027	10 501	36 366	16 645	34 310	117 382
			4) Patient day equivalents [PDE] in district hospitals Element ID 5	No	999 260	537 843	89 912	37 365	151 370	64 449	118 321	364 854
			5) OPD total headcounts in district hospitals Element ID 6.1	No	565 801	359 422	30 168	10 205	77 004	33 366	55 636	367 173
			6) Average length of stay in district hospitals	Days	2.9	3.0	3.0	2.7	3.0	2.7	2.7	4.3
			Numerator ID 7		698 661	350 577	73 056	28 801	108 790	45 207	92 230	
			Denominator ID 4		237 292	115 443	24 027	10 501	36 366	16 645	34 310	
			7) Bed utilisation rate (based on usable beds) in district hospitals	%	77%	83%	77%	66%	74%	67%	71%	65.4%
			Numerator ID 7		698 661	350 577	73 056	28 801	108 790	45 207	92 230	
			Denominator ID 8		905 930	423 765	95 265	43 800	146 365	67 525	129 210	
2. Optimal financial management to maximise health outcomes.	2.1. Allocate sufficient funds to ensure access to the full package of quality district hospital services by 2014/15.	2.1.1. Achieve a district hospital expenditure of R1 405 per PDE by 2014/15 (in 2010/11 rands).	8) Expenditure per patient day equivalent [PDE] in district hospitals	R	1 508	1 587	1 434	1 489	1 361	1 389	1 465	
			Numerator ID 9		1 506 969 000	853 520 000	128 901 000	55 628 000	206 032 000	89 501 000	173 387 000	
			Denominator ID 5		999 260	537 843	89 912	37 365	151 370	64 449	118 321	
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 a 92% client satisfaction rate by 2014/15.	9) Percentage of complaints of users of district hospital services resolved within 25 days	%	68%	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	
			Numerator ID10		383	-	-	-	-	-	-	
			Denominator ID 11		562	-	-	-	-	-	-	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11	National Average / Total 2009/10
			10) Percentage of district hospitals with monthly mortality and morbidity meetings	%	58.8%	100.0%	100.0%	0.0%	33.3%	50.0%	42.9%	
			Numerator ID 12		20	9	4	-	2	2	3	
			Denominator ID 13		34	9	4	4	6	4	7	
			11) District hospital patient satisfaction rate	%	86%	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	
			Numerator ID14		7 267	-	-	-	-	-	-	
			Denominator ID 15		8 491	-	-	-	-	-	-	
			12) Number of district hospitals assessed for compliance against the 6 priorities of the core standards	No	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	

Notes:

Indicator 8: Financial figurers updated to reflect 2010/11 rands.

4.1.2 **District hospital performance indicators (refer Table 2.10)**

- The caesarean section rate was 23 per cent in 2010/11. The provincial performance was inflated by three large Cape Town Metro hospitals (Karl Bremer, Khayelitsha and Helderberg Hospitals) that have an average caesarean section rate of 37 per cent. The denominator used to calculate the caesarean section rate is the total number of deliveries that occur in district hospitals. As only patients with "complicated" deliveries are referred to the hospitals, it means that the denominator excludes all the normal deliveries that occur at midwife obstetric units (MOUs) in the catchment area of the district hospital. The caesarean section rate reflected by these hospitals is therefore skewed and erroneously high.
- The overall trend for these indicators over the course of some years shows an increase in the Cape Town Metro with a slight decrease in the rural districts. Note that, prior to 1 April 2011; patients seen at an outpatient department were classified as either an OPD headcount or a PHC headcount. Those classified as PHC headcounts were incorporated into the total PHC headcount for DHS. This resulted in an increased PHC headcount for DHS and a decreased OPD headcount (and resulting PDE) for district hospitals. From 1 April 2011 all patients seen at an outpatient department are classified as OPD headcounts and targets for both indicators have been adjusted accordingly.
- The average length of stay in district hospitals was 2.9 days in 2010/11, varying from 2.7 days in the West Coast District to 3.0 days in the Cape Town Metro and compared to a national average of 4.0 days. The bed utilisation rate in district hospitals was 77 per cent in 2010/11, varying from 66 per cent in the Central Karoo District to 83 per cent in the Cape Town Metro.

4.2 **CHALLENGES**

- Less than satisfactory patient experiences across the district hospitals.
- The limited range of services offered in many district hospitals leads to a sub-optimal response to the burden of disease in the respective catchment populations. The provision of maternal and neonatal care services is a specific challenge, in light of the provincial, national and Millennium Development Goal (MDG) priorities. This creates a burden for emergency medical services which is then required to transport patients to more distant referral sites which increases the clinical risk to seriously ill patients.
- There continues to be a relatively low bed utilisation rate, especially in the smaller rural hospitals.

4.3 **PRIORITIES**

The overall district hospital priorities for 2012/13 are:

1) Improve the patient's experience of quality of care by responding to complaints timeously and implementing the national core standards wherever feasible.
2) Increase the package of services offered across district hospitals in order to respond more effectively to the burden of disease in the populations served. Improved access to maternal and neonatal care services at district hospitals is a priority.
3) Increase the work outputs in district hospitals. Strategies to innovatively deploy resources across the entire service platform to maximise service outputs will be co-ordinated within the GSAs. The expansion of district hospital outputs will also be facilitated by setting realistic targets for specific surgical procedures, within the GSAs.

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

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

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	Usable beds in district hospitals	1	2 312	2 464	2 482	2 595	2 705	2 705	2 705
SINJANI	Caesarean sections in district hospitals	2	6 093	6 587	6 761	7 020	7 051	7 197	7 342
SINJANI	Deliveries in district hospitals	3	29 648	30 078	29 019	29 434	30 265	30 889	31 512
SINJANI	Separations	4	221 365	238 085	237 292	244 001	250 667	261 641	261 641
SINJANI	PDE- Sum of: inpatient days + 1/2 day patients + 1/3 OPD headcount + 1/3 emergency headcount	5	963 020	986 481	999 260	1 153 795	1 158 253	1 198 277	1 206 544
SINJANI	Total OPD and emergency headcount	6	840 810	844 149	901 798	1 191 908	1 215 746	1 240 061	1 264 862
SINJANI	OPD headcount	6.1	508 504	504 673	565 801	874 556	892 047	909 888	928 086
SINJANI	Emergency headcount	6.2	331 676	339 476	335 997	317 352	323 699	330 173	336 776
SINJANI	Patient days	7	682 960	705 098	698 661	756 492	753 004	784 923	784 923
SINJANI	Total usable beds days	8	843 880	899 360	905 930	905 261	947 175	987 325	987 325
BAS- CFO	Total expenditure in district hospitals (in 2010/11 rands)	9	1 391 455 000	1 537 197 000	1 506 969 000	1 585 275 000	1 665 485 000	1 693 312 000	1 695 498 000
SINJANI	Complaints resolved within 25 days	10	283	498	383	289	311	340	372
SINJANI	Complaints lodged	11	375	679	562	423	444	466	490
SINJANI	District hospitals with M & M meetings every month	12	20	25	20	23	28	31	34
Facility list	District hospitals	13	32	34	34	34	34	34	34
DHIS	Number of questionnaires with 1 or 2 recorded for pleased with treatment	14	Not required to report	Not required to report	7 267	3 776	3 879	4 001	4 126
DHIS	Number of questionnaires for pleased with treatment	15	Not required to report	Not required to report	8 491	4 226	4 311	4 397	4 485
NDoH assessment tool	District hospitals assessed against the core standards	16	Not required to report	Not required to report	Not required to report	34	0	34	0

Notes:

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

Element ID 9: Financial figurers updated to reflect 2010/11 rands.

Element ID 16: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

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

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Address the burden of disease.	1.1. Increase access to acute district hospital services in the Western Cape.	1.1.1. Establish 2 705 acute district hospital beds in the DHS by 2014/15.	1) Number of district hospital beds Element ID 1	No	2 705	2 312	2 464	2 482	2 595	2 705	2 705	2 705	
			2) Caesarean section rate in district hospitals	%		21%	22%	23%	24%	23%	23%	23%	15%
			Numerator ID 2			6 093	6 587	6 761	7 020	7 051	7 197	7 342	
			Denominator ID 3			29 648	30 078	29 019	29 434	30 265	30 889	31 512	
			3) Total separations in district hospitals Element ID 4	No		221 365	238 085	237 292	244 001	250 667	261 641	261 641	
			4) Patient day equivalents [PDE] in district hospitals Element ID 5	No		963 020	986 481	999 260	1 153 795	1 158 253	1 198 277	1 206 544	
			5) OPD total headcounts in district hospitals Element ID 6.1	No		508 504	504 673	565 801	874 556	892 047	909 888	928 086	
			6) Average length of stay in district hospitals	Days		3.1	3.0	2.9	3.1	3.0	3.0	3.0	3.5 days
			Numerator ID 7			682 960	705 098	698 661	756 492	753 004	784 923	784 923	
			Denominator ID 4			221 365	238 085	237 292	244 001	250 667	261 641	261 641	
			7) Bed utilisation rate (based on usable beds) in district hospitals	%		81%	78%	77%	84%	79%	79%	79%	75%
			Numerator ID 7			682 960	705 098	698 661	756 492	753 004	784 923	784 923	
			Denominator ID 8			843 880	899 360	905 930	905 261	947 175	987 325	987 325	
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 405 per PDE by 2014/15 (in 2010/11 rands).	8) Expenditure per patient day equivalent [PDE] in district hospitals (in 2010/11 rands)	Rand	R 1 405	R 1 445	R 1 558	R 1 508	R 1 374	R 1 438	R 1 413	R 1 405	
			Numerator ID 9		1 695 498 000	1 391 455 000	1 537 197 000	1 506 969 000	1 585 275 000	1 665 485 000	1 693 312 000	1 695 498 000	
			Denominator ID 5		1 206 544	963 020	986 481	999 260	1 153 795	1 158 253	1 198 277	1 206 544	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
3. Improve the quality of health services and the patient experience.	3.1. Improve the experience of clients utilising district hospital services.	3.1.1. Achieve an 92% client satisfaction rate by 2014/15.	9) Percentage of complaints of users of district hospital services resolved within 25 days	%		75%	73%	68%	68%	70%	73%	**76%**	100%
			Numerator ID10			283	498	383	289	311	340	372	
			Denominator ID 11			375	679	562	423	444	466	490	
			10) Percentage of district hospitals with monthly mortality and morbidity meetings	%		63%	74%	59%	68%	82%	91%	100%	100%
			Numerator ID 12			20	25	20	23	28	31	34	
			Denominator ID 13			32	34	34	34	34	34	34	
			11) District hospital patient satisfaction rate	%	92%	Not required to report	Not required to report	86%	89%	90%	91%	92%	
			Numerator ID14		4 126	-	-	7 267	3 776	3 879	4 001	4 126	
			Denominator ID 15		4 485	-	-	8 491	4 226	4 311	4 397	4 485	
			12) Number of district hospitals assessed for compliance against the 6 priorities of the core standards	No		Not required to report	Not required to report	Not required to report	34	0	34	0	
			Element ID 16										

Notes:

Indicator 5: Change to the definition from 1 April 2011: PHC headcount at district hospitals is now reflected as OPD headcount.

Indicator 8: Financial figurers updated to reflect 2010/11 rands.

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

4.5 QUARTERLY TARGETS FOR DISTRICT HOSPITALS

Table 2.10: Quarterly targets for district hospitals for 2012/13 [DHS9]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
1. Address the burden of disease.	1.1. Increase access to acute district hospital services in the Western Cape.	1.1.1. Establish 2 705 acute district hospital beds in the DHS by 2014/15.	1) Number of district hospital beds Element ID 1	Quarterly	2 705	2 705	2 705	2 705	2 705
			2) Caesarean section rate in district hospitals	Quarterly	23%	23%	23%	23%	23%
			Numerator ID 2		7 051	1 763	1 763	1 763	1 763
			Denominator ID 3		30 265	7 566	7 566	7 566	7 566
			3) Total separations in district hospitals Element ID 4	Quarterly	250 667	62 667	62 667	62 667	62 667
			4) Patient day equivalents [PDE] in district hospitals Element ID 5	Quarterly	1 158 253	289 563	289 563	289 563	289 563
			5) OPD total headcounts in district hospitals Element ID 6	Quarterly	892 047	223 012	223 012	223 012	223 012
			6) Average length of stay in district hospitals	Quarterly	3.0	3.0	3.0	3.0	3.0
			Numerator ID 7		753 004	188 251	188 251	188 251	188 251
			Denominator ID 4		250 667	62 667	62 667	62 667	62 667
			7) Bed utilisation rate (based on usable beds) in district hospitals	Quarterly	79%	79%	79%	79%	79%
			Numerator ID 7		753 004	188 251	188 251	188 251	188 251
			Denominator ID 8		947 175	236 794	236 794	236 794	236 794
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 405 per PDE by 2014/15 (in 2010/11 rands).	8) Expenditure per patient day equivalent [PDE] in district hospitals (in 2010/11 rands)	Quarterly	R 1 438	1 438	1 438	1 438	1 438
			Numerator ID 9		1 665 485 000	416 371 250	416 371 250	416 371 250	416 371 250
			Denominator ID 5		1 158 253	289 563	289 563	289 563	289 563
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 a 92% client satisfaction rate by 2014/15.	9) Percentage of complaints of users of district hospital services resolved within 25 days	Quarterly	70%	69%	70%	70%	70%
			Numerator ID10		311	77	78	78	78
			Denominator ID 11		444	111	111	111	111

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
			10) Percentage of district hospitals with monthly mortality and morbidity meetings	Quarterly	82%	82%	82%	82%	82%
			Numerator ID 12		28	28	28	28	28
			Denominator ID 13		34	34	34	34	34
			11) District hospital patient satisfaction rate	Annually	90%	-	-	-	90%
			Numerator ID14		3 879	-	-	-	3 879
			Denominator ID 15		4 311	-	-	-	4 311
			12) Number of district hospitals assessed for compliance against the 6 priorities of the core standards	Annually	0	-	-	-	-
			Element ID 16						

Notes:

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

5. HIV AND AIDS, STI'S AND TB CONTROL (HAST)

5.1 SITUATION ANALYSIS

The principal mandate of the HAST sub-programme (Sub-programme 2.6) is to co-ordinate a provincial response to the HIV and TB epidemics. As such it focuses both on prevention and treatment of these two major infectious diseases that beset the Western Cape.

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

In an environment of a resurgent epidemic of drug-sensitive TB and an emerging epidemic of drug-resistant TB, special attention needs to be given to the large provincial population of HIV-infected individuals (approximately 300 000 people) who are at particularly high risk of acquiring tuberculosis infection or progressing to active tuberculosis disease. Early detection and case-holding of TB-infected individuals is therefore of paramount importance.

The HAST program co-ordinated two major national campaigns in 2010/11. An HCT (HIV counselling and testing) campaign and an ART (anti-retroviral therapy) scale-up campaign. A total of 1 042 095 clients were tested (against a target of 1.1 million) during the HCT campaign that lasted from 1 April 2010 until 30 June 2011. For more detail on ART patients, refer to the table on performance indicators later in this section.

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

Table 2.11: Data elements for situation analysis indicators in Table 2.12

Source	Data element	Element ID	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11
Annual antenatal HIV & syphilis survey results	HIV positive women aged 15 - 24 years	1	492	267	68	4	80	42	31
Annual antenatal HIV & syphilis survey results	Women aged 15 - 24 years tested for HIV	2	3 527	1 680	549	50	630	233	385
PGWC HIV DB. mdb	Cumulative number of patients on an ARV regimen	3	96 011	72 400	9 642	632	7 422	2 926	2 989
SINJANI	Male condoms distributed	4	89 376 081	64 887 379	8 182 608	511 301	7 305 219	2 120 576	6 368 998
Information Management	Male population 15 years and over	5	2 021 542	1 341 282	269 305	20 135	197 155	83 453	110 212
ETR. net	New smear positive PTB cases who defaulted	6	1 103	620	200	17	131	42	93
ETR. net	New smear positive PTB cases registered	7	15 761	8 481	2 632	193	2 208	782	1 465
SINJANI	HCT clients tested for HIV	8	747 139	466 969	89 283	6 207	85 731	44 977	53 972
SINJANI	HCT clients pre-test counselled	9	767 174	479 327	92 375	6 333	86 771	47 441	54 927
ETR. net	Number of HIV and TB co-infected people receiving ART	10	7 952	6 386	517	46	626	123	254
ETR. net	Number of co-infected people with a CD4 count of 350 or less	11	17 138	12 245	1 702	139	1 572	705	775
ETR. net	New smear positive PTB cases cured	12	12 689	6 784	2 069	158	1 875	689	1 114
ETR. net	New smear positive PTB clients who converted at 2 months	13	11 683	6 611	1 851	151	1 460	607	1 003
ETR. net	Smear conversion PTB cases registered	14	15 458	8 518	2 620	245	1 893	776	1 406

Table 2.12: Situation analysis indicators for HIV and AIDS, STI's and TB control [HIV 1]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Type	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11	National Average 2009/10 2010/11
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 11.5% in 2014/15.	1) HIV prevalence in women aged 15 – 24 years	%	13.9%	15.9%	12.4%	8.0%	12.7%	18.0%	8.1%	
			Numerator ID 1		492	267	68	4	80	42	31	
			Denominator ID 2		3 527	1680	549	50	630	233	385	
			2) Total number of patients (children and adults) on ART	No	96 011	72 400	9 642	632	7 422	2 926	2 989	1 063 644
			Element ID 3									
			3) Male condom distribution rate	No	44.2	48.4	30.4	25.4	37.1	25.4	57.8	13.2
			Numerator ID 4		89 376 081	64 887 379	8 182 608	511 301	7 305 219	2 120 576	6 368 998	
			Denominator ID 5		2 021 542	1 341 282	269 305	20 135	197 155	83 453	110 212	
			4) New smear positive PTB defaulter rate	%	7.0%	7.3%	7.6%	8.8%	5.9%	5.4%	6.3%	7.4%
			Numerator ID 6		1 103	620	200	17	131	42	93	
			Denominator ID 7		15 761	8 481	2 632	193	2 208	782	1 465	
			5) HCT testing rate	%	97%	97%	97%	98%	99%	95%	98%	
			Numerator ID 8		747 139	466 969	89 283	6 207	85 731	44 977	53 972	
			Denominator ID 9		767 174	479 327	92 375	6 333	86 771	47 441	54 927	
			6) Percentage of HIV-TB co-infected patients placed on ART	%	46%	52%	30%	33%	40%	17%	33%	
			Numerator ID 10		7 952	6 386	517	46	626	123	254	
			Denominator ID 11		17 138	12 245	1 702	139	1 572	705	775	
			7) New smear positive PTB cure rate	%	81%	80%	79%	82%	85%	88%	76%	66%
			Numerator ID 12		12 689	6 784	2 069	158	1 875	689	1 114	
			Denominator ID 7		15 761	8 481	2 632	193	2 208	782	1 465	
			8) PTB two month smear conversion rate	%	76%	78%	71%	62%	77%	78%	71%	
			Numerator 13		11 683	6 611	1 851	151	1 460	607	1 003	
			Denominator ID 14		15 458	8 518	2 620	245	1 893	776	1 406	

5.2 CHALLENGES

1) Reducing the rate of new HIV infections. The overall provincial HIV prevalence was 16.9 per cent in 2009 and 17.3 per cent in 2010. The increasingly successful roll-out of anti-retroviral therapy (ART) means that it is unlikely that the general HIV prevalence will decline in the short term as the survivors on ART will continue to contribute to the provincial prevalence.

   The Department must continue with global HIV prevention programmes but must also focus on tailored HIV prevention strategies for teenagers and young adults. This may necessitate the use of strategic partners and specific expertise.

2) Integration of TB and HIV interventions at a provincial health programme level and at service level.

3) Managing large cohorts on ART treatment for extended durations results in logistical, administrative, informational and organisational challenges.

5.3 PRIORITIES

1) HIV prevention:

   - Continue HCT on a large scale and develop novel post-test counselling strategies for those who test negative.
   - Expand combination prevention strategies.
   - Improve coverage of the prevention of mother-to-child transmission (PMTCT) programme.
   - Extend the use of barrier methods and employ more sophisticated strategies for marketing and distribution.
   - Promote and increase voluntary male medical circumcision (VMMC).
   - Research - more detailed analysis of know your epidemic (KYE) is required in order to generate a more detailed response.

2) ART coverage needs to be reviewed in the light of recent changes in the initiation threshold. Actions include:

   - Continue to initiate ART in adults according to a uniform single CD4 threshold of 350 cells/mm^3.
   - Achieve maximum coverage for paediatric ART.
   - Improve linkages between point of HIV diagnosis and ART initiation.
   - On-treatment case-holding is becoming an increasing priority – effective service models will have to be produced to manage large numbers of clients on ART. These clients have, for the most part, successfully negotiated severe immunosuppressive disease and often simply require regular drug delivery and occasional clinical consultations.
   - Nurse prescribing of ART and training in HIV clinical skills.

3) TB active case identification and case-holding:

- Accelerate the integration of TB and HIV/ART services.
- Intensive case-finding for TB – community screening outreaches. TB screening will become a routine part of pre-ART work-up, regardless of the presence or absence of TB symptoms.

4) Multi-drug resistant and extreme drug resistant tuberculosis management:

- Review the targets that will be adjusted to accommodate more rapid diagnostic processes.

5.4 STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR HIV AND AIDS

Table 2.13: Data elements and related actual and projected performance values for Tables 2.14 – 2.15

Source	Data element	Element ID	Audited /Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Annual antenatal HIV & syphilis survey results	HIV positive women aged 15 - 24 years	1	Not required to report	545	492	517	554	540	518
Annual antenatal HIV & syphilis survey results	Women aged 15 - 24 years tested for HIV	2	Not required to report	4 405	3 527	4 101	4 500	4 500	4 500
PGWC HIV DB.mdb	Cumulative number of patients on an ARV regimen	3	54 703	75 002	96 011	115 237	135 018	152 803	167 256
SINJANI	Male condoms distributed	4	63 830 181	74 081 286	89 376 081	91 298 442	106 995 125	119 434 318	130 000 000
Information Management	Male population 15 years and over	5	1 934 249	1 977 894	2 021 542	2 065 191	2 108 839	2 152 485	2 196 129
ETR. net	New smear positive PTB cases who defaulted	6	1 534	1 322	1 103	1 018	960	911	828
ETR. net	New smear positive PTB cases registered	7	16 317	16 194	15 761	15 195	16 233	16 558	16 889
SINJANI	HCT clients tested for HIV	8	353 959	397 704	747 139	816 269	824 431	832 675	841 002
SINJANI	HCT clients pre-test counselled	9	370 306	411 411	767 174	822 536	841 256	849 669	858 166
ETR. net	Number of HIV and TB co-infected people receiving ART	10	Not required to report	6 948	7 952	9 847	10 241	10 651	11 077
ETR. net	Number of co-infected people with a CD4 count of 350 or less	11	Not required to report	16 950	17 138	13 739	14 014	14 294	14 580
ETR. net	New smear positive PTB cases cured	12	12 990	12 853	12 689	12 387	13 311	13 743	14 356
ETR. net	New smear positive PTB clients who converted at 2 months	13	11 516	11 263	11 683	11 586	12 175	12 418	12 667
ETR. net	Smear conversion PTB cases registered	14	16 317	15 620	15 458	15 480	15 812	16 137	16 468

Notes:

Element ID 10 & 11: Data from the current information system is not reliable.
There is no cross-tabulation between patients who qualify for ART and patients' current ART status.
The patient's current ART status also relies on patient verbal verification.

Table 2.14: Strategic objectives, indicators and annual targets for HIV and AIDS, STI and TB control [HIV 2 and 3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 11.5% in 2014/15.	1) HIV prevalence in women aged 15 – 24 years	%	11.5%	Not required to report	12.4%	13.9%	12.6%	12.3%	12.0%	11.5%	
			Numerator ID 1		518	-	545	492	517	554	540	518	
			Denominator ID 2		4 500	-	4 405	3 527	4 101	4 500	4 500	4 500	
			2) Total number of patients (children and adults) on ART Element ID 3	No		54 703	75 002	96 011	115 237	135 018	152 803	167 256	3.2 million
			3) Male condom distribution rate	No		33.0	37.5	44.2	44.2	50.7	55.5	59.2	60
			Numerator ID 4			63 830 181	74 081 286	89 376 081	91 298 442	106 995 125	119 434 318	130 000 000	
			Denominator ID 5			1 934 249	1 977 894	2 021 542	2 065 191	2 108 839	2 152 485	2 196 129	
			4) New smear positive PTB defaulter rate	%		9.4%	8.2%	7.0%	6.7%	5.9%	5.5%	4.9%	<5%
			Numerator ID 6			1 534	1 322	1 103	1 018	960	911	828	
			Denominator ID 7			16 317	16 194	15 761	15 195	16 233	16 558	16 889	
			5) HCT testing rate	%		95.6%	96.7%	97.4%	99.2%	98.0%	98.0%	98.0%	
			Numerator ID 8			353 959	397 704	747 139	816 269	824 431	832 675	841 002	
			Denominator ID 9			370 306	411 411	767 174	822 536	841 256	849 669	858 166	
			6) Percentage of HIV-TB co-infected patients placed on ART	%		Not required to report	41.0%	46.4%	71.7%	73.1%	74.5%	76.0%	100%
			Numerator ID 10			-	6 948	7 952	9 847	10 241	10 651	11 077	
			Denominator ID 11			-	16 950	17 138	13 739	14 014	14 294	14 580	
			7) New smear positive PTB cure rate	%		79.6%	79.4%	80.5%	81.5%	82.0%	83.0%	85.0%	85%
			Numerator ID 12			12 990	12 853	12 689	12 387	13 311	13 743	14 356	
			Denominator ID 7			16 317	16 194	15 761	15 195	16 233	16 558	16 889	
			8) PTB two month smear conversion rate	%		70.6%	72.1%	75.6%	74.8%	77.0%	77.0%	76.9%	
			Numerator 13			11 516	11 263	11 683	11 586	12 175	12 418	12 667	
			Denominator ID 14			16 317	15 620	15 458	15 480	15 812	16 137	16 468	

Notes:

Indicator 3: The 2010/11 target was based on the calculation of 52 condoms per adult male per year. This was not achieved because of supply chain problems. The 2011/12 target is still calculated at 52 per adult male per year, but the number of adult males has increased by about 2%. The target is based on the assumption that supply chain problems have been resolved.

Indicator 6: Data from the current information system is not reliable. There is no cross-tabulation between patients who qualify for ART and patients' current ART status. The patient's current ART status also relies on patient verbal verification.

5.5 QUARTERLY TARGETS FOR HAST

Table 2.15: Quarterly targets for HIV and AIDS, STI and TB control [HIV4]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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.	Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15-24 years to 11.5% in 2014/15.	1) HIV prevalence in women aged 15 – 24 years	Annual	12.3%	-	-	-	12.3%
			Numerator ID 1		554	-	-	-	554
			Denominator ID 2		4 500	-	-	-	4 500
			2) Total number of patients (children and adults) on ART	Quarterly	135 018	33 755	33 755	33 755	33 753
			Element ID 3						
			3) Male condom distribution rate	Quarterly	50.7	50.7	50.7	50.7	50.7
			Numerator ID 4		106 995 125	26 748 781	26 748 781	26 748 781	26 748 782
			Denominator ID 5		2 108 839	527 210	527 210	527 210	527 209
			4) New smear positive PTB defaulter rate	Quarterly	5.9%	5.9%	5.9%	5.9%	5.9%
			Numerator ID 6		960	240	240	240	240
			Denominator ID 7		16 233	4 058	4 058	4 058	4 059
			5) HCT testing rate	Quarterly	98%	98%	98%	98%	98%
			Numerator ID 8		824 431	206 108	206 108	206 108	206 107
			Denominator ID 9		841 256	210 314	210 314	210 314	210 314
			6) Percentage of HIV-TB co-infected patients placed on ART	Quarterly	73%	73%	73%	73%	73%
			Numerator ID 10		10 241	2 560	2 560	2 560	2 561
			Denominator ID 11		14 014	3 503	3 503	3 503	3 505

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
			7) New smear positive PTB cure rate	Quarterly	82%	82%	82%	82%	82%
			Numerator ID 12		13 311	3 328	3 328	3 328	3 327
			Denominator ID 7		16 233	4 058	4 058	4 058	4 059
			8) PTB two month smear conversion rate	Quarterly	77%	77%	77%	77%	77%
			Numerator 13		12 175	3 044	3 044	3 044	3 043
			Denominator ID 14		15 812	3 953	3 953	3 953	3 953

6. MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION [MCWH & N]

6.1 SITUATION ANALYSIS FOR MCWH & N

Women and children bear a disproportionate burden of preventable disease. Children continue to die of avoidable diseases such as pneumonia and diarrhoea, with many of the deaths being due to underlying malnutrition and/or HIV disease. A woman's health is particularly vulnerable during pregnancy, where HIV and AIDS account for almost one in two of all puerperal deaths.

This inequity is borne out by the fact that many of the Millennium Development Goals (MDGs) focus on addressing health problems prevalent amongst these populations.

Maternal, Child and Women's Health (MCWH) and Nutrition services are rendered at all facilities within the Province, including secondary, tertiary and specialised hospitals and within communities, including community outreach programmes. The MCWH and Nutrition component strives towards implementing evidence-based key interventions to contribute towards achieving MDG 4 (Reduce by two-thirds between 1990 and 2015 the under-five mortality rate) and MDG 5 (Reduce by three quarters between 1990 and 2015 the maternal mortality ratio).

As malnutrition is a major contributing factor to morbidity and mortality, the Integrated Nutrition Programme (INP) has been implemented within health programmes. It focuses on the specific health needs of individuals through the stages of the human life cycle, namely: maternal; neonatal; infant and early childhood; late childhood; adolescence; adulthood and old age (geriatric). The programme links with cross cutting issues including HIV, AIDS, TB and other chronic debilitating conditions. Liaison and co-operation with other departments and programmes (e.g. Education, Social Development, Local Government) assists with case prevention and implementation of health programmes.

Goals of the MCWH and Nutrition programme are to:

- Prevent and reduce morbidity and mortality during pregnancy, birth, post-delivery, infancy and early childhood.
- Prevent infectious diseases through immunisation.
- Render high quality health services for maternal and child survival.
- Contribute to the institutional care of clients through access to high quality health care.
- Contribute to the improvement of nutritional status and food security.

Table 2.16: Data elements for situation analysis indicators in Table 2.17

Source	Data element	Element ID	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11
SINJANI	Immunised fully under 1 year	1	89 508	59 185	11 473	1 028	8 769	3 577	5 476
Information Management	Population under 1 year	2	104 175	70 337	13 212	1 219	9 552	4 442	5 413
SINJANI	Vitamin A supplement to 12 to 59 months child	3	261 714	135 519	44 650	4 838	39 026	14 175	23 506
Info Man	Population 1 to 4 years X 2	4	846 079	564 399	110 217	10 333	80 032	35 708	45 390
SINJANI	PCV 3rd dose	5	70 629	41 256	11 331	1 034	8 629	3 135	5 244
SINJANI	Rotavirus vaccine (RV) 2nd dose	6	62 803	37 774	9 842	881	6 916	2 653	4 737
SINJANI	Measles 1st dose under 1 year	7	92 944	61 845	11 970	1 041	9 049	3 636	5 403
SINJANI	PMTCT baby tested positive for HIV	8	388	275	41	3	34	13	22
SINJANI	PMTCT baby tested for HIV	9	12 149	8 855	1 204	56	1 005	522	507
SINJANI	Diarrhoea under 5 years- new ambulatory	10	47 887	31 319	7 172	538	3 219	2 858	2 781
Information Management	Population under 5 years	11	527 215	352 536	68 321	6 385	49 568	22 296	28 109
SINJANI	Pneumonia under 5 years- new ambulatory	12	34 582	23 785	3 691	224	1 487	3 963	1 432
SINJANI	Facility Inpatient deaths under 1 year	13	1 077	692	156	20	168	13	28
SINJANI	Live births in facility	14	92 594	59 919	13 856	1 039	9 507	3 150	5 123
SINJANI	Facility Inpatient deaths under 5 years	15	1 235	810	170	22	187	10	36
SINJANI	Maternal deaths in facilities	16	41	33	4	1	2	-	1
SINJANI	Cervical (pap) smear in women 30 years and older screened for cervical cancer	17	82 125	47 614	13 203	772	11 343	3 932	5 261
Information Management	Female population 30 years and older DIVIDED BY 10	18	128 998	85 068	16 702	1 320	13 008	5 678	7 223
SINJANI	Deliveries to women under 18 years	19	6 484	3 911	1 136	92	650	279	416
SINJANI	Delivery in facility- SUM OF: Normal deliveries + Assisted deliveries + Caesarean sections	20	93 192	63 082	12 156	1 043	9 042	2 948	4 921
SINJANI	Antenatal 1st visits before 20 weeks	21	54 520	31 635	8 255	706	6 745	2 783	4 396
SINJANI	Antenatal 1st visit: SUM OF: Antenatal 1st visit before 20 weeks + Antenatal 1st visit 20 weeks or later	22	103 447	68 258	13 230	1 231	10 085	4 193	6 450
SINJANI	**Contraceptive years equivalent = SUM OF:**	23	**560 684**	**343 819**	**82 699**	**5 566**	**63 574**	**26 001**	**39 025**
SINJANI	Male sterilisations X 20		13 979	10 499	1 960	60	660	460	340
SINJANI	Female sterilisations X 10		59 500	26 381	12 290	970	13 740	3 689	2 430
SINJANI	Medroxyprogesterone one injection / 4		210 647	117 584	37 342	2 830	22 105	13 260	17 526
SINJANI	Norethisterone enanthate injection / 6		51 717	37 061	4 724	303	6 103	1 363	2 163

Source	Data element	Element ID	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11
SINJANI	Oral pill cycles / 13		36 109	18 915	7 050	380	4 304	2 132	3 328
SINJANI	IUCD X 4		9 980	3 604	2 968	-	2 052	856	500
SINJANI	Male condoms / 500		178 752	129 775	16 365	1 023	14 610	4 241	12 738
Information Management	Female population 15 to 44 years	24	1 380 714	923 846	186 405	13 096	128 497	53 927	74 943

Table 2.17: Situation analysis indicators for MCWH & N [MCWH1]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11	National Average 2009/10
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 95% in children under the age of 5 years by 2014/15.	1) Immunisation coverage under 1 year	Rate	85.9%	84.1%	86.8%	84.3%	91.8%	80.5%	101.2%	95.5%
			Numerator ID 1		89 508	59 185	11 473	1 028	8 769	3 577	5 476	
			Denominator ID 2		104 175	70 337	13 212	1 219	9 552	4 442	5 413	
			2) Vitamin A coverage 12 – 59 months	%	30.9%	24.0%	40.5%	46.8%	48.8%	39.7%	51.8%	36.6%
			Numerator ID 3		261 714	135 519	44 650	4 838	39 026	14 175	23 506	
			Denominator ID 4		846 079	564 399	110 217	10 333	80 032	35 708	45 390	
			3) Pneumococcal vaccine (PCV) 3rd dose coverage	%	67.8%	58.7%	85.8%	84.8%	90.3%	70.6%	96.9%	23.1%
			Numerator ID 5		70 629	41 256	11 331	1 034	8 629	3 135	5 244	
			Denominator ID 2		104 175	70 337	13 212	1 219	9 552	4 442	5 413	
			4) Rotavirus (RV) 2nd dose coverage	%	60.3%	53.7%	74.5%	72.3%	72.4%	59.7%	87.5%	34.7%
			Numerator ID 6		62 803	37 774	9 842	881	6 916	2 653	4 737	
			Denominator ID 2		104 175	70 337	13 212	1 219	9 552	4 442	5 413	
			5) Measles 1st dose under 1 year coverage	%	89.2%	87.9%	90.6%	85.4%	94.7%	81.9%	99.8%	98.8%
			Numerator ID 7		92 944	61 845	11 970	1 041	9 049	3 636	5 403	
			Denominator ID 2		104 175	70 337	13 212	1 219	9 552	4 442	5 413	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11	National Average 2009/10
			6) Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	%	3.2%	3.1%	3.4%	5.4%	3.4%	2.5%	4.3%	11.0%
			Numerator ID 8		388	275	41	3	34	13	22	
			Denominator ID 9		12 149	8 855	1 204	56	1 005	522	507	
			7) Diarrhoea incidence under 5 years	No / 1 000	90.83	88.8	105.0	84.3	64.9	128.2	98.9	
			Numerator ID 10		47 887	31 319	7 172	538	3 219	2 858	2 781	
			Denominator ID 11		527	353	68	6	50	22	28	
			8) Pneumonia incidence under 5 years	No / 1 000	65.6	67.5	54.0	35.1	30.0	177.7	50.9	
			Numerator ID 12		34 582	23 785	3 691	224	1 487	3 963	1 432	
			Denominator ID 11		527	353	68	6	50	22	28	
			9) Facility infant mortality (under 1) rate	No / 1 000	11.63	11.55	11.26	19.25	17.67	4.13	5.47	9.9
			Numerator ID 13		1 077	692	156	20	168	13	28	
			Denominator ID 14		92.6	59.9	13.9	1.0	9.5	3.2	5.1	
			10) Facility child mortality (under 5) rate	No / 1 000	13.3	13.5	12.3	21.2	19.7	3.2	7.0	6.4
			Numerator ID 15		1 235	810	170	22	187	10	36	
			Denominator ID 14		92.6	59.9	13.9	1.0	9.5	3.2	5.1	
	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 53.4 per 100 000 live births by 2014/15.	11) Facility maternal mortality rate	No / 100 000	44.28	55.07	28.87	96.25	21.04	-	19.52	
			Numerator ID 16		41	33	4	1	2	-	1	
			Denominator ID 14		0.93	0.60	0.14	0.01	0.10	0.03	0.05	
			12) Cervical cancer screening coverage	%	63.7%	56.0%	79.0%	58.5%	87.2%	69.2%	72.8%	47.6%
			Numerator ID 17		82 125	47 614	13 203	772	11 343	3 932	5 261	
			Denominator ID 18		128 998	85 068	16 702	1 320	13 008	5 678	7 223	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11	National Average 2009/10
			13) Delivery rate for women under 18 years	%	7.0%	6.2%	9.3%	8.8%	7.2%	9.5%	8.5%	8.2%
			Numerator ID 19		6 484	3 911	1 136	92	650	279	416	
			Denominator ID 20		93 192	63 082	12 156	1 043	9 042	2 948	4 921	
			14) Antenatal visits before 20 weeks rate	%	52.7%	46.3%	62.4%	57.4%	66.9%	66.4%	68.2%	34.5%
			Numerator ID 21		54 520	31 635	8 255	706	6 745	2 783	4 396	
			Denominator ID 22		103 447	68 258	13 230	1 231	10 085	4 193	6 450	
			15) Couple year protection rate	%	40.6%	37.2%	44.4%	42.5%	49.5%	48.2%	52.1%	31.7%
			Numerator ID 23		560 684	343 819	82 699	5 566	63 574	26 001	39 025	
			Denominator ID 24		1 380 714	923 846	186 405	13 096	128 497	53 927	74 943	

Notes:

Indicator 3: Vitamin A coverage is not linked to the schedule for other routine vaccines. (Anecdotal reports suggest that most mothers are conscientious about immunisations in the first year, but attendance falls off thereafter.) Health care attendance for children over one, especially when the child is not ill or an immunisation is not known to be scheduled, tends to be low.

Indicator 4 & 5: Performance is poorer in the Metro for two possible reasons: not all of the City of Cape Town (CoCT) sites might be reporting timeously (review of 2010/11 quarterly performance per Metro sub-district reveals data gaps in CoCT sites) and there were stock-outs for both Prevenar and Rotarix between April and September. Stock-outs affect the Metro disproportionately because, unlike other districts, it does not have a holding depot.

6.2 CHALLENGES

1) Under-achievement against women's health performance targets in the previous financial year 2010/11, notably antenatal bookings rate under 20 weeks and cervical cancer screening.

2) Under-achievement of immunisation targets.

6.3 PRIORITIES

1) Impacting on childhood morbidity and mortality:

- Immunisation coverage will be improved through a combination of contract management with vaccine providers, in-facility management and outreach campaigns.
- PMTCT coverage will improve and will strive to have a target of zero vertical transmission over the MTEF. A coherent provincial breastfeeding strategy will be effectively implemented and will incorporate simple uniform messaging to mothers, staff and partners.
- Mortality rates amongst infants and children under-five will be monitored, causes of death identified per GSA, and mitigating strategies employed in community and facility settings (e.g. "diarrhoeal disease season" across the GSA).
- Hospital admissions for diarrhoea and pneumonia will be monitored as a measure of effectiveness of above-mentioned mitigating strategies.
- Malnutrition will be identified and nutritional support offered where identified.

2) Impacting on female morbidity and mortality:

- Cervical screening coverage will be improved. Linkages between cervical screening and effective care will have to be improved simultaneously.
- Early antenatal booking will be encouraged – community-based services have a potentially important role in this regard.
- There will be a renewed focus on contraception and preventing teenage pregnancies.
- Improved management of obstetrical and neonatal emergencies and GSA-wide co-ordination with emergency medical services.

3) Improving information systems for childhood and maternal morbidity and mortality.

6.4 STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR MCWH AND N

Table 2.18: Data elements and related actual and projected performance values for Tables 2.19 – 2.20

Source	Data element	Element ID	Audited /Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	Immunised fully under 1 year	1	94 540	98 622	89 508	89 145	103 218	105 344	107 470
Information Management	Population under 1 year	2	99 700	101 937	104 175	106 413	108 651	110 889	113 126
SINJANI	Vitamin A supplement to 12 to 59 months child	3	456 575	307 267	261 714	288 153	364 698	406 829	495 000
Information Management	Population 1 to 4 years X 2	4	809 797	827 937	846 079	864 221	882 363	900 503	918 643
SINJANI	PCV 3rd dose	5	Not required to report	Not required to report	70 629	81 872	103 218	105 344	107 470
SINJANI	Rotavirus vaccine (RV) 2nd dose	6	Not required to report	Not required to report	62 803	89 534	103 218	105 344	107 470
SINJANI	Measles 1st dose under 1 year	7	97 726	101 154	92 944	93 076	103 218	105 344	107 470
SINJANI	PMTCT baby tested positive for HIV	8	487	404	388	224	243	224	203
SINJANI	PMTCT baby tested for HIV	9	10 797	11 223	12 149	11 676	13 500	14 000	14 500
SINJANI	Diarrhoea under 5 years- new ambulatory	10	73 606	73 389	47 887	40 368	37 946	35 669	33 529
Information Management	Population under 5 years	11	504 598	515 906	527 215	538 524	549 832	561 140	572 448
SINJANI	Pneumonia under 5 years- new ambulatory	12	42 548	42 614	34 582	41 735	38 488	36 474	34 000
SINJANI	Facility Inpatient deaths under 1 year	13	902	952	1 077	1 104	1 024	955	932
SINJANI	Live births in facility	14	94 540	92 861	92 594	93 216	100 470	100 980	103 020
SINJANI	Facility Inpatient deaths under 5 years	15	1 060	1 043	1 235	1 328	1 223	1 129	1 072
SINJANI	Maternal deaths in facilities	16	80	74	41	71	65	60	55
SINJANI	Cervical (pap) smear in women 30 years and older screened for cervical cancer	17	63 127	70 345	82 125	87 624	90 508	93 392	98 085
Information Management	Female population 30 years and older DIVIDED BY 10	18	123 436	126 217	128 998	131 779	134 560	137 341	140 122
SINJANI	Deliveries to women under 18 years	19	7 412	7 060	6 484	6 666	6 304	6 039	6 023
SINJANI	Delivery in facility- SUM OF: Normal deliveries + Assisted deliveries + Caesarean sections	20	94 139	96 907	93 192	99 029	98 500	99 000	101 000
SINJANI	Antenatal 1st visits before 20 weeks	21	43 413	48 351	54 520	53 636	61 800	68 621	75 377
SINJANI	Antenatal 1st visit: SUM OF: Antenatal 1st visit before 20 weeks + Antenatal 1st visit 20 weeks or later	22	106 909	104 256	103 447	97 540	103 500	105 570	107 681
SINJANI	**Contraceptive years equivalent = SUM OF:**	23	**532 161**	**550 014**	**560 684**	**560 382**	**619 028**	**634 006**	**663 671**
SINJANI	Male sterilisations X 20		13 939	13 401	13 980	17 000	17 340	17 686	18 041
SINJANI	Female sterilisations X 10		67 880	64 630	59 500	61 500	62 730	63 985	65 264

Source	Data element	Element ID	Audited /Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	Medroxyprogesterone one injection / 4		214 168	219 309	210 647	209 700	212 753	211 797	214 881
SINJANI	Norethisterone enanthate injection / 6		55 947	55 834	51 716	51 100	52 233	51 611	52 755
SINJANI	Oral pill cycles / 13		41 748	40 035	36 109	33 980	36 740	34 320	36 835
SINJANI	IUCD X 4		8 252	8 328	9 980	15 428	15 582	15 738	15 895
SINJANI	Male condoms / 500		130 227	148 477	178 752	171 674	221 650	238 869	260 000
Information Management	Female population 15 to 44 years	24	1 321 073	1 350 892	1 380 714	1 410 535	1 440 356	1 470 176	1 499 995

Table 2.19: Strategic objectives, indicators and annual targets for MCWH and N [MCWH & N: 2 & 3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 95% in children under the age of 5 years by 2014/15.	1) Immunisation coverage under 1 year	%	95.0%	96.5%	96.7%	85.9%	83.8%	95.0%	95.0%	95.0%	90%
			Numerator ID 1		107 470	94 540	98 622	89 508	89 145	103 218	105 344	107 470	
			Denominator ID 2		113 126	99 700	101 937	104 175	106 413	108 651	110 889	113 126	
			2) Vitamin A coverage 12 - 59 months	%		56.4%	37.1%	30.9%	33.3%	41.3%	45.2%	53.9%	80%
			Numerator ID 3			456 575	307 267	261 714	288 153	364 698	406 829	495 000	
			Denominator ID 4			809 797	827 937	846 079	864 221	882 363	900 503	918 643	
			3) Pneumococcal vaccine (PCV) 3rd dose coverage	%		Not required to report	Not required to report	67.8%	76.9%	95.0%	95.0%	95.0%	90%
			Numerator ID 5			-	-	70 629	81 872	103 218	105 344	107 470	
			Denominator ID 2			-	-	104 175	106 413	108 651	110 889	113 126	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
			4) Rotavirus (RV) 2nd dose coverage	%		Not required to report	Not required to report	60.3%	84.1%	95.0%	95.0%	95.0%	90%
			Numerator ID 6			-	-	62 803	89 534	103 218	105 344	107 470	
			Denominator ID 2			-	-	104 175	106 413	108 651	110 889	113 126	
			5) Measles 1st dose under 1 year coverage	%		98.0%	99.2%	89.2%	87.5%	95.0%	95.0%	95.0%	90%
			Numerator ID 7			97 726	101 154	92 944	93 076	103 218	105 344	107 470	
			Denominator ID 2			99 700	101 937	104 175	106 413	108 651	110 889	113 126	
			6) Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks.	%		4.5%	3.6%	3.2%	1.9%	1.8%	1.6%	1.4%	<5%
			Numerator ID 8			487	404	388	224	243	224	203	
			Denominator ID 9			10 797	11 223	12 149	11 676	13 500	14 000	14 500	
			7) Diarrhoea incidence under 5 years	No / 1 000		145.9	142.3	90.8	75.0	69.0	63.6	58.6	
			Numerator ID 10			73 606	73 389	47 887	40 368	37 946	35 669	33 529	
			Denominator ID 11			505	516	527	539	550	561	572	
			8) Pneumonia incidence under 5 years	No / 1 000		84.3	82.6	65.6	77.5	70.0	65.0	59.4	
			Numerator ID 12			42 548	42 614	34 582	41 735	38 488	36 474	34 000	
			Denominator ID 11			505	516	527	539	550	561	572	
			9) Facility infant mortality (under 1) rate	No / 1 000		9.5	10.3	11.6	11.8	10.2	9.5	9.0	
			Numerator ID 13			902	952	1 077	1 104	1 024	955	932	
			Denominator ID 14			95	93	93	93	100	101	103	
			10) Facility child mortality (under 5) rate	No / 1 000		11.2	11.2	13.3	14.2	12.2	11.2	10.4	
			Numerator ID 15			1 060	1 043	1 235	1 328	1 223	1 129	1 072	
			Denominator ID 14			95	93	93	93	100	101	103	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
	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 53.4 per 100 000 live births by 2014/15.	11) Facility maternal mortality rate	No / 100 000	53.4	84.6	79.7	44.3	76.3	65.0	59.4	53.4	
			Numerator ID 16		55	80	74	41	71	65	60	55	
			Denominator ID 14		1.03	0.95	0.93	0.93	0.93	1.00	1.01	1.03	
			12) Cervical cancer screening coverage	%		51.1%	55.7%	63.7%	66.5%	67.3%	68.0%	70.0%	70%
			Numerator ID 17			63 127	70 345	82 125	87 624	90 508	93 392	98 085	
			Denominator ID 18			123 436	126 217	128 998	131 779	134 560	137 341	140 122	
			13) Delivery rate for women under 18 years	%		7.9%	7.3%	7.0%	6.7%	6.4%	6.1%	6.0%	10
			Numerator ID 19			7 412	7 060	6 484	6 666	6 304	6 039	6 023	
			Denominator ID 20			94 139	96 907	93 192	99 029	98 500	99 000	101 000	
			14) Antenatal visits before 20 weeks rate	%		40.6%	46.4%	52.7%	55.0%	59.7%	65.0%	70.0%	70%
			Numerator ID 21			43 413	48 351	54 520	53 636	61 800	68 621	75 377	
			Denominator ID 22			106 909	104 256	103 447	97 540	103 500	105 570	107 681	
			15) Couple year protection rate	%		40.3%	40.7%	40.6%	39.7%	43.0%	43.1%	44.2%	75%
			Numerator ID 23			532 161	550 014	560 684	560 382	619 028	634 006	663 671	
			Denominator ID 24			1 321 073	1 350 892	1 380 714	1 410 535	1 440 356	1 470 176	1 499 995	

Notes:

Indicator 1: All the immunisation indicators have a standard, WHO recommended, target of 95% coverage. The 2011/12 figures are projected performance after 9 months of data. The targets will not be achieved in 2011/12 but the province should not deviate from globally recommended targets for immunisation.

Indicator 2: The indicator reported in previous financial years referred to the vitamin A coverage for children under 1 year. The new indicator looks at the children aged 1 to 4 years. Since two doses of vitamin A supplementation are required per child per year, the denominator is double the population 1 – 4 years.

Indicator 9 to 11: To improve performance against these indicators a multi-sectorial approach is required to address the burden of disease at the level of the fundamental cause. Internal GSA communication and referral efficiencies will result in more timeous referral of sick patients across the different levels of care.

Indicator 11: There is most likely a quality of data issue regarding the Maternal Mortality Rate and this will be investigated.

Table 2.20: Quarterly targets for MCWH&N for 2012/13 [MCWH4]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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 95% in children under the age of 5 years by 2014/15.	1) Immunisation coverage under 1 year	Quarterly	95.0%	95.0%	95.0%	95.0%	95.0%
			Numerator ID 1		103 218	25 805	25 805	25 805	25 803
			Denominator ID 2		108 651	27 163	27 163	27 163	27 162
			2) Vitamin A coverage 12 - 59 months	Quarterly	41.3%	41.3%	41.3%	41.3%	41.3%
			Numerator ID 3		364 698	91 175	91 175	91 175	91 173
			Denominator ID 4		882 363	220 591	220 591	220 591	220 590
			3) Pneumococcal vaccine (PCV) 3rd dose coverage	Quarterly	95.0%	95.0%	95.0%	95.0%	95.0%
			Numerator ID 5		103 218	25 805	25 805	25 805	25 803
			Denominator ID 2		108 651	27 163	27 163	27 163	27 162
			4) Rotavirus (RV) 2nd dose coverage	Quarterly	95.0%	95.0%	95.0%	95.0%	95.0%
			Numerator ID 6		103 218	25 805	25 805	25 805	25 803
			Denominator ID 2		108 651	27 163	27 163	27 163	27 162
			5) Measles 1st dose under 1 year coverage	Quarterly	95.0%	95.0%	95.0%	95.0%	95.0%
			Numerator ID 7		103 218	25 805	25 805	25 805	25 803
			Denominator ID 2		108 651	27 163	27 163	27 163	27 162
			6) Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	Quarterly	1.8%	1.8%	1.8%	1.8%	1.8%
			Numerator ID 8		243	60	61	61	61
			Denominator ID 9		13 500	3 375	3 375	3 375	3 375
			7) Diarrhoea incidence under 5 years	Quarterly	69.0	69.2	69.2	69.2	68.3
			Numerator ID 10		37 946	9 486	9 486	9 486	9 488
			Denominator ID 11		550	137	137	137	139

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
			8) Pneumonia incidence under 5 years	Quarterly	70.0	70.2	70.2	70.2	69.2
			Numerator ID 12		38 488	9 622	9 622	9 622	9 622
			Denominator ID 11		550	137	137	137	139
			9) Facility infant mortality (under 1) rate	Quarterly	10.2	10.2	10.2	10.2	10.2
			Numerator ID 13		1 024	256	256	256	256
			Denominator ID 14		100	25	25	25	25
			10) Facility child mortality (under 5) rate	Quarterly	12.2	12.2	12.2	12.2	12.2
			Numerator ID 15		1 223	306	306	306	305
			Denominator ID 14		100	25	25	25	25
	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 53.4 per 100 000 live births by 2014/15.	11) Facility maternal mortality rate	Quarterly	65.0	68.0	64.0	64.0	64.0
			Numerator ID 16		65	17	16	16	16
			Denominator ID 14		1.00	0.25	0.25	0.25	0.25
			12) Cervical cancer screening coverage	Quarterly	67.3%	67.3%	67.3%	67.3%	67.3%
			Numerator ID 17		90 508	22 627	22 627	22 627	22 627
			Denominator ID 18		134 560	33 640	33 640	33 640	33 640
			13) Delivery rate for women under 18 years	Quarterly	6.4%	6.4%	6.4%	6.4%	6.4%
			Numerator ID 19		6 304	1 576	1 576	1 576	1 576
			Denominator ID 20		98 500	24 625	24 625	24 625	24 625
			14) Antenatal visits before 20 weeks rate	Quarterly	59.7%	59.7%	59.7%	59.7%	59.7%
			Numerator ID 21		61 800	15 450	15 450	15 450	15 450
			Denominator ID 22		103 500	25 875	25 875	25 875	25 875
			15) Couple year protection rate	Quarterly	43.0%	43.0%	43.0%	43.0%	43.0%
			Numerator ID 23		619 028	154 757	154 757	154 757	154 757
			Denominator ID 24		1 440 356	360 089	360 089	360 089	360 089

7. DISEASE PREVENTION AND CONTROL

7.1 SITUATION ANALYSIS FOR DISEASE PREVENTION AND CONTROL

Environmental Health Services (EHS), which relates to disease prevention, are primarily a local government function. The provincial government is responsible for monitoring the delivery of EHS, port health services, hazardous substances and malaria control.

Malaria is not endemic in the Western Cape and the few cases that were identified in the past were imported into the Province. Despite this, the Province is still monitoring the incidence of malaria.

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

The National Department of Health previously set a cataract surgery rate target of 2 000 per million which has now been adjusted to 1 500 per million which is more realistic in relation to the available resources.

The Department will continue to implement district–based four seasons of promotion/ prevention interventions for purposes of:

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

Table 2.21: Data elements for situation analysis indicators in Table 2.22

Source	Data element	Element ID	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11
Notifiable medical conditions system	Deaths from malaria	1	1	1	0	0	0	0	0
Notifiable medical conditions system	Malaria cases reported	2	72	60	6	2	4	0	0
Notifiable medical conditions system	Deaths from cholera	3	0	0	0	0	0	0	0
Notifiable medical conditions system	Cholera cases reported	4	0	0	0	0	0	0	0
SINJANI	Cataract operations reported	5	6 681	5485	541	41	554	32	28
Information Management	Total population	6	5 634 323	3 724 347	754 426	60 407	551 937	233 292	309 914

Table 2.22: Situation analysis indicators for disease prevention and control [DCP1]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11	National Average 2010/11
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	%	1.4%	1.7%	0%	0%	0%	0%	0%	
			Numerator ID 1		1	1	0	0	0	-	-	
			Denominator ID 2		72	60	6	2	4	-	-	
			2) Cholera fatality rate	%	0%	0%	0%	0%	0%	0%	0%	
			Numerator ID 3		-	-	-	-	-	-	-	
			Denominator ID 4		-	-	-	-	-	-	-	
	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	No / million popu-lation	1 186	1 473	717	679	1 004	137	90	
			Numerator ID 5		6 681	5 485	541	41	554	32	28	
			Denominator ID 6/ 1 000 000		5.63	3.72	0.75	0.06	0.55	0.23	0.31	

7.2 CHALLENGES

1) Prevention of future disease outbreaks due to emerging and re-emerging infectious diseases.
2) Prevention of blindness.
3) To reduce the significant burden of non-communicable diseases.

7.3 PRIORITIES

1) Institute a provincial disease surveillance unit, focusing on preventable diseases and notifiable medical conditions.
2) Implement high volume cataract surgery procedures at designated health facilities.
3) Strengthen the healthy lifestyle programme.

7.4 STRATEGIC OBJECTIVES, INDICATORS AND TARGETS FOR DISEASE PREVENTION AND CONTROL [DCP2]

Table 2.23: Data elements and related actual and projected performance values for Tables 2.24 – 2.25

Source	Data element	Element ID	Audited /Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Notifiable medical conditions system	Deaths from malaria	1	0	0	1	0	0	0	0
Notifiable medical conditions system	Malaria cases reported	2	0	62	72	80	72	64	58
Notifiable medical conditions system	Deaths from cholera	3	0	0	0	0	0	0	0
Notifiable medical conditions system	Cholera cases reported	4	0	1	0	2	2	2	2
SINJANI	Cataract operations reported	5	5 670	6 022	6 681	5 208	6 909	8 398	9 000
Information Management	Total population	6	5 391 765	5 513 039	5 634 323	5 755 607	5 876 887	5 998 164	6 119 435

Table 2.24: Strategic objectives, indicators and annual targets for disease prevention and control [DCP 3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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%	1.4%	0.0%	0.0%	0.0%	0.0%	
			Numerator ID 1			-	0	1	0	0	0	0	
			Denominator ID 2			-	62	72	80	72	64	58	
			2) Cholera fatality rate	%		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
			Numerator ID 3			-	0	-	0	0	0	0	
			Denominator ID 4			-	1	-	2	2	2	2	
	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	No / million popu-lation	1 471	1 052	1 092	1 186	905	1 175	1 400	1 471	
			Numerator ID 5		9 000	5 670	6 022	6 681	5 208	6 909	8 398	9 000	
			Denominator ID 6/ 1 000 000		6.12	5.39	5.51	5.63	5.76	5.88	6.00	6.12	

8.5 QUARTERLY TARGETS FOR DISEASE PREVENTION AND CONTROL

Table 2.25: Quarterly targets for disease prevention and control for 2012/13 [DCP4]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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 fatality rate (annual)	Annually	0	-	-	-	0
			Numerator ID 2		0	-	-	-	0
			Denominator ID 1		72	-	-	-	72
			2) Cholera fatality rate (annual)	Annually	0	-	-	-	0
			Numerator ID 4		0	-	-	-	0
			Denominator ID 3		2	-	-	-	2
	1.2. Provide for cataract surgeries.	1.2.1. Increase the number of cataract surgeries to 1 471 per1 000 000 by 2014/15.	3) Cataract surgery rate (annual)	Annually	1 175	-	-	-	1 175
			Numerator ID 5		6 909	-	-	-	6 909
			Denominator ID 6/ 1 000 000		5.88	-	-	-	5.88

8. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND THE MTEF

Table 2.26: Summary of payments and estimates – Programme 2: District Health Services

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
1. District Mangement [c]	164 641	212 080	238 329	288 047	264 602	250 022	263 372	5.34	282 322	300 300
2. Community Health Clinics [b,c]	649 969	760 215	891 434	978 983	981 270	972 572	1 041 401	7.08	1 108 394	1 168 706
3. Community Health Centres [b]	705 342	813 712	935 306	1 019 448	1 042 270	1 037 345	1 127 754	8.72	1 204 910	1 272 042
4. Community Based Services [b]	106 033	119 334	128 499	145 645	148 277	151 158	157 842	4.42	166 660	175 617
5. Other Community Services				1	1	1	1		1	1
6. HIV and Aids [a]	268 931	383 531	554 971	660 614	660 614	660 614	738 080	11.73	927 547	1 074 487
7. Nutrition	17 068	18 885	19 854	24 680	24 680	25 302	26 920	6.39	28 529	29 812
8. Coroner Services	83 538			1	1	1	1		1	1
9. District Hospitals [b]	1 030 902	1 312 167	1 506 969	1 642 713	1 646 014	1 698 079	1 939 715	14.23	2 087 358	2 212 392
10. Global Fund	113 376	102 606	92 018	166 462	181 583	143 653	203 009	41.32	209 388	230 314
Total payments and estimates	3 139 800	3 722 530	4 367 380	4 926 594	4 949 312	4 938 747	5 498 095	11.33	6 015 110	6 463 672

[a] 2012/13: National Conditional grant: Comprehensive HIV and Aids: R738 080 000 (Compensation of employees R287 142 000; Goods and services R273 010 000, Transfers and subsidies R174 710 000 and Payments for capital assets R3 218 000).

[b] 2012/13: National Conditional grant: Health Professions Training and Development: R63 873 000 (Compensation of employees R46 463 000; Goods and services R17 411 000).

[c] 2012/13: National Conditional grant: National Health Insurance Grant - R3 000 000 (Goods and services R 3 000 000).

Note: Contributing factors to the increase of funding in this programme in 2007/08 are the creation of the District Health Service structures in sub-programme 2.1 and the allocation of GF Jooste, Helderberg and Karl Bremer Hospitals from sub-programme 4.

Note: A contributing factor to the decrease of funding in sub-programme 2.5 in 2008/09 is the shift of allocations to more appropriate sub-programmes within programme 2 (mostly to sub-programme 2.2).

Note: A contributing factor to the increase of funding in this programme is the allocation of Victoria Hospital from sub-programme 4.1 to sub-programme 2.9 with effect of 1 April 2009.

Note: A contributing factor to the increase of funding in this programme is the allocation of Victoria Hospital from sub-programme 4.1 to sub-programme 2.9 with effect of 1 April 2009.

Table 2.27: Payments and estimates by economic classification – Programme 2: District Health Services

Economic classification R'000	Outcome						Medium-term estimate			
	Audited	Audited	Audited	Main appro-priation	Adjusted appro-priation	Revised estimate	% Change from Revised estimate			
	2008/09	2009/10	2010/11	2011/12	2011/12	2011/12	2012/13	2011/12	2013/14	2014/15
Current payments	2 730 836	3 235 936	3 831 320	4 298 944	4 312 976	4 301 602	4 830 629	12.30	5 300 702	5 699 358
Compensation of employees	1 699 818	2 005 421	2 354 906	2 702 533	2 727 436	2 714 915	3 041 900	12.04	3 317 873	3 581 118
Salaries and wages	1 501 085	1 775 659	2 088 287	2 386 046	2 411 338	2 396 322	2 683 118	11.97	2 926 227	3 158 071
Social contributions	198 733	229 762	266 619	316 487	316 098	318 593	358 782	12.61	391 646	423 047
Goods and services	1 030 729	1 230 200	1 476 398	1 596 411	1 585 540	1 586 687	1 788 729	12.73	1 982 829	2 118 240
of which										
Administrative fees		2	12			16	22	37.50	22	22
Advertising	783	578	1 647	18 248	8 895	8 760	1 866	(78.70)	3 380	4 390
Assets <R5 000	12 580	9 716	14 265	18 571	22 104	20 071	16 288	(18.85)	17 553	19 084
Audit cost: External	561	565	692	563	563	563	603	7.10	622	684
Catering: Departmental activities	1 786	1 342	1 788	2 161	2 381	2 305	2 585	12.15	2 764	2 960
Communication	20 577	20 910	23 873	24 607	24 574	24 334	24 900	2.33	26 486	27 455
Computer services	4 513	4 263	6 088	4 535	5 711	5 685	4 352	(23.45)	4 609	4 771
Cons/prof: Business and advisory services	4 522	3 520	1 886	25 677	14 434	14 035	15 676	11.69	17 146	19 125
Cons/prof: Infrastructure & planning		6								
Cons/prof: Laboratory services	145 907	187 705	193 419	206 501	214 302	207 659	204 792	(1.38)	236 573	252 824
Cons/prof: Legal costs	2	11	9	13	13	4	1	(75.00)	1	1
Contractors	19 396	25 095	27 434	27 439	28 822	31 019	32 617	5.15	34 552	35 777
Agency and support/ outsourced services	109 097	137 533	150 998	129 715	121 597	154 297	171 328	11.04	182 051	188 497
Entertainment	36	30	65	84	81	78	63	(19.23)	66	67
Inventory: Food and food supplies	26 436	33 677	40 936	48 237	51 167	46 379	43 508	(6.19)	48 515	50 893
Inventory: Fuel, oil and gas	8 828	10 857	13 612	12 958	12 979	13 561	15 000	10.61	15 890	16 451
Inventory: Materials and supplies	4 898	3 304	4 302	5 772	5 784	4 231	4 451	5.20	4 725	4 901
Inventory: Medical supplies	118 544	147 614	186 505	186 748	209 515	233 746	288 221	23.31	323 662	346 355
Inventory: Medicine	366 367	456 576	570 482	634 648	604 028	540 773	666 415	23.23	745 141	808 241
Inventory: Other consumables	21 952	30 163	37 832	37 361	36 198	38 015	36 579	(3.78)	38 999	40 577
Inventory: Stationery and printing	18 968	17 931	25 249	25 438	26 842	28 274	31 834	12.59	34 359	36 843
Lease payments	9 157	5 225	8 304	6 894	18 330	20 039	25 904	29.27	27 451	28 432
Rental and hiring						107	13	(87.85)	13	13
Property payments	73 898	80 894	104 408	109 997	111 198	122 043	138 486	13.47	147 902	153 610
Transport provided: Departmental activity	862	782	701	1 056	1 106	702	917	30.63	1 009	1 085
Travel and subsistence	40 596	40 305	48 047	45 858	40 263	45 232	40 803	(9.79)	44 394	46 582
Training and development	8 439	7 514	7 956	13 605	15 868	14 737	13 644	(7.42)	15 864	17 335
Operating expenditure	9 869	3 033	3 934	4 172	4 169	6 094	5 337	(12.42)	5 735	6 009
Venues and facilities	2 155	1 049	1 954	5 553	4 616	3 928	2 524	(35.74)	3 345	5 256
Interest and rent on land	289	315	16							
Interest	289	315	16							
Transfers and subsidies to	323 408	404 255	471 233	572 767	575 778	576 487	605 547	5.04	647 809	692 503
Provinces and municipalities	165 186	228 424	263 107	315 436	322 763	321 941	340 354	5.72	365 261	385 922
Municipalities	165 186	228 424	263 107	315 436	322 763	321 941	340 354	5.72	365 261	385 922
Municipalities	165 186	228 424	263 107	315 436	322 763	321 941	340 354	5.72	365 261	385 922
Non-profit institutions	155 029	170 521	200 252	253 690	249 374	249 402	261 296	4.77	278 458	302 288
Households	3 193	5 310	7 874	3 641	3 641	5 144	3 897	(24.24)	4 090	4 293
Social benefits	3 193	5 310	7 814	3 482	3 641	5 144	3 897	(24.24)	4 090	4 293
Other transfers to households			60	159						
Payments for capital assets	85 069	81 570	60 377	54 883	60 558	59 154	61 919	4.67	66 599	71 811
Buildings and other fixed structures	48 754	40 314	6 482	6 140	6 645	6 645	7 675	15.50	7 916	8 707
Buildings	48 754	40 314	6 482	6 140	6 645	6 645	7 675	15.50	7 916	8 707
Machinery and equipment	36 307	41 037	53 895	48 369	53 539	52 135	54 244	4.05	58 683	63 104
Transport equipment	3 917	6 539	9 675	4 893	4 938	4 921	3 890	(20.95)	4 156	4 443
Other machinery and equipment	32 390	34 498	44 220	43 476	48 601	47 214	50 354	6.65	54 527	58 661
Software and other intangible assets	8	219		374	374	374		(100.00)		
Of which: "Capitalised Goods and services" included in Payments for capital assets	48 558	43 754	6 074	9 443	8 175	8 175	7 818	(4.37)	8 068	8 869
Payments for financial assets	487	769	4 450			1 504		(100.00)		
Total economic classification	3 139 800	3 722 530	4 367 380	4 926 594	4 949 312	4 938 747	5 498 095	11.33	6 015 110	6 463 672

8.1 PERFORMANCE AND EXPENDITURE TRENDS

Programme 2 is allocated 37.57 per cent of the vote in 2012/13 in comparison to the 36.77 per cent allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R559.348 million or 11.33 per cent.

Sub-programmes 2.1 – 2.5, Primary Health Care Services, is allocated 47.11 per cent of the Programme 2 allocation in 2012/13 in comparison to the 48.82 per cent that was allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R179.272 million or 7.44 per cent.

Sub-programme 2.6: HIV and Aids is allocated 13.42 per cent of the Programme 2 allocation in 2012/13 in comparison to the 13.38 per cent allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R77.466 million or 11.73 per cent.

Sub-programme 2.9: District hospitals are allocated 35.28 per cent of the Programme 2 allocation in 2012/13, in comparison to the 34.38 per cent allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of 14.23 per cent or R241.636 million.

R3 million of the National Health Insurance Grant is allocated to Programme 2 for school health.

The new Khayelitsha Hospital has been largely funded through reprioritization of existing services as well as the shift of services from existing facilities to the new hospital.

The Global Fund's Rolling Continuation Channel (RCC -1) funding will enable the Department to strengthen grant programme management; expand ART infrastructure and ART services, strengthen the PMTCT system; peer education and palliative care services from 1 July 2010 to 30 June 2013. The RCC -2 will follow directly after this initial period to cover the subsequent three year's grant programme funding.

Nutrition is located within the budget Sub-programme 2.7.

No dedicated budgets exist for MCWH at provincial level except for the new vaccines, pneumococcal and rotavirus. Funding for other MCWH activities are integrated within the district budgets.

From 2007/08 to 2009/10, the cataract surgery performance has been steady with only a 10 per cent increase over the four financial years. The Department will be undertaking a province-wide situational analysis to estimate future needs and resources required for expansion.

8.2 RISK MANAGEMENT

Risks facing the District Health Services division have previously been listed under each sub-programme. It has been decided to consolidate the divisional risks into a single table in order to make it easier to identify, and prioritise, the risks facing the Department as a whole. The consolidated table appears below:

Risks	Measures to mitigate impact
1. Funding for full commissioning of Khayelitsha and Mitchells Plain District Hospitals.	• The Department has prioritised the opening of these hospitals. One of the options being considered is the top-slicing of the shortfall from the total departmental budget for 2012/13.
2. Continued dual authority for PPHC services in the City of Cape Town Metro.	• Political decision and additional funding are being sought to provincialise the PPHC services in City of Cape Town Metro.
3. Drug stock outs in facilities.	• Improved management systems in the Cape Medical Depot and improved stock management systems at facility level.
4. Inconsistent supply and distribution of vaccines to the districts leading to low immunisation coverage (in some sub-districts).	• Review the service level agreement with BIOVAC as a service provider. • Monitor contract management with BIOVAC.
5. Non-compliance of NPOs with respect to achieving targets.	• Implement contract management principles to ensure that NPOs are compliant with Finance Instruction G54 of 2009.
6. Increased pressures on services arising from emerging and re-emerging infectious diseases.	• Implementation of robust surveillance systems and appropriate disease preparedness plans.
7. Emerging and imported disease outbreaks requiring strong partnerships with municipalities and other sectors.	• Establishment of Health Impact Assessment unit with a sub-directorate that has the capacity to play a central co-ordinating role in outbreaks. • Strengthen partnerships with key sectors to implement surveillance systems and outbreak preparedness plans.

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

1. PROGRAMME PURPOSE

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

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

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 3.1: EMERGENCY MEDICAL SERVICES

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

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

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

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

3. SITUATIONAL ANALYSIS

There have been no changes to the budget programme structure since the publication of the Strategic Plan 2010 – 2014.

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

3.1 EMERGENCY MEDICAL SERVICES: OPERATIONS

Emergency Medical Services Operations delivers ambulance, rescue and patient transport services from fifty two stations in five rural district EMS services and four Cape Town divisional EMS services with a fleet of 248 ambulances, 1 424 operational personnel and 98 supervisors (officers). Forty nine per cent (703) of the operational personnel are trained in Basic Life Support (BLS), forty three per cent (611) in Intermediate Life Support (ILS) and eight per cent (110) in Advanced Life Support (ALS).

The service performed 538 017 ambulance missions in 2011 transporting 479 079 patients with an urban priority 1 response performance of 68.9 per cent within 15 minutes and rural priority 1 response performance of 89.2 per cent within 40 minutes.

EMS patient transport or HealthNET performs outpatient department (OPD) transfers between levels of care within districts and across districts to regional and tertiary hospitals.

Approximately four thousand patients per month are transported to Cape Town hospitals from rural areas. HealthNET in Cape Town transports approximately 5 500 patients per month to surrounding rural areas and relieves the emergency service by transporting non-acute patients from clinics to hospitals in the city. HealthNET has installed a booking system progressively within health institutions and with the assistance of the Centre for e-Innovation (Ce-I) is developing a reporting tool to deliver accurate patient transport data.

HealthNET has seventy-eight patient transporters which are variously configured with either thirteen or twenty two seats, or two stretchers and two seats, or one stretcher and six seats or two wheel chairs and four seats, in order to ensure that any category of outpatient can be accommodated. HealthNET is staffed by ninety-five personnel at a minimum qualification level of Basic Ambulance Assistant and post level of Emergency Care Officer. HealthNET is used as an entry portal for personnel into the Ambulance Services.

3.2 EMERGENCY MEDICAL SERVICES: SUPPORT SERVICES

Emergency Medical Services Support Services includes:

- The Air Mercy Service (AMS) which provides for the transfer of acutely ill or injured patients to referral hospitals. This service performed 1 520 missions in 2011/12, transporting 1 405 patients to secondary and tertiary care facilities. The rotor wing programme transported 469 patients through the Cape Town operation and 315 patients via the Oudtshoorn operation. Seventy-eight rescue missions resulted in 83 patients being rescued from the wilderness areas or the sea with a combined flight time of 90.2 hours. This is the highest number of rescues performed in the Province in the history of EMS. December 2011 accounted for 23 per cent of these hours and coincides with the peak tourist season. The AMS travelled 316 006 kilometres by fixed-wing and flew 1 307 hours by helicopter. The service makes an essential contribution to maintaining rural response times, as not only does it ensure equitable access for critically ill patients to higher levels of care in specialist hospitals, but it frees up rural ambulances to remain in their area which is particularly important in small towns with only one ambulance.
- The Fleet Management Services which ensures the provision of an operational vehicle fleet in co-operation with Government Motor Transport (GMT) with whom EMS has an excellent working relationship. EMS achieved a vehicle availability of greater than 90 per cent of the total fleet per shift. EMS lost six vehicles to accidents in 2011 and has an aggressive approach to the prevention of accidents. Every accident involving an EMS vehicle is rigorously investigated and negligent staff is dismissed from the service. Speeding transgressions automatically result in disciplinary action.
- The Information Communication Technology (ICT) Services which provides contact centre access to public patients and the communication systems necessary to communicate with mobile and fixed EMS resources and deliver management information on service performance. The 2011/12 cycle presented a total of 674 576 calls to the Tygerberg ECC (Emergency Control Centre) which is down from the 742 040 calls presented in 2010. This, combined with a decrease in the abandonment rate, illustrates the measure of performance improvement and efficiency gains achieved in

the field of Emergency Communications. This was achieved with an average handling time of only 112 seconds, which is well within the 120 second target.

Dispatch times have also improved considerably with the Tygerberg centre achieving above 80 per cent of its priority 1 incidents dispatched within five minutes with an average dispatch time of four minutes. These improvements account in significant measure for the 68.9 per cent priority1 response performance in less than 15 minutes achieved in the year.

- The Special Event Services which provides medical cover to many community events every year, most notably the Argus Cycle Tour and the Two Oceans Marathon.
- The Facility Management Services which co-ordinate the delivery and maintenance of EMS building infrastructure throughout the Province. Of the 52 EMS facilities, 65 per cent are purpose built and steady progress is being made in providing eighteen new stations. In addition, EMS has identified a further eight towns as key sites for the establishment of local EMS stations (Albertinia, Botrivier, Great Brak, Kleinmond, Saldanha, Sedgefield, Velddrif and Wellington) to provide improved access to rural communities within response time targets.

3.3 EMERGENCY MEDICINE

Emergency medicine provides for the clinical governance and co-ordination of emergency medicine within emergency centres and EMS across the Province. Emergency medicine also supports the under-graduate and post-graduate training in emergency medicine at the Universities of Cape Town and Stellenbosch and provides initial and continuous emergency care training for EMS personnel.

The emergency medicine division of EMS has the principle functions of education and training of under-graduates and post-graduates in emergency medicine; the co-ordination of emergency medicine through the development of emergency centre patients records; consulting on design and commissioning of emergency centres; emergency care pathways, emergency triage systems and disaster medicine including mass event medical planning and services (e.g. Hospital Disaster Planning and Argus Cycle Tour).

Emergency medicine provides a quality management structure for EMS which monitors patient incidents, investigates adverse patient events and makes recommendations to improve the quality of care and the patient experience through changes to clinical and operational procedures.

Table 3.1: Data elements for situation analysis indicators in Tables 3.2

Source	Data element	Element ID	Province wide value 2010/11	Cape Town District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11
Efficiency report	Rostered ambulances: Calculation Total ambulance personnel hours worked for the reporting period / 2 X 24 hours per day for the reporting period	1	132	67	16	7	18	13	11
Information Management	Total population	2	5 634 323	3 724 347	754 426	60 407	551 937	233 292	309 914
Efficiency report	Patients transported by ambulance	3	446 566	304 787	45 976	11 763	48 437	19 628	15 975
Efficiency report	Priority 1 ambulance responses under 15 minutes- urban	4	59 276	39 728	5 281	1 267	5 492	4 528	2 980
Efficiency report	Priority 1 ambulance responses - urban	5	112 773	85 018	8 671	1 357	7 312	6 291	4 124
Efficiency report	Priority 1 ambulance responses under 40 minutes- rural	6	8 646	14	2 013	452	3 103	1 823	1 241
Efficiency report	Priority 1 ambulance responses - rural	7	10 218	34	2 497	472	3 690	2 261	1 264
Efficiency report	All ambulance responses under 60 minutes	8	367 948	203 412	46 124	15 357	52 762	25 752	24 541
Efficiency report	Total ambulance responses	9	519 228	323 812	58 893	15 997	60 993	29 543	29 990
Efficiency report	Hospital patients transferred to a higher level of care	10	132 345	61 093	21 448	5 148	23 001	11 442	10 213
SINJANI	Emergency headcount at district and regional hospitals	11	619 090	374 665	92 490	15 488	89 448	24 359	22 640

Notes:

It is not a mandatory requirement to include the above table. However, the purpose is to provide an easy reference to raw data from which values for indicators are determined and to facilitate the audit trail.

The purpose of the column 'Element ID' is purely to facilitate cross referencing between the tables.

Strategic objective performance indicators are highlighted in yellow.

Provincially determined performance indicators are highlighted.

Table 3.2: Situation analysis indicators for EMS and patient transport [EMS1]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Province wide value 2010/11	Cape Town Metro District 2010/11	Cape Winelands District 2010/11	Central Karoo District 2010/11	Eden District 2010/11	Overberg District 2010/11	West Coast District 2010/11	National Average 2009/10
1. Address the burden of disease.	1.1. Fully implement the 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 157 rostered ambulances per hour in the CSP by 2014/15.	1) Rostered ambulances per 10 000 people	No	0.23	0.18	0.21	1.16	0.33	0.56	0.35	
			Numerator ID 1		132	67	16	7	18	13	11	1 564
			Denominator ID 2 / 10 000		563	372	75	6	55	23	31	
			2) Total number of EMS emergency cases		446 566	304 787	45 976	11 763	48 437	19 628	15 975	
			Element ID 3									
	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 70% for P1 urban and 89.2% 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) P1 calls with a response of time <15 minutes in an urban area	%	52.6%	46.7%	60.9%	93.4%	75.1%	72.0%	72.3%	50.4%
			Numerator ID 4		59 276	39 728	5 281	1 267	5 492	4 528	2 980	
			Denominator ID 5		112 773	85 018	8 671	1 357	7 312	6 291	4 124	
			4) P1 calls with a response time of <40 minutes in a rural area	%	84.6%	41.2%	80.6%	95.8%	84.1%	80.6%	98.2%	55.1%
			Numerator ID 6		8 646	14	2 013	452	3 103	1 823	1 241	
			Denominator ID 7		10 218	34	2 497	472	3 690	2 261	1 264	
			5) All calls with a response time within 60 minutes	%	70.9%	62.8%	78.3%	96.0%	86.5%	87.2%	81.8%	67.7%
			Numerator ID 8		367 948	203 412	46 124	15 357	52 762	25 752	24 541	
			Denominator ID 9		519 228	323 812	58 893	15 997	60 993	29 543	29 990	
	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.	6) Percentage of ambulance patients transferred between facilities	%	21.4%	16.3%	23.2%	33.2%	25.7%	47.0%	45.1%	
			Numerator ID 10		132 345	61 093	21 448	5 148	23 001	11 442	10 213	
			Denominator ID 11		619 090	374 665	92 490	15 488	89 448	24 359	22 640	

4. CHALLENGES

The challenges in EMS include the following:

4.1 COMMUNICATIONS

1) The absence of a national 112 emergency number system.
2) Inadequate technology to process emergency call demand for over 500 000 responses per annum.
3) Insufficient human resources quantitatively and qualitatively to process the call demand.
4) No professional remuneration structures for contact centre supervisory personnel.

4.2 HUMAN RESOURCES

1) A poorly constructed occupational specific dispensation (OSD) for EMS with inadequate remuneration structures and which has failed in the stated objective of retaining and recruiting competent EMS professionals. EMS has lost more than fifty advanced life support paramedics since implementing the OSD.
2) Poor development structures for supervisory and management cadres.
3) Significant vacancies in supervisory and operational posts with thirty-two per cent of operational posts and sixty-five per cent of supervisory posts vacant against the 2010 establishment.
4) Training rural EMS personnel within the constraints of the Health Professions Council of South Africa rules which prevent students from living and learning in rural areas resulting in social disruption for those students.
5) Recruiting highly technical ICT personnel at current public service remuneration grades.

4.3 OPERATIONAL PERFORMANCE

1) Achieving urban response time targets.
2) The high demand for outpatient access to central hospitals.
3) Increasing demand for EMS services.
4) Medical rescue of patients in entrapments by virtue of their environment within prescribed response times.

5. PRIORITIES

5.1 COMMUNICATIONS

- Establish appropriate information communication technology and systems to facilitate rational dispatch and achievement of response time targets.
- Entrench geographic information systems within the EMS ICT suite in order to inform provincial strategic objectives with respect to trauma, violence and injury.

5.2 OPERATIONAL PERFORMANCE

- Improve quality of care and the patients' experience of the service.
- Improve co-ordination between health facilities and EMS within geographic service areas and districts.
- Operational modelling to achieve response time efficiencies including expanding HealthNET to relieve outpatient load on acute services.
- Maintain personal wellness in the emotionally and physically challenging environment of EMS.
- Maintain performance within existing resource constraints.

5.3 HUMAN RESOURCES

- Overcome the human resource challenges in EMS with specific reference to management, advanced life support and communications personnel.
- Inculcate organisational values within each EMS unit.
- Develop and train personnel from local rural communities to serve those communities.

6. STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR EMS

Table 3.3: Data elements and related actual and projected performance values for Tables 3.4 – 3.5

Source	Data element	Element ID	Audited /Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Efficiency report	Rostered ambulances: Calculation- Total ambulance personnel hours worked for the reporting period (365 x 2 X 24) hours per day for the reporting period	1	230	251	132	141	150	153	157
Information Management	Total population	2	5 391 765	5 513 039	5 634 323	5 755 607	5 876 887	5 998 164	6 119 435
Efficiency report	Patients transported by ambulance	3	404 134	461 940	446 566	479 079	487 781	497 847	507 913
Efficiency report	Priority 1 ambulance responses under 15 minutes- urban	4	35 908	39 320	59 276	73 421	76 049	77 571	79 121
Efficiency report	Priority 1 ambulance responses - urban	5	82 410	95 231	112 773	106 512	108 642	110 815	113 031
Efficiency report	Priority 1 ambulance responses under 40 minutes- rural	6	7 607	7 050	8 646	12 740	12 994	13 254	13 519
Efficiency report	Priority 1 ambulance responses - rural	7	10 090	8 907	10 218	14 280	14 566	14 857	15 154
Efficiency report	All ambulance responses under 60 minutes	8	296 483	325 121	367 948	402732	410787	419002	427382
Efficiency report	Total ambulance responses	9	373 940	414 154	519 228	538 017	548 777	559 753	570 948
Efficiency report	Hospital patients transferred to a higher level of care	10	80 586	127 033	132 345	131 156	133 779	136 454	139 183
Information Management	Emergency headcount at district and regional hospitals	11	620 995	630 995	619 090	628 376	637 173	645 457	653 202

Notes to Tables 3.3, 3.4 and 3.5:

Element ID 1: 2007/08 to 2009/10: The number of ambulances in the fleet was used for this indicator.

From 2010/11 onwards, the number of rostered ambulances is used i.e. the average number of ambulances available per hour as calculated from the available working hours of ambulance personnel.

Rostered ambulances = hours by ambulance personnel worked for the period/days in the period x hours in a day x two personnel (hours accumulated by one ambulance unit with two personnel). Hours worked takes into account absenteeism due to leave, sick leave, training etc.

Rostered ambulances of 2012/13: This number includes the volunteer hours that were previously excluded from hours worked by ambulance personnel.

Element ID 8: This target has been reset as a result of the strategic decision of EMS to improve the performance of priority 1 calls, at the expense of priority 2 performance.

Targets in the outer years are derived by projecting an 8.3% increase per annum, relative to the population.

Strategic objective performance indicators are highlighted in yellow in Tables 3.4 and 3.5

Provincially determined performance indicators are highlighted in Tables 3.4 and 3.5.

Table 3.4: Performance indicators for EMS and patient transport [EMS3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Address the burden of disease.	1.1. Fully implement the 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 157 rostered ambulances per hour in the CSP by 2014/15.	1) Rostered ambulances per 10 000 people	No	0.26	0.43	0.46	0.23	0.24	0.26	0.26	0.26	1
			Numerator ID 1		157	230	251	132	141	150	153	157	
			Denominator ID 2 / 10 000		612	539	551	563	576	588	600	612	
			2) Total number of EMS emergency cases	No		404 134	461 940	446 566	479 079	487 781	497 847	507 913	
			Element ID 3										
	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 70% for P1 urban and 89.2% 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) P1 calls with a response time of <15 minutes in an urban area	%	70.0%	43.6%	41.3%	52.6%	68.9%	70.0%	70.0%	70.0%	80%
			Numerator ID 4		79 121	35 908	39 320	59 276	73 421	76 049	77 571	79 121	
			Denominator ID 5		113 031	82 410	95 231	112 773	106 512	108 642	110 815	113 031	
			4) P1 calls with a response time of <40 minutes in a rural area	%	89.2%	75.4%	79.2%	84.6%	89.2%	89.2%	89.2%	89.2%	80%
			Numerator ID 6		13 519	7 607	7 050	8 646	12 740	12 994	13 254	13 519	
			Denominator ID 7		15 154	10 090	8 907	10 218	14 280	14 566	14 857	15 154	
			5) All calls with a response time within 60 minutes	%		79.3%	78.5%	70.9%	74.9%	74.9%	74.9%	74.9%	100%
			Numerator ID 8			296 483	325 121	367 948	402732	410787	419002	427382	
			Denominator ID 9			373 940	414 154	519 228	538017	548777	559 753	570 948	
	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.	6) Percentage of ambulance patients transferred between facilities	%	21.3%	13.0%	20.1%	21.4%	20.9%	21.0%	21.1%	21.3%	
			Numerator ID 10		139 183	80 586	127 033	132 345	131 156	133 779	136 454	139 183	
			Denominator ID 11		653 202	620 995	630 995	619 090	628 376	637 173	645 457	653 202	

Table 3.5: Quarterly targets for EMS and patient transport for 2010/11 [EMS4]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
1. Address the burden of disease.	1.1 Fully implement the 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 157 rostered ambulances per hour in the CSP by 2014/15.	1) Rostered ambulances per 10 000 people	Quarterly	0.26	0.26	0.26	0.26	0.26
			Numerator ID 1		150	150	150	150	150
			Denominator ID 2 / 10 000		588	588	588	588	588
			2) Total number of EMS emergency cases	Quarterly	487 781	121 945	121 945	121 945	121 946
			Element ID 3						
	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 70.0% for P1 urban and 89.2% 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) P1 calls with a response time of <15 minutes in an urban area	Quarterly	70.0%	70.0%	70.0%	70.0%	70.0%
			Numerator ID 4		76 049	19 012	19 012	19 012	19 013
			Denominator ID 5		108 642	27 161	27 161	27 161	27 159
			4) P1 calls with a response time of <40 minutes in a rural area	Quarterly	89%	89%	89%	89%	89%
			Numerator ID 6		12 994	3 249	3 249	3 249	3 247
			Denominator ID 7		14 566	3 641	3 641	3 641	3 643
			5) All calls with a response time within 60 minutes	Quarterly	63%	63%	63%	63%	63%
			Numerator ID 8		348 119	87 030	87 030	87 030	87 029
			Denominator ID 9		548 777	137 194	137 194	137 194	137 195
	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.	6) Percentage of ambulance patients transferred between facilities	Quarterly	21%	21%	21%	21%	21%
			Numerator ID 10		133 779	33 445	33 445	33 445	33 444
			Denominator ID 11		637 173	159 293	159 293	159 293	159 294

7. RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND THE MTEF

Table 3.6: Summary of payments and estimates: - Programme 3: Emergency Medical Services [EMS5]

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
1. Emergency Transport [a]	378 469	492 887	551 619	566 520	572 469	578 132	639 840	10.67	684 261	725 405
2. Planned Patient Transport	24 649	37 243	44 491	49 527	49 947	49 763	61 552	23.69	65 496	68 512
Total payments and estimates	403 118	530 130	596 110	616 047	622 416	627 895	701 392	11.71	749 757	793 917

[a] 2012/13: National Conditional grant: Health professions training and development: R2 454 000 (Compensation of employees R1 818 000; Goods and services R636 000).

Table 3.7: Payments and estimates by economic classification – Programme 3: Emergency Medical Services

Economic classification R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
Current payments	371 842	470 719	545 823	565 754	572 123	576 805	649 796	12.65	695 283	736 402
Compensation of employees	259 484	315 071	369 212	378 835	394 204	403 059	443 661	10.07	476 936	510 323
Salaries and wages	223 654	271 863	319 241	325 923	341 192	346 764	380 090	9.61	408 595	437 198
Social contributions	35 830	43 208	49 971	52 912	53 012	56 295	63 571	12.92	68 341	73 125
Goods and services	112 329	155 626	176 611	186 919	177 919	173 746	206 135	18.64	218 347	226 079
of which										
Advertising				1	1					
Assets <R5 000	2 446	3 533	3 613	3 063	3 063	3 013	3 280	8.86	3 475	3 598
Catering: Departmental activities	112	213	316	111	111	237	74	(68.78)	77	78
Communication	4 312	8 910	10 175	10 889	10 889	11 253	10 702	(4.90)	11 335	11 738
Computer services	415	268	217	230	230	176	78	(55.68)	83	86
Cons/prof: Business and advisory services	329	909	639	114	114	44	39	(11.36)	41	42
Cons/prof: Legal costs		1		2	2					
Contractors	1 029	2 126	7 397	8 808	8 808	9 130	9 234	1.14	9 779	10 126
Agency and support/ outsourced services	174	566	277	253	253	287	225	(21.60)	238	247
Entertainment	1	1	2	14	14	7	4	(42.86)	4	4
Inventory: Food and food supplies	1									
Inventory: Fuel, oil and gas	2 161	3 995	5 843	4 087	4 087	5 946	5 929	(0.29)	6 280	6 501
Inventory: Materials and supplies	434	773	1 304	1 196	1 196	1 649	1 698	2.97	1 799	1 862
Inventory: Medical supplies	4 473	8 982	7 249	9 865	9 865	4 177	3 486	(16.54)	3 692	3 823
Inventory: Medicine	194	323	342	300	300	406	458	12.81	486	502
Inventory: Other consumables	329	5 836	5 431	6 423	6 423	6 363	9 717	52.71	10 295	10 656
Inventory: Stationery and printing	1 389	2 098	1 566	2 906	2 906	1 871	1 221	(34.74)	1 293	1 339
Lease payments	8 254	483	456	1 500	29 600	30 261	54 532	80.21	57 764	59 810
Property payments	2 353	2 542	3 558	4 760	4 760	3 622	3 130	(13.58)	3 313	3 430
Travel and subsistence	81 775	112 903	127 303	131 339	94 239	94 191	101 813	8.09	107 848	111 674
Training and development		819	586	768	768	733	253	(65.48)	268	277
Operating expenditure	1 779	335	302	281	281	296	173	(41.55)	183	189
Venues and facilities	369	10	35	9	9	84	89	5.95	94	97
Interest and rent on land	29	22								
Interest	29	22								
Transfers and subsidies to	20 972	29 264	37 446	39 355	35 355	35 355	36 761	3.98	38 600	40 530
Non-profit institutions	20 906	29 172	37 058	39 281	35 281	35 281	36 692	4.00	38 527	40 453
Households	66	92	388	74	74	74	69	(6.76)	73	77
Social benefits	66	92	388	74	74	74	69	(6.76)	73	77
Payments for capital assets	9 486	27 950	12 050	10 938	14 938	14 835	14 835		15 874	16 985
Machinery and equipment	9 479	27 780	12 050	10 938	14 938	14 835	14 835		15 874	16 985
Transport equipment	2 697	10 264	1 940	2 077	7 227	7 227	7 227		7 733	8 274
Other machinery and equipment	6 782	17 516	10 110	8 861	7 711	7 608	7 608		8 141	8 711
Software and other intangible assets	7	170								
Of which: "Capitalised Goods and services" included in Payments for capital assets		3 446		103	103	78		(100.00)		
Payments for financial assets	818	2 197	791			900		(100.00)		
Total economic classification	403 118	530 130	596 110	616 047	622 416	627 895	701 392	11.71	749 757	793 917

8. PERFORMANCE AND EXPENDITURE TRENDS

8.1 Programme 3 is allocated 4.79 per cent of the vote in 2012/13 in comparison to the 4.68 per cent allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R73.497 million or 11.71 per cent.

8.2 Significant alterations to the dispatch model in the City of Cape Town, appointment of additional staff and the application of overtime expenditure have resulted in an urban priority 1 response time within 15 minutes improvement to 68.9 per cent. Rural priority 1 response times within 40 minutes are consistently above 89 per cent.

8.3 Evidence in emergency medicine is clear that the shortest time to definitive care in emergent patient conditions improves patient care quality, patient experience and outcome.

8.4 The focus on improving response times is in the City of Cape Town and the next focus will be on priority 2 responses within 30 minutes. Additional human resources and fleet will be required to further improve the response times because the mission time for ambulances remains constant for priority 1 or 2 responses. Mission times have improved (decreased by 30 minutes in the City of Cape Town) which illustrate the improved efficiency that has been achieved by operational remodeling (dispatch areas linked to hospitals).

8.5 EMS currently has a 32 per cent vacancy rate against the establishment for operational personnel and a 65 per cent vacancy rate for supervisory personnel against the establishment (2011). Performance and expenditure on personnel are directly related.

8.6 The estimated expenditure necessary in respect of ICT and computer-aided dispatch is fifty million rand per annum. EMS cannot manage over 500 000 responses effectively across the geographic distribution of the Province without sophisticated technology. The information management value adds from geospatial location of incident, illness or injury will enhance the Province's strategic objectives for increasing access to safe and efficient transport (SO3), increasing wellness (SO4) and increasing safety (SO5). The recruitment of appropriate ICT personnel within current remuneration structures is a challenge. The technical demands of modern call-taking and dispatch systems require skilled ICT personnel for which the Department competes in the open market. An amount of R15 million is allocated for this purpose in 2012/13.

8.7 The increase in responses and patients transported illustrates the rising demand for EMS as populations in both rural district towns and Cape Town increases. The obvious visible growth in informal housing establishments in all rural towns (housing dependent indigent people) places increasing demands on both emergency and outpatient transport. The recent 600 new applicants for entrance to schools in Grabouw (2012) illustrates the accelerated urbanisation/migration to towns which places increasing pressure on EMS because it provides a key access to health services particularly after hours.

8.8 The locus of control of access to HealthNET (non-emergency transport) lies within the district health system and the central and regional hospitals. Focused engagement within geographic services areas should begin to rationalise OPD transport and ensure that all visits are appropriate. The number of outpatients transported in 2011 increased despite efforts by the hospital services to rationalise outpatient attendance at regional and central hospitals.

8.9 Outpatients are inconvenienced by long distance transfers and, in a client centered environment, every effort must be made to provide services as close to the place of residence as possible, ensuring that for reasons of equity, access to specialised services reaches a greater number of new patients while stable patients are followed up in the DHS. Transport will then be available to more local intra-district clients and transport will be affordable within the current budget envelopes.

8.10 EMS provides good, competent medical rescue services in the Western Cape. The Wilderness Search and Rescue System (WSAR) is unique in the country. The rescue system is built around the existing EMS services and is therefore a very efficient service that consumes little of the resources invested in EMS. Response time performance of the rescue services is sub-optimal and requires resource inputs of both vehicles and personnel. Strategic partnerships with other services sharing this platform could partially resolve these challenges. A further challenge is establishing tertiary training for rescue technicians in line with current South African Qualifications Authority (SAQA) regimes as universities are not funded to initiate new programmes.

8.11 EMS has taken the decision to procure less expensive ambulances in order to reduce fleet costs and maximise cost benefit. Both capital and operational expenditure are reduced through the deployment of smaller ambulances. The consequences of smaller ambulances on personnel morale will need to be managed.

8.12 EMS will issue a new bid for aero-medical services in an attempt to drive down both fixed and operational costs of this essential service.

9. RISK MANAGEMENT

Risk	Mitigating factors
1. Failure of the information communication technology and computer aided dispatch (CAD) in EMS.	1.1. Discussion and negotiation with cellular providers to provide latitude and longitude data. 1.2. Navigation must not be dependent on social infrastructure (roads, signs and numbers). 1.3. New CAD ICT solution and operational remodelling. 1.4. Creating redundant data connectivity through TETRA Trunk Radio Network 1.5. Strategic proposal to the Provincial Government to support a Provincial TETRA Trunk Radio network in co-operation with all provincial departments.
2. Poor emergency care quality.	2.1. Good competency development in foundation training. 2.2. Continuous personnel development programme. 2.3. Quality management structure and process with close co-operation by emergency medicine specialists.
3. Increase in service demand.	3.1. Greater emphasis on injury and illness prevention. 3.2. Co-operation with the private sector. 3.3. Improved information communication technology.

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

1. PROGRAMME PURPOSE

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

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 4.1: GENERAL (REGIONAL) HOSPITALS

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

2.2 SUB-PROGRAMME 4.2: TUBERCULOSIS HOSPITALS

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

2.3 SUB-PROGRAMME 4.3: PSYCHIATRIC HOSPITALS

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

2.4 SUB-PROGRAMME 4.4: REHABILITATION SERVICES

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

2.5 SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

Rendering an affordable and comprehensive oral health service and providing a platform for training and research.

3. STRATEGIC DIRECTION AND OBJECTIVES FOR THE PROGRAMME:

This programme responds to the many challenges facing the health sector by maintaining a high quality, efficient and equitable health system that is accessible to the population of the Western Cape, addressing the burden of disease, injury, disability and death.

A key strategic direction for the programme is to expand the general specialist service platform across the Western Cape. This involves not only the general specialist (regional) hospitals, but also involves providing support to the district health service platform. Strengthening of the general specialist hospitals will continue with an added focus on strengthening the geographic service areas and district specialist support teams, in line with the national directive to strengthen the workforce at the coalface of service delivery.

District specialist teams (anaesthetics, obstetrics and gynaecology, and paediatrics) will be appointed at New Somerset Hospital to support the Metro West District Health Services, at Tygerberg Hospital to support the Metro East District Health Services, and at the three rural

regional hospitals in Paarl, Worcester and George to provide support for the respective geographic service areas. In order to address the burden of disease the services in this programme require a workforce that consists of skilled health care workers who have the flexibility to respond to changing health needs.

Continued emphasis will be placed on managing the acute psychiatric burden of disease particularly in the Metro where the explosion of the Tik epidemic and other forms of drug abuse continue to place a heavy burden on the institutions.

Rehabilitation services will deliver an inter-disciplinary outcome-based service in line with the Rehabilitation and Disability Management Service Plan.

Quality of care remains an integral part of service delivery. The application of core standards ensures consistency across the health platform. The priority areas of quality patient care include safety, cleanliness, infection control, staff attitudes, waiting times and drug supply.

Continued strong emphasis will be placed on sound governance and fiscal discipline. The full implementation of functional business units at all regional hospitals, psychiatric hospitals and the Western Cape Rehabilitation Centre remains a priority. This will equip managers to manage within the allocated budget. Efforts have been intensified to improve procurement processes and minimise audit risks.

The reprioritisation of expenditure within Programme 4 continues to be a priority. The expenditure on agency staff has been significantly reduced for the 2011/12 financial year in line with this strategy.

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

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 the required health services.
5) Develop and maintain appropriate health technology, infrastructure and information communication technology (ICT).
6) Optimal financial management to maximise health outcomes.

4. SUB-PROGRAMME 4.1: GENERAL SPECIALIST (REGIONAL) HOSPITALS

4.1 SITUATIONAL ANALYSIS

Sub-programme 4.1 funds general specialist (regional) hospital services in New Somerset and Mowbray Maternity Hospitals in the Cape Town Metro District and Paarl, Worcester and George Hospitals in the rural districts. The reconfiguration and strengthening of these hospitals, particularly in the rural districts, will continue as they focus on the provision of general specialist services with continued outreach and support to district hospitals. In the five geographic service areas (GSAs); i.e. Metro West, Metro East, West Coast, Winelands/ Overberg and Eden/Central Karoo; structures have been created to enable better service co-ordination and communication between institutions and across levels of care.

Between 1 April 2008 and 31 March 2011 the level 2 beds in the central hospitals were funded from Sub-programme 4.1. However, this differentiation of services within the central hospitals proved difficult to implement and monitor and therefore the funding of the level 2 beds in the central hospitals reverted to Programme 5 from the 2011/12 financial year. All central hospital services and related expenditure are therefore reported in Sub-programme 5.1. Cognisance must be taken of these shifts when the data trends are analysed.

The major objectives in this sub-programme include the reconfiguration of services within these hospitals and the expansion and strengthening of rural regional hospitals. Service reconfiguration per discipline continues to enhance optimal health care provision and improve efficiencies.

A pilot project has been launched in four regional hospitals to assess the feasibility of using diagnostic related groups (DRG) as a management tool to understand case mix and improve efficiency It is envisaged that the findings will enhance the effective and efficient treatment of patients.

The appointed emergency medicine specialists will ensure that the emergency centres in the regional hospitals function at an optimal level, improving the overall patient experience as well as the clinical outcomes.

The expenditure on agency staff has been dramatically reduced within this programme as a whole, and full time employees have been appointed in key clinical, nursing and administrative posts, reflecting a more accurate salary bill and stabilising the workforce through permanent appointments. In order to improve the health outcomes, the programme will continue to address the need for adequate staff numbers and correct the mix of highly skilled staff.

4.2 CHALLENGES

The challenges identified below will be addressed through increased management capacity, the timeous filling of posts, capacity building, mentoring and succession training:

- Managing the acute caseload in general specialist hospitals.
- Appropriate devolution of outpatient activities to primary health care.
- Improving infectious disease management.

4.3 PRIORITIES FOR 2012/13

The priorities in this sub-programme for 2012/13 will be addressed in an integrated approach to service delivery across the health platform in line with the vision and principles of the 2020 strategy as well as, contributing towards the Millennium Development Goals, National Service Delivery Agreement outcomes and the key priorities identified by the Department.

One of the sub-programme's key priorities for 2012/13 is to improve systems and appoint appropriate staff in order to strengthen the emergency centres.

Safety and security risks will be monitored.

Organisational design recommendations will be implemented in a phased manner in line with affordable budgets.

In addition, the implementation of the functional business units will facilitate greater devolution of decision-making to the senior clinicians within each of the major disciplines, which, it is anticipated, will maximise efficiencies and improve service delivery.

4.3.1 Address the burden of disease

1) Continue the strengthening of general specialist services within regional hospitals.
2) Ensure equity of access to services by implementing the geographical service area model and ensure co-operation of all service levels within a geographical area.
3) Improve access to ambulatory services for new patients and identify outpatients for devolution to primary care for follow up.
4) District specialist teams (anaesthetics, obstetrics and gynaecology, and paediatrics) will be appointed at New Somerset Hospital to support Metro West District Health Services; at Tygerberg Hospital to support the Metro East District Health Services as well as the three rural regional hospitals to provide support for the respective geographic service areas.
5) Improve maternal, child and women's health by:
   - The provision of specialist gynaecology outreach services.
   - Providing a specific training programme for interns, midwives and medical officers in improving obstetric skills using the national Essential Steps in the Management of Obstetric Emergencies (ESMOE) package and training material.
6) Continue to improve responsiveness to the diarrhoeal season, with Somerset Hospital providing additional support to the service platform in the Metro.
7) Further commissioning of the level 1 beds at Paarl Hospital. The commissioning of sixteen adult level 1 beds at Paarl Hospital will be an important leverage providing crucial relief to the current service pressures on emergency care, medicine and psychiatry.
8) Improve infectious disease management by strengthening TB control measures, which are aimed at the prevention of intra-hospital spread of TB, in general hospitals. The focus will remain on the management of the occupational health risks posed to staff and other patients by patients with TB.

4.3.2 Improve the quality of health services and the patient experience

1) Improve service delivery in all hospitals with a special focus on the findings of the annual patient satisfaction surveys.

2) Immediate focus areas will be to improve staff attitudes, reduce waiting times, ensure clean facilities, protect the safety of staff and patients, avoid transmission of infections and cross-infection, and ensure that medicines and supplies are available.

3) Improve the quality of services by monthly morbidity and mortality reviews and acting appropriately on recommendations and findings.

4) Investigate and address adverse incidents and patient complaints.

5) Assess adherence to the identified priorities extracted from the national core standards, which will be used as the basis for strengthening quality of health services. A standardised assessment process is being progressively rolled out to identify and address critical gaps within regional hospitals. Quality improvement plans will be developed to address the shortfalls identified through the baseline audits.

4.3.3 Ensure and maintain organisational strategic management capacity and synergy

1) Implement interventions that are designed to improve management competency at hospital level and which will facilitate improved management and functioning of the health system.

2) Ensure a unified approach towards service delivery within geographical services areas, strengthening clinical governance and leadership in pursuit of common departmental goals.

3) Functional business units to be operational, ensuring the stabilisation of a reliable cost accounting system, assisting clinical managers in accepting responsibility for their budgets and aiming for fair resource allocations.

4) Assess skills and competencies of staff and ensure appropriate training at all levels.

5) Ensure audit compliance within the accountability framework by enhancing financial management.

6) Each hospital will develop an annual operational plan (AOP) that will reflect the specific objectives of the hospital that are aligned with the strategic direction of the Department. Each hospital's AOP translates the Department's priorities into tangible and measurable activities and includes:
   - Outlining the deliverables and required resources for the forthcoming year.
   - Outlining the performance measures and actions to mitigate risks.
   - Clearly communicating the accountability and performance expectations.

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

The Department will undertake the following initiatives to become the employer of choice in the health sector, by creating an environment for a satisfied workforce:

1) Progressive implementation of the organisational design recommendations in line with the service priorities and affordable budget envelope.

2) Recruit and retain staff within key clinical and administrative posts.

3) Implement an integrated career development framework comprising remuneration, career progression and performance management.

4) Staff development and training of mid-level workers.

5) Respond appropriately to the findings of staff satisfaction surveys.

4.3.5 Develop and maintain appropriate health technology, infrastructure and Information Communication Technology

1) Implement preventative maintenance and infrastructure development plans of buildings and equipment in collaboration with the Directorate: Engineering.
2) Conclude revitalisation projects within the rural regional hospitals.
3) Complete the implementation of the Picture Archive Communication System and Radiological Imaging Systems (PACS/RIS) and appoint appropriate staff to support the systems.
4) Strengthen the information management cadre within all hospitals and ensure compliant, auditable information management systems and processes within hospitals.

4.3.6 Optimal financial management to maximise health outcomes

Ensure the sustainable generation of financial resources to fund the provision of health services:

1) Allocate equitable budgets that are aligned with the expected outcomes and deliver an optimal service at an appropriate cost per patient day equivalent.
2) Improve the systems for procuring medicines to ensure a reliable and uninterrupted supply of medication.
3) Focus on revenue projects to achieve the revenue targets and providing opportunities for hospitals to increase expenditure votes.

4.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR GENERAL (REGIONAL) HOSPITALS

Table 4.1: Data elements of performance indicators for General (Regional) Hospitals

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	Usable beds in regional hospitals	1	2 490	2 364	2 385	1 359	1 375	1 375	1 375
SINJANI	Separations	2	196 668	185 919	174 307	108 257	110 778	111 886	113 005
SINJANI	PDE	3	1 122 369	1 051 150	1 022 675	557 653	565 286	570 938	576 648
SINJANI	OPD headcount (general and specialist) + Emergencies	4	718 131	628 931	580 840	397 813	407 959	412 038	416 158
SINJANI	Emergency headcount	4.1	302 187	296 299	283 091	156 676	160 867	162 475	164 100
SINJANI	OPD headcount	4.2	718 131	628 931	580 840	241 137	247 092	249 563	252 058
SINJANI	Caesarean sections in regional hospitals	5	8 211	8 425	9 339	10 268	10 371	10 474	10 579
SINJANI	Deliveries in regional hospitals	6	25 040	25 961	25 689	26 424	26 688	26 955	27 225
BAS	Total expenditure in regional hospitals (in 2010/11 rands)	7	2 074 481 703	1 947 490 654	2 005 781 043	1 046 886 483	1 041 461 954	1 045 349 565	1 042 082 088
SINJANI	Patient days	8	782 263	742 740	734 698	425 049	429 299	433 592	437 928
SINJANI	Total usable beds days	9	908 850	862 860	870 525	496 035	501 875	501 875	501 875
SINJANI	Regional hospitals with M & M meetings every month	10	9	5	8	5	5	5	5
Facility list	Regional hospitals	11	9	5	8	5	5	5	5
SINJANI	Complaints resolved within 25 days	12	-	552	484	250	253	255	258
SINJANI	Complaints lodged	13	-	669	583	300	300	300	300
DHIS	Number of questionnaires with 1 or 2 recorded for pleased with treatment	14	Not required to report	Not required to report	2 484	2 625	2 800	2 800	3 000
DHIS	Number of questionnaires for pleased with treatment	15	Not required to report	Not required to report	3 324	3 324	3 500	3 500	3 500
NDoH assessment tool	Regional hospitals assessed against the core standards	16	Not required to report	Not required to report	Not required to report	5	5	5	5

Note:

General: The level 2 services in the central hospitals were reflected in sub-programme 4.1 for the 2008/09 to 2010/11 financial years and are reflected in Programme 5 as from 1 April 2011.

Element ID12 and 13: A new electronic information system was implemented during 2011/12. The electronic data is much lower than the data reported on the manual system. It is uncertain if the manual data was an over-count or if the electronic data is incomplete for the 2011/12 financial year.

Element ID 16: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

It is not a mandatory requirement to include the above table. However, the purpose is to provide an easy reference to raw data from which values for indicators are determined and to facilitate the audit trail. The purpose of the column 'Element ID' is purely to facilitate cross referencing between the tables.

Table4.2: Strategic objectives, performance indicators and annual for general (regional) hospitals [PHS1 & 2]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Address the burden of disease.	1.1. Ensure access to general specialist hospital services.	1.1.1. Ensure access to regional hospitals services by providing 1 375 regional hospital beds by 2014/15.	1) Number of regional hospital beds Element ID 1	%	1 375	2 490	2 364	2 385	1 359	1 375	1 375	1 375	
			2) Total separations in regional hospitals Element ID 2	No		196 668	185 919	174 307	108 257	110 778	111 886	113 005	
			3) Patient day equivalents [PDE] in regional hospitals Element ID 3	No		1 122 369	1 051 150	1 022 675	557 653	565 286	570 938	576 648	
			4) OPD total headcounts in regional hospitals Element ID 4.2	No		718 131	628 931	580 840	241 137	247 092	249 563	252 058	
	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% by 2014/15.	5) Caesarean section rate for regional hospitals	%	39%	33%	32%	36%	39%	39%	39%	39%	
			Numerator ID 5		10 579	8 211	8 425	9 339	10 268	10 371	10 474	10 579	
			Denominator ID 6		27 225	25 040	25 961	25 689	26 424	26 688	26 955	27 225	
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 R1 807 per PDE by 2014/15 (2010/11 rands).	6) Expenditure per patient day equivalent [PDE] in regional hospitals [2010/11 rand].	R	R 1 807	R 1 848	R 1 853	R 1 961	R 1 877	R 1 842	R 1 831	R 1 807	
			Numerator ID 7		1 042 082 088	2 074 481 703	1 947 490 654	2 005 781 043	1 046 886 483	1 041 461 954	1 045 349 565	1 042 082 088	
			Denominator ID 3		576 648	1 122 369	1 051 150	1 022 675	557 653	565 286	570 938	576 648	
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 87% and an average length of stay of 3.9 days by 2014/15.	7) Bed utilisation rate (based on usable beds) in regional hospitals	%	87%	86%	86%	84%	86%	86%	86%	87%	
			Numerator ID 8		437 928	782 263	742 740	734 698	425 049	429 299	433 592	437 928	
			Denominator ID 9		501 875	908 850	862 860	870 525	496 035	501 875	501 875	501 875	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
			8) Average length of stay in regional hospitals	Days	3.9	4.0	4.0	4.2	3.9	3.9	3.9	3.9	
			Numerator ID 8		437 928	782 263	742 740	734 698	425 049	429 299	433 592	437 928	
			Denominator ID 2		113 005	196 668	185 919	174 307	108 257	110 778	111 886	113 005	
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 patients risk in regional hospitals by monthly mortality and morbidity meetings by 2014/15.	9) Percentage of regional hospitals with monthly mortality and morbidity meetings	%	100%	100%	100%	100%	100%	100%	100%	100%	
			Numerator ID 10		5	9	5	8	5	5	5	5	
			Denominator ID 11		5	9	5	8	5	5	5	5	
			10) Percentage of complaints of users of regional hospitals resolved within 25 days	%		100%	83%	83%	83%	84%	85%	86%	
			Numerator ID 12			-	552	484	250	253	255	258	
			Denominator ID 13			-	669	583	300	300	300	300	
			11) Regional hospital patient satisfaction rate	%		Not required to report	Not required to report	75%	79%	80%	80%	86%	
			Numerator ID 14			-	-	2 484	2 625	2 800	2 800	3 000	
			Denominator ID 15			-	-	3 324	3 324	3 500	3 500	3 500	
			12) Number of regional hospitals assessed for compliance with the 6 priorities of the core standards	No		Not required to report	Not required to report	Not required to report	5	5	5	5	
			Element ID 16										

Note:

All indicators: The level two services within central hospitals were included in this sub-programme as from 1 April 2008 and reflect in Programme 5 as from 1 April 2011.
Targets adjusted for 2014/15(Strategic Plan adjusted accordingly).

General: Victoria Hospital shifted to Programme 2 from 1 April 2009.

Indicator 6: From 2011/12 the funding for the Level 3 services reverted to the central hospitals (Programme 5) resulting in a lower cost per PDE.
The cost per PDE continues to decrease over the MTEF period due to an increase in the PDEs.

Indicator 10: A new electronic information system was implemented during 2011/12. The electronic data is much lower than the data reported on the manual system.
It is uncertain if the manual data was an over-count or if the electronic data is incomplete for the 2011/12 financial year.

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

Strategic objective performance indicators are highlighted in yellow.

Provincially determined performance indicators are highlighted.

Table 4.3: Quarterly targets for general (regional) hospitals for 2012/13 [PHS3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
1. Address the burden of disease.	1.1. Address the burden of disease by ensuring access to general specialist hospital services.	1.1.1. Ensure access to regional hospitals services by providing 1 375 regional hospital beds by 2014/15.	1) Number of regional hospital beds Element ID 1	Quarterly	1 375	1 375	1 375	1 375	1 375
			2) Total separations in regional hospitals Element ID 2	Quarterly	110 778	27 695	27 695	27 695	27 695
			3) Patient day equivalents [PDE] in regional hospitals Element ID 3	Quarterly	565 286	141 321	141 321	141 321	141 321
			4) OPD total headcounts in regional hospitals Element ID 4	Quarterly	247 092	61 773	61 773	61 773	61 773
	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% in 2014/15.	5) Caesarean section rate for regional hospitals	Quarterly	39%	39%	39%	39%	39%
			Numerator ID 5		10 371	2 593	2 593	2 593	2 593
			Denominator ID 6		26 688	6 672	6 672	6 672	6 672
2. Optimal financial management to maximise health outcomes.	2.1. Optimal financial management to maximise health outcomes.	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 R1 807 per PDE by 2014/15. [2010/11 rands].	6) Expenditure per patient day equivalent [PDE] in regional hospitals	Quarterly	R 1 842	R 1 842	R 1 842	R 1 842	R 1 842
			Numerator ID 7	R'000	1 041 461 954	260 365 488	260 365 488	260 365 489	260 365 489
			Denominator ID 3		565 286	141 321	141 321	141 321	141 321
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure and maintain organisational strategic management capacity and synergy.	3.1.1. Efficiently manage the allocated resources of regional hospitals to achieve a target bed utilisation rate of 87% and an average length of stay of 3.9 days by 2014/15.	7) Bed utilisation rate (based on usable beds) in regional hospitals	Quarterly	86%	86%	86%	86%	86%
			Numerator ID 8		429 299	107 325	107 325	107 325	107 325
			Denominator ID 9		501 875	125 469	125 469	125 469	125 469
			8) Average length of stay in regional hospitals	Quarterly	3.9	3.9	3.9	3.9	3.9
			Numerator ID 8		429 299	107 325	107 325	107 325	107 325
			Denominator ID 2		110 778	27 695	27 695	27 695	27 695

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
3. 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 patients risk in regional hospitals by monthly mortality and morbidity meetings by 2014/15.	9) Percentage of regional hospitals with monthly mortality and morbidity meetings	Quarterly	100%	100%	100%	100%	100%
			Numerator ID 10		5	5	5	5	5
			Denominator ID 11		5	5	5	5	5
			10) Percentage of complaints of users of regional hospitals resolved within 25 days	Quarterly	84%	84%	84%	84%	84%
			Numerator ID 12		253	63	63	63	63
			Denominator ID 13		300	75	75	75	75
			11) Regional hospital patient satisfaction rate	Annual	80%	80%	80%	80%	80%
			Numerator ID 14		2 800	700	700	700	700
			Denominator ID 15		3 500	875	875	875	875
			12) Number of regional hospitals assessed for compliance with the 6 priorities of the core standards	Annual	5	-	-	-	3
			Element ID 16						

Notes:

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

4.5 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND THE MTEF

Please refer to Tables 4.16 and 4.17 for the detailed financial information.

4.5.1 PERFORMANCE AND EXPENDITURE TRENDS

Sub-Programme 4.1 is allocated 8.29 per cent of the total vote in 2012/13 in comparison to the 8.62 per cent that was allocated in the revised estimate of the 2011/12 budget.

Sub-Programme 4.1 is allocated 52.51 per cent of the Programme 4 budget in 2012/13 in comparison to the 53.48 per cent allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R 56.216 million or 4.86 per cent.

R2 million provincial equitable share is allocated to Programme 4 for family physician posts at Paarl Hospital.

R5.5 million of the National Health Insurance Grant is allocated to Programme 4 for general specialist posts.

4.5.1.1 Impact of the budget on performance targets and measures that will be put in place to ensure that the strategic objectives continue to be realised:

The budget will be used to strengthen regional hospital services to improve the quality of care as well as outreach and support to district health services.

Despite funding limitations, the impact of the improved conditions of service, occupational specific dispensation and medical inflation, this sub-programme will remain focused on achieving the predetermined objectives established.

4.6 RISK MANAGEMENT

Risk	Mitigating factors
1. **Financial management and over-expenditure**: Financial constraints which are exacerbated by the significant demand for services as a result of the increased burden of disease. This is against the backdrop of the increased cost of service provision due to the escalating costs of labour and goods and services.	1.1. A more rigorous process of priority setting is being implemented in line with the affordable budget envelope. 1.2. Cost containment strategies are being institutionalised, especially in the areas of agency utilisation, blood, laboratories and medicine and medical and surgical supplies. 1.3. Expenditure reports and projections are tabled monthly with an analysis of the cost drivers. 1.4. Functional business units are being implemented. 1.5. Financial, supply chain and human resource components at institutions will be strengthened by appointing appropriate staff. 1.6. The devolved internal control unit at the regional office will assist hospitals towards financial compliance. 1.7. Contract management will be improved at regional and institutional level to ensure compliance with contract management regulations.

Risk	Mitigating factors
	1.8. Asset management will be strengthened to ensure the proper procurement, recording and safekeeping of assets.
2. **Human Resource Management** The ability to recruit and retain sufficient numbers of appropriately qualified and experienced professional health workers and support staff.	2.1. Maintenance of an approved post list per institution and the fast tracking of the filling of posts to decrease the impact of staff turnover. 2.2. Improve the management of human resources and focus on decreasing staff absenteeism. 2.3. Training and development programmes are being geared towards strengthening the workforce. 2.4. It is envisaged that the occupation specific dispensation will impact positively on retaining special skills. 2.5. Phased implementation of the recommendations from the organisational design investigation.
3. **Improving Quality of Care** The escalating workload within a resource constrained environment increases the risk of compromised quality of care. This could lead to an increase in adverse incidents, nosocomial infections, morbidity and mortality.	3.1. Hospitals will ensure that staff is made available to perform quality control and infection control functions. 3.2. The departmental clinical governance policy will be implemented. 3.3. Clinical audit and mortality and morbidity meetings will continue to ensure compliance and address risks. 3.4. The challenges identified through patient and staff satisfaction surveys and patient complaints will be addressed to improve the health service. 3.5. There is a heightened awareness and improved measures regarding patient and staff safety, clean hospitals, reducing waiting times, infection control and availability of medicine. 3.6. Baseline audits are undertaken to assess compliance with national core standards in priority areas. These audits will form the basis for action plans to improve quality.
4. **Information Management** The lack of good quality data compromises the planning, monitoring and management of health service.	4.1. Improving data quality is being prioritised at all levels. 4.2. Standard operating procedures are being developed and implemented at all levels of the service. 4.3. The capacity and systems are being strengthened. 4.4. Appointment of health information staff at hospitals. 4.5. Ensuring audit compliance.
5. **Clinical risk management**	5.1. Standardised policies and procedures with regards to patient management. 5.2. Integrated and functioning quality assurance mechanisms, including adverse incident reporting.

Risk	Mitigating factors
	5.3. Provincial co-ordinating committees in the major disciplines will enable better co-ordination and sharing of clinical experiences across the health service. 5.4. Co-operation within geographical service areas.

5. SUB-PROGRAMME 4.2 TUBERCULOSIS HOSPITALS

5.1 SITUATION ANALYSIS

The funding for TB hospitals resorts in Sub-programme 4.2 although the sub-programme is functionally managed by Programme 2 in order to provide a seamless TB service from primary health care level to the level of specialised TB hospitals.

There are currently three designated drug resistant tuberculosis (DR-TB) units in the Western Cape namely Brewelskloof, Harry Comay and Brooklyn Chest Hospitals. DP Marais and Harry Comay Hospitals were provincialised from the South African National Tuberculosis Association (SANTA) in recent years. In October 2010, Brooklyn Chest and DP Marias Hospitals were amalgamated into the Metro TB Complex with the appointment of a single management structure.

The Infectious Diseases (ID) TB Hospital in Malmesbury and Sonstraal TB Hospital in Paarl have been amalgamated into the West Coast TB Complex. This complex will in future serve the West Coast District and the Stellenbosch and Drakenstein Sub-districts. The complex needs to be fully capacitated to admit more acutely ill TB and TB/HIV co-infected patients. This process has commenced with the appointment of two medical officers but further strengthening is required.

A pilot infectious disease palliative centre established at Nelspoort Hospital in the Central Karoo District was opened in December 2011 to manage patients with extreme drug resistant tuberculosis (XDR-TB) treatment failure.

5.2 CHALLENGES

1) To provide sufficient access to TB beds in the Metro District to allow for efficient transfer of stable acutely ill patients into TB hospitals.
2) The strengthening of the West Coast Complex to become a fully functioning TB and MDR-TB hospital to meet all the needs of the area that the hospital serves.
3) The transfer of stable TB patients to primary care level and community based services to ensure that available beds are optimally used for acutely ill patients.
4) The growing burden of drug resistant tuberculosis and co-infected HIV/TB patients places a strain on human and financial resources at TB hospitals.
5) Providing a safe, infection-controlled environment for the management of highly infectious patients

5.3 PRIORITIES

1) Fill priority posts within the financial constraints and the CSP framework in TB hospitals.
2) Review and streamline infection control measures at TB and general hospitals.
3) Improve clinical treatment outcomes for the MDR-TB and XDR-TB programme.
4) Strengthen clinical governance and improve the patient experience in all TB hospitals.
5) Consolidate and complete a province-wide roll-out of the decentralised drug–resistance (DR) TB management plan.
6) Train medical officers, family physicians, nurses and CHWs in the management of infectious diseases, including HIV and TB co-morbidity.

5.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR TB HOSPITALS

Table 4.4: Data elements of performance indicators for TB hospitals

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	Usable beds	1	1 040	1 016	1 028	1 033	1 040	1 115	1 115
SINJANI	Separations- Sum of: day patients + inpatient deaths + inpatient discharges + inpatient transfers out	2	3 725	3 684	4 192	4 133	4 235	4 541	4 541
SINJANI	PDE- Sum of: inpatient days + 1/2 day patients + 1/3 OPD headcount + 1/3 emergency headcount	3	304 302	305 833	302 828	299 162	306 830	328 730	328 730
SINJANI	OPD headcount- Sum of: OPD new case referred + OPD new case not referred + OPD follow-up	4	1 818	3 208	7 192	9 335	9 450	9 450	9 450
BAS	Total expenditure (2010/11 rands) R'000	5	179 527 950	180 720 074	178 426 943	184 949 399	187 541 491	188 152 999	187 395 387
SINJANI	Inpatient days + 1/2 days patients	6	303 696	304 764	300 431	296 051	303 680	325 580	325 580
SINJANI	Total usable bed days	7	379 600	370 840	375 220	377 045	379 600	406 975	406 975
SINJANI	TB hospitals with M & M meetings every month	8	4	4	4	4	6	6	6
Facility List	TB hospitals	9	6	6	6	6	6	6	6
SINJANI	Complaints resolved within 25 days	10	-	129	129	150	153	156	159
SINJANI	Complaints lodged	11	-	179	179	200	202	204	206
DHIS	Number of questionnaires with 1 or 2 recorded for pleased with treatment	12	Not required to report	Not required to report	506	510	514	518	522
DHIS	Number of questionnaires for pleased with treatment	13	Not required to report	Not required to report	606	600	602	605	608
NDoH assessment tool	TB hospitals assessed against the core standards	14	Not required to report	Not required to report	Not required to report	1	2	3	5

Notes:

Element ID 14: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

Table 4.5: Strategic objectives, performance indicators and annual targets for TB hospitals [PHS 1 & 2]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 1 115 TB hospital beds by 2014/15.	1) Number of TB hospital beds3 Element ID 1	No	1 115	1 040	1 016	1 028	1 033	1 040	1 115	1 115	
			2) Total separations in TB hospitals Element ID 2	No		3 725	3 684	4 192	4 133	4 235	4 541	4 541	
			3) Patient day equivalents [PDE] in TB Hospitals Element ID	No		304 302	305 833	302 828	299 162	306 830	328 730	328 730	
			4) OPD total headcounts in TB hospitals Element ID 4	No		1 818	3 208	7 192	9 335	9 350	9 450	9 450	
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 R570 per PDE by 2014/15. [2010/11 rands].	5) Expenditure per patient day equivalent [PDE] in TB hospitals	R	R 570	R 590	R 591	R 589	618	611	572	570	
			Numerator ID 5	R'000	187 395 387	179 527 950	180 720 074	178 426 943	184 949 399	187 541 491	188 152 999	187 395 387	
			Denominator ID 3		328 730	304 302	305 833	302 828	299 162	306 830	328 730	328 730	
3. Ensure and maintain or-ganisational 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 80% and an average length of stay of 71.7 days by 2014/15.	6) Bed utilisation rate (based on usable beds) in TB hospitals	%	80.0%	80.0%	82.2%	80.1%	78.5%	80.0%	80.0%	80.0%	
			Numerator ID 6		325 580	303 696	304 764	300 431	296 051	303 680	325 580	325 580	
			Denominator ID 7		406 975	379 600	370 840	375 220	377 045	379 600	406 975	406 975	
			7) Average length of stay in TB hospitals	Days	71.7	81.5	82.7	71.7	71.6	71.7	71.7	71.7	
			Numerator ID 6		325 580	303 696	304 764	300 431	296 051	303 680	325 580	325 580	
			Denominator ID 2		4 541	3 725	3 684	4 192	4 133	4 235	4 541	4 541	
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) Percentage of TB hospitals with monthly mortality and morbidity meetings	%	100%	66.7%	66.7%	66.7%	66.7%	100.0%	100.0%	100.0%	
			Numerator ID 8		6	4	4	4	4	6	6	6	
			Denominator ID 9		6	6	6	6	6	6	6	6	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
			9) Percentage of complaints of users of TB hospitals resolved within 25 days	%		100.0%	72.1%	72.1%	75.0%	75.7%	76.5%	77.2%	
			Numerator ID 10			-	129	129	150	153	156	159	
			Denominator ID 11			-	179	179	200	202	204	206	
			10) TB hospital patient satisfaction rate	%		Not required to report	Not required to report	83.5%	85.0%	85.4%	85.7%	85.9%	
			Numerator ID 12			-	-	506	510	514	518	522	
			Denominator ID 13			-	-	606	600	602	605	608	
			11) Number of TB hospitals assessed for compliance with the 6 priorities of the core standards	No		Not required to report	Not required to report	Not required to report	1	0	6	0	
			Element ID 14										

Notes:

General: Some targets may appear to be conservative, given the pressure on beds in acute hospitals, however TB hospitals are currently in phase of transition:

- Sonstraal Hospital is in the process of being capacitated to manage a complete package of care inclusive of drug resistant TB as well as the electronic and paper based recording and reporting system.
- Harry Comay Hospital is currently admitting their own XDR patients
- Strengthening of systems to effectively decentralise drug resistant care.

Indicator 4: From 2010/11, data is reported in line with the data element definition and includes clients seen by allied health professionals, radiology, pharmacy, etc.

Indicator 7: The average length of stay has been reduced from 83 days to 71 days, which will contribute to a higher turnover of patients.

Indicator 11: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

5.5 QUARTERLY TARGETS FOR TB HOSPITALS

Table 4.6: Quarterly targets for TB hospitals for 2012/13 [PHS3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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 1 115 TB hospital beds by 2014/15.	1) Number of TB hospital beds3 Element ID 1	Quarterly	1 040	1 040	1 040	1 040	1 040
			2) Total separations in TB hospitals Element ID 2	Quarterly	4 235	1 059	1 059	1 059	1 059
			3) Patient day equivalents [PDE] in TB Hospitals Element ID 3	Quarterly	306 830	76 708	76 708	76 708	76 708
			4) OPD total headcounts in TB hospitals Element ID 4	Quarterly	9 350	2 338	2 338	2 338	2 338
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 R570 per PDE by 2014/15. [2010/11 rands].	5) Expenditure per patient day equivalent [PDE] in TB hospitals	Quarterly	611	611	611	611	611
			Numerator ID 5	R'000	187 541 491	46 885 373	46 885 373	46 885 373	46 885 373
			Denominator ID 3		306 830	76 708	76 708	76 708	76 708
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 80%and an average length of stay of 71.7 days by 2014/15.	6) Bed utilisation rate (based on usable beds) in TB hospitals	Quarterly	80.0%	80.0%	80.0%	80.0%	80.0%
			Numerator ID 6		303 680	75 920	75 920	75 920	75 920
			Denominator ID 7		379 600	94 900	94 900	94 900	94 900
			7) Average length of stay in TB hospitals	Quarterly	71.7	71.7	71.7	71.7	71.7
			Numerator ID 6		303 680	75 920	75 920	75 920	75 920
			Denominator ID 2		4 235	1 059	1 059	1 059	1 059
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) Percentage of TB hospitals with monthly mortality and morbidity meetings	Quarterly	100.0%	100.0%	100.0%	100.0%	100.0%
			Numerator ID 8		6	6	6	6	6
			Denominator ID 9		6	6	6	6	6
			9) Percentage of complaints of users of TB hospitals resolved within 25 days	Quarterly	75.7%	75.7%	75.7%	75.7%	75.7%
			Numerator ID 10		153	38	38	38	38
			Denominator ID 11		202	51	51	51	51

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
			10) TB hospital patient satisfaction rate	Annual	85.4%				
			Numerator ID 12		514				
			Denominator 13		602				
			11) Number of TB hospitals assessed for compliance with the 6 priorities of the core standards	Annual	0	-	-	-	-
			Element ID 14						

Notes:

Indicator 11: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

5.6 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Please refer to Table 4.16 and 4.17 for the detailed financial information.

5.7 PERFORMANCE AND EXPENDITURE TRENDS

Sub-Programme 4.2 TB Hospitals is allocated 9.27 per cent of the Programme 4 budget in 2012/13 in comparison to the 9.08 per cent that was allocated in the revised estimate of the 2011/12 budget. This is a nominal increase of R17.598 million or 8.95 per cent.

Although there appears to be a slight decline in the need for TB beds this trend will have to be carefully monitored as cohort data indicates that there is an increase in drug-resistant tuberculosis in the Western Cape [Provincial Annual Case finding (2007: 764), (2008: 1153), (2009: 1204), (2010: 1310)]. Unfortunately the outcomes for MDR and XDR-TB remain poor with high defaulter rates and high mortality rates. This highlights the need for close co-ordination and co-operation between TB hospitals and primary health care services. There must be a seamless flow between hospital and community, and counselling and support services to TB patients need to be strengthened.

The West Coast TB Complex is not yet fully functioning and therefore not able to meet all the needs of the area the hospital serves. This is mainly due to the hospital being underfunded. The district was not able to fill key posts such as an institutional head, pharmacist, and sufficient nursing staff for the hospital. Various strategies are in place to address these problems but increasing this complex's budget will have to be considered if the objectives of the complex are to be achieved.

5.8 RISK MANAGEMENT

Risk	Mitigating factors
1. The lack of inpatient TB beds in the Cape Metro due to a high burden of disease.	1.1 The provision of decentralised DR-TB services at primary care level will attempt to alleviate bed pressures in TB hospitals. 1.2 Earlier diagnosis and initiation of treatment (TB and ART) will help to curtail transmission, decrease complications and help to decrease the need for hospitalisation.
2. Terminal DR-TB patients who have failed XDR-TB treatment and require long-term hospitalisation.	2.1. A centralised palliative care unit will be established at Nelspoort Hospital as well availing palliative care beds at Harry Comay Hospital (Eden District). 2.2. Implement the provincial home isolation policy to provide guidance to the care givers of home isolation clients.
3. Psycho-social patient factors that prevent the successful completion of treatment.	3.1. Address the social determinants or upstream causes of disease that relates strongly to the Provincial Strategic Objective 4: Increasing Wellness in which steps are being taken to identify issues and implement appropriate actions by provincial government collectively to increase wellness. 3.2. The Department of Health provides, effective patient counselling and education, facilitates patient access to social support mechanisms, and establishes support groups to support patient adherence.

6. SUB-PROGRAMME 4.3 PSYCHIATRIC HOSPITALS

6.1 SITUATIONAL ANALYSIS

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

The services at New Beginnings, on the premises of Stikland Hospital, have been expanded from 40 to 105 beds, which has assisted in relieving the acute bed pressures in the system.

There is an average length of stay of 45 to 60 days in the acute services that reflects a significant throughput of patients, especially at Valkenberg Hospital. An analysis of the lists of patients awaiting transfer from district to specialist hospitals reflects the growing burden of illness throughout the service. The overall shortage of acute, male admission beds in the Metro West geographical service area led to an executive decision to increase acute male beds at Valkenberg Hospital. The reprioritisation of services will continue in order to address the increasing acute patient load.

A three-way patient shift between Valkenberg Hospital, Lentegeur Hospital and New Beginnings resulted in the creation of 22 acute, male admission beds at Valkenberg Hospital within the existing bed totals and 65 new, sub- acute, residential beds at New Beginnings.

The waiting list for forensic observation remains high at a six month level for men awaiting trial. The number of state patients grows steadily as approximately one third of people observed return as state patients. This leads to pressure on the fixed number of state patient beds in the maximum secure unit where beds are shared between patients admitted for observation and psychiatric state patients. More stable patients are referred to Lentegeur Hospital. However, this cycle leads to further limitation of beds available for patients requiring observations. The hospital revitalisation programme at Valkenberg Hospital which will provide an increased number of beds and a separation of patients requiring observation and state patients should provide some relief to this situation.

The relocation and consolidation of the acute services at Stikland Hospital and the upgrading of various wards improved workflow and the admission of patients.

Integrated assertive community team (ACT) services form an important part of the acute services continuum of care and resort under the senior psychiatrists in these services. The ACT services improve quality of care and treatment adherence and have been very effective in reducing the readmission of patients and the duration of stay of those patients who do get admitted.

Ambulatory services have been strengthened and play a critical role in containing patients that are prematurely discharged owing to acute bed pressures.

In accordance with the Mental Health Care Act, this Province has a single Mental Health Review Board with five members. The functioning of the board has established a benchmark for the country. The function of the board is to protect the rights of mental health care users and their families and the board interfaces closely with the Cape High Court in this regard.

6.2 CHALLENGES

1) Staff safety and security.
2) Hospital estate management and physical infrastructure.
3) Continuous pressure on acute adult services.
4) The serious impact of co-morbid infectious diseases, namely HIV and drug resistant TB, and substance abuse on acuity of mental illness, complexity of treatment and length of hospital stay.
5) The waiting list of awaiting trial prisoners for the male observation service remains high, leading to overcrowding of the minimum and medium secure wards.
6) Commissioning of a separate adolescent psychiatric ward at Tygerberg Hospital.

6.3 PRIORITIES FOR 2012/13

6.3.1 Address the burden of disease

1) Continued emphasis will be placed on managing the acute burden of disease of mentally ill patients. The waiting list management concept that was implemented across the platform during the 2010/11 financial year will continue to be strengthened. This plays a particularly important support function to the district health services.
2) Continue to manage the residential psychosocial rehabilitation programmes at William Slater and New Beginnings effectively and efficiently.
3) Reconfigure intellectual disability services within the psychiatric hospital services to provide the appropriate type of care for identified groups of patients and to make best use of available professional resources.
4) Maintain outreach and support from the psychiatric hospitals to the acute regional and district hospitals.
5) Strengthen appropriate outpatient psychiatric services at all levels of care.

6.3.2 Optimal financial management to maximise health outcomes

1) Allocate equitable budgets that are aligned with the expected deliverables and provide an optimal service at an appropriate and affordable cost per patient day equivalent.
2) Focus on revenue projects to achieve revenue targets, and in the process provide opportunities for hospitals to increase expenditure.
3) Ensure payment from the National Department of Justice for forensic psychiatric observation services rendered.
4) Encourage funding initiatives by the hospital facility boards, which contribute to improved patient amenities in psychiatric hospitals.

6.3.3 Ensure and maintain organisational strategic management capacity and synergy

1) Implementation of functional business units (FBU's) as a mechanism assisting clinical managers in decision making and accountability.

2) The Mental Health Provincial Co-ordinating Committee continues to ensure the co-ordination of mental health services across the service platform.

6.3.4 **Improve the quality of health services and the patient experience**

1) Mortality and morbidity meetings will ensure the monitoring of adverse and safety and security incidents, improving management of clinical risks.
2) Results from annual client satisfaction surveys will be assessed and recommendations implemented.
3) Annual staff satisfaction survey results will be analysed and recommendations will be implemented.
4) Continue to maintain long-term quality improvement partnerships which include inter-departmental forums, academic institutions and other professional groups outside the Department of Health.
5) Assess adherence to identified priorities extracted from the national core standards and develop action plans to address the gaps.

6.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR PSYCHIATRIC HOSPITALS

Table 4.7: Data elements of performance indicators for psychiatric hospitals

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	Usable beds	1	1 934	1 792	1 742	1 698	1 698	1 698	1 698
SINJANI	Separations- Sum of: day patients + inpatient deaths + inpatient discharges + inpatient transfers out	2	5 051	5 369	5 690	5 802	5 860	5 919	5 978
SINJANI	PDE- Sum of: inpatient days + 1/2 day patients + 1/3 OPD headcount	3	616 296	595 471	567 123	551 852	557 370	562 944	568 573
SINJANI	OPD headcount- Sum of: OPD new case referred + OPD new case not referred + OPD follow-up	4	23 955	34 521	31 152	28 495	28 780	29 067	29 358
BAS	Total expenditure (2010/11 rands) R'000	5	548 826 471	542 568 510	542 356 335	565 077 839	578 222 551	581 000 685	580 526 472
SINJANI	Patient days=Inpatient days + 1/2 day patients	6	606 826	583 871	556 739	542 337	547 761	553 238	558 771
SINJANI	Total usable bed days	7	698 883	654 080	635 830	619 770	619 770	619 770	619 770
SINJANI	Psychiatric hospitals with M & M meetings every month	8	4	1	2	4	4	4	4
Facility list	Psychiatric hospitals	9	4	4	4	4	4	4	4
SINJANI	Complaints resolved within 25 days	10	-	52	52	65	70	75	85
SINJANI	Complaints lodged	11	-	87	87	100	100	100	100
DHIS	Number of questionnaires with 1 or 2 recorded for pleased with treatment	12	Not required to report	Not required to report	467	480	480	480	480
DHIS	Number of questionnaires for pleased with treatment	13	Not required to report	Not required to report	588	600	600	600	600
NDoH assessment tool	Psychiatric hospitals assessed against the core standards	14	Not required to report	Not required to report	Not required to report	4	0	4	0
Stepdown beds									
SINJANI	Number of useable step down beds	15	New indicator	127	82	145	145	145	145
SINJANI	Inpatient days in step down beds	16	New indicator	36 738	19 390	43 987	44 427	44 871	45 320
SINJANI	Total usable bed days in step down beds	17	New indicator	46 355	29 930	52 925	52 925	52 925	52 925

Note:

Element ID 4: The OPD head count has been corrected from 1 April 2011.
The system calculated an inpatient seen by a service group staff member as an OPD headcount, instead of only an OPD visit to the service group.

Element ID 14: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

Element ID 15: During the 2009/10 financial year there were 127 beds. The planned activity for 2010/11 was to hand over 45 beds from William Slater to an NGO, but this did not realise.
The beds were increased to 145 shared between William Slater and New Beginnings.

Table 4.8: Strategic objectives, performance indicators and annual targets for psychiatric hospitals [PHS1 & 2]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 psychiatric hospital beds Element ID 1	No	1 698	1 934	1 792	1 742	1 698	1 698	1 698	1 698	
			2) Total separations in psychiatric hospitals Element ID 2	No		5 051	5 369	5 690	5 802	5 860	5 919	5 978	
			3) Patient day equivalents [PDE] in psychiatric hospitals Element ID 3	No		616 296	595 471	67 123	551 852	557 370	562 944	568 573	
			4) OPD total headcounts in psychiatric hospitals Element ID 4	No		23 955	34 521	31 152	28 495	28 780	29 067	29 358	
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 delivery of the full package of psychiatric hospital services at a rate of R1 021 per PDE by 2014/15 (2010/11 rands)	5) Expenditure per patient day equivalent [PDE] in psychiatric hospitals	R	R 1 021	R 891	R 911	R 956	R 1 024	R 1 037	R 1 032	R 1 021	
			Numerator ID 5	R'000	580 526 472	548 826 471	542 568 510	542 356 335	565 077 839	578 222 551	581 000 685	580 526 472	
			Denominator ID 3		568 573	616 296	595 471	567 123	551 852	557 370	562 944	568 573	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1. Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 93 days by 2014/15.	6) Bed utilisation rate (based on usable beds) in psychiatric hospitals	%	90%	87%	89%	88%	88%	88%	89%	90%	
			Numerator ID 6		558 771	606 826	583 871	556 739	542 337	547 761	553 238	558 771	
			Denominator ID 7		619 770	698 883	654 080	635 830	619 770	619 770	619 770	619 770	
			7) Average length of stay in psychiatric hospitals	Days	93	120	109	98	93	93	93	93	
			Numerator ID 6		558 771	606 826	583 871	556 739	542 337	547 761	553 238	558 771	
			Denominator ID 2		5 978	5 051	5 369	5 690	5 802	5 860	5 919	5 978	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 patients risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014/15.	8) Percentage of psychiatric hospitals with monthly mortality and morbidity meetings	%	100%	100%	25%	50%	100%	100%	100%	100%	
			Numerator ID 8		4	4	1	2	4	4	4	4	
			Denominator ID 9		4	4	4	4	4	4	4	4	
			9) Percentage of complaints of users of psychiatric hospitals resolved within 25 days	%		100%	60%	60%	65%	70%	75%	85%	
			Numerator ID 10			-	52	52	65	70	75	85	
			Denominator ID 11			-	87	87	100	100	100	100	
			10) Psychiatric hospital patient satisfaction rate	%		Not required to report	Not required to report	79%	80%	80%	80%	80%	
			Numerator ID 12			-	-	467	480	480	480	480	
			Denominator ID13			-	-	588	600	600	600	600	
			11) Number of psychiatric hospitals assessed for compliance with the 6 priorities of the core standards	No		Not required to report	Not required to report	Not required to report	4	0	4	0	
			Element ID 14										
Strategic objectives and annual targets 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 86% in sub-acute facilities by 2014/15.	1) Number of useable beds in step down beds Element ID 15	No		New indicator	127	82	145	145	145	145	
			2) Bed utilisation rate in step down facilities	%o		New indicator	79%	65%	83%	84%	85%	86%	
			Numerator ID 16			-	36 738	19 390	43 987	44 427	44 871	45 320	
			Denominator ID 17			-	46 355	29 930	52 925	52 925	52 925	52 925	
			3) Total number of patient days Element ID 16	No		New indicator	46 355	29 930	52 925	52 925	52 925	52 925	

Note:

General: Some of the 2014/15 targets were adjusted.

Indicator 4: OPD headcount corrected from 1 April 2011. The system calculated an inpatient seen by a service group staff member as an OPD headcount, instead of only an OPD visit to the service group.

Indicator 5: The total cost of the public private partnership (PPP) is managed as a separate entity against Sub-programme 4.4, which artificially inflates the cost per PDE of this sub-programme, since approximately 60% of the PPP funding is for the benefit of Lentegeur Hospital (Sub-programme 4.3). For the 2012/13 financial year, only the budgets of WCRC and Lentegeur will be used to calculate the cost per PDE and for monitoring and evaluation purposes, the costs of the PPP is proportionally divided between the sub-programmes for accurate reflection of the total cost of the services.

Indicator 11: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

Table 4.9: Quarterly targets for psychiatric hospitals for 2012/13 [PHS3]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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 psychiatric hospital beds Element ID 1	Quarterly	1 698	1 698	1 698	1 698	1 698
			2) Total separations in psychiatric hospitals Element ID 2	Quarterly	5 860	1 465	1 465	1 465	1 465
			3) Patient day equivalents [PDE] in psychiatric hospitals Element ID 3	Quarterly	557 370	139 343	139 343	139 343	139 343
			4) OPD total headcounts in psychiatric hospitals Element ID 4	Quarterly	28 780	7 195	7 195	7 195	7 195
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 delivery of the full package of psychiatric hospital services at a rate of R1 021 per PDE by 2014/15 (2010/11 rands)	5) Expenditure per patient day equivalent [PDE] in psychiatric hospitals	Quarterly	R 1 037	R 1 037	R 1 037	R 1 037	R 1 037
			Numerator ID 5	R'000	578 222 551	144 555 638	144 555 638	144 555 638	144 555 638
			Denominator ID 3		557 370	139 343	139 343	139 343	139 343
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1. Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 93 days by 2014/15.	6) Bed utilisation rate (based on usable beds) in psychiatric hospitals	Quarterly	88%	88%	88%	88%	88%
			Numerator ID 6		547 761	136 940	136 940	136 940	136 940
			Denominator ID 7		619 770	154 943	154 943	154 943	154 943
			7) Average length of stay in psychiatric hospitals	Quarterly	93	93	93	93	93
			Numerator ID 6		547 761	136 940	136 940	136 940	136 940
			Denominator ID 2		5 860	1 465	1 465	1 465	1 465

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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 patients risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014/15.	8) Percentage of psychiatric hospitals with monthly mortality and morbidity meetings	Quarterly	100%	100%	100%	100%	100%
			Numerator ID 8		4	4	4	4	4
			Denominator ID 9		4	4	4	4	4
			9) Percentage of complaints of users of psychiatric hospitals resolved within 25 days	Quarterly	70%	70%	70%	70%	70%
			Numerator ID 10		70	18	18	18	18
			Denominator ID 11		100	25	25	25	25
			10) Psychiatric hospital patient satisfaction rate	Annual	80%	-	-	-	80%
			Numerator ID 12		480	-	-	-	120
			Denominator ID 13		600	-	-	-	150
			11) Number of psychiatric hospitals assessed for compliance with the 6 priorities of the core standards	Annual	0	-	-	-	-
			Element ID 14						
Strategic objectives and annual targets 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 86% in sub-acute facilities by 2014/15.	1) Number of useable beds in step down beds	Quarterly	145	145	145	145	145
			Element ID15						
			2) Bed utilisation rate in step down facilities	Quarterly	84%	84%	84%	84%	84%
			Numerator ID 16		44 427	11 107	11 107	11 107	11 107
			Denominator ID 17		52 925	13 231	13 231	13 231	13 232
			3) Total number of patient days	Quarterly	52 925	13 231	13 231	13 231	13 231
			Element ID 16						

Notes:

Indicator 11: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

6.5 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Please refer to Tables 4.16 and 4.17 for the detailed financial information.

6.6 PERFORMANCE AND EXPENDITURE TRENDS

Sub-Programme 4. 3, Psychiatric Hospitals, are allocated 27.82 per cent of the Programme 4 budget in 2012/13 in comparison to the 26.35 per cent that was allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R60.181 million or 10.55 per cent.

6.6.1 Impact of the budget on performance targets and measures that will be put in place to ensure that the strategic objectives continue to be realised:

Psychiatric services continue to remain under pressure particularly as a result of the high rate of substance abuse. It is therefore important that the Department continue to focus on the de-institutionalisation of clients and the strengthening of acute, inpatient and outpatient services.

6.7 RISK MANAGEMENT

Risk	Mitigating factors
1. **Financial management and over expenditure**: Financial constraints which are exacerbated by the increasing demand for services as a result of the increased burden of disease. This is against the backdrop of the increased cost of service provision due to the escalating costs of labour and goods and services.	1.1 A more rigorous process of priority setting is being implemented in line with the affordable budget envelope. 1.2 Cost containment strategies are being institutionalised, especially in the areas of agency utilisation and medicine. 1.3 Expenditure reports and projections are tabled monthly with an analysis of the cost drivers. 1.4 Functional business units are being implemented. 1.5 Financial, supply chain and human resource components at institutions will be strengthened by appointing appropriate staff. 1.6 The devolved internal control unit at the regional office will assist hospitals towards financial compliance. 1.7 Contract management will be improved at regional and institutional level to ensure compliance with contract management regulations. 1.8 Asset management will be strengthened to ensure the proper procurement, recording and safekeeping of assets.
2. **Human Resource Management** The ability to recruit and retain sufficient numbers of appropriately qualified and experienced professional health workers and support staff.	2.1. Maintenance of an approved post list per institution and the fast tracking of the filling of posts to decrease the impact of staff turnover. 2.2. Improve the management of human resources and focus on decreasing staff absenteeism, particularly in areas that are directly patient related. 2.3. Training and development programmes are being geared towards strengthening the workforce in areas that are understaffed.

Risk	Mitigating factors
	2.4. It is envisaged that the occupation specific dispensation will impact positively on retaining special skills. 2.5. Phased implementation of the recommendations from the organisational design investigation.
3. **Improving Quality of Care** The escalating workload within a resource constrained environment increases the risk of compromised quality of care. This could lead to an increase in adverse incidents, nosocomial infections, morbidity and mortality.	3.1. Hospitals will ensure that staff is made available to perform quality control and infection control functions. 3.2. The departmental clinical governance policy will be implemented. 3.3. Clinical audit and mortality and morbidity meetings will continue to ensure compliance and address risks. 3.4. The challenges identified through patient and staff satisfaction surveys and patient complaints will be addressed to improve the health service 3.5. There is a heightened awareness and improved measures regarding patient and staff safety, clean hospitals, reducing waiting times, infection control and availability of medicine. 3.6. Baseline audits are undertaken to assess compliance with national core standards in priority areas. These audits will form the basis for action plans to improve quality.
4. **Information Management** The lack of good quality data compromises the planning, monitoring and management of health services.	4.1. Improving data quality is being prioritised at all levels. 4.2. Standard operating procedures to be developed and to be implemented. 4.3. The capacity and systems are being strengthened. 4.4. Appointment of health information staff. 4.5. Ensuring audit compliance.
5. **Clinical risk management**	5.1. Standardised policies and procedures with regards to patient management. 5.2. Integrated and functioning quality assurance mechanisms, including adverse incident reporting. 5.3. Provincial co-ordinating committees for mental health services will enable better co-ordination and sharing of clinical experiences across the health service.

7. SUB-PROGRAMME 4.4: SPECIALISED REHABILITATION SERVICES

Sub-programme 4.4 consists of the Western Cape Rehabilitation Centre (WCRC), which provides specialised rehabilitation services for people with physical disabilities and the Orthotic and Prosthetic Centre (OPC). The sub-programme has been designated Specialised Rehabilitation Services.

7.1 SITUATIONAL ANALYSIS

7.1.1 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.
- This service includes the provision of mobility- and other assistive devices, including orthotics and prosthetics where indicated, as well as a training platform for rehabilitation related training.
- The WCRC follows an outcomes-based approach within the International Classification of Functioning Disability and Health framework. Outcome levels on admission and discharge clearly demonstrates the positive impact of the service on re-integrating disabled clients back to their homes, communities and where appropriate, a return to productive activity.
- Specialised outpatient services are provided at urology-, orthopaedics-, plastics- and specialised seating clinics, for referred patients.
- The WCRC provides support as requested to district health services to facilitate the development and provision of quality rehabilitation services for persons with physical disabilities.

7.1.2 Orthotic and Prosthetic Services

- The implemented strategic plan for orthotic and prosthetic services continues to be monitored and evaluated in terms of the reprioritisation of 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.
- The reduced waiting lists for patients waiting three to six months and six months and longer for orthotic and prosthetic devices continues to be addressed through various strategies to increase productivity, the appointment of medical orthotists and prosthetists and the development of clinical guidelines and standard operating procedures for prescription of orthotic and prosthetic devices.

7.1.3 Management of the Public Private Partnership (PPP) contract

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

- The monitoring of the PPP necessitates stringent financial controls through various management structures ensuring best value for money.

7.2 CHALLENGES

1) High therapist to patient ratios (1:22-24) compared with international norms (1:6-8).
2) High turnover of rehabilitation professionals due to limited career-path prospects despite implementation of the OSD for therapists.
3) Slow and inadequate development of rehabilitation services at a primary level, ensuring retention of functional gains after discharge of clients back into their communities.
4) Long-term sustainability of the project using trained persons with disabilities as peer supporters.
5) Facilitating adherence to the core package of wheelchair and seating services at all levels.
6) The relocation of the orthotic and prosthetic services from the Conradie site to WCRC within the context of a PPP.
7) Addressing the lists of patients waiting for orthotic and prosthetic devices.

7.3 PRIORITIES FOR 2012/13

7.3.1 Address the burden of disease

1) Deliver inter-disciplinary outcome-based rehabilitation services within an International Classification of Functioning Disability and Health framework and in line with the Rehabilitation and Disability Management Service Plan.
2) Facilitate service solutions for the prevention of secondary complications in persons with disabilities, particularly in high risk groups such as the spinal cord injured.
3) Provide support 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.
4) Render on-site, off-site as well as outreach orthotic and prosthetic services to all districts in the Western Cape.

7.3.2 Optimal financial management to maximise health outcomes

1) Allocate sufficient funds to ensure delivery of specialised rehabilitation services and address the objectives within an affordable cost per patient day.
2) Encourage participation in funding initiatives of the hospital facility board.
3) Monitor the outputs of the public private partnership (PPP) through the various management structures to ensure compliance with contractual obligations, and best value for money.

7.3.3 **Ensure and maintain organisational strategic management capacity and synergy**

1) Continue to provide support to FBU managers to ensure effective and efficient management of cost centres and FBUs.
2) Facilitate improved communication between all levels of management and clinical staff
3) Facilitate training of top-and middle managers in lean management principles and the performance of clinical audits.

7.3.4 **Improve the quality of health services and the patient experience**

1) Improve the quality of rehabilitation services in terms of the client experience of care.
2) Continue with active participation of task teams in the identified priority areas of reducing patient falls, pressure sores, and catheter-acquired urinary tract infections (the latter being a Best Care Always initiative).
3) Facilitate appropriate behaviours in staff through the use of value champions as change agents.
4) Hold monthly mortality and morbidity meetings to improve management and mitigation of clinical risks.
5) Assess the results of the annual client and staff satisfaction surveys and implement remedial actions where appropriate.
6) Assess adherence to the identified priorities extracted from the national core standards.

7.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR REHABILITATION HOSPITALS

Table 4.10: Data elements of performance indicators for Rehabilitation Hospitals

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	Usable beds	1	156	156	156	156	156	156	156
SINJANI	Separations- Sum of: day patients + inpatient deaths + inpatient discharges + inpatient transfers out	2	944	829	949	876	885	894	903
SINJANI	PDE- Sum of: inpatient days + 1/2 day patients + 1/3 OPD headcount + 1/3 emergency headcount	3	54 940	56 801	51 775	45 748	45 789	45 801	45 801
SINJANI	OPD headcount- Sum of: OPD new case referred + OPD new case not referred + OPD follow-up	4	16 227	25 107	30 812	12 441	12 565	12 600	12 600
BAS	Total expenditure (2010/11 rands) R'000	5	101 356 331	98 172 963	95 895 366	98 534 908	99 021 753	99 329 631	98 879 139
SINJANI	Patient days=Inpatient days + 1/2 days patients	6	49 176	48 431	41 505	41 600	41 600	41 600	41 600
SINJANI	Total usable bed days	7	56 940	56 940	56 940	56 940	56 940	56 940	56 940
SINJANI	Rehabilitation hospitals with M & M meetings every month	8	1	-	-	1	1	1	1
Facility list	Rehabilitation hospitals	9	1	1	1	1	1	1	1
SINJANI	Complaints resolved within 25 days	10	-	13	13	14	15	15	15
SINJANI	Complaints lodged	11	-	15	15	16	16	16	16
DHIS	Number of questionnaires with 1 or 2 recorded for pleased with treatment	12	Not required to report	Not required to report	176	190	192	193	195
DHIS	Number of questionnaires for pleased with treatment	13	Not required to report	Not required to report	184	200	200	200	200
NDoH assessment tool	Rehabilitation hospitals assessed against the core standards	14	Not required to report	Not required to report	Not required to report	1	0	1	0

Note:

Element ID 4: The OPD headcount has been corrected from 1 April 2011. The system calculated an inpatient seen by a service group staff member as an OPD headcount, instead of only an OPD visit to the service group.

Element ID 14: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

Table 4.11: Strategic objectives and annual targets for rehabilitation hospitals [PHS1 & 2]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 rehabilitation hospital beds Element ID 1	No	156	156	156	156	156	156	156	156	
			2) Total separations in rehabilitation hospitals Element ID 2	No		944	829	949	876	885	894	903	
			3) Patient day equivalents [PDE] in rehabilitation hospitals Element ID 3	No		54 940	56 801	51 775	45 748	45 789	45 801	45 801	
			4) OPD total headcounts in rehabilitation hospitals Element ID 4	No		16 227	25 107	30 812	12 441	12 565	12 600	12 600	
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 159 per PDE by 2014/15 (2010/11 rands)	5) Expenditure per patient day equivalent [PDE] in rehabilitation hospitals	R	R 2 159	R 1 845	R 1 728	R 1 852	R 2 154	R 2 163	R 2 169	R 2 159	
			Numerator ID 5	R'000	98 879 139	101 356 331	98 172 963	95 895 366	98 534 908	99 021 753	99 329 631	98 879 139	
			Denominator ID 3		45 801	54 940	56 801	51 775	45 748	45 789	45 801	45 801	
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 manages the allocated resources of rehabilitation services to achieve a target bed utilisation rate of 73% and an average length of stay of 46 days by 2014/15.	6) Bed utilisation rate (based on usable beds) in rehabilitation hospitals	%	73%	86%	85%	73%	73%	73%	73%	73%	
			Numerator ID 6		41 600	49 176	48 431	41 505	41 600	41 600	41 600	41 600	
			Denominator ID 7		56 940	56 940	56 940	56 940	56 940	56 940	56 940	56 940	
			7) Average length of stay in rehabilitation hospitals	Days	46	52	58	44	47	47	47	46	
			Numerator ID 6		41 600	49 176	48 431	41 505	41 600	41 600	41 600	41 600	
			Denominator ID 2		903	944	829	949	876	885	894	903	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 patients risk rehabilitation hospitals by monthly mortality and morbidity meetings by 2014/15.	8) Percentage of rehabilitation hospitals with monthly mortality and morbidity meetings	%	100%	100%	0%	0%	100%	100%	100%	100%	
			Numerator ID 8		1	1	-	-	1	1	1	1	
			Denominator ID 9		1	1	1	1	1	1	1	1	
			9) Percentage of complaints of users of rehabilitation hospitals resolved within 25 days	%		100%	87%	87%	90%	92%	94%	96%	
			Numerator ID 10			-	13	13	14	15	15	15	
			Denominator ID 11			-	15	15	16	16	16	16	
			10) Rehabilitation hospital patient satisfaction rate	%		Not required to report	Not required to report	96%	95%	96%	97%	98%	
			Numerator ID 12			-	-	176	190	192	193	195	
			Denominator ID 13			-	-	184	200	200	200	200	
			11) Number of rehabilitation hospitals assessed for compliance with the core standards	No		Not required to report	Not required to report	Not required to report	1	0	1	0	
			Element ID 14										

Note:

General (i): WCRC went on the Clinicom patient system during 20008/09.

General (ii): Strategic objective 1.1.1 has been aligned with the performance indicators.

General (iii): Targets adjusted for 2014/15 (Strategic Plan adjusted.)

Indicator 4: OPD headcount has been corrected from 1 April 2011. The system calculated an inpatient seen by a service group staff member as an OPD headcount, instead of only an OPD visit to the service group. This indicator influences the targets of other indicators.

Indicator 5: The total cost of the PPP is managed as a separate entity against Sub-programme 4.4, which artificially inflates the cost per PDE of this sub-programme, since approximately 60% of the PPP funding is for the benefit of Lentegeur Hospital (Sub-programme 4.3). For the 2012/13 financial year, only the budgets of WCRC and Lentegeur will be used to calculate the cost per PDE and for monitoring and evaluation purposes, the costs of the PPP is divided proportionally between the two sub-programmes for accurate reflection of the total cost of the services.

Indicator 11: Quality improvement plans to address the findings of the 2011/12 baseline audit will be developed and implemented during 2012/13.

Table 4.12: Quarterly targets for Rehabilitation Hospitals for 2012/13 [PHS3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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 rehabilitation hospital beds Element ID 1	Quarterly	156	156	156	156	156
			2) Total separations in rehabilitation hospitals Element ID 2	Quarterly	885	221	221	221	221
			3) Patient day equivalents [PDE] in rehabilitation hospitals Element ID 3	Quarterly	45 789	11 447	11 447	11 447	11 447
			4) OPD total headcounts in rehabilitation hospitals Element ID 4	Quarterly	12 565	3 141	3 141	3 141	3 142
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 159 per PDE by 2014/15 (2010/11 rands).	5) Expenditure per patient day equivalent [PDE] in rehabilitation hospitals	Quarterly	R 2 163	R 2 163	R 2 163	R 2 163	R 2 163
			Numerator ID 5	R'000	99 021 753	24 755 438	24 755 438	24 755 438	24 755 438
			Denominator ID 3		45 789	11 447	11 447	11 447	11 447
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 manages the allocated resources of rehabilitation services to achieve a target bed utilisation rate of 73% and an average length of stay of 46 days by 2014/15.	6) Bed utilisation rate (based on usable beds) in rehabilitation hospitals	Quarterly	73%	73%	73%	73%	73%
			Numerator ID 6		41 600	10 400	10 400	10 400	10 400
			Denominator ID 7		56 940	14 235	14 235	14 235	14 235
			7) Average length of stay in rehabilitation hospitals	Quarterly	47	47	47	47	47
			Numerator ID 6		41 600	10 400	10 400	10 400	10 400
			Denominator ID 2		885	221	221	221	221
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 patients risk rehabilitation hospitals by monthly mortality and morbidity meetings by 2014/15.	8) Percentage of rehabilitation hospitals with monthly mortality and morbidity meetings	Quarterly	100%	100%	100%	100%	100%
			Numerator ID 8		1	1	1	1	1
			Denominator ID 9		1	1	1	1	1

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
			9) Percentage of complaints of users of rehabilitation hospitals resolved within 25 days	Quarterly	92%	92%	92%	92%	92%
			Numerator ID 10		15	4	4	4	4
			Denominator ID 11		16	4	4	4	4
			10) Rehabilitation hospital patient satisfaction rate	Quarterly	96%	-	-	-	96%
			Numerator ID 12		192	-	-	-	48
			Denominator ID 13		200	-	-	-	50
			11) Number of rehabilitation hospitals assessed for compliance with the core standards	Annual	0	-	-	-	-
			Element ID 14						

Notes:

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

7.5 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Please refer to Tables 4.16 and 4.17 for the detailed financial information.

7.6 PERFORMANCE AND EXPENDITURE TRENDS

Sub-programme 4.4, Rehabilitation Hospitals is allocated 6.17 per cent of the 2012/13 allocation in comparison to the 6.33 per cent that was allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R5.763 million or 4.21 per cent.

7.6.1 Impact of the budget on performance targets and measures that will be put in place to ensure that the strategic objectives continue to be realised:

In order to ensure that rehabilitation services can continue to be provided to clients, it is important that the budget for assistive devices is increased. The 6.61 per cent nominal increase will contribute towards reducing the backlogs for assistive devices.

7.7 RISK MANAGEMENT

Risk	Mitigating factors
1. **Financial management and over expenditure**: Financial constraints which are exacerbated by the increasing demand for services as a result of the increased burden of disease. This is against the backdrop of the increased cost of service provision due to the escalating costs of labour and goods and services.	1.1. A more rigorous process of priority setting is being implemented in line with the affordable budget envelope. 1.2. Cost containment strategies are being institutionalised. 1.3. Expenditure reports and projections are tabled monthly with an analysis of the cost drivers. 1.4. Functional business units are being implemented. 1.5. Financial, supply chain and human resource components at institutions will be strengthened by appointing appropriate staff. 1.6. The devolved internal control unit at the regional office will assist towards financial compliance. 1.7. Contract management will continue to be improved at institutional level to ensure compliance with contract management regulations and ensure best value for money in terms of the expected deliverables by the private party.
2. **Human Resource Management** The ability to recruit and retain appropriate numbers of appropriately qualified and experienced professional health workers and support staff.	2.1. Maintenance of an approved post list per institution and the fast tracking of the filling of posts to decrease the impact of staff turnover. 2.2. Improve the management of human resources and focus on decreasing staff absenteeism, particularly in areas that are directly patient related. 2.3. Training and development programmes are being geared towards strengthening the workforce in areas that are understaffed. 2.4. It is envisaged that the occupation specific

Risk	Mitigating factors
	dispensation will impact positively on retaining special skills.
3. **Improving Quality of Care** The escalating workload within a resource constrained environment increases the risk of compromised quality of care. This could lead to an increase in adverse incidents, nosocomial infections, morbidity and mortality.	3.1. Staff will perform quality control and infection control functions. 3.2. The departmental clinical governance policy will be implemented. 3.3. Clinical audit and mortality and morbidity meetings will continue to ensure compliance and address risks. 3.4. There is an increased focus on monitoring the quality of care. The challenges identified through patient and staff satisfaction surveys and patient complaints will be addressed to improve the health service. 3.5. There is a heightened awareness and improved measures regarding patient and staff safety. 3.6. Baseline audits are undertaken to assess compliance with national core standards in priority areas. These audits will form the basis for action plans to improve quality.
4. **Information Management** The lack of good quality data compromises the planning, monitoring and management of health services.	4.1. Standard operating procedures to be implemented. 4.2. The information management capacity and systems are being strengthened.
5. **Clinical risk management**	5.1. Standardised policies and procedures with regards to patient management. 5.2. Integrated and functioning quality assurance mechanisms, including adverse incident reporting. 5.3. Provincial co-ordinating committee in the rehabilitation services will enable better co-ordination and sharing of clinical experiences across the health service.

8. SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

8.1 SITUATIONAL ANALYSIS

The dental training hospitals provide a service to patients at the oral health centres.

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

The provincial oral health plan was developed with a view to a phased implementation approach.

- Primary oral health services are provided within clinics and community health centres. Where this is not possible, these services are located within district hospitals.
- Theatre facilities and anaesthetists are available at district hospitals for treatments requiring general anaesthesia.
- The package of care provided at primary health care facilities is in line with the national policy. The package of care consists of promotive and primary preventative services as well as basic treatment services. School children and pre-school children are the priority patient groups.

8.2 CHALLENGES

1) The availability of sufficient theatre time.
2) Increasing clinical sessions for students.
3) Implementation of the Oral Health Plan.
4) Improvement of data collection.

8.3 PRIORITIES FOR 2012/13

1) Ensure access to an integrated oral health service and training platform.
2) Phased implementation of the oral health plan in line with the affordable budget envelope.
3) Performing maxillofacial procedures.
4) Provision of quality removable prosthetic devices.
5) Provision of quality orthodontic services to dental patients.

8.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND TARGETS FOR SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

Table 4.13: Data elements of performance indicators for Dental Training Hospitals

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Clinicom	Sum of patient visits at: Tygerberg and UWC Oral Health centres + Other oral health clinics (outreach clinics)	1	199 021	175 200	120 207	115 000	120 000	125 000	126 000
Theatre register	Dental health theatre cases	2	1 523	1 578	1 162	1 126	1 137	1 149	1 160
Laboratory register	Prosthetic units (dentures) issued	3	2 519	3 026	4 103	6 134	6 150	6 180	6 200
Orthodontic register	New patients banded for orthodontic treatment	4	Not required to report	Not required to report	201	200	200	200	200

Notes:

Indicator 1: The actual performance of 2008/09 and 2009/10 was based on manual statistics and the reliability of these statistics is questionable.
The actual performance of 2010/11 was based on Clinicom data and forms a reliable basis for productivity estimates for target setting.

Indicator 2: Since 2009/10 the introduction of a post graduate diploma in Conscious Sedation has allowed the facility to do many cases under conscious sedation and these cases are not reflected as theatre statistics, therefore the lower outputs in the following years.

Indicator 3: Previously sets of dentures were reported as one unit. From 2010/11 each prosthesis is counted as one unit to accurately reflect productivity as the involvement in making a set is more interactive than making a unit and therefore a set is not reflective as an output measure.

Indicator 4: The output is dependent on the number of orthodontic registrar posts that are filled at any one time as this work can only be done by a specialist and clinical assistant while training as a registrar.

Table 4.14: Strategic objectives and annual targets for Dental Training Hospitals [PHS2]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 126 000 patient visits per annum by 2014/15.	1) Number of oral health patient visits per annum Element ID 1	No	126 000	199 021	175 200	120 207	115 000	120 000	125 000	126 000	
		1.1.2. Performing 1 160 maxillofacial surgery procedures by 2014/15.	2) Number of oral health theatre cases per annum Element ID 2	No	1 160	1 523	1 578	1 162	1 126	1 137	1 149	1 160	
		1.1.3 Provide quality removable prosthetic devices to patients with a target of 6 200 by 2014/15.	3) Number of removable oral health prosthetic devices manufactured (dentures) Element ID 3	No	6 200	2 519	3 026	4 103	6 134	6 150	6 180	6 200	
		1.1.4. Provide a quality orthodontic service to dental patients with a target of 200 by 2014/15.	4) Number of new patients banded for orthodontic treatment (braces) Element ID 4	No	200	Not required to report	Not required to report	201	200	200	200	200	

Note:

Targets for 2014/15 adjusted.

Table 4.15: Quarterly targets for dental training hospitals for 2012/13 [PHS3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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 126 000 patient visits per annum by 2014/15.	1) Number of oral health patient visits per annum Element ID 1	Quarterly	120 000	29 000	32 400	28 000	30 600
		1.1.2. Performing 1 160 maxillofacial surgery procedures by 2014/15.	2) Number of oral health theatre cases per annum Element ID 2	Quarterly	1 137	280	300	260	297
		1.1.3 Provide quality removable prosthetic devices to patients with a target of 6 200 by 2014/15.	3) Number of removable oral health prosthetic devices manufactured (dentures) Element ID 3	Quarterly	6 150	1 520	1 850	1 260	1 520
		1.1.4. Provide a quality orthodontic service to dental patients with a target of 200 by 2014/15.	4) Number of new patients banded for orthodontic treatment (braces) Element ID 4	Quarterly	200	48	60	45	47

8.5 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Please refer to Tables 4.16 and 4.17 for the detailed financial information.

8.6 PERFORMANCE AND EXPENDITURE TRENDS

Sub-programme 4.5, Dental Training Hospitals, is allocated 4.76 per cent of the Programme 4 budget for 2012/13 which is the same percentage that was allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R7.102 million or 6.90 per cent.

8.6.1 Impact of the budget on performance targets and measures that will be put in place to ensure that the strategic objectives continue to be realised:

Given the limited resources and many competing needs, only minor steps can be taken annually to implement the oral health plan. The renewed focus on the fluoridation of water, which is a key upstream factor in the prevention of dental caries, will continue.

Budgetary constraints will require stringent financial management, cost containment measures and priority setting. Only funded posts within the approved post list will be filled.

There will be renewed measures to improve data collection, analysis and reporting.

Priority equipment will be funded as per the capital acquisition plan for dental services.

8.7 RISK MANAGEMENT

Risk	Mitigating factors
1. Financial management and over expenditure.	1.1 Credible budget allocation to the sub-programme. 1.2 Prioritisation of planned objectives.
2. Service load.	2.1 Resource allocation to key priority areas. 2.2 Collaboration with other partners and service providers. 2.3 Clinical governance.
3. Human resource management.	3.1 Facilitate the recruitment and retention of appropriate staff. 3.2 Prioritise the filling of critical posts on the Approved Post List and fast track the filling of posts to decrease the impact of staff turnover. 3.3 Organisational design. 3.4 Formulate skills development plans to facilitate the implementation of training and development programmes to strengthen the workforce. 3.4 Employee Assistance Programme to support staff will be implemented. 3.5 A staff satisfaction survey will be conducted.
4. Information management.	4.1 Development of standard operating procedures.

Risk	Mitigating factors
	4.2 Ensure auditable and verifiable information.
5. Clinical risk management	5.1 Standardised policies and procedures with regards to patient management. 5.2 Integrated and functioning quality assurance mechanisms, including adverse incident reporting.

9. RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND THE MTEF

Table 4.16: Summary of payments and estimates: Programme 4: Provincial Hospital Services

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
1. General Hospitals [a,b]	1 567 744	1 698 619	2 020 367	1 148 730	1 155 485	1 157 379	1 213 595	4.86	1 299 002	1 377 065
2. Tuberculosis Hospitals [a]	135 635	157 627	178 427	194 867	196 519	196 519	214 117	8.95	229 066	242 584
3. Psychiatric/Mental Hospitals [a]	391 902	448 401	516 351	569 950	570 983	570 342	630 523	10.55	675 929	718 940
4. Chronic Medical Hospitals [a]	99 317	110 461	121 901	136 024	136 927	136 927	142 690	4.21	152 336	160 553
5. Dental Training Hospitals [a]	66 052	85 980	98 195	102 900	103 384	102 924	110 026	6.90	117 976	125 552
Total payments and estimates	2 260 650	2 501 088	2 935 241	2 152 471	2 163 298	2 164 091	2 310 951	6.79	2 474 309	2 624 694

[a] 2012/13: National Conditional grant: Health professions training and development: R81 433 000 (Compensation of employees R59 628 000; Goods and services R21 805 000).

[b] 2012/13: National Conditional grant: Health professions training and development: R81 433 000 (Compensation of employees R59 628 000; Goods and services R21 805 000).

Note: The increase in 2008/09 is due to the shift of the equitable share funding for level 2 beds in the central hospitals that is allocated to sub-programme 4.1 from sub-programme 5.1, and Orthotic and Prosthetic Services previously in sub-programme 7.

Note: A contributing factor to the decrease of funding in this programme in 2009/10 is the allocation of Victoria Hospital from sub-programme 4.1 to sub-programme 2.9.

Note: Sub-programme 1.2.2 allocations from 2010/11 was shifted to sub-programme 4.1.

Table 4.17: Payments and estimates by economic classification: Programme 4: Provincial Hospital Services

Economic classification R'000	Outcome						Medium-term estimate			
	Audited	Audited	Audited	Main appro-priation	Adjusted appro-priation	Revised estimate	% Change from Revised estimate			
	2008/09	2009/10	2010/11	2011/12	2011/12	2011/12	2012/13	2011/12	2013/14	2014/15
Current payments	2 243 275	2 478 921	2 899 341	2 127 715	2 137 979	2 134 879	2 287 568	7.15	2 449 356	2 598 065
Compensation of employees	1 553 809	1 746 601	2 016 945	1 520 829	1 537 112	1 539 841	1 666 499	8.23	1 791 490	1 916 894
Salaries and wages	1 381 181	1 557 298	1 798 610	1 349 400	1 364 850	1 364 276	1 474 914	8.11	1 585 531	1 696 519
Social contributions	172 628	189 303	218 335	171 429	172 262	175 565	191 585	9.12	205 959	220 375
Goods and services	689 388	732 320	882 396	606 886	600 867	595 038	621 069	4.37	657 866	681 171
of which										
Administrative fees		16	28	8	8	20	16	(20.00)	17	17
Advertising	37	71	28	113	120	33	33		35	36
Assets <R5 000	7 483	5 432	9 124	7 421	7 328	7 567	8 110	7.18	8 590	8 894
Audit cost: External	377									
Catering: Departmental activities	686	130	266	465	414	311	404	29.90	428	442
Communication	12 005	14 215	17 233	14 020	14 038	14 000	14 927	6.62	15 811	16 369
Computer services	1 279	1 638	3 037	1 821	1 821	2 723	1 230	(54.83)	1 302	1 348
Cons/prof: Business and advisory services	39 261	41 391	42 618	49 885	49 885	45 332	49 382	8.93	52 308	54 163
Cons/prof: Laboratory services	91 809	98 154	100 411	58 236	57 361	53 234	52 279	(1.79)	55 377	57 339
Cons/prof: Legal costs		2	1	1	1	1		(100.00)		
Contractors	22 268	32 284	33 360	24 650	24 954	26 285	25 491	(3.02)	27 001	27 959
Agency and support/ outsourced services	103 917	93 692	81 202	55 418	48 201	53 546	42 469	(20.69)	44 986	46 580
Entertainment	1	1	9	25	25	19	15	(21.05)	15	15
Inventory: Food and food supplies	29 898	31 520	36 938	29 516	29 608	25 607	27 126	5.93	28 734	29 753
Inventory: Fuel, oil and gas	4 969	4 595	6 496	4 080	4 088	3 241	3 159	(2.53)	3 347	3 465
Inventory: Materials and supplies	7 281	8 229	10 833	8 266	7 752	7 737	8 858	14.49	9 381	9 712
Inventory: Medical supplies	162 190	182 609	245 739	137 304	138 320	139 612	154 794	10.87	163 968	169 780
Inventory: Medicine	69 139	69 655	92 669	64 291	62 610	53 692	56 924	6.02	60 294	62 430
Inventory: Other consumables	17 887	23 596	30 131	22 146	21 503	22 200	22 214	0.06	23 530	24 363
Inventory: Stationery and printing	8 127	8 367	11 422	9 296	9 064	9 845	9 710	(1.37)	10 286	10 649
Lease payments	5 475	2 940	3 955	3 811	4 350	5 900	6 283	6.49	6 656	6 891
Rental and hiring						4	7	75.00	7	7
Property payments	84 320	98 389	139 374	94 052	97 889	108 460	121 818	12.32	129 036	133 610
Transport provided: Departmental activity	1 095	421	611	1 542	1 542	350	326	(6.86)	346	357
Travel and subsistence	8 778	9 380	11 020	11 023	10 524	9 727	10 163	4.48	10 765	11 147
Training and development	4 202	4 352	4 346	7 973	7 940	3 853	4 072	5.68	4 313	4 466
Operating expenditure	6 828	1 193	1 497	1 410	1 408	1 669	1 219	(26.96)	1 290	1 335
Venues and facilities	76	48	48	113	113	70	40	(42.86)	43	44
Interest and rent on land	78									
Interest	78									
Transfers and subsidies to	4 863	4 116	3 055	2 885	2 885	3 780	3 239	(14.31)	3 400	3 569
Non-profit institutions	1 226									
Households	3 637	4 116	3 055	2 885	2 885	3 780	3 239	(14.31)	3 400	3 569
Social benefits	3 637	4 116	3 055	2 885	2 885	3 780	3 239	(14.31)	3 400	3 569
Payments for capital assets	12 337	17 914	32 492	21 871	22 434	25 145	20 144	(19.89)	21 553	23 060
Buildings and other fixed structures	588	69	173							
Buildings	588	69	173							
Machinery and equipment	11 738	17 839	32 319	21 813	22 376	25 137	20 144	(19.86)	21 553	23 060
Transport equipment	11	536	1 044	580	580	620	885	42.74	947	1 012
Other machinery and equipment	11 727	17 303	31 275	21 233	21 796	24 517	19 259	(21.45)	20 606	22 048
Software and other intangible assets	11	6		58	58	8		(100.00)		
Of which: "Capitalised Goods and services" included in Payments for capital assets		242		182	95	95	5	(94.74)	5	5
Payments for financial assets	175	137	353			287		(100.00)		
Total economic classification	2 260 650	2 501 088	2 935 241	2 152 471	2 163 298	2 164 091	2 310 951	6.79	2 474 309	2 624 694

10. PERFORMANCE AND EXPENDITURE TRENDS

Programme 4 is allocated 15.79 per cent of the vote during 2012/13 in comparison to the 16.11 per cent allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R146.860 million or 6.79 per cent.

PROGRAMME 5: CENTRAL HOSPITAL SERVICES

1. PROGRAMME

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

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 5.1. CENTRAL HOSPITAL SERVICES

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

3. SITUATION ANALYSIS

Institutions within the Western Cape and beyond provincial boundaries refer patients to the three central hospitals, which are Groote Schuur, Tygerberg and Red Cross War Memorial Children's Hospitals.

Between 2008/09 and 2010/11 central hospitals received funding from Programme 4.1 (for general specialist services) and Programme 5.1 (for highly specialised services). From 2011/12 the Programme 4.1 and Programme 5.1 funding for central hospitals were consolidated in Programme 5.1. Functional business units (FBUs) were established to differentiate and account separately for the general and highly specialised services.

In 2011/12 the general and highly specialised services in the three central hospitals were provided in 2 545 beds, related outpatient clinics, operating theatres and procedure rooms.

Table 5.1: Number of beds operated per central hospital

Central hospital	Number of beds
Groote Schuur Hospital	945
Tygerberg Hospital	1 310
Red Cross War Memorial Children's Hospital	290
TOTAL	**2 545**

Each central hospital provides regional, central referral and some unique national referral services. Unique services and achievements in 2011/12 are outlined below.

3.1 GROOTE SCHUUR HOSPITAL

Groote Schuur Hospital provides a full package of adult tertiary services, and is the referral centre for the following unique services:

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

3.1.1 **Key achievements for Groote Schuur Hospital include:**

1) Managing the burden of disease towards an increased life expectancy and improved health outcomes for patients by strengthening acute hospital services by establishing three general specialist theatre lists for orthopaedics, general surgery and an additional list for urgent theatre cases as well as commissioned an additional Orthopaedic clinic.
2) Improved the patient experience and the quality of emergency services by measuring the waiting times in emergency centres and developing strategies to reduce them.
3) Improved the delivery of woman's health services by supporting a colposcopy clinic at Victoria Hospital.
4) Bolstered the services rendered in bottleneck areas like theatres and critical care by:
    - Increasing the post-anaesthetic high care unit capacity to a total of four beds.
    - Reinstating seven theatre operating lists.
    - Appointing four operating theatre practitioners as a pilot project, to bolster theatre operating capacity.
    - Extending the scanning hours for computerised tomography (CT) services.
5) Improved the quality of health services by implementing the Best Care Always initiatives policies to prevent central line infections in selected clinical areas.
6) Established health infrastructure and technology to support service delivery by completing the infrastructure changes to accommodate the Picture Archive Communication System (PACS) system.

3.2 **TYGERBERG HOSPITAL**

Tygerberg Hospital provides a full spectrum of adult and paediatric tertiary services, apart from paediatric cardiac surgery and heart, liver and bone marrow transplantation which are centralised in Groote Schuur and Red Cross War Memorial Children's Hospitals. Tygerberg Hospital provides the following unique services:

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

3.2.1 **Key achievements for Tygerberg Hospital include:**

1) Managing the burden of disease towards an increased life expectancy and improved health outcomes for patients by strengthening acute hospital services by:
    - Strengthening general medicine services by appointing a head of general medicine in Tygerberg Hospital to oversee general medicine services in the GSA.

- Implementing an improved clinical protocol in respect of management of venous ulcers.

2) Improved the patient experience and the quality of emergency services by appointing two emergency medicine specialists to bolster emergency care.

3) Improved the delivery of woman's health services by:

   - Reorganising the labour ward to achieve single bed delivery rooms for improved patient privacy and clinical care.
   - Implementing a dedicated labour ward specialist consultant to assist and oversee deliveries.

4) Bolstered the services rendered in bottleneck areas like theatres and critical care by:

   - Sustainably operating ten paediatric intensive care beds.
   - Commissioning four additional neonatal high care beds.
   - Appointing five operating theatre practitioners as a pilot project, to bolster theatre operating capacity.
   - Implementing extended scanning hours for CT and MRI scanning to improve access to both emergency and elective scans.

5) Improved the quality of health services by:

   - Implementing the Best Care Always initiatives to reduce the occurrence of ventilator acquired infections in respiratory ICU, central line associated blood infections in surgical ICU and expansion of the hospital's infection prevention and control manual.

6) Established and maintained sufficient health infrastructure and technology to support service delivery by:

   - Completing the infrastructure changes to accommodate the Western Cape Positron Emission Tomography (PET)-CT scanner as well as a new cardiac catheterisation theatre and cardiac echocardiography suite scanner.
   - Concluding the planning for infrastructure work towards establishing the emergency centre and re-organisation of the haematology services to protect neutropenic patients from hospital acquired infections.

3.3 RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

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

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

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

1) Managed the burden of disease towards an increased life expectancy and improved health outcomes for patients by strengthening acute hospital services by:

- Increasing access to otorhinolaryngology services by re-allocating four additional beds.
- Appointing a provincial co-ordinator for burns and formulating a plan for the re-organisation of provincial burns services as well as conducting lecture courses in burn care to primary health care personnel.

2) Improved the patient experience and the quality of emergency services by:

- Concluding the basic requirements for the upgrading of the emergency centre infrastructure to improve patient and work flow.
- Participating with the Walter Sisulu Paediatric Cardiac Foundation by providing and co-ordinating theatre and ICU services to perform 39[1] additional cardiothoracic operations.

3) Bolstered the services rendered in bottleneck areas like theatres and critical care by:

- Performing 54 additional general paediatric and ENT operations through doing additional elective theatre cases on Saturdays during the third quarter.
- Hosting a facial project focussing on facial reconstruction in children with an associated training course for registrars.
- Hosting an initiative of the Smile Foundation and operating 22 children with cleft lips and palates.

4) Improved the quality of health services with on-going implementation of the Best Care Always initiatives policies to prevent ventilator associated pneumonia.

5) Established and maintained sufficient health infrastructure and technology to support service delivery by completing the infrastructure changes to accommodate the PACS system by appointing PAC/RIS administrators, upgrading server rooms and purchasing the required equipment.

3.4 MAITLAND COTTAGE HOME

Maitland Cottage Home is a provincially aided health facility which operates as an extension of Red Cross War Memorial Children's Hospital and provides for specialist orthopaedic surgery, post-operative care and rehabilitation for children with orthopaedic conditions. The facility operates 85 beds and performs, on average, 540 operations per annum.

3.5 STRENGTHENING THE HEALTH SYSTEM

Apart from service delivery, central hospitals strengthened the health system within the geographic service areas as follows:

- Heads of general specialist services in the Metro East and Metro West GSAs support clinical governance, skills development and monitor the appropriateness of referrals.
- Performing outreach and support to district health services in all disciplines.

Higher education institutions partnered with the Province for the training of health sciences learners. The central hospitals form a substantive part of the platform where training and

[1] As on 31 December 2011.

research takes place. Research evidence influences the provision and practise of appropriate health care to attain the best health outcomes.

3.6 REPRIORITISATION

The programme has, over time, systematically reprioritised within its baseline. The re-prioritisation focus has been on increasing efficiencies and using savings to strengthen the ability of the service to better respond to the large service need. The conditional grant (HPTDG and NTSG) contribution, which is a significant portion of the central hospital budget, has not kept pace with the actual costs of outputs, and the HPTDG has not been adjusted for to compensate for inflation or Occupational Specific Dispensation. However, through increased efficiencies, the central hospitals have maintained and improved the patient activity outputs.

Examples include the following:

- Opening psychiatric inpatient services in Groote Schuur Hospital to treat patients referred from GF Jooste Hospital.
- Reducing expenditure on laboratory services by means of an electronic gatekeeping system, and redirecting funding to other service needs.
- Converting funds paid for agency staff to fund and fill permanent posts. This improved human resource capacity and has positively impacted on quality of care.

4. CHALLENGES

4.1 DIFFERENTIATING SERVICES BY LEVELS OF CARE IN CENTRAL HOSPITALS

The policy imperative of the departmental strategic transformation plan (i.e. the Comprehensive Service Plan) is to functionally differentiate central hospital services into general and highly specialised services. Once achieved this would improve efficiencies and accountability, strengthen clinical governance, and provide an appropriate platform for training. Differentiating and reporting on the highly specialised and general specialist services~~,~~ delivered in one facility~~,~~ has been a challenge. Information systems are not able to automatically report between levels of care and a range of manual processes are required to report on differentiated clinical and financial data.

Functional business units, based on cost centres, have been established as a mechanism to differentiate delivery and accounting separately for general and highly specialised services. FBU managers are accountable for financial and human resources~~,~~ as well as service delivery and quality of care.

4.2 ACUTE BED PRESSURES

Acute bed pressures are pronounced in critical care, neonatology, obstetrics, and medicine and are reflected in bed utilisation rates often exceeding the optimal performance norm of 85 per cent. Redirection of ambulances to other facilities occurs as a result of service pressures across metro hospitals.

4.3 QUALITY OF CARE

The service need outstrips available resources and is most prominent in theatre, radiology, therapeutic radiation procedures and emergency centres. The patient waiting times in

emergency centres for folders, medication and therapeutic procedures are often a challenge.

4.4 CHANGE OF DRAINAGE AREA WHEN KHAYELITSHA DISTRICT HOSPITAL OPENS

Patients from Khayelitsha are currently admitted into hospitals across the Metro District. An estimated 52 per cent of all referrals for more specialised services are currently admitted in Metro West. Following the commissioning of the Khayelitsha District Hospital in 2012, patients requiring specialised care will be referred to Tygerberg Hospital in Metro East. The capacity at Tygerberg Hospital needs to be strengthened to accommodate these service shifts.

Shifting the resources to follow the shift of patients will be challenging as staff are permanently appointed at a particular facility and have associated academic responsibilities. To accommodate this change in the drainage area, Tygerberg Hospital will commission 74 beds. The 74 beds will not be additional beds, but will be internally shifted from Groote Schuur (54) and Red Cross War Memorial Children's Hospital (20). It is uncertain what the immediate effect will be on the health seeking behaviour of patients. These shifts will influence the service outputs during the transitional period, making accurate target setting difficult.

4.5 DEMAND FOR HIGHLY SPECIALISED SERVICES

The hospitals collectively experience an increased demand for highly specialised services and have done well to reprioritise the services through the process of rationing and priority setting. Despite active priority setting initiatives, the demand, for example, for category 1 renal dialysis remains a challenge. There is also a need to improve the response to women with breast cancer, especially access to surgery and radiation therapy.

4.6 HUMAN RESOURCES

There are challenges in the recruitment and retention of several categories of staff, such as:

- Professional nurses with post basic qualifications in theatre technique and intensive care. This limits the ability to improve access to surgical procedures and critical care.
- Clinical technologists, who are critical for the maintenance of health equipment.
- Medical physicists who are key to supporting radiation oncology services.

5. PRIORITIES FOR 2012/13

In 2012/13 the central hospitals will address identified challenges, risks and departmental strategic goals, as well as contribute towards the progressive realisation of key priorities of the national Negotiated Service Delivery Agreement. The programme systematically reprioritises its spending towards these focus areas.

5.1 CENTRAL HOSPITALS

The programme will focus on the following priorities that are common to all three central hospitals, during the 2012/13 year, in the following key performance areas:

- Improving service delivery.
- Improving quality of care and clinical governance.
- Improving corporate governance.

5.1.1 **Improving service delivery**

- Improve acute hospital services by focussing on the following priority areas:
  - Strengthen general specialist services.
  - Improve maternal, child and women's health services and health outcomes.
  - Improve the management of bottleneck areas such as intensive care units (ICU), theatres and radiology.
  - Improve theatre efficiencies and monitor operating theatre starting times and cancellation rates to ensure optimal usage of available theatre time.
  - Care pathways for breast cancer management.
  - Improve the management of chronic conditions.
  - Increase access to patient renal dialysis and radiation oncology.
- Improve access to ambulatory services for new patients.
- Strengthen the ability of Tygerberg Hospital to receive referrals from Khayelitsha District Hospital.

5.1.2 **Improving quality of care and clinical governance**

- Strengthen clinical governance and clinical leadership across levels of care within geographic service areas (GSAs) together with district health services.
- Strengthen the competencies to improve the health impact and health outcomes in the GSA.
- Improve service management effectiveness, monitoring and evaluation through functional business units (FBUs) for each clinical discipline with decentralised decision making, monitoring and evaluation.
- Enhance the capacity to improve the prevention and management of hospital acquired infections through the Best Care Always initiative.
- Improve the patient experience in the delivery of emergency services by implementing interventions to reduce waiting times in emergency centres.
- Conduct and respond to the findings of the annual patient satisfaction survey.
- Develop quality improvement plans to ensure full compliance with the vital national core standard criteria.

5.1.3 **Improving corporate governance**

- Progressive implementation of the finalised organisational design investigation for each central hospital.
- Strengthen audit compliance for predetermined objectives, financial management and human resources management.
- Implement the Picture Archive Communication System (PACS) in each central hospital, conclude the pilot of the Radiological Imaging System (RIS) at Tygerberg Hospital and commence roll out to the rest of the central hospitals.
- Respond to the findings of staff satisfaction surveys.
- Acquire health technology (equipment) according to a prioritised procurement plan.

5.2 GROOTE SCHUUR HOSPITAL

In addition to the above, the priorities that are specific to Groote Schuur Hospital are:

5.2.1 Improving service delivery

- Strengthen general specialist service by establishing dedicated general orthopaedic and general surgery operating theatre lists.
- Establish the ability to provide non-invasive urological procedures.
- Expand the delivery of surgical day cases and participate in the GSA's initiatives to increase the outputs in surgical procedures, such as circumcision and cataract surgery.
- Increase access to dialysis services for patients with renal failure.
- Improve efficiencies by consolidating certain services, especially surgical services related to abdominal surgery, as well as geriatric, psychiatry and neuropsychiatry services to ensure the provision of a comprehensive, quality service.
- Improve the delivery of women's health services:
  - Provide comprehensive services for high risk pregnancies.
  - Strengthen the outreach and support for colposcopy services in the GSA.
  - Improve care pathways for women with breast cancer.
- Improve efficiencies and reduce bottlenecks in theatres and critical care by:
  - Measuring the starting times and cancellation rate for theatres to ensure the optimal use of available theatre time.
  - Concluding and evaluating the pilot project to train operating theatre practitioners.
  - Commissioning three additional orthopaedic high care beds.
  - Improving access to medical imaging by extending the scanning hours for Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) services.

5.2.2 Clinical governance and quality of care

- Reduce waiting times by piloting an electronic and automated dispensing system to reduce the waiting times for pharmacy services.

5.2.3 Corporate governance

- Strengthen medical physics staff capacity with an intern.
- Install a new linear accelerator machine to improve management of oncology patients.
- Implement the PACS and RIS projects.

5.3 TYGERBERG HOSPITAL

In addition to the general priorities that were previously addressed, the priorities that are specific to Tygerberg Hospital are:

5.3.1 Improving service delivery

- Prepare the hospital to receive referrals and provide outreach and support to Khayelitsha District Hospital that was commissioned during January 2012.

- Strengthen the GSA outreach and support in specialities such as urology, ophthalmology, and ear, nose and throat (ENT). This will reduce referrals from rural regional hospitals to Tygerberg Hospital.
- Improve efficiencies and reduce bottlenecks in theatres and critical care. Increase access to operating theatres by improving efficiencies, as measured by surgery start times and cancellation of operations.

5.3.2 **Clinical governance and quality of care**

- Strengthen clinical governance by participating in the clinical audit of caesarean sections, management of strokes and child mortalities in the GSA.
- Improve the patient experience and the delivery of emergency services with specific reference to waiting times.
- Host the appointed specialists for district support in Metro East.
- Reduce the risk of hospital acquired infections with continuation of the Best Care Always project.

5.3.3 **Corporate governance**

- Upgrade the emergency centre, labour and paediatric wards.
- Achieve full functionality of PACS and RIS.

5.4 **RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL**

In addition to the above, the priorities that are specific to Red Cross War Memorial Children's Hospital are:

5.4.1 **Improving service delivery**

- Implement steps recommended by the World Health Organisation (WHO) to manage malnutrition in children and promote breastfeeding.
- Strengthen the functioning of the poison centre as a provincial / national resource.
- Improve efficiencies and reduce bottlenecks such as theatres and critical care by:
    - Reducing surgical waiting times in ENT procedures.
- Provide outreach and support to less specialised levels of care to strengthen the comprehensive delivery of tracheostomy services and the tracheostomy programme.
- Establish 24-hour access to the therapeutic learning centre for children (psychiatric care).

5.4.2 **Clinical governance and quality of care**

- Improve the patient experience and the delivery of emergency services with specific reference to waiting times.

5.4.3 **Corporate governance**

- Commence upgrading infrastructure in the emergency centre and two medical wards.
- Implement PACS and RIS.

Table 5.2: Data elements of performance indicators for central hospitals

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	Caesarean sections in central hospitals	1	4 915	5 052	6 024	5 225	5 595	5 670	5 745
SINJANI	Deliveries in central hospitals	2	12 123	11 509	13 055	11 019	11 750	11 900	12 050
SINJANI	Usable beds in central hospitals	3	1 460	1 468	1 473	2 545	2 545	2 545	2 545
SINJANI	Separations	4	62 555	68 231	68 490	136 883	140 395	139 438	139 947
SINJANI	OPD headcount (general and specialist)	5	543 461	537 749	541 079	850 009	852 065	849 911	847 624
SINJANI	Total OPD headcount + Emergencies	5.1				989 401	948 384	891 411	887 624
SINJANI	PDE- Sum of: inpatient days + 1/2 day patients + 1/3 OPD headcount + 1/3 emergency headcount	6	603 475	625 661	634 782	1 100 898	1 123 389	1 113 189	1 117 470
SINJANI	Patient days	7	422 267	446 411	454 423	771 098	792 868	784 385	789 929
SINJANI	Total usable bed days	8	532 900	535 820	537 645	928 925	930 750	928 925	928 925
BAS- CFO	Total expenditure in central hospitals`(2010/11 Rands)	9	2 593 819 484	2 677 613 966	2 670 354 627	3 656 032 192	3 643 886 225	3 657 322 183	3 645 709 482
SINJANI	Central hospitals with M & M meetings every month	10	3	3	3	3	3	3	3
SINJANI	Complaints resolved within 25 days	11	678	618	630	129	198	192	185
SINJANI	Complaints lodged	12	768	704	700	262	260	238	217
SINJANI	Number of questionnaires with 1 or 2 recorded for pleased with treatment	13	Not required to report	Not required to report	2 936	4 551	4 950	4 950	4 950
SINJANI	Number of questionnaires for pleased with treatment	14	Not required to report	Not required to report	3 323	4 882	5 500	5 500	5 500
SINJANI	Central hospitals assessed against the core standards	15	Not required to report	Not required to report	Not required to report	3	0	3	0

Note:

It is not a mandatory requirement to include the above table. However, the purpose is to provide an easy reference to raw data from which values for indicators are determined and to facilitate the audit trail.

The purpose of the column 'Element ID' is purely to facilitate cross referencing between the tables.

Table 5.3: Performance indicators for Central Hospitals [CHS3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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) Caesarean section rate in central hospitals	%	47.7%	40.5%	43.9%	46.1%	47.4%	47.6%	47.6%	47.7%	30%
			Numerator ID 1		5 745	4 915	5 052	6 024	5 225	5 595	5 670	5 745	
			Denominator ID 2		12 050	12 123	11 509	13 055	11 019	11 750	11 900	12 050	
	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 2 545 beds.	2) Number of actual beds in central hospitals	No	2 545	1 460	1 468	1 473	2 545	2 545	2 545	2 545	
			Element ID 3										
			3) Total separations in central hospitals	No		62 555	68 231	68 490	136 883	140 395	139 438	139 947	
			Element ID 4										
			4) OPD total headcounts in central hospitals	No		543 461	537 749	541 079	850 009	852 065	849 911	847 624	
			Element ID 5										
			5) Patient day equivalents [PDE] in central hospitals	No		603 475	625 661	634 782	1 100 898	1 123 389	1 113 189	1 117 470	
			Element ID 6										
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 85% by 2014/15.	6) Bed utilisation rate (based on actual beds) in central hospitals	%	85.0%	79%	83%	85%	83%	85%	84%	85%	75%
			Numerator ID 7		789 929	422 267	446 411	454 423	771 098	792 868	784 385	789 929	
			Denominator ID 8		928 925	532 900	535 820	537 645	928 925	930 750	928 925	928 925	
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 262 per patient day equivalent by 2014/15 (2010/11 rands)	7) Expenditure per patient day equivalent [PDE] in central hospitals	R	R 3 262	R 4 298	R 4 280	R 4 207	R 3 321	R 3 244	R 3 285	R 3 262	
			Numerator ID 9		3 645 709 482	2 593 819 484	2 677 613 966	2 670 354 627	3 656 032 192	3 643 886 225	3 657 322 183	3 645 709 482	
			Denominator ID 6		1 117 470	603 475	625 661	634 782	1 100 898	1 123 389	1 113 189	1 117 470	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 5.6 days for central hospitals by 2014/15.	8) Average length of stay in central hospitals	Days	5.6	6.8	6.5	6.6	5.6	5.6	5.6	5.6	5.5
			Numerator ID 7		789 929	422 267	446 411	454 423	771 098	792 868	784 385	789 929	
			Denominator ID 4		139 947	62 555	68 231	68 490	136 883	140 395	139 438	139 947	
4. Improve the quality of health services and improve 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) Number of central hospitals with monthly mortality and morbidity meetings	No	3	3	3	3	3	3	3	3	
			Element ID 10										
			10) Percentage of complaints of users of central hospital services resolved within 25 days	%		88%	88%	90%	49%	76%	81%	85%	
			Numerator ID 11			678	618	630	129	198	192	185	
			Denominator ID 12			768	704	700	262	260	238	217	
			11) Central hospital patient satisfaction rate	%		Not required to report	Not required to report	88%	93%	90%	90%	90%	
			Numerator ID 13			-	-	2 936	4 551	4 950	4 950	4 950	
			Denominator ID 14			-	-	3 323	4 882	5 500	5 500	5 500	
			12) Number of central hospital assessed for compliance with core standards	No		Not required to report	Not required to report	Not required to report	3	0	3	0	
			Element ID 15										

Notes:

All: From 2008/09 to 2010/11 the general specialist services outputs in central hospitals were reflected in Programme 4.1.
As from 2011/12 all service activities in central hospitals are reflected in Programme 5.1, therefore increasing the service outputs in the following years.

Indicator 1: The caesarean section rate indicated is for the combined central hospital services.

Indicator 2: The increase of beds from 2010/11 to 2011/12 is as a result of reporting the general specialist outputs together with the highly specialised outputs.

Indicator 7: The expenditure per patient day equivalent for the period 2008/09 to 2010/11 is for the highly specialised services in the central hospitals only.
As from 2011/12 the expenditure per patient day equivalent is for both, i.e. the combined general specialised and the highly specialised services.

Indicator 10: Due to a change in the definition and reporting systems, a new baseline was established. Mechanisms will be implemented to continuously improve performance in subsequent years.

Strategic objective performance indicators are highlighted in yellow.

Provincially determined performance indicators are highlighted.

Table 5.4: Quarterly targets for central hospitals for 2012/13 [CHS6]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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) Caesarean section rate in central hospitals	Quarterly	48%	48%	48%	48%	48%
			Numerator ID 1		5 595	1 399	1 399	1 399	1 399
			Denominator ID 2		11 750	2 938	2 938	2 938	2 938
	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 2 545 beds.	2) Number of actual beds in central hospitals Element ID 3	Quarterly	2 545	2 545	2 545	2 545	2 545
			3) Total separations in central hospitals Element ID 4	Quarterly	140 395	35 099	35 099	35 099	35 099
			4) OPD total headcounts in central hospitals Element ID 5	Quarterly	852 065	213 016	213 016	213 016	213 016
			5) Patient day equivalents [PDE] in central hospitals Element ID 6	Quarterly	1 123 389	280 847	280 847	280 847	280 847
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1 Efficiently manage resources to achieve the target bed occupancy rate of 85% by 2014/15.	6) Bed utilisation rate (based on actual beds) in central hospitals	Quarterly	85%	85%	85%	85%	85%
			Numerator ID 7		792 868	198 217	198 217	198 217	198 217
			Denominator ID 8		930 750	232 688	232 688	232 688	232 688
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 262 per patient day equivalent by 2014/15 (2010/11 rands)	7) Expenditure per patient day equivalent [PDE] in central hospitals	Quarterly	R 3 244	R 3 244	R 3 244	R 3 244	R 3 244
			Numerator ID 9	R'000	3 643 886 225	910 971 306	910 971 306	910 971 306	910 971 307
			Denominator ID 6		1 123 389	280 847	280 847	280 847	280 848
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 5.6 days for central hospitals by 2014/15.	8) Average length of stay in central hospitals	Quarterly	6.0	6.0	6.0	6.0	6.0
			Numerator ID 7		792 868	198 217	198 217	198 217	198 217
			Denominator ID 4		140 395	35 099	35 099	35 099	35 099
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) Number of central hospitals with monthly mortality and morbidity meetings Element ID 10	Quarterly	3	3	3	3	3

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
			10) Percentage of complaints of users of central hospital services resolved within 25 days	Quarterly	76%	76%	76%	76%	76%
			Numerator ID 11		198	48	48	50	50
			Denominator ID 12		260	65	65	65	65
			11) Central hospital patient satisfaction rate	Annually	90%	-	-	-	90%
			Numerator ID 13		4 950	-	-	-	4 950
			Denominator ID 14		5 500	-	-	-	5 500
			12) Number of central hospital assessed for compliance with core standards	Annually	0				
			Element ID 15						

Table 5.5: Data elements of performance indicators for Groote Schuur Hospital

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	Caesarean sections in GSH	1	2 587	2 861	3 875	2 824	2 970	3 024	3 078
SINJANI	Deliveries in GSH	2	5 094	5 452	7 139	5 293	5 500	5 600	5 700
SINJANI	Usable beds in GSH	3	695	625	630	945	891	891	891
SINJANI	Separations	4	33 785	33 293	32 788	51 479	50 416	48 829	48 863
SINJANI	OPD headcount (General and Specialist)	5	259 361	268 551	262 463	399 797	395 056	389 217	384 638
SINJANI	Total OPD headcount + Emergencies	5.1				439 493	395 056	389 217	384 638
SINJANI	PDE- Sum of: inpatient days + 1/2 day patients + 1/3 OPD headcount + 1/3 emergency headcount	6	302 817	300 397	301 512	447 484	436 697	427 595	426 068
SINJANI	Patient days	7	216 308	210 880	214 025	300 987	293 679	286 189	286 189
SINJANI	Total usable bed days	8	250 025	228 125	229 950	344 467	325 215	325 215	325 215
BAS- CFO	Total expenditure in GSH 2010/11 Rands)	9	1 295 292 768	1 253 744 037	1 285 841 884	1 519 526 497	1 511 059 744	1 516 434 354	1 511 180 054
SINJANI	M & M meetings every month	10	Yes	Yes	Yes	Yes	Yes	Yes	Yes
SINJANI	Complaints resolved within 25 days	11	448	385	432	49	60	56	51
SINJANI	Complaints lodged	12	512	458	480	71	80	70	60
SINJANI	Number of questionnaires with 1 or 2 recorded for pleased with treatment	13	Not required to report	Not required to report	2 055	2 052	2 610	2 610	2 610
SINJANI	Number of questionnaires for pleased with treatment	14	Not required to report	Not required to report	2 302	2 280	2 900	2 900	2 900
SINJANI	GSH assessed against the core standards	15	Not required to report	Not required to report	Not required to report	1	0	1	0

Table 5.6: Performance indicators for Groote Schuur Hospital [CHS5]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Address the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 54% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Groote Schuur Hospital	%	54.0%	50.8%	52.5%	54.3%	53%	54.0%	54.0%	54.0%	30%
			Numerator ID 1		3 078	2 587	2 861	3 875	2 824	2 970	3 024	3 078	
			Denominator ID 2		5 700	5 094	5 452	7 139	5 293	5 500	5 600	5 700	
	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 Groote Schuur Hospital services by providing 891 beds by 2014/15.	2) Number of actual beds in Groote Schuur Hospital	No	891	695	625	630	945	891	891	891	
			Element ID 3										
			3) Total separations in Groote Schuur Hospital	No		33 785	33 293	32 788	51 479	50 416	48 829	48 863	
			Element ID 4										
			4) OPD total headcounts in Groote Schuur Hospital	No		259 361	268 551	262 463	399 797	395 056	389 217	384 638	
			Element ID 5										
			5) Patient day equivalents [PDE] in Groote Schuur Hospital	No		302 817	300 397	301 512	447 484	436 697	427 595	426 068	
			Element ID 6										
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 88% by 2014/15.	6) Bed utilisation rate (based on actual beds) in Groote Schuur Hospital	%	88%	87%	92%	93%	87%	90%	88%	88%	75%
			Numerator ID 7		286 189	216 308	210 880	214 025	300 987	293 679	286 189	286 189	
			Denominator ID 8		325 215	250 025	228 125	229 950	344 467	325 215	325 215	325 215	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 Groote Schuur Hospital at a target cost of R3 547 per patient day equivalent by 2014/15 (2010/11 rands)	7) Expenditure per patient day equivalent [PDE] in Groote Schuur Hospital	R	R 3 547	R 4 277	R 4 174	R 4 265	R 2 895	R 3 460	R 3 546	R 3 547	
			Numerator ID 9		1 511 180 054	1 295 292 768	1 253 744 037	1 285 841 884	1 519 526 497	1 511 059 744	1 516 434 354	1 511 180 054	
			Denominator ID 6		426 068	302 817	300 397	301 512	447 484	436 697	427 595	426 068	
3. Ensure 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 5.9 days for Groote Schuur Hospital.	8) Average length of stay in Groote Schuur Hospital	Days	5.9	6.4	6.3	6.5	5.8	5.8	5.9	5.9	5.5
			Numerator ID 7		286 189	216 308	210 880	214 025	300 987	293 679	286 189	286 189	
			Denominator ID 4		48 863	33 785	33 293	32 788	51 479	50 416	48 829	48 863	
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. Ensure appropriate mechanisms to measure improvement in quality of health services.	9) Groote Schuur Hospital with monthly mortality and morbidity meetings	Y / N	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Element ID 10										
			10) Percentage of complaints of users of Groote Schuur Hospital resolved within 25 days	%		88%	84%	90%	69%	75%	80%	85%	
			Numerator ID 11			448	385	432	49	60	56	51	
			Denominator ID 12			512	458	480	71	80	70	60	
			11) Patient satisfaction rate in Groote Schuur Hospital	%		Not required to report	Not required to report	89%	90%	90%	90%	90%	
			Numerator ID 13			-	-	2 055	2 052	2 610	2 610	2 610	
			Denominator ID 14			-	-	2 302	2 280	2 900	2 900	2 900	
			12) Groote Schuur Hospital assessed for compliance with core standards	No		Not required to report	Not required to report	Not required to report	1	0	1	0	
			Element ID 15										

Notes:

All: From 2008/09 to 2010/11 the general specialist services outputs in central hospitals were reflected in Programme 4.1.
As from 2011/12 all service activities in Groote Schuur Hospital is reflected in Programme 5.1.

Indicator 1: The caesarean section rate indicated is for Groote Schuur Hospital services as a whole, including the level 2 services.

Indicator 2: The increase of beds from 2010/11 to 2011/12 is as a result of reporting the general specialist outputs together with the highly specialised outputs.

Indicator 3: The reduction of the bed numbers from 2011/12 to 2012/13 is as a result of the transfer of beds to Tygerberg Hospital to accommodate the change in the drainage of the newly commissioned Khayelitsha District Hospital.

Indicator 7: The expenditure per patient day equivalent for the period 2008/09 to 2010/11 is for the highly specialised services in Groote Schuur Hospital.
As from 2011/12 the expenditure per patient day equivalent is for both the general specialised and the highly specialised services.

Indicator 10: Due to a change in the definition and reporting systems, a new baseline was established. Mechanisms will be implemented to continuously improve performance in subsequent years.

Table 5.7: Quarterly targets for Groote Schuur Hospital for 2012/13 [CHS6]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
1. Address the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 54% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Groote Schuur Hospital	Quarterly	54%	54%	54%	54%	54%
			Numerator ID 1		2 970	743	743	743	743
			Denominator ID 2		5 500	1 375	1 375	1 375	1 375
	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 Groote Schuur Hospital services by providing 891 beds by 2014/15.	2) Number of actual beds in Groote Schuur Hospital Element ID 3	Quarterly	891	891	891	891	891
			3) Total separations in Groote Schuur Hospital Element ID 4	Quarterly	50 416	12 604	12 604	12 604	12 604
			4) OPD total headcounts in Groote Schuur Hospital Element ID 5	Quarterly	395 056	98 764	98 764	98 764	98 764
			5) Patient day equivalents [PDE] in Groote Schuur Hospital Element ID 6	Quarterly	436 697	109 174	109 174	109 174	109 174
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 88% by 2014/15.	6) Bed utilisation rate (based on actual beds) in Groote Schuur Hospital	Quarterly	90%	90%	90%	90%	90%
			Numerator ID 7		293 679	73 420	73 420	73 420	73 420
			Denominator ID 8		325 215	81 304	81 304	81 304	81 304

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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 Groote Schuur Hospital at a target cost of R3 547 per patient day equivalent by 2014/15 (2010/11 rands)	7) Expenditure per patient day equivalent [PDE] in Groote Schuur Hospital	Quarterly	R 3 460	R 3 460	R 3 460	R 3 460	R 3 460
			Numerator ID 9	R'000	1 511 059 744	377 764 936	377 764 936	377 764 936	377 764 936
			Denominator ID 6		436 697	109 174	109 174	109 174	109 175
3. Ensure 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 5.9 days for Groote Schuur Hospital.	8) Average length of stay in Groote Schuur Hospital	Quarterly	5.8	5.8	5.8	5.8	5.8
			Numerator ID 7		293 679	73 420	73 420	73 420	73 420
			Denominator ID 4		50 416	12 604	12 604	12 604	12 604
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) Groote Schuur Hospital with monthly mortality and morbidity meetings	Quarterly	Yes	Yes	Yes	Yes	Yes
			Element ID 10						
			10) Percentage of complaints of users of Groote Schuur Hospital resolved within 25 days	Quarterly	75%	75%	75%	75%	75%
			Numerator ID 11		60	15	15	15	15
			Denominator ID 12		80	20	20	20	20
			11) Patient satisfaction rate in Groote Schuur Hospital	Annually	90%	-	-	-	90%
			Numerator ID 13		2 610	-	-	-	2 610
			Denominator ID 14		2 900	-	-	-	2 900
			12) Groote Schuur Hospital assessed for compliance with core standards	Annually	0				
			Element ID 15						

Table 5.8: Data elements of performance indicators for Tygerberg Hospital

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	Caesarean sections in TBH	1	2 328	2 191	2 149	2 401	2 625	2 646	2 667
SINJANI	Deliveries in TBH	2	7 029	6 057	5 916	6 102	6 250	6 300	6 350
SINJANI	Usable beds in TBH	3	538	608	608	1 310	1 384	1 384	1 384
SINJANI	Separations	4	18 548	22 611	23 214	62 439	68 456	69 549	70 338
SINJANI	OPD headcount (General and Specialist)	5	203 643	187 654	197 259	325 669	335 927	340 498	342 973
SINJANI	Total OPD headcount + Emergencies	5.1				382 246	386 246	340 498	342 973
SINJANI	PDE- Sum of: inpatient days + 1/2 day patients + 1/3 OPD headcount + 1/3 emergency headcount	6	205 995	225 672	232 604	509 951	547 104	547 730	553 607
SINJANI	Patient days	7	138 114	163 121	166 851	382 536	413 961	414 231	419 283
SINJANI	Total usable bed days	8	196 370	221 920	221 920	480 333	505 160	505 160	505 160
BAS- CFO	Total expenditure in TBH 2010/11 Rands)	9	908 190 044	1 021 633 348	1 008 310 388	1 645 293 056	1 656 451 106	1 662 857 350	1 658 207 843
SINJANI	M & M meetings every month	10	Yes	Yes	Yes	Yes	Yes	Yes	Yes
SINJANI	Complaints resolved within 25 days	11	158	202	180	62	120	120	119
SINJANI	Complaints lodged	12	181	214	200	171	160	150	140
SINJANI	Number of questionnaires with 1 or 2 recorded for pleased with treatment	13	Not required to report	Not required to report	385	860	810	810	810
SINJANI	Number of questionnaires for pleased with treatment	14	Not required to report	Not required to report	437	894	900	900	900
SINJANI	TBH assessed against the core standards	15	Not required to report	Not required to report	Not required to report	1	0	1	0

Table 5.9: Performance indicators for Tygerberg Hospital [CHS5]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Address the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 42% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Tygerberg Hospital	%	42.0%	33.1%	36.2%	36.3%	39.4%	42.0%	42.0%	42.0%	30%
			Numerator ID 1		2 667	2 328	2 191	2 149	2 401	2 625	2 646	2 667	
			Denominator ID 2		6 350	7 029	6 057	5 916	6 102	6 250	6 300	6 350	
	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 Tygerberg Hospital services by providing 1 384 beds.	2) Number of actual beds in Tygerberg Hospital	No	1 384	538	608	608	1 310	1 384	1 384	1 384	
			Element ID 3										
			3) Total separations in Tygerberg Hospital	No		18 548	22 611	23 214	62 439	68 456	69 549	70 338	
			Element ID 4										
			4) OPD total headcounts in Tygerberg Hospital	No		203 643	187 654	197 259	325 669	335 927	340 498	342 973	
			Element ID 5										
			5) Patient day equivalents [PDE] in Tygerberg Hospital	No		205 995	225 672	232 604	509 951	547 104	547 730	553 607	
			Element ID 6										
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 83% by 2014/15.	6) Bed utilisation rate (based on actual beds) in Tygerberg Hospital)	%	83%	70%	74%	75%	80%	82%	82%	83%	75%
			Numerator ID 7		419 283	138 114	163 121	166 851	382 536	413 961	414 231	419 283	
			Denominator ID 8		505 160	196 370	221 920	221 920	480 333	505 160	505 160	505 160	
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 Tygerberg Hospital at a target cost of R2 995 per patient day equivalent by 2014/15 (2010/11 rands)	7) Expenditure per patient day equivalent in Tygerberg Hospital	R	R 2 995	R 4 409	R 4 527	R 4 335	R 3 226	R 3 028	R 3 036	R 2 995	
			Numerator ID 9		1 658 207 843	908 190 044	1 021 633 348	1 008 310 388	1 645 293 056	1 656 451 106	1 662 857 350	1 658 207 843	
			Denominator ID 6		553 607	205 995	225 672	232 604	509 951	547 104	547 730	553 607	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 days for Tygerberg Hospital by 2014/15.	8) Average length of stay in Tygerberg Hospital	Days	6.0	7.4	7.2	7.2	6.1	6.0	6.0	6.0	5.5
			Numerator ID 7		419 283	138 114	163 121	166 851	382 536	413 961	414 231	419 283	
			Denominator ID 4		70 338	18 548	22 611	23 214	62 439	68 456	69 549	70 338	
4. Improve the quality of health services and the patient experience.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) Tygerberg Hospital has monthly mortality and morbidity meetings	Y / N	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Element ID 10										
			10) Percentage of complaints of users of Tygerberg Hospital resolved within 25 days	%		87%	94%	90%	36%	75%	80%	85%	
			Numerator ID 11			158	202	180	62	120	120	119	
			Denominator ID 12			181	214	200	171	160	150	140	
			11) Patient satisfaction rate in Tygerberg Hospital	%		Not required to report	Not required to report	88%	96%	90%	90%	90%	
			Numerator ID 13			-	-	385	860	810	810	810	
			Denominator ID 14			-	-	437	894	900	900	900	
			12) Tygerberg Hospital assessed for compliance with core standards	No		Not required to report	Not required to report	Not required to report	1	0	1	0	
			Element ID 15										

Notes:

All: From 2008/09 to 2010/11 the general specialist services outputs in central hospitals were reflected in Programme 4.1.
As from 2011/12 all service activities in Tygerberg Hospital is reflected in Programme 5.1.

Indicator 1: The caesarean section rate indicated is for Tygerberg Hospital services as a whole, including the level 2 services. The increase in the caesarean section rate is as a result of an improved data collection process and not a change in clinical protocol.

Indicator 2: The increase in the bed numbers from 2011/2012 to 2012/2013 is as a result of the transfer of beds from Groote Schuur and Red Cross War Memorial Children's Hospital to Tygerberg Hospital to accommodate the change in drainage areas with the commissioning of the Khayelitsha District Hospital.

Indicator 7: The expenditure per patient day equivalent for the period 2008/09 to 2010/11 is for the highly specialised services in Tygerberg Hospital.
As from 2011/12 the expenditure per patient day equivalent is for both the general specialised and the highly specialised services.

Indicator 10: Due to a change in the definition and reporting systems, a new baseline was established. Mechanisms will be implemented to continuously improve performance in subsequent years.

Table 5.10: Quarterly targets for Tygerberg Hospital for 2012/13 [CHS6]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
1. Address the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 42% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Tygerberg Hospital	Quarterly	42%	42%	42%	42%	42%
			Numerator ID 1		2 625	656	656	656	656
			Denominator ID 2		6 250	1 563	1 563	1 563	1 563
	1.2. Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	1.1.2. Ensure access to Tygerberg Hospital services by providing 1 384 beds.	2) Number of actual beds in Tygerberg Hospital Element ID 3	Quarterly	1 384	1 384	1 384	1 384	1 384
			3) Total separations in Tygerberg Hospital Element ID 4	Quarterly	68 456	17 114	17 114	17 114	17 114
			4) OPD total headcounts in Tygerberg Hospital Element ID 5	Quarterly	335 927	83 982	83 982	83 982	83 982
			5) Patient day equivalents [PDE] in Tygerberg Hospital Element ID 6	Quarterly	547 104	136 776	136 776	136 776	136 776
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.1.3. Efficiently manage resources to achieve the target bed occupancy rate of 83% by 2014/15.	6) Bed utilisation rate (based on actual beds) in Tygerberg Hospital)	Quarterly	82%	82%	82%	82%	82%
			Numerator ID 7		413 961	103 490	103 490	103 490	103 490
			Denominator ID 8		505 160	126 290	126 290	126 290	126 290
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 Tygerberg Hospital at a target cost of R2 995 per patient day equivalent by 2014/15 (2010/11 rands)	7) Expenditure per patient day equivalent in Tygerberg Hospital	Quarterly	R 3 028	R 3 028	R 3 028	R 3 028	R 3 028
			Numerator ID 9	R'000	1 656 451 106	414 112 776	414 112 776	414 112 777	414 112 777
			Denominator ID 6		547 104	136 776	136 776	136 776	136 776
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 days for Tygerberg hospital by 2014/15.	8) Average length of stay in Tygerberg Hospital	Quarterly	6.0	6.0	6.0	6.0	6.0
			Numerator ID 7		413 961	103 490	103 490	103 490	103 490
			Denominator ID 4		68 456	17 114	17 114	17 114	17 114
4. Improve the quality of health services and the patient experience.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) Tygerberg Hospital has monthly mortality and morbidity meetings Element ID 10	Quarterly	Yes	Yes	Yes	Yes	Yes

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
			10) Percentage of complaints of users of Tygerberg Hospital resolved within 25 days	Quarterly	75%	75%	75%	75%	75%
			Numerator ID 11		120	30	30	30	30
			Denominator ID 12		160	40	40	40	40
			11) Patient satisfaction rate in Tygerberg Hospital	Annually	90%	-	-	-	90%
			Numerator ID 13		810	-	-	-	810
			Denominator ID 14		900	-	-	-	900
			12) Tygerberg Hospital assessed for compliance with core standards	Annually	0				
			Element ID 15						

Table 5.11: Data elements of performance indicators for Red Cross War Memorial Children's Hospital

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
SINJANI	Caesarean sections in RCWMCH	1	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
SINJANI	Deliveries in RCWMCH	2	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
SINJANI	Usable beds in RCWMCH	3	227	235	235	290	270	270	270
SINJANI	Separations	4	10 222	12 327	12 488	22 965	21 523	21 060	20 746
SINJANI	OPD headcount(General and Specialist)	5	80 457	81 544	81 357	124 544	121 082	120 196	120 013
SINJANI	Total OPD headcount + Emergencies	5.1				167 662	167 082	161 696	160 013
SINJANI	PDE- Sum of: inpatient days + 1/2 day patients + 1/3 OPD headcount + 1/3 emergency headcount	6	94 664	99 592	100 666	143 463	139 588	137 864	137 795
SINJANI	Patient Days (Inpatient Days + 1/2 Day Patients)	7	67 845	72 411	73 547	87 576	85 228	83 965	84 457
SINJANI	Total usable bed days	8	82 855	85 775	85 775	106 333	100 375	98 550	98 550
BAS- CFO	Total expenditure in RCWMCH `(2010/11 Rands)	9	390 336 671	402 236 581	376 202 354	491 212 639	476 375 374	478 030 480	476 321 585
SINJANI	M & M meetings every month	10	Yes	Yes	Yes	Yes	Yes	Yes	Yes
SINJANI	Complaints resolved within 25 days	11	72	31	18	18	18	16	15
SINJANI	Complaints lodged	12	75	31	20	20	20	18	17
SINJANI	Number of questionnaires with 1 or 2 recorded for pleased with treatment	13	Not required to report	Not required to report	385	1 639	1 530	1 530	1 530
SINJANI	Number of questionnaires for pleased with treatment	14	Not required to report	Not required to report	437	1 708	1 700	1 700	1 700
SINJANI	RCWMCH assessed against the core standards	15	Not required to report	Not required to report	Not required to report	1	0	1	0

Table 5.12: Performance indicators for Red Cross War Memorial Children's Hospital [CHS5]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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) Caesarean section rate in Red Cross War Memorial Children's Hospital [RCWMCH]	%		Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	30%
			Numerator: ID 1			-	-	-	-	-	-	-	
			Denominator: ID 2			-	-	-	-	-	-	-	
	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 RCWMCH services by providing 270 beds.	2) Number of actual beds in RCWMCH Element ID 3	No		227	235	235	290	270	270	270	
			3) Total separations in RCWMCH Element ID 4	No		10 222	12 327	12 488	22 965	21 523	21 060	20 746	
			4) OPD total headcounts in RCWMCH Element ID 5	No		80 457	81 544	81 357	124 544	121 082	120 196	120 013	
			5) Patient day equivalents [PDE] in RCWMCH Element ID 6	No		94 664	99 592	100 666	143 463	139 588	137 864	137 795	
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 86% by 2014/15.	6) Bed utilisation rate (based on actual beds) in RCWMCH	%		82%	84%	86%	82%	85%	85%	86%	75%
			Numerator ID 7			67 845	72 411	73 547	87 576	85 228	83 965	84 457	
			Denominator ID 8			82 855	85 775	85 775	106 333	100 375	98 550	98 550	
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 RCWMCH at a target cost of R3 457 per patient day equivalent by 2014/15 (2010/11 rands)	7) Expenditure per patient day equivalent [PDE] in RCWMCH		R 3 457	R 4 123	R 4 039	R 3 737	R 3 424	R 3 413	R 3 467	R 3 457	
			Numerator ID 9	R	476 321 585	390 336 671	402 236 581	376 202 354	491 212 639	476 375 374	478 030 480	476 321 585	
			Denominator ID 6		137 795	94 664	99 592	100 666	143463	139 588	137 864	137 795	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 4.1 days for RCWMCH by 2014/15.	8) Average length of stay in RCWMCH	Days	4.1	6.6	5.9	5.9	3.8	4.0	4.0	4.1	5.5
			Numerator ID 7		84 457	67 845	72 411	73 547	87 576	85 228	83 965	84 457	
			Denominator ID 4		20 746	10 222	12 327	12 488	22 965	21 523	21 060	20 746	
4. Improve the quality of health services and the patient experience.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) RCWMCH has monthly mortality and morbidity meetings	Y / N	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Element ID 10										
			10) Percentage of complaints of users of RCWMCH resolved within 25 days	%		96%	100%	90%	90%	90%	90%	90%	
			Numerator ID 11			72	31	18	18	18	16	15	
			Denominator ID 12			75	31	20	20	20	18	17	
			11) Patient satisfaction rate in RCWMCH	%		Not required to report	Not required to report	88%	96%	90%	90%	90%	
			Numerator ID 13			-	-	385	1 639	1 530	1 530	1 530	
			Denominator ID 14			-	-	437	1 708	1 700	1 700	1 700	
			12) RCWMCH assessed for compliance with core standards	No		Not required to report	Not required to report	Not required to report	1	0	1	0	
			Element ID 15										

Notes:

All: From 2008/09 to 2010/11 the general specialist services outputs in central hospitals were reflected in Programme 4.1.
As from 2011/12 all service activities in RCWMCH is reflected in Programme 5.1.

Indicator 1: The caesarean section rate indicated is for RCWMCH services as a whole, including the level 2 services.

Indicator 2: The increase in the bed numbers from 2011/2012 to 2012/2013 is as a result of the transfer of beds from Groote Schuur and Red Cross War Memorial Children's Hospital to Tygerberg Hospital to accommodate the change in drainage areas with the commissioning of the Khayelitsha District Hospital..

Indicator 7: The expenditure per patient day equivalent for the period 2008/09 to 2010/11 is for the highly specialised services in RCWMCH.
As from 2011/12 the expenditure per patient day equivalent is for both the general specialised and the highly specialised services.

Table 5.13: Quarterly targets for Red Cross War Memorial Children's Hospital FOR 2012/13 [CHS6]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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) Caesarean section rate in RCWMCH	Quarterly	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
			Numerator ID 1		-	-	-	-	-
			Denominator ID 2		-	-	-	-	-
	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 RCWMCH services by providing 270 beds.	2) Number of actual beds in RCWMCH	Quarterly	270	290	270	270	270
			Element ID 3						
			3) Total separations in RCWMCH	Quarterly	21 523	5 596	5 381	5 166	5 381
			Element ID 4						
			4) OPD total headcounts in RCWMCH	Quarterly	121 082	31 481	30 271	29 060	30 271
			Element ID 5						
			5) Patient day equivalents [PDE] in RCWMCH	Quarterly	139 588	36 293	34 897	33 501	34 897
			Element ID 6						
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 86% by 2014/15.	6) Bed utilisation rate (based on actual beds) in RCWMCH	Quarterly	85%	85%	85%	85%	85%
			Numerator ID 7		85 228	21 307	21 307	21 307	21 307
			Denominator ID 8		100 375	25 094	25 094	25 094	25 094
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 RCWMCH at a target cost of R3 457 per patient day equivalent by 2014/15. (2010/11 rands)	7) Expenditure per patient day equivalent [PDE] in RCWMCH	Quarterly	R 3 413	R 3 413	R 3 413	R 3 413	R 3 413
			Numerator ID 9	R'000	476 375 374	119 093 843	119 093 843	119 093 844	119 093 844
			Denominator ID 6		139 588	34 897	34 897	34 897	34 897
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 4.1 days for RCWMCH by 2014/15.	8) Average length of stay in RCWMCH	Quarterly	4.0	3.8	4.0	4.1	4.0
			Numerator ID 7		85 228	21 307	21 307	21 307	21 307
			Denominator ID 4		21 523	5 596	5 381	5 166	5 381

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
4. Improve the quality of health services and the patient experience.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) RCWMCH has monthly mortality and morbidity meetings Element ID 10	Quarterly	Yes	Yes	Yes	Yes	Yes
			10) Percentage of complaints of users of RCWMCH resolved within 25 days	Quarterly	90%	90%	90%	90%	90%
			Numerator ID 11		18	5	5	5	5
			Denominator ID 12		20	5	5	5	5
			11) Patient satisfaction rate in RCWMCH	Annually	90%	-	-	-	90%
			Numerator ID 13		1 530	-	-	-	1 530
			Denominator ID 14		1 700	-	-	-	1 700
			12) RCWMCH assessed for compliance with core standards Element ID 15	Annually	0				

7. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND MTEF

Table 5.14: Summary of payments and estimates – Programme 5: Central hospitals [CHS 7]

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
1. Central Hospital Services [a,b,c]	1 970 686	2 347 345	2 681 739	3 953 753	3 959 727	3 971 758	4 211 787	6.04	4 507 020	4 776 767
Total payments and estimates	1 970 686	2 347 345	2 681 739	3 953 753	3 959 727	3 971 758	4 211 787	6.04	4 507 020	4 776 767

[a] 2012/13: National Conditional grant: National tertiary services: R2 182 468 000.

[b] 2012/13: National Conditional grant: Health professions training and development: R269 728 000 (Compensation of employees R199 956 000; Goods and services R69 772 000).

[c] 2012/13: National Conditional grant: National Health Insurance Grant - R 3 000 000 (Compensation of employees R3 000 000).

Note: Contributing factors to the decrease in funding in 2008/09 is the shift of the equitable share funding for level 2 beds in the central hospitals that is allocated to sub-programme 4.1. Increase from 2011/12 as level 2 services is shifted back to sub programme 5.1.

Table 5.15: Payments and estimates by economic classification – Programme 5: Central Hospital Services [HFM4]

Economic classification R'000	Outcome						Medium-term estimate			
	Audited	Audited	Audited	Main appro-priation	Adjusted appro-priation	Revised estimate		% Change from Revised estimate		
	2008/09	2009/10	2010/11	2011/12	2011/12	2011/12	2012/13	2011/12	2013/14	2014/15
Current payments	1 906 294	2 256 659	2 584 066	3 835 449	3 850 795	3 861 561	4 118 590	6.66	4 408 031	4 671 648
Compensation of employees	1 186 494	1 453 200	1 759 828	2 650 867	2 668 680	2 694 162	2 889 950	7.27	3 106 589	3 323 963
Salaries and wages	1 067 606	1 313 054	1 591 043	2 401 578	2 417 093	2 433 049	2 606 524	7.13	2 801 916	2 997 976
Social contributions	118 888	140 146	168 785	249 289	251 587	261 113	283 426	8.55	304 673	325 987
Goods and services	719 800	803 459	824 238	1 184 582	1 182 115	1 167 399	1 228 640	5.25	1 301 442	1 347 685
of which										
Administrative fees	1	1	2	1						
Advertising	21	34	153	36	255	162	168	3.70	178	184
Assets <R5 000	6 015	5 878	8 067	6 050	11 417	11 387	9 893	(13.12)	10 479	10 851
Catering: Departmental activities	173	131	180	191	163	335	234	(30.15)	248	257
Communication	5 074	8 290	6 095	10 451	10 510	9 000	8 240	(8.44)	8 728	9 037
Computer services	120	938	651	868	943	1 236	5 233	323.38	5 522	5 817
Cons/prof: Business and advisory services	1 920	522	2 560	1 771	1 088	723	779	7.75	826	856
Cons/prof: Laboratory services	111 337	109 168	113 206	167 628	163 024	150 652	159 015	5.55	168 440	174 412
Cons/prof: Legal costs	3	1	1	1	1	13	24	84.62	25	26
Contractors	41 773	42 146	40 089	49 184	48 993	50 428	52 793	4.69	55 923	57 905
Agency and support/ outsourced services	57 564	62 669	45 335	67 682	70 341	63 710	72 543	13.86	76 841	79 566
Entertainment	8	4	14	15	14	15	12	(20.00)	13	13
Inventory: Food and food supplies	11 776	18 075	15 666	30 559	28 342	28 161	28 045	(0.41)	29 707	30 760
Inventory: Fuel, oil and gas	3 411	5 551	3 787	8 260	7 427	7 471	8 182	9.52	8 668	8 975
Inventory: Materials and supplies	9 695	8 667	9 003	18 059	12 916	14 027	16 256	15.89	17 220	17 830
Inventory: Medical supplies	266 161	307 691	338 248	450 199	455 977	448 018	467 564	4.36	495 275	512 838
Inventory: Medicine	114 209	134 934	123 076	184 364	174 194	170 362	174 425	2.38	184 763	191 314
Inventory: Other consumables	17 564	25 689	26 502	39 598	36 509	37 506	42 546	13.44	45 068	46 666
Inventory: Stationery and printing	7 830	8 039	9 932	11 165	11 479	12 829	12 430	(3.11)	13 167	13 634
Lease payments	6 043	4 080	2 996	3 143	4 374	3 688	3 375	(8.49)	3 576	3 704
Property payments	49 552	54 559	73 029	126 270	136 184	148 324	157 498	6.19	166 834	172 747
Transport provided: Departmental activity	153	94	144	150	150	157	126	(19.75)	133	138
Travel and subsistence	2 019	2 630	2 587	3 919	2 984	3 664	3 087	(15.75)	3 270	3 386
Training and development	1 641	2 672	2 041	3 867	3 464	3 561	4 006	12.50	4 243	4 393
Operating expenditure	5 649	768	689	694	1 083	1 829	2 050	12.08	2 172	2 249
Venues and facilities	88	228	185	457	283	141	116	(17.73)	123	127
Transfers and subsidies to	9 811	10 588	13 515	13 627	13 627	14 583	16 315	11.88	17 131	17 988
Non-profit institutions	5 812	7 232	7 695	8 157	8 157	8 157	8 483	4.00	8 907	9 352
Households	3 999	3 356	5 820	5 470	5 470	6 426	7 832	21.88	8 224	8 636
Social benefits	3 999	3 356	5 820	5 470	5 470	6 426	7 832	21.88	8 224	8 636
Payments for capital assets	54 318	79 726	83 761	104 677	95 305	95 305	76 882	(19.33)	81 858	87 131
Machinery and equipment	54 318	79 341	83 658	104 067	91 663	91 663	76 882	(16.13)	81 858	87 131
Transport equipment				30	30		260		278	297
Other machinery and equipment	54 318	79 341	83 658	104 037	91 633	91 663	76 622	(16.41)	81 580	86 834
Software and other intangible assets		385	103	610	3 642	3 642		(100.00)		
Of which: "Capitalised Goods and services" included in Payments for capital assets				188	188	188		(100.00)		
Payments for financial assets	263	372	397			309		(100.00)		
Total economic classification	1 970 686	2 347 345	2 681 739	3 953 753	3 959 727	3 971 758	4 211 787	6.04	4 507 020	4 776 767

Note:

Expenditure between 2008/2009 till 2010/2011 only reflects the expenditure incurred for the highly specialised services while expenditure from 2011/2012 is for general and highly specialised services. Expenditure trends for these periods are therefore not comparable.

7.1 PERFORMANCE AND EXPENDITURE TRENDS

7.1.1 Expenditure trends

Programme 5 is allocated 28.78 per cent of the vote in 2012/13 in comparison to the 29.57 per cent of the vote that was allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R240.029 million or 6.04 per cent.

R3 million of the National Health Insurance Grant is allocated to Programme 5 for specialist posts.

In real terms, given improved conditions of service (ICS), occupational specific dispensation (OSD) and medical inflation, the programme focused on maintaining outputs through increased efficiencies despite funding challenges.

The cost of compensation of employees increased, on average, by 19.7 per cent over the 2008/09 to 2010/11 period, largely due to ICS and the OSD for nursing and medical staff. The 2011/12 amounts are not comparable to the 2008/09, 2009/10 and 2010/11 years as it represents the consolidated Programme 4.1 and Programme 5.1 budget.

The Modernisation of Tertiary Services (MTS) grant was utilised for implementing the Picture Archive Communication System (PACS) at Tygerberg and Groote Schuur Hospitals and to commence the roll out at Red Cross War Memorial Children's Hospital. The Radiological Imaging System (RIS) has been piloted in Tygerberg Hospital and roll out to Groote Schuur and Red Cross War Memorial Children's Hospital will commence early in 2012/13. In addition the grant was used to fund clinical engineers responsible for medical equipment maintenance.

Expansion of central and national referral services is unlikely due to budget limitations. The increasing proportion of the equitable share to the central hospitals is not sustainable. The National Department of Health is currently reviewing funding levels and allocations of the National Tertiary Services Grant (NTSG) and the Health Professions Training and Development Grant (HPTDG) which will hopefully resolve the funding for tertiary services and for the training of health science students.

7.1.2 Performance trends

The bed utilisation rate for the central hospitals has increased from 79 per cent in 2008/09 to a projected 83 per cent in 2011/12. This is an indication of the escalating service pressures.

The combined caesarean section rate for Tygerberg and Groote Schuur Hospitals remained between 44 per cent and 48 per cent for the last three years. The caesarean section rate would be lower if it were calculated as a percentage of all the deliveries in the catchment area, as opposed to using only the deliveries within the institution as the denominator for the calculation.

Other clinical performance indicators are not comparable to the performance of previous years, as the general and highly specialised services are jointly reported in the APP as from 2011/12.

7.1.3 Relating funding trends to strategic goals

7.1.3.1 Funding trends

Conditional grants constituted 57 per cent of the 2011/12 budget. The conditional grants are the National Tertiary Service Grant (NTSG) and the Health Professional Training and Development Grant (HPTDG). The programme received an equitable share allocation which assisted in funding the occupation specific dispensation (OSD) for professional staff categories as well as the modernisation of tertiary services (MTS) for equipment in oncology, medical imaging and related modalities.

Table 5.16: Sources of funding for Programme 5.1

Source of funds (R'000)	2009/10	2010/11	2011/12	Percentage contribution to total Programme 5.1 budget during 2011/12
National Tertiary Services Grant	R1 583 991	R1 763 234	R 1 973 127	50%
Health Professions Training and Development Grant	R200 000	R 200 000	R 259 142	7%
Equitable share	R486 509	R 712 337	R 1 721 484	43%
Total	**R 2 270 500**	**R 2 675 571**	**R 3 953 753**	**100%**

Note:

The Equitable Share allocation includes all improved conditions of service (ICS) and OSD improvements and the MTS allocation for equipment in oncology, imaging and related modalities.

The funding for general and highly specialised services in central hospitals was consolidated in Programme 5 from 2011/12.

7.1.3.2 Resource considerations

Tables 5.14 and 5.15 provide more detail on expenditure trends, further explained by the brief notes below.

7.1.3.3 Compensation of employees

Personnel expenditure has increased over the MTEF period mainly due to improved conditions of service (ICS) and occupational specific dispensation (OSD) for nurses, doctors, allied health staff and engineers. The OSD has accelerated expenditure and remains one of the primary cost drivers.

The HPTDG was not adjusted to accommodate the OSD personnel cost implications, while the NTSG was partially adjusted. This resulted in further reducing the ability of these grants to purchase a sustainable quantum of outputs.

Table 5.17: Full time staff numbers:

Category	15 April 2010	15 April 2011	15 November 2011
Medical	1 226	1 242	1 252
Nursing	3 879	3 884	3 848
Allied Health	541	541	546
Other	3 325	3 374	3 371
Total	8 971	9 041	9 017

Note:

The figures quoted are for filled posts and not for all funded posts as more posts are funded, but vacant posts due to normal staff attrition.

7.1.3.4 Goods and services

Medical inflation, particularly for highly specialised health services, exceeds general inflation. A report from Statistics South Africa[2] indicated that medical inflation amounts to 8 per cent for medical services and 5.9 per cent for medical products. In general the inflationary adjustments received are less than medical inflation, resulting in the year-on-year reduction in the ability to purchase a sustained quantum of services. Despite the reduction in the real purchasing power of funding, service outputs have been sustained by means of improved efficiencies and prioritisation. Tertiary services represent the end of the referral chain and leverages on advanced health technology, which often comes at a premium in terms of cost of acquisition and maintenance.

Expenditure between 2008/09 and 2010/11 only reflects the expenditure incurred for highly specialised services while expenditure from 2011/12 is for general and highly specialised services. Expenditure trends between these periods are therefore not comparable.

Control measures for the purchase of goods and services are in place to ensure that decisions to purchase are based on the best value for money and remain within the allocated budget.

7.1.4 Conditional grants

7.1.4.1 National Tertiary Services Grant (NTSG)

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

The Western Cape provides access to the following tertiary services funded by the National Tertiary Services Grant[3]:

Table 5.18: Tertiary services partially funded by the National Tertiary Services Grant

Cardiology general, complex and intervention	Cardiothoracic (heart transplantation)
Cardiothoracic surgery	CAT scan
Clinical haematology	Clinical haematology (bone marrow transplantation)
Clinical immunology	Colorectal surgery
Craniofacial surgery (maxillo-facial and oral surgery)	Dermatology
Endocrinology service	Complex otorhinolaryngology
Gastroenterology	Hepatobiliary surgery
Hepatology	Human genetics
Infectious disease	Intensive care
Liver transplantation	Medical oncology
MRI scan	Neonatal ICU
Nephrology	Nephrology (renal dialysis)

[2] Statistics South Africa, Consumer price Index, September 2010, p6

[3] The services funded by the NTSG are as on 20 January 2011.

Neurology	Neurosurgery
Nuclear medicine	Obstetrics and gynaecology- tertiary/specialised
Ophthalmology - general and complex	Orthopaedics - general and complex
PET scan	Plastic and reconstructive surgery
Radiation oncology	Renal transplant
Respiratory medicine (pulmonology)	Rheumatology
Specialised neonatal surgery	Spinal injury management service
Urology	Vascular surgery service

The NTSG is a schedule 4 conditional grant which subsidises funding and does not fund all the grant related activities. Many of the NTSG service activities are funded from the equitable share.

Challenges:

- A National Tertiary Health Plan that determines the distribution of services across the country is required.
- There is an on-going gap in the funding for tertiary services in the Province. The gap in the NTSG-funded services in 2011/12 is estimated at R434.5 million.
- Funding adjustments, introduced in 2011/12, to compensate for the implementation of OSD remain insufficient to address the full funding gap.

7.1.4.2 **Health Professions Training and Development Grant (HPTDG)**

The purpose of the Health Professional Training and Development Grant is to support the funding of service costs associated with the training of health professionals on the services platform. Students from four institutes of higher education, i.e. the University of Stellenbosch, University of Cape Town, University of Western Cape, and Cape Peninsula University of Technology, access the service platform for training.

Table 5.19: Key estimated outputs for 2012/13, partially supported by the HPTDG

Table 20**Key outputs**	**Estimated output for 2012/13**
Undergraduate medical and dental students trained	2 900
Number of registrars receiving and providing training support	680
Medical interns receiving further teaching and training	310
Medical officers receiving and providing training support	520
Community service doctors receiving and providing training support	190
Medical and dental specialists providing training support	850

Challenges:

- The conditional grant allocation amount is not underpinned by a quantified national human resource plan or accurate costing base.
- The funding level of the grant has not kept pace with inflation, or the implications of the OSD. A costing study, concluded in 2007, indicated that there was a shortfall of

R468.4 million in the amount required to provide a service platform for teaching and training students.

- The grant funding is grossly insufficient and is therefore only used to fund medical and dental students and not all health sciences.
- There is a recommendation from the Department of Higher Education that the conditional grant should be transferred to that department from Health and that the funds then should be directly disbursed to the universities with Health Science Faculties. This recommendation is strongly opposed by the health sector.

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

8. RISK MANAGEMENT

Risk Identified for the Programme	Mitigation Strategies
1. Over-expenditure as a result of insufficient budget from the following sources: • Equitable share • Conditional grants: o National Tertiary Services Grant o Health Professionals Training and Development Grant	1.1. Motivation to the National Department of Health for additional funds in the conditional grants and participate in the grant review process. 1.2. Establish FBUs for decentralised decision-making and management controls. 1.3. Reprioritisation of services.
2. Escalating workload-and resource constrains with compromised quality of care. Major adverse clinical incidents with medico legal risk.	2.1. Support the delivery of district health services through outreach, support and clinical governance. 2.2. Conduct morbidity and mortality meetings for all clinical disciplines. 2.3. Establish provincial clinical co-ordinating committees for each discipline to enhance clinical governance. 2.4. Prevent hospital acquired infections by participating in the Best Care Always initiative.
3. Limitation in recruitment and retention of key health professionals and other staff categories.	3.1. Prioritise critical posts for filling and use the bursary system to attract possible candidates for scarce categories of staff. 3.2. Hospitals will have specific skills development plans in place to address skill shortcomings. 3.3. Employee Assistance Programme to support staff in the service. 3.4. Implementation of the Occupational Specific Dispensation.

Risk Identified for the Programme	Mitigation Strategies
4. Unreliable management information leading to a qualified audit in financial, human resources and information management systems.	4.1. Enhance compliance through standard operating procedures, checklists (CMI) and improved training to staff involved in processes. 4.2. Staff performance management.

PROGRAMME 6: HEALTH SCIENCES AND TRAINING (HST)

1. PROGRAMME PURPOSE

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

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 6.1: NURSE TRAINING COLLEGE (DIRECTORATE: WESTERN CAPE COLLEGE OF NURSING - WCCN)

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

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

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

2.3 SUB-PROGRAMME 6.3: BURSARIES

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

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

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

2.5 SUB-PROGRAMME 6.5: TRAINING (OTHER)

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

3. SITUATION ANALYSIS: PROGRAMME 6

There have been no changes to the budget programme structure during the 2011/12 financial year.

The Department is required to ensure a capacitated workforce to manage the burden of disease and ensure quality of care and the improved patient experience. Programme 6 facilitates the recruitment, retention; education, training and development of the appropriate numbers of personnel with the appropriate competencies to provide current and future service requirements across the levels of care. This is done within the geographic service areas, through human resource planning and the implementation of the human resource strategy.

The Human Resource Plan (HRP) and Workplace Skills Plan (WSP) which are based on the strategic goals and priorities and the 2020 principles, address the scarce and critical skills gap of the current and future workforce.

An analysis of the current supply of scarce skills within the Department indicates that there is an inadequate supply of staff in key occupational categories. Although there is an oversupply of general professional nurses at present compared to the available funded vacant posts in the Department to meet the needs of graduating bursars, there is a shortage in the high risk areas such as nursing specialities of clinical nurse practitioners, trauma and emergency and; operating theatre nurses. Doctors in specialised categories are also in short supply, as are allied health occupations, emergency medical services, medical orthotists/prosthetists, forensic pathology technicians, clinical technologists and industrial technicians as well as human resource, information management and finance support staff. These are focus areas to which recruitment and retention, and education, training and development strategies will be directed.

3.1 SUB-PROGRAMME 6.1: NURSE TRAINING COLLEGE (DIRECTORATE: WESTERN CAPE COLLEGE OF NURSING - WCCN)

3.1.1 Situation analysis

The Western Cape College of Nursing consists of three nursing college campuses, in Metro-West in Athlone, Metro East on the Stikland Hospital site and the Boland/Overberg campus in Worcester. There are also six satellite nursing campuses at Groote Schuur Hospital, Tygerberg Hospital, Western Cape Rehabilitation Centre, Worcester Hospital Nursing School, George Nursing School and Beaufort West Nursing School.

The nursing college campuses, in partnership with the higher education institutions (HEIs), are the major providers of nurse training at an under-graduate and post basic level.

In order to give effect to the provincial nursing strategy the Department invests significantly in marketing nursing as a career choice, in recruitment and retention strategies and in the education, training and development of nurses in order to increase the number of competent nurses in the service.

3.1.2 Challenges

- The new Nursing Qualifications Framework affects the current status of the Nursing College and nursing schools and will result in the re-curriculation of programmes.
- Delays in accreditation of additional teaching sites, programmes and clinical facilities by the South African Nursing Council (SANC).
- Failure and attrition rate of students and the associated quality of candidates.
- A diminishing supply of adequately capacitated lecturing staff.

3.1.3 Priorities

- Accreditation of additional programmes and clinical facilities by SANC.
- Expand the number of post basic programmes to address priority needs.
- Implementation of the Integrated Nurse Education and Training Framework.
- Improve academic student support.

3.2 SUB-PROGRAMME 6.2: EMERGENCY MEDICAL SERVICES (EMS) TRAINING COLLEGE: PGWC COLLEGE OF EMERGENCY CARE

3.2.1 Situation analysis

Emergency Medical Services (EMS) estimates the number and skill mix of emergency care personnel that need to be trained to meet the current and future requirement for EMS services.

The PGWC College of Emergency Care is responsible for the emergency medical care training including the Emergency Care Technician Certificate which is a two-year programme.

3.2.2 Challenges

- Retaining lecturing staff due to Occupational Specific Dispensation (OSD).
- Uncertainty from the Health Professions Council of South Africa (HPCSA) about the timing of closure of short courses which impacts on the intake of training numbers and the recruitment of staff.
- Rescue training is not accredited by the HPCSA and accreditation by the South African Qualifications Authority (SAQA) requires meeting infrastructure demands as a higher education institution.
- The need for student accommodation.

3.2.3 Priorities

- Second phase accreditation for the Emergency Care Technician (ECT) programme.
- Additional lecturing staff for ECT training.
- Provision of management training.
- Meet infrastructure requirements for accreditation as an Higher Education Institution.

3.3 SUB-PROGRAMME 6.3: BURSARIES

3.3.1 Situation analysis

The Directorate: Human Resource Development (DHRD) uses the Human Resource Plan to determine the staff requirement per occupational category. This information is used to determine the allocation of bursaries, as a recruitment and retention strategy, to actual and potential employees to ensure that the current and projected skills are developed.

The number of bursaries available is determined by the available funding and bursary holders are required to work back a reciprocal number of years for each year of bursary received.

The Department engages regularly with the respective higher education institutions to ensure a supply of appropriately trained health workers.

3.3.2 Challenges

- Recruitment and retention of scarce skills.

- Lack of adequate funding for:
  - Community service posts.
  - Nursing posts for newly qualified bursary holders
- Funding for relief staff to enable full time staff the opportunities for further education, training and development is limited.
- Lack of an integrated HR information system.

3.3.3 **Priorities**

- Bursaries to ensure the recruitment and retention of scarce skills based on the HR plan.
- Ring fencing community service posts.
- Address the funding for relief staff to enable training of staff without adverse effects on service delivery.
- Ensure funding of vacant nursing posts.
- Implementation of the Bursary Implementation Management System (BIMS).
- Development of a public service wide Human Resource Information System (HRIS) via a National Cabinet directive through the HR Connect process.

3.4 SUB-PROGRAMME 6.4: PRIMARY HEALTH CARE TRAINING

3.4.1 Situation analysis

The Improvement and Maintenance of Competencies (iMOCOMP) project is an important initiative to strengthen the capacity, particularly the clinical skills, of health professionals at all levels of care and across all geographic service areas. These initiatives may be linked to the continuous professional development (CPD) of health professionals.

3.4.2 Challenges

- Ensure proficient training providers, internal and external, to meet the clinical training needs of health professionals.
- Evaluation of training and the impact on service delivery.

3.4.3 Priorities

- Capacity audit of relevant training providers to meet the Department's service delivery needs, particularly to address iMOCOMP training needs.
- Explore the role of the family physician in outreach.

3.5 SUB-PROGRAMME 6.5: TRAINING (OTHER)

3.5.1 Situation analysis

Within the framework of the Workplace Skills Plan, the Directorate: Human Resource Development provides skills development for all occupational categories in the Department, for example, management development and the Expanded Public Works Programme (EPWP).

The EPWP strengthens community-based services through the training of community-based care-givers (CCGs) towards formal qualifications in ancillary health care and community health work. This contributes to alleviating poverty through creating 'stipended' work opportunities and training of relief workers who are recruited from the community.

Other opportunities to create job opportunities for recent matriculants include:

- Learnership programmes (learner basic pharmacist's assistants) for unemployed persons in the pharmaceutical services.
- Internship opportunities through the EPWP data capturer programme.
- The Artisan-to-Artisan (ATA) programme will be continued in 2012.
- Additional EPWP funded internship programmes for HR and finance interns will be introduced to address critical needs within the Department.

3.5.2 Challenges

- Training and development to ensure strategic management capacity.
- Evaluation of EPWP training and the impact on service delivery.

3.5.3 Priorities

- Training and development to ensure strategic management capacity based on HR needs.
- Strengthen EPWP through the expansion into areas of need within the Department, i.e. human resources, pharmaceutical services and finance.
- Ensure on-going evaluation of EPWP to test the effectiveness of the programme.

4. STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND TARGETS FOR HEALTH SCIENCES AND TRAINING

Table 6.1: Data elements for performance indicators for Health Sciences and Training

Source	Data element	Element ID	Audited /Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
HEI survey	Intake of student nurses (1st year at nursing college)	1	330	442	271	350	270	280	290
HEI survey	Intake of student nurses (1st to 4th year at nursing college and Higher Education Institutions (HEIs)	2	671	2 906	2 230	2 404	2 400	2 450	2 500
HEI survey	Basic student nurses graduating (at nursing college)	3	74	60	191	206	220	230	240
HEI survey	Basic student nurses graduating (at nursing college and HEIs)	4	111	171	437	392	500	550	600
HRD full-time bursary database	Students with bursaries from the province	5	2 343	2 436	2 877	2 900	3 000	3 100	3 250
EPWP web based system: database	Intake of EMC staff on accredited HPCSA courses	6	Not required to report	Not required to report	297	134	132	132	150
EPWP web based system: database	Registration of Home Community Based carers on training	7	1 792	1 896	1 614	2 000	2 000	2 100	2 200
EPWP web based system: database	Intake of data capturer interns	8	165	110	267	150	140	150	160
EPWP web based system: database	Intake of pharmacist's assistants	9	Not required to report	40	100	113	110	130	130
EPWP web based system: database: municipal info system for infrastructure (MIS)	Intake of Assistant to Artisans (ATAs) interns	10	Not required to report	Not required to report	147	113	120	120	120
EPWP web based system: database	Intake of HR and Finance interns	11	Not required to report	Not required to report	Not required to report	106	120	130	140

Notes:

Element ID 1 & 2: Previously the intake of nurse students across all four years of study at the nursing college and HEIs was reported. The indicator required by the National Department of Health refers specifically to the intake of 1st year students only at nursing colleges (excluding HEIs). The previous indicator (2) was however retained.

Element ID 2: Western Cape College of Nursing (WCCN) had no intake of student nurses for 2004 and low numbers of student nurses at University of the Western Cape (UWC) prior to 2005. The student intakes from 2005 at WCCN and UWC were increased significantly with the advent of the Cape Higher Education Consortium (CHEC) teaching platform.

Element ID 3 & 4: Previously the nurse students at the nursing college and HEIs were reported. The indicator required by the National Department of Health refers specifically to nursing colleges (excluding HEIs). The previous indicator (4) was however retained.

Element ID 4: There was a substantial increase of basic nurse students graduating between 2009/10 and 2010/11 due to the increased intake at WCCN and UWC from 2005. The number of students graduating from WCCN was further increased by the successful completion by students who had previously failed as well as the benefits of improved curriculum support to students. The attrition rate has also consistently dropped over the last few years i.e. from 2006 to the 2010 academic years (15%; 11.5%; 8%; 8% and 3.5% respectively).

Element ID 6: The EMC intake estimate for 2011/12 and the medium term targets are more than 50% less than the actual achieved in 2010/11 due to the reduction of short course accredited Health Professions Council of South Africa (HPCSA) courses, and the focus of resources toward the accredited Emergency Care Technician training.

Element ID 7: Target for training of Home Community Based Carers will be maintained at 2000 for 2012/ 2013 due to training need stabilising.

It is not a mandatory requirement to include the above table. However, the purpose is to provide an easy reference to raw data from which values for indicators are determined and to facilitate the audit trail.

The purpose of the column 'Element ID' is purely to facilitate cross referencing between the tables.

Strategic objective performance indicators are highlighted in yellow.

Provincially determined performance indicators are highlighted.

Table 6.2: Performance indicators for health sciences and training [HST1 & 2]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Develop and maintain a capacitated workforce to deliver the required health services.	1.1 Develop, implement, monitor and evaluate a comprehensive Training Plan guided by the Human Resource Plan for health and support professionals in line with the Comprehensive 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) Element ID 1	No		330	442	271	350	270	280	290	
			2) Intake of nurse students (1st to 4th year at HEIs and nursing college) Element ID 2	No		671	2 906	2 230	2 404	2 400	2 450	2 500	
			3) Basic nurse students graduating (at nursing college) Element ID 3	No		74	60	191	206	220	230	240	
			4) Basic nurse students graduating (at nursing college and HEIs) Element ID 4	No	600	111	171	437	392	500	550	600	
			5) Students with bursaries from the province Element ID 5	No		2 343	2 436	2 877	2 953	3 000	3 100	3 250	
		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 Element ID 6	No	150	Not required to report	Not required to report	297	134	132	132	150	

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
	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 2 200 per annum by 2014/15.	7) Intake of Home Community Based Carers (HCBCs) Element ID 7	No	2 200	1 792	1 896	1 614	2 000	2 000	2 100	2 200	
		1.2.2 Increase the number of data capturer interns required at health care facilities to 160 per annum by 2014/15.	8) Intake of data capturer interns Element ID 8	No	160	165	110	267	150	140	150	160	
		1.2.3 Expand the number of pharmacy assistant basic and post-basic learnerships to meet the needs of health care facilities to 130 per annum by 2014/15.	9) Intake of pharmacy assistants Element ID 9	No	130	Not required to report	40	100	113	110	130	130	
		1.2.4 Increase the numbers of Assistant to Artisans (ATAs) interns to address the maintenance of health care facilities to 120 per annum by 2014/15.	10) Intake of Assistant to Artisan (ATA) interns Element ID 10	No	120	Not required to report	Not required to report	147	113	120	120	120	
		1.2.5 Increase the number of human resource and finance interns to 140 per annum by 2014/15.	11) Intake of HR and finance interns Element ID 11	No	140	Not required to report	Not required to report	Not required to report	106	120	130	140	

Note:

Indicator 1: The intake of nurses at the College will decrease in 2012/13 due to the re-evaluation of the HR nursing need based on the availability of vacant funded posts and the supply of nurses exceeding the demand.

In the short term the number of basic nurse students graduating will continue to increase until 2016/17. Thereafter the number of basic nurse students graduating will diminish and stabilise.

Table 6.3: Quarterly targets for Health Sciences and Training for 2010/11 [HST3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
1. Develop and maintain a capacitated workforce to deliver the required health services.	1.1 Develop, implement, monitor and evaluate a comprehensive Training Plan guided by the Human Resource Plan for health and support professionals in line with the Comprehensive Service Plan (CSP).	1.1.1 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) Element ID 1	Annual	270	270	-	-	-
			2) Intake of nurse students (1st to 4th year at HEIs and nursing college) Element ID 2	Annual	2 400	2 400	-	-	-
			3) Basic nurse students graduating (at nursing college) Element ID 3	Annual	220	220	-	-	-
			4) Basic nurse students graduating (at nursing college and HEIs) Element ID 4	Annual	500	500	-	-	-
			5) Students with bursaries from the province Element ID 5	Annual	3 000	3 000	-	-	-
		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 Element ID 6	Annual	132	-	132	-	-
	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 2200 per annum by 2014/15.	7) Intake of Home Community Based Carers (HCBCs) Element ID 7	Annual	2 000	-	2 000	-	-
		1.2.2 Increase the number of data capturer interns required at health care facilities to 160 per annum by 2014/15.	8) Intake of data capturer interns Element ID 8	Annual	140	-	-	140	-
		1.2.3 Expand the number of pharmacy assistant basic and post-basic learnerships to meet the needs of health care facilities to 130 per annum by 2014/15.	9) Intake of pharmacy assistants Element ID 9	Annual	110	-	110	-	-

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
		1.2.4 Increase the numbers of Assistant to Artisans (ATAs) interns to address the maintenance of health care facilities to 120 per annum by 2014/15.	10) Intake of Assistant to Artisan (ATA) interns Element ID 10	Annual	120	-	-	120	-
		1.2.5 Increase the number of human resource and finance interns to 140 per annum by 2014/15.	11) Intake of HR and finance interns Element ID 11	Annual	120	-	-	120	-

5. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 6.4: Summary of payments and estimates – Programme 6: Health Sciences and Training

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
1. Nursing Training College	35 767	39 191	48 428	51 501	51 501	50 049	58 304	16.49	62 365	66 080
2. Emergency Medical Services Training Colleges	7 156	7 631	10 526	12 784	13 784	15 939	16 803	5.42	17 989	19 083
3. Bursaries	31 249	60 155	98 946	71 713	71 713	71 713	73 680	2.74	77 431	81 193
4. Primary Health Care Training				1	1		1		1	1
5. Training Other	62 457	87 647	83 474	97 467	100 456	99 688	106 090	6.42	105 352	112 726
Total payments and estimates	136 629	194 624	241 374	233 466	237 455	237 389	254 878	7.37	263 138	279 083

Table 6.5: Payments and estimates by economic classification – Programme 6: Health Sciences and Training

Economic classification R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
Current payments	77 980	105 113	108 645	128 764	122 311	123 493	153 741	24.49	156 100	165 991
Compensation of employees	30 917	36 096	43 309	49 478	46 358	47 748	71 913	50.61	77 328	82 742
Salaries and wages	27 098	31 648	37 620	43 201	40 081	41 690	64 718	55.24	69 594	74 468
Social contributions	3 819	4 448	5 689	6 277	6 277	6 058	7 195	18.77	7 734	8 274
Goods and services	47 063	69 017	65 336	79 286	75 953	75 745	81 828	8.03	78 772	83 249
of which										
Advertising	32	36	222	36	36	251	264	5.18	280	291
Assets <R5 000	761	184	396	464	464	407	520	27.76	551	571
Bursaries (employees)	4 581	7 365	8 724	7 723	7 723	9 973	7 130	(28.51)	7 553	7 821
Catering: Departmental activities	1 980	2 355	2 106	2 209	2 209	1 035	522	(49.57)	560	598
Communication	734	652	753	750	750	648	920	41.98	974	1 009
Computer services	145	14		34	34	16	28	75.00	30	31
Cons/prof: Business and advisory services	1 850	4 698	3 422	3 932	3 932	3 219	1 582	(50.85)	1 702	1 821
Contractors	2	12	395	10	10	864	1 324	53.24	1 403	1 453
Agency and support/ outsourced services	703	847	1 586	1 416	1 416	1 533	1 825	19.05	1 934	2 003
Entertainment	1					1	2	100.00	2	2
Inventory: Food and food supplies	1 248	1 658	2 317	2 433	2 433	4 385	4 834	10.24	5 121	5 303
Inventory: Fuel, oil and gas	1 016	853	1 159	1 104	1 104	1 529	1 401	(8.37)	1 484	1 537
Inventory: Materials and supplies	449	304	212	350	350	470	828	76.17	877	908
Inventory: Medical supplies	18	46	78	63	63	80	103	28.75	109	113
Inventory: Medicine						3		(100.00)		
Inventory: Other consumables	268	369	625	490	490	635	743	17.01	787	815
Inventory: Stationery and printing	663	601	975	1 058	1 058	1 409	1 077	(23.56)	1 141	1 182
Lease payments	534	522	464	789	1 289	1 091	1 189	8.98	1 260	1 305
Property payments	4 029	4 883	3 162	4 741	4 741	3 220	3 365	4.50	3 564	3 690
Travel and subsistence	7 137	10 329	11 050	8 693	9 193	6 963	3 806	(45.34)	4 056	4 254
Training and development	20 215	32 693	26 157	42 073	34 620	33 736	36 258	7.48	39 006	41 718
Operating expenditure	95	5	741	6	3 126	4 166	14 039	236.99	6 305	6 746
Venues and facilities	602	591	792	912	912	111	68	(38.74)	73	78
Transfers and subsidies to	57 750	89 198	131 406	103 827	114 269	111 777	100 562	(10.03)	106 423	112 433
Departmental agencies and accounts	2 795	2 997	3 042	3 880	3 880	3 116	3 535	13.45	3 804	4 070
Provide list of entities receiving transfers	2 795	2 997	3 042	3 880	3 880	3 116	3 535	13.45	3 804	4 070
SETA	2 795	2 997	3 042	3 880	3 880	3 116	3 535	13.45	3 804	4 070
Universities and technikons			1 400	1 926	1 926	470	1 603	241.06	1 683	1 767
Non-profit institutions	28 482	33 000	36 483	33 359	43 801	43 801	28 474	(34.99)	30 638	32 783
Households	26 473	53 201	90 481	64 662	64 662	64 390	66 950	3.98	70 298	73 813
Social benefits	43	590	259	672	672	400	400		420	441
Other transfers to households	26 430	52 611	90 222	63 990	63 990	63 990	66 550	4.00	69 878	73 372
Payments for capital assets	695	131	1 322	875	875	2 093	575	(72.53)	615	659
Machinery and equipment	695	131	1 322	875	875	2 093	575	(72.53)	615	659
Transport equipment				455	455	460	395	(14.13)	422	452
Other machinery and equipment	695	131	1 322	420	420	1 633	180	(88.98)	193	207
Payments for financial assets	204	182	1			26		(100.00)		
Total economic classification	136 629	194 624	241 374	233 466	237 455	237 389	254 878	7.37	263 138	279 083

6. PERFORMANCE AND EXPENDITURE TRENDS

Programme 6 is allocated 1.74 per cent of the vote in 2012/13 in comparison to the 1.77 per cent that was allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R17.489 million or 7.37 per cent.

Earmarked allocations:
Included in Programme 6 is an earmarked allocation amounting to R8 801000 (2012/13), for the purpose of the Social Sector Expanded Public Works Programme.

Training of staff is key to addressing the challenges of recruitment and retention as well as enabling the focus on improving the quality of health services. The Department will continue to further invest in the training of, amongst others, nurses, EMS staff, home based carers and provide learnership opportunities to a range of staff categories to enable them to hone their skills.

7. RISK MANAGEMENT

Risk	Mitigating factors
1. Attrition/ failure rate of nurse students.	1.1. Developing academic support programmes to assist students. 1.2. Selection and admission criteria reviewed.
2. Shortage of key health and other professionals: 1) The nursing specialties of clinical nurse practitioner, trauma and emergency and operating theatre nurses. 2) Doctors in specialised categories. 3) Allied health occupations, emergency medical services, medical orthotists/prosthetists, forensic pathology technicians, clinical technologists and industrial technicians. 4) Human resource, information management and finance support staff.	2.1. These are focus areas to which recruitment and retention, and education, training and development strategies will be directed in the Human Resource (HR) Plan and Workplace Skills Plan (WSP).

The Department continually measures and monitors the failure and attrition rates of nurse students and puts contingency measures in place in order to improve attrition.

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

1. PROGRAMME PURPOSE

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

2. PROGRAMME STRUCTURE

2.1 PROGRAMME 7.1: LAUNDRY SERVICES

Rendering a laundry and related technical support service to health facilities.

2.2 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.

2.3 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.

2.4 PROGRAMME 7.4: ORTHOTIC AND PROSTHETIC SERVICES

Rendering specialised orthotic and prosthetic services.

This service is reported in Sub-programme 4.4.

2.5 PROGRAMME 7.5: MEDICINE TRADING ACCOUNT

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

There are no changes to the structure of the budget programme in comparison to the information provided in the Strategic Plan 2012 – 2014.

3. SUB-PROGRAMME 7.1: LAUNDRY SERVICES

3.1 SITUATION ANALYSIS

The purpose of the laundry services is to provide an on-going supply of linen (bedding, theatre linen and clothing, dressing linen, etc.) and other related items to all health facilities. The efficiency and effectiveness of the service is currently affected by the aging of the laundry equipment.

Linen and laundry services to health facilities are provided by the following three types of service:

1) Large central in-house laundries to economically serve health facilities that are concentrated in and around the metropolitan areas.

The three central in-house laundries are located in George and on the premises of the Tygerberg and Lentegeur Hospitals. The Tygerberg Laundry has 168 approved posts, Lentegeur 67, and George 36. Three of the approved posts at these laundries are currently vacant, one at Tygerberg Laundry and two at George Laundry (February 2012).

The construction for the upgrading and extension of the Lentegeur Laundry, which will be equipped with modern and environmentally friendly equipment, is scheduled to begin during the 2012/13 financial year. The primary aim is to cater for the additional demand being created by the commissioning of Khayelitsha and Mitchell's Plain Hospitals.

2) Laundries that are on the premises of the more remotely situated health facilities and which are funded and managed by the relevant institutions.

   A number of rural hospitals, such as Beaufort West, Bredasdorp, Caledon, Citrusdal, Clanwilliam, Ladismith, Laingsburg, Malmesbury, Murraysburg, Nelspoort, Prince Albert, Swellendam, Uniondale and Vredendal, have their own small on-site laundries.

3) Private laundries that are contracted, managed and funded by the individual health facilities on an outsourced basis.

   At present the outsourcing of laundry services is arranged in the following groups of hospitals:

   - Groote Schuur, Brewelskloof, Worcester, Robertson, Montague and Ceres;
   - Khayelitsha (until the commissioning of the upgraded Lentegeur Laundry), Victoria, Eerste River;
   - False Bay; and
   - Vredenburg.

Although the health facilities are fully responsible for their own outsourcing and on-premises laundries, they are supported by the Directorate: Engineering and Technical Support Services with the preparation of outsourcing and equipment specifications, quality monitoring and the ad-hoc maintenance of on-premises laundry equipment.

Approximately fifteen million pieces of laundry are processed annually by the in-house laundries in comparison to the approximately five million pieces that are outsourced.

3.2 CHALLENGES

Challenges currently facing Laundry Services include:

- Replacement of aging laundry equipment with modern, environmentally friendly equivalents.
- The recent, and projected, increases in the cost of utilities (electricity, water and sewerage), as well as that of coal continues, resulting in rising costs which emphasises the need for effective and efficient laundry machinery and systems.
- To maximise the in-house laundry capacity to improve efficiency and effectiveness and reduce down-time of machinery and equipment.

- To achieve the most appropriate balance between in-house and outsourced laundry services to ensure an on-going and uninterrupted provision of laundry items.

3.3 PRIORITIES

The priority is to increase the efficiency of in-house services. It is thus planned to:

1) Maximise the production capacity of Lentegeur Laundry by means of upgrading and extension of the facility.
2) Ensure on-going replacement of aging equipment at the George Laundry.
3) Reduce electricity and water consumption at in-house laundries. The baseline consumption of these utilities will be determined during 2012/13 and indicators, with the related data definitions and audit trails, will be developed for inclusion in the APP from 2013/14. The aim is to reduce water and electricity consumption by 5 per cent by 2015/16.
4) Reduce the long-term carbon footprint of laundries. The first step in this regard has been to incorporate environmentally friendly processes, as requirements, in the procurement specifications of both equipment and consumables in laundry and linen services.
5) Improve the in-house laundry services rendered to health facilities. Appropriate indictors to monitor the quality of the laundry services are being developed and will be tested during 2012/13 with a view to being included in the 2013/14 APP.

3.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR LAUNDRY SERVICES

Table 7.1: Data elements for performance indicators for laundry services

Source	Data element	Element ID	Audited /Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	20010/11	20011/12	20012/13	20013/14	20014/15
BAS	Expenditure on in-house laundries excluding capital	1	30 450 000	28 500 000	48 817 557	54 000 000	61 500 000	73 705 800	90 098 900
BAS	Expenditure on outsourced laundry services	2	8 750 000	9 350 000	17 707 724	18 150 000	19 800 200	20 900 800	25 300 000
Laundry returns.xls	Pieces laundered: In-house	3	14 500 000	15 000 000	13 996 985	15 000 000	15 000 000	15 042 000	15 271 000
Private laundry returns.xls	Pieces laundered: Outsourced	4	5 500 000	5 500 000	6 289 501	5 500 000	5 500 000	5 500 000	5 500 000

Table 7.2: Provincial strategic objectives, performance indicators and annual targets for laundry services [SUP1]

Strategic Goal	Strategic Objective: Title	Strategic Objective: Statement	Performance Indicator	Type	Strategic Objective Target	Audited/Actual Performance			Estimated performance	Medium term targets			National Target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
1. Develop and maintain appropriate health technology, infra-structure 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	R	R 5.90	R 2.10	R 1.90	R 3.49	R 3.60	R 4.10	R 4.90	R 5.90	
			Numerator ID 1		90 098 900	30 450 000	28 500 000	48 817 557	54 000 000	61 500 000	73 705 800	90 098 900	
			Denominator ID 3		15 271 000	14 500 000	15 000 000	13 996 985	15 000 000	15 000 000	15 042 000	15 271 000	
			2) Average cost per item laundered outsourced	R		R 1.59	R 1.70	R 2.82	R 3.30	R 3.60	R 3.80	R 4.60	
			Numerator ID 2			8 750 000	9 350 000	17 707 724	18 150 000	19 800 200	20 900 800	25 300 000	
			Denominator ID 4			5 500 000	5 500 000	6 289 501	5 500 000	5 500 000	5 500 000	5 500 000	

Note:

The opening of Khayelitsha Hospital will not impact on the quantity of linen to be processed during 2012/13 as beds are shifted from Tygerberg Hospital.

3.5 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR LAUNDRY SERVICES

Table 7.3: Quarterly targets for Laundry Services for 2012/13 [SUP2]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
1. Develop and maintain appropriate health technology, infrastructure. and ICT	1.2. Effective and efficient laundry service.	1.2.1. Provide a cost effective and efficient laundry service to all health facilities by 2014/15.	1) Average cost per item laundered in-house	Quarterly	R 4.10	R 4.10	R 4.10	R 4.10	R 4.10
			Numerator ID 1		61 500 000	17 630 000	17 630 000	13 530 000	12 710 000
			Denominator ID 3		15 000 000	4 300 000	4 300 000	3 300 000	3 100 000
			2) Average cost per item laundered outsourced	Quarterly	R 3.60	R 3.60	R 3.60	R 3.60	R 3.60
			Numerator ID 2		19 800 200	4 500 200	4 320 000	5 220 000	5 760 000
			Denominator ID 4		5 500 000	1 250 000	1 200 000	1 450 000	1 600 000

3.6 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND MTEF

Please refer to Tables 7.14 and 7.15 in paragraph 8 for the detailed financial information.

3.7 PERFORMANCE AND EXPENDITURE TRENDS

Sub-programme 7.1 is allocated 24.21 per cent of the 2012/13 Programme 7 budget in comparison to the 24.10 per cent that was allocated in the revised estimate of the 2011/12 budget. This is a nominal increase of R5.477 million or 8.47 per cent.

The performance targets for Programme 7.1 Laundry Services are based on historical trends of linen usage by the hospitals as well as expenditure related to the laundering thereof.

The indicators that are being developed regarding water and electricity consumption and also the quality of the service will assist in monitoring efficiency and the reduction of the carbon footprint and the quality of the service provided.

3.8 RISK MANAGEMENT

The risks highlighted for Programme 7.1 are as follows:

Risk	Mitigating factors
1. Aging laundry equipment.	1.1. The upgrading of Lentegeur Laundry will result in the replacement of most of the old equipment.
2. Fraud: linen losses.	2.1. Uncontrolled linen losses occur at health facilities. 2.2. Continued advice will be provided to health facilities with a possible implementation of a linen control management system should this become viable. Video monitoring is strongly recommended to curb losses as implemented at Groote Schuur Hospital.
3. Shortage of qualified and experienced technical and professional personnel: Lack of laundry managers.	3.1. An initiative has been launched to enhance in-service training and to identify accredited training courses for laundry managers.

4. SUB-PROGRAMME 7.2 ENGINEERING SERVICES

4.1 SITUATION ANALYSIS

The responsibility of maintenance of health facilities is provided as follows:

- Preventive, day-to-day, emergency and clinical engineering maintenance is undertaken by health facilities and, where there is no appropriate capacity, by the central workshops (engineering services).
- Scheduled maintenance and preventative maintenance to newly built facilities are the responsibility of Programme 8.

In accordance with the approved organisational structure each health facility should have access to technical capacity to provide for all preventative and day-to-day maintenance. Unfortunately, most of the technical posts remain vacant due to a general lack of skills in this sector. This is especially evident in the clinical engineering component and has resulted in a considerable maintenance backlog of infrastructure, machinery and equipment, including medical equipment. Moreover, the lack of an appropriate maintenance management system has further exacerbated the situation and has led to the fragmentation of the roles and responsibilities (health facilities, Department of Transport and Public Works, and engineering services) for the overall building maintenance programme.

The individual health facility workshops are assisted by central workshops located at Bellville, Zwaanswyk and Goodwood. The workshops at Bellville and Zwaanswyk provide advanced technical support to the individual health facility workshops. These two workshops are also known as the "mobile workshops" because they have suitable vehicles to enable them to move personnel and equipment to wherever they are needed. The Goodwood workshop is a dedicated clinical engineering workshop that specialises in the maintenance of medical equipment. These central workshops provide specialist engineering expertise and capacity to deal with maintenance work that is beyond the capability of the health facility workshops.

In order to improve efficiency and better utilisation of scarce skills, the Western Cape Infrastructure Delivery Management System (WC IDMS) has been developed. With the exception of the central hospitals, which run their own technical workshops, it is envisaged that all the other facilities will implement what is referred to as the 'hub-and-spoke' model. This is currently being implemented through the Human Resources Strategy – a study begun in early 2011 in the Western Cape Departments of Health, Public Works, Education and Treasury, under the auspices of the Infrastructure Delivery Improvement Programme (IDIP) and in conjunction with the Department of the Premier. This strategy will result in changes to the organisational structure of the Chief Directorate: Infrastructure Management as well as in staff complements and capacity. It will also include an effective distribution of maintenance resources and know-how to the health facilities.

A measure to address the issue of skills shortages is the implementation of an Expanded Public Works Programme (EPWP) training project, known as the Artisan Technical Assistant (ATA). ATA initially started with 147 trainees for the period 1 July 2010 to 30 June 2011 of which 128 completed the program and entered the marketplace. For the 2011/12 financial year 120 trainees were recruited from across the province. It is planned to again recruit 120 trainees during 2012/13.

The increasing cost of utilities and the production of greenhouse gasses at all health facilities are major challenges currently facing the Department.

4.2 CHALLENGES

1) Insufficient funding allocated for maintenance (clinical engineering, emergency, day-to-day and preventative) at health facilities, which indicates a failure to prioritise within budget processes as well as capital stock that is unaffordable.
2) Difficulty in recruiting and retaining qualified and experienced technical staff.
3) The lack of an enterprise web-based maintenance management system to enable effective maintenance planning, budgeting and decision making.
4) Aligning the services provided by the directorate with the districts to cover all health facilities, including ambulance stations and forensic pathology laboratories.
5) The lack of an up-to-date Immovable Asset Register (IAR) which is the responsibility of the Department of Transport and Public Works. This hampers effective planning and budgeting for maintenance at facilities.
6) The increasing cost of utilities and the production of greenhouse gasses pertaining to the running of health facilities.

4.3 PRIORITIES

1) Implement the Western Cape Infrastructure Delivery Management System.
2) Monitor expenditure for the routine and day-to-day maintenance at each health facility to improve co-ordination.
3) Need to prioritise maintenance within institutional and departmental budgets.
4) Continue to strive to fill all technical posts with qualified and experienced personnel and ensure an adequate succession plan is put in place.
5) Investigate and develop the business plan for an enterprise web based maintenance system for the health immovable asset portfolio.
6) Implement the HR strategy in accordance to the funds available.
7) Utilise the ATA project to develop a cadre of suitably qualified technical resources.
8) Determine a baseline regarding electrical (measured in average kilowatt hour per bed) and water consumption (measured in kilolitres per bed) at hospitals (excluding laundry consumption), by the end of March 2013. The aim is to measure consumption per month against the baseline consumption from April 2013 onwards.
9) Determine a baseline of incidents reported in terms of the Occupational Health and Safety (OHS) Act, as a result of unsafe machinery and equipment at all facilities maintained by engineering services. The aim is to start measuring the safety of machinery and equipment at all health facilities against this baseline with effect from 2013/14.

4.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR ENGINEERING SERVICES

Table 7.4: Data elements for performance indicators for Engineering Services

Source	Data element	Element ID	Audited /Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	20010/11	20011/12	20012/13	20013/14	20014/15
Job card system	The number of engineering emergency cases attended to within 48 hours	1	New indicator	New indicator	New indicator	New indicator	154	164	164
Job card system	Total number of engineering emergency cases reported	2	New indicator	New indicator	New indicator	New indicator	171	180	178
BAS	Total Programme 7 maintenance expenditure	3	New indicator	New indicator	New indicator	New indicator	94 159	100 750	107 803
BAS	Total Programme 7 maintenance budget	4	New indicator	New indicator	New indicator	New indicator	94 159	100 750	107 803
Job card system	Number of clinical engineering jobs completed	5	New indicator	New indicator	New indicator	New indicator	13 221	13 882	13 744
Job card system	Number of clinical engineering jobs reported	6	New indicator	New indicator	New indicator	New indicator	13 882	14 576	14 431
Job card system	Number of maintenance jobs (excluding clinical engineering and emergency jobs) completed	7	New indicator	New indicator	New indicator	New indicator	12 687	13 321	13 186
Job card system	Number of maintenance jobs (excluding clinical engineering and emergency jobs) reported	8	New indicator	New indicator	New indicator	New indicator	13 321	13 987	13 845

Table 7.5: Strategic objectives, performance indicators and annual targets for Engineering Services [SUP1]

Strategic Goal	Strategic Objective: Title	Strategic Objective: Statement	Performance Indicator	Type	Strategic Objective Target	Audited/Actual Performance			Estimated performance	Medium term targets			National Target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
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 92% of all engineering emergency cases reported are attended to within 48 hours by 2014/15.	1) Percentage of engineering emergency cases attended to within 48 hours	%	92%	New indicator	New indicator	New indicator	New indicator	90%	91%	92%	
			Numerator ID 1		164	-	-	-	-	154	164	164	
			Denominator ID 2		178	-	-	-	-	171	180	178	
	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	%	100%	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	
			Numerator ID 3		107 803	-	-	-	-	94 159	100 750	107 803	
			Denominator ID 4		107 803	-	-	-	-	94 159	100 750	107 803	
			3) Percentage of clinical engineering maintenance jobs completed	No		New indicator	New indicator	New indicator	New indicator	95%	95%	95%	
			Numerator ID 5			-	-	-	-	13 221	13 882	13 744	
			Denominator ID 6			-	-	-	-	13 882	14 576	14 431	
			4) Percentage of maintenance jobs (excluding clinical engineering jobs) completed	No		New indicator	New indicator	New indicator	New indicator	95%	95%	95%	
			Numerator ID 7			-	-	-	-	12 687	13 321	13 186	
			Denominator ID 8			-	-	-	-	13 321	13 987	13 845	

4.5 QUARTERLY TARGETS FOR ENGINEERING SERVICE

Table 7.6: Quarterly targets for Engineering Services for 2012/13 [SUP2]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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 92% of all engineering emergency cases reported are attended to within 48 hour by 2014/15.	1) Percentage of engineering emergency cases attended to within 48 hours	Quarterly	90%	90%	89%	89%	89%
			Numerator ID 1		154	37	42	36	39
			Denominator ID 2		171	41	47	40	43
	1.2. Efficiency and effectiveness of Engineering Services.	1.2.2. Provide an effective and efficient maintenance service to all health facilities maintained by Engineering Services by 2014/15.	2) Percentage of maintenance budget spent	Quarterly	100%	100%	100%	100%	100%
			Numerator ID 3		94 159	18 831	28 248	28 248	18 832
			Denominator ID 4		94 159	18 831	28 248	28 248	18 832
			3) Percentage of clinical engineering maintenance jobs completed	Quarterly	95%	95%	95%	95%	95%
			Numerator ID 5		13 221	3 210	3 612	3 094	3 305
			Denominator ID 6		13 882	3 371	3 793	3 249	3 469
			4) Percentage of maintenance jobs (excluding clinical engineering jobs) completed	Quarterly	95%	95%	95%	95%	95%
			Numerator ID 7		12 687	3 080	3 466	2 969	3 172
			Denominator ID 8		13 321	3 234	3 639	3 117	3 331

4.6 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND MTEF

Please refer to Tables 7.14 and 7.15 for the detailed financial information.

4.7 PERFORMANCE AND EXPENDITURE

Sub-programme 7.2 is allocated 32.77 per cent of the Programme 7 budget in 2012/13 in comparison to the 34.53 per cent that was allocated in the revised estimate of the 2011/12 budget. This is a nominal increase of R2.311 million or 2.50 per cent.

The decrease in the trend in percentage for 2012/13 is due to the transfer of funds from Programme 8 to Programme 7 during 2011/12 for contingency projects and to fund the EPWP project as an adjustment budget.

The performance targets for Sub-programme 7.2: Engineering Services are based on the historical trends of actual jobs completed.

4.8 RISK MANAGEMENT

The risks highlighted for Sub-programme 7.2 are as follows:

Risk	Mitigating factors
1. Aging engineering equipment.	1.1. Preventative maintenance to newly installed engineering equipment.
2. Inadequate funding.	2.1. Improve efficiency in the management of utilities. 2.2. Implementation of the HR strategy (hub and spokes) to gain efficiency.
3. Shortage of qualified and experienced technical and professional personnel.	3.1. OSD implementation for built environment professional. 3.2. Bursary scheme for clinical technicians. 3.3. EPWP for assistant-to-artisan (ATA) programme.
4. Lack of enterprise web-based maintenance management software.	4.1. Specifications to be drafted. 4.2. Improved Immovable Asset Register from the Department of Transport and Public Works.

5. SUB-PROGRAMME 7.3 FORENSIC PATHOLOGY SERVICE

5.1 SITUATION ANALYSIS

This service is rendered via eighteen forensic pathology facilities across the Province which includes two M6 academic forensic pathology laboratories in the Cape Town Metro District, two academic departments of forensic medicine, three referral FPS laboratories (M3) and smaller forensic pathology laboratories and holding centres (M1 and M2) in the West Coast, Cape Winelands, Overberg, Eden and Central Karoo Districts.

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

Table 7.7: Grading of Forensic Pathology Services (FPS) facilities

FPL Grade	Number of Post Mortems	Facilities in the Province in this Category
M1	0 - 249	Vredendal, Vredenburg, Malmesbury, Wolseley, Swellendam, Riversdale, Beaufort West, Laingsburg
M2	250 – 499	Hermanus, Mossel Bay, Knysna
M3	500 - 999	Regional Referral Centres: Paarl, Worcester, George, Stellenbosch, Oudtshoorn
M4	1 000 – 1 499	None
M5	1 500 – 1 999	None
M6 (Academic)	> 2 000	Salt River, Tygerberg

Forensic Pathology Services include the following:

- Investigation at the scene of death.
- Collection of evidence.
- Assistance to the South African Police Service with the identification of deceased persons.
- Autopsy and post mortem examinations including specimen collection.
- Safe custody of all forms of evidence and specimens.
- Preparation of judicial reports and statements.
- Provide testimony in court proceedings.
- Training of doctors, registrars, undergraduate students and forensic officers.
- Rendering FPS assistance to other provinces and countries**.**
- Provision of mortality data to relevant stakeholders to inform research and prevention strategies.

The Forensic Pathology Service further provides for the inspector of anatomy functions. This function is in the process of being established and the role and responsibilities will expand with the implementation of Chapter 8 of the National Health Act and the subsequent regulations.

The Forensic Pathology Service contributes to the Provincial Strategic Objective 4 (Increasing wellness), Strategic Objective 5 (Increasing safety) and Strategic objective 8 (Increasing Social Cohesion) by providing expertise and information in terms of mortality to the burden of disease project that informs policy direction as well as targeted interventions.

Three new 'fit-for-purpose' facilities were commissioned during the 2011/12 financial year in Malmesbury, Worcester and Paarl, with Paarl and Worcester being referral centres. This will significantly improve the experience or relatives of the deceased who have to access this service under difficult circumstances.

5.2 CHALLENGES

5.2.1 Funding

Sub-programme 7.3 is now fully funded from the equitable share allocation as the conditional grant allocation ceased at the end of the 2011/12 financial year despite motivation to retain the allocation. The grant had ensured that the upgrading and delivery of forensic pathology service received prominence within the provincial budget and contributed to improved service delivery.

5.2.2 Infrastructure

Improving the physical infrastructure remains a priority. The implementation of the infrastructure plan has been severely affected by delays in construction projects as well as the increase in building costs. Six new forensic pathology laboratories (George, Worcester, Paarl, Hermanus, Malmesbury and Beaufort West) have been constructed. Twelve of the eighteen forensic pathology laboratories still require either relocation or upgrading.

Currently services are rendered via private undertaker premises in Riversdale and Vredenburg. Investigation is underway to secure property in Wolseley. A property in Swellendam was purchased from a private undertaker during the 2009/10 financial year. This facility now requires some refurbishing and upgrading.

5.2.3 Human resources

The proposed human resource plan cannot be fully implemented due to funding constraints. The high workload and related stress continues to impact on the ability to recruit and retain personnel in the Forensic Pathology Service. This needs to be addressed by the implementation of an occupation specific dispensation as well as career progression for the forensic officer categories.

The institutionalisation of a structured and dedicated employee wellness programmes within the Forensic Pathology Service remains a priority.

The establishment of a formal accredited training programme for the forensic officer categories remains a challenge.

5.2.4 Stakeholder Interaction

The reliance on stakeholders to deliver on the Forensic Pathology Service mandate remains a risk. Aspects of service delivery that are impacted on are the following:

- Identification of deceased.
- Death scene investigation.
- Processing of toxicology and blood alcohol samples to inform post-mortem findings.
- Response and adequate management of major incidents.

The risk is being mitigated through the implementation of a memorandum of understanding and regular interaction with the relevant stakeholders.

5.2.5 **Functions of the inspector of anatomy**

The function of the inspector of anatomy with regards to the management of human tissue which includes organ donation as well as blood is still to be fully established.

5.3 PRIORITIES

The priorities for 2012/13 remain as outlined in the five-year strategic plan namely:

5.3.1 **Burden of disease**

Ensuring access to the Forensic Pathology Service will be achieved through the management of response times as well as turnaround times of forensic pathology cases. Specific targets have been set per geographic service area.

Improving the quality and access to medico legal investigation of death as well as death scene investigation per geographic service area through the creation of additional capacity and targeted training interventions.

5.3.2 **Quality assurance**

Integrate quality assurance into all aspects of the service through the implementation of standard operating procedures and quality improvement initiatives.

5.3.3 **Financial management**

Strengthen financial management including compliance with financial prescripts.

5.3.4 **Recruitment, retention, development and support personnel**

Various categories of staff are required in the service areas listed below. Each service area has specific needs, which will be addressed within the human resource plan as determined by the available funding.

5.3.4.1 **Metro East and Metro West Geographic Service Area:**

Facilities within these two service areas serve the population of the Cape Town Metro and have the highest service burden as this area has both the highest population density and the largest burden of disease. The area also includes the Faculties of Health Science of the Universities of Cape Town and Stellenbosch both of which provide the training platform for specialist forensic pathologists. The faculties are key partners in the delivery of forensic pathology services both within the Metro East and West Geographic Service areas.

5.3.4.2 **Winelands Overberg Geographic Service Area**

The Worcester facility acts as a referral centre for the area and further provides outreach and support to the geographic service area which includes Hermanus, Wolseley and Swellendam facilities.

5.3.4.3 **West Coast Geographic Service Area**

The Paarl facility acts as a referral centre for the area and further provides outreach and support to the geographic service area which includes Stellenbosch, Vredenburg, Vredendal, and Malmesbury facilities.

5.3.4.4 **Eden Karoo Geographic Service Area**

The George facility acts as referral centre for the area and further provides outreach and support to the geographic service area which includes Knysna, Mossel Bay, Riversdale, Oudtshoorn, Beaufort West and Laingsburg facilities.

5.3.5 **Health technology, infrastructure and information communication technology that meets the service needs**

This includes:

5.3.5.1 **Metro West Geographic Service Area**

- Construct a new M6 academic facility on the Groote Schuur Hospital (GSH) site and relocate the current Salt River (M6 academic facility) to this site.
- Expand the Tygerberg (M6 academic) facility to adequately deal with the caseload and also to act as the provincial disaster response centre.

5.3.5.2 **Eden Karoo Geographic Service Area**

- Construct a new M1 facility in Riversdale. This facility is currently on the premises of a private undertaker.
- Construct a new facility in Mossel Bay as part of the Hospital Revitalisation project.

5.3.5.3 **Winelands Overberg Geographic Service Area**

- Construct a new facility in Wolseley (M1) which is currently on SAPS premises.

5.3.5.4 **West Coast Geographic Service Area**

- Construct a new facility to replace the current facility in Stellenbosch (M3), which is inadequate to deal with the caseload.
- Construct a new facility in Vredenburg (M1) which is currently on private undertaker premises.

5.3.5.5 **Information technology**

Implement enhancements to the Forensic Pathology business solution and expand electronic content management to ensure adequate and responsive information technology.

5.3.5.6 **Stakeholder interaction and building strategic partnerships**

Continue to interact with strategic partners to ensure synergy and optimal service delivery. These partners include the South African Police Service, Home Affairs, National Forensic Chemistry Laboratory and National Prosecuting Authority.

5.3.6 **Major incidents**

Be prepared to deal with major incidents as well as surges in service demands.

These priorities will also address the negotiated service delivery agreements (NSDA) with regard to the strengthening of health system effectiveness.

5.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR FORENSIC PATHOLOGY SERVICES

Table 7.8: Data elements for performance indicators for Forensic Pathology Services

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Rural: FPS R003; index register; Metro: EMS system	Forensic Pathology scenes attended within the 40 minute target	1	New indicator	New indicator	New indicator	6 838	7 140	7 268	7 399
Rural: FPS R003; index register; Metro: EMS system	Forensic pathology scenes attended (body receipt and deferral)	2	New indicator	New indicator	New indicator	8 767	8 925	9 085	9 249
Rural: FPS R003; index register; Metro: EMS system	FPS cases examined within the target of 3 days	3	New indicator	New indicator	New indicator	6 630	6 939	7 258	7 388
FPS R003; metro: index register	Forensic pathology cases examined during the reporting period	4	New indicator	New indicator	New indicator	9 338	9 506	9 677	9 851
FPS R003; metro: index register	FPS cases released within the target of 5 days	5	New indicator	New indicator	New indicator	6 194	6 407	6 522	6 640
FPS R003; metro: index register	Bodies released (excluding paupers)	6	New indicator	New indicator	New indicator	8 391	8 542	8 696	8 853
FPS R003; metro: index register	Deceased still unidentified after 90 days have elapsed	7	197	111	88	115	90	90	90

Table 7.9: Strategic objectives, performance indicators and annual targets for Forensic Pathology Services [SUP1]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 80 % within the 40 minutes target by 2014/15.	1) Percentage of FPS cases responded to within 40 minutes	%	80%	New indicator	New indicator	New indicator	78%	80%	80%	80%	
			Numerator ID 1		7 399	-	-	-	6 838	7 140	7 268	7 399	
			Denominator ID 2		9 249	-	-	-	8 767	8 925	9 085	9 249	
			2) Percentage of cases examined within 3 days	%	75%	New indicator	New indicator	New indicator	71%	73%	75%	75%	
			Numerator ID 3		7 388	-	-	-	6 630	6 939	7 258	7 388	
			Denominator ID 4		9 851	-	-	-	9 338	9 506	9 677	9 851	
			3) Percentage of FPS cases released within 5 days (excluding unidentified persons)	%	75%	New indicator	New indicator	New indicator	74%	75%	75%	75%	
			Numerator ID 5		6 640	-	-	-	6 194	6 407	6 522	6 640	
			Denominator ID 6		8 853	-	-	-	8 391	8 542	8 696	8 853	
2. Ensure and maintain organisational strategic management capacity and synergy.	2.1. Develop integrated support and management structures to render effective FPS.	2.1.1. Improve the management of deceased with unknown identity by reducing the annual number to < 90 by 2014/15.	4) Deceased with unknown identity exceeding 90 days	Days	90	197	111	88	115	90	90	90	
			Element ID 7										

Note:

Indicator 1: The target is maintained at 80% of scenes attended within the 40 minute target. The response can only be improved with the employment of additional resources and an increased vehicle fleet. This is not a reality in the current MTEF. The performance from June 2011 to January 2012 indicates performance between 75 and 78% month on month. The 80% target is therefore a stretch target.

5.5 QUARTERLY TARGETS FOR FORENSIC PATHOLOGY SERVICES

Table 7.10: Quarterly targets for Forensic Pathology Services for 2012/13 [SUP2]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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 80 % within the 40 minutes target by 2014/15.	1) Percentage of FPS cases responded to within 40 minutes	Quarterly	80.0%	80.0%	80.0%	80.0%	80.0%
			Numerator ID 1		7 140	1 785	1 785	1 785	1 785
			Denominator ID 2		8 925	2 231	2 231	2 231	2 232
			2) Percentage of cases examined within 3 days	Quarterly	73.0%	73.0%	73.0%	73.0%	73.0%
			Numerator ID 3		6 939	1 735	1 735	1 735	1 734
			Denominator ID 4		9 506	2 377	2 377	2 376	2 376
			3) Percentage of FPS cases released within 5 days (excluding unidentified persons)	Quarterly	75.0%	75.0%	75.0%	75.0%	75.0%
			Numerator ID 5		6 407	1 602	1 602	1 602	1 601
			Denominator ID 6		8 542	2 136	2 136	2 135	2 135
2. Ensure and maintain organisational strategic management capacity and synergy.	2.1. Develop integrated support and management structures to render effective FPS.	2.1.1. Improve the management of deceased with unknown identity by reducing the annual number to < 90 by 2014/15.	4) Deceased with unknown identity exceeding 90 days	Quarterly	90	90	90	90	90
			Element ID 7						

Note:

Indicator 4: The list of deceased with unknown identity should be kept below 90 in each quarter of the year. (This is a cumulative figure and not the sum of deceased with unknown identity in each quarter.)

5.6 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND MTEF

Sub-programme 7.3 is allocated 36.62 per cent of the Programme 7 budget in 2012/13 in comparison to the 36.69 that was allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R7.673 million or 7.80 per cent in nominal terms.

5.7 PERFORMANCE AND EXPENDITURE TRENDS

Improvement to the physical infrastructure remains a largely unfunded priority. Twelve of the eighteen forensic pathology laboratories still require either relocation or upgrading. The conditional grant phased out at the end of the 2011/12 financial year. These construction projects can only proceed if additional funding is secured.

The Human Resource Plan for the service will be implemented with the maintenance of the Approved Post List at 260 out of an establishment of 306 in 2012/13 financial year.

Incident response time will be maintained and targets have been set per geographic service area taking into consideration distances to be travelled.

5.8 RISK MANAGEMENT

Risk	Mitigating factors
1. The reliance on external stakeholders to deliver on the Forensic Pathology Services mandate remains at risk. Aspects of service delivery that are impacted on are the following: • Identification of deceased. • Processing of toxicology and blood alcohol samples to inform post mortem findings. • Response and adequate management of major incidents.	1.1. The risk is being mitigated through the implementation of a memorandum of understanding and regular interaction with relevant stakeholders. 1.2. Implementation of new technology to limit the number of toxicology samples submitted to the Forensic Chemistry Laboratory.
2. The conditional grant allocation was phased out at the end of the 2011/12 financial year.	2.1. Ensure adequate funding allocation.
3. The current funding allocation is not sufficient to implement the service according to the original business plan that was approved by Cabinet as the allocation has not addressed: • The increase in infrastructure costs. • Inflationary pressures. • Increases in staff salaries.	3.1. Implement the service within the available budget.
4. The implementation of the infrastructure plan is limited by the availability of funding.	4.1. Business cases will be submitted to proceed with prioritised projects within available funding.
5. The ability to respond to major incidents.	5.1. The implementation of local, district and provincial Major Incident Response Plans and will collaborate with EMS in this regard.

6. SUB-PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

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

7. SUB-PROGRAMME 7.5 MEDICINE TRADING ACCOUNT

7.1 SITUATION ANALYSIS

The Medicine Trading Account is used to fund the operations of the Cape Medical Depot (CMD). The CMD purchases medicines in bulk. The bulk supplies are stored and repackaged in smaller quantities for distribution to health care facilities.

The CMD is located in a multi-storey building in Chiappinni Street in central Cape Town. The building is old and unsuitable for purpose.

The Department will in future incorporate the CMD into the Department budget structure and thus abolish the current trading account arrangement. However, this requires further processes to address budget, legal, governance, accounting and labour relations issues. The initial step in the process will be the repeal of Provincial Ordinance 3 of 1962, which it is anticipated will occur by either the 2012 Adjusted Estimate or from 1 April 2013.

7.2 CHALLENGES

- The augmentation of the capital account for at least an inflationary amount is required to ensure the adequate procurement of stock to meet service delivery demands.
- The physical infrastructure of the current depot is largely unsuitable for the warehousing of medicines and supplies using current warehouses principles.

7.3 PRIORITIES

The priorities for Sub-programme 7.5 are:

- Incorporation of the CMD within the departmental budget structure as indicated above.
- Ensuring adequate infrastructure for the Cape Medical Depot, including a computerised system implemented for the relevant warehouse functions with respect to the procurement, warehousing and accounting requirements to meet its own as well as its clients' needs.
- On-going quality improvement efforts will include:
    - Improving service delivery to facilities.
    - The timely purchase of adequate stock.
    - Adequately funded capital account.

7.4 STRATEGIC OBJECTIVE, PERFORMANCE INDICATOR AND ANNUAL TARGET FOR THE MEDICINE TRADING ACCOUNT

Table 7.11: Data element for performance indicator for the Medicine Trading Account

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
MEDSAS	Working capital for Cape Medical Depot	1	46 792 000	48 507 000	88 332 000	110 000 000	110 000 000	110 000 000	110 000 000
MEDSAS	Pharmaceutical items that are in stock at the CMD	2	New indicator	New indicator	New indicator	735	735	735	735
MEDSAS	Pharmaceutical items on the stock register	3	New indicator	New indicator	New indicator	758	758	758	758

Table 7.12: Strategic objective performance indicator and annual target for the Medicine trading account [SUP1]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
1. Ensure and maintain organisational strategic management capacity and synergy.	1.1. To ensure adequate working capital to allow for efficient stockholding of pharmaceuticals and non-pharmaceuticals at the Cape Medical Depot.	1.1.1. Increase working capital annually in line with the projected inflator with a target of R110 million by 2014/15.	1) Working capital in the medicine trading account Element ID 1	Rand	110 000 000	46 792 000	48 507 000	88 332 000	110 000 000	110 000 000	110 000 000	110 000 000	
	1.2. To ensure optimum pharmaceutical stock levels to meet the demand.	1.2.1. Ensure pharmaceutical stock levels of 97% at the CMD by 2014/15.	2) Percentage of pharmaceutical stock available		97%	New indicator	New indicator	New indicator	97%	97%	97%	97%	
			Numerator ID 2		735	-	-	-	735	735	735	735	
			Denominator ID 3		758	-	-	-	758	758	758	758	

7.4.2 QUARTELRY TARGETS FOR THE MEDICINE TRADING ACCOUNT

Table 7.13: Strategic objective performance indicator and annual target for Medicine trading account [SUP1]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
1. Ensure and maintain organisational strategic management capacity and synergy.	1.1. To ensure adequate working capital to allow for efficient stockholding of pharmaceuticals and non-pharmaceuticals at the Cape Medical Depot.	1.1.1. Increase working capital annually in line with the projected inflator with a target of R110 million by 2014/15.	1) Working capital in the medicine trading account	Annual	110 000 000	27 500 000	27 500 000	27 500 000	27 500 000
	1.2. To ensure optimum pharmaceutical stock levels to meet the demand.	1.2.1. Ensure pharmaceutical stock levels of 97% at the CMD by 2014/15.	2) Percentage of pharmaceutical stock available		97%	97%	97%	97%	97%
			Numerator ID 2		735	735	735	735	735
			Denominator ID 3		758	758	758	758	758

Note:

Indicator 2: 3% stock unavailability takes into account irregular supplies from manufacturers.

7.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND MTEF

Sub-programme 7.5 is allocated 6.40 per cent of the Programme 7 budget in 2012/13 in comparison to the 4.67 per cent of the Programme 7 budget that was allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase R6.001 or 47.87 per cent.

7.6 RISK MANAGEMENT

The risks highlighted for Sub-programme 7.5 are as follows:

Risk	Mitigating factors
1. Maintenance of the current CMD building to legislative norms and standards.	1.1. Replacement of condemned large walk-in fridges for the storage of thermo labile medication. 1.2. Air-conditioning contract for a period of three years awarded to fulfil pharmacy legislative requirements.
2. Further deterioration of the infrastructure of current building, increasing the current site's unsuitability for purpose.	2.1. Comprehensive business plan to address the issue of adequate infrastructure for the CMD to be drafted and consulted within the Department in 2012/13.
3. Shortage of qualified and experienced professional and technical personnel for the rendition of pharmaceutical warehousing services.	3.1. Recruitment, selection and the retention of pharmacist professionals for the CMD. 3.2. Formal training for the relevant staff with respect to both basic and post basic pharmacist assistants categories, as required by the Department.

8 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND THE MTEF

Programme 7 is allocated 1.98 per cent of the vote in 2012/13 in comparison to the 2.00 per cent allocated in the revised estimate of the 2011/12 budget. This amounts to a nominal increase of R21.462 million or 8.00 per cent.

Orthotic and Prosthetic Services, previously in Sub-programme 7.4 were transferred to Sub-programme 4.4 with effect from 1 April 2008.

Table 7.14: Summary of payments and estimates: - Programme 7: Health Care Support Services [SUP 3]

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
1. Laundry Services	45 134	53 109	60 237	64 641	64 641	64 641	70 118	8.47	74 841	78 825
2. Engineering Services	49 443	58 535	74 830	75 459	92 599	92 599	94 910	2.50	101 221	106 525
3. Forensic Services [a]		84 246	95 503	98 391	98 391	98 391	106 064	7.80	113 668	120 848
4. Orthotic and Prosthetic Services				1	1	1	1		1	1
5. Medicine Trading Account	1 573	1 715	52 299	12 535	12 535	12 535	18 536	47.87	13 963	14 661
Total payments and estimates	96 150	197 605	282 869	251 027	268 167	268 167	289 629	8.00	303 694	320 860

[a] 2012/13: National Conditional grant: Health professions training and development: R7 142 000 (Compensation of employees R5 290 000; Goods and services R1 852 000)

Note: The Orthotic and Prosthetic Services previously in Sub-programme 7.4 has been transferred to Sub-programme 4.4 with effect of 1 April 2008.

Note: The Forensic Services previously in Sub-programme 2.8 has been transferred to Sub-programme 7.3 with effect of 1 April 2009.

Table 7.15: Payments and estimates by economic classification – Programme 7: Health Care Support Services

Economic classification R'000	Outcome						Medium-term estimate			
	Audited	Audited	Audited	Main appro-priation	Adjusted appro-priation	Revised estimate	% Change from Revised estimate			
	2008/09	2009/10	2010/11	2011/12	2011/12	2011/12	2012/13	2011/12	2013/14	2014/15
Current payments	93 208	179 506	217 654	229 205	246 367	246 400	261 108	5.97	279 068	294 813
Compensation of employees	43 515	104 448	123 811	142 157	142 019	139 670	157 773	12.96	169 604	181 474
Salaries and wages	37 477	90 315	106 972	124 405	124 267	122 229	135 905	11.19	146 096	156 322
Social contributions	6 038	14 133	16 839	17 752	17 752	17 441	21 868	25.38	23 508	25 152
Goods and services	49 693	75 058	93 843	87 048	104 348	106 730	103 335	(3.18)	109 464	113 339
of which										
Administrative fees							27		29	30
Advertising		2	17	5	5	18	19	5.56	20	21
Assets <R5 000	262	768	701	842	842	666	744	11.71	787	815
Catering: Departmental activities	1	103	68	95	95	96	157	63.54	166	172
Communication	433	1 670	2 054	1 950	1 950	1 828	2 117	15.81	2 243	2 323
Computer services	20	2 545	2 125	2 005	2 005	2 135	2 183	2.25	2 312	2 394
Cons/prof: Business and advisory services		220	1 448	11	11	92	101	9.78	107	111
Cons/prof: Laboratory services		684	354	726	726	440	571	29.77	605	627
Contractors	2 463	6 246	7 444	7 518	7 518	8 067	7 506	(6.95)	7 951	8 232
Agency and support/ outsourced services	4 014	6 871	7 384	7 340	7 340	8 099	9 990	23.35	10 583	10 958
Entertainment	2	5	7	9	9	9	12	33.33	12	12
Inventory: Food and food supplies	117	124	164	175	175	155	148	(4.52)	158	163
Inventory: Fuel, oil and gas	870	768	936	1 132	1 132	1 113	1 268	13.93	1 344	1 391
Inventory: Materials and supplies	6 420	9 598	10 296	11 099	11 099	10 717	11 113	3.70	11 773	12 190
Inventory: Medical supplies	2	757	572	879	879	637	996	56.36	1 054	1 091
Inventory: Other consumables	8 984	10 845	10 529	12 166	13 666	11 434	10 079	(11.85)	10 678	11 056
Inventory: Stationery and printing	551	1 405	1 433	1 622	1 622	1 355	1 565	15.50	1 657	1 716
Lease payments	130	1 150	956	636	2 435	4 348	8 749	101.22	9 267	9 594
Rental and hiring						5	9	80.00	10	10
Property payments	20 816	17 148	27 079	22 917	33 417	37 086	32 878	(11.35)	34 827	36 061
Travel and subsistence	4 354	13 421	16 992	15 095	13 318	14 152	9 775	(30.93)	10 356	10 723
Training and development	202	487	550	639	639	609	494	(18.88)	524	542
Operating expenditure	16	163	2 731	161	5 439	3 654	2 834	(22.44)	3 001	3 107
Venues and facilities	36	78	3	26	26	15		(100.00)		
Transfers and subsidies to	1 657	2 881	52 416	12 953	12 953	12 691	19 600	54.44	15 080	15 834
Departmental agencies and accounts	1 573	1 715	52 299	12 535	12 535	12 535	18 536	47.87	13 963	14 661
Entities receiving transfers	1 573	1 715	52 299	12 535	12 535	12 535	18 536	47.87	13 963	14 661
CMD Capital Augmentation	1 573	1 715	52 299	12 535	12 535	12 535	18 536	47.87	13 963	14 661
Households	84	1 166	117	418	418	156	1 064	582.05	1 117	1 173
Social benefits	84	1 166	117	418	418	156	1 064	582.05	1 117	1 173
Payments for capital assets	1 203	15 164	12 478	8 869	8 847	8 847	8 921	0.84	9 546	10 213
Buildings and other fixed structures	385	12 486	8 157	5 140	5 140	5 140	5 140		5 500	5 885
Buildings	385	12 486	8 157	5 140	5 140	5 140	5 140		5 500	5 885
Machinery and equipment	818	2 678	4 321	3 729	3 707	3 707	3 781	2.00	4 046	4 328
Transport equipment		524	860	860	860	860		(100.00)		
Other machinery and equipment	818	2 154	3 461	2 869	2 847	2 847	3 781	32.81	4 046	4 328
Of which: "Capitalised Goods and services" included in Payments for capital assets		12 020	8 021	5 162	5 140	5 140	5 140		5 500	5 885
Payments for financial assets	82	54	321			229		(100.00)		
Total economic classification	96 150	197 605	282 869	251 027	268 167	268 167	289 629	8.00	303 694	320 860

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

1. PROGRAMME PURPOSE:

The provision of new health facilities and the upgrading and maintenance of existing facilities.

2. PROGRAMME STRUCTURE

2.1. SUB-PROGRAMME 8.1: COMMUNITY HEALTH FACILITIES

Planning, construction, upgrading, refurbishment, additions, and maintenance of community health centres, community day centres, and clinics.

2.2. SUB-PROGRAMME 8.2: EMERGENCY MEDICAL SERVICES

Planning, construction, upgrading, refurbishment, additions, and maintenance of emergency medical services facilities.

2.3. SUB-PROGRAMME 8.3: DISTRICT HOSPITAL SERVICES

Planning, construction, upgrading, refurbishment, additions, and maintenance of district hospitals.

2.4. SUB-PROGRAMME 8.4: PROVINCIAL HOSPITAL SERVICES

Planning, construction, upgrading, refurbishment, additions, and maintenance of provincial hospitals.

2.5. SUB-PROGRAMME 8.5: CENTRAL HOSPITAL SERVICES

Planning, construction, upgrading, refurbishment, additions, and maintenance of central hospitals.

2.6. SUB-PROGRAMME 8.6: OTHER FACILITIES

Planning, construction, upgrading, refurbishment, additions, and maintenance of other health facilities, including forensic pathology facilities and nursing colleges.

There have been no changes to the budget programme structure since the publication of the Strategic Plan 2010 – 2014.

3. SITUATION ANALYSIS

3.1 HEALTH IMMOVABLE ASSET MANAGEMENT

The Chief Directorate: Infrastructure Management is responsible for the management and implementation of Programme 8. This is done in partnership with the Western Cape Department of Transport and Public Works (WCDTPW) as its implementing department. The relationship with WCDTPW is managed through the monitoring of the alignment to the Western Cape Infrastructure Delivery Management System (WC IDMS) and the service delivery agreement – the latter being revised and signed annually.

In addition to the equitable share, the funding to implement the infrastructure programme emanates from three national grants, namely, the Health Infrastructure Grant (HIG), the Hospital Revitalisation Grant (HRG) and Nursing Colleges Grant (NCG). The HIG is a Schedule 4 Grant[1], while the HRG and NCG are Schedule 5 Grants[2].

In addition to fulfilling the role of implementing department on behalf of the Department of Health, WCDTPW is also the custodian of the Provincial Immovable Asset Portfolio, as described in the Government Immovable Asset Management Act, No.19 of 2007 (GIAMA). GIAMA prescribes the preparation of the document known as the User Asset Management Plan (U-AMP), which, *inter alia,* outlines the conditions and the suitability of every facility utilised by the Department of Health as well as the requirement for new, upgrading, extension, preventative[3] and scheduled maintenance for all health facilities. Programme 8, through the Chief Directorate: Infrastructure Management is responsible for the annual preparation and updating of this U-AMP.

A Human Resources Strategy study, begun in early 2011 in the Western Cape Departments of Health, Public Works, Education and Treasury, under the auspices of the Infrastructure Delivery Improvement Programme (IDIP), and in conjunction with the Department of the Premier, is now reaching finality (Refer to 8.1).

3.2 APPROACH

The primary objective of the infrastructure programme is to promote and advance the health and well-being of health facility users in the province in a sustainable responsible manner. This objective is being met through what has been termed the "4Ls Agenda":

1) Long life (Sustainability)
2) Loose fit (Flexibility)
3) Low impact (Reduction of carbon footprint)
4) Luminous healing space (Enlightened healing environment)

As part of the above 4Ls Agenda, Programme 8 has now begun aligning itself with the purpose and goals of Provincial Strategic Objective 7: "Mainstreaming sustainability and resource-use efficiency", as well as the National Climate Change Response White Paper of October 2011.

[1] Schedule 4 allocations to provinces are used to supplement funding of programmes or functions that are funded by the provincial budget.

[2] Schedule 5 grants are specific purpose allocations to provinces.

[3] Preventative maintenance of newly built facilities completed since 2006.

4. CHALLENGES

The primary challenges for the planning, delivery and maintenance of health infrastructure include:

- Limited capacity within the Departments of Health and Transport and Public Works and the implementation of the HR Strategy, given financial constraints.
- Reducing the carbon footprint of the health infrastructure portfolio.
- Addressing the infrastructure backlog within the context of limited financial, natural, and human resources.
- Aligning infrastructure delivery to maximise the impact on the burden of disease.
- Ensuring sustainability, quality, cost-efficiencies, and value for money in the delivery and maintenance of health infrastructure.

5. PRIORITIES

5.1 PROGRAMME 8

The main priorities for Programme 8 in the 2012/13 MTEF are outlined as follows:

- Create, strengthen, and improve the Primary Health Care infrastructure in all GSAs.
- Design and build emergency centres at district hospitals.
- Develop a strategic planning and prioritisation model to ensure sustainable, efficient and accessible health facilities.
- Implement the Human Resource Strategy as far as the limited financial resources allow.
- Implement the WC IDMS.
- Collaborate with the National Department of Health, Council for Scientific and Industrial Research (CSIR), Development Bank of South Africa (DBSA) in the implementation of the Infrastructure Unit Systems Support (IUSS) for the development of norms and standards, capital project status reporting, project management information system, and cost modelling.
- Implement the Preventative Maintenance Programme for all new health facilities completed since 2006.

5.2 PRIORITIES – SUB-PROGRAMME LEVEL

The primary projects prioritised for implementation at the respective phases[4] in each of the sub-programmes are outlined below. The status of projects is as at the current date i.e. January 2012.

[4] Note: The phases as outlined here are aligned with the milestones as included in the Infrastructure Reporting Model (IRM), as prescribed by National Treasury.

5.2.1 Sub-Programme 8.1 priorities: Community Health Facilities

No.	Current Project Phase		
	Identification / Feasibility	**Design / Tender**	**Construction / Handover**
1.	New Beaufort West: Hill Side Clinic	New Du Noon CHC	Knysna new CDC (Witlokasie)
2.	New Bonnievale Clinic	New Rawsonville Clinic	Malmesbury – new Wesbank CDC
3.	New Caledon Clinic	New Strand Nonzamo: Asanda Clinic	Grabouw CHC extension and upgrade
4.	New Fisante Kraal Clinic	New Delft Symphony Way CDC	
5.	New Gansbaai Clinic	New District Six CDC	
6.	New Gugulethu CHC	New Hermanus CDC	
7.	New Hanover Park CDC	New Ruyterwacht CDC	
8.	New Houtbay CDC	Horizon Clinic upgrade and extension	
9.	New Khayelitsha Swartklip CDC		
10.	New Klipfontein: Barselona CDC		
11.	New Mbekweni CDC		
12.	New Mitchell's Plain Weltevedren CDC		
13.	New Mossel Bay Kwanonqaba CDC		
14.	New Napier Clinic		
15.	New Prince Alfred Hamlet Clinic		
16.	New Sandhills Clinic		
17.	New Vredenburg CDC		
18.	New Wolseley Clinic		
19.	Beaufort West CDC upgrade and extension		
20.	Bergsig Clinic upgrade and extension		
21.	Strand: Gustrow Clinic upgrade and extension		
22.	New George: Thembalethu CDC		
23.	Worcester CDC dental unit		
24.	New Mossel Bay Alma Clinic		
25.	New Worcester: Avian Park Clinic		
26.	New Ceres CDC		
27.	New Cloetesville CDC		
28.	New George Centrum CHC		
29.	New Louwvillle Clinic		
30	New Vredendal CDC		
31	De Doorns Clinic Upgrade		
32	Elsies River CHC Upgrade		
33.	Knysna Old Witlokasie Clinic Upgrade		

5.2.2 Sub-Programme 8.2: Emergency Medical Services (all new buildings)

No.	Current Project Phase		
	Identification / Feasibility	**Design / Tender**	**Construction / Handover**
1.	Albertina Ambulance Station	Heidelberg Ambulance Station	Malmesbury Ambulance Station
2.	Barrydale Ambulance Station	Piketberg Ambulance Station	Tulbach Ambulance Station
3.	Darling Ambulance Station	Robertson Ambulance Station	Leeu Gamka Ambulance Station
4.	De Doorns Ambulance Station		
5.	Franschhoek Ambulance Station		
6.	Grootbrak Ambulance Station		
7.	Haarlem Ambulance Station		
8.	Kleinmond Ambulance Station		
9.	Laingsburg Ambulance Station		
10.	Porterville Ambulance Station		
11.	Sedgefield Ambulance Station		
12.	Uniondale Ambulance Station		
13.	Villiersdorp Ambulance Station		
14.	Wellington Ambulance Station		
15.	Bonnievale Ambulance Station		
16.	Swellendam Ambulance Station		
17.	Tygerberg EMS Training College		
18.	Pinelands EMS		
19.	Botriver Ambulance Station		
20.	Caledon Communication Centre		
21.	Mossel Bay Ambulance Station		

5.2.3 Sub-Programme 8.3: District Hospital Services

No.	Current Project Phase		
	Identification / Feasibility	**Design / Tender**	**Construction / Handover**
1.	Beaufort West Hospital Extension	Caledon Hospital Upgrade	Malmesbury: Swartland Hospital EC
2.	Karl Bremer Hospital Parking	Karl Bremer Hospital EC	Ceres Hospital EC
3.	Ladismith (Alan Blyth) Hospital Upgrade	Knysna Hospital EC	Hermanus Hospital Extension
4.	Oudtshoorn Hospital EC	Robertson Hospital Bulk Store	Riversdale Hospital Upgrade
5.	Robertson Hospital Upgrade	Vredenburg hospital Phase 2B	New Mitchell's Plain Hospital
6.	Stellenbosch Hospital EC		
7.	Victoria Hospital EC		
8.	Vredendal Hospital Upgrade		
9.	Wesfleur Hospital Extension		
10.	New Mossel Bay Hospital		
11.	New GF Jooste Hospital		
12.	New Helderberg Hospital		

5.2.4 Sub-Programme 8.4 priorities: Provincial Hospital Services

No.	Current Project Phase		
	Identification / Feasibility	Design / Tender	Construction / Handover
1	Western Cape Rehabilitation Centre OPC	Valkenberg Hospital revitalisation	George: Harry Comay TB Hospital
2	George: Harry Comay TB Hospital Upgrade Phase 3	George: Harry Comay TB Hospital Upgrade Phase 2	Paarl Sonstraal TB Hospital Upgrade Phase 1
3	Stikland Hospital Upgrade		Brooklyn Chest TB hospital MDR & XDR wards
4	George hospital Waste area		George Hospital Upgrade
5	Brooklyn Chest Hospital Upgrade and Extension		

5.2.5 Sub Programme 8.5 priorities: Central Hospital Services

No.	Current Project Phase		
	Identification / Feasibility	Design / Tender	Construction / Handover
1	Red Cross Hospital EC	Tygerberg Hospital EC upgrade	Groote Schuur Hospital Security \Phase 2
2	Groote Schuur Hospital EC		
3	New Tygerberg Hospital PPP		

5.2.6 Sub-Programme 8.6 priorities: Other facilities

No.	Current Project Phase		
	Identification / Feasibility	Design / Tender	Construction / Handover
1	New Observatory FPL	New Riversdale FPS	New Beaufort West FPL
2	New Stellenbosch FPL	Mitchell's Plain Laundry Upgrade & Extension	
3	New Vredenburg FPS		
4	Tygerberg FPS Upgrade		
5	New Mossel Bay FPL		
6	George: Eden Nurse College Upgrade		
7	Athlone Western Cape College of Nursing Upgrade		
8	Worcester: Boland Nurse College Upgrade		
9	Stikland Nurse College Upgrade		

6. STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND TARGETS FOR HEALTH FACILITIES MANAGEMENT

Table 8.1: Data elements of performance indicators for Health Facilities Management

Source	Data element	Element ID	Audited / Actual performance			Estimate	Medium term targets		
			2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
BAS	Preventative maintenance expenditure (Equitable Share)	1	New indicator	New indicator	New indicator	New indicator	11 465	20 465	21 570
BAS	Preventative maintenance budget (Equitable Share)	2	New indicator	New indicator	New indicator	New indicator	11 465	20 465	21 570
BAS	Scheduled maintenance expenditure (Equitable Share)	3	New indicator	New indicator	New indicator	New indicator	146 918	155 733	163 724
BAS	Scheduled maintenance budget (Equitable Share)	4	New indicator	New indicator	New indicator	New indicator	146 918	155 733	163 724
BAS	Health Infrastructure Grant (HIG) expenditure	5	New indicator	New indicator	New indicator	New indicator	131 411	139 296	150 171
BAS	Health Infrastructure Grant (HIG) budget	6	New indicator	New indicator	New indicator	New indicator	131 411	139 296	150 171
BAS	Hospital Revitalisation Grant (HRG) expenditure	7	New indicator	New indicator	New indicator	New indicator	496 085	503 526	511 079
BAS	Hospital Revitalisation Grant (HRG) budget	8	New indicator	New indicator	New indicator	New indicator	496 085	503 526	511 079
BAS	Equitable Share Capital Expenditure	9	New indicator	New indicator	New indicator	New indicator	79 882	84 439	88 860
BAS	Equitable Share Capital Budget	10	New indicator	New indicator	New indicator	New indicator	79 882	84 439	88 860
RPM	Number of capital projects completed	11	New indicator	New indicator	New indicator	New indicator	10	11	12
RPM	Number of capital projects planned for completion	12	New indicator	New indicator	New indicator	New indicator	10	11	12

Table 8.2: Strategic objectives, performance indicators and annual targets for Health Facilities Management [HFM2]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Type	Strategic objective target	Audited/actual performance			Estimated performance	Medium term targets			National target
					2014/15	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2014/15
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 preventative maintenance (Equitable Share) budget spent	%	100%	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	
			Numerator ID1	R'000	21 570					11 465	20 465	21 570	
			Denominator ID2	R'000	21 570					11 465	20 465	21 570	
			2) Percentage of scheduled maintenance (Equitable Share) budget spent	%	100%	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	
			Numerator ID3	R'000	163 724					146 918	155 733	163 724	
			Denominator ID4	R'000	163 724					146 918	155 733	163 724	
			3) Percentage of Health Infrastructure Grant (HIG) budget spent	%	100%	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	
			Numerator ID5	R'000	150 171					131 411	139 296	150 171	
			Denominator ID6	R'000	150 171					131 411	139 296	150 171	
			4) Percentage of Hospital Revitalisation Grant (HRG) budget spent	%	100%	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	
			Numerator ID7	R'000	511 079					496 085	503 526	511 079	
			Denominator ID8	R'000	511 079					496 085	503 526	511 079	
			5) Percentage of Equitable Share capital budget spent	%	100%	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	
			Numerator ID9	R'000	88 860					79 882	84 439	88 860	
			Denominator ID10	R'000	88 860					79 882	84 439	88 860	
	1.2. Effective and efficient management of infrastructure delivery	1.2.1. Ensure 100% achievement of projects planned for completion annually	6) Percentage of capital projects completed	%	100%	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	
			Numerator ID11	No	12					10	11	12	
			Denominator ID12	No	12					10	11	12	

Table 8.3: Quarterly targets for Health Facilities Management for 2012/13 [HFM3]

Strategic goal statement	Strategic objective: Title	Strategic objective: Statement	Performance indicator	Reporting period	Annual target	Quarterly targets			
					2012/13	Q1	Q2	Q3	Q4
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 preventative maintenance (Equitable Share) budget spent	Quarterly	100%	20%	30%	30%	20%
			Numerator ID1		11 465	2 293	3 440	3 440	2 293
			Denominator ID2		11 465	11 465	11 465	11 465	11 465
			2) Percentage of scheduled maintenance (Equitable Share) budget spent	Quarterly	100%	20%	30%	30%	20%
			Numerator ID3		146 918	29 384	44 075	44 075	29 384
			Denominator ID4		146 918	146 918	146 918	146 918	146 918
			3) Percentage of Health Infrastructure Grant (HIG) budget spent	Quarterly	100%	20%	30%	30%	20%
			Numerator ID5		131 411	26 282	39 423	39 423	26 283
			Denominator ID6		131 411	131 411	131 411	131 411	131 411
			4) Percentage of Hospital Revitalisation Grant (HRG) budget spent	Quarterly	100%	20%	30%	30%	20%
			Numerator ID7		496 085	99 217	148 826	148 826	99 217
			Denominator ID8		496 085	496 085	496 085	496 085	496 085
			5) Percentage of Equitable Share capital budget spent	Quarterly	100%	20%	30%	30%	20%
			Numerator ID9		79 882	15 976	23 965	23 965	15 976
			Denominator ID10		79 882	79 882	79 882	79 882	79 882
	1.2. Effective and efficient management of infrastructure delivery	1.2.1. Ensure 100% achievement of projects planned for completion annually	6) Percentage of capital projects completed	Quarterly	100%	20%	40%	70%	100%
			Numerator ID11		10	2	4	7	10
			Denominator ID12		10	10	10	10	10

7. RECONCILING THE PERFORMANCE TARGETS WITH THE EXPENDITURE TRENDS

Table 8.4: Summary of payments and estimates – Programme 8: Health Facilities Management [HFM4]

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2008/09	Audited 2009/10	Audited 2010/11	Main appro-priation 2011/12	Adjusted appro-priation 2011/12	Revised estimate 2011/12	2012/13	% Change from Revised estimate 2011/12	2013/14	2014/15
1. Community Health Facilities [a,b,d]	28 026	24 236	105 722	66 773	85 738	85 738	104 834	22.27	151 678	148 810
2. Emergency Medical Rescue Services [b]	7 892	10 985	24 301	29 317	32 771	32 771	20 156	(38.49)	15 495	22 420
3. District Hospital Services [a,b]	132 460	210 005	432 740	423 517	430 841	430 841	424 846	(1.39)	149 035	241 931
4. Provincial Hospital Services [a,b]	176 875	274 398	236 968	166 795	159 062	159 062	185 929	16.89	404 768	342 135
5. Central Hospital Services [a,b]	41 775	79 959	77 815	93 265	78 411	78 411	69 634	(11.19)	111 399	134 952
6. Other Facilities [a,b,c]	12 680	11 419	40 888	36 813	28 007	28 007	71 682	155.94	86 048	66 106
Total payments and estimates	399 708	611 002	918 434	816 480	814 830	814 830	877 081	7.64	918 423	956 354

[a] 2012/13: National Conditional grant: Hospital revitalisation: R496 085 000 (Compensation of employees R14 739 000; Goods and services R20 385 000; Machinery and Equipment R37 698 000 and Buildings and other fixed structures R423 263 000).

[b] 2012/13: National Conditional grant: Health Infrastructure grant: R131 411 000 (Buildings and other fixed structures R131 411 00).

[c] 2012/13 National Conditional grant: Nursing Colleges and Schools Grant - R10 320 000 (Buildings and other fixed structures R10 320 000).

[d] 2012/13: National Conditional grant: Expanded Public Works Programme Integrated Grant for Provinces - R1 000 000 (Goods and Services R1 000 000).

Earmarked allocations:

Included in Programme 8 is an earmarked allocation amounting to R47 128 000 (2012/13), R49 720 000 (2013/14) and R52 405 000 (2014/15) for the purpose of maintaining current infrastructure funding.

Included in Programme 8 is an earmarked allocation amounting to R11 465 000 000 (2012/13), R20 465 000 (2013/14) and R21 570 000 (2014/15), for Preventative maintenance.

Included in Programme 8 is an earmarked allocation amounting to R179 672 000 (2012/13), R178 452 000 (2013/14) and R189 179 000 (2014/15), for the purpose of Maintenance and Capital.

Included in Programme 8 is an earmarked allocation amounting to R12 000 000 (2013/14) and R11 000 (2014/15) for Donations for Red Cross Hospital.

Included in Programme 8 is an earmarked allocation amounting to R1 000 000 (2012/13), for Expanded Public Works Programme Infrastructure Incentive Grant to Provinces.

Table 8.5: Payments and estimates by economic classification – Programme 8: Health Facilities Management [HFM4

Economic classification R'000	Outcome						Medium-term estimate			
	Audited	Audited	Audited	Main appro-priation	Adjusted appro-priation	Revised estimate	% Change from Revised estimate			
	2008/09	2009/10	2010/11	2011/12	2011/12	2011/12	2012/13	2011/12	2013/14	2014/15
Current payments	104 490	137 659	149 112	182 887	165 747	165 747	194 507	17.35	202 645	209 523
Compensation of employees	6 021	9 198	16 321	17 470	17 470	17 470	14 739	(15.63)	14 474	14 883
Salaries and wages	5 875	8 664	15 248	16 433	16 433	16 433	14 118	(14.09)	13 853	14 262
Social contributions	146	534	1 073	1 037	1 037	1 037	621	(40.12)	621	621
Goods and services	98 469	128 461	132 791	165 417	148 277	148 277	179 768	21.24	188 171	194 640
of which										
Advertising	5		3							
Assets <R5 000	5 915	5 663	4 878	17 503	17 503	17 459	18 927	8.41	10 927	8 300
Catering: Departmental activities	119	78	136	121	121	120	98	(18.33)	98	98
Communication	4	23	60	50	50	50	59	18.00	59	59
Computer services	5	43	5			179		(100.00)		
Cons/prof: Business and advisory services	3 076	3 561	5 325	3 568	3 568	3 546	412	(88.38)		
Cons/prof: Infrastructure & planning	4 425	2 909	990							
Contractors	719	4 623	208	84	84	84		(100.00)		
Agency and support/ outsourced services	1 298	617	1 374	65	65	65		(100.00)		
Entertainment		2	2	6	6		12		12	12
Inventory: Materials and supplies	1 355	8 880	4 306	100	100	185		(100.00)		
Inventory: Medical supplies	4	36	20			233		(100.00)		
Inventory: Other consumables	143	789	277	100	100	3 782		(100.00)		
Inventory: Stationery and printing	66	157	170	140	140	503	204	(59.44)	204	204
Lease payments	500	439	34			71		(100.00)		
Property payments	79 676	98 683	113 406	142 667	125 527	120 984	159 383	(100.00)	176 198	185 294
Travel and subsistence	343	687	482	404	404	404	467	(49.01)	467	467
Training and development	773	1 075	1 082	454	454	454	206	(100.00)	206	206
Operating expenditure		99	11			3		(100.00)		
Venues and facilities	43	97	22	155	155	155		(100.00)		
Transfers and subsidies to			4 559	5 150	9 772	9 772		(100.00)	12 000	11 000
Households			4 559	5 150	9 772	9 772		(100.00)	12 000	11 000
Other transfers to households			4 559	5 150	9 772	9 772		(100.00)	12 000	11 000
Payments for capital assets	295 218	473 343	764 763	628 443	639 311	639 311	682 574	6.77	703 778	735 831
Buildings and other fixed structures	278 392	440 748	725 716	523 955	540 022	540 022	612 234	13.37	663 165	704 981
Buildings	278 392	440 748	725 716	523 955	540 022	540 022	612 234	13.37	663 165	704 981
Machinery and equipment	16 809	32 595	39 025	104 488	99 289	99 289	70 340	(29.16)	40 613	30 850
Other machinery and equipment	16 809	32 595	39 025	104 488	99 289	99 289	70 340	(29.16)	40 613	30 850
Software and other intangible assets	17		22							
Of which: "Capitalised Compensation" included in Payments for capital assets		141	137							
Of which: "Capitalised Goods and services" included in Payments for capital assets	278 393	440 607	725 579	523 955	540 022	540 022	612 234	13.37	663 165	704 981
Total economic classification	399 708	611 002	918 434	816 480	814 830	814 830	877 081	7.64	918 423	956 354

8. PERFORMANCE AND EXPENDITURE TRENDS

The performance targets for infrastructure delivery are generally calculated in accordance with the funding available in the MTEF budget allocations. Should these allocations not be realised, or should the allocations for the outer years be reduced or not follow a similar pattern, the performance targets will not be met.

During the 2010/11 financial year, the Department recorded an expenditure amount of R932.769 million, or 97.9%, against an adjusted infrastructure budget of R952.995 million.

Programme 8 is allocated 5.99 per cent of the vote in 2012/13 in comparison to the 6.07 per cent that was allocated in the revised estimate of the 2011/12 budget. This translates into a nominal increase of R62.251 million or 7.64 per cent.

8.1 RESOURCE CONSIDERATIONS

The Chief Directorate: Infrastructure Management is responsible for the planning, delivery and maintenance (except day-to-day maintenance), of all health infrastructure in the province. In accordance with a Provincial Cabinet resolution of December 2009, the Department of Health makes use of the Western Cape Department of Transport and Public Works as its Implementing Department for the delivery of capital and planned maintenance projects. The processes and methodologies that must be followed, as well as roles and responsibilities of relevant parties, are outlined in the Framework Western Cape Infrastructure Delivery Management System, or WC IDMS – as approved by PGWC Cabinet in April 2011. The WC IDMS has recently been implemented and it is anticipated that this will lead to improved efficiencies in the delivery and maintenance of health facilities in the province.

The Department of Health established the Chief Directorate: Infrastructure Management which has three components responsible for managing and implementing Programme 8:

- Directorate: Infrastructure Support;
- Directorate: Hospital Revitalisation Programme (HRP); and
- Directorate: Engineering and Technical Support Services.

However, a Human Resources Strategy study, begun in early 2011 in the Western Cape Departments of Health, Transport and Public Works, Education, and Treasury, under the auspices of the Infrastructure Delivery Improvement Programme (IDIP) and in conjunction with the Department of the Premier, is now reaching finality. This strategy will result in further changes to the organisational structure of the Chief Directorate; and in staff complements and capacity. Similar changes are anticipated in the Department of Transport and Public Works. Once fully implemented, it is anticipated that a substantial improvement in the effectiveness and the efficiencies in the delivery and maintenance of health facilities in the province will result.

During November 2010, the National Department of Health, in collaboration with the CSIR and Development Bank of South Africa (DBSA), embarked on the Infrastructure Unit Support Service (IUSS) project. The overall objective of the project is to optimise the acquisition, operation, and management of South Africa's public healthcare infrastructure through all stages of the infrastructure life-cycle and is being implemented in all of the provinces. As part of this initiative, the Chief Directorate: Infrastructure Management will receive support through the consultants appointed to the Programme Management Support Unit (PMSU).

In addition, the Chief Directorate continues to receive support through the IDIP Programme.

9. RISK ASSESSMENT

Risk	Mitigating Actions
1. Appropriately skilled and experienced personnel cannot be sourced to fill relevant positions in the Chief Directorate: Infrastructure Management. (Human Resource)	1.1. Provincial HR Strategy, currently being undertaken under the auspices of IDIP, has included an investigation into the efficacy of occupation specific dispensation (OSD) as one of its activities. 1.2. Relevant training.
2. Non-adherence to Western Cape Infrastructure Delivery Management System (WC-IDMS). (Compliance)	2.1. Monitoring compliance. 2.2. Improve relationship with the Department of Transport and Public Works. 2.3. Implementation of Gate Control (i.e. a control mechanism for approval of a project at different stages as part of the WC-IDMS) 2.4. Relevant training.
3. Operational inefficiency. (Efficiency)	3.1. Develop of standard operation procedures. 3.2. Standardisation based on approved space planning norms and standards, cost norms, standard drawings and technical specifications, and standard designs is currently underway. 3.3. Introduction of programme management information system.
4. Implementing department not performing. Management of service providers. (Service Delivery)	4.1. Review the WC-IDMS.

10. CAPITAL INFRASTRUCTURE PROGRAMME

10.1 DELIVERABLES

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

10.2 DEFINITIONS

Identified / Feasibility:	Project has been identified, but project brief has not been prepared and/or site has not been acquired.
Design / Tender:	Department of Transport and Public Works have received the brief from the Department of Health and are proceeding with the design or tender.
Construction / Hand over:	Project is under construction or in the process of being handed over
Retention:	Project has reached practical completion, but final account has not been finalised and paid.
Start Date:	Health brief provided to Implementing Department (Western Cape Department of Transport and Public Works) equivalent to start of Design Stage.
Completion Date:	Practical completion of the project achieved (i.e. the professional team has issued a Practical Completion Certificate).
Total Budget Available	Project cost – all inclusive (VAT, professional fees, escalation, construction).

Schedule 1: Sub-programme 8.1 Community Health Facilities

No.	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage	Start Date	Completion Date	Project Duration Months	Total Project Cost (at Completion)	11/12 Adjusted Appropriation	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's	2016/17 R000's
1	HIG	Beaufort West CDC	Central Karoo	Extension of van Schalkwyk St CDC	Identified / feasibility	Apr-15	Mar-17	23	8 000	0	0	0	0	400	4 000
2	HIG	Beaufort West: Hill Side Clinic	Central Karoo	New Clinic	Identified / feasibility	Apr-12	Mar-15	35	15 000	0	1 000	3 000	4 500	6 500	0
3	HIG	Bergsig Clinic	Cape Winelands	Clinic Extension	Identified / feasibility	Apr-16	Mar-18	23	5 700	0	0	0	0	0	1 000
4	HIG	Bonnievale Clinic	Cape Winelands	New Clinic	Identified / feasibility	Apr-13	Mar-16	35	12 000	0	0	100	500	9 500	0
5	HIG	Caledon Clinic	Overberg	New Clinic	Identified / feasibility	Apr-14	Mar-17	35	12 000	0	0	0	500	8 000	3 500
6	PES	Ceres CDC	Cape Winelands	New CDC	Identified / feasibility	Apr-14	Mar-17	35	40 000	0	0	0	500	10 449	20 000
7	PES	Cloetesville CDC	Cape Winelands	CDC Replacement	Identified / feasibility	Apr-15	Mar-19	47	40 000	0	0	0	0	500	1 600
8	PES	De Dooms Clinic	Cape Winelands	Clinic Extension	Identified / feasibility	Apr-14	May-16	25	4 900	0	0	0	200	4 600	100
9	PES	Delft Symphony Way CDC	City of Cape Town	New CDC	Design / tender	Apr-10	Mar-15	59	40 000	1 500	8 600	20 000	8 500	1 000	0
10	PES	District Six CDC	City of Cape Town	New CDC	Design / tender	Apr-10	Mar-16	71	60 000	1 500	5 730	10 000	37 049	6 000	0
11	HIG	Du Noon CHC	City of Cape Town	New CHC	Design / tender	Apr-10	Dec-13	44	76 000	1 000	15 000	50 020	10 000	0	0
12	PES	Elsies River CHC	City of Cape Town	CHC upgrade and renovation	Identified / feasibility	Apr-14	Mar-18	47	20 000	0	0	0	0	2 000	5 000
13	HIG	Fisante Kraal Clinic	City of Cape Town	New Clinic	Identified / feasibility	Apr-15	Mar-18	35	30 000	0	0	0	0	100	6 000
14	HIG	Gansbaai Clinic	Overberg	New Clinic	Identified / feasibility	Apr-15	Mar-18	35	15 000	0	0	0	0	100	6 000
15	PES	George Centrum CHC	Eden	New Community Health Centre & MOU	Identified / feasibility	Apr-14	Mar-17	35	50 000	0	0	0	400	5 000	9 000
16	HIG	George: Thembalethu CDC	Eden	Extension and Renovations	Identified / feasibility	Apr-15	Mar-18	35	15 000	0	0	500	1 734	6 000	6 700
17	HIG	Grabouw CHC	Overberg	Upgrade & extension (co-sponsor French Govt)	Construction / handover	Sep-09	Apr-12	31	14 000	1 000	340	0	0	0	0
18	HIG	Grassy Park Clinic	City of Cape Town	New Clinic	Retention / final account	Apr-08	Sep-11	41	20 514	9 889	25	0	0	0	0
19	HIG	Gugulethu CHC	City of Cape Town	CHC replacement	Identified / feasibility	Apr-15	Mar-18	35	50 000	0	0	0	0	500	16 000
20	HIG	Hannover Park CDC	City of Cape Town	CDC replacement	Identified / feasibility	Apr-14	Mar-18	47	40 000	0	0	0	100	12 000	17 000
21	PES	Hermanus CDC	Overberg	New CDC	Design / tender	Apr-10	Mar-15	59	40 000	1 614	15 000	16 470	5 000	1 500	0
22	HIG	Houtbay CDC	City of Cape Town	New CDC	Identified / feasibility	Apr-12	Mar-17	59	40 000	0	100	2 000	19 600	1 300	900
23	HIG	Khayelitsha Swartklip CDC	City of Cape Town	New CDC	Identified / feasibility	Apr-15	Mar-18	35	35 000	0	0	0	0	500	5 000
24	HIG	Klipfontein: Barselona CDC	City of Cape Town	CDC replacement	Identified / feasibility	Apr-15	Mar-18	35	35 000	0	0	0	0	500	5 000
25	HIG	Knysna new CDC (Witlokasie)	Eden	New CDC	Construction / handover	Apr-09	Apr-13	48	36 500	5 000	20 700	10 000	300	0	0

No.	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage	Start Date	Completion Date	Project Duration Months	Total Project Cost (at Completion)	11/12 Adjusted Appropriation	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's	2016/17 R000's
26	PES	Knysna old Witlokasie clinic	Eden	Clinic upgrade	Identified / feasibility	Apr-16	Mar-18	23	5 000	0	0	0	0	0	100
27	HIG	Laingsburg Hospital	Central Karoo	Clinic upgrade & extensions	Identified / feasibility	Apr-16	Mar-18	23	11 000	0	0	0	0	0	100
28	PES	Louwvillle Clinic	West Coast	Clinic Replacement	Identified / feasibility	Apr-16	Mar-18	23	12 000	0	0	0	0	0	50
29	HIG	Malmesbury - Wesbank CDC	West Coast	New CDC	Construction / handover	Apr-08	Feb-12	46	31 431	20 397	600	0	0	0	0
30	HIG	Mbekweni CDC	Cape Winelands	New Clinic	Identified / feasibility	Apr-16	Mar-18	23	20 000	0	0	0	0	0	100
31	HIG	Melkhoutfountein Clinic	Eden	Clinic Replacement	Retention / final account	Sep-10	Jul-11	10	3 560	3 147	0	0	0	0	0
32	HIG	Mitchell's Plain Weltevedren CDC	City of Cape Town	New CDC	Identified / feasibility	Apr-14	Mar-17	35	40 000	0	0	0	250	10 000	29 000
33	PES	Mossel Bay Alma clinic	Eden	Clinic Replacement	Identified / feasibility	Apr-14	Mar-18	47	15 000	0	0	0	0	3 000	6 000
34	HIG	Mossel Bay Kwanonqaba CDC	Eden	New CDC	Identified / feasibility	Apr-16	Mar-19	35	35 000	0	0	0	0	0	100
35	HIG	Napier Clinic	Overberg	Clinic Replacement	Identified / feasibility	Apr-12	Mar-15	35	10 100	100	550	7 500	1 950	0	0
36	PES	New Horizon clinic	Eden	Clinic upgrade and extensions	Design / tender	Apr-12	Mar-14	23	2 500	0	2 000	500	0	0	0
37	HRG	Paarl TC Newman CHC	Cape Winelands	Community Health Centere upgrade	Retention / final account	Apr-06	Nov-11	67	40 700	2 471	100	0	0	0	0
38	HIG	Prince Alfred Hamlet Clinic	Cape Winelands	Clinic Replacement	Identified / feasibility	Apr-11	Mar-16	59	15 000	309	0	100	6 651	7 440	500
39	HIG	Rawsonville Clinic	Cape Winelands	New Clinic	Design / tender	Apr-10	Jan-14	45	12 000	600	4 500	5 900	1 000	0	0
40	PES	Ruyterwacht CDC	City of Cape Town	New CDC	Design / tender	Jul-11	Jul-12	12	8 000	2 000	4 000	0	0	0	0
41	HIG	Sandhills Clinic	Cape Winelands	New Clinic	Identified / feasibility	Apr-16	Mar-18	23	10 000	0	0	0	0	0	100
42	HIG	Strand Nonzamo: Asanda Clinic	City of Cape Town	New Clinic	Design / tender	Apr-10	Dec-15	68	21 000	714	2 500	4 500	9 286	4 000	0
43	HIG	Strand: Gustrow Clinic	City of Cape Town	Extension & Renovations	Identified / feasibility	Apr-12	Mar-14	23	9 500	0	100	1 500	7 400	500	0
44	HIG	Vredenburg CDC	West Coast	New CDC	Identified / feasibility	Apr-14	Mar-17	35	40 500	0	0	0	100	5 000	20 000
45	PES	Vredendal CDC	West Coast	New CDC	Identified / feasibility	Apr-16	Mar-19	35	40 000	0	0	0	200	7 000	12 532
46	HIG	Wolseley Clinic	Cape Winelands	New Clinic	Identified / feasibility	Apr-11	Mar-15	47	13 000	309	600	0	10 000	2 000	100
47	HIG	Worcester CDC	Cape Winelands	Extension for a Dental Suite	Identified / feasibility	Apr-14	Mar-16	23	3 500	0	0	0	2 000	1 500	0
48	PES	Worcester: Avian Park Clinic	Cape Winelands	Clinic Replacement	Identified / feasibility	Apr-14	Mar-17	35	15 000	0	0	0	456	10 000	4 000
GRAND TOTAL									1 168 405	51 550	81 445	132 090	128 176	126 889	179 482

Schedule 2: Sub-Programme 8.2 Emergency Medical Services

No.	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage	Start Date	Completion Date	Project Duration Months	Total Project Cost (at Completion)	11 / 12 Adjusted Appropriation	2012 / 13 R000's	2013 / 14 R000's	2014 / 15 R000's	2015 / 16 R000's	2016 / 17 R000's
1	Eq Share	Albertina ambulance station	Eden	New Ambulance station	Identified / feasibility	Apr-16	Oct-17	18	5 500	0	0	0	0	0	100
2	Eq Share	Barrydale Ambulance Station	Overberg	New Ambulance station	Identified / feasibility	Apr-16	Oct-17	18	5 500	0	0	0	0	0	100
3	Eq Share	Bonnievale Ambulance Station	Cape Winelands	Convert the existing clinic into ambulance station	Identified / feasibility	Apr-16	Oct-17	18	5 500	0	0	0	0	0	100
4	HIG	Botriver ambulance station	Overberg	Ambulance Station Extensions & Upgrade	Identified / feasibility	Apr-16	Jun-18	26	1 000	0	0	0	0	0	100
5	HIG	Caledon Hospital	Overberg	EMS Communication centre	Identified / feasibility	Apr-16	Mar-18	23	5 000	0	0	0	0	0	100
6	Eq Share	Darling Ambulance Station	West Coast	New Ambulance station	Identified / feasibility	Apr-14	Mar-16	23	5 500	0	0	0	500	3 500	1 500
7	Eq Share	De Doorns ambulance station	Cape Winelands	New Ambulance station	Identified / feasibility	Apr-13	Oct-15	30	5 500	0	0	142	5 000	400	0
8	Eq Share	Franschoek ambulance station	Cape Winelands	New Ambulance station	Identified / feasibility	Apr-16	Dec-17	20	6 000	0	0	0	0	0	100
9	Eq Share	Grootbrak Ambulance Station	Eden	New Ambulance station	Identified / feasibility	Apr-15	Mar-17	23	6 600	0	0	0	0	800	5 800
10	Eq Share	Haarlem ambulance station	Eden	New Ambulance station	Identified / feasibility	Apr-16	Dec-17	20	6 600	0	0	0	0	0	150
11	Eq Share	Heidelberg ambulance station	Eden	New Ambulance station	Design / tender	Apr-11	Mar-16	59	6 650	500	0	0	5 150	1 000	500
12	Eq Share	Kleinmond ambulance station	Overberg	New Ambulance station	Identified / feasibility	Apr-16	Dec-17	20	6 600	0	0	0	0	0	150
13	Eq Share	Laingsburg Ambulance Station	Central Karoo	New Ambulance station	Identified / feasibility	Apr-14	Mar-16	23	6 600	0	0	0	0	368	6 000
14	HIG	Leeu Gamka Ambulance Station	Central Karoo	New Ambulance station	Construction / handover	Apr-08	Feb-12	46	14 677	11 134	220	0	0	0	0
15	Eq Share	Malmesbury Ambulance Station	West Coast	New Ambulance Station and Health Net accommodation	Construction / handover	Apr-10	May-13	37	12 000	3 534	5 168	3 266	0	0	0
16	HRG	Mossel Bay Ambulance Station	Eden	New Ambulance Station (PPP)	Identified / feasibility	Apr-13	Apr-16	36	8 100	0	0	500	2 000	1 000	1 000
17	Eq Share	Piketberg Ambulance Station	West Coast	New Ambulance Station (tender documentation ready, on hold for 1 year)	Design / tender	Apr-10	Mar-15	59	7 500	342	0	4 600	2 210	0	0
18	HIG	Pinelands EMS	City of Cape Town	New Ambulance station	Identified / feasibility	Apr-16	Apr-19	36	30 000	0	0	0	0	0	100
19	Eq Share	Porterville Ambulance Station	West Coast	New Ambulance station	Identified / feasibility	Apr-15	Mar-17	23	6 600	0	0	0	0	500	6 000
20	Eq Share	Robertson Ambulance Station	Cape Winelands	New Ambulance station	Design / tender	Apr-11	Mar-14	35	6 000	400	2 700	2 600	300	0	0

No.	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage	Start Date	Completion Date	Project Duration Months	Total Project Cost (at Completion)	11 / 12 Adjusted Appropriation	2012 / 13 R000's	2013 / 14 R000's	2014 / 15 R000's	2015 / 16 R000's	2016 / 17 R000's
21	Eq Share	Sedgefield Ambulance Station	Eden	New Ambulance station	Identified / feasibility	Apr-16	Mar-18	23	6 600	0	0	0	0	0	100
22	Eq Share	Swellendam Ambulance Station	Overberg	Extension and Renovations	Identified / feasibility	Apr-14	Mar-16	23	1 000	0	100	0	200	1 000	0
23	Eq Share	Tulbach Ambulance Station	West Coast	New Ambulance station	Construction / handover	Apr-10	Mar-13	35	6 500	3 533	2 358	609	0	0	0
24	Eq Share	Tygerberg EMS Training College	City of Cape Town	Teaching facilities and practical labs upgrade	Identified / feasibility	Apr-14	Mar-16	23	11 400	0	0	0	500	5 000	0
25	Eq Share	Uniondale Ambulance Station	Central Karoo	New Ambulance station	Identified / feasibility	Apr-14	Mar-16	23	6 000	0	0	0	2 500	4 000	0
26	Eq Share	Villiersdorp Ambulance Station	Overberg	New Ambulance station	Identified / feasibility	Apr-15	Mar-18	35	6 600	0	0	0	0	800	1 838
27	HIG	Vredendal Ambulance Station	West Coast	New Ambulance Station	Retention / final account	Apr-07	Dec-11	56	8 500	6 903	25	0	0	0	0
28	Eq Share	Wellington Ambulance Station	Cape Winelands	New Ambulance station	Identified / feasibility	Apr-16	Oct-17	18	6 600	0	0	0	0	0	100
GRAND TOTAL									210 627	26 346	10 571	11 717	18 360	18 368	23 838

Schedule 3: Sub-Programme 8.3 District Health Services

No.	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage	Start Date	Completion Date	Project Duration Months	Total Project Cost (at Completion)	11/12 Adjusted Appropriation	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's	2016/17 R000's
1	HIG	Beaufort West Hospital	Central Karoo	Extension of waiting area and reconfiguration	Identified/feasibility	Apr-14	Mar-17	35	8 000				100	6 500	1 400
2	HIG	Caledon Hospital	Overberg	Upgrade - Disa ward phase 2	Design/tender	Apr-09	Apr-13	48	13 600	1 700	12 293	907			
3	HIG	Ceres Hospital	Cape Winelands	New Emergency Centre	Construction/ handover	Apr-10	Mar-12	23	12 300	9 934	240				
4	HRG	GF Jooste Hospital	City of Cape Town	Health Technology	Identified/feasibility	Apr-16	Mar-19	35							68 000
5	HRG	GF Jooste Hospital	City of Cape Town	Hospital Replacement	Identified/feasibility	Apr-12	Mar-17	59	500 000		1 000	5 000	114 000	190 000	250 000
6	HRG	GF Jooste Hospital	City of Cape Town	OD and QA	Identified/feasibility	Apr-13	Mar-17	47				500	1 500	1 500	1 500
7	HRG	Helderberg Hospital	City of Cape Town	Hospital Replacement (PPP)	Identified/feasibility	Apr-16	Apr-21	60	600 000						1 000
8	HIG	Hermanus Hospital	Overberg	EC, new wards, OPD and Administration	Construction/ handover	Apr-09	Aug-12	40	65 000	23 628	28 240	64			
9	HIG	Karl Bremer Hosp	City of Cape Town	Civil work, cafeteria & pharmacy	Identified/feasibility	Apr-16	Mar-18	23	10 000						100
10	HIG	Karl Bremer Hosp	City of Cape Town	New Emergency Centre	Design/tender	Apr-09	Dec-13	56	53 500	2 539	22 689	14 914	9 500	1 000	
11	HRG	Khayelitsha hospital	City of Cape Town	Health Technology	In Progress	Apr-07	Apr-13	72	75 765	74 765	8 000				
12	HRG	Khayelitsha hospital	City of Cape Town	New hospital and ambulance station	Retention/ final account	Apr-05	Oct-11	78	500 000	119 944	5 000				
13	HRG	Khayelitsha hospital	City of Cape Town	OD and QA	In Progress	Apr-07	Apr-13	72	4 612	4 612	25				
14	HIG	Knysna Hospital	Eden	New emergency Centre and OPD	Design/tender	Apr-09	Mar-15	71	44 000	1 079	9 000	18 000	14 000	1 000	
15	HIG	Ladismith (Alan Blyth) Hospital	Eden	Extension to Emergency Centre and Administration	Identified/feasibility	Apr-16	Mar-18	23	8 000						100
16	Eq Share	Malmesbury: Swartland Hospital	West Coast	Emergency Centre Extension	Construction/ handover	Apr-10	May-13	37	6 500		5 550	500			
17	HRG	Mitchell's Plain hospital	City of Cape Town	Health Technology	In Progress	Apr-12	Apr-14	24	80 000		64 000	5 000			
18	HRG	Mitchell's Plain hospital	City of Cape Town	New hospital	Construction/ handover	Apr-05	Oct-12	90	490 000	147 369	169 500	9 500			
19	HRG	Mitchell's Plain hospital	City of Cape Town	OD and QA	In Progress	Apr-08	Mar-14	71	8 928	3 428	2 551	1 000			
20	HRG	Mossel Bay Hospital	Eden	Hospital Replacement (PPP)	Identified/feasibility	Apr-13	Apr-20	84	400 000			3 466	20 000	15 000	20 000
21	HRG	Mossel Bay Hospital	Eden	OD and QA	Identified/feasibility	Apr-15	Mar-17	23	3 500				500	1 500	1 500
22	HIG	Oudtshoorn Hospital	Eden	New Emergency Centre	Identified/feasibility	Apr-16	Mar-18	23	8 000						100
23	HIG	Riversdale Hospital	Eden	Phase 3 upgrade	Construction/ handover	Apr-09	Feb-12	34	12 340	9 309	314				
24	HIG	Robertson Hospital	Cape Winelands	New Bulk Store	Design/tender	Apr-11	Apr-13	24	5 000	600	4 000	393			
25	HIG	Robertson Hospital	Cape Winelands	New EC and new wards phases 1	Identified/feasibility	Apr-14	Apr-19	60	60 000				100	12 000	26 500

No.	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage	Start Date	Completion Date	Project Duration Months	Total Project Cost (at Completion)	11/12 Adjusted Appropriation	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's	2016/17 R000's
26	HIG	Stellenbosch Hospital	Cape Winelands	New Emergency Centre	Identified/feasibility	Apr-13	Mar-16	35	8 000			100	900	6 500	500
27	HIG	Victoria hospital	City of Cape Town	New Emergency Centre	Identified/feasibility	Apr-13	Mar-16	35	14 000			100	3 000	10 800	100
28	HRG	Vredenburg hospital	West Coast	Health Technology	In Progress	Apr-04	Apr-15	132	30	676		3 540	15 500		
29	HRG	Vredenburg hospital	West Coast	OD and QA	In Progress	Apr-04	Apr-15	132	1 671	1 671	856	1 000	1 000		
30	HRG	Vredenburg hospital	West Coast	Upgrading phase 2A	Retention/final account	Apr-06	Nov-11	67	37 000	4 798	100				
31	HRG	Vredenburg hospital	West Coast	Upgrading phase 2B	Design/tender	Apr-07	Mar-15	95	169 000	6 137	68 000	59 000	31 000	1 000	
32	HIG	Vredendal Hospital	West Coast	Hospital Extension and renovations	Identified/feasibility	Apr-17	Mar-20	35	40 000						100
33	HIG	Wesfleur Hospital	City of Cape Town	New Emergency Centre C and Paediatric Ward	Identified/feasibility	Apr-12	Apr-15	36	9 000		500	2 500	5 500	500	
GRAND TOTAL									3 247 746	412 189	401 858	125 484	216 600	247 300	370 900

Schedule 4: Sub-Programme 8.4 Provincial Hospital Services

No.	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage	Start Date	Completion Date	Project Duration Months	Total Project Cost (at Completion)	11/12 Adjusted Appropriation	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's	2016/17 R000's
1	HRG	Brooklyn Chest Hospital	City of Cape Town	Health Technology	Identified / feasibility	Apr-15	Mar-19	47	0	0	0	0	0	1 000	15 000
2	HRG	Brooklyn Chest Hospital	City of Cape Town	OD and QA	Identified / feasibility	Apr-13	Mar-19	71	0	0	0	500	1 000	1 000	1 000
3	HRG	Brooklyn Chest Hospital	City of Cape Town	Hospital Upgrade & Extension	Identified / feasibility	Apr-13	Mar-19	71	700 000	0	0	5 000	60 000	50 000	165 000
4	Eq Share	Brooklyn Chest TB hospital	City of Cape Town	New MDR & XDR wards	Construction / handover	Apr-09	Dec-12	44	23 000	4 239	16 596	3 100	0	0	0
5	HIG	George hospital	Eden	Extension Refuse Area, Theatre Recovery & Store, Renal Unit	Identified / feasibility	Apr-16	Apr-18	24	2 000	0	0	0	0	0	500
6	HRG	George hospital	Eden	Health Technology	In Progress	Apr-12	Mar-13	11	0	0	5 355	0	0	0	0
7	HRG	George hospital	Eden	Hospital Upgrade Phase 3	Construction / handover	Apr-08	Jul-12	51	81 000	30 100	3 400	0	0	0	0
8	HRG	George hospital	Eden	OD and QA	In Progress	Apr-12	Mar-13	11	1 660	1 740	674	0	0	0	0
9	Eq Share	George: Harry Comay TB Hospital	Eden	Hospital upgrade	Construction / handover	Apr-09	Dec-11	32	5 010	5 690	232	0	0	0	0
10	Eq Share	George: Harry Comay TB Hospital	Eden	Upgrade. Phase 2	Identified / feasibility	Apr-15	Dec-17	32	10 000	0	0	0	0	1 000	8 800
11	PES	George: Harry Comay TB Hospital	Eden	Hospital upgrade	Design / tender	Apr-11	Mar-13	23	5 000	750	4 000	200	0	0	0
12	HIG	Lentegeur Hospital	City of Cape Town	Relocation of Lifecare Step Down Facility	Construction / handover	Jan-11	Feb-12	13	11 000	1 841	20	0	0	0	0
13	HRG	Paarl Hospital	Cape Winelands	Health Technology	In Progress	Apr-04	Apr-14	120	28 832	15 332	6 146	2 000	0	0	0
14	HRG	Paarl Hospital	Cape Winelands	Hospital upgrade	Construction / handover	Apr-00	Dec-11	140	477 000	27 212	7 350	0	0	0	0
15	HRG	Paarl Hospital	Cape Winelands	New Psychiatric Unit & Doctor's Quarter Upgrade	Identified / feasibility	Apr-11	Mar-14	35	27 100	100	5 000	21 500	500	0	0
16	HRG	Paarl Hospital	Cape Winelands	OD & QA	In Progress	Apr-04	Apr-15	132	1 839	1 839	850	1 000	500	0	0
17	Eq Share	Paarl Sonstraal TB Hospital	West Coast	UV Lights & extraction installation	Construction / handover	Apr-10	Mar-12	23	1 682	2 081	50	0	0	0	0
18	HIG	Somerset Hospital	City of Cape Town	Lift Upgrade	Retention / final account	Apr-09	Nov-11	31	5 640	2 536	25	0	0	0	0
19	Eq Share	Stikland Hospital	City of Cape Town	OPD , sportsfield & swimming pool	Identified / feasibility	Apr-16	Mar-18	23	10 000	0	0	0	0	0	200
20	PES	Stikland Hospital	City of Cape Town	Wards 1, 6, 7 & 11 Upgrade	Retention / final account	Apr-09	Sep-11	29	11 184	5 459	8	0	0	0	0
21	HRG	Valkenberg hospital	City of Cape Town	Health Technology	Identified / feasibility	Apr-14	Mar-17	35	0	0	0	0	23 150	12 000	18 000
22	HRG	Valkenberg hospital	City of Cape Town	Hospital upgrading	Design / tender	Apr-09	Jul-17	99	900 000	2 000	84 000	300 000	200 000	236 000	5 000
23	HRG	Valkenberg hospital	City of Cape Town	OD & QA	Identified / feasibility	Apr-12	Mar-17	59	0	0	100	2 000	2 500	2 400	1 500
24	Eq Share	Western Cape Rehabilitation Centre	City of Cape Town	Relocation Orthotic & Prosthetic Centre to WCRC	Identified / feasibility	Apr-13	Apr-17	48	31 000	0	0	106	5 091	16 074	9 423

No.	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage	Start Date	Completion Date	Project Duration Months	Total Project Cost (at Completion)	11/12 Adjusted Appropriation	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's	2016/17 R000's
25	HRG	Worcester Hospital	Cape Winelands	Health Technology	In Progress	Apr-04	Mar-14	119	17 000	16 000	5 500	3 000	0	0	0
26	HRG	Worcester Hospital	Cape Winelands	OD & QA	In Progress	Apr-04	Mar-15	131	1 476	1 476	727	1 200	609	0	0
27	HRG	Worcester hospital Ph 4	Cape Winelands	Hospital upgrade phase 4	Construction / handover	Apr-08	Jul-12	51	55 800	8 208	10 871	0	0	0	0
28	HRG	Worcester Hospital Ph 5	Cape Winelands	Hospital upgrade phase 5	Identified / feasibility	Apr-12	Apr-14	24	32 000	50	500	25 000	6 500	0	0
GRAND TOTAL									2 439 223	126 653	151 404	364 606	299 850	319 474	224 423

Schedule 5: Sub-Programme 8.5 Central Hospital Services

No.	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage	Start Date	Completion Date	Project Duration Months	Total Project Cost (at Completion)	11/12 Adjusted Appropriation	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's	2016/17 R000's
1	Eq Share	Groote Schuur Hospital	City of Cape Town	OPD K Floor Refurbishment	Identified / feasibility	Apr-13	Mar-16	35	16 000	0	0	7 796	4 004	4 200	0
3	HIG	Groote Schuur Hospital	City of Cape Town	E-floor upgrading	Identified / feasibility	Apr-16	Mar-18	23	8 000	0	0	0	0	0	500
5	HIG	Groote Schuur Hospital	City of Cape Town	Upgrade of the Emergency Centre	Identified / feasibility	Apr-12	Mar-16	47	19 200	0	1 000	2 600	14 000	1 541	17
6	PES	Groote Schuur Hospital	City of Cape Town	Fire Detection Phase 3	Identified / feasibility	Apr-14	Mar-17	35	5 700	0	0	0	100	4 500	500
7	PES	Groote Schuur Hospital	City of Cape Town	NMB fire detection Phase 2	Construction / handover	Apr-09	Jun-12	38	5 000	3 340	640	50	0	0	0
8	PES	Groote Schuur Hospital	City of Cape Town	Upgrade Pharmacy	Construction / handover	Apr-08	Dec-11	44	10 882	7 678	50	0	0	0	0
9	PES	Groote Schuur Hospital	City of Cape Town	New Linear Acceleration Installation	Identified / feasibility	Apr-12	Mar-13	11	2 000	0	2 000	0	0	0	0
10	Eq Share	Red Cross Hospital	City of Cape Town	Radiology & ICU Upgrade and Extension (in partnership with the Trust)	Identified / feasibility	Apr-13	Mar-15	23	48 000	0	0	12 000	11 000	0	0
11	HIG	Tygerberg Hospital	City of Cape Town	Linen Bank Extension	Identified / feasibility	Mar-16	Sep-18	30	6 000	0	0	0	0	0	50
12	HIG	Tygerberg Hospital	City of Cape Town	Medical ICU and Pulmonology Isolation A5 Upgrade	Identified / feasibility	Apr-15	Mar-17	23	3 000	0	0	0	0	500	1 700
13	HRG	Tygerberg Hospital	City of Cape Town	Health Technology	Identified / feasibility	Apr-10	Apr-25	180	180	180	180	0	0	0	0
14	HRG	Tygerberg Hospital	City of Cape Town	Hospital Replacement (PPP)	Identified / feasibility	Apr-12	Mar-21	107	3 500 000	0	2 000	4 000	20 000	20 000	15 742
15	HRG	Tygerberg Hospital	City of Cape Town	OD and QA	Identified / feasibility	Apr-10	Apr-25	180	1 820	1 000	1 820	1 820	1 820	1 820	1 820
16	PES	Tygerberg Hospital	City of Cape Town	Emergency Centre Upgrade	Design / tender	Apr-09	Mar-15	71	8 500	900	5 100	2 500	0	0	0
GRAND TOTAL									3 634 282	13 098	12 790	30 766	50 924	32 561	20 329

Schedule 6: Sub-Programme 8.6 Other Facilities

No.	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage	Start Date	Completion Date	Project Duration Months	Total Project Cost (at Completion)	11/12 Adjusted Appropriation	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's	2016/17 R000's
1	NCG	Athlone Western Cape College of Nursing	City of Cape Town	Security upgrading	Identified / feasibility	Apr-12	Mar-13	11	3 200	0	2 386	814	0	0	0
2	NCG	Athlone Western Cape College of Nursing	City of Cape Town	To convert garages into workshop	Identified / feasibility	Apr-12	Mar-13	11	1 600	0	1 500	100	0	0	0
3	NCG	Athlone Western Cape College of Nursing	City of Cape Town	To install smoke detectors in all residence rooms	Identified / feasibility	Apr-14	Mar-15	11	3 500	0	0	0	1 500	2 000	0
4	NCG	Athlone Western Cape College of Nursing	City of Cape Town	Electrified perimeter fence	Identified / feasibility	Apr-14	Mar-17	35	5 700	0	0	0	500	4 700	500
5	NCG	Athlone Western Cape College of Nursing	City of Cape Town	New Archives & Master plan	Identified / feasibility	Apr-14	Mar-15	11	2 500	0	434	0	1 500	1 000	0
6	HIG	Beaufort West Hospital	Central Karoo	New Forensic Pathology Laboratory	Construction / handover	Apr-09	Mar-12	35	11 300	9 794	230	0	0	0	0
7	NCG	George: Eden Nurse College	Eden	New Nurse Hostel	Identified / feasibility	Apr-15	Mar-17	23	30 000	0	0	0	0	2 007	13 039
8	NCG	George: Eden Nurse College	Eden	New training accommodation	Identified / feasibility	Apr-16	Mar-18	23	20 000	0	0	0	0	5 000	10 000
9	HRG	Infrastructure Unit	City of Cape Town	Head Office	In Progress	Apr-12	Mar-17	59	6 258	6 258	6 500	6 500	6 500	6 524	7 186
10	HRG	Mitchell's Plain Laundry	City of Cape Town	Health Technology	In Progress	Apr-12	Mar-14	23	39 500	0	1 000	38 000	500	0	0
11	HRG	Mitchell's Plain Laundry	City of Cape Town	Regional Laundry Upgrade & Extension	Design / tender	Apr-11	Mar-13	23	37 000	200	33 800	3 000	0	0	0
12	HRG	Mossel Bay FPL	Eden	New Forensic Pathology Laboratory (PPP)	Identified / feasibility	Apr-13	Mar-19	71	8 300	0	0	500	2 000	1 000	1 000
13	HIG	Observatory FPL	City of Cape Town	New Forensic Pathology Laboratory	Identified / feasibility	Jan-12	Mar-17	62	90 500	500	6 600	14 598	27 200	41 000	300
14	HIG	Riversdale FPS	Eden	New Forensic Pathology Laboratory	Design / tender	Mar-15	Mar-17	24	6 500	800	0	0	0	1 000	8 000
15	HIG	Stellenbosch FPL	Cape Winelands	New Forensic Pathology Laboratory	Identified / feasibility	Apr-16	Mar-18	23	25 000	0	0	0	0	0	100
16	NCG	Stikland Nurse College	City of Cape Town	AC for auditorium	Identified / feasibility	Apr-12	Mar-13	11	500	0	500	0	0	0	0
17	NCG	Stikland Nurse College	City of Cape Town	Various upgrades	Identified / feasibility	Apr-12	Mar-13	11	2 000	0	1 000	1 000	0	0	0
18	HIG	Tygerberg FPS	City of Cape Town	Forensic laboratory: additional refrigeration, dissection & accommodation	Identified / feasibility	Apr-15	Oct-18	42	38 000	0	0	0	0	500	4 000
19	HIG	Vredenburg FPS	West Coast	New Forensic Laboratory	Identified / feasibility	Apr-15	Mar-18	35	10 000	0	0	0	0	500	3 265
20	NCG	Worcester: Boland Nurse College	Cape Winelands	Additional Nurses accommodation	Identified / feasibility	Apr-12	Mar-15	35	20 000	0	500	7 000	9 000	3 500	0
21	NCG	Worcester:Boland Nurse College	Cape Winelands	Upgrading of Nurses accommodation in Erica	Identified / feasibility	Apr-12	Mar-13	11	3 000	0	2 500	500	0	0	0
22	NCG	Worcester:Boland Nurse College	Cape Winelands	Training facility at Keerom	Identified / feasibility	Apr-12	Mar-15	35	20 000	0	1 500	5 550	8 450	4 000	0
GRAND TOTAL									384 358	17 552	58 450	77 562	57 150	72 731	47 390

PART C
LINKS TO OTHER PLANS

PART C: LINKS TO OTHER PLANS

1. LINKS TO THE LONG-TERM INFRASTRUTURE AND OTHER CAPITAL

Table C1: Links to the long-term infrastructure plan

Table 1: New and replacement assets

Sub-programme	District	Outputs	Type of infrastructure	Outcome			Main Appropriation	Medium term estimates		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
				R'000	R'000	R'000	R'000	R'000	R'000	R'000
8.2	Eden	Albertina ambulance station	New Ambulance Station							
8.2	Overberg	Barrydale Ambulance Station	New Ambulance station							
8.6	Central Karoo	Beaufort West Hospital	New Forensic Pathology Laboratory	0	1 198	9 794	230			
8.1	Central Karoo	Beaufort West: Hill Side Clinic	New clinic				1 000	3 000	4 500	6 500
8.1	Cape Winelands	Bonnievale Clinic	New Clinic					100	500	9 500
8.1	Overberg	Caledon Clinic	New Clinic						500	8 000
8.1	Cape Winelands	Ceres CDC	New Community Day Centre						500	10 449
8.1	Cape Winelands	Cloetesville CDC	Community Day Centre Replacement							500
8.2	West Coast	Darling Ambulance Station	New Ambulance Station						500	3 500
8.2	Cape Winelands	De Doorns ambulance station	New Ambulance station					142	5 000	400
8.1	City of Cape Town	Delft Symphony Way CDC	New Community Day Centre		0	1 500	8 600	20 000	8 500	1 000
8.1	City of Cape Town	District Six CDC	New Community Day Centre		0	1 500	5 730	10 000	37 049	6 000
8.1	City of Cape Town	Du Noon CHC	New Community Health Centre		725	1 000	15 000	50 020	10 000	
8.1	City of Cape Town	Fisante Kraal Clinic	New Clinic							100
8.2	Cape Winelands	Franschoek ambulance station	New ambulance station							
8.1	Overberg	Gansbaai Clinic	New Clinic							100
8.1	Eden	George Centrum CHC	New Community Health Centre and MOU						400	5 000
8.6	Eden	George: Eden Nurse College	New Nurse Hostel							2 007
8.6	Eden	George: Eden Nurse College	New training accommodation							5 000
8.1	City of Cape Town	Grassy Park Clinic	New Clinic	859	9 507	9 889	25			
8.2	Eden	Grootbrak Ambulance Station	New ambulance station							800
8.1	City of Cape Town	Gugulethu CHC	CHC replacement							500
8.2	Eden	Haarlem ambulance station	New ambulance station							
8.1	City of Cape Town	Hannover Park CDC	CDC replacement						100	12 000

Sub-programme	District	Outputs	Type of infrastructure	Outcome			Main Appropriation	Medium term estimates		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
				R'000	R'000	R'000	R'000	R'000	R'000	R'000
8.2	Eden	Heidelberg ambulance station	New Ambulance Station			500			5 150	1 000
8.1	Overberg	Hermanus CDC	New Community Day Centre		7	1 614	15 000	16 470	5 000	1 500
8.1	City of Cape Town	Houtbay CDC	New Community Day Centre				100	2 000	19 600	1 300
8.3	City of Cape Town	Khayelitsha hospital	New hospital and ambulance station	108 000	245 304	119 944	5 000			
8.3	City of Cape Town	Khayelitsha hospital	Health Technology		890	74 765	8000			
8.3	City of Cape Town	Khayelitsha hospital	OD and QA		4 232	4 612	25			
8.1	City of Cape Town	Khayelitsha Swartklip CDC	New CDC							500
8.2	Overberg	Kleinmond ambulance station	New ambulance station							
8.1	City of Cape Town	Klipfontein: Barselona CDC	CDC replacement							500
8.1	Eden	Knysna new CDC (Witlokasie)	New Community Day Centre		1 010	5 000	20 700	10 000	300	
8.2	Central Karoo	Laingsburg Ambulance Station	New Ambulance station							368
8.2	Central Karoo	Leeu Gamka Ambulance Station	New Ambulance station	364	2 002	11 134	220			
8.1	West Coast	Louwvillle Clinic	Clinic Replacement							
8.1	West Coast	Malmesbury - Wesbank CDC	New Community Day Cente	1 337	8 967	20 397	600			
8.2	West Coast	Malmesbury Ambulance Station	New Ambulance Station and Health Net accomodation			3 534	5 168	3 266		
8.1	Cape Winelands	Mbekweni CDC	New clinic							
8.1	Eden	Melkhoutfountein Clinic	Clinic Replacement		433	3 147				
8.3	City of Cape Town	Mitchell's Plain hospital	New hospital	11 710	111 749	147 369	169 500	9 500		
8.3	City of Cape Town	Mitchell's Plain hospital	OD and QA		2 771	3 428	2 551	1 000		
8.3	City of Cape Town	Mitchell's Plain hospital	Health Technology	-	-		64 000	5 000		
8.1	City of Cape Town	Mitchell's Plain Weltevedren CDC	New Community Day Centre						250	10 000
8.1	Eden	Mossel Bay Alma clinic	Clinic replacement							3 000
8.2	Eden	Mossel Bay Ambulance Station	New Ambulance Station (PPP)					500	2 000	1 000
8.6	Eden	Mossel Bay FPL	New Forensic Pathology Laboratory (PPP)					500	2 000	1 000
8.3	Eden	Mossel Bay Hospital	Hospital Replacement (PPP)					3 466	20 000	15 000
8.1	Eden	Mossel Bay Kwanonqaba CDC	New Community Day Centre							
8.1	Overberg	Napier Clinic	Clinic Replacement			100	550	7 500	1 950	
8.6	City of Cape Town	Observatory FPL	New Forensic Pathology Laboratory		0	500	6 600	14 598	27 200	41 000
8.2	West Coast	Piketberg Ambulance Station	New Ambulance Station (tender documentation ready, on hold for one year)		90	342		4 600	2 210	
8.2	City of Cape Town	Pinelands EMS	New Ambulance station							
8.2	West Coast	Porterville Ambulance Station	New Ambulance station							500

Sub-programme	District	Outputs	Type of infrastructure	Outcome			Main Appropriation	Medium term estimates		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
				R'000	R'000	R'000	R'000	R'000	R'000	R'000
8.1	Cape Winelands	Prince Alfred Hamlet Clinic	Clinic Replacement			309		100	6 651	7 440
8.1	Cape Winelands	Rawsonville Clinic	New Clinic		0	600	4 500	5 900	1 000	
8.6	Eden	Riversdale FPS	New Forensic Pathology Laboratory		9 838	800				1 000
8.2	Cape Winelands	Robertson Ambulance Station	New Ambulance station			400	2 700	2 600	300	
8.1	City of Cape Town	Ruyterwacht CDC	New Community Day Centre			2 000	4 000			
8.1	Cape Winelands	Sandhills Clinic	New Clinic							
8.2	Eden	Sedgefield Ambulance Station	New Ambulance Station							
8.6	Cape Winelands	Stellenbosch FPL	New Forensic Pathology Laboratory							
8.1	City of Cape Town	Strand Nonzamo: Asanda Clinic	New Clinic			714	2 500	4 500	9 286	4 000
8.2	West Coast	Tulbach Ambulance Station	New Ambulance station		499	3 533	2 358	609		
8.5	City of Cape Town	Tygerberg Hospital*	Hospital Replacement (PPP)				2 000	4 000	20 000	20 000
8.2	Central Karoo	Uniondale Ambulance Station	New Ambulance station						2 500	4 000
8.2	Overberg	Villiersdorp Ambulance Station	New Ambulance station							800
8.1	West Coast	Vredenburg CDC	New Community Day Centre						100	5 000
8.6	West Coast	Vredenburg FPS	New Forensic Laboratory							500
8.2	West Coast	Vredendal Ambulance Station	New Ambulance Station	234	2 508	6 903	25			
8.1	West Coast	Vredendal CDC	New Community Day Centre						200	7 000
8.2	Cape Winelands	Wellington Ambulance Station	New Ambulance Station							
8.4	City of Cape Town	Western Cape Rehabilitation Centre	Relocation Orthotic & Prosthetic Centre to WCRC					106	5 091	16 074
8.1	Cape Winelands	Wolseley Clinic	New Clinic			309	600		10 000	2 000
8.1	Cape Winelands	Worcester: Avian Park Clinic	Clinic Replacement						456	10 000
GRAND TOTAL				122 504	401 730	435 637	347 282	179 477	208 793	225 838

*Funded through the Hospital Revitalisation Grant

Table 2: Rehabilitations, renovations and refurbishments

Sub-programme	District	Outputs	Type of infrastructure	Outcome			Main Appropriation	Medium term estimates		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
				R'000	R'000	R'000	R'000	R'000	R'000	R'000
8.4	City of Cape Town	Brooklyn Chest Hospital	Health Technology							1 000
8.4	City of Cape Town	Brooklyn Chest Hospital	OD and QA					500	1 000	1 000
8.4	City of Cape Town	Brooklyn Chest Hospital	Hospital Upgrade & Extension					5 000	60 000	50 000
8.4	Eden	George hospital	Hospital Upgrade Phase 3	22 400	24 715	30 100	3 400			
8.4	Eden	George hospital	Health Technology				5 355			
8.4	Eden	George hospital	OD and QA		2 938	1 740	674			
8.3	City of Cape Town	GF Jooste Hospital	Hospital Replacement				1 000	5 000	114 000	190 000
8.3	City of Cape Town	GF Jooste Hospital	OD and QA					500	1 500	1 500
8.3	City of Cape Town	GF Jooste Hospital	Health Technology	-	-					
8.3	City of Cape Town	Helderberg Hospital	Hospital Replacement (PPP)							
8.6	City of Cape Town	Infrastructure Unit	Head Office		5 649	6 258	6 500	6 500	6 500	6 524
8.6	City of Cape Town	Mitchell's Plain Laundry	Regional Laundry Upgrade & Extension			200	33 800	3 000		
8.6	City of Cape Town	Mitchell's Plain Laundry	Health Technology				1 000	38 000	500	
8.3	Eden	Mossel Bay Hospital	OD and QA						500	1 500
8.4	Cape Winelands	Paal Hospital	OD and QA		3 903	1 839	850	1 000	500	
8.4	Cape Winelands	Paarl Hospital	Hospital upgrade	119 130	89 468	27 212	7 350			
8.4	Cape Winelands	Paarl Hospital	New Psychiatric Unit and Doctor's Quarter Upgrade			100	5 000	21 500	500	
8.4	Cape Winelands	Paarl Hospital	Health Technology		24 907	15 332	6 146	2 000		
8.1	Cape Winelands	Paarl TC Newman CHC	Community Health Center upgrade		21 273	2 471	100			
8.5	City of Cape Town	Tygerberg Hospital	OD and QA			1 000	1 820	1 820	1 820	1 820
8.5	City of Cape Town	Tygerberg Hospital	Health Technology			180	180			
8.4	City of Cape Town	Valkenberg hospital	Health Technology						23 150	12 000
8.4	City of Cape Town	Valkenberg hospital	OD and QA				100	2 000	2 500	2 400
8.4	City of Cape Town	Valkenberg hospital	Hospital upgrading		2 178	2 000	84 000	300 000	200 000	236 000
8.3	West Coast	Vredenburg hospital	Upgrading phase 2A	15 300	13 840	4 798	100			
8.3	West Coast	Vredenburg hospital	Upgrading phase 2B	2 400	2 680	6 137	68 000	59 000	31 000	1 000
8.3	West Coast	Vredenburg hospital	Health Technology		567	676		3 540	15 500	
8.3	West Coast	Vredenburg hospital	OD and QA		1 653	1 671	856	1 000	1 000	
8.4	Cape Winelands	Worcester Hospital	Health Technology		6 917	16 000	5 500	3 000		
8.4	Cape Winelands	Worcester Hospital	OD and QA		2 372	1 476	727	1 200	609	

Sub-programme	District	Outputs	Type of infrastructure	Outcome			Main Appropriation	Medium term estimates		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
				R'000	R'000	R'000	R'000	R'000	R'000	R'000
8.4	Cape Winelands	Worcester hospital phase 4	Hospital upgrade phase 4	4 912	28 408	8 208	10 871			
8.4	Cape Winelands	Worcester Hospital phase 5	Hospital upgrade phase 5			50	500	25 000	6 500	
GRAND TOTAL #				409 150	1 034 928	998 722	938 593	838 514	884 665	956 420

Table 3: Upgrades and additions

Sub-programme	District	Outputs	Type of infrastructure	Outcome			Main Appropriation	Medium term estimates		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
				R'000	R'000	R'000	R'000	R'000	R'000	R'000
8.6	City of Cape Town	Athlone Western Cape College of Nursing	Security upgrading				2 386	814		
8.6	City of Cape Town	Athlone Western Cape College of Nursing	To convert garages into workshop				1 500	100		
8.6	City of Cape Town	Athlone Western Cape College of Nursing	New Archives & Masterplan				434		1 500	1 000
8.6	City of Cape Town	Athlone Western Cape College of Nursing	To install smoke detectors in all residence rooms						1 500	2 000
8.6	City of Cape Town	Athlone Western Cape College of Nursing	Electrified perimeter fence						500	4 700
8.1	Central Karoo	Beaufort West CDC	Extenstion of van Schalkwyk street CDC							400
8.3	Central Karoo	Beaufort West Hospital	Extension of waiting area and reconfiguration						100	6 500
8.1	Cape Winelands	Bergsig Clinic	Clinic Extension							
8.2	Cape Winelands	Bonnievale Ambulance Station	Convert the existing clinic into ambulance station							
8.2	Overberg	Botriver ambulance station	Ambulance Station Extensions & Upgrade							
8.4	City of Cape Town	Brooklyn Chest TB hospital	New MDR & XDR wards		888	4 239	16 596	3 100		
8.3	Overberg	Caledon Hospital	Upgrade - Disa ward phase 2		1 013	1 700	12 293	907		
8.2	Overberg	Caledon Hospital	EMS Communication centre							
8.3	Cape Winelands	Ceres Hospital	New Emergency Centre	90	1 697	9 934	240			
8.1	Cape Winelands	De Doorns Clinic	Clinic Extension						200	4 600
8.1	City of Cape Town	Elsies River CHC	CHC upgrade and renovation							2 000
8.4	Eden	George hospital	Extension Refuse Area, Theater Recovery and Store, Renal Unit							
8.4	Eden	George: Harry Comay TB Hospital	Hospital Upgrade		412	5 690	232			
8.4	Eden	George: Harry Comay TB Hospital	Hospital Upgrade			750	4 000	200		
8.4	Eden	George: Harry Comay TB Hospital	Upgrade. Phase 2							1 000

Sub-programme	District	Outputs	Type of infrastructure	Outcome			Main Appropriation	Medium term estimates		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
				R'000	R'000	R'000	R'000	R'000	R'000	R'000
8.1	Eden	George: Thembalethu CDC	Extension and Renovations					500	1 734	6 000
8.1	Overberg	Grabouw CHC	Upgrade & extension (co-sponsor French Government) _ VAT			1 000	340			
8.5	City of Cape Town	Groote Schuur Hospital	Upgrade Pharmacy			7 678	50			
8.5	City of Cape Town	Groote Schuur Hospital	NMB fire detection ph 2		0	3 340	640	50		
8.5	City of Cape Town	Groote Schuur Hospital	New Linear Acceleration Installation				2 000			
8.5	City of Cape Town	Groote Schuur Hospital	OPD K Floor Refurbishement					7 796	4 004	4 200
8.5	City of Cape Town	Groote Schuur Hospital	Upgrade of the Emergency Centre				1 000	2 600	14 000	1 541
8.5	City of Cape Town	Groote Schuur Hospital	Fire Detection Phase 3						100	4 500
8.5	City of Cape Town	Groote Schuur Hospital	E-floor upgrading							
8.3	Overberg	Hermanus Hospital	EC, new wards, OPD and Administration	2 000	5 292	23 628	28 240	64		
8.3	City of Cape Town	Karl Bremer Hosp	New Emergency Centre		1 764	2 539	22 689	14 914	9 500	1 000
8.3	City of Cape Town	Karl Bremer Hosp	Civil work, cafeteria & pharmacy							
8.3	Eden	Knysna Hospital	New emergency Centre and OPD		975	1 079	9 000	18 000	14 000	1 000
8.1	Eden	Knysna old Witlokasie clinic	Clinic upgrade							
8.3	Eden	Ladismith (Alan Blyth) Hospital	Extension to Emergency Centre and Administration							
8.1	Central Karoo	Laingsburg Hospital	Clinic upgrade and extensions							
8.4	City of Cape Town	Lentegeur Hospital	Relocation of Lifecare Step Down Facility		278	1 841	20			
8.3	West Coast	Malmesbury: Swartland Hospital	Emergency Centre Extension				5 550	500		
8.1	Eden	New Horizon clinic	Clinic upgrade and extensions				2 000	500		
8.3	Eden	Oudtshoorn Hospital	New Emergency Centre							
8.4	West Coast	Paarl Sonstraal TB Hospital	UV Lights & extraction installation			2 081	50			
8.5	City of Cape Town	Red Cross Hospital	Radiology & ICU Upgrade and Extension (in partnership with the Trust)		5 668			12 000	11 000	
8.3	Eden	Riversdale Hospital	Phase 3 upgrade		2 931	9 309	314			
8.3	Cape Winelands	Robertson Hospital	New Bulk Store			600	4 000	393		
8.3	Cape Winelands	Robertson Hospital	New EC and new wards phases 1						100	12 000
8.4	City of Cape Town	Somerset Hospital	Lift Upgrade		2 692	2 536	25			
8.3	Cape Winelands	Stellenbosch Hospital	New Emergency Centre					100	900	6 500
8.4	City of Cape Town	Stikland Hospital	Wards 1, 6, 7 & 11 Upgrade	936	4 886	5 459	8			
8.4	City of Cape Town	Stikland Hospital	OPD , sportfield and swimming pool							

Sub-programme	District	Outputs	Type of infrastructure	Outcome			Main Appropriation	Medium term estimates		
				2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
				R'000	R'000	R'000	R'000	R'000	R'000	R'000
8.6	City of Cape Town	Stikland Nurse College	AC for auditorium				500			
8.6	City of Cape Town	Stikland Nurse College	Various upgrades				1 000	1 000		
8.1	City of Cape Town	Strand: Gustrow Clinic	Extension and Renovations				100	1 500	7 400	500
8.2	Overberg	Swellendam Ambulance Station	Extension and Renovations			-	100		200	1 000
8.2	City of Cape Town	Tygerberg EMS Training College	Teaching facilities and practical labs upgrade						500	5 000
8.6	City of Cape Town	Tygerberg FPS	Forensic laboratory: additional refrigeration, dissection and accommodation							500
8.5	City of Cape Town	Tygerberg Hospital	Emergency Centre Upgrade		0	900	5 100	2 500		
8.5	City of Cape Town	Tygerberg Hospital	Medical ICU and Pulmonology Isolation A5 Upgrade							500
8.5	City of Cape Town	Tygerberg Hospital	Linen Bank Extension							
8.3	City of Cape Town	Victoria hospital	New Emergency Centre					100	3 000	10 800
8.3	West Coast	Vredendal Hospital	Hospital Extension and renovations							
8.3	City of Cape Town	Wesfleur Hospital	New Emergency Centre C and Paediatric Ward				500	2 500	5 500	500
8.1	Cape Winelands	Worcester CDC	Extension for a Dental Suite						2 000	1 500
8.6	Cape Winelands	Worcester: Boland Nurse College	Additional Nurses accommodation				500	7 000	9 000	3 500
8.6	Cape Winelands	Worcester:Boland Nurse College	Upgrading of Nurses accommodation in Erica				2 500	500		
8.6	Cape Winelands	Worcester:Boland Nurse College	Training facility at Keerom				1 500	5 550	8 450	4 000
GRAND TOTAL				3 026	28 496	84 303	125 407	83 188	95 188	86 741

2. CONDITIONAL GRANTS

Table C4: Conditional grants

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Outputs 2012/13
Health Infrastructure Grant (HIG)	To supplement provincial funding of health infrastructure to accelerate the provision of health facilities including medical equipment and ensure proper maintenance of provincial health infrastructure.	Delivery of infrastructure in accordance with the schedules provided for Programme 8:	
		Number of health facilities in identification/feasibility phase	9
		Number of health facilities in design/tender phase	7
		Number of health facilities in construction/handover phase	3
		Number of health facilities in retention/final account phase	0
		Number of health facilities maintained	0
		Number of work opportunities created	1 940
Hospital Revitalisation Grant (HRG)	To provide funding to enable provinces to plan, manage, modernise, rationalise and transform health infrastructure, health technology, monitoring and evaluation of health facilities in line with national policy objectives. Supplement expenditure on health infrastructure delivered through public-private partnerships.	Delivery of infrastructure in accordance with the schedules provided for Programme 8:	
		Hospitals funded to upgrade, rebuilt and fully commissioned as per approved 2012/13 Project Implementation Plan (PIP).	9
		Number of work opportunities created	7 330
Nursing Colleges and Schools Grant (NCG)	To supplement provincial funding of health infrastructure to accelerate the provision of health facilities including office furniture and related equipment, and also to ensure proper maintenance of provincial health infrastructure for nursing colleges and schools.	Delivery of infrastructure in accordance with the schedules provided for Programme 8:	
		Nursing colleges planned, designed, constructed, maintained and operationalised.	7
		Nursing schools planned, designed, constructed, maintained and operationalised.	0
		Number of work opportunities created	150
National Tertiary Services Grant (NTSG)	Ensure adequate provision of tertiary health services for all South African citizens and to compensate tertiary facilities for the additional costs associated with spill over effects.	NTSG funded clinical tertiary services provided. Please refer to Table 5.18 for the list of services.	45 services
Health Professions Training and Development Grant (HPTDG)	Support provinces to fund service costs associated with training of health professionals and support and strengthen undergraduate and post graduate training processes in health facilities.	Higher education institutions receiving access to the health platform with service costs funded by the HPTDG to train health science students.	3 HEIs (US, UWC, UCT)
		Undergraduate medical and dental students trained on the public health service platform	2 900
		Registrars receiving and providing training support on the public service platform	680
		Medical interns receiving further teaching and training on the public health service platform	310
		Medical officers receiving and providing training support on the public health service platform	520

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Outputs 2012/13
		Community service doctors receiving and providing training support on the public health service platform	190
		Medical and dental specialists providing training support on the public health service platform	850
Comprehensive HIV and AIDS Grant	To provide financial resources in order to accelerate the effective implementation of a programme that has been identified as a priority in the 10-point plan of the National Department of Health. The grant is utilised in line with the National Operational Plan for HIV and AIDS Care, Management and Treatment in South Africa, the National and Provincial HIV / AIDS / STI Strategic Plans 2007-2011 and Healthcare 2010. For the coming three years, Global Fund Phase 1 RCC Funding will supplement the grant to contribute towards the attainment of planned outputs and outcomes, notably infrastructure, ARVs, human resources, laboratory costs and health system strengthening.	Fixed public health facilities offering ART services	330
		New patients started on ART	33 000
		Total number of patients on ART remaining in care	135 018
		Beneficiaries served by home-based carers	50 000
		Active home-based carers receiving stipends	3 050
		Male condom distributed	106 995 125
		Female condoms distributed	1 000 000
		HTA intervention sites	80
		ANC clients initiated on life-long ART	5 505
		Babies PCR tested at 6 weeks	13 500
		HIV positive client screened for TB	85% of all HIV positive clients
		HIV positive patients started on IPT (Isoniazide prevention therapy)	10 000
		Active lay counsellors on stipends	646
		Clients pre-test counselled on HIV testing (including antenatal)	841 256
		Clients tested for HIV (including antenatal)	824 431
		Health facilities offering medical male circumcision (MMC) services	30
		Medical male circumcision performed	35 000
		Sexual assault cases offered ARV prophylaxis	5 200
		Step-down care (SDC) facilities/units	22
		Doctors and professional nurses trained on HIV and AIDS, STIs, TB and chronic diseases	500

Note:

UCT: University of Cape Town

US: University of Stellenbosch

UWC: University of the Western Cape

3. PUBLIC PRIVATE PARTNERSHIPS

Table C.5: Public-private partnerships [PPP]

Name of PPP	Purpose	Outputs	Current annual budget R thousand	Date of termination	Measures to ensure smooth transfer of responsibilities
Western Cape Rehabilitation Centre (WCRC) Public Private Partnership	Provision of equipment, facilities management and all associated services at the Western Cape Rehabilitation Centre and the Lentegeur Hospital.	**Western Cape Rehabilitation Centre [WCRC]:** The private party ensures the provision of catering services, manning the Helpdesk, cleaning of all areas, provision of general estate management services, general grounds and garden maintenance, supply, maintenance and replacement of linen, control of pests and infestations, provision, management, calibration, repair, maintenance, cleaning and replacement of all medical devices, waste management, security services provision, utilities management and remedial works. **Lentegeur Hospital:** The private party ensures the provision of catering services, cleaning services, gardens and grounds maintenance, pest control services, security services and waste management.	49 845	28 February 2019	Partnership Management Plan Governance Structures PPP agreement Performance indicators Patients and other stakeholder satisfaction Knowledge management systems
Tygerberg Hospital Public Private Partnership		**Replacement of the existing Tygerberg Hospital using a Public Private Partnership procurement approach.** **Note that this contract is in the process of being developed.**	-		

ANNEXURE A

UPDATED STRATEGIC OBJECTIVES PER PROGRAMME

PART A: STRATEGIC OVERVIEW

1. MISSION STATEMENT UPDATE

The mission statement as published in the Strategic Plan 2010 – 2014 has been refined and updated. The amendments are highlighted and reflected in italic font, as follows.

1.1. **Mission statement published on page 1 of the Strategic Plan 2010 – 2014**:

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

1.2. **Updated mission statement**:

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.*

2. STRATEGIC GOAL

The revisions to the strategic goals are highlighted in grey and in italic font in Table 1 and followed by the revised strategic goals in Table 1.1.

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

STRATEGIC GOAL	GOAL STATEMENT	JUSTIFICATION	LINKS
1. Burden of disease.	1.1. Manage the burden of disease. *Address* the burden of disease.	This strategic goal relates to the core business of the Department, i.e. delivering a health service as well as advocating for interventions to address the upstream factors that generate this burden of disease. All the related strategic objectives are focussed on effective and efficient service delivery in order to maximise health outcomes/increase wellness.	Millennium Development Goals No4, 5 and 6. Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: Burden of disease report. **Outcomes**: • Increase life expectancy • Decreasing maternal and child mortality • Combating HIV and AIDS and decreasing the burden of disease from tuberculosis • Reduce mortality and morbidity from injuries. Provincial strategic objective 04: Increase wellness.
2. Quality of health services.	2.1. Improve the quality of health services Improve the quality of health services *and the patient experience.*	The purpose of this goal is to focus on the importance of delivering a quality service.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
3. Strategic management capacity and synergy.	3.1. Ensure and maintain organisational strategic management capacity and synergy.	This goal aims to ensure that: • The Department has a clear plan and targets against which to measure its performance. • Management systems are in place to optimally utilise available resources in a co-ordinated manner.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
4. A capacitated workforce.	4.1. Develop and maintain a capacitated workforce to deliver the required health services.	The purpose of this goal is to ensure that staff is adequately recruited and retained; appropriately trained and skilled to perform the functions for which they are employed.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.

STRATEGIC GOAL	GOAL STATEMENT	JUSTIFICATION	LINKS
5. Health technology, infrastructure *and Information Communication Technology (ICT).*	5.1. Provide and maintain appropriate health technology and infrastructure. *Develop* and maintain appropriate health technology, Infrastructure *and ICT*.	This goal addresses the provision of the appropriate infrastructure to deliver the required service in the most cost effective and efficient manner. It addresses buildings, equipment and information communication technology.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
6. Sustainable income. *Financial management*	*6.1. Ensure a sustainable income to provide the required health services according to the needs.* *Optimal financial management to maximise health outcomes*	Given that the need for health services outstrips the available funding the purpose of this goal is to focus attention on: • The importance of appropriate budgeting and financial control. • The need to explore all appropriate avenues of revenue generation to supplement the budget. • Optimal value for the health rand and maximising efficiencies in all sections of the Department.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.

Table 1.1: Strategic goals for the Western Cape Department of Health for 2010 – 2014 to improve wellness [A1]

STRATEGIC GOAL	GOAL STATEMENT	JUSTIFICATION	LINKS
1. Burden of disease.	1.1. Address the burden of disease.	This strategic goal relates to the core business of the Department, i.e. delivering a health service as well as advocating for interventions to address the upstream factors that generate this burden of disease. All the related strategic objectives are focussed on effective and efficient service delivery in order to maximise health outcomes/increase wellness.	Millennium Development Goals No4, 5 and 6. Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: Burden of disease report. **Outcomes**: • Increase life expectancy • Decreasing maternal and child mortality • Combating HIV and AIDS and decreasing the burden of disease from tuberculosis • Reduce mortality and morbidity from injuries. Provincial strategic objective 04: Increase wellness.
2. Quality of health services.	*2.1.* Improve the quality of health services and the patient experience.	The purpose of this goal is to focus on the importance of delivering a quality service.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
3. Strategic management capacity and synergy.	3.1. Ensure and maintain organisational strategic management capacity and synergy.	This goal aims to ensure that: • The Department has a clear plan and targets against which to measure its performance. • Management systems are in place to optimally utilise available resources in a co-ordinated manner.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
4. A capacitated workforce.	4.1. Develop and maintain a capacitated workforce to deliver the required health services.	The purpose of this goal is to ensure that staff is adequately recruited and retained; appropriately trained and skilled to perform the functions for which they are employed.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.

STRATEGIC GOAL	GOAL STATEMENT	JUSTIFICATION	LINKS
5. Health technology, infrastructure and Information Communication Technology (ICT).	5.1. Develop and maintain appropriate health technology, Infrastructure and ICT.	This goal addresses the provision of the appropriate infrastructure to deliver the required service in the most cost effective and efficient manner. It addresses buildings, equipment and information communication technology.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.
6. Financial management	6.1. Optimal financial management to maximise health outcomes.	Given that the need for health services outstrips the available funding the purpose of this goal is to focus attention on: • The importance of appropriate budgeting and financial control. • The need to explore all appropriate avenues of revenue generation to supplement the budget. • Optimal value for the health rand and maximising efficiencies in all sections of the Department.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans: **Outcomes**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness.

PROGRAMME 1: ADMINISTRATION

STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2014

Table 1.1 below is reflected on page 60 of the Strategic Plan 2010 – 2014.

The strategic objectives that are being updated are highlighted in grey and in italic font. The revised Table 1.1 is subsequently reflected.

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

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance measure, baseline and target			Justification	Links
			Strategic Objective Baseline Measure	2009/10	2014/15		
1. Ensure and maintain organisational strategic management capacity and synergy.	1.1. To have an effective and efficient and skilled workforce.	*1.1.1. To provide sufficient staff with appropriate skills per occupational group.* Provide sufficient staff with appropriate skills per occupational group by 2014/15.	1) Number of medical officers per 100 000 people	32.73	*29.2* 31.34	Systematically reviewing human resource needs to ensure that the required number of employees, with the required competencies, is available when required.	DPSA - HR Plan Ten Point Plan: • Improve Human Resources Increasing wellness Comprehensive Service Plan Public Service Regulations, 2001 Public Service Act, 1994 Employment Equity Act, 1998 Skills Development Act, 1998 Labour Relations Act, 1995 Public Finance Management Act, 1999 Treasury Regulations, 2002
			Numerator:	1 844	*1 787* 1 918		
			Denominator:	5 634 323	6 119 435		
			2) Number of professional nurses per 100 000 people	92.31	*85.8* 92.08		
			Numerator:	5 201	*5 252* 5 635		
			Denominator:	5 634 323	6 119 435		
			3) Number of pharmacists per 100 000 people	5.93	*5.42* 6.01		
			Numerator:	334	*332* 368		
			Denominator:	5 634 323	6 119 435		
2. Ensure a sustainable income to provide the required health services. Optimal financial management to maximise health outcomes required health services.	2.1. Promote efficient financial resource use.	2.1.1. Promote sound financial governance and management to ensure the under/over spending of the annual equitable share is within 1% of the budget allocation.	4) Percentage expenditure of the annual equitable share budget allocation	100.3%	100%	To ensure sound financial management by aligning the annual allocated budget with the department's strategic objectives.	PFMA Provincial Treasury Instructions National Treasury Regulations Department of Revenue Act
			Numerator:	7 519 280 m	*11 724 698 m* 11 376 773 m		
			Denominator:	7 489 777 m	*11 724 698 m* 11 376 773 m		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance measure, baseline and target			Justification	Links
			Strategic Objective Baseline Measure	2009/10	2014/15		
3. Develop and maintain a capacitated workforce, Develop and maintain a capacitated workforce to deliver the required health service.	3.1. Develop and maintain a comprehensive human resource plan for the Department.	3.1.1. Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.	5) Amended Human Resource Plan submitted timeously to DPSA	Yes	Yes	Systematically reviewing human resource needs to ensure that the required number of employees, with the required competencies, is available when required.	DPSA - HR Plan Ten Point Plan: • Improve Human Resources Increasing wellness Comprehensive Service Plan Public Service Regulations, 2001 Public Service Act, 1994 Employment Equity Act, 1998 Skills Development Act, 1998 Labour Relations Act, 1995 Public Finance Management Act, 1999 Treasury Regulations, 2002

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

Strategic Goal Statement	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance measure, baseline and target			Justification	Links
			Strategic Objective Baseline Measure	2009/10	2014/15		
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) Number of medical officers per 100 000 people	32.73	31.34	Systematically reviewing human resource needs to ensure that the required number of employees, with the required competencies, is available when required.	DPSA - HR Plan Ten Point Plan: • Improve Human Resources Increasing wellness Comprehensive Service Plan Public Service Regulations, 2001 Public Service Act, 1994 Employment Equity Act, 1998 Skills Development Act, 1998 Labour Relations Act, 1995 Public Finance Management Act, 1999 Treasury Regulations, 2002
			Numerator:	1 844	1 918		
			Denominator:	5 634 323	6 119 435		
			2) Number of professional nurses per 100 000 people	92.31	92.08		
			Numerator:	5 201	5 635		
			Denominator:	5 634 323	6 119 435		
			3) Number of pharmacists per 100 000 people	5.93	6.01		
			Numerator:	334	368		
			Denominator:	5 634 323	6 119 435		
2. Optimal financial management to maximise health outcomes required health services.	2.1. Promote efficient financial resource use.	2.1.1. Promote sound financial governance and management to ensure the under/over spending of the annual equitable share is within 1% of the budget allocation.	4) Percentage expenditure of the annual equitable share budget allocation	100.3%	100%	To ensure sound financial management by aligning the annual allocated budget with the department's strategic objectives.	PFMA Provincial Treasury Instructions National Treasury Regulations Department of Revenue Act
			Numerator:	7 519 280 m	11 376 773 m		
			Denominator:	7 489 777 m	11 376 773 m		
3. Develop and maintain a capacitated workforce to deliver the required health service	3.1. Develop and maintain a comprehensive human resource plan for the Department.	3.1.1. Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.	5) Amended Human Resource Plan submitted timeously to DPSA	Yes	Yes	Systematically reviewing human resource needs to ensure that the required number of employees, with the required competencies, is available when required.	DPSA - HR Plan Ten Point Plan: • Improve Human Resources Increasing wellness Comprehensive Service Plan Public Service Regulations, 2001 Public Service Act, 1994 Employment Equity Act, 1998 Skills Development Act, 1998 Labour Relations Act, 1995 Public Finance Management Act, 1999 Treasury Regulations, 2002

PROGRAMME 2: DISTRICT HEALTH SERVICES

SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2015

Table 2.1 below is reflected on page 72 of the Strategic Plan 2010 – 2014.

The strategic objectives that are being updated are highlighted in grey and in italic font. The revised Table 2.1 is subsequently reflected.

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

Strategic Goal	Strategic Objective	Strategic Objective Statement	Strategic objective performance indicator, baseline & target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Manage the burden of disease. 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 3.84 visits per person per annum by 2014/15.* Achieve a PHC utilisation rate of 2.9 visits per person per annum by 2014/15.	1) Utilisation rate – PHC Numerator Denominator	3.0 15 848 973 5 321 416	*3.0* 2.9 *18 722 105* 17 580 328 *6 240 702* 6 119 435	This is in line with the Comprehensive Service Plan to ensure that 90% of all first contacts are seen in the District Health System.	NSDA: • Increase life expectancy • HIV and AIDS • TB caseload NDOH Ten Point Plan: • Improve quality of health services • Mass mobilisation for the better health of the people. Provincial priority: • Increasing wellness.
	1.2 Increase access to acute services / district hospital services in the DHS in the Western Cape.	1.2.1 *Establish 2 673 acute district hospital beds in the DHS by 2014/15.* Establish 2 705 acute district hospital beds in the DHS by 2014/15.	2) Number of beds in district hospitals	2 464	*2 673* 2 705	This is in line with the Service Plan to ensure that 90% of all first contacts are seen in the District Health System	
	1.3 MDG Goal 6: Have halted and begun to reverse the spread of HIV and AIDS and TB by 2015.	1.3.1 *Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15-24 years to 8% in 2015.* Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15-24 years to 11.5% in 2014/15.	3) HIV prevalence in women aged 15 – 24 years Numerator Denominator	10.9% 545 4 405	*8%* 11.5% *360* 518 4 500	This will reduce the prevalence of HIV. This is in line with the Millennium Development Goal to combat HIV and AIDS, malaria and other diseases and the National Strategic Objective to accelerate implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases.	MDG 6 NSDA: • HIV and AIDS • TB caseload NDOH Ten Point Plan: 7: • Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases. Provincial priority: • Increasing wellness.
	1.4 MDG goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	1.4.1 Reduce the mortality in children under the age of 5 years to 30 per 1 000 live births by 2015.	4) Under-5 mortality rate	38.6 per 1 000 live births	30 per 1 000 live births	Children and youth are priority vulnerable groups.	MDG to reduce child mortality NSDA: • Reduce child mortality NDOH Ten Point Plan: 7: • Mass mobilisation for better health of the population. Provincial priority: • Increasing wellness.

Strategic Goal	Strategic Objective	Strategic Objective Statement	Strategic objective performance indicator, baseline & target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
		Improve the coverage of effective immunisations to 95% in children under the age of 5 years by 2014/15.	Immunisation coverage under 1 year Numerator Denominator	96.7% 98 622 101 937	95% 107 470 113 126		
	1.5 MDG goal 5: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	1.5.1 *Reduce the maternal mortality ratio to 90 per 100 000 live births by 2015.* Reduce the maternal mortality ratio to 53.4 per 100 000 live births by 2014/15.	*5) Public health facility maternal mortality rate* Facility maternal mortality rate Numerator Denominator	103 per 100 000 live births 100 97 185	*27 per 100 000 live births* 53.4 per 100 000 live births *27* 55 *99 685* 103 020	Women are s priority vulnerable group	MDG to improve maternal health NSDA: • Decrease the maternal mortality ratio. NDOH Ten Point Plan: 7: • Mass mobilisation for better health of the population. Provincial priority: Provincial priority: • Increasing wellness.
	1.6 *Preparation for the dealing with epidemics and disasters.* Plan for epidemics and disasters.	1.6.1 Ensure that all districts have plans to deal with outbreaks and epidemics.	*6) Malaria fatality rate (annual)* Malaria case fatality rate Numerator Denominator	0% 0 62	0% 0 - 58		
	1.7 *Chronic disease management.* Provide for cataract surgeries.	1.7.1 *Increase cataract surgery rate.* Increase the number of cataract surgeries to 1 471 per 1 000 000 by 2014/15.	7) Cataract surgery rate (annual) Numerator Denominator	1 132 per 1 million population 6 022 5 321 416	*1 500 per 1 million population* 1 471 per 1 million population *9 361* 9 000 *6 240 702* 6 119 435		
2. Ensure a sustainable income to provide the required health services according to the needs. 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.	2.1.1 *Achieve a primary health care (PHC) expenditure of R450 per uninsured person by 2015 (in 2009/10 rands).* Achieve a primary health care (PHC) expenditure of R472 per uninsured person by 2014/15 (in 2010/11 rands).	8) Provincial PHC expenditure per uninsured person Numerator Denominator	R406 1 786 006 483 4 396 294	*R450* R472 *2 190 743 550* 2 253 115 426 *4 868 319* 4 773 922	Allocation of sufficient funds is required to ensure the delivery of the full package of PHC services.	NSDA: • Health system effectiveness. Provincial priority: • Increasing wellness. Department: • Aligned with the CSP.

Strategic Goal	Strategic Objective	Strategic Objective Statement	Strategic objective performance indicator, baseline & target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
	2.2 Allocate sufficient funds to ensure access to the full package of quality district hospital services by 2014/15.	2.2.1 *Achieve a district hospital expenditure of R1 650 per PDE by 2014/15 (in 2009/10 rands).* Achieve a district hospital expenditure of R1 405 per PDE by 2014/15 (in 2010/11 rands).	9) Expenditure per patient day equivalent (PDE) in district hospitals Numerator Denominator	R1 330 1 312 166 986 481	*R1 650* R1 405 *1 824 456 150* 1 695 498 000 *1 105 731* 1 206 544	Allocation of sufficient funds is required to ensure the delivery of the full package of DH services.	
3. Improve the quality of health services. 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 80% client satisfaction rate by 2014/15.*	*10) Percentage of district hospitals with monthly mortality and morbidity meetings.* *Numerator* *Denominator*	*73.5%* *25* *34*	*100%* *34* *34*		
		Achieve a 92% client satisfaction rate by 2014/15.	District hospital patient satisfaction rate Numerator Denominator	Not required to report - -	92% 4 126 4 485		
	3.2 Improve the experience of clients utilising the PHC services.	3.2.1 Achieve a 70% client satisfaction rate by 2014/15.	11) Percentage of complaints of users of PHC services resolved within 25 days Numerator Denominator	Not required to report - -	70% 194 277		

Table 2.2: REVISED specification of strategic objectives and expected outcomes for 2010 – 2014

Strategic Goal Statement	Strategic Objective	Strategic Objective Statement	Strategic objective performance indicator, baseline & target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Address the burden of disease.	1.1 Increase access to PHC services in the DHS in the Western Cape.	1.1.1 Achieve a PHC utilisation rate of 2.9 visits per person per annum by 2014/15.	1) Utilisation rate – PHC Numerator Denominator	3.0 15 848 973 5 321 416	2.9 17 580 328 6 119 435	This is in line with the Comprehensive Service Plan to ensure that 90% of all first contacts are seen in the District Health System.	NSDA: • Increase life expectancy • HIV and AIDS • TB caseload NDOH Ten Point Plan: • Improve quality of health services • Mass mobilisation for the better health of the people. Provincial priority: • Increasing wellness.
	1.2 Increase access to acute services / district hospital services in the DHS in the Western Cape.	1.2.1 Establish 2 705 acute district hospital beds in the DHS by 2014/15.	2) Number of beds in district hospitals	2 464	2 705	This is in line with the Service Plan to ensure that 90% of all first contacts are seen in the District Health System	
	1.3 MDG Goal 6: Have halted and begun to reverse the spread of HIV and AIDS and TB.	1.3.1 Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15-24 years to 11.5% in 2014/15.	3) HIV prevalence in women aged 15 – 24 years Numerator Denominator	10.9% 545 4 405	11.5% 518 4 500	This will reduce the prevalence of HIV. This is in line with the Millennium Development Goal to combat HIV and AIDS, malaria and other diseases and the National Strategic Objective to accelerate implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases.	MDG 6 NSDA: • HIV and AIDS • TB caseload NDOH Ten Point Plan: 7: • Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases. Provincial priority: • Increasing wellness.
	1.4 MDG goal 4: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.	1.4.1 Improve the coverage of effective immunisations to 95% in children under the age of 5 years by 2014/15.	4) Immunisation coverage under 1 year Numerator Denominator	96.7% 98 622 101 937	95% 107 470 113 126		
	1.5 MDG goal 5: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	1.5.1 Reduce the maternal mortality ratio to 53.4 per 100 000 live births by 2014/15.	5) Facility maternal mortality rate Numerator Denominator	103 per 100 000 live births 100 97 185	53.4 per 100 000 live births 55 103 020	Women are s priority vulnerable group	MDG to improve maternal health NSDA: • Decrease the maternal mortality ratio. NDOH Ten Point Plan: 7: • Mass mobilisation for better health of the population. Provincial priority: Provincial priority: • Increasing wellness.

Strategic Goal Statement	Strategic Objective	Strategic Objective Statement	Strategic objective performance indicator, baseline & target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
	1.6 Plan for epidemics and disasters.	1.6.1 Ensure that all districts have plans to deal with outbreaks and epidemics by 2014/15.	6) Malaria case fatality rate	0%	0%		
			Numerator	0	0		
			Denominator	62	58		
	1.7 Provide for cataract surgeries.	1.7.1 Increase the number of cataract surgeries to 1 471 per 1 000 000 by 2014/15.	7) Cataract surgery rate (annual)	1 132 per 1 million population	1 471 per 1 million population		
			Numerator	6 022	9 000		
			Denominator	5 321 416	6 119 435		
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.	2.1.1 Achieve a primary health care (PHC) expenditure of R472 per uninsured person by 2014/15 (in 2010/11 rands).	8) Provincial PHC expenditure per uninsured person	406	472	Allocation of sufficient funds is required to ensure the delivery of the full package of PHC services.	NSDA: • Health system effectiveness. Provincial priority: • Increasing wellness. Department: • Aligned with the CSP.
			Numerator	1 786 006 483	2 253 115 426		
			Denominator	4 396 294	4 773 922		
	2.2 Allocate sufficient funds to ensure access to the full package of quality district hospital services.	2.2.1 Achieve a district hospital expenditure of R1 405 per PDE by 2014/15 (in 2010/11 rands).	9) Expenditure per patient day equivalent (PDE) in district hospitals (2010/2011 rands)	1 330	1 405	Allocation of sufficient funds is required to ensure the delivery of the full package of DH services.	
			Numerator	1 312 166	1 695 498 000		
			Denominator	986 481	1 206 544		
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 a 92% client satisfaction rate by 2014/15.	10) District hospital patient satisfaction rate	Not required to report	92%		
			Numerator	-	4 126		
			Denominator	-	4 485		
	3.2 Improve the experience of clients utilising the PHC services.	3.2.1 Achieve a 70% client satisfaction rate by 2014/15.	11) Percentage of complaints of users of PHC services resolved within 25 days	Not required to report	70%		
			Numerator	-	194		
			Denominator	-	277		

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2014

Table 3.1 below is reflected on page 80 of the Strategic Plan 2010 – 2014.

The strategic objectives that are being updated/removed are highlighted in grey and in italic font. The revised Table 3.1 is subsequently reflected.

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

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Manage the burden of disease. Address the burden of disease.	1.1. Fully implement the Comprehensive Service Plan model for EMS by 2014.	*1.1.1. To complete the implementation of the Comprehensive Service Plan by operationalising the EMRS resources (542 vehicles, 54 bases and **2 366** personnel) necessary to the specified service levels of ~~156~~ 157 rostered ambulances per hour in the CSP by 2014/15.* Deploying the EMS resources (542 vehicles, 54 bases and 2 366 personnel) necessary to the specified service levels of 157 rostered ambulances per hour in the CSP by 2014/15.	1) Rostered ambulances per 10 000 people Numerator Denominator	0.47 251 551	*0.25* 0.26 *156* 157 *611* 612	Service levels specified in the CSP can only be met by the implementation of the full resource complement.	Millennium Development Goals • Reduce Child Mortality • Improve Maternal Health • Emergency Care is a Constitutional and legal imperative NDOH Ten Point Plan • Overhauling the Healthcare System and improve its management NSDA: • Increasing life expectancy • Decreasing maternal and child mortality • Strengthening health system effectiveness. Provincial strategic objective 04: • Increasing wellness
	1.2. Provide roadside to bedside definitive emergency care within defined emergency time frames within and across geographic and clinical service platforms.	1.2.1 *To meet the response time performance for urban (90% P1 Within 15 min) and rural (90% P1 within 40 min) clients and ensure the shortest time to definitive care by integrated management of pre-hospital and hospital emergency care resources by 2014.* Meet the response time performance of 70% for P1 urban and 89.2% 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) *Percentage of urban Priority 1 responses within 15 minutes* P1 calls with a response time of <15 minutes in an urban area Numerator Denominator	40.1% 39 320 95 231	65% 70% 94 590 79 121 105 000 113 031	Emergency Care is a Constitutional and legal imperative.	

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	**Baseline 2009/10**	**Target 2014/15**		
			3) *Percentage of rural Priority 1 responses within 40 minutes* P1 calls with a response time of <40 minutes in a rural area	79.2%	80% 89.2%		
			Numerator	7 050	7 272 13 519		
			Denominator	8 907	9 090 15 154		
	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 EMRS Service by 2014.* To meet the patient response, transport and inter-hospital transfer needs of the department in line with the 90:10 CSP model by realigning the configuration of the EMS service by 2014/15.	4) Percentage of ambulance patients transferred between facilities	27.5%	10% 21.3%	Monitor measures introduced to facilitate improved access to health services.	
			Numerator	127 033	45 600 139 183		
			Denominator	461 940	456 000 653 202		
	1.4 Efficiently and effectively manage chronic diseases.	1.4.1 To meet the appropriate outpatient transfer needs of patients per year through intra district and trans district HealthNET transport system ensuring that patients are managed at the appropriate level of care by 2014.	5) Number of outpatients transferred by HealthNET to regional and central hospitals	113 830	91 650		

Note:

Indicator 1: During 2009/10 the number of ambulances in the fleet was used for this indicator. From 2010/11 onwards, the number of rostered ambulances is used i.e. the average number of ambulances available per hour.

Table 3.2: REVISED Specification of strategic objectives and expected outcomes for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Address the burden of disease.	1.1. Fully implement the Comprehensive Service Plan model for EMS by 2014.	1.1.1. Deploying the EMS resources (542 vehicles, 54 bases and 2 366 personnel) necessary to the specified service levels of 157 rostered ambulances per hour in the CSP by 2014/15.	1) Rostered ambulances per 10 000 people	0.47	0.26	Service levels specified in the CSP can only be met by the implementation of the full resource complement.	Millennium Development Goals • Reduce Child Mortality • Improve Maternal Health • Emergency Care is a Constitutional and legal imperative NDOH Ten Point Plan • Overhauling the Healthcare System and improve its management NSDA: • Increasing life expectancy • Decreasing maternal and child mortality • Strengthening health system effectiveness. Provincial strategic objective 04: • Increasing wellness
			Numerator	251	157		
			Denominator	551	612		
	1.2. Provide roadside to bedside definitive emergency care within defined emergency time frames within and across geographic and clinical service platforms.	1.2.1 Meet the response time performance of 70% for P1 urban and 89.2% 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) P1 calls with a response of time <15 minutes in an urban area	40.1%	70%	Emergency Care is a Constitutional and legal imperative.	
			Numerator	39 320	79 121		
			Denominator	95 231	113 031		
			3) P1 calls with a response time of <40 minutes in a rural area	79.2%	89.2%		
			Numerator	7 050	13 519		
			Denominator	8 907	15 154		
	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.	4) Percentage of ambulance patients transferred between facilities	27.5%	21.3%	Monitor measures introduced to facilitate improved access to health services.	
			Numerator	127 033	139 183		
			Denominator	461 940	653 202		

Note:

Indicator 1: During 2009/10 the number of ambulances in the fleet was used for this indicator. From 2010/11 onwards, the number of rostered ambulances is used i.e. the average number of ambulances available per hour.

PROGRAMME 4: PROVINCIAL HOSPITALS

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

Table 4.1 below is reflected on page 88 of the Strategic Plan 2010 – 2014.

The strategic objectives that are being updated are highlighted in grey and in italic font. The revised Table 4.1 is subsequently reflected.

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

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Manage the burden of disease. Address the burden of disease.	1.1. Ensure access to general specialist hospital services.	*1.1.1. Ensure access to regional hospitals services by providing 1 340 regional hospital beds by 2014.* Ensure access to regional hospitals services by providing 1 375 regional hospital beds by 2014/15.	1) Number of regional hospital beds.	2 364	*1 340* 1 375	• Escalating burden of disease and the increased acuity of patients caused by HIV and TB. • Improve the Western Cape's population health status. Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care. • Ensure progress is made towards providing the complete package of care within regional hospitals, thus increasing access to services. • Provision of outreach and support to District Health Services, especially district hospitals.	NSDA Outputs: • Increasing life expectancy • Decreasing maternal and child mortality • Combating HIV and AIDS and the burden of disease from Tuberculosis • Strengthening health system effectiveness. National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness Departmental priority: Comprehensive Service Plan.
	1.2. Reduce facility maternal mortality.	*1.2.1. Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies at a target of 35% by 2014.* Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies at a target of 39% by 2014/15.	2) Caesareans section rate for regional hospitals Numerator Denominator	32.5% 8 425 25 961	*35%* 39% *5 127* 10 579 *14 426* 27 225	• Ensure an improved health outcome for mothers and babies.	Millennium development goal 5 (MDG): Improve maternal health.

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
2. Ensure a sustainable income to provide the required health services according to the needs. Optimal financial management to maximise health outcomes.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality general specialist hospital services.	*2.1.1. Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R2 100 per PDE by 2014. [Constant 2009/10 rand].* Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R1 807 per PDE by 2014/15. [2010/11 rands].	3) Expenditure per patient day equivalent [PDE] in regional hospitals	R1 626	*R2 100* R1 807	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Maximising health outcomes
			Numerator	1 709 636 442	*1 164 058 000* 1 042 082 088		
			Denominator	1 051 150	*554 313* 576 648		
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services.	*3.1.1. Efficiently manage the allocated resources of regional hospitals to achieve a target bed utilisation rate of 85% and an average length of stay of 4 days by 2014.* Efficiently manage the allocated resources of regional hospitals to achieve a target bed utilisation rate of 87% and an average length of stay of 3.9 days by 2014/15.	4) Bed utilisation rate (based on usable beds) in regional hospitals	86%	*85%* 87%	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Maximising health outcomes
			Numerator	742 740	*415 735* 437 928		
			Denominator	862 860	*489 100* 501 875		
			5) Average length of stay in regional hospitals	4 days	*4 days* 3.9 days		
			Numerator	742 740	*415 735* 437 928		
			Denominator	185 919	*103 934* 113 005		
4. Quality of health services. 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 patients risk in regional hospitals by monthly mortality and morbidity meetings by 2014.	6) Percentage of regional hospitals with monthly mortality and morbidity meetings	100%	100 %	Systematically assess patient risk through an institutionalised process of regular mortality and morbidity meetings.	
			Numerator	8	5		
			Denominator	8	5		

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

Strategic Goal statement	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Address the burden of disease.	1.1. Ensure access to general specialist hospital services.	1.1.1. Ensure access to regional hospitals services by providing 1 375 regional hospital beds by 2014/15.	1) Number of regional hospital beds.	2 364	1 375	• Escalating burden of disease and the increased acuity of patients caused by HIV and TB. • Improve the Western Cape's population health status. Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care. • Ensure progress is made towards providing the complete package of care within regional hospitals, thus increasing access to services. • Provision of outreach and support to District Health Services, especially district hospitals.	NSDA Outputs: • Increasing life expectancy • Decreasing maternal and child mortality • Combating HIV and AIDS and the burden of disease from Tuberculosis • Strengthening health system effectiveness. National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness Departmental priority: Comprehensive Service Plan.
	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% by 2014/15.	2) Caesareans section rate for regional hospitals	32.5%	39%	• Ensure an improved health outcome for mothers and babies.	Millennium development goal 5 (MDG): Improve maternal health.
			Numerator	8 425	10 579		
			Denominator	25 961	27 225		
2. Optimal financial management to maximise health outcomes	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality general specialist hospital services.	2.1.1. Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R1 807 per PDE by 2014/15. [2010/11 rands].	3) Expenditure per patient day equivalent [PDE] in regional hospitals	R1 626	R1 807	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Maximising health outcomes
			Numerator	1 709 636 442	1 042 082 088		
			Denominator	1 051 150	576 648		
3. Ensure and maintain or-ganisational 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 87% and an average length of stay of 3.9 days by 2014/15.	4) Bed utilisation rate (based on usable beds) in regional hospitals	86%	87%	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Maximising health outcomes
			Numerator	742 740	437 928		
			Denominator	862 860	501 875		
			5) Average length of stay in regional hospitals	4 days	3.9 days		
			Numerator	742 740	437 928		
			Denominator	185 919	113 005		

Strategic Goal statement	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
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 patients risk in regional hospitals by monthly mortality and morbidity meetings by 2014/15.	6) Percentage of regional hospitals with monthly mortality and morbidity meetings	100%	100 %	Systematically assess patient risk through an institutionalised process of regular mortality and morbidity meetings.	
			Numerator	8	5		
			Denominator	8	5		

Table 4.2: Strategic objectives and expected outcomes for tuberculosis hospitals for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Manage the burden of disease. 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 1 284 TB hospital beds by 2014.* Ensure access to the full package of TB hospital services by providing 1 115 TB hospital beds by 2014/15.	1) Number of TB hospital beds	1 016	*1 284* 1 115	• Increase access to TB beds in view of XDR/MDR fuelled by HIV causing acuity of TB patients to increase. • Improve the Western Cape's population health status. • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care, • Ensure that the complete package of care within hospitals are provided, thus increasing access to services. • Provision of outreach and support.	NDSA output: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis. National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness Departmental priority: Comprehensive Service Plan.
2. Ensure a sustainable income to provide the required health services according to the needs. 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 R510 per PDE by 2014. [Constant 2009/10 rand].* Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R538 per PDE by 2014/15. [2010/11 rands].	2) Expenditure per patient day equivalent [PDE] in TB hospitals	R515	*R510* R538	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Overhauling the health system and improving its management.
			Numerator	157 626 336	*187 396 525* 187 395 387		
			Denominator	305 833	*367 444* 348 470		
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services.	*3.1.1. Effectively manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 85 days by 2014.* Effectively manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 85% and an average length of stay of 71.7 days by 2014/15.	3) Bed utilisation rate (based on usable beds) in TB hospitals	82%	*90%* 85.0%	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence. • Minimize patient transfers between institutions.	NDSA output: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis. National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness Departmental priority: Comprehensive Service Plan.
			Numerator	304 764	*366 278* 345 929		
			Denominator	370 840	*406 975* 406 975		
			4) Average length of stay in TB hospitals	81 days	*85 days* 71.7 days	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	
			Numerator	304 764	*366 278* 345 929		
			Denominator	3 693	*4 309* 4 825		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	**Baseline 2009/10**	**Target 2014/15**		
4. Quality of health services. 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.	5) Percentage of TB hospitals with monthly mortality and morbidity meetings.	67%	100%	Systematically assess patient risk through an institutionalised process of regular mortality and morbidity meetings.	
			Numerator	4	6		
			Denominator	6	6		

Table 4.2: REVISED Strategic objectives and expected outcomes for tuberculosis hospitals for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
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 1 115 TB hospital beds by 2014/15.	1) Number of TB hospital beds	1 016	1 115	• Increase access to TB beds in view of XDR/MDR fuelled by HIV causing acuity of TB patients to increase. • Improve the Western Cape's population health status. • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care, • Ensure that the complete package of care within hospitals are provided, thus increasing access to services. • Provision of outreach and support.	NDSA output: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis. National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness Departmental priority: Comprehensive Service Plan.
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 R538 per PDE by 2014/15. [2010/11 rands].	2) Expenditure per patient day equivalent [PDE] in TB hospitals	R515	R 538	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Overhauling the health system and improving its management.
			Numerator	157 626 336	187 395 387		
			Denominator	305 833	348 470		
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 85% and an average length of stay of 71.7 days by 2014/15.	3) Bed utilisation rate (based on usable beds) in TB hospitals	82%	85.0%	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence. • Minimize patient transfers between institutions.	NDSA output: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis. National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness Departmental priority: Comprehensive Service Plan.
			Numerator	304 764	345 929		
			Denominator	370 840	406 975		
			4) Average length of stay in TB hospitals	81 days	71.7 days	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	
			Numerator	304 764	345 929		
			Denominator	3 693	4 825		
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) Percentage of TB hospitals with monthly mortality and morbidity meetings.	67%	100%	Systematically assess patient risk through an institutionalised process of regular mortality and morbidity meetings.	
			Numerator	4	6		
			Denominator	6	6		

Table 4.3: Strategic objectives and expected outcomes for psychiatric hospitals for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Manage the burden of disease. Address the burden of disease.	1.1. Ensure access to psychiatric hospital services.	*1.1.1. Ensure access to the full package of psychiatric hospital services by providing 1 528 psychiatric hospital beds by 2014.* Ensure access to the full package of psychiatric hospital services by providing 1 698 psychiatric hospital beds by 2014/15.	1) Number of psychiatric hospital beds	1 792	*1 528* 1 698	• Increase in mental illness globally and locally especially with co morbidity of substances. Pressure on access to acute beds to be increased. • Improve the Western Cape's population health status. • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care. • Ensure that the complete package of care within hospitals are provided, thus increasing access to services. • Provision of outreach and support. • Continue the de-institutionalisation of chronic patients. • Sub-acute beds to be shifted away from Programme 4 during the MTEF period	National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness Departmental priority: Comprehensive Service Plan
	1.2. Address the burden of disease by ensuring access to step-down facilities.	*1.2.1. Provide a total of 145 step-down beds and maintain a bed occupancy rate of 86% in sub-acute facilities by 2014/15.*	2) *Number of usable beds in step-down facilities*	*127*	*145*		
			3) *Bed utilisation rate in step-down facilities*	*79%*	*86%*		
			Numerator	*36 738*	*45 320*		
			Denominator	*46 355*	*52 925*		
2. Ensure a sustainable income to provide the required health services according to the needs. 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 R850 per PDE by 2014. [Constant 2009/10 rands).* Allocate sufficient funds to ensure the delivery of the full package of psychiatric hospital services at a rate of R1 021 per PDE by 2014/15. [2010/11 rands).	4) Expenditure per patient day equivalent [PDE] in psychiatric hospitals	R753	*R850* R1 021	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Increasing wellness
			Numerator	448 360 000	*435 297 467* 580 526 472		
			Denominator	595 471	*512 115* 568 573		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services	3.1.1. Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 90% by 2014 Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 93 days by 2014/15.	5) Bed utilisation rate (based on usable beds) in psychiatric hospitals Numerator Denominator	89% 583 871 654 080	*90%* 90% *501 948* 558 771 *557 720* 619 770	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence. • Minimize patient transfers between institutions.	
			6) Average length of stay in psychiatric hospitals Numerator Denominator	109 days 583 871 5 369	*90 days* 93 days *501 948* 558 771 *5 577* 5 978	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Increasing wellness.
4. Quality of health services. 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 patients risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014.	7) Percentage of psychiatric hospitals with monthly mortality and morbidity meetings Numerator Denominator	100% 4 4	100% 4 4	Systematically assess patient risk through an institutionalised process of regular mortality and morbidity meetings	National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness.

Table 4.3: REVISED Strategic objectives and expected outcomes for psychiatric hospitals for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Address the burden of disease.	1.1. Ensure access to psychiatric hospital services.	1.1.1. Ensure access to the full package of psychiatric hospital services by providing 1 698 psychiatric hospital beds by 2014/15.	1) Number of psychiatric hospital beds	1 792	1 698	• Increase in mental illness globally and locally especially with co morbidity of substances. Pressure on access to acute beds to be increased. • Improve the Western Cape's population health status. • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care. • Ensure that the complete package of care within hospitals are provided, thus increasing access to services. • Provision of outreach and support. • Continue the de-institutionalisation of chronic patients. • Sub-acute beds to be shifted away from Programme 4 during the MTEF period	National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness Departmental priority: Comprehensive Service Plan
	1.2. Address the burden of disease by ensuring access to step-down facilities	1.2.1. Provide a total of 145 step-down beds and maintain a bed occupancy rate of 86% in sub-acute facilities by 2014/15	2) Number of usable beds in step-down facilities	127	145		
			3) Bed utilisation rate in step-down facilities	79%	86%		
			Numerator	36 738	45 320		
			Denominator	46 355	52 925		
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 021 per PDE by 2014/15. [2010/11 rands).	4) Expenditure per patient day equivalent [PDE] in psychiatric hospitals	R753	R 1 021	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Increasing wellness
			Numerator	448 360 000	580 526 472		
			Denominator	595 471	568 573		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services	3.1.1. Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 93 days by 2014/15	5) Bed utilisation rate (based on usable beds) in psychiatric hospitals	89%	90%	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence. • Minimize patient transfers between institutions.	
			Numerator	583 871	558 771		
			Denominator	654 080	619 770		
			6) Average length of stay in psychiatric hospitals	109 days	93 days	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Increasing wellness.
			Numerator	583 871	558 771		
			Denominator	5 369	5 978		
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 patients risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014.	7) Percentage of psychiatric hospitals with monthly mortality and morbidity meetings	100%	100%	Systematically assess patient risk through an institutionalised process of regular mortality and morbidity meetings	National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness.
			Numerator	4	4		
			Denominator	4	4		

Table 4.4: Strategic objectives and expected outcomes for rehabilitation hospitals for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Manage the burden of disease. Address the burden of disease.	1.1. Ensure access to rehabilitation services.	1.1.1. Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014.	1) Number of rehabilitation hospital beds	156	156	• Prevalence of disability has increased with a need to find innovative ways to increase access at general services • Improve the Western Cape's population health status • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care • Ensure that the complete package of care within hospitals are provided • Provision of outreach and support	National Department of Health Ten Point Plan: • Improve the quality of health services Negotiated Service Delivery Agreement [NSDA]: • Combating HIV and AIDS and decrease the burden of disease from TB. Provincial priority: Increasing wellness. Departmental priority: Comprehensive Service Plan
2. Ensure a sustainable income to provide the required health services according to the needs. Optimal financial management to maximise health outcomes.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality rehabilitation hospital services by 2014.	*2.1.1. Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R2 300 per PDE by 2014. [Constant R2009/10 rands].* Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R2 159 per PDE by 2014/15. [2010/11 rands].	2) Expenditure per patient day equivalent [PDE] in rehabilitation hospitals Numerator Denominator	R 1 945 110 461 638 56 801	*R 2 300* R 2 159 *117 391 233* 98 879 139 *51 040* 45 801	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Increasing wellness.
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained and strategic direction in the delivery of health services with well-defined efficiency targets towards improving quality of care.	*3.1.1. Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilization rate of 75% and an average length of stay of 50 days by 2014.* Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilization rate of 73% and an average length of stay of 46 days by 2014/15.	3) Bed utilisation rate (based on usable beds) in rehabilitation hospitals Numerator Denominator	85% 48 431 56 940	*75%* 73% *42 705* 41 600 *56 940* 56 940	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence. • Minimize patient transfers between institutions.	
			4) Average length of stay in rehabilitation hospitals Numerator Denominator	58 days 48 431 829	*50 days* 46 days *42 705* 41 600 *854* 903	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Increasing wellness.

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
4. Quality of health services. 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 patients risk rehabilitation hospitals by monthly mortality and morbidity meetings by 2014.	5) Percentage of rehabilitation hospitals with monthly mortality and morbidity meetings	0%	100%	Systematically assess patient risk through an institutionalised process of regular mortality and morbidity meetings	National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness
			Numerator	0	1		
			Denominator	1	1		

Table 4.4: REVISED Strategic objectives and expected outcomes for rehabilitation hospitals for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Address the burden of disease.	1.1. Ensure access to rehabilitation services.	1.1.1. Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014/15.	1) Number of rehabilitation hospital beds	156	156	• Prevalence of disability has increased with a need to find innovative ways to increase access at general services • Improve the Western Cape's population health status • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care • Ensure that the complete package of care within hospitals are provided • Provision of outreach and support	National Department of Health Ten Point Plan: • Improve the quality of health services Negotiated Service Delivery Agreement [NSDA]: • Combating HIV and AIDS and decrease the burden of disease from TB. Provincial priority: Increasing wellness. Departmental priority: Comprehensive Service Plan
2. Optimal financial management to maximise health outcomes	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality rehabilitation hospital services by 2014.	2.1.1. Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R2 159 per PDE by 2014/15. [2010/11 rands].	2) Expenditure per patient day equivalent [PDE] in rehabilitation hospitals	1 945	R 2 159	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Increasing wellness.
			Numerator	110 461 638	98 879 139		
			Denominator	56 801	45 801		
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained and strategic direction in the delivery of health services with well-defined efficiency targets towards improving quality of care.	3.1.1. Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilization rate of 73% and an average length of stay of 46 days by 2014/15.	3) Bed utilisation rate (based on usable beds) in rehabilitation hospitals	85%	73%	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence. • Minimize patient transfers between institutions.	
			Numerator	48 431	41 600		
			Denominator	56 940	56 940		
			4) Average length of stay in rehabilitation hospitals	58 days	46 days	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	National Department of Health Ten Point Plan: • Improve the quality of health services. • Overhauling the health system and improving its management. Provincial priority: Increasing wellness.
			Numerator	48 431	41 600		
			Denominator	829	903		
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 patients risk rehabilitation hospitals by monthly mortality and morbidity meetings by 2014/15.	6) Percentage of rehabilitation hospitals with monthly mortality and morbidity meetings	0%	100%	Systematically assess patient risk through an institutionalised process of regular mortality and morbidity meetings	National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Increasing wellness
			Numerator	0	1		
			Denominator	1	1		

Table 4.5: Strategic objectives and expected outcomes for dental training hospitals for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Manage the burden of disease. 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 185 454 patient visits per annum by 2014.* Ensure access to an integrated oral health service and training platform by providing for 126 000 patient visits per annum by 2014/15.	1) Number of oral health patient visits per annum	175 200	*185 454* 126 000	• Increase patient access to dental services. • Improve the Western Cape's population health status. • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care.	
		1.1.2 Perform 1 160 maxillofacial surgery procedures by 2014/15.	2) Number of oral health theatre cases per annum	1 578	1 160		
		1.1.3 Provide quality removable prosthetic devices to patients with a target of 6 200 by 2014/15.	3) Number of removable oral health prosthetic devices manufactured (dentures)	3 026	6 200		
		1.1.4 Provide a quality orthodontic service to dental patients with a target of 200 by 2014/15.	4) Number of new patients banded for orthodontic treatment (braces)	New indicator	200		

Table 4.5: REVISED Strategic objectives and expected outcomes for dental training hospitals for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
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 126 000 patient visits per annum by 2014/15.	1) Number of oral health patient visits per annum	175 200	126 000	• Increase patient access to dental services. • Improve the Western Cape's population health status. • Maximize access to services and specialized care ensuring clinical skills and expertise are concentrated at the correct level of care.	
		1.1.2 Perform 1 160 maxillofacial surgery procedures by 2014/15.	2) Number of oral health theatre cases per annum	1 578	1 160		
		1.1.3 Provide quality removable prosthetic devices to patients with a target of 6 200 by 2014/15.	3) Number of removable oral health prosthetic devices manufactured (dentures)	3 026	6 200		
		1.1.4 Provide a quality orthodontic service to dental patients with a target of 200 by 2014/15.	4) Number of new patients banded for orthodontic treatment (braces)	New indicator	200		

PROGRAMME 5: CENTRAL HOSPITAL SERVICES (HIGHLY SPECIALISED)

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

Table 5.1 below is reflected on page 99 of the Strategic Plan 2010 – 2014.

The strategic objectives that are being updated are highlighted in grey and in italic font. The revised Table 5.1 is subsequently reflected.

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

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Manage the burden of disease Address the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	*1.1.1. Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.* Perform appropriate 47.7% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in central hospitals[1] Numerator Denominator	44% 5 052 11 509	*43%* 47.7% *5 800* 5 745 *13 600* 12 050	Ensure an improved health outcome for mothers and babies.	MDG 5: Improve maternal health. NSDA: • Increase life expectancy: Decrease the maternal mortality ratio NDOH Ten Point Plan, 8: • Mass mobilisation for the better health of the population. Provincial priority: • Increasing wellness.
	1.2. Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	*1.2.1. Ensure access to central hospital services by providing 2 536 beds.* Ensure access to central hospital services by providing 2 545 beds.	2) Number of operational beds in central hospitals.	1 460	*2 536* 2 545	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	NSDA: • Health system effectiveness NDOH Ten Point Plan: • Overhauling the health care system and improving its management. Provincial priority: • Increasing wellness.
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	*1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.* Efficiently manage resources to achieve the target bed occupancy rate of 85% by 2014/15.	3) Bed utilisation rate (based on usable beds) in central hospitals Numerator Denominator	83% 446 411 535 820	*84%* 85.0% *780 877* 789 929 *925 640* 928 925	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
2. Ensure a sustainable income to provide the required health services according to the needs. 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 000 per patient day equivalent [Constant 2009/10 rands].* Ensure the cost effective management of central hospitals at a target cost of R3 262 per patient day equivalent by 2014/15 [2010/11 rands].	4) Expenditure per patient day equivalent in central hospitals Numerator Denominator	R3 733 2 335 490 820 625 661	*R3 000* R3 262 *3 362 032 548* 3 645 709 482 *1 120 678* 1 117 470	Ensure the efficient application of resources in rendering health services.	NDOH Ten Point Plan: • Provision of strategic leadership and creation of a social compact for better health outcomes. Provincial priority: • Increasing wellness.
3. Ensure 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 5.5 days for central hospitals by 2014/15.* Effectively manage allocated resources to achieve the target average length of stay of 5.6 days for central hospitals by 2014/15.	5) Average length of stay in central hospitals. Numerator Denominator	6.5 days 446 411 68 231	*5.5 days* 5.6 days *780 877* 789 929 *140 749* 139 947	Ensure the optimal utilisation of hospital resources.	NDOH Ten Point Plan: • Overhauling the health care system and improving its management.. Provincial priority: • Increasing wellness.
4. Quality of health services. Improve the quality of health services and the patient experience.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	6) Number of central hospitals with monthly mortality and morbidity meetings	3	3	Ensure the maintenance and constant improvement of the quality of health services.	NSDA: • Health system effectiveness NDOH Ten Point Plan: • Improve quality of health services. Provincial priority: • Increasing wellness.

Table 5.2: REVISED Strategic objectives and expected outcomes for central hospitals for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
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) Caesarean section rate in central hospitals[1] Numerator Denominator	44% 5 052 11 509	47.7% 5 745 12 050	Ensure an improved health outcome for mothers and babies.	MDG 5: Improve maternal health. NSDA: • Increase life expectancy: Decrease the maternal mortality ratio NDOH Ten Point Plan, 8: • Mass mobilisation for the better health of the population. Provincial priority: • Increasing wellness.
	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 2 545 beds.	2) Number of operational beds in central hospitals.	1 460	2 545	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	NSDA: • Health system effectiveness NDOH Ten Point Plan: • Overhauling the health care system and improving its management. Provincial priority: • Increasing wellness.
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 85% by 2014/15.	3) Bed utilisation rate (based on usable beds) in central hospitals Numerator Denominator	83% 446 411 535 820	85.0% 789 929 928 925	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	
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 262 per patient day equivalent by 2014/15 [2010/11 rands].	4) Expenditure per patient day equivalent in central hospitals Numerator Denominator	R3 733 2 335 490 820 625 661	R3 262 3 645 709 482 1 117 470	Ensure the efficient application of resources in rendering health services.	NDOH Ten Point Plan: • Provision of strategic leadership and creation of a social compact for better health outcomes. Provincial priority: • Increasing wellness.
3. Ensure 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 5.6 days for central hospitals by 2014/15.	5) Average length of stay in central hospitals. Numerator Denominator	6.5 days 446 411 68 231	5.6 days 789 929 139 947	Ensure the optimal utilisation of hospital resources.	NDOH Ten Point Plan: • Overhauling the health care system and improving its management.. Provincial priority: • Increasing wellness.
4. Improve the quality of health services and the patient experience.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	6) Number of central hospitals with monthly mortality and morbidity meetings	3	3	Ensure the maintenance and constant improvement of the quality of health services.	NSDA: • Health system effectiveness NDOH Ten Point Plan: • Improve quality of health services. Provincial priority: • Increasing wellness.

Table 5.3: REVISED Strategic objectives and expected outcomes for Groote Schuur hospital for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Address the burden of disease	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 54% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Groote Schuur hospital Numerator Denominator	52.5% 2 861 5 452	54% 3 078 5 700	Ensure an improved health outcome for mothers and babies.	MDG 5: Improve maternal health. NSDA: • Increase life expectancy: Decrease the maternal mortality ratio NDOH Ten Point Plan, 8: • Mass mobilisation for the better health of the population. Provincial priority: • Increasing wellness.
	1.2. Ensure the delivery of Groote Schuur 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 891 beds.	2) Number of operational beds in Groote Schuur hospital.	625	891	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	NSDA: • Health system effectiveness NDOH Ten Point Plan: • Overhauling the health care system and improving its management. Provincial priority: • Increasing wellness.
	1.3. Ensure optimal access to Groote Schuur services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 88% by 2014/15.	3) Bed utilisation rate (based on usable beds) in Groote Schuur Numerator Denominator	83% 446 411 535 820	88% 286 189 325 215	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	
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, Groote Schuur services.	2.1.1. Ensure the cost effective management of Groote Schuur at a target cost of R3 547 per patient day equivalent by 2014/15 [2010/11 rands].	4) Expenditure per patient day equivalent in Groote Schuur Numerator Denominator	R3 733 2 335 490 820 625 661	R3 547 1 511 180 054 426 068	Ensure the efficient application of resources in rendering health services.	NDOH Ten Point Plan: • Provision of strategic leadership and creation of a social compact for better health outcomes. Provincial priority: • Increasing wellness.
3. Ensure 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 services.	3.1.1. Effectively manage allocated resources to achieve the target average length of stay of 5.9 days for Groote Schuur by 2014/15.	5) Average length of stay in Groote Schuur. Numerator Denominator	6.5 days 446 411 68 231	5.9 days 286 189 48 863	Ensure the optimal utilisation of hospital resources.	NDOH Ten Point Plan: • Overhauling the health care system and improving its management.. Provincial priority: • Increasing wellness.
4. Improve the quality of health services and the patient experience.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	6) Groote Schuur with monthly mortality and morbidity meetings	Yes	Yes	Ensure the maintenance and constant improvement of the quality of health services.	NSDA: • Health system effectiveness NDOH Ten Point Plan: • Improve quality of health services. Provincial priority: • Increasing wellness.

Table 5.4: REVISED Strategic objectives and expected outcomes for Tygerberg hospital for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Address the burden of disease	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 42% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Tygerberg hospital Numerator Denominator	36.2% 2 191 6 057	42% 2 667 6 350	Ensure an improved health outcome for mothers and babies.	MDG 5: Improve maternal health. NSDA: • Increase life expectancy: Decrease the maternal mortality ratio NDOH Ten Point Plan, 8: • Mass mobilisation for the better health of the population. Provincial priority: • Increasing wellness.
	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.	2) Number of operational beds in Tygerberg hospital	608	1 384	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	NSDA: • Health system effectiveness NDOH Ten Point Plan: • Overhauling the health care system and improving its management. Provincial priority: • Increasing wellness.
	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 occupancy rate of 83% by 2014/15.	3) Bed utilisation rate (based on usable beds) in Tygerberg hospital Numerator Denominator	83% 446 411 535 820	83% 419 283 505 160	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	
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, Tygerberg hospital services.	2.1.1. Ensure the cost effective management of Tygerberg hospital at a target cost of R2 995 per patient day equivalent by 2014/15 [2010/11 rands].	4) Expenditure per patient day equivalent in Tygerberg hospital Numerator Denominator	R3 733 2 335 490 820 625 661	R2 995 1 658 207 843 553 607	Ensure the efficient application of resources in rendering health services.	NDOH Ten Point Plan: • Provision of strategic leadership and creation of a social compact for better health outcomes. Provincial priority: • Increasing wellness.
3. Ensure 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 services.	3.1.1. Effectively manage allocated resources to achieve the target average length of stay of 6 days for Tygerberg hospital by 2014/15.	5) Average length of stay in Tygerberg hospital. Numerator Denominator	6.5 days 446 411 68 231	6.0 days 419 283 70 338	Ensure the optimal utilisation of hospital resources.	NDOH Ten Point Plan: • Overhauling the health care system and improving its management.. Provincial priority: • Increasing wellness.
4. Improve the quality of health services and the patient experience.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	6) Tygerberg hospital with monthly mortality and morbidity meetings	Yes	Yes	Ensure the maintenance and constant improvement of the quality of health services.	NSDA: • Health system effectiveness NDOH Ten Point Plan: • Improve quality of health services. Provincial priority: • Increasing wellness.

Table 5.5: REVISED Strategic objectives and expected outcomes for Red Cross war Memorial Children's Hospital for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Address the burden of disease	1.1. Ensure the delivery of RCWMCH services to manage the burden of disease at the appropriate level of care.	1.1.1. Ensure access to RCWMCH services by providing 270 beds	1) Number of operational beds in RCWMCH	235	270	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	NSDA: • Health system effectiveness NDOH Ten Point Plan: • Overhauling the health care system and improving its management. Provincial priority: Increasing wellness.
	1.2. Ensure optimal access to RCWMCH services to manage the burden of disease.	1.2.1. Efficiently manage resources to achieve the target bed occupancy rate of 86% by 2014/15.	2) Bed utilisation rate (based on usable beds) in RCWMCH Numerator Denominator	84% 72 411 85 775	86% 84 457 98 550	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening	•
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, RCWMCH services.	2.1.1. Ensure the cost effective management of RCWMCH at a target cost of R3 457 per patient day equivalent by 2014/15 [2010/11 rands].	3) Expenditure per patient day equivalent in RCWMCH Numerator Denominator	R3 733 2 335 490 820 625 661	R3 457 476 321 585 137 795	Ensure the efficient application of resources in rendering health services.	NDOH Ten Point Plan: • Provision of strategic leadership and creation of a social compact for better health outcomes. Provincial priority: • Increasing wellness.
3. Ensure 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 services.	3.1.1. Effectively manage allocated resources to achieve the target average length of stay of 4.1 days for RCWMCH by 2014/15.	4) Average length of stay in RCWMCH Numerator Denominator	6.5 days 446 411 68 231	4.1 days 84 457 20 746	Ensure the optimal utilisation of hospital resources.	NDOH Ten Point Plan: • Overhauling the health care system and improving its management.. Provincial priority: • Increasing wellness.
4. Improve the quality of health services and the patient experience.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	5) RCWMCH with monthly mortality and morbidity meetings	Yes	Yes	Ensure the maintenance and constant improvement of the quality of health services.	NSDA: • Health system effectiveness NDOH Ten Point Plan: • Improve quality of health services. Provincial priority: • Increasing wellness.

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010 – 2014

Table 6.1 below is reflected on page 108 of the Strategic Plan 2010 – 2014.

The strategic objectives that are being updated are highlighted in grey and in italic font. The revised Table 6.1 is subsequently reflected.

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

Strategic Goal statement	Strategic Objective Title	Strategic Objective Statement	Strategic objective indicator, baseline and target			Justification	Links
			Strategic objective indicator	2009/10 Baseline	2014/15 Target		
1. Develop and maintain a capacitated workforce to deliver the required health services.	1.1 Develop, implement, monitor and evaluate a comprehensive Training Plan guided by the Human Resource Plan for health and support professionals in line with the Comprehensive Service Plan (CSP).	*1.1.1 Number of basic nurse students graduating (output).* Increase the number of basic nurse students graduating (output) to 600 per annum by 2014/15.	1) *Basic nurse students graduating* Basic nurse students graduating (at nursing college and HEIs)	299	600	Increase the critical mass of health science students to address scarce skills.	NSDA: Focus area: • Health system effectiveness NDOH Ten Point Plan for 2009 - 2014, priority 5: • Improve human resources Provincial strategic plan: • Increasing wellness
	1.2 Ensure optimum competency levels of health and support professionals through education, training and development.	*1.2.1 Number of EMC staff intake on HPCSA accredited Programmes (one of these courses is a 2 year course).* 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	250	150	Increase the number of competent EMC staff.	NSDA: Focus area: • Health system effectiveness NDOH Ten Point Plan for 2009 - 2014, priority 5: • Improve human resources Provincial strategic plan: • Increasing wellness
	1.3 Use the Expanded Public Works Programme (EPWP) to create employment opportunities linked to training in line with the Human Resource Plan.	*1.3.1 Expand community-based care services through the optimum training and development of home based carers as part of Expanded Public Works Programme (EPWP).* Expand community-based care services through the optimum training and development of home based carers as part of Expanded Public Works Programme (EPWP) to 2 200 per annum by 2014/15.	3) *Number of Home Community Based Carers (HCBCs) trained* 4) Intake of Home Community Based Carers (HCBCs)	1 840	*2 500* 2 200	To create additional community-based services capacity for step-down de-hospitalised care to service patients in the communities where they live and to facilitate access to employment for unemployed persons.	NSDA: Focus area: • Health system effectiveness NDOH Ten Point Plan for 2009 - 2014, priority 5: • Improve human resources Provincial strategic plan: • Increasing wellness

Strategic Goal statement	Strategic Objective Title	Strategic Objective Statement	Strategic objective indicator, baseline and target			Justification	Links
			Strategic objective indicator	2009/10 Baseline	2014/15 Target		
		1.3.2 Increase the number of data capturer interns required at health care facilities. Increase the number of data capturer interns required at health care facilities to 160 per annum by 2014/15.	5) *Number of data capturer interns* Intake of data capturer interns	192	160	To increase the critical mass of data capturers to address scarce skills.	
		1.3.3 Expand the number of pharmacist's assistant basic and post-basic learnerships to meet the health care needs. Expand the number of pharmacy assistant basic and post-basic learnerships to meet the needs of health care facilities to 130 per annum by 2014/15.	6) *Number of pharmacist's assistants in training* Intake of pharmacy assistants in training	40	*140* 130	To increase the critical mass of pharmacy assistants post-basic to address scarce skills.	
		1.3.4 Increase the number of Assistant to Artisans (ATAs) interns to address the maintenance of health care facilities. Increase the numbers of Assistant to Artisans (ATAs) interns to address the maintenance of health care facilities to 120 per annum by 2014/15.	7) *Number of Assistant to Artisans (ATAs) interns* Intake of Assistant to Artisans (ATAs) interns	147	120	To increase the critical mass of Assistant to Artisans (ATAs) to address the continuous maintenance requirements of health facilities.	
		1.3.5 Increase the number of human resource and finance interns. Increase the number of human resource and finance interns to 140 per annum by 2014/15.	8) *Number of HR and finance interns* Intake of HR and finance interns	0	140	HR and Finance functionaries are viewed as critical and scarce skills within the HR Plan.	

Table 6.2: REVISED Strategic objectives and expected outcomes for 2010 – 2015

Strategic Goal Statement	Strategic Objective Title	Strategic Objective Statement	Strategic objective indicator, baseline and target			Justification	Links
			Strategic objective indicator	2009/10 Baseline	2014/15 Target		
1. Develop and maintain a capacitated workforce to deliver the required health services.	1.1 Develop, implement, monitor and evaluate a comprehensive Training Plan guided by the Human Resource Plan for health and support professionals in line with the Comprehensive Service Plan (CSP).).	1.1.1 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)	299	600	Increase the critical mass of health science students to address scarce skills.	NSDA: Focus area: • Health system effectiveness NDOH Ten Point Plan for 2009 - 2014, priority 5: • Improve human resources Provincial strategic plan: • Increasing wellness
		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	250	150	Increase the number of competent EMC staff.	
	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 2 200 per annum by 2014/15.	3) Intake of Home Community Based Carers (HCBCs)	1 840	2 200	To create additional community-based services capacity for step-down de-hospitalised care to service patients in the communities where they live and to facilitate access to employment for unemployed persons.	NSDA: Focus area: • Health system effectiveness NDOH Ten Point Plan for 2009 - 2014, priority 5: • Improve human resources Provincial strategic plan: • Increasing wellness
		1.2.2. Increase the number of data capturer interns required at health care facilities to 160 per annum by 2014/15.	4) Intake of data capturer interns	192	160	To increase the critical mass of data capturers to address scarce skills.	
		1.2.3. Expand the number of pharmacy assistant basic and post-basic learnerships to meet the needs of health care facilities to 130 per annum by 2014/15.	5) Intake of pharmacy assistants in training	40	130	To increase the critical mass of pharmacy assistants post-basic to address scarce skills.	
		1.2.4. Increase the numbers of Assistant to Artisans (ATAs) interns to address the maintenance of health care facilities to 120 per annum by 2014/15.	6) Intake of Assistant to Artisans (ATAs) interns	147	120	To increase the critical mass of Assistant to Artisans (ATAs) to address the continuous maintenance requirements of health facilities.	
		1.2.5. Increase the number of human resource and finance interns to 140 per annum by 2014/15.	7) Intake of HR and finance interns	0	140	HR and Finance functionaries are viewed as critical and scarce skills within the HR Plan.	

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

SUB-PROGRAMME 7.1 LAUNDRY SERVICES

Table 7.1 below is reflected on page 113 of the Strategic Plan 2010 – 2014.

The strategic objectives that are being updated are highlighted in grey and in italic font. The revised Table 7.1 is subsequently reflected.

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

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Provide and maintain appropriate health technology and infrastructure.	1.1 Provide an effective and efficient laundry service to all hospitals.	1.1.1 Provide all health facilities with the quantity of clean disinfected linen required to deliver quality healthcare	1) Total number of pieces laundered	20.05m	20.5m	An uninterrupted supply of clean, disinfected linen is essential for the delivery of healthcare. Clean linen stocks at most hospitals will be depleted in 3 days if the laundry service were to fail.	NSDA: • Health system effectiveness. National Ten Point Plan Priority 6: Improve the quality of health services Departmental Strategic Goals: • Reduce and effectively manage the burden of disease. • Ensure and maintain organisational strategic management capacity and synergy. • Provide and maintain appropriate health technology and Infrastructure.
		1.1.2. Provide a laundry service using in-house laundries	2) Total number of pieces laundered: in-house	15m	15m	In-house laundries are provided in areas where private sector laundries are unable to supply a service. In addition in-house laundries are maintained to ensure that the State is not wholly dependent on the private sector.	
		1.1.3. Provide a laundry service using outsourced laundries in the private sector	3) Total number of pieces laundered: outsourced	5.5m	5.5m	Linen can be processed by the private sector at a lower cost than the in-house laundries. In many instances there is a considerable saving by out-sourcing laundry services to the private sector.	
		1.1.4. Provide cost effective in-house laundry service	4) Average cost per item laundered: in-house	R1.90	R4.90	The average cost per piece of in-house laundry services is monitored to ensure that the service is not unduly expensive when compared to the private sector.	
		1.1.5. Provide cost effective outsourced laundry service	5) Average cost per item laundered: outsourced	R1.70	R5.20	The average cost per piece of out-sourced laundry services is monitored to ensure that utilising the private sector leads to a real saving in laundry costs.	
1. Develop and maintain appropriate health technology, infra-structure 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 Numerator Denominator	R1.90 28 500 000 15 000 000	R5.90 90 098 900 15 271 000	The average cost per piece of in-house laundry services is monitored to ensure that the service is not unduly expensive when compared to the private sector.	

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

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Develop and maintain appropriate health technology, infra-structure 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 Numerator Denominator	R1.90 28 500 000 15 000 000	R5.90 90 098 900 15 271 000	The average cost per piece of in-house laundry services is monitored to ensure that the service is not unduly expensive when compared to the private sector.	NSDA: • Health system effectiveness. National Ten Point Plan Priority 6: Improve the quality of health services Departmental Strategic Goals: • Reduce and effectively manage the burden of disease. • Ensure and maintain organisational strategic management capacity and synergy. • Provide and maintain appropriate health technology and Infrastructure.

SUB-PROGRAMME 7.2 ENGINEERING SERVICES

Table 7.2 below is reflected on page 116 of the Strategic Plan 2010 – 2014.

The strategic objectives that are being updated are highlighted in grey and in italic font. The revised Table 7.2 is subsequently reflected.

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

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Provide and maintain appropriate health technology and infrastructure.	*1.1 Provide an effective and efficient maintenance service to all health facilities.*	*1.1.1 Provide effective maintenance on facilities, plant and equipment.*	*1) Number of maintenance jobs completed*	*13 000*	*13 500*	*The Department has physical assets with a replacement value estimated at R20 billion. Effective maintenance will maximise the lifespan of these assets, reduce breakdowns and ensure safety.*	*NSDA* • *Health system effectiveness.* *National Ten Point Plan Priority 6:* • *Improve the quality of health services* • *Revitalisation of infrastructure* *Departmental Strategic Goals:* • *Manage the burden of disease.* • *Provide and maintain appropriate health technology and Infrastructure.* • *Improve the quality of health services.*
		1.1.2 Provide preventative maintenance to critical equipment.	*2) Number of preventative maintenance jobs completed*	*2 200*	*2 100*	*Effective preventative maintenance will reduce breakdowns, promote safety and lengthen the lifespan of equipment.*	
		1.1.3 Provide repairs and renovation to DoH infrastructure.	*3) Number of repairs completed*	*10 800*	*11 400*	*An effective repair service will reduce the impact of breakdowns and deterioration of assets through age.*	
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 92% of all engineering emergency cases reported are attended to within 48 hours by 2014/15.	1) Percentage of engineering emergency cases attended to within 48 hours Numerator Denominator	New indicator	92% 164 178	It is essential to keep health facilities operational and emergency maintenance cases must be attended to within a maximum of 48 hours (not necessarily resolved) to ensure these facilitate remain fully functional.	NSDA: • Strengthening health system effectiveness. National Ten Point Plan Priority 6: Revitalisation of infrastructure Departmental Strategic Goals: • Address the burden of disease. • Improve the quality of health services and the patient experience • Ensure and maintain organisational strategic management capacity and synergy. • Develop and maintain a capacitated workforce to deliver the required health services. • Develop and maintain appropriate health technology
	1.2 Efficiency and effectiveness of Engineering Services.	1.1.2 Provide an effective and efficient maintenance service to all health facilities maintained by Engineering Services by 2014/15.	2) Percentage of maintenance budget spent Numerator Denominator	New indicator	100% 107 803 m 107 803 m	The Department needs to eradicate the maintenance backlog on buildings and equipment whilst ensuring that maintenance of newly built / upgraded facilities is also upheld. It is therefore essential that the maintenance budget is spent.	
			3) Percentage of clinical engineering maintenance jobs completed Numerator Denominator	New indicator	95% 13 744 14 431	Effective maintenance of clinical engineering equipment will maximise the lifespan of these assets, reduce breakdowns and ensure patient and staff safety.	

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
			4) Percentage of maintenance jobs (excluding clinical engineering jobs) completed	New indicator	95%	The Department has physical assets with a replacement value estimated at R20 billion. Effective maintenance will maximise the lifespan of these assets, reduce breakdowns and ensure patient and staff safety.	
			Numerator		13 186		
			Denominator		13 845		

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

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
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 92% of all engineering emergency cases reported are attended to within 48 hours by 2014/15.	1) Percentage of engineering emergency cases attended to within 48 hours	New indicator	92%	It is essential to keep health facilities operational and emergency maintenance cases must be attended to within a maximum of 48 hours (not necessarily resolved) to ensure these facilitate remain fully functional.	NSDA: • Strengthening health system effectiveness. National Ten Point Plan Priority 6: Revitalisation of infrastructure Departmental Strategic Goals: • Address the burden of disease. • Improve the quality of health services and the patient experience • Ensure and maintain organisational strategic management capacity and synergy. • Develop and maintain a capacitated workforce to deliver the required health services. • Develop and maintain appropriate health technology, infrastructure and ICT. • Optimal financial management to maximise health outcomes
			Numerator	-	164		
			Denominator	-	178		
	1.2 Efficiency and effectiveness of Engineering Services.	1.1.2 Provide an effective and efficient maintenance service to all health facilities maintained by Engineering Services by 2014/15.	2) Percentage of maintenance budget spent	New indicator	100%	The Department needs to eradicate the maintenance backlog on buildings and equipment whilst ensuring that maintenance of newly built / upgraded facilities is also upheld. It is therefore essential that the maintenance budget is spent.	
			Numerator	-	107 803 m		
			Denominator	-	107 803 m		
			3) Percentage of clinical engineering maintenance jobs completed	New indicator	95%	Effective maintenance of clinical engineering equipment will maximise the lifespan of these assets, reduce breakdowns and ensure patient and staff safety.	
			Numerator	-	13 744		
			Denominator	-	14 431		
			4) Percentage of maintenance jobs (excluding clinical engineering jobs) completed	New indicator	95%	The Department has physical assets with a replacement value estimated at R20 billion. Effective maintenance will maximise the lifespan of these assets, reduce breakdowns and ensure patient and staff safety.	
			Numerator	-	13 186		
			Denominator	-	13 845		

SUB-PROGRAMME 7.3 FORENSIC PATHOLOGY SERVICES

Table 7.4 below is reflected on page 122 of the Strategic Plan 2010 – 2014.

The strategic objectives that are being updated are highlighted in grey and in italic font. The revised Table 7.4 is subsequently reflected.

Table 7.3: Strategic objectives and outcomes for Forensic Pathology Services for 2010 – 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
1. Manage the consequences of the burden of disease. 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 average response times ≤ 40 minutes.*	*1) Average response time from dispatch to arrival of FPS on scene*	*37 minutes*	*≤ 40 minutes*	Management of response times is an indicator of the quality of service being rendered. This also measure equity, access and efficiency.	NSDA: • Health system effectiveness. National Ten Point Plan Priority 6: • Improve the quality of health services Provincial Strategic Plan: • Increasing wellness. Departmental Strategic Goals: • Manage the burden of disease. Batho Pele Principles
			Numerator	*-*	*392 000*		
			Denominator	*-*	*9 800*		
		Provide an efficient Forensic Pathology Service through maintenance of response times to achieve a response of 80% within the 40 minutes target by 2014/15.	Percentage of FPS cases responded to within 40 minutes	New indicator	80%		
			Numerator	-	7 399		
			Denominator	-	9 249		
		1.1.2 Provide an efficient Forensic Pathology Service through maintenance of turnaround time from admission to examination done ≤ 3.5 days.	*2) Average turnaround time from admission to examination done.*	*3.55 days*	*≤ 3.5 days*	The Forensic Pathology Service contributes to the development of a just society through the medico-legal investigation of death	
			Numerator	*-*	*33 600*		
			Denominator	*-*	*9 604*		
		Provide an efficient Forensic Pathology Service through ensuring 75% of FPS cases are examined within three days from admission 2014/15.	Percentage of cases examined within 3 days	New indicator	75%		
			Numerator	-	7 388		
			Denominator	-	9 851		
		1.1.3 Manage the turnaround time from admission to release of deceased (excluding unidentified persons) to below 5.5 days.	*3) Average turnaround time from admission to release of deceased (Excluding unidentified persons).*	*5.11 days*	*≤ 5.5 days*	*Management of the turnaround time from admission to release is an indicator of the quality of service being rendered. This also measure equity, access and efficiency as well as the contribution to the medico-legal investigation of death.*	
			Numerator	*-*	*46 464*		
			Denominator	*8 131*	*8 448*		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
		Manage the turnaround time from admission to release of deceased to within 5 days (excluding unidentified persons) to 75% by 2014/15.	Percentage of FPS cases released within 5 days (excluding unidentified persons) Numerator Denominator	New indicator - 8 131	75% 6 640 8 853		
2. Ensure and maintain organisational strategic management capacity and synergy.	2.1 Develop integrated support and management structures to render effective FPS.	*2.1.1 Develop integrated support and management structures to render effective FPS service* Improve the management of deceased of unknown identity by reducing the annual number to ≤ 90 by 2014/15.	4) Deceased with unknown identity exceeding 90 days	111	*≤125* 90	The Forensic Pathology Service contributes to the development of a just society through the medico-legal investigation of death Endeavour to protect the rights of all persons	

Table 7.3: REVISED Strategic objectives and outcomes for Forensic Pathology Services for 2010 – 2014

Strategic Goal statement	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
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 80% within the 40 minutes target by 2014/15.	1) Percentage of FPS cases responded to within 40 minutes Numerator Denominator	New indicator - -	80% 7 399 9 249	Management of response times is an indicator of the quality of service being rendered. This also measure equity, access and efficiency.	NSDA: • Health system effectiveness. National Ten Point Plan Priority 6: • Improve the quality of health services Provincial Strategic Plan: • Increasing wellness. Departmental Strategic Goals: • Manage the burden of disease. Batho Pele Principles
		1.1.2 Provide an efficient Forensic Pathology Service through ensuring 75% of FPS cases are examined within three days from admission 2014/15.	2) Percentage of cases examined within 3 days Numerator Denominator	New indicator - -	75% 7 388 9 851	The Forensic Pathology Service contributes to the development of a just society through the medico-legal investigation of death	
		1.1.3 Manage the turnaround time from admission to release of deceased to within 5 days (excluding unidentified persons) to 75% by 2014/15.	3) Percentage of FPS cases released within 5 days (excluding unidentified persons) Numerator Denominator	New indicator - 8 131	75% 6 640 8 853	Management of the turnaround time from admission to release is an indicator of the quality of service being rendered. This also measure equity, access and efficiency as well as the contribution to the medico-legal investigation of death.	
2. Ensure and maintain organisational strategic management capacity and synergy.	2.1 Develop integrated support and management structures to render effective FPS	2.1.1 Improve the management of deceased of unknown identity by reducing the annual number to ≤ 90 by 2014/15.	4) Deceased with unknown identity exceeding 90 days	111	90	The Forensic Pathology Service contributes to the development of a just society through the medico-legal investigation of death Endeavour to protect the rights of all persons	

SUB-PROGRAMME 7.5 MEDICINE TRADING ACCOUNT

Table 7.5 below is reflected on page 126 of the Strategic Plan 2010 – 2014 and is updated.

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

Strategic Goal	Strategic Goal Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification (Rationale)	Links (Expected Outcomes)
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Ensure and maintain organisational strategic management capacity and synergy.	1.1. To ensure adequate working capital to allow for efficient stockholding of pharmaceuticals and non-pharmaceuticals at the Cape Medical Depot.	*1.1.1. Increase working capital annually in line with projected inflator.* Increase working capital annually in line with the projected inflator with a target of R110 m by 2014/15.	1) Working capital in the medicine trading account	R58,3 m	*R84 m* R110 m	Maintain adequate stock to ensure service delivery.	MTSF: Focus area NSDA • Health system effectiveness. National Ten Point Plan Priority 6: • Improve the quality of health services Departmental Strategic Goals: • Manage the burden of disease.
	1.2. To ensure optimum pharmaceutical stock levels to meet the demand	1.2.1. Ensure pharmaceutical stock levels of 97% at the CMD by 2014/15.	2) Percentage of pharmaceutical stock available	New indicator	97%		
			Numerator	-	735		
			Denominator	-	758		

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

Strategic Goal	Strategic Goal Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification (Rationale)	Links (Expected Outcomes)
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Ensure and maintain organisational strategic management capacity and synergy.	1.1. To ensure adequate working capital to allow for efficient stockholding of pharmaceuticals and non-pharmaceuticals at the Cape Medical Depot.	1.1.1. Increase working capital annually in line with the projected inflator with a target of R110 m by 2014/15.	1) Working capital in the medicine trading account	R58,3 m	R110 m	Maintain adequate stock to ensure service delivery.	MTSF: Focus area NSDA • Health system effectiveness. National Ten Point Plan Priority 6: • Improve the quality of health services Departmental Strategic Goals: • Manage the burden of disease.
	1.2. To ensure optimum pharmaceutical stock levels to meet the demand	1.2.1. Ensure pharmaceutical stock levels of 97% at the CMD by 2014/15.	2) Percentage of pharmaceutical stock available	New indicator	97%		
			Numerator	-	735		
			Denominator	-	758		

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Table 8.1 below is reflected on page 131 of the Strategic Plan 2010 – 2014.

The strategic objectives that are being updated are highlighted in grey and in italic font. The revised Table 8.1 is subsequently reflected.

Table 8.1: Strategic objectives and outcomes for 2010 - 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
1. Provide and maintain appropriate health technology and infrastructure.	*1.1 Construct and commission new health care facilities and upgrade facilities to ensure access to the integrated comprehensive health care platform.*	*1.1.1. Allocate 6% of the total health budget to Programme 8 capital funding by 2014/15*	*1) Programme 8 capital funding as a percentage of total health expenditure*	*6%*	*6%*	*The Programme 8 capital budget provides funding to construct new facilities and to substantially upgrade existing facilities.*	*NDSA: Strengthening health system effectiveness*
			Numerator	*R599m*	*R800*	*Quality healthcare requires facilities that are fit for purpose and many of the existing facilities do not meet this criterium.*	*• Improved physical infrastructure for healthcare delivery,*
			Denominator	*R9 893m*	*R13 200*		*National Ten Point Plan Priority 6:*
							• Revitalisation of Infrastructure
							Provincial priority:
							• Increasing wellness
							Departmental Strategic Goals:
							• Manage the burden of disease.
							• Provide and maintain appropriate health technology and Infrastructure
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 preventative maintenance (Equitable Share) budget spent	New indicator	100%	It is essential that preventative maintenance is undertaken to reduce the incidence and need for day-to-day maintenance and to extend the lifespan of assets.	NSDA:
			Numerator	-	21 570 m		• Strengthening health system effectiveness.
			Denominator	-	21 570 m		National Ten Point Plan Priority 6:
			2) Percentage of scheduled maintenance (Equitable Share) budget spent	New indicator	100%	Scheduled maintenance must be undertaken to ensure that health facilities can function optimally.	Revitalisation of infrastructure
			Numerator	-	163 724 m		Departmental Strategic Goals:
			Denominator	-	163 724 m		• Address the burden of disease.
			3) Percentage of Health Infrastructure Grant (HIG) budget spent	New indicator	100%	HIG funding is utilised to construct new health facilities, upgrade and extend existing health facilities.	• Improve the quality of health services and the patient experience
			Numerator	-	150 171 m	Quality healthcare requires facilities that are fit for purpose and many of the existing facilities do not meet this criterion.	• Ensure and maintain organisational strategic management capacity and synergy.
			Denominator	-	150 171 m		• Develop and maintain a capacitated workforce to deliver the required health services.
							• Develop and maintain appropriate health technology, infrastructure and ICT.
							• Optimal financial management to maximise health outcomes

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	**Baseline 2009/10**	**Target 2014/15**		
			4) Percentage of Hospital Revitalisation Grant (HRG) budget spent	New indicator	100%	The HRG funding is utilised to build new health facilities and to revitalise existing facilities.	
			Numerator	-	511 079 m	Quality healthcare requires facilities that are fit for purpose and many of the existing facilities do not meet this criterion.	
			Denominator	-	511 079 m		
			5) Percentage Equitable Share capital budget spent	New indicator	100%	This funding is utilised to improve the health infrastructure of the Department. In the light of the current condition of many of the health facilities it is essential to upgrade these to be fit for purpose.	
			Numerator	-	88 860 m		
			Denominator	-	88 860 m		
	1.2 Effective and efficient management of infrastructure delivery.	1.1.2. Ensure 100 per cent achievement of projects planned for completion annually.	6) Percentage of capital projects completed	New indicator	100%		
			Numerator	-	12		
			Denominator	-	12		

Table 8.2: REVISED Strategic objectives and outcomes for 2010 - 2014

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Strategic objective performance indicator, baseline and target			Justification	Links
			Strategic objective performance indicator	Baseline 2009/10	Target 2014/15		
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 preventative maintenance (Equitable Share) budget spent	New indicator	100%	It is essential that preventative maintenance is undertaken to reduce the incidence and need for day-to-day maintenance and to extend the lifespan of assets.	NSDA: • Strengthening health system effectiveness. National Ten Point Plan Priority 6: Revitalisation of infrastructure Departmental Strategic Goals: • Address the burden of disease. • Improve the quality of health services and the patient experience • Ensure and maintain organisational strategic management capacity and synergy. • Develop and maintain a capacitated workforce to deliver the required health services. • Develop and maintain appropriate health technology, infrastructure and ICT. • Optimal financial management to maximise health outcomes
			Numerator	-	21 570 m		
			Denominator	-	21 570 m		
			2) Percentage of scheduled maintenance (Equitable Share) budget spent	New indicator	100%	Scheduled maintenance must be undertaken to ensure that health facilities can function optimally.	
			Numerator	-	163 724 m		
			Denominator	-	163 724 m		
			3) Percentage of Health Infrastructure Grant (HIG) budget spent	New indicator	100%	The HIG funding is utilised to construct new health facilities, upgrade and extend existing health facilities. Quality healthcare requires facilities that are fit for purpose and many of the existing facilities do not meet this criterion.	
			Numerator	-	150 171 m		
			Denominator	-	150 171 m		
			4) Percentage of Hospital Revitalisation Grant (HRG) budget spent	New indicator	100%	The HRG funding is utilised to build new health facilities and to revitalise existing facilities. Quality healthcare requires facilities that are fit for purpose and many of the existing facilities do not meet this criterion.	
			Numerator	-	511 079 m		
			Denominator	-	511 079 m		
			5) Percentage Equitable Share capital budget spent	New indicator	100%	This funding is utilised to improve the health infrastructure of the Department. In the light of the current condition of many of the health facilities it is essential to upgrade these to be fit for purpose.	
			Numerator	-	88 860 m		
			Denominator	-	88 860 m		
	1.2 Effective and efficient management of infrastructure delivery.	1.1.2. Ensure 100 per cent achievement of projects planned for completion annually.	6) Percentage of capital projects completed	New indicator	100%		
			Numerator	-	12		
			Denominator	-	12		

ANNEXURE B
INDICATOR DEFINITIONS

PROGRAMME 1: ADMINISTRATION

HUMAN RESOUCES: TABLE ADMIN 1

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Medical officers per 100 000 people	Filled medical officer posts on the last day of the reporting period per 100 000 people.	Tracks the number of filled medical officer posts as part of monitoring the availability of human resources for Health.	Numerator: Personnel records Denominator: Population data	Numerator: PERSAL Denominator: StatsSA	Numerator: Filled medical officer posts at the end of the reporting period Denominator: Total population	100 000	Dependant on accuracy of PERSAL system and estimated total population from StatsSA.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of medical officers contributes to improving the access to and the quality of clinical care.	Director: Human Resource Management
2) Medical officers per 100 000 people in rural districts	Filled medical officer posts in rural districts on the last day of the reporting per 100 000 people.	Tracks the number of filled medical officer posts in the rural districts as part of monitoring the availability of human resources for Health in rural districts. This indicator also assists in assessing urban / rural equity.	Numerator: Personnel records Denominator: Population data	Numerator: PERSAL Denominator: StatsSA	Numerator: Filled medical officer posts in rural districts at the end of the reporting period Denominator: Population in rural districts	100 000	Dependant on accuracy of PERSAL system and estimated population in rural districts from StatsSA.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of medical officers in rural districts contributes to improving the access to and the quality of clinical care in rural districts.	Director: Human Resource Management
3) Professional nurses per 100 000 people	Filled professional nurse posts on the last day of the reporting period per 100 000 people.	Tracks the number of filled professional nurse posts as part of monitoring the availability of human resources for Health.	Numerator: Personnel records Denominator: Population data	Numerator: PERSAL Denominator: StatsSA	Numerator: Filled professional nurse posts at the end of the reporting period Denominator: Total population	100 000	Dependant on accuracy of PERSAL system and estimated total population from StatsSA.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of professional nurses contributes to improving the access to and the quality of health services.	Director: Human Resource Management
4) Professional nurses per 100 000 people in rural districts	Filled professional nurse posts in rural districts on the last day of the reporting period per 100 000 people.	Tracks the number of filled professional nurse posts in rural districts as part of monitoring the availability of human resources for Health in rural districts. This indicator also assists in assessing urban / rural equity.	Numerator: Personnel records Denominator: Population data	Numerator: PERSAL Denominator: StatsSA	Numerator: Filled professional nurse posts in rural districts at the end of the reporting period Denominator: Population in rural districts	100 000	Dependant on accuracy of PERSAL system and estimated population in rural districts from StatsSA.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of professional nurses in rural districts contributes to improving the access to and the quality of health services in rural districts.	Director: Human Resource Management

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Pharmacists per 100 000 people	Filled pharmacist posts on the last day of the reporting period per 100 000 people.	Tracks the number of filled pharmacists posts to monitor the availability of human resources for Health.	Numerator: Personnel records Denominator: Population data	Numerator: PERSAL Denominator: StatsSA	Numerator: Filled pharmacist posts at the end of the reporting period Denominator: Total population	100 000	Dependant on accuracy of PERSAL system and estimated total population from StatsSA.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of pharmacists lead to better quality of care.	Director:-Human Resource Management
6) Pharmacists per 100 000 people in rural districts	Filled pharmacist posts in rural districts on the last day of the reporting period per 100 000 people.	Tracks the number of filled pharmacist posts in rural districts, as part of monitoring the availability of human resources for Health in rural districts. This indicator also assists in assessing urban /rural equity.	Numerator: Personnel records Denominator: Population data	Numerator: PERSAL Denominator: StatsSA	Numerator: Filled pharmacist posts in rural districts at the end of the reporting period Denominator: Population in rural districts	100 000	Dependant on accuracy of PERSAL system and estimated population in rural districts from StatsSA.	Input	Ratio per 100 000 population	Annual	No	Increase in the number of pharmacists lead to better quality of care in rural districts.	Director:-Human Resource Management
7) Vacancy rate for professional nurses	Percentage of vacant funded professional nurse posts on the last day of the reporting period.	Tracks the number of vacant funded professional nurses posts to monitor availability of human resources.	Numerator: Personnel record Denominator: Personnel records	Numerator: PERSAL Denominator: PERSAL	Numerator: Vacant funded professional nurse posts at the end of the reporting period Denominator: Funded professional nurse posts on staff establishment	100 (%)	Dependant on accuracy of PERSAL system.	Process	Percentage	Quarterly	No	Decrease in the vacancy rate implies an increase in the number of professional nurses, which lead to better quality of care.	Director:-Human Resource Management
8) Vacancy rate for doctors	Percentage of vacant funded doctor (medical officer) posts on last day of the reporting period.	Tracks the number of vacant funded doctor (medical officer) posts to monitor availability of human resources.	Numerator: Personnel records Denominator: Personnel records	Numerator: PERSAL Denominator: PERSAL	Numerator: Vacant funded doctor (medical officer) posts at the end of the reporting period Denominator: Funded doctor (medical officer) posts on staff establishment	100 (%)	Dependant on accuracy of PERSAL system.	Process	Percentage	Quarterly	No	Decrease in the vacancy rate implies an increase in the number of doctors (medical officers), which lead to better quality of care.	Director:-Human Resource Management

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
9) Vacancy rate for medical specialists	Percentage of vacant funded medical specialist posts on last day of the reporting period	Tracks the number of vacant funded medical specialists posts to monitor availability of human resources.	Numerator: Personnel records Denominator: Personnel records	Numerator: PERSAL Denominator: PERSAL	Numerator: Vacant funded medical specialists posts at the end of the reporting period Denominator: Funded medical specialist posts on staff establishment	100 (%)	Dependant on accuracy of PERSAL system.	Process	Percentage	Quarterly	No	Decrease in the vacancy rate implies an increase in the number of medical specialists, which lead to better quality of care.	Director:-Human Resource Management
10) Vacancy rate for pharmacists	Percentage of vacant funded pharmacist posts on last day of the reporting period.	Tracks the number of vacant funded pharmacist posts to monitor availability of human resources.	Numerator: Personnel records Denominator: Personnel records	Numerator: PERSAL Denominator: PERSAL	Numerator: Vacant funded pharmacist posts at the end of the reporting period Denominator: Funded pharmacist posts on staff establishment	100 (%)	Dependant on accuracy of PERSAL system.	Process	Percentage	Quarterly	No	Decrease in the vacancy rate implies an increase in the number of pharmacists, which lead to better quality of care.	Director:-Human Resource Management

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

ADMINISTRATION: TABLE ADMIN 2

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Percentage expenditure of the annual equitable share budget allocation	Percentage of the allocated equitable share annual budget that was spent by the Department. During the quarters, use the projected annual expenditure versus the annual budget.	Ensure the under- / over-spending of the equitable share is within 1% of the budget allocation.	Numerator: Expenditure reports Denominator: Annual allocated budget	Numerator: BAS Denominator: BAS	Numerator: Annual expenditure on equitable share budget (Quarterly, use projected annual expenditure on the equitable share budget) Denominator: Total BAS annual equitable share budget allocation.	100 (%)	Dependant on accurate expenditure information on the equitable share budget. (Quarterly dependant on realistic projected expenditure.)	Output	Percentage	Annually	No	The over- / under-spending of the annual equitable share do not exceed 1% of the budget allocation.	Chief Financial Officer (CFO)
2) Amended Human Resource Plan submitted timeously to DPSA	The amended Human Resource Plan is submitted to the Department of Public Service and Administration (DPSA) by 30 September.	Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.	Submission of the amended Human Resource Plan	Submission of the amended Human Resource Plan	Amended Human Resource Plan submitted timeously to DPSA	Yes / No	Dependent on the HR planning data being submitted by role-players. Dependant on accuracy of PERSAL data.	Input	Compliance	Annually	No	Adherence to the annual due date for the submission of the plan to the Department of Public Service and Administration.	Director: Human Resource Management

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

PROGRAMME 2: DISTRICT HEALTH SERVICES

DISTRICT HEALTH SERVICES: TABLES DHS 3, DHS 4&5 AND DHS 6

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Utilisation rate - PHC	Rate at which services are utilised by the target population, represented as the average number of visits per person during the reporting period in the target population.	Tracks the uptake of primary health care (PHC) services at PHC facilities for the purposes of allocating staff and other resources.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: PHC total headcount Denominator: Total population	None (no)	Dependant on the accuracy of PHC patient records kept at facility level. Dependant on the accuracy of the estimated total population from StatsSA.	Output	Rate (annualised)	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease or greater reliance on the public health system.	District Health Services (DHS) Programme Manager
2) PHC total headcount	Number of PHC patients seen during the reporting period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen. Include the headcount for both provincial and local government PHC facilities.	Tracks the uptake of primary health care (PHC) services at PHC facilities for the purposes of allocating staff and other resources.	Routine Monthly Report	SINJANI	PHC total headcount	None (no)	Dependant on the accuracy of PHC patient records kept at facility level.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	DHS Programme Manager
3) Utilisation rate - PHC under 5 years	Rate at which services are utilised by the target population under 5 years, represented as the average number of visits per person under 5 years per period in the target population under 5 years.	Tracks the uptake of children under 5 years in primary health care (PHC) services at PHC facilities for the purposes of allocating staff and other resources.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: PHC headcount under 5 years Denominator: Population under 5 years	None (no)	Dependant on the reliability of PHC patient records kept at facility level. Dependant on the accuracy of estimated population under 5 years from StatsSA.	Output	Rate (annualised)	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease amongst children or greater reliance on the public health system.	DHS Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
4) PHC total headcount - under 5 years	Number of PHC patients under the age of 5 years seen during the reporting period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen. Include the headcount for both provincial and local government PHC facilities.	Tracks the uptake of children under 5 years in primary health care (PHC) services at PHC facilities for the purposes of allocating staff and other resources.	Routine Monthly Report	SINJANI	PHC headcount under 5 years	None (no)	Dependant on the reliability of PHC patient records kept at facility level.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease amongst children or greater reliance on the public health system.	DHS Programme Manager
5) Fixed PHC facilities with a monthly supervisory visit rate	Percentage of fixed PHC facilities that were visited by a supervisor at least once every month (official supervisor report completed). A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Tracks the supervision rate of all PHC facilities.	Numerator: Routine Monthly Report Denominator: Facility list	Numerator: SINJANI Denominator: Facility list	Numerator: Supervisor visit this month (fixed facilities only) ÷ number of months in the reporting period Denominator: Fixed PHC facilities	100 (%)	Dependant on accuracy of data from reporting facilities and in particular the purpose of the visit by the supervisor.	Quality	Percentage	Quarterly	No	Higher levels indicate better support to PHC facilities.	District Health Services Manager
6) Percentage of CHCs and CDCs with a resident doctor	Percentage of community health centres (CHCs) and community day centres (CDCs) that are supported by at least one resident doctor. A resident doctor is a doctor that is on the staff establishment of the CHC or CDC.	Tracks the national norms of the PHC package.	Numerator: Routine Monthly Report Denominator: Facility list	Numerator: SINJANI Denominator: Facility list	Numerator: CHCs and CDCs with a resident doctor Denominator: Number of CHCs and CDCs	100 (%)	Dependant on accuracy of data from reporting facilities.	Input	Percentage	Quarterly	No	Higher percentage indicates better compliance to the national norms.	DHS Programme Manager
7) Number of NPO appointed home carers	The number of home carers (i.e. caregivers) appointed by non-profit organisations (NPOs) funded by the Department of Health.	Tracks the provision of home-based care for prioritised clients in need of care.	CHBC NPO Monthly Staff Expenditure claim	NPO home community care worker database	NPO appointed home carers	None (no)	Accuracy is dependant on the records maintained by non-profit organisations.	Input	Cumulative	Quarterly	No	Higher number indicates greater capacity to render home-based care services.	CBS Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
8) Provincial expenditure per PHC headcount	Expenditure per primary health care (PHC) headcount by the provincial Department of Health (DoH) at provincial PHC facilities.	Tracks the cost to the provincial DoH for every headcount seen at provincial PHC facilities.	Numerator: Financial data Denominator: Routine Monthly Report	Numerator: BAS Denominator: SINJANI	Numerator: Expenditure on PHC by provincial DoH at PHC facilities (Sub-programmes 2.1, 2.2, 2.3, 2.4 and 2.5) Denominator: PHC total headcount	None (no)	Dependant on accuracy of expenditure allocation. Dependant on accuracy of data from reporting facilities.	Efficiency	Rate	Quarterly	No	Lower expenditure could indicate efficient use of financial resources or incomplete provision of the comprehensive PHC package.	DHS Programme Manager
9) Provincial PHC expenditure per uninsured person	Expenditure on primary health care (PHC) by the provincial Department of Health (DoH) per uninsured population.	To monitor adequacy of funding levels for PHC services.	Numerator: Financial data Denominator: Population data	Numerator: BAS Denominator: StatsSA	Numerator: Provincial expenditure on PHC services (Sub-programmes 2.1, 2.2, 2.3, 2.4 and 2.5) Denominator: Uninsured population in the province	None (no)	Dependant on accuracy of expenditure allocation. Dependant on the accuracy of the estimated total population from StatsSA.	Input	Rate (annualised)	Quarterly	No	Higher levels of expenditure reflect prioritisation of PHC services.	DHS Programme Manager
10) Percentage of complaints of users of PHC services resolved within 25 days	Percentage of complaints of users of primary health care services resolved within 25 days.	To monitor the management of complaints in primary health care services.	Numerator: Complaints and Compliments Register Denominator: Complaints and Compliments Register	Numerator: SINJANI Denominator: SINJANI	Numerator: Complaints resolved within 25 days in PHC facilities Denominator: Complaints lodged in PHC facilities	100 (%)	Dependant on accuracy of data, in particular the time stamp for each complaint, from reporting facilities.	Quality	Percentage	Quarterly	No	Higher percentage suggests better management of complaints in PHC facilities.	DHS Programme Manager
11) Number of PHC facilities assessed for compliance against the core standards	Percentage of PHC facilities assessed for compliance against the 6 priority areas of the core standards for quality assurance.	Tracks the levels of compliance against the 6 priority areas of the core standards for quality assurance.	Routine Monthly Report	SINJANI	PHC facilities that conducted a national core standards self-assessment	None (no)	Implementation plan and assessment tool to be provided by National Department of Health.	Process	Sum for period under review	Annual	No	Higher number indicates better compliance with the core standards in PHC facilities.	DHS Programme Manager

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

DISTRICT HOSPITALS: TABLES DHS 7, DHS 7&8 AND DHS 9

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of district hospital beds	Actual (usable) beds in district hospitals are beds actually available for use within the district hospital, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of district hospital beds to ensure accessibility of district hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds in district hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Actual (usable) beds should remain constant and should be operated within affordability limits while providing access for patients to clinical services.	District Health Services (DHS) Programme Manager
2) Caesarean section rate in district hospitals	Caesarean section deliveries in district hospitals expressed as a percentage of all deliveries in district hospitals.	Tracks the performance of obstetric care at district hospitals.	Numerator: Outpatient and Inpatient Related Services Denominator: Outpatient and Inpatient Related Services	Numerator: SINJANI Denominator: SINJANI	Numerator: Caesarean sections in district hospitals Denominator: Deliveries in district hospitals	100 (%)	Dependant on accuracy of data from reporting facilities.	Output	Percentage	Quarterly	No	Lower percentage desired. Higher percentage of caesarean sections indicates higher burden of disease, and/or poorer quality of antenatal care.	DHS Programme Manager
3) Total separations in district hospitals	Recorded completion of treatment and/or the accommodation of an inpatient in district hospitals. Separations include day patients and inpatients who were discharged, transferred out to other hospitals or who died.	Monitoring the service volumes in district hospitals.	Inpatient Throughput Form	SINJANI	Sum of: • Day patients • Inpatient deaths • Inpatient discharges • Inpatient transfers out in district hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	DHS Programme Manager
4) Patient day equivalents (PDE) in district hospitals	Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Monitoring the service volumes in district hospitals.	Inpatient Throughput Form Outpatient and Inpatient Related Services	SINJANI SINJANI	Sum of: • Inpatient days • 1/2 day patients • 1/3 OPD headcount • 1/3 emergency headcount in district hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	DHS Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) OPD total headcounts in district hospitals	A headcount of all outpatients attending an outpatient clinic in district hospitals.	Monitoring the service volumes in district hospitals.	Outpatient and Inpatient Related Services	SINJANI	Sum of: • OPD new case not referred • OPD new case referred • OPD follow-up in district hospitals OR Sum of: • OPD general • OPD specialist in district hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	DHS Programme Manager
6) Average length of stay in district hospitals	Average number of patient days that an admitted patient spends in district hospitals before separation.	To monitor the efficiency of district hospitals.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in district hospitals Denominator: Total separations in district hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might hide poor quality of hospital care.	DHS Programme Manager
7) Bed utilisation rate (based on usable beds) in district hospitals	Patient days in district hospitals during the reporting period, expressed as a percentage of the sum of the daily number of actual (usable) beds in district hospitals.	Track the over / under utilisation of district hospital beds.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in district hospitals Denominator: Number of actual (usable) bed days in district hospitals (Actual (usable) beds x number of days in the reporting period)	100 (%)	Dependant on accuracy of data from reporting facilities.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	DHS Programme Manager
8) Expenditure per patient day equivalent (PDE) in district hospitals	Average cost per patient day equivalent in district hospitals. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in district hospitals.	Numerator: Financial data Denominator: Inpatient Throughput Form Outpatient and Inpatient Related Services	Numerator: BAS Denominator: SINJANI	Numerator: Total expenditure in district hospitals (sub-programme 2.9) Denominator: Patient day equivalent (PDE) in district hospitals	None (no)	Accuracy of expenditure dependant on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facilities.	Efficiency	Rate	Quarterly	No	Lower rate indicates efficient use of financial resources.	DHS Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
9) Percentage of complaints of users of district hospital services resolved within 25 days	Percentage of complaints of users of district hospital services resolved within 25 days.	To monitor the management of complaints in district hospitals.	Numerator: Complaints and Compliments Register Denominator: Complaints and Compliments Register	Numerator: SINJANI Denominator: SINJANI	Numerator: Complaints resolved within 25 days in district hospitals Denominator: Complaints lodged in district hospitals	100 (%)	Dependant on accuracy of data, in particular the time stamp for each complaint, from reporting facilities.	Quality	Percentage	Quarterly	No	Higher percentage suggests better management of complaints in district hospitals.	DHS Programme Manager
10) Percentage of district hospitals with monthly mortality and morbidity meetings	Percentage of district hospitals having mortality and morbidity (M&M) meetings every month (3 per quarter, 12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases adverse events (morbidity) and proportion of deaths (mortality).	Numerator: Hospital Semi-permanent Data version 2 Denominator: Facility list	Numerator: SINJANI Denominator: Facility list	Numerator: District hospitals with M&M meetings every month Denominator: District hospitals	100 (%)	Dependant on accuracy of data from reporting facilities.	Quality	Percentage	Quarterly	No	Higher number suggests better clinical governance.	DHS Programme Manager
11) District hospital patient satisfaction rate	Percentage of users that participated in the district hospital client satisfaction survey that were satisfied with the services. The question "I was pleased with the way I was treated" in the general satisfaction domain will be used to assess the client's overall satisfaction.	Tracks the service satisfaction of district hospital users.	Numerator: Client satisfaction survey Denominator: Client satisfaction survey	Numerator: SINJANI Denominator: SINJANI	Numerator: Number of questionnaires with 1 or 2 recorded for pleased with treatment Denominator: Number of questionnaires for pleased with treatment	100 (%)	Ability to generalise results dependant on the number of users participating in the survey.	Quality	Percentage	Annual	No	Higher percentage indicates better levels of satisfaction in district hospital services.	DHS Programme Manager
12) Number of district hospitals assessed for compliance against the 6 priorities of the core standards	Percentage of district hospitals assessed for compliance against the 6 priority areas of the core standards for quality assurance.	Tracks the levels of compliance against the 6 priority areas of the core standards for quality assurance.	Hospital Semi-permanent Data version 2	SINJANI	District hospitals that conducted a national core standards self-assessment	None (no)	Implementation plan and assessment tool to be provided by National Department of Health.	Quality	Sum for period under review	Annual	No	Higher number indicates better compliance with the drive to assess district hospitals against the 6 priority areas of the core standards.	DHS Programme Manager

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

HIV AND AIDS, TB AND STI CONTROL: TABLES HIV 1, HIV 2&3 AND HIV 4

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) HIV prevalence in women aged 15 – 24 years	The percentage of HIV positive antenatal women aged 15 - 24 years in the province tested during the national component of the annual antenatal HIV and syphilis survey.	To determine the HIV prevalence and the success of prevention programmes at halting and/or reversing the number of new cases.	Numerator: Annual Antenatal HIV and Syphilis Survey Denominator: Annual Antenatal HIV and Syphilis Survey	Numerator: Annual Antenatal HIV and Syphilis Survey results Denominator: Annual Antenatal HIV and Syphilis Survey results	Numerator: HIV positive women aged 15 - 24 years Denominator: Women aged 15-24 years tested for HIV	100 (%)	Insufficient specimen collection from 15-24 age group, incomplete data completion of forms, analysis of results.	Outcome	Percentage	Annual	No	Used to monitor and evaluate impact of prevention programmes.	HIV and AIDS Programme Manager
2) Total number of patients (children and adults) on ART	Number of patients on an antiretroviral (ARV) regimen.	Track the number of patients receiving ARV treatment.	ART register	PGWC HIV DB.mdb	Cumulative number of patients (children and adults) on an ARV regimen	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Higher total indicates a larger population on ART treatment.	HIV and AIDS Programme Manager
3) Male condom distribution rate	Number of male condoms distributed to clients by the facility per male population 15 years and over.	Track the contraceptive measures.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: Male condoms distributed Denominator: Male population 15 years and over	None (no)	Dependant on accuracy of data from reporting facilities. Dependant on the accuracy of the estimated total population from StatsSA.	Process	Rate (annualised)	Quarterly	No	Higher rate indicates better contraceptive measures which should lead to a decrease in HIV and AIDS incidence.	HIV and AIDS Programme Manager
4) New smear positive PTB defaulter rate	Percentage of new smear positive pulmonary tuberculosis (PTB) cases who interrupt (default) their TB treatment.	Monitor the percentage of patients who interrupt their TB treatment which impacts directly on the TB cure rate.	Numerator: TB register Denominator: TB register	Numerator: ETR.net Denominator: ETR.net	Numerator: New smear positive PTB cases who defaulted Denominator: New smear positive PTB cases registered (outcomes)	100 (%)	Dependant on accuracy of data from reporting facilities.	Output	Percentage	Quarterly	No	Lower levels of interruption reflect improved case holding which is important for facilitating successful TB treatment.	TB Programme Manager
5) HCT testing rate	The percentage of clients who received pre-test counselling and were consequently tested for HIV. Antenatal clients are included.	Monitors HIV Counselling and Testing (HCT) i.e. the number of people who agreed to undergo HIV testing.	Numerator: HIV Counselling and Testing Register Denominator: HIV Counselling and Testing Register	Numerator: SINJANI Denominator: SINJANI	Numerator: HCT clients (including antenatal clients) tested for HIV Denominator: HCT clients (including antenatal clients) pre-test counselled	100 (%)	Dependant on accuracy of data from reporting facilities.	Process	Percentage	Quarterly	No	Higher percentage indicates increased population knowing their HIV status.	HIV and AIDS Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
6) Percentage of HIV-TB co-infected patients placed on ART	Percentage of HIV and TB co-infected patients receiving ante-retroviral treatment (ART).	Monitors the coverage of ART among the HIV and TB co-infected population.	Numerator: TB register Denominator: TB register	Numerator: ETR.net Denominator: ETR.net	Numerator: Total number of HIV and TB co-infected people receiving ART Denominator: Total number of co-infected people with a CD4 count of 350 or less	100 (%)	Dependant on the accuracy of the Electronic TB Register.	Output	Percentage	Quarterly	No	Higher percentage indicates better coverage of HIV and TB co-infected patients.	TB Programme Manager
7) New smear positive PTB cure rate	Percentage of new smear positive PTB cases cured at first attempt.	Monitors the TB cure rate.	Numerator: TB register Denominator: TB register	Numerator: ETR.net Denominator: ETR.net	Numerator: New smear positive PTB cases cured Denominator: New smear positive PTB cases registered (outcomes)	100 (%)	Dependant on accuracy of data from reporting facilities.	Outcome	Percentage	Quarterly	No	Higher percentage indicates better cure rate.	TB Programme Manager
8) PTB two month smear conversion rate	The percentage of new smear positive PTB clients who converted to smear negative after being on treatment for 2 months.	Tracks the mortality and morbidity due to TB and the routine sputum collection in all TB patients at 2 months.	Numerator: TB register Denominator: TB register	Numerator: ETR.net Denominator: ETR.net	Numerator: New smear positive PTB clients who converted at 2 months Denominator: New smear positive PTB smear conversion clients registered (previous cohort)	100 (%)	Dependant on accuracy of data from reporting facilities.	Outcome	Percentage	Quarterly	No	Higher smear conversion rates will lead to better TB cure rate.	TB Programme Manager

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

MATERNAL, CHILD AND WOMEN'S HEALTH & NUTRITION: TABLES MCWH 1, MCWH 2&3 AND MCWH 4

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Immunisation coverage under 1 year	Percentage of all children under one year who complete their primary course of immunisation during the reporting period. A primary course includes BCG, OPV 0 & 1, DTaP-IPV-Hib 1, 2 & 3, HepB 1, 2 & 3, and 1st measles at 9 month.	Monitors the implementation of the Extended Programme on Immunisation (EPI).	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: Immunised fully under 1 year Denominator: Population under 1 year	100 (%)	Dependant on accuracy of data from reporting facilities. Dependant on the accuracy of the estimated total population from StatsSA.	Output	Percentage (annualised)	Quarterly	No	Higher percentage indicates better immunisation coverage.	Expanded Programme on Immunisation (EPI) Programme Manager
2) Vitamin A coverage 12 – 59 months	Percentage of children aged 12 – 59 months who received 200 000 units Vitamin A twice a year. (The denominator is therefore the target population 1 - 4 years multiplied by 2.)	Monitors the Vitamin A coverage of children aged 12 – 59 months.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: Vitamin A supplement to 12 – 59 months child Denominator: Population 1 – 4 years X 2	100 (%)	Dependant on accuracy of data from reporting facilities. Dependant on the accuracy of the estimated total population from StatsSA.	Output	Percentage (annualised)	Quarterly	No	Higher percentage indicates better Vitamin A coverage, and better nutritional support to children.	Nutrition Programme Manager
3) Pneumococcal vaccine (PCV) 3rd dose coverage	Percentage of children under 1 year who received the Pneumococcal Conjugated Vaccine (PCV) 3st dose at the age of 14 weeks.	Monitors PCV coverage.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: PCV 3rd dose Denominator: Population under 1 year	100 (%)	Dependant on accuracy of data from reporting facilities. Dependant on the accuracy of the estimated total population from StatsSA.	Output	Percentage (annualised)	Quarterly	No	Higher percentage indicates better pneumococcal coverage.	EPI Programme Manager
4) Rotavirus (RV) 2nd dose coverage	Percentage of children under 1 year who received the rotavirus (RV) vaccine 2nd dose at the age of 14 weeks.	Monitors rotavirus vaccine coverage.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: Rotavirus vaccine (RV) 2nd dose Denominator: Population under 1 year	100 (%)	Dependant on accuracy of data from reporting facilities. Dependant on the accuracy of the estimated total population from StatsSA.	Output	Percentage (annualised)	Quarterly	No	Higher percentage indicates better rotavirus vaccine coverage.	EPI Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Measles 1st dose under 1 year coverage	Percentage of children under 1 year who received their first measles vaccine at the age of 9 months.	Monitors measles vaccine coverage.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: Measles 1st dose under 1 year Denominator: Population under 1 year	100 (%)	Dependant on accuracy of data from reporting facilities. Dependant on the accuracy of the estimated total population from StatsSA.	Output	Percentage (annualised)	Quarterly	No	Higher percentage indicates better measles vaccine coverage.	EPI Programme Manager
6) Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	The proportion of babies on the prevention of mother-to-child transmission (PMTCT) programme who tested HIV positive at 6 weeks.	Tracks mother-to-child transmission rate of HIV.	Numerator: PMTCT Baby Follow-up Register Denominator: PMTCT Baby Follow-up Register	Numerator: SINJANI Denominator: SINJANI	Numerator: PMTCT baby PCR test positive at 6 weeks Denominator: PMTCT baby PCR test around 6 weeks	100 (%)	Accuracy dependant on quality of data from health facilities.	Outcome	Percentage	Quarterly	No	A lower transmission rate means fewer babies were infected with HIV through mother-to-child transmission.	PMTCT Programme Manager
7) Diarrhoea incidence under 5 years	The number of children who were diagnosed with diarrhoea expressed per 1 000 children in the target population. Diarrhoea is formally defined as 3 or more watery stools in 24 hours, but any episode diagnosed and/or treated as diarrhoea after an interview with the adult accompanying the child should be counted.	Monitor incidence of water borne disease.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: Diarrhoea under 5 years – new ambulatory Denominator: Population under 5 years	1 000	Dependant on accuracy of data from reporting facilities and accuracy of diagnosis.	Outcome	Incidence per 1 000	Quarterly (annualised)	No	Lower incidence indicates a healthy community.	MCWH Programme Manager
8) Pneumonia incidence under 5 years	The number of children who were diagnosed with pneumonia expressed per 1 000 children in the target population.	Monitor incidence of pneumonia.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: Pneumonia under 5 years – new ambulatory Denominator: Population under 5 years	1 000	Dependant on accuracy of data from reporting facilities and accuracy of diagnosis.	Outcome	Incidence per 1 000	Quarterly (annualised)	No	Lower incidence indicates a healthy community.	MCWH Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
9) Public health facility infant mortality (under 1) rate	The number of children who have died in a health facility between birth and their first birthday, expressed per thousand live births in the facility.	Monitoring of infant deaths on a routine basis is very important to monitor progress towards the MDG target.	Numerator: Inpatient Throughput Form Denominator: Outpatient and Inpatient Related Services	Numerator: SINJANI Denominator: SINJANI	Numerator: Inpatient death under 1 year Denominator: Live births in facility	1 000	Dependant on accuracy of data from reporting facilities. Indicator reliant on accuracy of classification of inpatient deaths.	Outcome	Ratio per 1 000 live births	Quarterly	No	Lower institutional rate indicate fewer avoidable deaths.	MCWH Programme Manager
10) Public health facility child (under 5) mortality rate	The number of children who have died in a health facility between birth and their fifth birthday, expressed per thousand live births in the facility.	Monitoring of children deaths on a routine basis is very important to monitor progress towards the MDG target.	Numerator: Inpatient Throughput Form Denominator: Outpatient and Inpatient Related Services	Numerator: SINJANI Denominator: SINJANI	Numerator: Inpatient death under 5 years Denominator: Live births in facility	1 000	Dependant on accuracy of data from reporting facilities. Indicator reliant on accuracy of classification of inpatient deaths.	Outcome	Ratio per 1 000 live births	Quarterly	No	Lower institutional rate indicate fewer avoidable deaths.	MCWH Programme Manager
11) Public health facility maternal mortality rate	Number of maternal deaths in the facility expressed per 100 000 live births. . A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (as cited in ICD 10).	Confidential enquiry into maternal deaths report only released every 3 - 5 years, so monitoring of maternal deaths on a routine basis is very important to monitor progress towards MDG target. Mortality and causes of death report does not give exact figures for maternal deaths.	Numerator: Outpatient and Inpatient Related Services Denominator: Outpatient and Inpatient Related Services	Numerator: SINJANI Denominator: SINJANI	Numerator: Maternal death in facility Denominator: Live births in facility	100 000	Dependant on accuracy of data from reporting facilities. Indicator reliant on accuracy of classification of inpatient deaths.	Outcome	Ratio per 100 000 live births	Annual	No	Lower institutional rate indicate fewer avoidable deaths.	MCWH Programme Manager
12) Cervical cancer screening coverage	Percentage of women aged 30 years and older who were screened for cervical cancer.	Monitor cervical cancer screening coverage.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: Cervical smear in woman 30 years and older screened for cervical cancer Denominator: Female population 30 years and older DIVIDED by 10	100 (%)	Dependant on accuracy of data from reporting facilities. Dependant on the accuracy of the estimated total population from StatsSA.	Output	Percentage (annualised)	Quarterly	No	Higher percentage indicates better cervical cancer coverage.	MCWH Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
13) Delivery rate for women under 18 years	Proportion of deliveries in facilities where the mother is under 18 years on the day of delivery.	Monitor the percentage of teenage deliveries in facilities.	Numerator: Outpatient and Inpatient Related Services Denominator: Outpatient and Inpatient Related Services	Numerator: SINJANI Denominator: SINJANI	Numerator: Delivery to woman under 18 years Denominator: Delivery in facility Sum of: • Normal deliveries • Assisted deliveries Caesarean sections	100 (%)	Dependant on accuracy of data from reporting facilities.	Outcome	Percentage	Quarterly	No	Lower percentage indicates decrease in the number of teenage deliveries.	MCWH Programme Manager
14) Antenatal visits before 20 weeks rate	Percentage of pregnant women who visit a health facility for the primary purpose of receiving antenatal care, often referred to as “a booking visit”, that occurs before 20 weeks after conception.	Monitors the utilisation of antenatal services.	Numerator: Routine Monthly Report Denominator: Routine Monthly Report	Numerator: SINJANI Denominator: SINJANI	Numerator: Antenatal 1st visit before 20 weeks Denominator: Antenatal 1st visit Sum of: • Antenatal 1st visit before 20 weeks Antenatal 1st visit 20 weeks or later	100 (%)	Dependant on accuracy of data from reporting facilities.	Process	Percentage	Quarterly	No	Higher percentage indicates better access to antenatal care.	MCWH Programme Manager
15) Couple year protection rate	Percentage women of reproductive age (15 – 44 years) who are using (or whose partner is using) a modern contraceptive method. Contraceptive methods include female and male sterilisation, injectable and oral hormones, intrauterine devices, diaphragms, spemicides and condoms.	Track the extent of the use of contraception (any method) amongst women of child bearing age.	Numerator: Routine Monthly Report Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: Contraceptive years equivalent Sum of: • Male sterilisations X 20 • Female sterilisations X10 • Medroxyprogesterone injection / 4 • Norethisterone enanthate injection / 6 • Oral pill cycles / 13 • IUCD X 4 • Male condoms / 500 Denominator: Female population 15 – 44 years	100 (%)	Dependant on accuracy of data from reporting facilities.	Output	Percentage	Annual	No	Higher percentage indicates higher prevalence of contraceptive methods.	MCWH Programme Manager

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

DISEASE PREVENTION AND CONTROL: TABLES DPC 1, DPC 2&3 AND DPC 4

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Malaria case fatality rate	Deaths from malaria as a percentage of the number of cases reported.	Monitors the number deaths caused by malaria.	Numerator: Notifiable Medical Conditions notification form Denominator: Notifiable Medical Conditions notification form	Numerator: Notifiable Medical Conditions System Denominator: Notifiable Medical Conditions System	Numerator: Deaths from malaria Denominator: Malaria cases reported	100 (%)	Dependant on accuracy of data from reporting facilities.	Outcome	Rate	Annual	No	Lower percentage indicates a decreasing burden of malaria.	Disease Surveillance Programme Manager
2) Cholera fatality rate	Deaths from cholera as a percentage of the number of cases reported.	Monitors the number deaths caused by cholera.	Numerator: Notifiable Medical Conditions notification form Denominator: Notifiable Medical Conditions notification form	Numerator: Notifiable Medical Conditions System Denominator: Notifiable Medical Conditions System	Numerator: Deaths from cholera Denominator: Cholera cases reported	100 (%)	Dependant on accuracy of data from reporting facilities.	Outcome	Rate	Annual	No	Lower percentage indicates a decreasing burden of cholera.	Disease Surveillance Programme Manager
3) Cataract surgery rate	Cataract operations completed per 1 000 000 population.	Monitors the number of cataract surgeries.	Numerator: Outpatient and Inpatient Related Services Denominator: Population data	Numerator: SINJANI Denominator: StatsSA	Numerator: Cataract operations performed Denominator: Total population	1 000 000	Dependant on accuracy of data from reporting facilities.	Outcome	Rate per 1 000 000 population (annualised)	Quarterly	No	Higher levels reflect a good contribution to sight restoration, especially amongst the elderly population.	CBS Programme Manager

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

PROGRAMME 3: EMERGENCY MEDICAL AND RESCUE SERVICES

EMERGENCY MEDICAL and PATIENT TRANSPORT SERVICES: TABLE EMS 1, EMS 3 AND EMS 4

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Rostered ambulances per 10 000 people	Number of all rostered ambulances per 10 000 population.	Demonstrates the equity of distribution and accessibility of ambulances within a geographic area.	Numerator: Efficiency Report Denominator: Population data	Numerator: Efficiency Reporting system or SINJANI* Denominator: StatsSA	Numerator: Total number of rostered ambulances (see definition below) Denominator: Total population in the province	10 000	Dependant on accuracy of data recorded on the Efficiency Report and population estimates by StatsSA.	Input	Rate per 10 000 population	Quarterly	No	Higher number of rostered ambulances may lead to access to an ambulance and faster response time.	EMS Manager
Number of rostered ambulances per hour	The number of operational (staffed, equipped and ready to respond) ambulances available per hour in the Western Cape. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	Monitors resource availability in EMS in terms of equitable access and allows comparison with other ambulance services.	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Efficiency Reporting system or SINJANI* Denominator: Efficiency Reporting system or SINJANI*	Numerator: The total ambulance personnel hours worked for the reporting period Denominator: 2 x 24 hours per day for the reporting period	None (no)	Dependant on accuracy of data recorded on the Efficiency Report.	Input	Cumulative	Quarterly	No	Higher number of rostered ambulances may lead to faster response time.	EMS Manager
2) Total number of EMS emergency cases	Number of patients transported by ambulance.	Monitor service volumes and demand.	Efficiency Report	Efficiency Reporting system or SINJANI*	Patients transported by ambulance	None (no)	Dependant on accuracy of data received from EMS stations.	Output	Sum for period under review	Quarterly	No	Higher numbers can indicate a greater reliance on emergency services or greater efficiency of resources.	EMS Manager
3) P1 calls with a response time of < 15 minutes in an urban area	Percentage of urban (built up area) responses classified as a priority 1 (P1) or emergency by the Emergency Call Centre agent where the response time is within the national urban target of 15 minutes or less.	Monitors response times to emergencies within the national urban target.	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Efficiency Reporting system or SINJANI* Denominator: Efficiency Reporting system or SINJANI*	Numerator: Priority 1 ambulance responses under 15 minutes - urban Denominator: Priority 1 ambulance responses - urban	100 (%)	Dependant on accuracy of data received from EMS stations.	Quality	Percentage	Quarterly	No	Higher percentage indicates appropriate resource allocation and co-ordination of the EMS system in order to achieve better response times in urban areas.	EMS Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
4) P1 calls with a response time of < 40 minutes in an rural area	Percentage of rural (farming areas outside of a town or built up area) responses classified as priority 1 (P1) or emergency by the Emergency Call Centre agent where the response time is within the national rural target of 40 minutes or less.	Monitor response times to emergencies within national rural target.	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Efficiency Reporting system or SINJANI* Denominator: Efficiency Reporting system or SINJANI*	Numerator: Priority 1 ambulance responses under 40 minutes - rural Denominator: Priority 1 ambulance responses - rural	100 (%)	Dependant on accuracy of data received from EMS stations.	Quality	Percentage	Quarterly	No	Higher percentage indicates appropriate resource allocation and co-ordination of the EMS system in order to achieve better response times in rural areas.	EMS Manager
5) All calls with a response time within 60 minutes	Percentage of all EMS responses with a response times within 60 minutes.	Monitor response times to both emergencies and urgent cases.	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Efficiency Reporting system or SINJANI* Denominator: Efficiency Reporting system or SINJANI*	Numerator: All ambulance responses under 60 minutes Denominator: Total ambulance responses	100 (%)	Dependant on accuracy of data received from EMS stations.	Quality	Percentage	Quarterly	No	Higher percentage indicates appropriate resource allocation and co-ordination of the EMS system in order to achieve better response times.	EMS Manager
6) Percentage of ambulance patients transferred between facilities	The percentage of emergency patients transferred between hospitals to a higher level of care. Patients who are transferred from district to regional hospitals and regional to central hospitals are included.	Monitors achievement of CSP targets (90:8:2) of patients being managed at the appropriate level of care.	Numerator: Efficiency Report Denominator: Outpatient and Inpatient Related Services	Numerator: Efficiency Reporting system or SINJANI* Denominator: SINJANI	Numerator: Hospital patients transferred to a higher level of care Denominator: Emergency headcount at district and regional hospitals	100 (%)	Dependant on accuracy of data received from EMS stations and hospitals.	Quality	Percentage	Quarterly	Yes	Lower percentage is desired. The target is the CSP target of 10% (8:2) of acute patient contacts and measures whether capacity exists at the appropriate level of care.	EMS Managers Hospital Managers

* The programme intends to implement the information on web based which will be exported to SINJANI by 1 April 2012 but if technical difficulties are experienced, will continue to report on the manual Efficiency Report system.

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

PROGRAMME 4: PROVINCIAL HOSPITALS

GENERAL (REGIONAL) HOSPITALS: TABLES PHS 1&2 AND PHS 3

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of regional hospital beds	Actual (usable) beds in regional hospitals are beds actually available for use within the regional hospital, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of regional hospital beds to ensure accessibility of regional hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds in regional hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Actual (usable) beds should remain constant and should be operated within affordability limits while providing access for patients to clinical services.	Provincial Hospital Services Programme Manager
2) Total separations in regional hospitals	Recorded completion of treatment and/or the accommodation of an inpatient in regional hospitals. Separations include day patients and inpatients who were discharged, transferred out to other hospitals or who died.	Monitoring the service volumes in regional hospitals.	Inpatient Throughput Form	SINJANI	Sum of: • Day patients • Inpatient deaths • Inpatient discharges • Inpatient transfers out in regional hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	Provincial Hospital Services Programme Manager
3) Patient day equivalents (PDE) in regional hospitals	Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Monitoring the service volumes in regional hospitals.	Inpatient Throughput Form Outpatient and Inpatient Related Services	SINJANI SINJANI	Sum of: • Inpatient days • 1/2 day patients • 1/3 OPD headcount • 1/3 emergency headcount in regional hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Provincial Hospital Services Programme Manager
4) OPD total headcounts in regional hospitals	A headcount of all outpatients attending an outpatient clinic in regional hospitals. This excludes emergency centre headcounts.	Monitoring the service volumes in regional hospitals.	Outpatient and Inpatient Related Services	SINJANI	Sum of: • OPD new case not referred • OPD new case referred • OPD follow-up in regional hospitals OR Sum of: • OPD general • OPD specialist in regional hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	Provincial Hospital Services Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Caesarean section rate for regional hospitals	Caesarean section deliveries in regional hospitals expressed as a percentage of all deliveries in regional hospitals.	Tracks the performance of obstetric care at regional hospitals.	Numerator: Outpatient and Inpatient Related Services Denominator: Outpatient and Inpatient Related Services	Numerator: SINJANI Denominator: SINJANI	Numerator: Caesarean sections in regional hospitals Denominator: Deliveries in regional hospitals	100 (%)	Dependant on accuracy of data from reporting facilities.	Output	Percentage	Quarterly	No	Lower percentage desired. Higher percentage of caesarean sections indicates higher burden of disease, and/or poorer quality of antenatal care.	Provincial Hospital Services Programme Manager
6) Expenditure per patient day equivalent (PDE) in regional hospitals	Average cost per patient day equivalent in regional hospitals. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in regional hospitals.	Numerator: Financial data Denominator: Inpatient Throughput Form Outpatient and Inpatient Related Services	Numerator: BAS Denominator: SINJANI	Numerator: Total expenditure in regional hospitals (sub-programme 4.1) Denominator: Patient day equivalent (PDE) in regional hospitals	None (no)	Accuracy of expenditure dependant on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facilities.	Efficiency	Rate	Quarterly	No	Lower rate indicates efficient use of financial resources.	Provincial Hospital Services Programme Manager
7) Bed utilisation rate (based on usable beds) in regional hospitals	Patient days in regional hospitals during the reporting period, expressed as a percentage of the sum of the daily number of actual (usable) beds in regional hospitals.	Track the over / under utilisation of regional hospital beds.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in regional hospitals Denominator: Number of actual (usable) beds days in regional hospitals (Actual (usable) beds x number of days in the reporting period)	100 (%)	Dependant on accuracy of data from reporting facilities.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	Provincial Hospital Services Programme Manager
8) Average length of stay in regional hospitals	Average number of patient days that an admitted patient spends in regional hospitals before separation.	To monitor the efficiency of regional hospitals.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in regional hospitals Denominator: Total separations in regional hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might hide poor quality of hospital care.	Provincial Hospital Services Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
9) Percentage of regional hospitals with monthly morbidity and mortality meetings	Percentage of regional hospitals having morbidity and mortality (M&M) meetings every month (3 per quarter, 12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases adverse events (morbidity) and proportion of deaths (mortality).	Numerator: Hospital Semi-permanent Data version 2 Denominator: Facility list	Numerator: SINJANI Denominator: Facility list	Numerator: Regional hospitals with M&M meetings every month Denominator: Regional hospitals	100 (%)	Dependant on accuracy of data from reporting facilities.	Quality	Percentage	Quarterly	No	Higher number suggests better clinical governance.	Provincial Hospital Services Programme Manager
10) Percentage of complaints of users of regional hospitals resolved within 25 days	Percentage of complaints of users of regional hospital services resolved within 25 days.	To monitor the management of complaints in regional hospitals.	Numerator: Complaints and Compliments Register Denominator: Complaints and Compliments Register	Numerator: SINJANI Denominator: SINJANI	Numerator: Complaints resolved within 25 days in regional hospitals Denominator: Complaints lodged in regional hospitals	100 (%)	Dependant on accuracy of data, in particular the time stamp for each complaint, from reporting facilities.	Quality	Percentage	Quarterly	No	Higher percentage suggests better management of complaints in regional hospitals.	Provincial Hospital Services Programme Manager
11) Regional hospital patient satisfaction rate	Percentage of users that participated in the regional hospital client satisfaction survey that were satisfied with the services. The question "I was pleased with the way I was treated" in the general satisfaction domain will be used to assess the client's overall satisfaction.	Tracks the service satisfaction of regional hospital users.	Numerator: Client satisfaction survey Denominator: Client satisfaction survey	Numerator: SINJANI Denominator: SINJANI	Numerator: Number of questionnaires with 1 or 2 recorded for pleased with treatment Denominator: Number of questionnaires for pleased with treatment	100 (%)	Ability to generalise results dependant on the number of users participating in the survey.	Output	Percentage	Annual	No	Higher percentage indicates better levels of satisfaction in regional hospital services.	Provincial Hospital Services Programme Manager
12) Number of regional hospitals assessed for compliance with the 6 priorities of the core standards	Percentage of regional hospitals assessed for compliance against the 6 priority areas of the core standards for quality assurance.	Tracks the levels of compliance against the 6 priority areas of the core standards for quality assurance.	Hospital Semi-permanent Data version 2	SINJANI	Regional hospitals that conducted a national core standards self-assessment	None (no)	Implementation plan and assessment tool to be provided by National Department of Health.	Process	Sum for period under review	Annual	No	Higher number indicates better compliance with the core standards in regional hospitals.	Provincial Hospital Services Programme Manager

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

TB HOSPITALS: TABLES PHS 1&2 AND PHS 3

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of TB hospital beds	Actual (usable) beds in TB hospitals are beds actually available for use within the TB hospital, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of TB hospital beds to ensure accessibility of TB hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds in TB hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Actual (usable) beds should remain constant and should be operated within affordability limits while providing access for patients to clinical services.	TB Hospital Services Programme Manager
2) Total separations in TB hospitals	Recorded completion of treatment and/or the accommodation of an inpatient in TB hospitals. Separations include day patients and inpatients who were discharged, transferred out to other hospitals or who died.	Monitoring the service volumes in TB hospitals.	Inpatient Throughput Form	SINJANI	Sum of: • Day patients • Inpatient deaths • Inpatient discharges • Inpatient transfers out in TB hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	TB Hospital Services Programme Manager
3) Patient day equivalents (PDE) in TB hospitals	Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Monitoring the service volumes in TB hospitals.	Inpatient Throughput Form Outpatient and Inpatient Related Services	SINJANI SINJANI	Sum of: • Inpatient days • 1/2 day patients • 1/3 OPD headcount • 1/3 emergency headcount in TB hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	TB Hospital Services Programme Manager
4) OPD total headcounts in TB hospitals	A headcount of all outpatients attending an outpatient clinic in TB hospitals.	Monitoring the service volumes in TB hospitals.	Outpatient and Inpatient Related Services	SINJANI	Sum of: • OPD new case not referred • OPD new case referred • OPD follow-up in TB hospitals OR Sum of: • OPD general • OPD specialist in TB hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	TB Hospital Services Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Expenditure per patient day equivalent (PDE) in TB hospitals	Average cost per patient day equivalent in TB hospitals. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in TB hospitals.	Numerator: Financial data Denominator: Inpatient Throughput Form Outpatient and Inpatient Related Services	Numerator: BAS Denominator: SINJANI	Numerator: Total expenditure in TB hospitals (sub-programme 5.1) Denominator: Patient day equivalent (PDE) in TB hospitals	None (no)	Accuracy of expenditure dependant on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facilities.	Efficiency	Rate	Quarterly	No	Lower rate indicates efficient use of financial resources.	TB Hospital Services Programme Manager
6) Bed utilisation rate (based on usable beds) in TB hospitals	Patient days in TB hospitals during the reporting period, expressed as a percentage of the sum of the daily number of actual (usable) beds in TB hospitals.	Track the over / under utilisation of TB hospital beds.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in TB hospitals Denominator: Number of actual (usable) bed days in TB hospitals (Actual (usable) beds x number of days in the reporting period)	100 (%)	Dependant on accuracy of data from reporting facilities.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	TB Hospital Services Programme Manager
7) Average length of stay in TB hospitals	Average number of patient days that an admitted patient spends in TB hospitals before separation.	To monitor the efficiency of TB hospitals.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in TB hospitals Denominator: Total separations in TB hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might hide poor quality of hospital care.	TB Hospital Services Programme Manager
8) Percentage of TB hospitals with monthly morbidity and mortality meetings	Percentage of TB hospitals having morbidity and mortality (M&M) meetings every month (3 per quarter, 12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases adverse events (morbidity) and proportion of deaths (mortality).	Numerator: Hospital Semi-permanent Data version 2 Denominator: Facility list	Numerator: SINJANI Denominator: Facility list	Numerator: TB hospitals with M&M meetings every month Denominator: TB hospitals	100 (%)	Dependant on accuracy of data from reporting facilities.	Quality	Percentage	Quarterly	No	Higher number suggests better clinical governance.	TB Hospital Services Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
9) Percentage of complaints of users of TB hospitals resolved within 25 days	Percentage of complaints of users of TB hospital services resolved within 25 days.	To monitor the management of complaints in TB hospitals.	Numerator: Complaints and Compliments Register Denominator: Complaints and Compliments Register	Numerator: SINJANI Denominator: SINJANI	Numerator: Complaints resolved within 25 days in TB hospitals Denominator: Complaints lodged in TB hospitals	100 (%)	Dependant on accuracy of data, in particular the time stamp for each complaint, from reporting facilities.	Quality	Percentage	Quarterly	No	Higher percentage suggests better management of complaints in TB hospitals.	TB Hospital Services Programme Manager
10) TB hospital patient satisfaction rate	Percentage of users that participated in the TB hospital client satisfaction survey that were satisfied with the services. The question "I was pleased with the way I was treated" in the general satisfaction domain will be used to assess the client's overall satisfaction.	Tracks the service satisfaction of TB hospital users.	Numerator: Client satisfaction survey Denominator: Client satisfaction survey	Numerator: SINJANI Denominator: SINJANI	Numerator: Number of questionnaires with 1 or 2 recorded for pleased with treatment Denominator: Number of questionnaires for pleased with treatment	100 (%)	Ability to generalise results dependant on the number of users participating in the survey.	Output	Percentage	Annual	No	Higher percentage indicates better levels of satisfaction in TB hospital services.	TB Hospital Services Programme Manager
11) Number of TB hospitals assessed for compliance with the 6 priorities of the core standards	Percentage of TB hospitals assessed for compliance against the 6 priority areas of the core standards for quality assurance.	Tracks the levels of compliance against the 6 priority areas of the core standards for quality assurance.	Hospital Semi-permanent Data version 2	SINJANI	TB hospitals that conducted a national core standards self-assessment	None (no)	Implementation plan and assessment tool to be provided by National Department of Health.	Process	Sum for period under review	Annual	No	Higher number indicates better compliance with the core standards in TB hospitals.	TB Hospital Services Programme Manager

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

PSYCHIATRIC HOSPITALS: TABLES PHS 1&2 AND PHS 3

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of psychiatric hospital beds	Actual (usable) beds in psychiatric hospitals are beds actually available for use within the psychiatric hospital, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of psychiatric hospital beds to ensure accessibility of psychiatric hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds in psychiatric hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Actual (usable) beds should remain constant and should be operated within affordability limits while providing access for patients to clinical services.	Associated Psychiatric Hospitals (APH) Programme Manager
2) Total separations in psychiatric hospitals	Recorded completion of treatment and/or the accommodation of an inpatient in psychiatric hospitals. Separations include day patients and inpatients who were discharged, transferred out to other hospitals or who died.	Monitoring the service volumes in psychiatric hospitals.	Inpatient Throughput Form	SINJANI	Sum of: • Day patients • Inpatient deaths • Inpatient discharges • Inpatient transfers out in psychiatric hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	APH Programme Manager
3) Patient day equivalents (PDE) in psychiatric hospitals	Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Monitoring the service volumes in psychiatric hospitals.	Inpatient Throughput Form Outpatient and Inpatient Related Services	SINJANI SINJANI	Sum of: • Inpatient days • 1/2 day patients • 1/3 OPD headcount • 1/3 emergency headcount in psychiatric hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	APH Programme Manager
4) OPD total headcounts in psychiatric hospitals	A headcount of all outpatients attending an outpatient clinic in psychiatric hospitals.	Monitoring the service volumes in psychiatric hospitals.	Outpatient and Inpatient Related Services	SINJANI	Sum of: • OPD new case not referred • OPD new case referred • OPD follow-up in psychiatric hospitals OR Sum of: • OPD general • OPD specialist in psychiatric hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	APH Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Expenditure per patient day equivalent (PDE) in psychiatric hospitals	Average cost per patient day equivalent in psychiatric hospitals. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in psychiatric hospitals.	Numerator: Financial data Denominator: Inpatient Throughput Form Outpatient and Inpatient Related Services	Numerator: BAS Denominator: SINJANI	Numerator: Total expenditure in psychiatric hospitals (sub-programme 5.1) Denominator: Patient day equivalent (PDE) in psychiatric hospitals	None (no)	Accuracy of expenditure dependant on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facilities.	Efficiency	Rate	Quarterly	No	Lower rate indicates efficient use of financial resources.	APH Programme Manager
6) Bed utilisation rate (based on usable beds) in psychiatric hospitals	Patient days in psychiatric hospitals during the reporting period, expressed as a percentage of the sum of the daily number of actual (usable) beds in psychiatric hospitals.	Track the over / under utilisation of psychiatric hospital beds.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in psychiatric hospitals Denominator: Number of actual (usable) bed days in psychiatric hospitals (Actual (usable) beds x number of days in the reporting period)	100 (%)	Dependant on accuracy of data from reporting facilities.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	APH Programme Manager
7) Average length of stay in psychiatric hospitals	Average number of patient days that an admitted patient spends in psychiatric hospitals before separation.	To monitor the efficiency of psychiatric hospitals.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in psychiatric hospitals Denominator: Total separations in psychiatric hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might hide poor quality of hospital care.	APH Programme Manager
8) Percentage of psychiatric hospitals with monthly morbidity and mortality meetings	Percentage of psychiatric hospitals having morbidity and mortality (M&M) meetings every month (3 per quarter, 12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases adverse events (morbidity) and proportion of deaths (mortality).	Numerator: Hospital Semi-permanent Data version 2 Denominator: Facility list	Numerator: SINJANI Denominator: Facility list	Numerator: Psychiatric hospitals with M&M meetings every month Denominator: Psychiatric hospitals	100 (%)	Dependant on accuracy of data from reporting facilities.	Quality	Percentage	Quarterly	No	Higher number suggests better clinical governance.	APH Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
9) Percentage of complaints of users of psychiatric hospitals resolved within 25 days	Percentage of complaints of users of psychiatric hospital services resolved within 25 days.	To monitor the management of complaints in psychiatric hospitals.	Numerator: Complaints and Compliments Register Denominator: Complaints and Compliments Register	Numerator: SINJANI Denominator: SINJANI	Numerator: Complaints resolved within 25 days in psychiatric hospitals Denominator: Complaints lodged in psychiatric hospitals	100 (%)	Dependant on accuracy of data, in particular the time stamp for each complaint, from reporting facilities.	Quality	Percentage	Quarterly	No	Higher percentage suggests better management of complaints in psychiatric hospitals.	APH Programme Manager
10) Psychiatric hospital patient satisfaction rate	Percentage of users that participated in the psychiatric hospital client satisfaction survey that were satisfied with the services. The question "I was pleased with the way I was treated" in the general satisfaction domain will be used to assess the client's overall satisfaction.	Tracks the service satisfaction of psychiatric hospital users.	Numerator: Client satisfaction survey Denominator: Client satisfaction survey	Numerator: SINJANI Denominator: SINJANI	Numerator: Number of questionnaires with 1 or 2 recorded for pleased with treatment Denominator: Number of questionnaires for pleased with treatment	100 (%)	Ability to generalise results dependant on the number of users participating in the survey.	Output	Percentage	Annual	No	Higher percentage indicates better levels of satisfaction in psychiatric hospital services.	APH Programme Manager
11) Number of psychiatric hospitals assessed for compliance with the 6 priorities of the core standards	Percentage of psychiatric hospitals assessed for compliance against the 6 priority areas of the core standards for quality assurance.	Tracks the levels of compliance against the 6 priority areas of the core standards for quality assurance.	Hospital Semi-permanent Data version 2	SINJANI	Psychiatric hospitals that conducted a national core standards self-assessment	None (no)	Implementation plan and assessment tool to be provided by National Department of Health.	Process	Sum for period under review	Annual	No	Higher number indicates better compliance with the core standards in psychiatric hospitals.	APH Programme Manager
STEP DOWN BEDS													
1) Number of actual (usable) beds in step down beds	Actual (usable) beds in psychiatric step down facilities are beds actually available for use within the psychiatric step down facility, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of psychiatric step down beds to ensure accessibility of psychiatric hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds in psychiatric step down facilities	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Actual (usable) beds should remain constant and should be operated within affordability limits while providing access for patients to clinical services.	Associated Psychiatric Hospitals (APH) Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
2) Bed utilisation rate in step down facilities	Patient days in psychiatric step down facilities during the reporting period, expressed as a percentage of the sum of the daily number of actual (usable) beds in psychiatric step down facilities.	Track the over / under utilisation of psychiatric step down beds.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in psychiatric step down facilities Denominator: Actual (usable) bed days in psychiatric hospitals (Actual (usable) beds x number of days in the reporting period)	100 (%)	Dependant on accuracy of data from reporting facilities.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	APH Programme Manager
3) Total number of patient days	Patient days in psychiatric step down facilities during the reporting period.	Monitoring the service volumes in psychiatric step down beds.	Numerator: Inpatient Throughput Form	Numerator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in psychiatric step down facilities	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	APH Programme Manager

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

SPECIALISED REHABILITATION SERVICES: TABLES PHS 1&2 AND PHS 3

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of rehabilitation hospital beds	Actual (usable) beds in rehabilitation hospitals are beds actually available for use within the rehabilitation hospital, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of rehabilitation hospital beds to ensure accessibility of rehabilitation hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds in rehabilitation hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Actual (usable) beds should remain constant and should be operated within affordability limits while providing access for patients to clinical services.	CEO Western Cape Rehabilitation Centre
2) Total separations in rehabilitation hospitals	Recorded completion of treatment and/or the accommodation of an inpatient in rehabilitation hospitals. Separations include day patients and inpatients who were discharged, transferred out to other hospitals or who died.	Monitoring the service volumes in rehabilitation hospitals.	Inpatient Throughput Form	SINJANI	Sum of: • Day patients • Inpatient deaths • Inpatient discharges • Inpatient transfers out in rehabilitation hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	CEO Western Cape Rehabilitation Centre
3) Patient day equivalents (PDE) in rehabilitation hospitals	Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Monitoring the service volumes in rehabilitation hospitals.	Inpatient Throughput Form Outpatient and Inpatient Related Services	SINJANI SINJANI	Sum of: • Inpatient days • 1/2 day patients • 1/3 OPD headcount • 1/3 emergency headcount in rehabilitation hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	CEO Western Cape Rehabilitation Centre
4) OPD total headcounts in rehabilitation hospitals	A headcount of all outpatients attending an outpatient clinic in rehabilitation hospitals.	Monitoring the service volumes in rehabilitation hospitals.	Outpatient and Inpatient Related Services	SINJANI	Sum of: • OPD new case not referred • OPD new case referred • OPD follow-up in rehabilitation hospitals OR Sum of: • OPD general • OPD specialist in rehabilitation hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	CEO Western Cape Rehabilitation Centre

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Expenditure per patient day equivalent (PDE) in rehabilitation hospitals	Average cost per patient day equivalent in rehabilitation hospitals. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in rehabilitation hospitals.	Numerator: Financial data Denominator: Inpatient Throughput Form Outpatient and Inpatient Related Services	Numerator: BAS Denominator: SINJANI	Numerator: Total expenditure in rehabilitation hospitals (sub-programme 5.1) Denominator: Patient day equivalent (PDE) in rehabilitation hospitals	None (no)	Accuracy of expenditure dependant on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facilities.	Efficiency	Rate	Quarterly	No	Lower rate indicates efficient use of financial resources.	CEO Western Cape Rehabilitation Centre
6) Bed utilisation rate (based on usable beds) in rehabilitation hospitals	Patient days in rehabilitation hospitals during the reporting period, expressed as a percentage of the sum of the daily number of actual (usable) beds in rehabilitation hospitals.	Track the over / under utilisation of rehabilitation hospital beds.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in rehabilitation hospitals Denominator: Number of actual (usable) bed days in rehabilitation hospitals (Actual (usable) beds x number of days in the reporting period)	100 (%)	Dependant on accuracy of data from reporting facilities.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	CEO Western Cape Rehabilitation Centre
7) Average length of stay in rehabilitation hospitals	Average number of patient days that an admitted patient spends in rehabilitation hospitals before separation.	To monitor the efficiency of rehabilitation hospitals.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in rehabilitation hospitals Denominator: Total separations in rehabilitation hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might hide poor quality of hospital care.	CEO Western Cape Rehabilitation Centre
8) Percentage of rehabilitation hospitals with monthly morbidity and mortality meetings	Percentage of rehabilitation hospitals having morbidity and mortality (M&M) meetings every month (3 per quarter, 12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases adverse events (morbidity) and proportion of deaths (mortality).	Numerator: Hospital Semi-permanent Data version 2 Denominator: Facility list	Numerator: SINJANI Denominator: Facility list	Numerator: Rehabilitation hospitals with M&M meetings every month Denominator: Rehabilitation hospitals	100 (%)	Dependant on accuracy of data from reporting facilities.	Quality	Percentage	Quarterly	No	Higher number suggests better clinical governance.	CEO Western Cape Rehabilitation Centre

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
9) Percentage of complaints of users of rehabilitation hospitals resolved within 25 days	Percentage of complaints of users of rehabilitation hospital services resolved within 25 days.	To monitor the management of complaints in rehabilitation hospitals.	Numerator: Complaints and Compliments Register Denominator: Complaints and Compliments Register	Numerator: SINJANI Denominator: SINJANI	Numerator: Complaints resolved within 25 days in rehabilitation hospitals Denominator: Complaints lodged in rehabilitation hospitals	100 (%)	Dependant on accuracy of data, in particular the time stamp for each complaint, from reporting facilities.	Quality	Percentage	Quarterly	No	Higher percentage suggests better management of complaints in rehabilitation hospitals.	CEO Western Cape Rehabilitation Centre
10) Rehabilitation hospital patient satisfaction rate	Percentage of users that participated in the rehabilitation hospital client satisfaction survey that were satisfied with the services. The question "I was pleased with the way I was treated" in the general satisfaction domain will be used to assess the client's overall satisfaction.	Tracks the service satisfaction of rehabilitation hospital users.	Numerator: Client satisfaction survey Denominator: Client satisfaction survey	Numerator: SINJANI Denominator: SINJANI	Numerator: Number of questionnaires with 1 or 2 recorded for pleased with treatment Denominator: Number of questionnaires for pleased with treatment	100 (%)	Ability to generalise results dependant on the number of users participating in the survey.	Output	Percentage	Annual	No	Higher percentage indicates better levels of satisfaction in rehabilitation hospital services.	CEO Western Cape Rehabilitation Centre
11) Number of rehabilitation hospitals assessed for compliance with the core standards	Percentage of rehabilitation hospitals assessed for compliance against the 6 priority areas of the core standards for quality assurance.	Tracks the levels of compliance against the 6 priority areas of the core standards for quality assurance.	Hospital Semi-permanent Data version 2	SINJANI	Rehabilitation hospitals that conducted a national core standards self-assessment	None (no)	Implementation plan and assessment tool to be provided by National Department of Health.	Process	Sum for period under review	Annual	Yes	Higher number indicates better compliance with the core standards in rehabilitation hospitals.	CEO Western Cape Rehabilitation Centre

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

DENTAL TRAINING HOSPITALS: TABLES PHS 2 AND PHS 3

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Number of oral health patient visits per annum	Total number of patient visits for treatment recorded at the various clinics of the oral health centres.	Monitoring the service volumes at the oral health centres.	Dental Training Hospital Form	SINJANI	Sum of patient visits at: • Tygerberg and UWC Oral Health Centres • Other oral health clinics (outreach clinics)	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	Dean: Dental Faculty
2) Number of oral health theatre cases per annum	Total number of dental health theatre cases at oral health centres. This entails performing maxillofacial surgery procedures during which one or more incisions are made to the head and neck area. Surgical procedures are performed in a registered operating theatre equipped for anaesthesia and able to provide sterile conditions.	Monitoring the service volumes of theatre cases in the oral health centres.	Dental Training Hospital Form	SINJANI	Dental health theatre cases	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	Dean: Dental Faculty
3) Number of removable oral health prosthetic devices manufactured (dentures)	Number of prosthetic units (dentures) manufactured that were issued to and received by the patient at the oral health centres.	Monitoring the service volumes for prosthetic units (dentures).	Dental Training Hospital Form	SINJANI	Prosthetic units (dentures) issued	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease and also a greater reliance on the public health system.	Dean: Dental Faculty
4) Number of new patients banded for orthodontic treatment (braces)	A headcount of new patients banded for orthodontic treatment (braces) at the oral health centres.	Monitoring the service volumes for orthodontic treatment (braces).	Dental Training Hospital Form	SINJANI	New patients banded for orthodontic treatment	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	Yes	Higher Levels of uptake may indicate an increased burden of disease and also a greater reliance on the public health system.	Dean: Dental Faculty

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

PROGRAMME 5: CENTRAL HOSPITAL SERVICES

CENTRAL HOSPITALS: TABLES CHS 3 AND CHS 6

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Caesarean section rate for central hospitals	Caesarean section deliveries in central hospitals expressed as a percentage of all deliveries in central hospitals.	Tracks the performance of obstetric care at central hospitals.	Numerator: Outpatient and Inpatient Related Services Denominator: Outpatient and Inpatient Related Services	Numerator: SINJANI Denominator: SINJANI	Numerator: Caesarean sections in central hospitals Denominator: Deliveries in central hospitals	100 (%)	Dependant on accuracy of data from reporting facilities.	Output	Percentage	Quarterly	No	Lower percentage desired. Higher percentage of caesarean sections indicates higher burden of disease, and/or poorer quality of antenatal care.	Central Hospital Services Programme Manager
2) Number of actual beds in central hospitals	Actual (usable) beds in central hospitals are beds actually available for use within central hospitals, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of central hospital beds to ensure accessibility of central hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds in central hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	Actual (usable) beds should remain constant and should be operated within affordability limits while providing access for patients to clinical services.	Central Hospital Services Programme Manager
3) Total separations in central hospitals	Recorded completion of treatment and/or the accommodation of an inpatient in central hospitals. Separations include day patients and inpatients who were discharged, transferred out to other hospitals or who died.	Monitoring the service volumes in central hospitals.	Inpatient Throughput Form	SINJANI	Sum of: • Day patients • Inpatient deaths • Inpatient discharges • Inpatient transfers out in central hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	Central Hospital Services Programme Manager
4) OPD total headcounts in central hospitals	A headcount of all outpatients attending an outpatient clinic in central hospitals. This excludes emergency centre headcounts.	Monitoring the service volumes in central hospitals.	Outpatient and Inpatient Related Services	SINJANI	Sum of: • OPD new case not referred • OPD new case referred • OPD follow-up in central hospitals OR Sum of: • OPD general • OPD specialist	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	Central Hospital Services Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Patient day equivalents (PDE) in central hospitals	Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Monitoring the service volumes in central hospitals.	Inpatient Throughput Form Outpatient and Inpatient Related Services	SINJANI SINJANI	Sum of: • Inpatient days • 1/2 day patients • 1/3 OPD headcount • 1/3 emergency headcount in central hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system	Central Hospital Services Programme Manager
6) Bed utilisation rate (based on actual beds) in central hospitals	Patient days in central hospitals during the reporting period, expressed as a percentage of the sum of the daily number of actual (usable) beds in central hospitals.	Track the over / under utilisation of central hospital beds.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in central hospitals Denominator: Number of actual (usable) beds days in central hospitals (Actual (usable) beds x number of days in the reporting period)	100 (%)	Dependant on accuracy of data from reporting facilities.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	Central Hospital Services Programme Manager
7) Expenditure per patient day equivalent (PDE) in central hospitals	Average cost per patient day equivalent in central hospitals. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in central hospitals.	Numerator: Financial data Denominator: Inpatient Throughput Form Outpatient and Inpatient Related Services	Numerator: BAS Denominator: SINJANI	Numerator: Total expenditure in central hospitals (sub-programme 5.1) Denominator: Patient day equivalent (PDE) in central hospitals	None (no)	Accuracy of expenditure dependant on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facilities.	Efficiency	Rate	Quarterly	No	Lower rate indicates efficient use of financial resources.	Central Hospital Services Programme Manager
8) Average length of stay in central hospitals	Average number of patient days that an admitted patient spends in central hospitals before separation.	To monitor the efficiency of central hospitals.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in central hospitals Denominator: Total separations in central hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might hide poor quality of hospital care.	Central Hospital Services Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
9) Percentage of central hospitals with monthly morbidity and mortality meetings	Percentage of central hospitals having a morbidity and mortality (M&M) meeting every month (3 per quarter, 12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases adverse events (morbidity) and proportion of deaths (mortality).	Numerator: Hospital Semi-permanent Data version 2 Denominator: Facility list	Numerator: SINJANI Denominator: Facility list	Numerator: Central hospitals with M&M meetings every month Denominator: Central hospitals	100 (%)	Dependant on accuracy of data from reporting facilities.	Quality	Percentage	Quarterly	No	Higher number suggests better clinical governance.	Central Hospital Services Programme Manager
10) Percentage of complaints of users of central hospital services resolved within 25 days	Percentage of complaints of users of central hospital services resolved within 25 days.	To monitor the management of complaints in central hospitals.	Numerator: Complaints and Compliments Register Denominator: Complaints and Compliments Register	Numerator: SINJANI Denominator: SINJANI	Numerator: Complaints resolved within 25 days in central hospitals Denominator: Complaints lodged in central hospitals	100 (%)	Dependant on accuracy of data, in particular the time stamp for each complaint, from reporting facilities.	Quality	Percentage	Quarterly	No	Higher percentage suggests better management of complaints in central hospitals.	Central Hospital Services Programme Manager
11) Central hospital patient satisfaction rate	Percentage of users that participated in the central hospital client satisfaction survey that were satisfied with the services. The question "I was pleased with the way I was treated" in the general satisfaction domain will be used to assess the client's overall satisfaction.	Tracks the service satisfaction of central hospital users.	Numerator: Client satisfaction survey Denominator: Client satisfaction survey	Numerator: SINJANI Denominator: SINJANI	Numerator: Number of questionnaires with 1 or 2 recorded for pleased with treatment Denominator: Number of questionnaires for pleased with treatment	100 (%)	Ability to generalise results dependant on the number of users participating in the survey.	Output	Percentage	Annual	No	Higher percentage indicates better levels of satisfaction in central hospital services.	Central Hospital Services Programme Manager
12) Number of central hospitals assessed for compliance with core standards	Percentage of central hospitals assessed for compliance against the 6 priority areas of the core standards and quality assurance.	Tracks the levels of compliance against the **6 priority areas of the core standards and quality assurance.**.	Hospital Semi-permanent Data version 2	SINJANI	Central hospitals that conducted a national core standards self-assessment	None (no)	Implementation plan and assessment tool to be provided by National Department of Health.	Quality	Cumulative	Annual	No	Higher number indicates better compliance with the core standards in central hospitals.	Central Hospital Services Programme Manager

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

GROOTE SCHUUR HOSPITAL: TABLES CHS 5 AND CHS 6

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Caesarean section rate in Groote Schuur Hospital	Caesarean section deliveries in Groote Schuur Hospital expressed as a percentage of all deliveries in Groote Schuur Hospital.	Tracks the performance of obstetric care at Groote Schuur Hospital.	Numerator: Outpatient and Inpatient Related Services Denominator: Outpatient and Inpatient Related Services	Numerator: SINJANI Denominator: SINJANI	Numerator: Caesarean sections in Groote Schuur Hospital Denominator: Deliveries in Groote Schuur Hospital	100 (%)	Dependant on accuracy of data from reporting facility.	Output	Percentage	Quarterly	No	Lower percentage desired. Higher percentage of caesarean sections indicates higher burden of disease, and/or poorer quality of antenatal care.	CEO Groote Schuur Hospital
2) Number of actual tertiary beds in Groote Schuur Hospital	Actual (usable) beds in Groote Schuur Hospital are beds actually available for use within Groote Schuur Hospital, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of central hospital beds to ensure accessibility of central hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds in Groote Schuur Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Input	Cumulative	Quarterly	No	Actual (usable) beds should remain constant and should be operated within affordability limits while providing access for patients to clinical services.	CEO Groote Schuur Hospital
3) Total separations in Groote Schuur Hospital	Recorded completion of treatment and/or the accommodation of an inpatient in Groote Schuur Hospital. Separations include day patients and inpatients who were discharged, transferred out to other hospitals or who died.	Monitoring the service volumes in Groote Schuur Hospital.	Inpatient Throughput Form	SINJANI	Sum of: • Day patients • Inpatient deaths • Inpatient discharges • Inpatient transfers out in Groote Schuur Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	CEO Groote Schuur Hospital
4) OPD total headcounts in Groote Schuur Hospital	A headcount of all outpatients attending an outpatient clinic in Groote Schuur Hospital.	Monitoring the service volumes in Groote Schuur Hospital.	Outpatient and Inpatient Related Services	SINJANI	Sum of: • OPD new case not referred • OPD new case referred • OPD follow-up in Groote Schuur Hospital OR Sum of: • OPD general • OPD specialist in Groote Schuur Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	CEO Groote Schuur Hospital

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Patient day equivalents (PDE) in Groote Schuur Hospital	Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Monitoring the service volumes in Groote Schuur Hospital.	Inpatient Throughput Form Outpatient and Inpatient Related Services	SINJANI SINJANI	Sum of: • Inpatient days • 1/2 day patients • 1/3 OPD headcount • 1/3 emergency headcount in Groote Schuur Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system.	CEO Groote Schuur Hospital
6) Bed utilisation rate (based on actual beds) in Groote Schuur Hospital	Patient days in Groote Schuur Hospital during the reporting period, expressed as a percentage of the sum of the daily number of actual (usable) beds in Groote Schuur Hospital.	Track the over / under utilisation of Groote Schuur Hospital beds.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in Groote Schuur Hospital Denominator: Number of actual (usable) bed days in Groote Schuur Hospital (Actual (usable) beds x number of days in the reporting period)	100 (%)	Dependant on accuracy of data from reporting facility.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	CEO Groote Schuur Hospital
7) Expenditure per patient day equivalent (PDE) in Groote Schuur Hospital	Average cost per patient day equivalent in Groote Schuur Hospital. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in Groote Schuur Hospital.	Numerator: Financial data Denominator: Inpatient Throughput Form Outpatient and Inpatient Related Services	Numerator: BAS Denominator: SINJANI	Numerator: Total expenditure in Groote Schuur Hospital (sub-programme 5.1) Denominator: Patient day equivalent (PDE) in Groote Schuur Hospital	None (no)	Accuracy of expenditure dependant on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facility.	Efficiency	Rate	Quarterly	No	Lower rate indicates efficient use of financial resources.	CEO Groote Schuur Hospital

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
8) Average length of stay in Groote Schuur Hospital	Average number of patient days that an admitted patient spends in Groote Schuur Hospital before separation.	To monitor the efficiency of Groote Schuur Hospital.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in Groote Schuur Hospital Denominator: Total separations in Groote Schuur Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might hide poor quality of hospital care.	CEO Groote Schuur Hospital
9) Groote Schuur Hospital conducts monthly morbidity and mortality meetings	Groote Schuur Hospital conducts at least one morbidity and mortality (M&M) meeting every month (3 per quarter, 12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases adverse events (morbidity) and proportion of deaths (mortality).	Hospital Semi-permanent Data version 2	SINJANI	M&M meetings conducted every month in Groote Schuur Hospital	(Y/N)	Dependant on accuracy of data from reporting facility.	Quality	Compliance (Yes / No)	Quarterly	No	Yes suggests better clinical governance.	CEO Groote Schuur Hospital
10) Percentage of complaints of users of Groote Schuur Hospital's services resolved within 25 days	Percentage of complaints received from the users of Groote Schuur Hospital's services that were resolved within 25 days.	To monitor the management of complaints in Groote Schuur Hospital.	Numerator: Complaints and Compliments Register Denominator: Complaints and Compliments Register	Numerator: SINJANI Denominator: SINJANI	Numerator: Complaints resolved within 25 days in central hospitals Denominator: Complaints lodged in central hospitals	100 (%)	Dependant on accuracy of data, in particular the time stamp for each complaint, from reporting facility.	Quality	Percentage	Quarterly	No	Higher percentage suggests better management of complaints in Groote Schuur Hospital.	CEO Groote Schuur Hospital
11) Groote Schuur Hospital patient satisfaction rate	Percentage of users that participated in the central hospital client satisfaction survey that were satisfied with the services. The question "I was pleased with the way I was treated" in the general satisfaction domain will be used to assess the client's overall satisfaction.	Tracks the service satisfaction of central hospital users.	Numerator: Client satisfaction survey Denominator: Client satisfaction survey	Numerator: SINJANI Denominator: SINJANI	Numerator: Number of questionnaires with 1 or 2 recorded for pleased with treatment Denominator: Number of questionnaires for pleased with treatment	100 (%)	Ability to generalise results dependant on the number of users participating in the survey.	Quality	Percentage	Annual	No	Higher percentage indicates better levels of satisfaction in Groote Schuur Hospital services.	CEO Groote Schuur Hospital
12) Groote Schuur Hospital assessed for compliance with core standards	Percentage of central hospitals assessed for compliance against the 6 priority areas of the core standards and quality assurance.	Tracks the levels of compliance against the **6 priority areas of the core standards and quality assurance.**	Hospital Semi-permanent Data version 2	SINJANI	Groote Schuur Hospital conducted a national core standards self-assessment	(Y/N)	Implementation plan and assessment tool to be provided by National Department of Health.	Quality	Compliance (Yes / No)	Annual	No	Yes indicates better compliance with the core standards in Groote Schuur Hospital.	CEO Groote Schuur Hospital

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

TYGERBERG HOSPITAL: TABLES CHS 5 AND CHS 6

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Caesarean section rate in Tygerberg Hospital	Caesarean section deliveries in Tygerberg Hospital expressed as a percentage of all deliveries in Tygerberg Hospital.	Tracks the performance of obstetric care at Tygerberg Hospital.	Numerator: Outpatient and Inpatient Related Services Denominator: Outpatient and Inpatient Related Services	Numerator: SINJANI Denominator: SINJANI	Numerator: Caesarean sections in Tygerberg Hospital Denominator: Deliveries in Tygerberg Hospital	100 (%)	Dependant on accuracy of data from reporting facility.	Output	Percentage	Quarterly	No	Lower percentage desired. Higher percentage of caesarean sections indicates higher burden of disease, and/or poorer quality of antenatal care.	CEO Tygerberg Hospital
2) Number of actual tertiary beds in Tygerberg Hospital	Actual (usable) beds in Tygerberg Hospital are beds actually available for use within Tygerberg Hospital, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of central hospital beds to ensure accessibility of central hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds in Tygerberg Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Input	Cumulative	Quarterly	No	Actual (usable) beds should remain constant and should be operated within affordability limits while providing access for patients to clinical services.	CEO Tygerberg Hospital
3) Total separations in Tygerberg Hospital	Recorded completion of treatment and/or the accommodation of an inpatient in Tygerberg Hospital. Separations include day patients and inpatients who were discharged, transferred out to other hospitals or who died.	Monitoring the service volumes in Tygerberg Hospital.	Inpatient Throughput Form	SINJANI	Sum of: • Day patients • Inpatient deaths • Inpatient discharges • Inpatient transfers out in Tygerberg Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	CEO Tygerberg Hospital
4) OPD total headcounts in Tygerberg Hospital	A headcount of all outpatients attending an outpatient clinic in Tygerberg Hospital.	Monitoring the service volumes in Tygerberg Hospital.	Outpatient and Inpatient Related Services	SINJANI	Sum of: • OPD new case not referred • OPD new case referred • OPD follow-up in Tygerberg Hospital OR Sum of: • OPD general • OPD specialist in Tygerberg Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	CEO Tygerberg Hospital

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Patient day equivalents (PDE) in Tygerberg Hospital	Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Monitoring the service volumes in Tygerberg Hospital.	Inpatient Throughput Form Outpatient and Inpatient Related Services	SINJANI SINJANI	Sum of: • Inpatient days • 1/2 day patients • 1/3 OPD headcount • 1/3 emergency headcount in Tygerberg Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system.	CEO Tygerberg Hospital
6) Bed utilisation rate (based on actual beds) in Tygerberg Hospital	Patient days in Tygerberg Hospital during the reporting period, expressed as a percentage of the sum of the daily number of actual (usable) beds in Tygerberg Hospital.	Track the over / under utilisation of Tygerberg Hospital beds.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in Tygerberg Hospital Denominator: Number of actual (usable) beds days in Tygerberg Hospital (Actual (usable) beds x number of days in the reporting period)	100 (%)	Dependant on accuracy of data from reporting facility.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	CEO Tygerberg Hospital
7) Expenditure per patient day equivalent (PDE) in Tygerberg Hospital	Average cost per patient day equivalent in Tygerberg Hospital. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in Tygerberg Hospital.	Numerator: Financial data Denominator: Inpatient Throughput Form Outpatient and Inpatient Related Services	Numerator: BAS Denominator: SINJANI	Numerator: Total expenditure in Tygerberg Hospital (sub-programme 5.1) Denominator: Patient day equivalent (PDE) in Tygerberg Hospital	None (no)	Accuracy of expenditure dependant on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facility.	Efficiency	Rate	Quarterly	No	Lower rate indicates efficient use of financial resources.	CEO Tygerberg Hospital
8) Average length of stay in Tygerberg Hospital	Average number of patient days that an admitted patient spends in Tygerberg Hospital before separation.	To monitor the efficiency of Tygerberg Hospital.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in Tygerberg Hospital Denominator: Total separations in Tygerberg Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might hide poor quality of hospital care.	CEO Tygerberg Hospital

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
9) Tygerberg Hospital conducts monthly morbidity and mortality meetings	Tygerberg Hospital conducts at least one morbidity and mortality (M&M) meeting every month (3 per quarter, 12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases adverse events (morbidity) and proportion of deaths (mortality).	Hospital Semi-permanent Data version 2	SINJANI	M&M meetings conducted every month in Tygerberg Hospital	(Y/N)	Dependant on accuracy of data from reporting facility.	Quality	Compliance (Yes / No)	Quarterly	No	Yes suggests better clinical governance.	CEO Tygerberg Hospital
10) Percentage of complaints of users of Tygerberg Hospital's services resolved within 25 days	Percentage of complaints received from the users of Tygerberg Hospital's services that were resolved within 25 days.	To monitor the management of complaints in Tygerberg Hospital.	Numerator: Complaints and Compliments Register Denominator: Complaints and Compliments Register	Numerator: SINJANI Denominator: SINJANI	Numerator: Complaints resolved within 25 days in central hospitals Denominator: Complaints lodged in central hospitals	100 (%)	Dependant on accuracy of data, in particular the time stamp for each complaint, from reporting facility.	Quality	Percentage	Quarterly	No	Higher percentage suggests better management of complaints in Tygerberg Hospital.	CEO Tygerberg Hospital
11) Tygerberg Hospital patient satisfaction rate	Percentage of users that participated in the central hospital client satisfaction survey that were satisfied with the services. The question "I was pleased with the way I was treated" in the general satisfaction domain will be used to assess the client's overall satisfaction.	Tracks the service satisfaction of central hospital users.	Numerator: Client satisfaction survey Denominator: Client satisfaction survey	Numerator: SINJANI Denominator: SINJANI	Numerator: Number of questionnaires with 1 or 2 recorded for pleased with treatment Denominator: Number of questionnaires for pleased with treatment	100 (%)	Ability to generalise results dependant on the number of users participating in the survey.	Quality	Percentage	Annual	No	Higher percentage indicates better levels of satisfaction in Tygerberg Hospital services.	CEO Tygerberg Hospital
12) Tygerberg Hospital assessed for compliance with core standards	Percentage of central hospitals assessed for compliance against the 6 priority areas of the core standards and quality assurance.	Tracks the levels of compliance against the **6 priority areas of the core standards and quality assurance.**	Hospital Semi-permanent Data version 2	SINJANI	Tygerberg Hospital conducted a national core standards self-assessment	(Y/N)	Implementation plan and assessment tool to be provided by National Department of Health.	Quality	Compliance (Yes / No)	Annual	No	Yes indicates better compliance with the core standards in Tygerberg Hospital.	CEO Tygerberg Hospital

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL: TABLES CHS 5 AND CHS 6

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Caesarean section rate for Red Cross War Memorial Children's Hospital (RCWMCH)	Caesarean section deliveries are not done at Red Cross War Memorial Children's Hospital.	N/A	Numerator: N/A Denominator: N/A	Numerator: N/A Denominator: N/A	Numerator: N/A Denominator: N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2) Number of actual tertiary beds in RCWMCH	Actual (usable) beds in RCWMCH are beds actually available for use within RCWMCH, regardless of whether they are occupied by a patient or a lodger.	Tracks the availability of central hospital beds to ensure accessibility of central hospital services.	Inpatient Throughput Form	SINJANI	Actual (usable) beds in RCWMCH	None (no)	Dependant on accuracy of data from reporting facility.	Input	Cumulative	Quarterly	No	Actual (usable) beds should remain constant and should be operated within affordability limits while providing access for patients to clinical services.	CEO RCWMCH
3) Total separations in RCWMCH	Recorded completion of treatment and/or the accommodation of an inpatient in RCWMCH. Separations include day patients and inpatients who were discharged, transferred out to other hospitals or who died.	Monitoring the service volumes in RCWMCH.	Inpatient Throughput Form	SINJANI	Sum of: • Day patients • Inpatient deaths • Inpatient discharges • Inpatient transfers out in RCWMCH	None (no)	Dependant on accuracy of data from reporting facility.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	CEO RCWMCH
4) OPD total headcounts in RCWMCH	A headcount of all outpatients attending an outpatient clinic in RCWMCH.	Monitoring the service volumes in RCWMCH.	Outpatient and Inpatient Related Services	SINJANI	Sum of: • OPD new case not referred • OPD new case referred • OPD follow-up in RCWMCH OR Sum of: • OPD general • OPD specialist in RCWMCH	None (no)	Dependant on accuracy of data from reporting facility.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on the public health system.	CEO RCWMCH

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Patient day equivalents (PDE) in RCWMCH	Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Monitoring the service volumes in RCWMCH.	Inpatient Throughput Form Outpatient and Inpatient Related Services	SINJANI SINJANI	Sum of: • Inpatient days • 1/2 day patients • 1/3 OPD headcount • 1/3 emergency headcount in RCWMCH	None (no)	Dependant on accuracy of data from reporting facility.	Output	Sum for period under review	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system.	CEO RCWMCH
6) Bed utilisation rate (based on actual beds) in RCWMCH	Patient days in RCWMCH during the reporting period, expressed as a percentage of the sum of the daily number of actual (usable) beds in RCWMCH.	Track the over / under utilisation of RCWMCH beds.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in RCWMCH Denominator: Number of actual (usable) bed days in RCWMCH (Actual (usable) beds x number of days in the reporting period)	100 (%)	Dependant on accuracy of data from reporting facility.	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels.	CEO RCWMCH
7) Expenditure per patient day equivalent (PDE) in RCWMCH	Average cost per patient day equivalent in RCWMCH. Patient day equivalent is a weighted combination of inpatient days, day patients, and OPD and emergency headcounts. All hospital activity is expressed as an equivalent to one inpatient day.	Track the expenditure per PDE in RCWMCH.	Numerator: Financial data Denominator: Inpatient Throughput Form Outpatient and Inpatient Related Services	Numerator: BAS Denominator: SINJANI	Numerator: Total expenditure in RCWMCH (sub-programme 5.1) Denominator: Patient day equivalent (PDE) in RCWMCH	None (no)	Accuracy of expenditure dependant on the correct expenditure allocation. Accuracy of PDE's dependant on quality of data from reporting facility.	Efficiency	Rate	Quarterly	No	Lower rate indicates efficient use of financial resources.	CEO RCWMCH
8) Average length of stay in RCWMCH	Average number of patient days that an admitted patient spends in RCWMCH before separation.	To monitor the efficiency of RCWMCH.	Numerator: Inpatient Throughput Form Denominator: Inpatient Throughput Form	Numerator: SINJANI Denominator: SINJANI	Numerator: • Inpatient days • 1/2 day patients in RCWMCH Denominator: Total separations in RCWMCH	None (no)	Dependant on accuracy of data from reporting facility.	Efficiency	Ratio expressed in days	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might hide poor quality of hospital care.	CEO RCWMCH

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
9) RCWMCH conducts monthly morbidity and mortality meetings	RCWMCH conducts at least one morbidity and mortality (M&M) meeting every month (3 per quarter, 12 per year).	To monitor the quality of hospital services, as reflected in levels of diseases adverse events (morbidity) and proportion of deaths (mortality).	Hospital Semi-permanent Data version 2	SINJANI	M&M meetings conducted every month in RCWMCH	(Y/N)	Dependant on accuracy of data from reporting facility.	Quality	Compliance (Yes / No)	Quarterly	No	Yes suggests better clinical governance.	CEO RCWMCH
10) Percentage of complaints of users of RCWMCH's services resolved within 25 days	Percentage of complaints received from the users of RCWMCH's services that were resolved within 25 days.	To monitor the management of complaints in RCWMCH.	Numerator: Complaints and Compliments Register Denominator: Complaints and Compliments Register	Numerator: SINJANI Denominator: SINJANI	Numerator: Complaints resolved within 25 days in central hospitals Denominator: Complaints lodged in central hospitals	100 (%)	Dependant on accuracy of data, in particular the time stamp for each complaint, from reporting facility.	Quality	Percentage	Quarterly	No	Higher percentage suggests better management of complaints in RCWMCH.	CEO RCWMCH
11) RCWMCH patient satisfaction rate	Percentage of users that participated in the central hospital client satisfaction survey that were satisfied with the services. The question "I was pleased with the way I was treated" in the general satisfaction domain will be used to assess the client's overall satisfaction.	Tracks the service satisfaction of central hospital users.	Numerator: Client satisfaction survey Denominator: Client satisfaction survey	Numerator: SINJANI Denominator: SINJANI	Numerator: Number of questionnaires with 1 or 2 recorded for pleased with treatment Denominator: Number of questionnaires for pleased with treatment	100 (%)	Ability to generalise results dependant on the number of users participating in the survey.	Quality	Percentage	Annual	No	Higher percentage indicates better levels of satisfaction in RCWMCH services.	CEO RCWMCH
12) RCWMCH assessed for compliance with core standards	Percentage of central hospitals assessed for compliance against the 6 priority areas of the core standards and quality assurance.	Tracks the levels of compliance against the **6 priority areas of the core standards and quality assurance.**	Hospital Semi-permanent Data version 2	SINJANI	RCWMCH conducted a national core standards self-assessment	(Y/N)	Implementation plan and assessment tool to be provided by National Department of Health.	Quality	Compliance (Yes / No)	Annual	No	Yes indicates better compliance with the core standards in RCWMCH.	CEO RCWMCH

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

HEALTH SCIENCES AND TRAINING: TABLE HST 1&2

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Intake of nurse students (1st year at nursing college)	Number of student nurses entering the first year of nursing college.	Tracks the training of nurses at nursing colleges.	Nurse Training Institutions (NEI) registration lists	HEI survey.xls	Intake of student nurses	None (no)	Dependant on accuracy of record keeping by both the Provincial DoH and nurse training institutions.	Input	Cumulative	Annual	No	Higher levels of intake are desired to increase the availability of nurses in future.	Human Resources Development (HRD) Programme Manager
2) Intake of nurse students (1st to 4th year at HEIs and nursing college)	Number of student nurses entering all years of study from 1st year to 4th year at nursing colleges AND higher education institutions (HEIs).	Tracks the training of nurses at nursing colleges AND HEIs.	Nurse Training Institutions (NEI) registration lists	HEI survey.xls	Intake of student nurses	None (no)	Dependant on accuracy of record keeping by both the Provincial DoH and nurse training institutions.	Input	Cumulative	Annual	No	Higher levels of intake are desired to increase the availability of nurses in future.	Human Resources Development (HRD) Programme Manager
3) Basic nurse students graduating (at nursing college)	Number of students who graduate from the basic nursing course at nursing colleges.	Tracks the production of nurses with a basic nursing qualification at nursing colleges.	Basic student nurses registration lists	HEI survey.xls	Basic student nurses graduating	None (no)	Dependant on accuracy of record keeping by both the Provincial DoH and nursing colleges.	Output	Cumulative	Annual	No	Higher numbers of student nurses graduating means an increase in the number of nurses that are available.	HRD Programme Manager
4) Basic nurse students graduating (at nursing college and HEIs)	Number of students who graduate from the basic nursing course at nursing colleges and higher education institutions (HEIs).	Tracks the production of nurses with a basic nursing qualification at nursing colleges AND HEIs.	Basic student nurses registration lists	HEI survey.xls	Basic student nurses graduating	None (no)	Dependant on accuracy of record keeping by both the Provincial DoH and nursing colleges.	Output	Cumulative	Annual	No	Higher numbers of student nurses graduating means an increase in the number of nurses that are available.	HRD Programme Manager
5) Students with bursaries from the province	Number of students provided with bursaries by the provincial Department of Health.	Tracks the number of health science students sponsored by the province to undergo training as future health care providers.	Signed bursary contract	HRD Full Time Bursary Database.mdb	Students with bursaries from the province	None (no)	Dependent on accuracy of record keeping by both the Provincial DoH and health science training institutions.	Input	Cumulative	Annual	No	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers.	HRD Programme Manager
6) EMC intake on accredited HPCSA courses	Number of EMC staff intake on HPCSA accredited programmes (one of these courses is a 2 year course).	Tracks the number of EMC staff who are registered on the HPCSA accredited courses.	EMC staff registration lists	EMC information system	Intake of EMC staff on accredited HPCSA courses	None (no)	Dependant on accuracy of record keeping by both the Provincial DoH and EMC College.	Input	Cumulative	Annual	No	Higher numbers of EMC staff graduating means an increase in the number of qualified EMC staff that are available.	HRD Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
7) Intake of Home Community Based Carers (HCBCs) trained	Intake of Home Community Based Carers (HCBCs) on training.	Tracks the training of Home Community Based Carers (HCBCs) on the various NQF levels.	Home Community Based Carers registration lists	EPWP web based database	Registration of Home Community Based Carers	None (no)	Dependant on accuracy of record keeping by both the Provincial DoH and training providers.	Input	Cumulative	Annual	No	Higher number of Home Community Based Carers receiving National Diplomas means an increase in the qualified Home Community Based Carers that are available.	HRD Programme Manager
8) Intake of data capturer interns	Intake of data capturer interns on a 12 month internship.	Tracks the number of data capturer interns.	Signed internship agreements	EPWP web based database	Intake of data capturer interns	None (no)	Dependant on accuracy of record keeping by the Provincial DoH.	Input	Cumulative	Annual	No	Higher number of data capturer interns means an increase in data capturer interns available for assimilation into posts at health care facilities leading to improved data management.	HRD Programme Manager
9) Intake of pharmacy assistants in training	Intake of learner pharmacist's assistants in training at basic and post basic level. (Learner pharmacist assistants basic for 12 months and post basic for 12 months.)	Tracks the training of pharmacist's assistants at a basic and post basic level.	Signed learnership agreements	EPWP web based database	Intake of pharmacist's assistants	None (no)	Dependant on accuracy of record keeping by both the Provincial DoH and training providers.	Input	Cumulative	Annual	No	Higher number of pharmacist's assistants in training means an increase in pharmacist's assistants available to address scarce skills.	HRD Programme Manager
10) Intake of Assistant to Artisan (ATAs) interns	Intake of Assistant to Artisan (ATAs) interns on a 12 month internship.	Tracks the number of Assistant to Artisan (ATAs) interns.	Signed learnership agreements	EPWP web based database: Municipal Information System for Infrastructure (MIS)	Intake of Assistant to Artisan (ATAs) interns	None (no)	Dependant on accuracy of record keeping by the Provincial DoH.	Input	Cumulative	Annual	No	Higher number of Assistant to Artisan (ATAs) interns means an increase ATAs available to address maintenance needs of health care facilities.	HRD Programme Manager
11) Intake of HR and finance interns	Intake of HR and finance interns on a 12 month internship.	Tracks the number of HR and finance interns.	Signed internship agreements	EPWP web based database	Intake of HR and finance interns	None (no)	Dependant on accuracy of record keeping by the Provincial DoH	Input	Cumulative	Annual	No	Higher number of HR and finance interns means an increase in HR and finance interns to address scarce skills.	HRD Programme Manager

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

LAUNDRY SERVICES: TABLES SUP 1 AND SUP 2

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Average cost per item laundered in-house	The average cost per linen item processed or laundered in-house at Tygerberg, Lentegeur and George Hospitals. The in-house laundry costs include the cost for electricity, water, coal, fuel, and salaries and wages. The expenditure on capital for buildings and equipment is excluded.	Monitor the cost per item laundered to ensure that in-house laundry services are cost effective.	Numerator: Financial records Denominator: Laundry linen count	Numerator: BAS Denominator: Laundry returns.xls	Numerator: Expenditure on in-house laundries excluding capital Denominator: Items laundered in-house	None (no)	Dependant on the accuracy of financial data and reliability of records kept by in-house laundries.	Efficiency	Rate	Quarterly	No	Lower cost indicates efficient use of financial resources.	Laundry manager (Directorate: Engineering and Technical Support)
2) Average cost per item laundered outsourced	The average cost per linen item processed or laundered by outsourced laundries. The outsourced laundry costs include the cost of capital, profit and VAT (all of which are not included in the in-house cost).	Monitor the cost per item laundered to ensure that outsourced laundry services are cost effective.	Numerator: Financial records Denominator: Private contractor accounts	Numerator: BAS Denominator: Private laundry returns.xls	Numerator: Expenditure on outsourced laundry services Denominator: Items laundered outsourced	None (no)	Dependant on the accuracy of financial data. Dependant on the submission of information and the reliability of records kept at private laundries.	Efficiency	Rate	Quarterly	No	Lower cost indicates efficient use of financial resources.	Laundry manager (Directorate: Engineering and Technical Support)

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Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

ENGINEERING SERVICES: TABLES SUP 1 AND SUP 2

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Percentage of engineering emergency cases attended to within 48 hours	The percentage of engineering emergency cases, reported by health facilities maintained by Engineering Services, that have been attended to (not necessarily resolved) within 48 hours from being reported.	To ensure emergency engineering repairs are undertaken as soon as possible in order that services can be rendered at health facilities.	Numerator: Engineering emergency repair job cards Denominator: Engineering emergency repair job cards	Numerator: Job card system Denominator: Job card system	Numerator: Engineering emergency repairs attended to within 48 hours Denominator: Engineering emergency repair job cards issued	100 (%)	Dependant on accuracy of record keeping at engineering workshops.	Output	Percentage	Quarterly	Yes	Higher percentage indicates better response time to emergencies.	Director: Engineering and Technical Support Services
2) Percentage of maintenance budget spent	Programme 7 expenditure on maintenance of health facilities as a percentage of the total Programme 7 budget for maintenance.	Tracks expenditure on maintenance of health facilities.	Numerator: Financial records Denominator: Financial records	Numerator: BAS Denominator: BAS	Numerator: Expenditure on maintenance Denominator: Budget for maintenance	100 (%)	Dependant on accuracy of financial data on BAS and costing of maintenance expenditure.	Input	Percentage	Quarterly	Yes	Higher percentage indicates efficient use of financial resources. Over-expenditure, if necessary funding is not available, however, is not desirable.	Director: Engineering and Technical Support Services
3) Percentage of clinical engineering maintenance jobs completed	The number of clinical engineering maintenance jobs completed (job cards closed) expressed as a percentage of clinical engineering maintenance jobs issued (job cards opened).	To ensure safety in terms of clinical engineering equipment at health facilities and to monitor progress on clinical engineering maintenance done by the Department.	Numerator: Clinical engineering job cards Denominator: Clinical engineering job cards	Numerator: Job card system Denominator: Job card system	Numerator: Clinical engineering jobs completed (job cards closed) Denominator: Clinical engineering job cards issued (job cards opened)	100 (%)	Dependant on accuracy of record keeping at clinical engineering workshop.	Output	Percentage	Quarterly	Yes	Higher percentage indicates more clinical engineering jobs have been completed resulting in improved safety of clinical engineering equipment at health facilities.	Director: Engineering and Technical Support Services
4) Percentage of maintenance jobs (excluding clinical engineering jobs) completed	The number of maintenance jobs (excluding clinical engineering jobs) completed (job cards closed) expressed as a percentage of maintenance jobs issued (job cards opened) excluding clinical engineering. Jobs include repairs, renovations, minor upgrades, etc. but exclude emergency jobs.	To ensure safety in terms of building and engineering equipment at health facilities and to monitor progress on maintenance done by the Department.	Numerator: Maintenance job cards Denominator: Maintenance job cards	Numerator: Job card system Denominator: Job card system	Numerator: Maintenance jobs completed (job cards closed) EXCLUDE clinical engineering and emergency jobs Denominator: Maintenance jobs issued (job cards opened) EXCLUDE clinical engineering and emergency jobs	100 (%)	Dependant on accuracy of record keeping at engineering workshops.	Output	Percentage	Quarterly	Yes	Higher percentage indicates more maintenance jobs have been completed resulting in improved safety of buildings and engineering equipment at health facilities.	Director: Engineering and Technical Support Services

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Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

FORENSIC PATHOLOGY SERVICES: TABLES SUP 1 AND SUP 2

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Percentage of FPS cases responded to within 40 minutes	Percentage of Forensic Pathology Service (FPS) cases responded to within the target of 40 minutes. The time is measured from receipt of the call until FPS arrives on the scene.	Monitor response times and therefore the efficiency of FPS.	Numerator: Rural: FPS 002 Metro: EMS Call Dispatch Log Denominator: Rural: FPS R003; Index Register Metro: EMS Call Dispatch Log	Numerator: Rural: FPS 002 Metro: EMS system Denominator: Rural: FPS R003; Index Register Metro: EMS system	Numerator: Cases responded to within 40 minutes (from receipt of call to arrival on FPS related death scenes) Denominator: Forensic pathology scenes attended (body receipt and deferral)	100 (%)	Dependent on accuracy of data from FPS laboratories.	Quality	Percentage	Quarterly	Yes	Higher percentage indicates appropriate resource allocation and co-ordination in FPS in order to achieve a 40 minute response time.	Forensic Pathology Services (FPS) Programme Manager
2) Percentage of FPS cases examined within 3 days	Percentage of FPS cases examined within three days from admission. The time is measured from when the deceased is admitted to FPS until the post-mortem examination is completed.	Monitor turnaround times and therefore the efficiency as well as available resources in FPS.	Numerator: Rural: FPS R003 Metro: FPS 002 Denominator: FPS R003 Death Notification	Numerator: Rural: FPS R003; Index Register Metro: Index Register Denominator: FPS R003 Metro: Index Register	Numerator: Cases examined within 3 days (from admission until post-mortem is completed) Denominator: Forensic pathology cases examined	100 (%)	Dependent on accuracy of data from FPS laboratories.	Quality	Percentage	Quarterly	Yes	Higher percentage indicates appropriate resource allocation and co-ordination in FPS in order to achieve a turnaround time of 3 days to examine FPS cases.	FPS Programme Manager
3) Percentage of FPS cases released within 5 days (excluding unidentified deceased)	Percentage of FPS cases released within 5 days from admission – excluding unidentified deceased. The time is measured from when the deceased is admitted to FPS until the post-mortem body is released for burial.	Monitor turnaround times and therefore the efficiency as well as available resources in FPS, internal to the service. Also monitor equity to access across the province.	Numerator: Rural: FPS R003 Metro: FPS 013 Denominator: FPS 013	Numerator: Rural: FPS R003; Index Register Metro: Index Register Denominator: FPS R003 Metro: Index Register	Numerator: Cases released within 5 days after admission (EXCLUDE unidentified deceased) Denominator: Bodies released (EXCLUDE unidentified deceased)	100 (%)	Dependent on accuracy of data from FPS laboratories.	Quality	Percentage	Quarterly	Yes	Higher percentage indicates appropriate resource allocation and co-ordination in FPS in order to achieve a turnaround time of 5 days for bodies to be released.	FPS Programme Manager

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
4) Deceased with unknown identity exceeding 90 days	Number of deceased within FPS who has not yet been positively identified after 90 days from admission. All unidentified deceased for which the 90 day period has elapsed during the reporting period should be included.	Monitor the efficiency within FPS as well as external stakeholders such as the SAPS and the Department of Home Affairs.	Rural: FPS R003 Metro: FPS 002	Rural: FPS R003 Metro: Index Register	Unidentified deceased after 90 days have elapsed (include only deceased for which the 90 day period elapsed during the reporting period)	None (no)	Dependent on accuracy of data from FPS laboratories.	Quality	Cumulative	Quarterly	Yes	Lower number indicates improved efficiency and/or better cooperation between various agencies responsible for the identification process.	FPS Programme Manager

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

MEDICINE TRADING ACCOUNT: TABLES SUP 1 AND SUP 2

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Working capital in the medicine trading account	The working capital available to support adequate stock-holding at the Cape Medical Depot.	Monitor that the working capital for the Cape Medical Depot is sufficient to support adequate stock holding.	Cape Medical Depot Capital Account	MEDSAS	Working capital for Cape Medical Depot	None (no)	Dependant on accuracy of MEDSAS system.	Input	Cumulative	Annual	No	Higher capital indicates ability to increase stock holding and avoid supply delays.	Director: Professional Support Services
2) Percentage of pharmaceutical stock availability	The percentage of pharmaceutical stock that is available at the Cape Medical Depot (CMD) from the list of stock that should be available at all times.	To ensure optimum pharmaceutical stock levels to meet demand.	Numerator: Stock master Denominator: Stock master	Numerator: MEDSAS Denominator: MEDSAS	Numerator: Pharmaceutical items that are in stock at the CMD Denominator: Pharmaceutical items on the stock register	100 (%)	Dependent on accuracy of data from FPS laboratories.	Efficiency	Percentage	Quarterly	Yes	Higher percentage indicate fewer items out of stock at the CMD.	Director: Professional Support Services

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

HEALTH FACILITIES MANAGEMENT: TABLE HFM 1 & 2 AND HFM 3

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
1) Percentage of preventative maintenance (equitable share) budget spent	Programme 8 expenditure on preventative maintenance for new buildings completed since 2006 expressed as a percentage of the Programme 8 budget allocation for preventative maintenance for new buildings completed since 2006. (Refers to earmarked funding.)	Tracks equitable share expenditure on preventative maintenance on new building projects completed since 2006.	Numerator: Financial data Denominator: Financial data	Numerator: BAS Denominator: BAS	Numerator: Expenditure on preventative maintenance (equitable share) on new buildings completed since 2006 Denominator Budget for preventative maintenance (equitable share) on new buildings completed since 2006	100 (%)	Dependant on the accuracy of financial data on BAS.	Input	Percentage	Quarterly	Yes	Higher percentage indicates efficient use of financial resources and well maintained health facilities. Over-expenditure, if necessary funding is not available, however, is not desirable.	Director: Engineering and Technical Services
2) Percentage of scheduled maintenance (equitable share) budget spent	Programme 8 expenditure on scheduled maintenance for health infrastructure and engineering equipment expressed as a percentage of the Programme 8 budget allocation for scheduled maintenance.	Tracks equitable share expenditure on scheduled maintenance for health infrastructure and engineering equipment.	Numerator: Financial data Denominator: Financial data	Numerator: BAS Denominator: BAS	Numerator: Operational expenditure (equitable share) on scheduled maintenance Denominator Budget for scheduled maintenance (equitable share)	100 (%)	Dependant on accuracy of financial data on BAS and costing of maintenance expenditure.	Input	Percentage	Quarterly	Yes	Higher percentage indicates efficient use of financial resources and improved condition of health facilities. Over-expenditure, if necessary funding is not available, however, is not desirable.	Director: Engineering & Technical Support Services
3) Percentage of Health Infrastructure Grant (HIG) budget spent	Health Infrastructure Grant expenditure expressed as a percentage of the Health Infrastructure Grant budget allocation.	Tracks expenditure on the Health Infrastructure Grant allocated to the Western Cape Department of Health by National Treasury.	Numerator: Financial data Denominator: Financial data	Numerator: BAS Denominator: BAS	Numerator: Health Infrastructure Grant expenditure Denominator: Health Infrastructure Grant budget	100 (%)	Dependant on accuracy of financial data on BAS.	Input	Percentage	Quarterly	Yes	Total budget allocated is spent in accordance with the cash flow.	Director: Infrastructure Support
4) Percentage of Hospital Revitalisation Grant (HRG) budget spent	Hospital Revitalisation Grant expenditure expressed as a percentage of the Hospital Revitalisation Grant budget allocation.	Tracks expenditure on the Hospital Revitalisation Grant allocated to the Western Cape Department of Health by National Treasury.	Numerator: Financial data Denominator: Financial data	Numerator: BAS Denominator: BAS	Numerator: Hospital Revitalisation Grant expenditure Denominator: Hospital Revitalisation Grant budget	100 (%)	Dependant on accuracy of financial data on BAS.	Input	Percentage	Quarterly	Yes	Total budget allocated is spent in accordance with the cash flow.	Director: Hospital Revitalisation Programme

Indicator title	Short definition	Purpose/Importance	Form (data collection)	Source	Method of Calculation	Factor (Type)	Data limitations	Type of indicator	Calculation type	Reporting cycle	New indicator	Desired performance	Indicator responsibility
5) Percentage of equitable share capital budget spent	Programme 8 capital expenditure on buildings and engineering equipment expressed as a percentage of the Programme 8 capital equitable share budget allocation.	Tracks equitable share expenditure on health infrastructure and engineering equipment.	Numerator: Financial data Denominator: Financial data	Numerator: BAS Denominator: BAS	Numerator Departmental and provincial equitable share expenditure Denominator Departmental and provincial equitable share budget	100 (%)	Dependant on accuracy of financial data on BAS.	Input	Percentage	Quarterly	Yes	Total budget allocated is spent in accordance with the cash flow. Higher percentage indicates efficient use of financial resources and improved health infrastructure and engineering equipment. Over-expenditure, if necessary funding is not available, however, is not desirable.	Director: Infrastructure Support
6) Percentage of capital projects completed	Number of projects that achieved practical completion (certificate issued by professional team) expressed as a percentage of the number of projects planned to achieve practical completion. (Joint Buildings Contracts Committee (JBCC) contract).	Tracks the progress of projects against the project plan i.e. the period allocated in which the project should be completed.	Numerator: Practical completion certificate Denominator: Practical completion certificate	Numerator: Rational Portfolio Manager (RPM) Denominator: RPM	Numerator: Practical completion certificates issued Denominator: Practical completion certificates planned / scheduled for issue	No (none)	Dependant on accuracy of data reflected on RPM.	Outcome	Percentage	Quarterly	Yes	A higher percentage will reflect that projects have been completed ahead of schedule.	Chief Director: Infrastructure Management

Note: Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

Provincial indicators (indicators additional to the nationally prescribed indicators) are highlighted in light purple.

ANNEXURE C
LIST OF FACILITIES

LIST OF FACILITIES AS AT FEBRUARY 2012

1. PRIMARY HEALTH CARE FACILITIES

1.1 Cape Town District

1.1.1 Eastern and Khayelitsha Sub-districts

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres Khayelitsha (Site B) CHC **Community Day Centres** Gustrouw CDC Ikhwezi CDC Kleinvlei CDC Macassar CDC Matthew Goniwe CDC Mfuleni CDC Michael Mapongwana CDC Nolungile CDC Strand CDC Town 2 CDC ***Midwife Obstetric Units*** *Khayelitsha (Site B) MOU* *Macassar MOU* *Michael Mapongwana MOU*	Blue Downs Clinic Dr Ivan Toms Clinic Gordon's Bay Clinic Khayelitsha (Site B) Clinic Kuyasa Clinic Luvuyo Clinic Macassar Clinic Male (Site C) Clinic Mayenzeke Clinic Nolungile Clinic Nolungile Youth Clinic Russel's Rest Clinic Sarepta Clinic Sir Lowry's Pass Clinic Site B Youth Clinic Site C Youth Clinic Somerset West Clinic Wesbank (Oostenberg) Clinic Zakhele Clinic	Driftsands Satellite Clinic Fagan Street Satellite Clinic Hillcrest (Kuils River) Satellite Clinic Kuilsriver Satellite Clinic	Macassar Mobile
1 CHC + 10 CDC	**19**	**4**	**1**

1.1.2 Klipfontein and Mitchells Plain Sub-districts

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres Guguletu CHC Hanover Park CHC Mitchells Plain CHC **Community Day Centres** Crossroads CDC Dr Abdurahman CDC Heideveld CDC Imzame Zabantu CDC Nyanga CDC Tafelsig CDC ***Midwife Obstetric Units*** *Guguletu MOU* *Hanover Park MOU* *Mitchells Plain MOU*	Crossroads 1 Clinic Crossroads 2 Clinic Eastridge Clinic Guguletu Clinic Hanover Park Clinic Heideveld Clinic Lansdowne Clinic Lentegeur Clinic Manenberg Clinic Masincedane Clinic Mzamomhle Clinic Nyanga Clinic Phumlani Clinic Rocklands Clinic Silvertown Clinic Vuyani Clinic Weltevreden Valley Clinic Westridge Clinic	Fezeka Satellite Clinic Hazendal Satellite Clinic Honeyside Satellite Clinic Mandalay Satellite Clinic Newfields Satellite Clinic	None
3 CHC + 6 CDC	**18**	**5**	**0**

1.1.3 Northern and Tygerberg Sub-districts

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres Delft CHC Elsies River CHC Kraaifontein CHC **Community Day Centres** Bellville South CDC Bishop Lavis CDC Dirkie Uys CDC Durbanville CDC Parow CDC Ravensmead CDC Reed Street CDC Ruyterwacht CDC Scottsdene CDC St Vincent CDC ***Midwife Obstetric Units*** *Bishop Lavis MOU* *Elsies River MOU* *Kraaifontein MOU*	Adriaanse Clinic Bishop Lavis Clinic Bloekombos Clinic Bothasig Clinic Brackenfell Clinic Brighton Clinic Delft South Clinic Dirkie Uys Clinic Durbanville Clinic Elsies River Clinic Fisantekraal Clinic Harmonie Clinic Kasselsvlei Clinic Netreg Clinic Northpine Clinic Parow Clinic Ravensmead Clinic Scottsdene Clinic St Vincent Clinic Uitsig Clinic Valhalla Park Clinic Wallacedene Clinic	Chestnut Satellite Clinic Groenvallei Satellite Clinic Leonsdale Satellite Clinic	Oostenberg Mobile
3 CHC + 10 CDC	**22**	**3**	**1**

1.1.4 Southern and Western Sub-districts

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres Retreat CHC Vanguard CHC **Community Day Centres** Albow Gardens CDC Grassy Park CDC Green Point CDC Hout Bay Harbour CDC Kensington CDC Lady Michaelis CDC Lotus River CDC Maitland CDC Mamre CDC Ocean View CDC Robbie Nurock CDC Woodstock CDC ***Midwife Obstetric Units*** *Retreat MOU* *Vanguard MOU*	Albow Gardens Clinic Chapel Street Clinic Cape Town Civic Centre Clinic Claremont Clinic Diep River Clinic Du Noon Clinic Factreton Clinic Fish Hoek Clinic Grassy Park Civic Centre Clinic Hout Bay Harbour Clinic Hout Bay Main Road Clinic Klip Road Clinic Langa Clinic Lavender Hill Clinic Lotus River Clinic Maitland Clinic Masiphumelele Clinic Melkbosstrand Clinic Muizenberg Clinic Parkwood Clinic Philippi Clinic Protea Park Clinic Retreat Clinic Saxon Sea Clinic Seawind Clinic Spencer Road Clinic Strandfontein Clinic Westlake Clinic Wynberg Clinic	Alphen Satellite Clinic Milnerton Satellite Clinic Pelican Park Satellite Clinic Pella Satellite Clinic Pinelands Satellite Clinic Schotscheskloof Satellite Clinic Sea Point Satellite Clinic Simon's Town Satellite Clinic Table View Satellite Clinic	Blaauwberg Mobile Redhill Mobile Melkbosstrand Mobile Witsand Mobile
2 CHC + 12 CDC	**29**	**9**	**4**

1.2 Cape Winelands District

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres	Aan-het-Pad Clinic	De Wet Satellite Clinic	Bonnievale Mobile
-	Annie Brown Clinic	Dirkie Uys Street Satellite Clinic	Bossieveld Mobile
	Bella Vista Clinic	Hexberg Satellite Clinic	Botha/Brandwacht Mobile
Community Day Centres	Bergsig Clinic	Maria Pieterse Satellite Clinic	Dal / E de Waal Mobile
Ceres CDC	Breerivier Clinic	Overhex Satellite Clinic	De Wet Mobile
Cloetesville CDC	Cogmanskloof Clinic	Rhodes Fruit Farm Satellite Clinic	Devon Valley Mobile
TC Newman CDC	Dalevale Clinic	Somerset Street Satellite Clinic	Franschhoek Mobile
Wellington CDC	De Doorns Clinic		Gouda Mobile
Worcester CDC	Don and Pat Bilton Clinic		Groot Drakenstein Mobile
	Empilisweni (Worcester) Clinic		Hermon Mobile
	Gouda Clinic		Hexberg Mobile
	Groendal Clinic		Karoo Mobile
	Happy Valley Clinic		Koelenhof Mobile
	Huis McCrone Clinic		Koue Bokkeveld Mobile
	Idas Valley Clinic		Montagu Mobile 1
	JJ Du Pre Le Roux Clinic		Montagu Mobile 2
	Kayamandi Clinic		Overhex Mobile
	Klapmuts Clinic		Robertson Mobile 1
	Klein Drakenstein Clinic		Robertson Mobile 2
	Klein Nederburg Clinic		Simondium Mobile
	Kylemore Clinic		Skurweberg Mobile
	Mbekweni Clinic		Slanghoek Mobile
	McGregor Clinic		Strand Road Mobile
	Montagu Clinic		Tulbagh Mobile
	Nduli Clinic		Warm Bokkeveld Mobile
	Nieuwedrift Clinic		Windmeul Mobile
	Nkqubela Clinic		Wolseley Mobile
	Op die Berg Clinic		
	Orchard Clinic		
	Patriot Plein Clinic		
	Phola Park Clinic		
	Prince Alfred Hamlet Clinic		
	Rawsonville Clinic		
	Sandhills Clinic		
	Saron Clinic		
	Simondium Clinic		
	Soetendal/Hermon Clinic		
	Touws River Clinic		
	Tulbagh Clinic		
	Victoria Street Clinic		
	Windmeul Clinic		
	Wolseley Clinic		
	Wolseley Medical Centre Clinic		
	Zolani Clinic		
0 CHC + 5 CDC	**44**	**7**	**27**

1.3 Central Karoo District

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres - **Community Day Centres** Beaufort West Hospital CDC	Beaufort West Constitution Street Clinic Kwamandlenkosi Clinic Laingsburg Clinic Leeu-Gamka Clinic Murraysburg Clinic Nelspoort Clinic Nieuveldpark Clinic Prince Albert Clinic	Klaarstroom Satellite Clinic Matjiesfontein Satellite Clinic Merweville Satellite Clinic	Beaufort West Mobile 1 Beaufort West Mobile 2 Laingsburg Mobile Leeu-Gamka Mobile Merweville Mobile Murraysburg Mobile Nelspoort Mobile Prince Albert Mobile
0 CHC + 1 CDC	**8**	**3**	**8**

1.4 Eden District

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres - **Community Day Centres** Alma CDC Bridgeton CDC Conville CDC Kwanokathula CDC Thembalethu CDC	Albertinia Clinic Amalienstein Clinic Blanco Clinic Bongolethu Clinic Calitzdorp (Bergsig) Clinic Crags Clinic D'Almeida Clinic De Rust (Blommenek) Clinic Dysselsdorp Clinic Eyethu Clinic George Civic Centre Clinic George Road Clinic Great Brak River Clinic Haarlem Clinic Heidelberg Clinic Hornlee Clinic Keurhoek Clinic Khayelethu Clinic Knysna Town Clinic Kranshoek Clinic Ladismith (Nissenville) Clinic Lawaaikamp Clinic New Horizon Clinic Oudtshoorn Clinic Pacaltsdorp Clinic Parkdene Clinic Plettenberg Bay Clinic Riversdale Clinic Rosemoor Clinic Sedgefield Clinic Toekomsrus Clinic Touwsranten Clinic Uniondale (Lyonsville) Clinic Wit Lokasie Clinic Zoar Clinic	Avontuur Satellite Clinic Brandwacht Satellite Clinic Dana Bay Satellite Clinic Friemersheim Satellite Clinic Hartenbos Satellite Clinic Herbertsdale Satellite Clinic Herold Satellite Clinic Karatara Satellite Clinic Melkhoutfontein Satellite Clinic Slangrivier Satellite Clinic Still Bay Satellite Clinic Van Wyksdorp Satellite Clinic Wittedrift Satellite Clinic	Albertinia Mobile Calitzdorp Mobile De Rust Mobile George Mobile Heidelberg Mobile Herold Mobile Keurhoek Mobile Knysna Mobile Ladismith Mobile Mossel Bay Mobile 1 Mossel Bay Mobile 2 Mossel Bay Mobile 3 Mossel Bay Mobile 4 Oudtshoorn Mobile 1 Oudtshoorn Mobile 3 Plettenberg Bay Mobile Riversdale Mobile Sedgefield Mobile Uniondale Mobile 1 Uniondale Mobile 2 Van Wyksdorp Mobile Zoar Mobile
0 CHC + 5 CDC	**35**	**13**	**22**

1.5 Overberg District

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres - **Community Day Centres** Grabouw CDC	Barrydale Clinic Botrivier Clinic Bredasdorp Clinic Buffeljagsrivier Clinic Caledon Clinic Elim Clinic Gansbaai Clinic Genadendal Clinic Greyton Clinic Hawston Clinic Hermanus Clinic Hermanus Hospital PHC Clinic Kleinmond Clinic Mount Pleasant Clinic Napier Clinic Railton Clinic Riviersonderend Clinic Stanford Clinic Struisbaai Clinic Suurbraak Clinic Swellendam Hospital PHC Clinic Willa Clinic Zwelihle Clinic	Baardskeerdersbos Satellite Clinic Bereaville Satellite Clinic Betty's Bay Satellite Clinic Onrus Satellite Clinic Pearly Beach Satellite Clinic Voorstekraal Satellite Clinic Waenhuiskrans Satellite Clinic	Barrydale Mobile 3 Bredasdorp Mobile 1 Bredasdorp Mobile 2 Caledon Mobile 1 Caledon Mobile 2 Caledon Mobile 3 Caledon/Hermanus/Stanford Mobile 4 Grabouw Mobile 1 Grabouw Mobile 2 Grabouw Mobile 3 Ruens Mobile 5 Swellendam Mobile 4 Villiersdorp Mobile 1 Villiersdorp Mobile 2
0 CHC + 1 CDC	**23**	**7**	**14**

1.6 West Coast District

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres - **Community Day Centres** None	Citrusdal Clinic Clanwilliam Clinic Darling Clinic Diazville Clinic Elandsbaai Clinic Graafwater Clinic Hanna Coetzee Clinic Klawer Clinic Laingville Clinic Lalie Cleophas Clinic Lamberts Bay Clinic Langebaan Clinic Louwville Clinic Lutzville Clinic Moorreesburg Clinic Piketberg Clinic Porterville Clinic Riebeeck Kasteel Clinic Riebeeck West Clinic Saldanha Clinic Van Rhynsdorp Clinic Velddrif Clinic Vredenburg Clinic Vredendal Central Clinic Vredendal North Clinic Wupperthal Clinic Wesbank (Malmesbury) Clinic	Abbotsdale Satellite Clinic Aurora Satellite Clinic Bitterfontein Satellite Clinic Chatsworth Satellite Clinic Doringbaai Satellite Clinic Ebenhaezer Satellite Clinic Eendekuil Satellite Clinic Goedverwacht Satellite Clinic Kalbaskraal Satellite Clinic Kliprand Satellite Clinic Koekenaap Satellite Clinic Koringberg Satellite Clinic Malmesbury Satellite Clinic Molsvlei Satellite Clinic Nuwerus Satellite Clinic Paternoster Satellite Clinic Redelinghuys Satellite Clinic Rietpoort Satellite Clinic Riverlands Satellite Clinic Sandy Point Satellite Clinic Stofkraal Satellite Clinic Wittewater Satellite Clinic Yzerfontein Satellite Clinic	Citrusdal Mobile 1 Clanwilliam Mobile Darling Mobile Graafwater Mobile Hopefield Mobile Klawer Mobile Leipoldtville Mobile Lutzville Mobile Malmesbury Mobile 1 Malmesbury Mobile 2 Moorreesburg Mobile Piketberg Mobile 1 Piketberg Mobile 2 Piketberg Mobile 5 Porterville Mobile Van Rhynsdorp Mobile Vredenburg Mobile Vredendal Mobile
0 + 0	**27**	**23**	**18**

2. HOSPITALS

2.1 Acute hospitals

2.1.1 District hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Eerste River False Bay GF Jooste Helderberg Karl Bremer Khayelitsha (Tygerb) Mitchells Plain Victoria Wesfleur	Ceres Montagu Robertson Stellenbosch	Beaufort West Laingsburg Murraysburg Prince Albert	Knysna Ladismith (Alan Blyth) Mossel Bay Oudtshoorn Riversdale Uniondale	Caledon Hermanus Otto du Plessis Swellendam	Citrusdal Clanwilliam LAPA Munnik Radie Kotze Swartland Vredenburg Vredendal	
9	**4**	**4**	**6**	**4**	**7**	**34**

2.1.2 Regional hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Mowbray Maternity Somerset	Paarl Worcester	-	George	-	-	
2	**2**	**0**	**1**	**0**	**0**	**5**

2.1.3 Tuberculosis hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Brooklyn Chest DP Marais	Brewelskloof	-	Harry Comay	-	Malmesbury ID Sonstraal	
2	**1**	**0**	**1**	**0**	**2**	**6**

2.1.4 Psychiatric hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Alexandra Lentegeur Stikland Valkenberg	-	-	-	-	-	
4	**0**	**0**	**0**	**0**	**0**	**4**

2.1.5 Rehabilitation hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Western Cape Rehab Centre	-	-	-	-	-	
1	**0**	**0**	**0**	**0**	**0**	**1**

2.1.6 Central hospitals

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Groote Schuur Red Cross War Memorial Children Tygerberg	-	-	-	-	-	
3	**0**	**0**	**0**	**0**	**0**	**3**

2.2 Step-down facilities

2.2.1 Step-down facilities

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Baphumelele Booth Memorial Hampton House Helderberg Hospice Ithemba Labantu Life Esidimeni Living Hope Trust Sarah Fox St Joseph's Home St Luke's Hospice Stepping Stones Themba Care Tygerberg Hospice	Boland Hospice Bram Care Ceres Step Down Luthando Stellenbosch Hospice	Cornerstone	@ Peace Palliative Bethesda Knysna Sub-acute Uniondale Step Down	Overstrand Care Themba Care	LAPA Munnik Siyabonga Vredendal Old Age Home	
13	**5**	**1**	**4**	**2**	**3**	**27**

2.2.2 Psychiatric step-down facilities

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
New Beginnings William Slater	-	-	-	-	-	
2	**0**	**0**	**0**	**0**	**0**	**2**

2.2.3 Chronic

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
-	-	Nelspoort	-	-	-	
0	**0**	**1**	**0**	**0**	**0**	**1**

2.2.4 Other specialised

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Maitland Cottage	-	-	-	-	-	
1	**0**	**0**	**0**	**0**	**0**	**1**

3. OTHER FACILITIES

3.1 Emergency Medical Services Ambulance Stations

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Khayelitsha Tygerberg Lentegeur Pinelands Atlantis	Bonnievale Ceres De Doorns Montagu Paarl Robertson Stellenbosch Touws River Tulbagh Worcester	Beaufort West Laingsburg Leeu-Gamka Murraysburg Prince Albert	Calitzdorp Dysselsdorp George Knysna Ladismith Mossel Bay Oudtshoorn Plettenberg Bay Riversdale Uniondale	Barrydale Bredasdorp Caledon Grabouw Hermanus Riviersonderend Swellendam Stanford Villiersdorp	Bitterfontein Citrusdal Clanwilliam Lamberts Bay Malmesbury Moorreesburg Piketberg Porterville Van Rhynsdorp Vredenburg Vredendal	
5	**10**	**5**	**10**	**9**	**11**	**50**

3.2 Forensic Pathology Laboratories (Mortuaries)

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Salt River Tygerberg Department of Forensic Medicine, University of Cape Town Department of Forensic Medicine, University of Stellenbosch	Paarl Stellenbosch Wolseley Worcester	Beaufort West Laingsburg	George Knysna Mossel Bay Oudtshoorn Riversdale	Hermanus Swellendam	Malmesbury Vredenburg Vredendal	
4	**4**	**2**	**5**	**2**	**3**	**20**

APPENDIX

CAPE TOWN WELLNESS DECLARATION

THE CAPE TOWN DECLARATION ON WELLNESS

8 NOVEMBER 2011

We, the participants in the first summit on wellness of the Premier of the Western Cape gathered in Cape Town on 8 November 2011:

1. Recognising that: -

1.1. Wellness is a key requirement for development

1.2. The Western Cape, as the other provinces of South Africa, principally suffers from a quadruple burden of disease consisting of high levels of:

1.2.1. HIV and AIDS and TB;

1.2.2. Maternal and childhood illnesses;

1.2.3. Intentional and non-intentional injuries;

1.2.4. Non-communicable diseases such as diabetes, cardio vascular, respiratory, cancers, mental diseases.

1.3. Wellness is built on a foundation of the health of children which starts at birth and is initiated and sustained with breastfeeding.

1.4. Ill health is strongly influenced by behavioural, socio - economic, structural and societal factors.

1.5. Inequity is strongly associated with increased ill health.

1.6. Achieving an increased state of wellness for all requires concerted interventions based on sound evidence and is best implemented through partnerships in an integrated whole of society approach.

2. Noting that: -

2.1. There are unacceptably high levels of risk factors and ill health, violence and road injuries in the Western Cape.

2.2. Ill health impacts on every stratum of the population in the province.

2.3. The most deprived are disproportionately affected by ill health and have unequal access to health care and this further exacerbates their vulnerability.

2.4. Most at - risk populations require specialised targeted interventions.

3. Affirm that: -

3.1. The province is committed to achieving the Millennium Development Goals related to infectious diseases, maternal and child health, gender equality, education, environmental sustainability and poverty as well as non - communicable diseases, violence and traffic injuries.

3.2. The province is committed to engage with the population, community and non - governmental organisations.

3.3. A shift towards a "whole of government" and a "whole of society" approach is imperative because government in South Africa cannot succeed without mobilising the ideas and energy of civil society and communities.

3.4. The prevention of risk factors, disease and its complications before it occurs must be the priority.

4. Realize that: -

4.1. To address infectious diseases

a. HIV prevention strategies including those addressing social, behaviour change and biomedical prevention strategies promoting safer sex is not at sufficient levels to stop new infections.

b. The increasing trend of multi-and extreme drug resistant TB suggests the need to identify cases of TB earlier and effect a first time cure.

c. HIV /AIDS and TB should be managed in an integrated manner.

4.2. To address child health

a. Important causes of death such as perinatal conditions, infectious disease, especially pneumonia, diarrhoea, TB and HIV / AIDS; violence and road injuries and non-communicable diseases must be tackled.

b. Poor nutrition, which is the underlying cause and the exacerbating risk factor of ill health in childhood, must be improved.

c. Effective early childhood development is required to reduce vulnerabilities during childhood, adolescence and adulthood.

d. The wellness of adolescents also needs to be addressed.

e. Improving the wellness and development of mothers, parents and families will advance the health of their children.

4.3. To address woman's health

a. Gender equality, reducing poverty, combating infectious diseases and reducing gender based violence is important.

b. It is essential to work with men and young boys to reduce and prevent gender-based violence and promote gender equality and women's wellness.

c. Quality and coverage of health services for women must be improved.

d. Awareness and management of sexual and reproductive health, cancers affecting women and mental health must be addressed.

4.4. To address violence and road injuries

a. It is necessary to accept that violence and road traffic injuries afflicting the province's citizens have reached epidemic proportions.

b. Men need to be included as an important focus group as they comprise a majority of injury deaths.

c. Alcohol, physical and social infrastructure are key risk factors for the burden of violence and road injuries and it is necessary to develop and implement strategies to reduce alcohol comsumption and improve physical and social infrastructure.

4.5. To address non communicable diseases and associated risk factors

a. Greater attention and focus must be given to non-communicable diseases which affect a large proportion of society.

b. Adequate attention to be given to mental disease, which contributes significantly to the burden of ill health, and places an undue strain on individuals, families, communities and social services.

c. Healthy choices related to healthy eating, physical activity, stopping smoking and the use of harmful drugs and the safe use of alcohol must be prioritised.

d. Efforts must be made to facilitate the right health choices which are not always the easiest or most affordable choice and often determined by the social and built environment.

e. Increase the availability of affordable healthy foods.

f. Synergies between the management of NCDs and chronic infectious diseases should be addressed.

5. Hereby commit to:-

5.1. Ensure sustainable long-term, inter-sectoral action to address the root causes of ill health, injuries and inequity.

5.2. Ensure gender equality and the education of all children as well as adult education.

5.3. Create environments in communities, schools and public and private institutions that reduce stigma and increase health literacy, are safe and stimulating for children and adults and that promote their wellness.

5.4. Address the structural, legislative and behavioural constraints and mobilise all members of society particularly in schools, workplaces communities and government to facilitate making the right choice to:

*eat healthy foods
*promote breastfeeding
*increase physical activity
* stop smoking and not smoke in the first place
*not do harmful drugs
*test for HIV and have safe sex
*drink alcohol safely
*drive safely
* stop violence
*responsibly use medicines
*immunise against infectious diseases.

5.5. Take responsibility for the wellness of our children.

5.6. Maximise the wellness of pregnant women and give special attention to the care of newborn babies

5.7. Promote early childhood nutrition through breastfeeding and effective early childhood development.

5.8. Support long-term adherence to medication and chronic disease management at individual and community level.

5.9. Interventions are informed by evidence and appropriate research.

5.10. Ensure a strong health system to detect and manage disease and their risk factors early and treat it effectively.

6. To fulfil these commitments

6.1. Develop policies and multi-sectoral interventions informed by evidence and provide resources to reduce the burden of disease and increase wellness.

6.2. Establish a robust surveillance (that includes both an estimation of mortality and morbidity), monitoring, evaluation and research capacity to support inter sectoral policy development and service delivery.

6.3. Establish / maintain/strengthen inter-sectoral working groups (that include infectious diseases, violence and traffic injuries prevention, women's health, maternal and child health, healthy lifestyles, mental health) to plan, co-ordinate, monitor and evaluate meaningful collaborative action towards specified health outcomes.

6.4. Engage Communities and build community capacity including the use of community agents/workers .

6.5. Establish information sharing, inter-sectoral fora of all parties including PPP interested in ensuring increased wellness in the province.

6.6. Determine and monitor targets to increase wellness.

7. Concluding statement

We acknowledge that this is the beginning of an important process for the whole of society to impact on the wellness of our people in the Western Cape.

ABBREVIATIONS

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ACSM	Advocacy, communication and social mobilisation
ACT	Assertive community teams
AECL(M)P	Acute emergency case load (management) policy
AGSA	Auditor-General of South Africa
AIDS	Acquired immune deficiency syndrome
ALS	Advanced life support
AMS	Air mercy service
AOP	Annual operational plan
AOS	Accounting officers system
APL	Approved post list
APP	Annual Performance Plan
ART	Anti-retroviral treatment
ARV	Anti-retroviral
ASSA	Actuarial Society of South Africa
ATA	Assistant to artisan
AZT	Azidothymidine / Zidovudine
BANC	Basic antenatal care
BAS	Basic Accounting System
BIMS	Bursary implementation management system
BLS	Basic life support
BMI	Budget management instrument
BOD	Burden of disease
CAD	Computer aided dispatch
CAT (scan)	Computerised axial tomography (scan)
CBS	Community-based services
CCG	Community care giver
CCW	Community care worker
CDC	Community day centre
CDU	Chronic dispensing unit
Ce-I	Centre for e-Innovation
CEO	Chief executive officer
CFO	Chief financial officer
CHC	Community health centre
CHS	Central hospital services
CHW	Community health worker
CI	Confidence interval
CIDB	Construction Industry Development Board
CMD	Cape Medical Depot
CMI	Compliance monitoring instrument
CMI-PO	Compliance monitoring instrument for predetermined objectives
CNP	Clinical nurse practitioner
CPD	Continuous professional development
CPIX	Consumer price index
CSIR	Council for Scientific and Industrial Research
CSP	Comprehensive Service Plan
CT	Computerised tomography
DBSA	Development Bank of South Africa
DDG	Deputy Director General
DH	District hospital
DHIS	District Health Information System
DHRD	Directorate: Human Resource Development
DHS	District health services / system
DMT	District management team
DOTS	Directly observed treatment short course
DPC	Disease prevention and control
DPSA	Department of Public Service and Administration
DR-TB	Drug resistant tuberculosis
DRG	Diagnostic related group

DTaP-IPV/Hib	Diphtheria, Tetanus, acellular Pertussis, inactivated polio vaccine and *Haemophilus influenza* type B combined
DTPW	Department of Transport and Public Works
EC	Emergency centre
ECC	Emergency control centre
ECD	Early child development
ECT	Emergency care technician
EHS	Environmental health services
EHWP	Employee Health and Wellness Programme
EMC	Emergency medical care
EMS	Emergency medical services
ENT	Ear, nose and throat
EPWP	Expanded Public Works Programme
Eq	Equitable
ESMOE	Essential steps in the management of obstetric emergencies
EXCO	Executive committee
FBU	Functional business unit
FP	Forensic pathologist
FPL	Forensic pathology laboratory
FPS	Forensic pathology services
GAAP	Generally accepted accounting principles
GBV	Gender based violence
GIAMA	Government Immovable Asset Management Act
GMT	Government motor transport
GSA	Geographic service area
GSH	Groote Schuur Hospital
H1N1	Subtype of Influenza Type A category virus (H1N1 – Haemagglutinin type 1 and Neuraminidase type 1)
HAST	HIV and AIDS, STIs and TB control
HCBC	Home community based carers
HCT	HIV counselling and testing
HEI	Higher education institution
HFM	Health facilities management
HIG	Health Infrastructure Grant
HIS	Hospital Information System
HIV	Human immunodeficiency virus
HOD	Head of Department
HPCSA	Health Professions Council of South Africa
HPTDG / HPT & D grant	Health professions training and development grant
HR	Human resource
HRD	Human resource development
HRG	Hospital Revitalisation Grant
HRH	Human resources for Health
HRIS	Human Resource Information System
HRM	Human resource management
HRP	Hospital revitalisation programme
HRP	Human resource plan
HST	Health sciences and training
IAR	Immovable asset register
ICD10	International classification of disease coding
ICS	Improved conditions of service
ICT	Information and communications technology
ICU	Intensive care unit
ID	Infectious diseases
ID	Implementing department
IDIP	Infrastructure delivery improvement programme
IGP	Infrastructure grant to provinces
ILS	Intermediate life support
IM	Information management
IMCI	Integrated management of childhood illnesses
IMLC	Institutional management labour committee

iMOCOMP	Improvement and maintenance of competencies of medical practitioners
IMR	Infant mortality rate
INP	Integrated nutrition programme
IPC	Infection Prevention and Control
IPT	Isoniazide prevention therapy
IPV	Intimate partner violence
IRM	Infrastructure reporting model
IT	Information technology
IUSS	Infrastructure Unit Systems Support
JBCC	Joint Buildings Contracts Committee
JIMI	Joint information management initiative
JOC	Joint operations centre
KYE	Know your epidemic
LG	Local government
LOGIS	Logistic Information Management System
M & E	Monitoring and evaluation
MCWH	Maternal, child, and women's health
MCWH & N	Maternal, child, and women's health and nutrition
MDG	Millennium development goal
MEC	Member of Executive Council
MDR	Multi-drug resistant
MIS	Municipal Information System
MMC	Medical male circumcision
MMR	Maternal mortality rate
MOU	Midwife obstetric unit
MRC	Medical Research Council
MRI	Magnetic Resonance Imaging
MSAT	Multi-sectoral action team
MTEF	Medium-term expenditure framework
MTS	Modernisation of tertiary services
N2	National road
NCCEMD	National Committee on Confidential Enquiry into Maternal Deaths
NCG	Nursing Colleges Grant
NDOH	National Department of Health
NDP	National Development Plan
NEC3	New engineering contract
NHI	National Health Insurance
NHS	National health system
NMB	New main building
NT	National Treasury
NPC	National Planning Commission
NPO	Non-profit organisation
NSDA	Negotiated service delivery agreement
NTSG	National tertiary services grant
OD	Organisational development
OHS	Occupational health and safety
OPC	Orthotic and Prosthetic Centre
OPD	Outpatient department
OSD	Occupational specific dispensation
P1	Priority 1
PACS	Picture Archive Communication System
PACS/RIS	Picture Archive Communication System and Radiological Imaging System
PAIA	Promotion of Access to Information Act
PCR	Polymerase chain reaction
PCV	Pneumococcal conjugate vaccine
PDE	Patient day equivalent
PEP	Post-exposure prophylaxis
PERSAL	Personnel and Salary Administration System
PET	Positron emission tomography
PES	Patient education system

PGWC	Provincial Government Western Cape
PHC	Primary health care
PHS	Primary health services
PHSDSBC	Public Health and Social Development Sectoral Bargaining Council
PIDAC	Provincial Infectious Diseases Advisory Committee
PILIR	Policy on incapacity leave and ill-health retirements
PMTCT	Prevention of mother-to-child transmission
PT	Provincial Treasury
PPHC	Personal primary health care services
PPHF	Public private Health Forum
PPP	Public private partnership
PPT	Planned patient transport
PSP	Professional service providers
PTB	Pulmonary tuberculosis
PTMS	Provincial Transversal Management System
QA	Quality assurance
R	Rand
RCC	Rolling continuation channel
RCWMCH	Red Cross War Memorial Children's Hospital
RIS	Radiological Imaging System
RPM	Risk and Performance Management
RTHB	Road-to-Health Booklet
RTI	Road traffic injuries
SA	South Africa
SADHS	South African Demographic and Health Survey
SANAC	South African National Aids Council
SANC	South African Nursing Council
SANTA	South African National Tuberculosis Association
SAPS	South African Police Service
SAQA	South African Qualifications Authority
SATS	South African Triage System
SCM	Supply chain management
SDC	Step-down care
SETA	Sector Education and Training Authority
SHERQ	Safety, health, environment risk and quality
SLA	Service level agreement
SM	Saving mothers
SMME	Small, medium and micro enterprise
SO	Strategic objective
SP	Strategic plan
STI	Sexually transmitted infection
TB	Tuberculosis
TBH	Tygerberg Hospital
U5MR	Under 5 mortality rate
U-AMP	User asset management plan
UCD's	Intra-uterine contraceptive devices
VAT	Value added tax
VMMC	Voluntary male medical circumcision
VPUU	Violence prevention through urban upgrade project
WCCN	Western Cape College of Nursing
WCDoH	Western Cape Department of Health
WCDTPW	Western Cape Department of Transport and Public Works
WCIDMS	Western Cape Infrastructure Delivery Management System
WCRC	Western Cape Rehabilitation Centre
WHO	World Health Organisation
WSAR	Wilderness search and rescue system
WSP	Workplace skills plan
XDR	Extreme drug resistant

LIST OF SOURCES

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1. ASSA 2003: ASSA2003 Model: Provincial Output. AIDS Committee of Actuarial Society of South Africa. http://www.actuarialsociety.co.za/aids/

2. BOD Project using data from City of Cape Town and Boland/Overberg mortality data, 2007.

3. Bourne, D., Matzopoulos, R., Bradshaw, D., Schaikh, N., Groenewald, P., Naledi, N.T., Brody, L., Blease, D., Laubscher, R., Zinyanktira, N., Daniels, J., Van Niekerk, M., Jeffries, D., & Van der Merwe, W. 2007. *Institutionalising a mortality surveillance system in the Western Cape Province to measure the burden of disease and the impact of preventive interventions: Western Cape burden of disease project*. Volume 2 of 7. Rondebosch: University of Cape Town.

4. Bradshaw, D. 2003. *Initial burden of disease estimates for South Africa, 2000.* Cape Town: Medical Research Council.

5. Bradshaw, D., Nannan, N., Groenewald, P., Joubert, J., Laubscher, R., Notilana, B., Norman. R., Pieterse, D., & Schneider, M. 2005. Provincial mortality in South Africa, priority-setting for now and a benchmark for the future. *South African Medical Journal*, 95 (7): 496-503.

6. Bradshaw, D., Nannan, N., Laubscher, R., Groenewald, P., Joubert, J., & Nojilana, B. 2004. *South African national burden of disease study 2000: Estimates of provincial mortality.* Cape Town: South African Medical Research Council.

7. Day C, Barron P, Monticelli P, Sello, editors. The District Health Barometer 2007/08. Health Systems Trust. Durban: Health Systems Trust; June 2009.

8. Department of Health. *Saving mothers: Fourth report on confidential enquiries into maternal deaths in South Africa 2005–2007*. Pretoria: Department of Health.

9. Department of Health. 2004. *South Africa demographic and health survey 2003-2004*. Preliminary report. Maryland: Measure DHS.

10. Department of Health. 2009. Framework for the national health planning guidelines for 5-year strategic plans of provincial departments of Health for 2010 – 2014. Pretoria: Department of Health.

11. Department of Health. 2010. Format for annual performance plans of provincial health departments for financial years 2011/12 – 2013/14. Pretoria: Department of Health.

12. Fact Sheet from foundation of Alcohol Related Research (FARR) found at http://www.farr.org.za/PDF/Fact_file.pdf

13. Groenewald, C. 2008. Western Cape: an overview. In Marindo, R. (reds.). The state of the population in the Western Cape. Cape Town: HSRC Press.

14. Groenewald, P., Bradshaw, D., van Niekerk, M., Jefferies, D. & Van der Merwe, W. 2007. Western Cape Province mortality. Report on cause of death and premature mortality in the Boland-Overberg Region 2004-2005. Western Cape Department of Health Burden of Disease Project.

15. Health Systems Trust (2010). South African Health Systems Review 2010. Durban: Health Systems Trust

16. Matzopoulos, R. 2005. Alcohol and injuries – a clear link. Southern African Journal of Epidemiology and Infection, 20: 114-115.

17. Millennium Development Goals: South Africa Country Report. The Presidency, Government of South Africa (2005). (http://www.statssa.gov.za)

18. National Planning Commission. 2011. National development plan: vision for 2030. The Presidency. Pretoria.

19. National Treasury. 2010. Framework for strategic plans and annual performance plans. http://www.treasury.gov.za

20. National Treasury. 2012. Budget formats guide for the preparation of the estimates of provincial revenue and expenditure 2012. Pretoria

21. National Treasury. 2012. Budget programme structure for publication – 2012 Budget. Pretoria.

22. Norman, R., Bradshaw, D., Schneider, M., Joubert, J., Groenewald, P., Lewin, S., Steyn, K., Vos, T., Laubscher, R., Nannan, N., Nojilana, B., Pieterse, D., & South African Comparative Risk Assessment Collaboration Group. 2007. A comparative risk assessment for South Africa in 2000: Towards promoting health and preventing disease. SAMJ, 97(8):637-641.

23. Norman, R., Matzopoulos, R., Groenewald, P., & Bradshaw, D. 2007.The high burden of injuries in South Africa. WHO Bulletin, 85 (9), 649-732

24. Provincial Treasury. 2008. Western Cape Provincial Government 2009 Budget Estimates of Provincial Expenditure. Cape Town: Western Cape Provincial Treasury

25. Statistics South Africa. 2001. Census 2001. Census in brief. Report no. 03-02-03 (2001). Pretoria: StatsSA.

26. Statistics South Africa. 2007. Community Survey. Pretoria: StatsSA.

27. Statistics South Africa. 2009. Mid-year population estimates, July 2009. Statistical release P0302. Pretoria: StatsSA.

28. Statistics South Africa. 2010. General household survey, August 2011. Statistical release P0318. Pretoria: StatsSA.

29. Statistics South Africa. 2010. Millennium development goals, country report 2010. Pretoria: StatsSA.

30. Statistics South Africa. 2011. Mid-year population estimates, July 2011. Statistical release P0302. Pretoria: StatsSA.

31. Statistics South Africa. 2011. Quarterly labour force survey. Statistical release P0211. Pretoria: StatsSA.

32. Stein, D.J., Seedat, S., Herman, A. 2008. Lifetime prevalence of psychiatric disorders in South Africa. The British Journal of Psychiatry, 192: 112-11

33. Western Cape Government: Health. 2007. Comprehensive service plan for the implementation of Health care 2010. Cape Town.

34. Western Cape Government: Health. 2011. Annual Report 2010/11. Cape Town.

35. Western Cape Government: Health. Directorate: Information Management, Circular H13/2010.

36. Western Cape Provincial Treasury. 2011. Medium term budget policy statement 2012 – 2015. Cape Town.

37. Western Cape Provincial Treasury. 2011. Provincial economic review and outlook. 2011. Cape Town

38. WHO (2004). Prevention of mental disorders: Effective interventions and policy options. World Health Organisation. Available: http://who.int/mentalhealth/evidence/en/preventionofmentaldisorderssr.pdf

39. Willet, Walter C. and Dietz, William H (1999): Guidelines for healthy weight. New England Journal of Medicine. Vol. 341: pg 247 - 434

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

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Afrikaans and isiXhosa versions of this publication are available on request.

Western Cape Government

Health

ISBN: 978-0-620-52911-2