ANNUAL PERFORMANCE PLAN

2011/2012

DEPARTMENT of HEALTH

Provincial Government of the Western Cape

WESTERN CAPE
DEPARTMENT OF HEALTH

ANNUAL PERFORMANCE PLAN
2011/12

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FOREWORD BY THE MINISTER OF HEALTH
ANNUAL PERFORMANCE PLAN: 2011/12

I look forward with excitement to the opening of the Khayelitsha District Hospital during the second half of 2011. The opening of this hospital is a significant milestone that will ensure more accessible health services to the people of the Western Cape. This will be followed by the completion of the Mitchells Plain Hospital during 2012.

During 2011 we will develop a vision and strategy for 2020 that will give effect to the Provincial strategic objective of increasing wellness amongst our people. This will be based on the sound technical foundations of the Comprehensive Service Plan, but will also focus on placing the patient back at the heart of the vision. This is aligned with the values of the Provincial Government of the Western Cape which are caring, competency, accountability, integrity and responsiveness.

The financial constraints within which the Department has to function mean that we have to work smarter in order to stretch our available resources to obtain the best possible value for money.

The provincial transversal management system in which task teams have been created will facilitate the work being done to address the upstream factors that impact on the burden of disease and the services that the Department is required to provide. It is anticipated that this will have a long term benefit on the disease profile of the people. I will continue to work with the private sector and other stakeholders to seek a coming together of the private and public sectors.

I would like to thank all the staff of the Department of Health for their hard work and commitment to providing this essential Health service, often in the face of difficult circumstances. Your contributions are sincerely appreciated.

I endorse this Annual Performance Plan which provides a detailed framework of the performance targets that have been set for the Department within the available funding constraints.

THEUNS BOTHA

WESTERN CAPE MINISTER OF HEALTH

FEBRUARY 2011

MESSAGE FROM THE HEAD OF DEPARTMENT

PROFESSOR KC HOUSEHAM

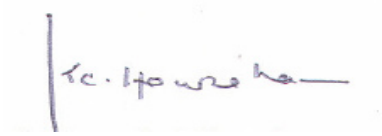
2011/12 is a landmark year in the recent history of the Department as the new, 230 bed Khayelithsha District Hospital will be commissioned in the latter half of 2011. This will be a major milestone in improving the access of the local community to a wide range of health services. The hospital will be a modern, world class facility that the Department and the community can be proud of and will go a long way in improving the patient experience of our services and also provide a pleasant working environment for staff.

2011/12 is also an important year as the strategic direction of the Department for the next ten years will be developed during 2011. There will be a structured public participation process to obtain comment on the draft plan. The Department will build on the achievements of the last decade and the implementation of the Comprehensive Service Plan. The key thrust of the Department for the forthcoming years will be on improving the quality of care and patient experience as well as improving efficiencies to get best value for the health rand. In particular the Department will focus on staff attitudes and address issues to improve staff morale.

The Department is committed to focus on a geographic and population based planning approach, which will enable specifics in each sub-district/district in terms of burden of disease, health outcomes and situational analysis and develop strategies to be identified and addressed.

The Provincial government is intent on becoming a values driven organization and has identified five key values: caring, competency, accountability, integrity and responsiveness. The Department will be following up on the results of the Departmental Barrett's survey to address specific areas of improvement in the Department.

My thanks go to all our staff for their commitment and dedication to the public health service. The Department would not achieve what it does without their daily efforts throughout the length and breadth of the health service. I also encourage everyone to actively participate in shaping the direction of the Department for the next decade.



PROFESSOR CRAIG HOUSEHAM

HEAD HEALTH: WESTERN CAPE

FEBRUARY 2011

OFFICIAL SIGN-OFF OF THE

ANNUAL PERFORMANCE PLAN: 2011/12

It is hereby certified that this Annual Performance Plan:

- Was developed by the management of the Western Cape Department of Health under the guidance of Minister Theuns Botha.
- Was prepared in line with the current Strategic Plan of the Western Cape Department of Health.
- Accurately reflects the performance targets which the Western Cape Department of Health will endeavour to achieve given the resources made available for 2011/12.

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 A: STRATEGIC OVERVIEW

PART B: PROGRAMME BUDGET PLANS

PART C: LINKS TO OTHER PLANS

PART A

STRATEGIC OVERVIEW

PART A: STRATEGIC OVERVIEW

1. VISION

Quality health for all.

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.

3. VALUES

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

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

These are reflected in the values of the Department of Health below, which are being reviewed to develop an approach to strengthen a values-based culture, based on the findings of the Barrett's Survey.

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

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.

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.	This strategic goal relates to the core business of the department, i.e. delivering a health service. 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.: **Outputs**: • Increase life expectancy • Decreasing maternal and child mortality • Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis Provincial strategic objective 04: Increase wellness
2. Quality of health services.	2.1. Improve the quality of health services.	The purpose of this goal is to focus on the importance of delivering a quality service in all spheres of the department to enable the department to deliver quality health care.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans.: **Outputs**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness
3. Strategic management capacity and synergy.	3.1. Ensure and maintain organizational 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.: **Outputs**: • 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.: **Outputs**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness
5. Health technology and infrastructure.	5.1. Provide and maintain appropriate health technology and Infrastructure.	This goal addresses the provision of the appropriate infrastructure to deliver the required service in the most cost effective and efficient manner. It address buildings, equipment and information communication technology.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans.: **Outputs**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness
6. Sustainable income.	6.1. Ensure a sustainable income to provide the required health services according to the needs.	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.	Negotiated Service Delivery Agreement [NSDA]: A long and healthy life for all South Africans.: **Outputs**: • Strengthening health system effectiveness Provincial strategic objective 04: Increasing wellness

5. LEGISLATIVE MANDATES AND NEW POLICY INITIATIVES

5.1 LEGISLATIVE MANDATES

The following provincial legislation has been recently promulgated:

- Western Cape District Health Councils Act, 5 of 2010

  "To provide for certain matters relating to district health councils so as to give effect to section 31 of the National Health Act, 2003; and to provide for matters connected therewith."

- Western Cape Ambulance Services Act, 3 of 2010

  "To provide for the licensing of ambulance services in the Province; and for matters connected therewith."

5.2 NEW POLICY INITIATIVES

The following policy initiatives are shaping the planning for the current budget cycle.

5.2.1 National government

The National Government will follow a new outcomes-based approach in developing the 2011 budget and has identified twelve targeted outcomes against which National Ministers have signed performance agreements with the President. These 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.

In order to achieve the above outcome for health there will be a focus on the following areas:

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.

5.2.2 Provincial government

The Provincial Government has a vision of an open opportunity society and has developed ten strategic objectives to address the most pressing challenges in development.

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) Increasing social cohesion
9) Poverty reduction and alleviation
10) Integrating service delivery for maximum impact
11) Increasing opportunities for growth and development in rural areas.

5.2.3 Increasing wellness [Extract of the Provincial Strategic Objective 4]

Key elements of the "Increasing wellness" provincial strategic objective, as approved by the Provincial Cabinet during 2010 are reflected in the shaded paragraphs below.

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

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

The nature of the burden of disease, which is addressed in the strategic objective, is not presented here as it is addressed in more detail in paragraph 6.3.

3. OUR APPROACH TO INCREASING WELLNESS

It follows from an understanding of the burden of disease that the Western Cape Department of Health cannot solely be responsible for increasing wellness. Indeed even collaborative action across all of government is not enough. What is needed is a whole-of-society approach that mobilises the resources, knowledge, creativity and concern of all role-players – including all three spheres of government, civil society, business, and individual citizens.

In order to structure our approach to increasing wellness coherently we have identified those areas of work which require collaboration between a number of government departments, and sometimes the whole of society, and separated these from those areas of work that are the core responsibility of the Department of Health.

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

4.1 Development of a new strategy towards 2020

The mandate of the Department of Health is the provision of a comprehensive package of health services, including the promotion of health, prevention of disease, curative care and rehabilitation, and training and education, delivered across all levels of care. In order to deliver on its mandate, the Department will develop a compelling vision for 2020 and an effective strategy to deliver on that vision by 1 August 2011.

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

Patient Centredness

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

public health sector in the Western Cape.

A move towards an outcomes based approach

The department will gear itself to focus on improving the health outcomes of patients and the broader population. This will include improving life expectancy and reducing maternal and child mortality. Targets will be guided by the millennium development goals. A strong culture and system of monitoring and evaluation will be embedded at all levels of the organization to ensure we deliver on these targets.

The retention of a Primary Health Care Philosophy

The PHC philosophy means providing a comprehensive service that includes preventive, promotive, curative and rehabilitative care. The primary care services are points of first contact for the patient. These services are supported and strengthened by all levels of care including acute and specialized referral hospitals and an efficient patient transport service.

The philosophy is also premised on the understanding that wellness cannot be promoted in isolation from social, economic and political factors. As per the World Health Organization, Health and Wellness is not seen as the mere absence of disease but a holistic state of physical, mental and emotional well-being. This therefore requires a strong inter-sectoral approach to improving health and wellness which is further elaborated below.

A central component of the PHC philosophy is the community involvement in health. This implies not only taking ownership and responsibility for their own health care at a personal level, but as a community also being involved in the decision making of the provision of health services.

Strengthening the District Health Services model

The DHS model gives the district health team the responsibility for achieving the health outcomes targeted for a specific geographical area. All health services (public and private) provided within the area are co-ordinated by the district health management team. The district manager is accountable and also plays a stewardship role in securing and accessing the support of other levels of the service.

The Department has begun to take early steps in this direction over the recent years. Health is delivered within well-defined sub - district and district boundaries in the province. PHC services and provincially aided district hospitals in the rural districts have been provincialised. This means that all public sector health services in the rural districts are provided by a single authority – the Provincial Government. District management structures and offices have been created. This consolidation will result in better co-ordination and improved efficiencies. The district model will be further strengthened to ensure the health outcomes necessary toward 2020.

Building Strategic Partnerships

Neither the Western Cape Department of Health nor the government as a whole can achieve increased wellness working alone. It is therefore essential that the provincial government seeks out and builds creative partnerships with actors in the

private sector, in civil society, in other spheres of government and internationally. This approach is also consistent with the government's vision of an open opportunity society for all in the Western Cape.

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

4.2 Immediate action

The Department of Health will continue to improve the service it provides while developing a 2020 vision and strategy. The immediate strategic goals for the Medium Term Economic Framework cycle are to:

- Manage the burden of disease (which includes improving quality of care).
- Ensure a sustainable income for the public health service.
- Develop and maintain a capacitated workforce.
- Ensure strategic management capacity.
- Provide and maintain appropriate health technology and infrastructure.

Key service delivery priorities for 2011/12 MTEF cycle (2011/12 – 2013/14) include:

- Focusing on quality of care initiatives.
- Commissioning the Khayelitsha District Hospital, scheduled for completion in January 2012.
- Commissioning the Mitchells Plain District Hospital, scheduled for completion 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.

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

5.1 Premier's summit on reducing the burden of disease

During the course of 2011 the Premier will host a summit on reducing the burden of disease. The purpose of the summit will be (1) to review the latest available data on the burden of disease, (2) to review the overall response to the burden of disease by all levels of government and by role-players outside of government in the private sector and civil society, (3) to identify an action agenda for

implementation designed to advance the collective effort of all role-players to reduce the burden of disease.

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

In order to address the greatest contributor to the burden of disease in the Western Cape, the government has endorsed a provincial HIV Counseling and Testing [HCT] plan. It contains the following targets for 2010/11 (to be adjusted annually):

- Test 1.2 million people for HIV
- Provide anti-retroviral therapy (ART) to 31 000 new clients
- Keep 96 000 HIV patients in care
- Screen 1.1 million patients for TB
- Distribute 122 million male condoms and 1 million female condoms

These steps will be supplemented by on-going campaigns to encourage the practice of safe sex and provide information about TB.

The HCT campaign uses the same opportunity to also screen for diabetes and high blood pressure. This is a partnership between all role players, including the private sector, and requires the en masse mobilization of communities.

The socio-economic contributory factors like poverty, unemployment, housing, education that underlie diseases such as TB, HIV and many others are addressed through other provincial government objectives.

5.3 Decreasing the incidence of injury

There are two primary drivers of the burden injury places on the health system: road accidents and violence relating to substance abuse, especially the abuse of alcohol.

To address these, two main strategies are being developed and implemented: first, a strategy to increase road safety with the aim of halving fatalities caused by road accidents; second, a strategy to reduce the incidence and harmful effects of substance abuse, including alcohol abuse. The road safety strategy is being developed as part of Provincial Strategic Objective 5, Increasing Safety, while the substance abuse strategy is part of Provincial Strategic Objective 8, Increasing Social Cohesion.

5.4 Promoting a healthy lifestyle

The primary cause of non-communicable diseases is unhealthy lifestyles, and in particular, (1) the excessive consumption of salt, unhealthy fats and sugar, (2) a lack of adequate exercise and (3) the long-term use of tobacco products.

In order to impact on lifestyles, a task team appointed by the Premier and including role-players from outside of government will investigate the creation of the Western Cape healthy lifestyles campaign, drawing on successful and well-documented examples of such campaigns elsewhere in the world. Behaviour change campaigns are notoriously difficult to make succeed and the design of a healthy lifestyles campaign in the Western Cape must be carefully considered by the best experts available.

5.5 Improving child health

The underlying driver of childhood illness and mortality is poverty and its consequences: unhealthy environments, inadequate access to quality healthcare and low levels of female education, particularly in respect of childhood health needs.

To address these, the PGWC will target both the environment and the healthcare response to the problem. Interventions include:

- An integrated human settlements strategy (Provincial Strategic Objective 6) designed to maximize the number of citizens with access to basic services, in particular clean water, sanitation, refuse removal and electricity. A key element of this strategy is the shift of resources from building top-structures to providing properly serviced sites. The target is to provide a total of 143 000 new housing opportunities (all of which include access to sufficient basic services) between 2010 and 2015.
- The accelerated rollout of the Department of Health's immunization programme
- The accelerated rollout of the Department of Health's programme to prevent the transmission of HIV from mothers to their children
- On-going implementation of the Department of Health's strategy to prevent deaths caused by diarrheal dehydration.

6. SITUATION ANALYSIS

6.1 POPULATION PROFILE

6.1.1 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 City of Cape Town. The Central Karoo covers the largest surface (38 873 km^2) whereas the City of Cape Town 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 2: Population estimates

District	Census 2001	Community Survey: 2007	2008	2009	2010	2011	2012	2013	2014	2015	% 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 3 reflects the inconsistent year on year growth rates in the published mid-year estimates. For this reason the Department of Health decided to use population projections based on Census 1996 and 2001 and the 2007 Community Survey for planning purposes.

Table 3: 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

Figure 1: Western Cape district municipalities

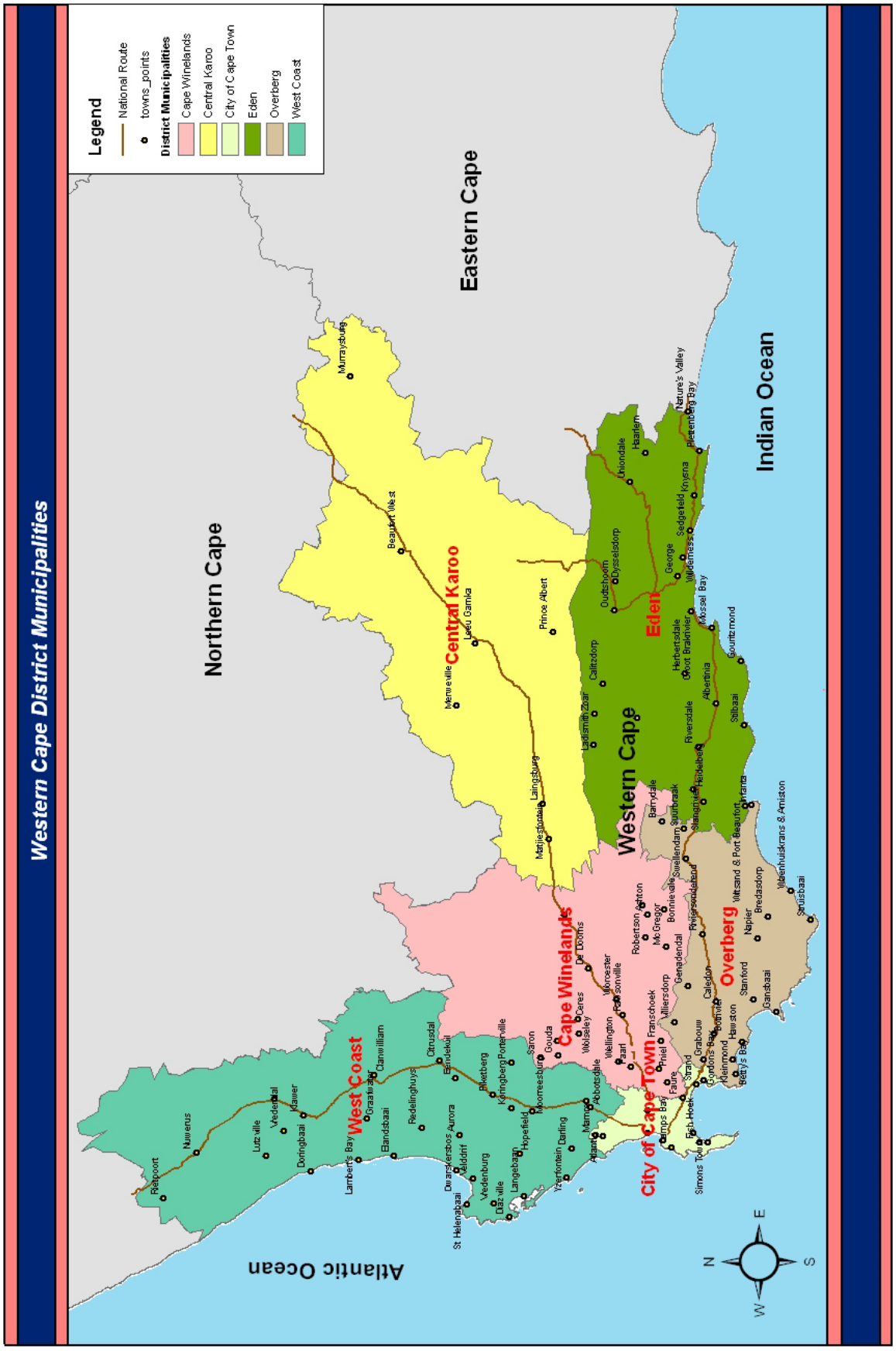
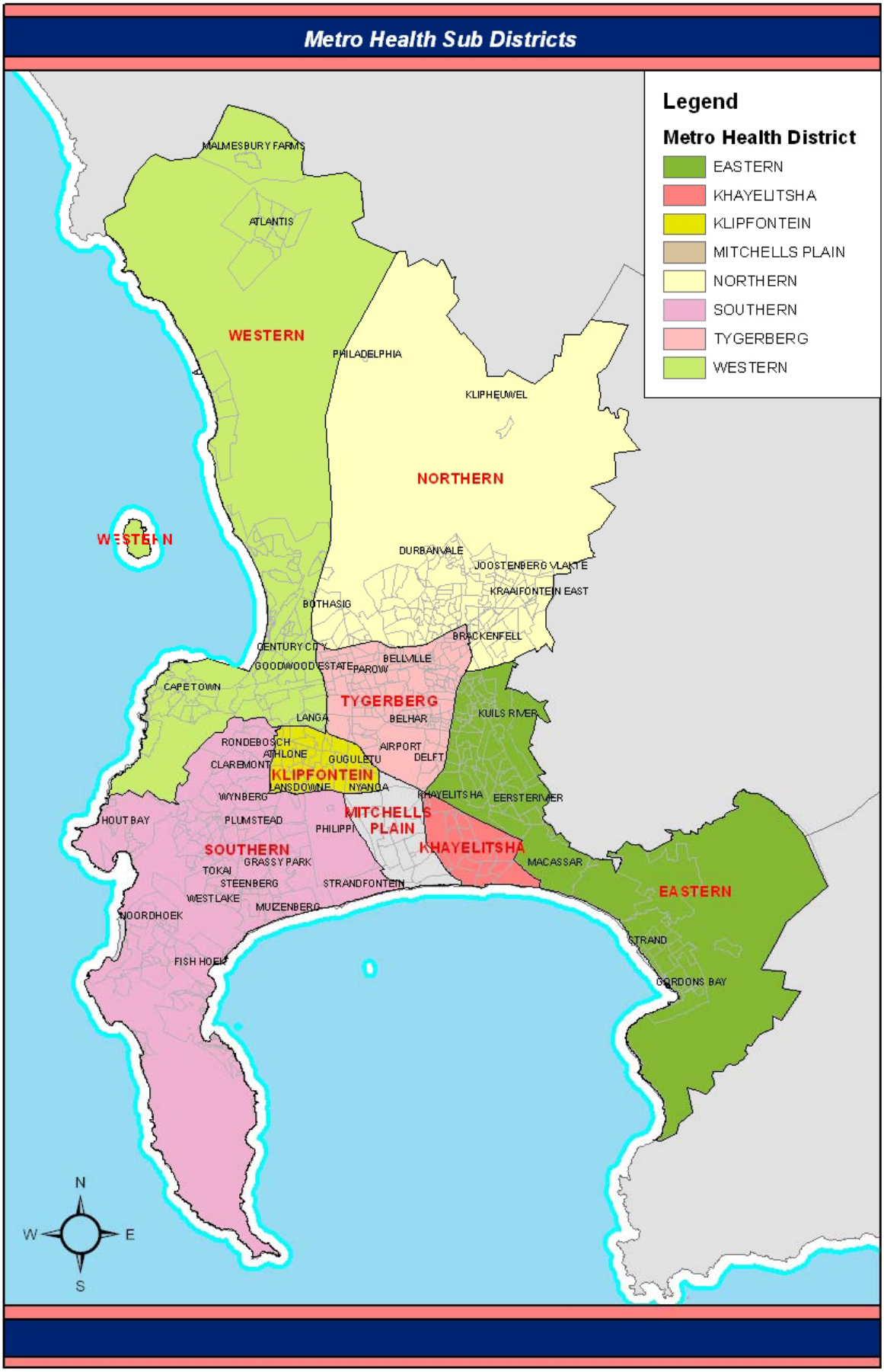


Figure 2: Cape Town Metro sub-districts



6.2 SOCIO-ECONOMIC PROFILE

The South African economic environment remains challenging as the projected tax revenues are relatively lower than those collected in previous periods. There is the added challenge that the national budget deficit as a ratio of the Gross Domestic Product increased significantly from 1% in 2008/09 to 6.7% in 2009/10.

The budgets of government departments therefore have to be prepared within stringent financial constraints which translates into 'doing more with what we already have' and probably 'doing more with less'.

The economic constraints impact directly on the Department's budget and its ability to provide health care. However, the economic climate also affects the well-being of the population through their ability to manage the drivers of the burden of disease.

According to the Quarterly Labour Force Survey, the Western Cape shed 25 000 jobs during the first half of 2010. The bulk of the losses are from the agricultural sector, mainly due to seasonal factors, followed by trade and private households sector. [Bureau for Economic Research: Quarterly Report for the Western Cape Department of Economic Development and Tourism: 12 August 2010].

Although the Western Cape has relatively good access to basic amenities compared to the rest of the provinces, inequities still exist between and within districts.

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 2007/08).

Province-specific deprivation indices (Stats SA) shows 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 1% 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 General Household Survey aims to determine the level of development in the country and has been undertaken on an annual basis since 2002. It is of concern that the population without adequate access to some of the basic services has increased over recent years. The following Table outlines that poverty and socio-demographic data obtained from the General Household Survey of 2009.

Table 4: Poverty and socio-demographic data for the Western Cape

Indicator	2002	2003	2005	2007	2009	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	-
Housing Percentage of households living in informal dwellings.	14.5%	15.6%	16.5%	19.1%	17.1%	13.4%
Source of energy Percentage of households connected to the mains electricity supply	88.4%	89.2%	92.7%	96.2%	90.0%	82.6%
Percentage of houses that use paraffin or wood for cooking	14.9%	14.8%	9.1%	6.0%	6.9%	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%	6.6%
Refuse removal Percentage of households whose refuse is removed by the municipality	84.0%	85.0%	91.6%	90.8%	73.6%	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%	89.3%

Source: General Household Survey: 2009

6.3 EPIDEMIOLOGICAL PROFILE/ BURDEN OF DISEASE

6.3.1 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/Aids
- TB
- Injuries (Violence and road traffic accidents)
- Non communicable diseases (Cardio vascular disease, high blood pressure, asthma, cancers and mental illness)
- Childhood illnesses

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 urbanization 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.

6.3.2 **Mortality rates**

The infant mortality rate (IMR) for the Western Cape was reported to be 45 per 1 000 live births compared to 43 per 1 000 live births nationally (2003 South African Demographic Health Survey) in 2003. However, prior to this, the 1998 South African Demographic and Household survey estimated the IMR to be 8.4 per 1 000 live births. Given the inconsistencies in the findings between the 2003 the 1998 survey results, the 2003 findings were considered implausible. The provincial mortality surveillance system of the Western Cape Burden of Disease project reports mortality data that accounts for 75% of the population in the province. Using this data the IMR for Cape Town is estimated to be 20.28. The ASSA 2003 model for IMR for 2003 also reports the estimate to be 26 per 1 000 live births compared to the national estimate of 48 per 1 000 live births.

Table 5: Infant Mortality Rate (per 1 000 live births)

	2002[1]	2003	2004	2005	2006	2007	Source
South Africa	59	-	-	-	48		[1]South African Health Review 2005: 302 [2]South African Health Review 2006: 386
Western Cape	30	-	-	-	26		
Cape Town Metro district	**-**	**25.16**	**23.74**	**22.28**	**21.40**	20.28	City of Cape Town 2009 Statistics are not available
Cape Town Metro Sub-districts	-						
Eastern	-	28.98	22.90	27.51	32.00	28.38	
Khayelitsha	-	42.11	36.61	34.72	31.33	30.16	
Klipfontein	-	28.65	28.79	27.41	24.65	24.74	
Mitchell's Plain	-	22.03	24.18	22.85	22.08	21.27	
Northern	-	24.55	20.80	22.88	20.62	21.08	
Southern	-	16.98	20.97	15.23	11.88	11.98	
Tygerberg	-	18.61	19.58	16.20	17.61	14.91	
Western	-	17.58	16.41	15.22	14.21	20.28	
Cape Winelands East				29	28		Groenewald et al. Cause of death and premature mortality in Boland Overberg Region, 2004-2006 (BOD Project)
Cape Winelands East Sub districts							
Breede River Winelands				28	24		
Breede Valley				21	23		
Witzenberg				42	45		
Overberg				35	26		
Overberg Subdistricts				29	28		
Cape Agulhas				35	23		
Overstrand				31	29		
Swellendam				11	23		
Theewaterskloof				31	26		

Note:
Cape Winelands East: Drakenstein and Stellenbosch data are not included in the infant mortality rates.

The 2000 Western Cape child (under 5 years) mortality rate was reported to be 46.3 per 100 000 live births compared to the national figure of 94.7 per 100 000 live births. (South

African Health Review 2006:386). The 2006 estimate using the 2003 ASSA model reported a child mortality rate of 39 per 1000 live births compared to the national estimate of 73 per 1000 live births.

Table 6: Trends in key provincial mortality indicators

Indicator	2000		2006 ASSA 2003		Source document	National Target
	Western Cape	National	Western Cape	National		
Infant mortality (under 1)	31.7	59.1	26	48	South African Health Review, 2006: 386	18 per 1 000 live births by 2014/15 South African Demographic and Health Survey (SADHS)
Child mortality (under 5)	46.3	94.7	39	73		20 per 1 000 live births by 2014/15 South African Demographic and Health Survey (SADHS)
	Western Cape					
	1999 - 2001	2002 - 2004	2005 - 2007			
INSITITUTIONAL maternal mortality ratio per 100,000 live births	56.4	86.2	67.6		Saving Mothers: Fourth report on confidential enquiries into maternal deaths in South Africa 2005 – 2007: 38, 311	100 per 100 000 live births

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

The population based measurement of maternal mortality remains a challenge and in the absence of complete vital registration reporting for births and deaths, developing countries have adopted various strategies to monitor these trends and in many areas, the data from the health facilities or institutions is the only source of continuous information.

According to the first triennial Saving Mothers (SM) report (1999 – 2001) the MMR for the Western Cape was reported as 56.4 per 100 000 live births. However, there was an increase in the SM 2002 – 2004 report, the MMR being 86,2/100 000 live births. The follow up triennial report, SM 2005 – 2007 the Western Cape had an MMR of 67.6/100 000 live births. The 2008 – 2010 triennial report is currently being completed. It is anticipated that there will be an increase in the latter because of the impact of the H1N1 pandemic. This indicates that despite being the lowest in the country, the provincial MMR still fluctuates between triennia.

When calculating a district MMR, an annual and even triennial comparison could be misleading, as the numbers of maternal deaths in some districts are very small. Therefore in the Fourth Saving Mothers Report (2005 – 2007) it was decided to calculate the district MMR over a six-year period i.e. over two triennia namely, 2002 – 2007.

Table 7: Institutional Maternal Mortality Ratio per district 2002 – 2007 in the Western Cape

DISTRICT	Number Maternal Deaths	Number Live Births	MMR Deaths per 100 000 Live births
Cape Town	243	333 687	72.82
Eden	50	54 137	92.36
Cape Winelands	35	75 439	46.4
West Coast	22	28 325	77.67
Central Karoo	9	6 408	140.45
Overberg	14	16 591	84.38

Saving Mothers Fourth report on Confidential Enquiries into maternal deaths in South Africa 2005 – 2007: 312 (Table 12.I.3)

The Saving Mother's Reports have identified the following "Big 5" causes of maternal deaths viz. non-pregnancy related infections (43.7%), of which AIDS is the main contributor; complications of hypertension (15.7%); obstetric haemorrhage (12.4%); pregnancy related sepsis (9.0%) and pre-existing maternal disease (6.0%) [Saving Mothers Report 2005 – 2007: page xi].

The Western Cape follows a similar pattern with the last two causes interchanging with acute collapse/embolism.

Although the Institutional MMR declined slightly from 2002-2004 to 2005-2007, it is still high in comparison to other middle income countries. The finding that 33.7% of all maternal deaths are "avoidable" indicates that there is considerable room for improvement. Some of the challenges relate to lack of emergency transport, specific facilities, such as intensive care units and theatres; and the non-availability of blood. From a management perspective issues such as adequate staffing and equipping of facilities needs to be addressed and from a health professional perspective there needs to be continued and extended outreach and support and skills training. [Saving Mothers: Fourth report on confidential enquiries into maternal deaths in South Africa 2005- 2007: 311-321].

Strategies to address these causes are, implementation of the PMTCT programme; providing antiretroviral therapy to those in need thereof and improving clinical skills of staff in managing obstetric emergencies. In addition to national guidelines developed by the National Committee on Confidential Enquiry into Maternal Deaths (NCCEMD) the Western Cape has also developed guidelines on managing the five main causes of maternal deaths.

To achieve a reduction of 75% in maternal deaths by 2015 the second part of MDG 5 namely "providing universal access to contraceptive services" should also receive attention.

6.3.3 HIV/AIDS

According to the 2009 National HIV Survey the estimated HIV prevalence for the Western Cape was 16.9% (CI 95%: 13.8 -20.5%). The weighted Provincial Survey estimate from the larger sub-district survey was 16.8% (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% (Table 2). 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%. 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 program 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 antiretroviral 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 program needs to expand its capacity to retain long-term ART patients in care.

6.3.4 **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. 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 79.4% last year. This 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 now stands at 8.2%. More effort will be required to reach the national and global 2011 target of a defaulter rate of below 5% and various partners as well as the community-based services are working towards achieving that goal. Reducing the default rate not only decreases the size of the infectious pool in the community but prevents the generation of drug resistant TB, which requires longer stays in hospital, is much more costly to treat, and has a very poor prognosis.

6.3.5 Injuries

The injury burden, which includes intentional injuries such as homicide and suicides, and unintentional injuries, such as road traffic injuries (RTI) and fire related injury, accounts for approximately 23.9% 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. 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.

6.3.6 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% of men and 27% of women are smokers.

The National Food Consumption Survey (2005) indicated that 26% of women of child bearing age (16-35years) in the Western Cape were overweight and 32.7% were obese. It is concerning that the prevalence of obesity is 8% 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.

6.3.7 **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. PROVINCIAL SERVICE DELIVERY ENVIRONMENT

7.1 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:

7.1.1 Service related successes:

1) The Chronic Dispensing Unit (CDU) has continued to improve service delivery as the number of prescriptions has risen throughout the reporting period, with approximately 140 000 prescriptions delivered to facilities in the Metro District Health Services and the West Coast District each month. At present there are approximately eighty facilities serviced by the CDU, which includes district hospitals, community health centres, clinics and old age homes. Patient waiting times at facilities where the CDU service is available have decreased significantly. The CDU promotes access by reducing the waiting times for medicines and improves the patient experience at health facilities.

2) Basic Antenatal Care (BANC) was successfully rolled out in the five rural districts, each of the five districts achieving at least 90% coverage for BANC implementation at PHC level.

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 (MOU's), that provide antenatal care services. Transmission rates have decreased from 3.6% in 2009/10 to an estimated 3% in 2010/11. 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.
- By the end of 2009/10 there were eighty-one fully functional ART service points in the Western Cape Province. At these eighty-one sites, there were 75 002 patients on ARV treatment at the end of March 2010. This is approximately 2% more than the target of 73 499.

4) **Steps taken to improve the management of TB patients across the service platform include:**

- Through the continued implementation of the TB Enhanced response, the TB Programme improved over the past year and targets for the TB cure rate and TB defaulter rate were exceeded.
- Seamless management of the TB service has been facilitated by the transfer of the management of the TB hospitals to the relevant district or sub-structure management team in District Health Services.
- A provincial project manager has been appointed on contract to co-ordinate monitoring and reporting functions at TB hospitals.
- Stable TB patients will be decanted into primary health care and community-based services to create more capacity to admit ill TB patients from acute hospitals.

5) MDR and XDR-TB is a serious and growing problem reflected by the significant increase in the number of patients registered during the past year. This has resulted in a chronic

shortage of TB hospital beds in the Cape Town Metro District. However, the Khayelitsha pilot model of ambulatory treatment of MDR-TB cases is demonstrating that MDR-TB patients can be successfully managed at primary health care level. Currently 80% of Khayelitsha MDR patients are treated at PHC clinics which has significantly reduced the burden on TB hospital beds. Early outcomes of the project show that patients are commenced on treatment much earlier and that the interruption rates have been reduced. The roll out of decentralised management of Drug-Resistant TB will be phased in from 2011/2012.

6) Expansion of community-based care services through the Expanded Public Works Programmes in Health has enabled people requiring health services, to be managed in communities where they live.

7) There are 155 non-profit organisations (NPOs) currently contracted with the Department providing community based care via approximately 2,455 care givers. Each care giver is expected to visit at least five patients during their 4.5 hour working day.

8) Day surgery capacity in regional hospitals has been increased. This cost effective provision of surgical services is welcomed in an environment where there is pressure on limited resources.

9) Red Cross War Memorial Children's Hospital commissioned the new digitalised theatre complex in 2009/10 with some theatres dedicated for certain surgical disciplines.

10) The package of care for acute hospitals has become a roadmap for the incremental expansion of services over the years. The package also provides a policy guideline for the services that should and should not be provided at each type of hospital. The services identified in the package also define the skills, and therefore the training that should be provided and the equipment that is required.

11) Each central hospital has a functioning infection prevention and control committee in place with key plans and monitoring systems aimed to improve patient safety.

12) Response time for emergency medical services in the Cape Town area has improved over the last year following the appointment of additional emergency medical services personnel. Improvement in response times involves a multi-pronged strategy and receives on-going attention. The response time in the rural districts of the Western Cape is good with 70% of responses being met within the target response time of less than 40 minutes.

13) Infrastructure: The construction of the Khayelitsha and Mitchell's Plain District Hospitals has commenced and is proceeding well. The buildings will be completed in the 2011/12 and 2012/13 financial years respectively. Other capital projects completed during 2010/11 are the Kwanokathula Community Day Centre and Ambulance Station; and the Ceres Ambulance Station. Three new Forensic Pathology facilities (Worcester, Paarl and Malmesbury) were commissioned during 2010/11.

14) A total of 271 nurses were successfully placed in health facilities across the Province for community nursing service.

15) A provincial nursing strategy was approved in August 2009 for implementation. In order to facilitate the implementation of the nursing strategy, the Integrated Nursing Education and Training Framework for the governance and execution of all formal and

informal nurse training in the Province was developed and approved by the Department. This framework allows for better co-ordination and alignment between service needs and training outputs. Additional facilities were accredited by the South African Nursing Council (SANC), as clinical placement areas for training nursing students.

16) 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.

17) Improvement in Clinical Governance

- Established provincial co-ordinating structures for each of the major clinical disciplines with a view to developing uniform clinical guidelines, system strengthening strategies and skills development at less specialised levels of care.
- Some of the clinical guidelines that have been developed include:
  - Priority setting in renal replacement therapy
  - Rural outpatient referral pathways
  - Radiation protection in theatres
  - CT scanning in children
  - Declaration of death protocol.
- Theatre management improvements through:
  - Uniform definitions and reporting
  - Monitoring theatre starting times and cancellation rates
  - Uniform management of the theatre service.
- Emergency centre management improved through the following:
  - Implementation of triage and the audit of performance.

18) Corporate Governance

- Together with Discovery Health the Department concluded a pilot project in Diagnostic Related Groups (DRGs), which will ultimately assist the Department towards effective management of its services and more appropriate resource allocation.

19) The table below reflects the trends in key provincial service volumes from 2007/08 to 2010/11, reflecting the extent of the service provided by the Department.

Table 8: Trends in key provincial service volumes [A2]

Indicator	2007/08 Actual	2008/09 Actual	2009/10 Actual	2010/11 Estimate
PHC total headcount	13 029 007	15 051 210	15 848 973	16 322 170
OPD headcount in district hospitals	515 501	508 504	504 673	541 840
Separations in district hospitals	203 932	221 365	238 085	238 363
OPD headcount in regional and central hospitals	1 320 299	1 261 592	1 165 841	1 181 003
Separations in regional and central hospitals	253 700	266 668	245 768	253 441
Total patient volume	15 322 439	17 309 339	18 003 340	18 536 817
Year on year change		13.0%	4.0%	3.0%

7.1.2 **Challenges**

Some of the challenges experienced include:

1) **Measles Outbreak**: There was a marked increase in hospital admissions due to the measles outbreak. This resulted in an additional workload for staff at all levels to manage the outbreak. The incidence of measles cases in the Province has decreased since June 2010, but sporadic cases are still being reported.
2) **Mass Campaign 2010 (Polio, Measles, H1N1, Vitamin A, Deworming medication)**: Large target groups and the capacity required to meet the campaign targets affected the coverage of routine vaccines. During the Mass Campaign HCT was launched which resulted in an increased workload for healthcare staff.
3) **Vaccine stock outs**: Major stock outs of Rotarix impacted on coverage.
4) **Rotarix vaccine stock outs**: This vaccine was introduced in the Western Cape on 1 November 2009 to reduce the incidence of diarrhoea due to Rotavirus but stock outs of the vaccine have impacted on the coverage. The challenge is that nationally there is a sole supplier of vaccines to the public health sector and there was contamination of the vaccine at manufacturer level resulting in country wide stock outs.
5) **Donated Fridges**: Cold chain capacity was expanded to accommodate the implementation of the new vaccines. Numerous breakdowns have resulted in stock losses and the transfer of stock to alternative storage space which has subjected vaccines to additional risk.
6) Providing antenatal care services at PHC facilities in the City of Cape Town.
7) Improving the uptake of contraceptive methods of the sexually active population.
8) Improving the skills of staff in promoting and inserting long acting contraceptive methods e.g. intrauterine contraceptive devices (UCD's).
9) The provision of theatre time is a significant challenge for surgical services. Several strategies have been implemented to improve theatre access for surgical patients. Theatre cancellations and surgical starting times for morning lists are carefully monitored to ensure optimal theatre utilisation.
10) Under spending on capital projects due to the lack of availability and delayed acquisition of appropriate sites, delays in planning, poor performance of service providers, i.e. professionals and contractors, and the current service delivery model.

- Hospital Revitalisation Programme (HRP)
  - The HRP budget was under-spent by approximately R50 million which is approximately 10% of the budget. Reasons for the under expenditure are the slow progress in the construction of Mitchells Plain and Worcester(Phase 4) Hospitals as well as the delay in the finalisation of the planning for Vredenburg Hospital
- Infrastructure Grant to Provinces (IGP)
  - The IGP was under-spent by R20 million. Reasons for the under expenditure are the delays in the planning and construction phases for the majority of the projects.

11) A rural nursing student campus of the Western Cape College of Nursing (WCCN) in Worcester was established and fifty students have commenced with a 4-year diploma nursing programme in January 2010. The proposed student campus at George could not be established due to the lack of a suitable building for the campus. The number of new nursing students enrolled at WCCN for a 4-year nursing diploma programme (R425) is 265 in 2008, 368 in 2009 and 361 in 2010 respectively. The actual number of students who remain on the programme decreases, however, due to attrition.

12) The fundamental capacity constraints facing the Department include:

- Insufficient funding for the appointment of the appropriate numbers and skill mix of personnel.
- The challenge of recruiting and retaining highly skilled and experienced health care personnel.
- The challenge of recruiting and retaining scarce skill categories of employees including skilled and experienced management/administrative personnel, particularly in human resource management, finance and people with technical skills such as artisans, medical technicians and engineers.

7.2 REVIEW THE PROGRESS TOWARDS THE HEALTH RELATED 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 9: 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.
		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.
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 % of under 5 year olds sleeping under insecticide treated bed-nets and treatment to be measured by % of under 5 year olds who are appropriately treated.
		Prevalence and death rates associated with TB.
		Proportion of TB cases detected and cured under 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.

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	2005	2006	2007	2008	2009	2015 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.		0.56%	0.89%	2.5%	2.45%	2.58%		9.3%		DHIS
		Numerator				11 331	12 291	12 865				
		Denominator				462 245	495 992	497 995				
		2) Incidence of severe underweight in children under 5 years of age	-	-	-		5/1 000	14/1 000				
		Numerator					2 248	8 861				
		Denominator					495 992	497 995				
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	25.3	-	-	15	43 per 1 000	14.3 or less per 1 000	SADHS 1998 and 2003 ASSA 2003
		4) Child (under 5) Mortality Rate/ 1000 live births	-	-	39.0	38.8	-	-	30	69 per 1 000	45 per 1 000	SADHS 1998 and 2003 conducted by NDOH
		5) Measles coverage under 1 year	91.7	90.7	93.7	102.8	99.7	-	>90	85.8% in 2007	100%	Departmental Annual Reports
Improve Maternal Health.	Reduce by three quarters between 1990 and 2015, the maternal mortality rate.	6) Maternal Mortality Ratio/100 000 live births	98.8*	-	-	-	-		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.
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.	15%	12.8%	11.%	11.0%	10.9%	12.1%	8%			Years 2004 to 2006 are reported from the published 2006 HIV and Syphilis prevention survey brochure. Years 2007 to 2009: the same method used for analysis for the previous years was used.
		9) Condom distribution rate from public sector health facilities (per male >15years)	15.6	20.1	25.7	41.1	36.9	-	-	33.6%		Departmental Annual Reports.
		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%	71.9%	77.6%	79.7%	79.4%	84%	65%	85%	Departmental Annual Reports.
		12) TB Incidence Rate per 100 000	967	1 041	1 038	1 004	947.8	909	-			Departmental Annual Reports.

7.3 NATIONAL HEALTH SYSTEMS [NHS] PRIORITIES FOR 2009 – 2014: THE NATIONAL DEPARTMENT OF HEALTH TEN POINT PLAN

Table 11: 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) Mobilize 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 program evaluation
	6) Development of a social compact
	7) Grassroots mobilization 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) Decentralization 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. Revitalization 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 revitalization
	29) Review the funding of the Revitalization program and submit proposals to get the participation of the private sector to speed up this program
7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases	30) Implementation of 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 programs
	34) Strengthen programmes focusing on Maternal, Child and Women's Health
	35) Place more focus on the programs 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

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

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

Output 1: Increasing life expectancy

Output 2: Decreasing maternal and child mortality

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

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

1) Revitalisation of Primary Health Care
2) Healthcare 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 12: Provincial contribution towards the achievement of the four NSDA outputs

PROVINCIAL PRIORITIES FOR 2011/12	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET [REQUIRED PROVINCIAL PERFORMANCE] BY 2014/15
1. 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 1.1.2. Convene a summit of all role-players to discuss the burden of disease and the 'whole of society' approach to wellness. 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.	Action plan to reduce the burden of disease developed and approved.
1.2. Decrease the incidence of injury	The following strategies are transversal across various departments 1.2.1. Reduce the burden of disease from intentional and unintentional injury: 1) Increase road safety with the aim of halving fatalities caused by road accidents. 2) Establish a workgroup to develop strategies to reduce the harmful effects of substance abuse, including alcohol.	Inter-sectoral action plan to reduce the harmful effects of alcohol abuse to be developed and approved.
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.
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.	P1 calls with a response time <15 minutes in an urban area. P1 calls with a response time <40 minutes in a rural area.
2. OUTPUT 2: DECREASING MATERNAL AND CHILD MORTALITY		
2.1. Decrease the maternal mortality rate	2.1.1. Implement the Saving Mothers and Children's Plan to address the recommendations of the National Committee on the Confidential Enquiry into Maternal Deaths that is being implemented. 2.1.2. Prioritisation of emergency transport 2.1.3. Accelerated staff training programmes	Reduction in Maternal mortality rate of less than 44 per 100 000 live births by 2014/15 Public health facility maternal mortality rate
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 1000 live births by 2014/15. Public health facility infant mortality rate
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 8% by 2014/15. ??? Projected 159 688 total registered patients receiving Antiretroviral Therapy (ART patients) by 2014/15

PROVINCIAL PRIORITIES FOR 2011/12	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET [REQUIRED PROVINCIAL PERFORMANCE] BY 2014/15
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/IHIV Treatment and Adherence Support .	New smear positive PTB cure rate above 85% by 2014/15
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.	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 a single provincial sphere of government in the Western Cape.
	Establish the six district health councils.	Implementation of the Western Cape District Health Councils Act and the establishment of the 6 district health councils.
4.2. **Health care financing and management:**		
4.2.1. Occupation specific dispensation for health professionals to be fully funded.	• Detailed costing of the required funding for OSD. • 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.
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 NDoH to demonstrate the funding and policy challenges.	
4.2.3. Develop and retain appropriate financial management capacity at all levels of the service.	4.2.3.1. Address auditor-general's 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.
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, • Organization 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.
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, programs and clinical placement sites of students with relevant coordination thereof;	An operational plan in place initially 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

PROVINCIAL PRIORITIES FOR 2011/12	PLANNED PROVINCIAL STRATEGIES AND ACTIVITIES	TARGET [REQUIRED PROVINCIAL PERFORMANCE] BY 2014/15
	4.3.2.6. Coordinate formal and informal nurse training programs and initiatives, in line with Comprehensive Service Plan, required strategic focus and nursing education legislation; 4.3.2.7. Harmonize and integrate nursing education and training with practice.	
4.4. **Quality of Health and accreditation of health establishments**:		
4.4.1. Develop a patient centred approach.	4.4.1.1. Develop an action plan to address and monitor progress for the six priority focus areas within the national core standards policy document.	Improved patient care and the satisfaction of the users of the health care system.
4.4.2. Monitoring and evaluation of the quality of clinical care.	4.4.2.1. Monthly mortality and morbidity meetings. 4.4.2.2. Participate in initiatives like Best Care Always	
4.4.3. Effective management and supervision 4.4.3.1. Licensing and inspectorate 4.4.3.2. Chronic Dispensing Unit	• The phased rollout of the implementation of the Core Standards to be the point of departure towards accreditation and licensing of facilities. • 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.	Establishment of a provincial licensing and inspectorate for all facilities (public and private) Drug supply management system implemented to ensure a stock out rate of <3% of stock items.
4.5. **Health infrastructure**:		
4.5.1. Construction of new District Health Service Facilities (Primary Health Service, and District Hospitals).	4.5.1.1. Construction completion of the new Khayelitsha and Mitchell's Plain Hospitals, 4.5.1.2. Upgrade and extension at Ceres, Karl Bremer, Knysna and Hermanus Hospitals, 4.5.1.3. Construction completion of the new Grassy Park Clinic, Knysna Witlokasie and Westbank Malmesbury Community Day Centres.	Allocate 6% of the total health budget to Programme 8 capital funding by 2014/15.
4.5.2. Construction of new EMS and FPL facilities	4.5.2.1. Construction completion of the new Leeu Gamka and Vredendal Ambulance Stations. 4.5.2.2. Construction completion of the new Beaufort West and Riversdale Forensic Pathology Laboratories.	Project completed
4.5.3. Hospital Revitalisation for Valkenberg and Brooklyn Chest Hospitals	4.5.3.1. Detailed design completed	Construction to be started in the MTEF 2011
4.5.4. PPP for the new Tygerberg Hospital	4.5.4.1. Feasibility Study	Business case to be concluded
4.5.5. Improving maintenance and life cycle costing for all health infrastructure	4.5.5.1. Maintenance Information Management System	Maintenance plan for all new health facilities
4.6. **Information, communication and technology and Health Information Systems: LIDA**		
4.6.1. Ensure good data quality by implementing the Compliance Management Instrument for predetermined objectives (CMI-PO)	4.6.1.1. Develop and refine the CMI – PO tool 4.6.1.2. Implement the CMI-PO within all sub-districts	100% of districts and district, regional and central hospitals implementing the CMI-PO by 2014/15.

8. ORGANISATIONAL ENVIRONMENT

8.1 SUMMARY OF THE ORGANISATIONAL STRUCTURE

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

In line with Healthcare 2010 and the Comprehensive Service Plan (CSP), new organisational and post structures have been implemented for the five rural districts.

The Department is implementing the new CSP aligned organisational and post structures for the Metro District Health Services, Psychiatric Hospitals and the TB Hospitals.

The development of new organisational and post structures at Worcester, George, Paarl, Tygerberg, Groote Schuur Hosptials and Red Cross War Memorial Children's Hospital will be concluded and a phased implementation initiated.

Figure 3: Organogram of the senior management of the Department

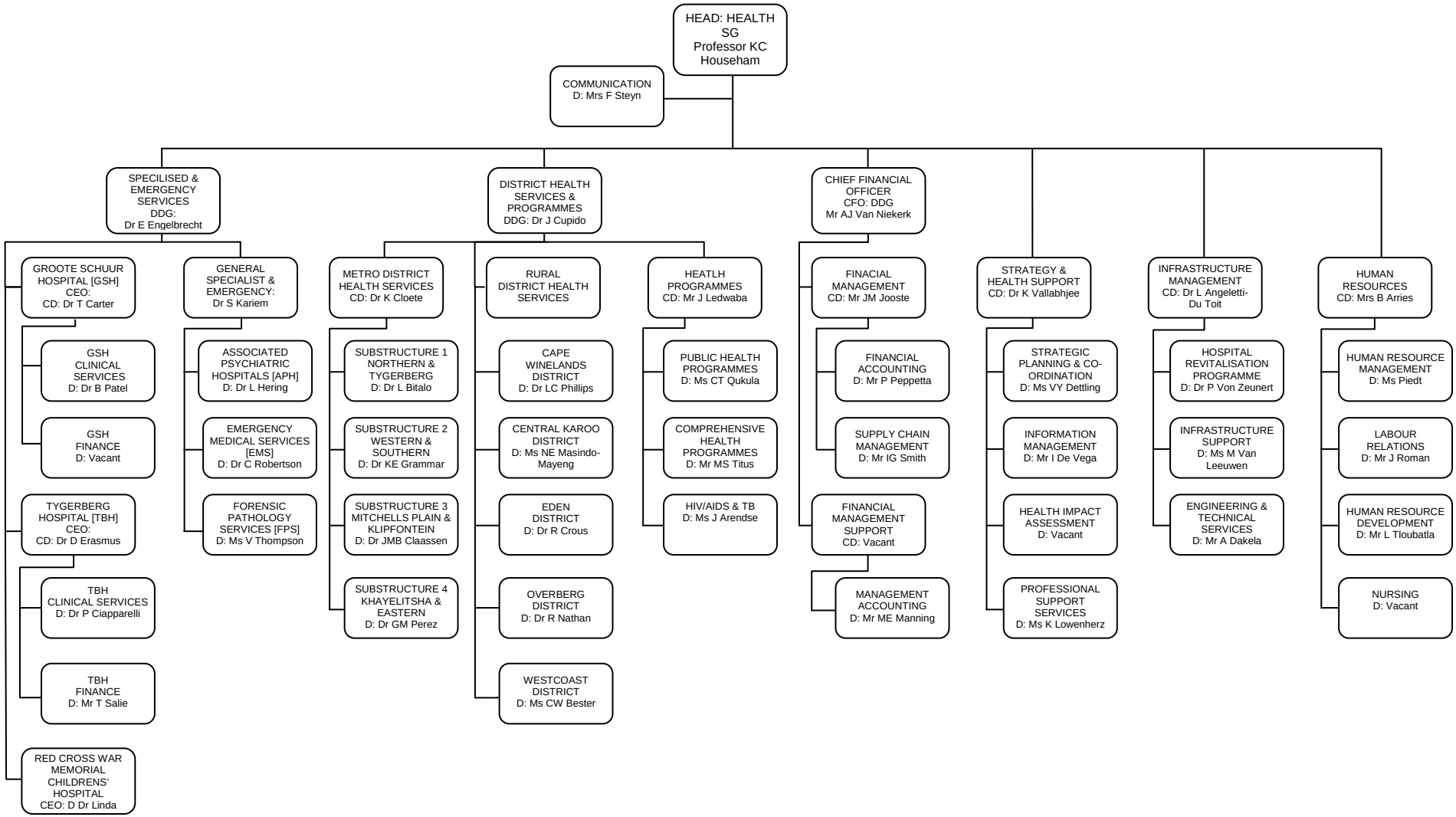


Table 13: Public health personnel in 2009/10 [ADMIN 1]

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
1) Medical Officers	1,844	6.58%	0.33	0.42	5.73%	9.28%	284,113
2) Medical Specialists	520	1.85%	0.092	0.12	6.64%	13.36%	1,450,672
3) Dental Specialists	25	0.09%	0.00	0.01	7.41%	0.24%	544,578
4) Dentists	66	0.24%	0.01	0.02	2.94%	0.56%	476,188
5) Professional Nurse	5,201	18.55%	0.92	1.18	5.56%	25.37%	275,477
6) Enrolled Nurses	2,199	7.84%	0.39	0.50	2.27%	6.08%	156,052
7) Enrolled Nursing Auxiliaries	4,156	14.82%	0.74	0.95	4.90%	8.96%	121,733
8) Student Nurses	-	-			-	-	-
9) Pharmacists	334	1.19%	0.06	0.08	12.34%	1.89%	319,622
10) Physiotherapists	126	0.45%	0.02	0.03	5.26%	0.42%	190,483
11) Occupational Therapists	126	0.45%	0.02	0.03	4.55%	0.43%	194,099
12) Clinical Psychologists	70	0.25%	0.01	0.02	6.67%	0.30%	242,992
13) Radiographers	409	1.46%	0.07	0.09	4.44%	1.60%	220,648
14) Emergency Medical Staff	1,504	5.36%	0.27	0.34	4.33%	4.95%	185,753
15) Dieticians	83	0.30%	0.01	0.02	4.60%	0.29%	199,949
16) Other allied health professionals & technicians	1,198	4.27%	0.21	0.27	11.19%	3.95%	186,151
17) Managers, Administrators & all other staff	10,173	36.29%	1.81	2.31	8.36%	22.33%	124,005
Grand Total	28,034	100.00%	4.98	6.38	6.53%	100.00%	201,473

Notes:
Vacancy rate indicated is based on the vacant funded posts.

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

8.2.1. A change in the demography of the communities and their burden of disease patterns contributes to a change in workload and service needs. This impacts on staff numbers, roles, competencies and distribution.

8.2.2. The increased workload without the necessary increase in financial and human resources contributes to a shortage of skilled personnel to deliver the required health service. This is exacerbated by the fact that service pressures and a stressful working environment contribute to sub-optimal performance, high level of absenteeism and low morale.

8.2.3. An analysis of the current supply of the core competencies within the Department indicates limited availability of professional occupational categories i.e. medical, nursing and allied health as well as certain finance, human resource and information management occupational categories.

8.2.4. The implementation of the various occupational specific dispensations has resulted in specific occupational streams, within occupations, having new job titles and remuneration packages. Included is a new competency mix (scope of practice) of positions, providing health services at ward/unit/clinic level. As a result, the entire organisation and post structure of the Department will be 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 with the occupational specific dispensation implementation is that restrictions have been placed on the appointment of specific professional staff. This is evident in occupations such as paramedics and certain nursing specialities. In professional occupational categories, the occupational specific dispensations are still not lucrative enough in comparison with the private sector and this limits the recruitment of nursing categories, pharmacists, paramedics as well as lecturers.

8.3 IMBALANCES IN SERVICE STRUCTURES AND STAFF MIX

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

8.3.2 The staffing mix in respect of specialists in Family Medicine within district hospitals must be addressed. Further high risk areas are speciality areas within nursing such as intensive care units, critical care, theatre technique, trauma and emergency; anaesthetics and radiographers working in radiotherapy, facility managers, forensic officers, forensic pathologists, medical orthotists and prosthetists, paramedics and clinical technologists.

8.4 SUMMARY OF PERFORMANCE AGAINST THE PROVINCIAL HUMAN RESOURCE PLAN

8.4.1 Current deployment of staff

8.4.1.1 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. Staff members that could not be placed have been declared in excess and will be redeployed in terms of the provisions as set out in Departmental Human Resource Restructuring Plan. A policy on the management of excess staff has been developed to assist districts/regions with this exercise. The individual profiles of these staff are being captured on a central data base. Vacancies will be advertised to specifically target the possible absorption of excess staff.

8.4.1.2. The Directorate Organisational Interventions, of the Department of the Premier, with the assistance of the Division Specialised and Emergency Services is in the process of finalising the new organisational structures within the central and regional hospitals. Once finalised, the redeployment exercise will commence.

8.4.2 Accuracy of staff establishment 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 the CSP structures have not been implemented in the other areas there are gaps with regard to service requirements. The current structures are regularly amended according to service requirements.

8.4.3 Staff recruitment, retention and challenges

8.4.3.1 The provision of sufficient funding for human resources remains a challenge. A relatively high percentage of posts on the approved post list cannot be funded. The vacancy rate impacts mainly on clinical and clinical support posts and prevents the appointment of critical human resources, e.g. Professional Nurses in speciality areas (ICU, Critical Care, Theatre, Trauma and Emergency; Obstetrics and Neonatology), Dentists, Dentist Technicians, Radiographers working in Radiotherapy, Medical Officer posts functioning as front-line production units within the academic/tertiary institutional environment. This includes trainee posts for incumbents to gain exposure to a particular field before entering the registrar training programme. The high vacancy rate impacts negatively on service delivery and contributes to medico-legal risks for the Department.

8.4.3.2 The non-filling of critical vacancies increases the workload of the existing staff members. The impact is two-fold namely:

1) It impacts on the employee's state of wellness, resulting in high absenteeism rates, a decrease in the provision of quality care and the probability of unnecessary employment terminations;

2) A decrease in patient/client satisfaction negatively affecting the image of public health institutions.

8.4.3.3 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.

8.4.3.4 The average age of the workforce of the Department of Health is 40 to 49 years, which poses significant challenges and indicates that more emphasis must be placed on the training, development and recruitment of younger persons to address the attrition of this group. The average age of initial entry into the Department by professionals is 26yrs of age 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 average attrition rate of the workforce is fourteen. The reasons for the majority of resignations are financial and there are instances where employees return to a contract position in order to receive the 37% service benefit per month.

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

8.4.4 **Absenteeism and staff turnover**

8.4.4.1 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 6 – 8, followed by employees within the salary level 9-12. (Probable groups: Staff Nurses, Prof Nurses, Clerks, Administrative first line supervisors, Forensic Officers, Emergency Care Officers). The current excessive workload due to the non-filling of posts and operational responsibilities and accountability could play a contributory role in the use of sick leave within these groups.

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

9.1 RESOURCE TRENDS OVER THE PAST 3 YEARS

Table 14, below, reflects the trends in spending over the past 3 years.

Table 14: Percentage increase/(decrease) in the year on year allocation per programme

Programme		2008/9 v 2009/10	2009/10 v 2010/11
1.	Administration	12%	14%
2	District Health Services	20%	19%
3.	Emergency Medical Services	36%	9%
4.	Provincial Hospital Services	8%	19%
5.	Central Hospital Services	16%	18%
6.	Health Sciences and Training	7%	14%
7.	Health Care Support Services	104%	22%
8.	Health Facilities Management	22%	29%
	TOTAL	**18%**	**19%**

The total increases are the result of Occupational Specific Dispensations implemented for doctors in 2009/10 and 2010/11, and the result of inflation. South Africa in general experienced a period of high inflation in the past few years. As indicated by table 15, Goods and Services increased by more than 15% per annum.

In Programme 2 the budget for Sub-Programme 2.6 (HIV/AIDS) increased from R242m in 2008/09 to R384m in 2009/10 to R555m in 2010/11. The Department's application for rolling continuation channel (RCC) funding from the Global Fund was successful. For this reason this budget (Sub-programme 2.10) did not significantly decline as it otherwise might have.

Programme 3, Emergency Medical Services, increased significantly in 2009/10 due to the preparation for FIFA and additional funding to achieve response time targets.

The high increase in Programme 7 in 2009/10 is due to the shift of Forensic Pathology from Programme 2 to Programme 7, in agreement with national prescripts. In 2010/11 the high increase in Programme 7 is due to the shift of the training of artisans (internships) from Programme 8.

Programme 8 increases due to the initiation of the Khayelitsha and Mitchell's Plain District Hospitals.

The percentage increase per Economic Classification and per programme is summarised below.

Table 15: Percentage increase (decrease) in per economic classification year-on-year

Percentage increase / (decrease) Per Economic Classification	2008/9 v 2009/10	2009/10 v 2010/11
Compensation of Staff	19%	21%
Goods and Services	17%	15%
Transfers and subsidies	18%	21%
Payments for capital assets	16%	16%
Total	**18%**	**19%**

The increase in the cost of personnel is mostly a function of Occupational Specific Dispensations and annual Improvements in Service Conditions. Staff numbers increased only marginally.

9.2 FOCUS ON LEVELS OF FUNDING AND SUSTAINABILITY OF HEALTH SERVICES

The MTEF budget does not allow for growth, other than for funding the two new district hospitals Khayalitsha Hospital and Mitchells Plain Hospital. The budget does not allow the Department to provincialise Metro Primary Health Care.

Aspects that are funded include:

- The future impact of OSD's and ICS (Improvement in the Conditions of Service);
- Appointment of an additional 22 family medicine registrars, a critical function to improve primary healthcare.
- Vaccines are fully funded, being a critical function to address the burden of disease;
- The Psychiatric Response Plan, to address the challenges of TIK and related psychiatric conditions.
- Critical Information Management posts, to improve the quality of management information;
- The Chronic Delivery Unit, which currently prepare about 1 140 000 scripts monthly;
- The further rollout of Hospital Information System (HIS);

The Department has not reduced the budget for maintenance of buildings and equipment. On the contrary, due to an earmarked allocation, the Department was able to increase this budget.

The Department has also not reduced the budget for EMS, which was allocated additional funding in the current financial year to support the FIFA world cup, and these additional funds are retained by Programme 3 over the MTEF period.

A important issue is that the allocated budget allowed the Department to provide for 4% inflation in year 2 of MTEF, which is considered too low, in the light of the 16% per annum growth over the last two years. In year 1 of MTEF the Department was able to provide 7%, which will already be a challenging target.

The current Approved Post List (APL) is funded, but no there is no increase in the APL. Similarly the 7% provided for inflation implies that no provision has been made for any future growth in patient numbers. Over the past number of years the average growth of weighted patient numbers was about 3% per annum.

9.3 FUNDING IMPLICATIONS OF CURRENT TRENDS OF SERVICE VOLUMES

The following table indicates the growth trends in patient numbers over the past two years.

Table 16: Growth in patient numbers

	2008 to 2009	2009 to 2010	2008 to 2010
District Hospitals	-6%	-2%	-8%
Personal Primary Healthcare	10%	3%	14%
Regional Hospitals	6%	-1%	4%
TB hospitals	-2%	4%	2%
Psychiatric Hospitals	-5%	-3%	-8%
Rehabilitation Hospital	6%	-7%	-1%
Central Hospitals	-1%	1%	0%
Weighted average	**0.7%**	**0.3%**	**1.0%**

The "weighted average" is calculated using the average cost per PDE or headcount as weights.

In previous years the average patient number growth was in the region of 3% per annum. The table above indicates a 1% growth over the last two years. It seems as if the Department's efforts to combat the burden of disease by preventative measures, as evidenced by the growth in Personal Primary Healthcare patient load, is finally reaping benefits.

In line with departmental policy, no growth is experienced in central hospitals, with a 4% growth over the last 2 years for regional general hospitals.

District hospitals should show an increase with the commissioning of the Khayelitsha and Mitchell's Plain hospitals. The reduction of psychiatric patients is due to the step down facilities recently introduces. The reduction is rehabilitation patients is mostly the result of not counting patients over weekends. The number of patients therefore did not actually reduce, but simply the way in which they are counted.

The patient number growth has not specifically been considered in the allocation of the MTEF budgets for hospitals and other entities. On condition that the low growth continues, a growth in patient numbers should not threaten the budget.

9.4 EXPENDITURE ESTIMATES

Table 17: Summary of payments and estimates

Programme R'000	Outcome						Medium-term estimate			
	Audited 2007/08	Audited 2008/09	Audited 2009/10	Main appro-priation 2010/11	Adjusted appro-priation 2010/11	Revised estimate 2010/11	2011/12	% Change from Revised estimate 2010/11	2012/13	2013/14
1. Administration [a,c]	205 333	249 104	266 710	397 522	349 843	349 843	445 222	27.26	471 365	518 075
2. District Health Services [b,c]	2 707 578	3 139 800	3 722 530	4 223 003	4 412 008	4 412 008	4 926 594	11.66	5 389 457	6 015 573
3. Emergency Medical Services [c]	341 877	403 118	530 130	560 578	581 995	581 995	616 047	5.85	652 639	703 942
4. Provincial Hospital Services [c]	1 306 027	2 260 650	2 501 088	2 876 231	2 966 299	2 966 299	2 152 471	(27.44)	2 291 606	2 469 271
5. Central Hospital Services [c,d]	2 349 884	1 970 686	2 347 345	2 595 971	2 683 266	2 683 266	3 953 753	47.35	4 204 724	4 533 910
6. Health Sciences and Training [h]	133 706	136 629	194 624	216 966	218 284	218 284	233 466	6.96	244 490	267 217
7. Health Care Support Services [g]	81 785	96 150	197 605	215 944	243 693	243 693	251 027	3.01	265 887	287 544
8. Health Facilities Management [e,f]	371 678	399 708	611 002	876 648	952 995	921 495	816 480	(11.40)	870 772	870 672
Total payments and estimates	7 497 868	8 655 845	10 371 034	11 962 863	12 408 383	12 376 883	13 395 060	8.23	14 390 940	15 666 204

[a] MEC total remuneration package: R1 491 514 with effect from 1 April 2010.

[b] National Conditional grant: Comprehensive HIV and Aids - R660 614 000 (2011/12) , R743 249 000 (2012/13) and R935 489 000 (2013/14).

[c] National Conditional grant: Health Professions Training and Development - R407 794 000 (2011/12), R428 120 000 (2012/13) and R451 667 000 (2013/14).

[d] National Conditional grant: National Tertiary Services - R1 973 127 000 (2011/12), R2 182 468 000 (2012/13) and R2 494 337 000 (2013/14).

[e] National Conditional grant: Hospital Revitalisation - R481 501 000 (2011/12), R501 096 000 (2012/13) and R471 397 000 (2013/14).

[f] National Conditional grant: Health Infrastructure Grant - R119 179 000 (2011/12), R131 411 000 (2012/13) and R138 638 000 (2013/14).

[g] National Conditional grant: Forensic Pathology Services - R70 226 000 (2011/12).

[h] National Conditional grant: Social Sector EPWP Incentive grant - R5 812 000 (2011/12), R7 079 000 (2012/13) and R8 297 000 (2013/14).

Table 18: Summary of payments and estimates by economic classification

Economic classification R'000	Outcome						Medium-term estimate		
	Audited 2007/08	Audited 2008/09	Audited 2009/10	Main appro-priation 2010/11	Adjusted appro-priation 2010/11	Revised estimate 2010/11	2011/12	% Change from Revised estimate 2010/11	2012/13
Current payments	6 609 562	7 756 666	9 111 684	10 436 523	10 753 308	10 737 696	11 781 235	9.72	12 684 80
Compensation of employees	4 138 765	4 876 271	5 780 151	6 609 793	6 937 042	6 925 932	7 637 201	10.27	8 274 36
Salaries and wages	3 668 483	4 328 659	5 145 145	5 876 877	6 177 031	6 165 921	6 802 826	10.33	7 378 40
Social contributions	470 282	547 612	635 006	732 916	760 011	760 011	834 375	9.78	895 96
Goods and services	2 470 797	2 879 999	3 331 196	3 826 730	3 816 266	3 811 727	4 144 034	8.72	4 410 43
of which									
Administrative fees	612	640	836	909	911	911	974	6.92	1 01
Advertising	15 662	21 625	11 087	19 869	18 431	18 431	34 254	85.85	37 27
Assets <R5 000	34 107	36 590	32 240	37 925	40 698	40 698	55 908	37.37	73 61
Audit cost: External	8 013	12 282	16 907	23 735	19 321	19 321	20 998	8.68	21 85
Bursaries (employees)	3 850	4 581	7 365	7 218	7 218	7 218	7 723	7.00	8 03
Catering: Departmental activities	3 990	5 241	4 735	5 482	5 255	5 255	5 861	11.53	6 11
Communication	47 585	47 942	60 160	66 803	65 359	65 359	69 065	5.67	71 84
Computer services	43 372	42 134	44 114	64 851	74 500	74 500	83 418	11.97	86 75
Cons/prof: Business and advisory service	75 671	85 723	101 619	110 228	104 719	104 719	149 624	42.88	158 20
Cons/prof: Infrastructure & planning	1 303	4 425	2 915						
Cons/prof: Laboratory service	282 719	349 059	395 711	457 368	470 406	470 406	433 091	(7.93)	459 52
Cons/prof: Legal cost	4 613	3 987	3 603	6 035	5 040	5 040	5 954	18.13	6 19
Contractors	96 923	92 800	115 450	137 143	134 359	134 359	146 906	9.34	152 88
Agency and support/ outsourced services	243 459	277 506	304 030	247 096	246 137	246 137	262 367	6.59	277 02
Entertainment	139	125	100	152	186	186	246	32.26	25
Inventory: Food and food supplies	57 703	69 478	85 056	104 785	105 691	105 691	110 925	4.95	118 64
Inventory: Fuel, oil and gas	20 862	21 258	26 619	27 617	28 937	28 937	31 621	9.28	32 88
Inventory: Materials and supplies	18 109	30 542	39 782	37 320	39 162	39 162	44 856	14.54	48 54
Inventory: Medical supplies	471 854	551 395	647 736	731 347	721 135	721 135	785 061	8.86	821 13
Inventory: Medicine	494 482	549 909	661 488	829 116	821 421	821 421	883 603	7.57	936 83
Inventory: Other consumables	55 916	67 149	97 356	109 413	111 286	111 286	118 347	6.34	123 08
Inventory: Stationery and printing	32 134	40 416	41 360	48 590	48 371	48 371	54 625	12.93	57 09
Lease payments	26 568	30 850	15 581	16 032	17 860	17 860	17 775	(0.48)	18 49
Property payments	247 565	315 055	357 415	445 691	445 668	445 668	505 579	13.44	564 49
Transport provided: Departmental activity	1 912	2 111	1 297	1 820	2 758	2 758	2 748	(0.36)	2 85
Travel and subsistence	122 676	151 548	197 790	219 202	210 159	210 159	225 703	7.40	234 81
Training and development	34 284	36 560	50 391	59 418	59 995	55 456	71 093	28.20	74 26
Operating expenditure	21 889	24 513	5 689	6 047	5 897	5 897	6 877	16.62	7 15
Venues and facilities	2 825	4 555	2 764	5 518	5 386	5 386	8 832	63.98	9 53
Interest and rent on land		396	337			37		(100.00)	
Interest		396	337			37		(100.00)	
Transfers and subsidies to	410 989	427 489	550 863	619 653	675 830	683 103	772 512	13.09	822 88
Provinces and municipalities	150 924	165 186	228 424	240 191	271 087	271 087	315 436	16.36	337 91
Municipalities	150 924	165 186	228 424	240 191	271 087	271 087	315 436	16.36	337 91
Municipalities *of which*	150 924	165 186	228 424	240 191	271 087	271 087	315 436	16.36	337 91
Departmental agencies and accounts	3 580	4 368	4 712	5 014	15 014	15 014	16 415	9.33	17 07
Entities receiving transfers	3 580	4 368	4 712	5 014	15 014	15 014	16 415	9.33	17 07
CMD Capital Augmentation	1 411	1 573	1 715	1 825	11 825	11 825	12 535	6.00	13 03
SETA	2 169	2 795	2 997	3 189	3 189	3 189	3 880	21.67	4 03
Universities and technikons	1 400			1 817	1 817	1 817	1 926	6.00	2 00
Non-profit institutions	191 404	211 455	239 925	271 514	287 662	287 662	334 487	16.28	359 82
Households	63 681	46 480	77 802	101 117	100 250	107 523	104 248	(3.05)	106 06
Social benefits	7 680	15 988	18 435	16 653	16 183	18 918	18 045	(4.61)	18 77
Other transfers to households	56 001	30 492	59 367	84 464	84 067	88 605	86 203	(2.71)	87 29

9.5 RELATING EXPENDITURE TRENDS TO SPECIFIC GOALS

The strategic priorities that have been funded are listed under section 9.2 above.

The above budget allocation does not keep pace with the increased demand in services, which impacts on the Department's ability to meet the strategic goal of managing the burden of disease. This is illustrated by the fact that in terms of the current MTEF allocation the Department only has the capacity to manage an inflation rate of 7% in Year 1 and 4% in Year 2 of the MTEF but has experienced 16% growth over the last two years.

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

The following important initiatives are not funded

- The provincialisation of Personal Primary Health Care services in the Cape Town Metro District.
- It is not possible to provide additional funding to Emergency Medical Services, which is required if it is to further improve its response times.
- Further strengthening of the specialist cadre in rural regional hospitals to allow for adequate cover within the regional hospital as well as optimal outreach and support to the districts.
- Provision for relief staff to allow full time staff time to attend training courses.

Table 13: Trends in provincial health expenditure [A9]

	Audited/ Actual			Estimate	Medium term projection		
Expenditure	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Current prices							
Total excluding capital	7 126 190 000	8 256 137 000	9 760 032 000	11 455 388 000	12 578 580 000	13 520 168 000	14 795 532 000
Total Capital	371 678 000	399 708 000	611 002 000	921 495 000	816 480 000	870 772 000	870 672 000
Grand Total	**7 497 868 000**	**8 655 845 000**	**10 371 034 000**	**12 376 883 000**	**13 395 060 000**	**14 390 940 000**	**15 666 204 000**
Total per person	1 391	1 570	1 841	2 150	2 279	2 399	2 560
Total per uninsured person	1 782	2 012	2 359	2 756	2 921	3 075	3 282
Constant 2009/10 prices							
Total excluding capital	9 272 967 103	9 512 355 047	9 760 032 000	9 778 429 379	10 023 916 568	10 136 648 526	10 466 921 583
Total Capital	483 646 642	460 525 838	611 002 000	786 596 995	650 655 909	652 855 032	615 946 459
Grand Total	**9 756 613 746**	**9 972 880 885**	**10 371 034 000**	**10 565 026 374**	**10 674 572 476**	**10 789 503 558**	**11 082 868 043**
Total per person	1 810	1 809	1 841	1 836	1 816	1 799	1 811
Total per uninsured person	2 319	2 318	2 359	2 353	2 328	2 306	2 322
% of Total spent on:-							
District Health Services	36.11%	36.27%	35.89%	35.65%	36.78%	37.45%	38.40%
Provincial Hospital Services	17.42%	26.12%	24.12%	23.97%	16.07%	15.92%	15.76%
Central Hospital Services	31.34%	22.77%	22.63%	21.68%	29.52%	29.22%	28.94%
Other Health Services	10.17%	10.22%	11.47%	11.26%	11.54%	11.36%	11.34%
Capital	4.96%	4.62%	5.89%	7.45%	6.10%	6.05%	5.56%
Health as % of total public expenditure (current prices)	34.9%	33.0%	36.4%	38.6%	38.2%	40.5%	41%

Table 14: CPIX multipliers for adjusting current prices to constant 2008/09 prices [A10]

2007/08	1.3013
2008/09	1.1522
2009/10	1.0000
2010/11	0.8536
2011/12	0.7969
2012/13	0.7497
2013/14	0.7074

PART B

BUDGET PROGRAMME PLANS

EXECUTIVE SUMMARY APP 2011

We enter the second decade of this millennium at an exciting time. The health policy context has been largely finalized at a strategic level. A framework for the National Health Insurance is expected in 2011. Nationally this is provided for within the Ten Point Plan and the more recent National Service Delivery Agreement signed by the National Minister of Health. The Provincial Government of the Western Cape has finalized its strategic priorities and the Provincial Strategic Plan will shortly be published for public comment. Both the national and provincial health priority frameworks embrace the Millennium Development Goals and their targets.

There have been more specific policy developments within the province that bear high-lighting. The provincial transversal management system (PTMS) approved by the provincial government is a system to address cross-cutting issues across departments, spheres of government and civil society. This is particularly significant in more effectively addressing the upstream factors that impact on the burden of disease in health. The Department of the Premier and the sectoral management structures will play a central role in ensuring alignment between the different interventions, resourcing of priorities and monitoring of progress in achieving its desired outcomes. The four priority focus areas within health are reduction of injuries, healthy lifestyles, women and child health, infectious diseases such as HIV/TB.

Two important pieces of legislation were passed towards the end of 2010 – the Ambulances Services Act and the Western Cape District Health Councils Act. The former provides a regulatory framework for this important service both in the public and private sector, while the latter provides for a governance structure within districts. Steps will need to take place to ensure implementation in 2011/12.

The Department of Health has begun to develop a service transformation plan for 2020. This requires robust technical work as well as the collective participation and input of a range of internal and external stakeholders. The principles that have emerged from a planning session in 2010 and generally adopted by the Provincial Cabinet when it endorsed the cabinet submission on Strategic Objective 4: Wellness include patient centredness and improved quality, outcomes-based approach, district health model, strengthening PHC, strategic partnerships, equity and affordable health services. There will be a two pronged approach to take the planning process forward. There will a hard technical modeling exercise that addresses the quantifiable variables in health service delivery such as the size of the health platform, staffing levels etc. required to effectively respond to the burden of disease and desired health outcomes per geographic unit (sub-district level). In parallel there will be a change management process that engages our staff at all levels to improve patient experience and the quality of care through addressing staff attitudes.

The changes in the policy context described above will need to be implemented while we continue to deliver a health service 24 hours a day year round. In 2011/12, we project to transport 429 000 patients with our ambulances, treat 16 461 036 patients at PHC level, admit 498 438 patients to our hospitals, treat 1 177 569 ambulatory patients as outpatients treat 116 345 patients on ARTs. We hope to achieve a TB cure rate of 80.5%, immunization coverage of 95%, reduce mother to child transmission to 3% and reduce maternal mortality within our institutions to 72 per 100 000 live births. It has been estimated that our patient

load grows on average by 3% a year for the last several years with variable service pressures in different geographic localities or clinical disciplines. The major service pressure areas are ambulance services, emergency centres, obstetric, neonatal and general medicine services, seasonally in child health (diarroheal season) and acute psychiatric services.

There will be some important developments within the service delivery platform. The phased commissioning of a modern Khayelithsha District Hospital towards the latter part of 2011 will significantly improve access to quality care for the local population. This new hospital has cost approximately R500million and is built for 230 beds which will be commissioned incrementally over time. This will include the relocation of the interim district hospital service that was housed at Tygerberg Hospital. The HCT testing campaign that was initiated in 2010 will continue. The Chronic Dispensing Unit service will be expanded through a new tender in the latter half of 2011. The dramatic reduction in the cost of ART drugs will enable an expansion of the programme to treat 27 000 new clients and to achieve a target of 116 345 clients on treatment by the end of 2011/12.

Primary health care services will further strengthen elements of this strategy within the province including community based services, family medicine as a specialist discipline and district level management.

Improving the patient experience and quality of care in general will be the cornerstone of the next 5 – 10 years and the first steps will be taken in 2011/12. A strategy to focus on improved quality will include several elements such as focused group discussions at various levels to discuss our values as individuals and an organization and commitment to patient care. The results of the Barretts survey will be used as a basis for engagement. A comprehensive set of core standards has been approved nationally that includes amongst others, patient rights and satisfaction, staff satisfaction and related human resource issues, clinical governance. The national minister has identified six priority areas (staff values and attitudes, patient safety, clean facilities, availability of medicines, infection prevention and control and reduced waiting times) that will be focused upon in the first phase of implementation. An implementation plan will be developed within the province to guide the process. Immediate steps will be implemented at PHC facilities to enhance the patient experience at clinics and health centres.

To enhance our effectiveness as a health system, we will strengthen mechanisms to improve inter-relationships between the different parts of the health service as well as between management and clinicians. The strategic management team (SMT) will oversee and support the various structures created in this regard including the provincial coordinating committees and the geographic service area committees. The overall impact must be to improve communication, co-ordination and facilitate transversal decision making in service delivery. A framework for integrated service delivery will be developed across the service divisions to start taking steps in the direction envisaged for 2020.

The balancing act between addressing service pressures and implementing policy changes while remaining within the budget envelope is an ongoing challenge. The Department received R13.4 billion for the 2011/12 year, which is an increase of 8%. In real terms, compared to the 2010 Adjusted Budget, additional funding has been received for the HIV/AIDS conditional grant (11%) and the National Tertiary Services Grant (4%), while the allocations to the Infrastructure conditional grants reduced materially (35%) in real terms. The Global Fund allocation also increased substantially (64%) in real terms. Fifty-nine per cent of the budget will be spent on personnel and 29% on goods and services. The budget

allows an increase of 7% on Goods and Services, which is low compared the 15% per annum increases over the previous two financial years. Existing tools such as the budget management instrument (BMI), approved post list (APL) and vetting will be strictly adhered to ensure expenditure is contained. The budget does not allow for expansion, except for the commissioning of the two new district hospitals in Khayelitsha and Mitchell's Plain respectively. Remaining within budget, in the light of the annual increase in patient load, will therefore be a challenge. Expenditure analyses and comparisons between entities, based on the Functional Business Units in regional and central hospitals and BAS and Sinjani information, will be an important mechanism for decentralised management and improved accountability for expenditure and health outcomes.

The budget envelope does not allow for any significant expansion of staffing levels within the health service. The impact of OSD on the ability to better recruit and retain various categories of clinical staff will be monitored. Training of basic and post basic nurses remains a priority in 2011/12. The training of the first operating practitioners in collaboration with Medi-Clinic is an exciting venture to ultimately increase theatre capacity.

The Department intends maintaining its track record of an unqualified audit in 2011/12. A new challenge is the audit of performance information ("predetermined objectives") for which a strategy and various tools have been developed. Implementation and compliance at various levels of the Department remains the single most important challenge in this regard. Information Management capacity, including the filling of posts and training, is also being addressed to enable implementation.

Advances in information technology provide some exciting opportunities for the Department of Health. Almost 70% of the population in South Africa has cell phones! The use of text messaging to communicate is being explored and will be piloted in the HCT and other prevention campaigns in 2011 and will be further enhanced in 2012/13. The PACS/RIS will enable the transmission of radiology images across institutions. This will enable remote specialist reporting on X-rays and other images. This project has started at Tygerberg Hospital and will be rolled out to Groote Schuur and Red Cross Hospitals, and the rural regional hospitals of Paarl, George and Worcester. The Provincial Government has embarked upon an electronic content management (ECM) project. The Department has piloted the project at Tygerberg Hospital and the Forensic Pathology Service. It will be implemented at the new Khayelithsha Hospital in 2011/12. A software solution is being sought to improve the management and functioning of the emergency medical services. The tender will hopefully be awarded in 2011/12. The roll-out of the PHC information system (PHCIS) will be completed at 45 facilities and extended to an additional 55 facilities in 2011/12 bringing the total number of facilities connected on PHCIS to 190. The HIS project will be stabilized at existing hospitals and rolled out to Paarl and Khayelitsha Hospitals and possibly three rural hospitals. The pharmacy management system will be rolled out to six provincial hospitals to strengthen drug control and patient drug management.

From an infrastructure perspective, in addition to the new Khayelitsha District Hospital, two new Primary Health Care facilities will be completed: the Grassy Park Clinic and the Malmesbury Westbank Community Day Centre. The Kwanokathula CDC will be commissioned in March/April 2011. The Vrendendal Ambulance Station and the Beaufort West Forensic Pathology Laboratory will also be completed in 2011/12. The final phase for the upgrade of Riversdale hospital will be completed by September 2011.

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

To make limited provision for maintenance and accommodation needs.

2.2.1 Sub-programme 1.2.1: Central management

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

To make limited provision for maintenance and accommodation needs.

3. SITUATION ANALYSIS

There have not been any changes to the structure of the budget programme during the 2010/11 financial year.

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 ensuring 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 coordinated both via the provincial Minister and the office of the Head of Department.

3.2 FINANCE

Purpose: To provide sound budget and financial administration within the Department.

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

3.2.1 Financial management

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

The key focus areas of the two directorates are:

- Transport management;
- Salary administration.

3.2.2 Financial management support

Financial Management Support has only one directorate, namely Management Accounting.

The key focus areas of the directorate are:

- Budget and income management;
- Revenue generation;
- Computer and manual systems for patient billing;
- Financial business intelligence.

3.2.3 Overview

Financial Management is currently developing in many respects. The raising of the "bar" with respect to financial accounting on the one hand, and the need to efficiently support management decisions requires improved financial management systems and processes.

The goal of Financial Management is to continue to achieve an unqualified audit opinion on financial matters. Therefore compliance and strengthening of financial governance is critical. This is achieved through progressive management action and the implementation of various dynamic management tools, briefly mentioned below to achieve this objective.

- The Budget Management Instrument (BMI), whereby all expenditure is measured against budgets within respective economic classifications throughout the programmes and entities of the Department on a monthly basis.
- The staff establishment is managed through an Approved Post List (APL) that incorporates all funded posts in a joint initiative with Human Resources.

- Review of the effectiveness of departmental expenditure through monthly reporting and assessment of its expenditure against performance indicators.
- Vetting, budgeting and reporting of results, per cost centre and/or functional business unit occurs at different stages of maturity throughout the Department.

3.2.4 **Challenges**

1) Lack of skilled financial staff.
2) Poor financial information technology (IT) systems.

3.2.5 **Priorities**

Key priorities include:

- Unqualified Annual Financial Statements;
  - Improved internal controls;
  - Improved communication processes with respect to internal controls;
- Spending equal to budget;
  - Successful implementation of Approved Post Lists and improved appointment measures;
- Better value for money;
  - Higher level of standardisation of products and services acquired;
  - Develop specifications and interact with Provincial Treasury to address the financial IT systems;
  - Devolvement of financial authority and accountability, via
    - Vetting processes;
    - Cost centre accounting (called Functional Business Units in the Department).

3.3 **HUMAN RESOURCES**

Purpose: To render an effective, integrated human resource service.

The Chief Directorate consists of the following directorates/unit:

- Human Resource Management
- Human Resource Development
- Labour Relations
- Nursing Services
- Transformation Unit

3.3.1 **Human Resource Management**

Purpose: To render an efficient human resource management advisory and support service to the line managers of the Department of Health with specific reference to the application of the public service regulatory framework, collective agreements, conditions of service as well as organisational change within the Department.

The Directorate consists of three sub-directorates, namely:

- Organisation Dynamics
- Human Resource Management Practices
- Advisory Services

The key focus of the Directorate is to:

- Assist line management in the managing of organisational change through the implementation of the Departmental Human Resource Restructuring Plan as well as the Departmental Human Resource Plan;
- Ensure sound human resource management practices by the implementation and maintenance of human resource policies and procedures;
- Manage compensation management through the implementation of national collective agreements and directives on remuneration issues;
- Render an effective client service through sound salary administration, as well as a consultancy service to human resource offices and line managers within districts and regions.

Although there has been significant progress in the implementation of the Comprehensive Service Plan in an effort to improve service delivery, on-going challenges and gaps are still evident characterised by the system, human and institutional weaknesses. There has also been significant progress in the review of the Human Resources Plan.

Human Resource Management has identified the need to improve collaboration with its internal clients to remedy these weaknesses in order to achieve high levels of quality and impact, and ultimately a significant improvement in service delivery.

3.3.1.1 **Challenges**

1) The turnaround time taken to fill vacant posts;
2) Unsatisfactory staff performance management systems;
3) Misalignment between the organisational structures and PERSAL;
4) Retention of staff;
5) Concluding the review process of the Human Resource Plan;
6) Employee absenteeism.

3.3.1.2 **Priorities**

Key priorities include:

- Implementation of the Comprehensive Service Plan's organisational structures in conjunction with service delivery objectives and priorities determined in the Strategic Plan, as well as the matching and placement of staff and identification of excess staff;
- Implementation of the Human Resource Plan for 2009 - 2014 which will, inter alia, include the performing of a skills audit and the drafting of action plans to give effect to the identified human resource priorities;
- Develop a monitoring framework to measure progress in the implementation of the Human Resource Plan;
- Drive capacity building and support to human resource personnel at institutions through targeted training and ensuring staff are fit for purpose;
- Reduce the turnaround time in the filling of vacancies;
    - Review the recruitment and selection policy;
    - Report on the recruitment turnaround times and the filling of vacancies to the Executive Committee (EXCO) on a monthly basis;
- Training line management to manage absenteeism effectively;
- Implement cost effective recruitment methods/techniques in order to attract more skilled staff;
- Implement strategies that would assist the Department in the retention of scarce skill staff;
- Improve PERSAL data integrity through verification between PERSAL and the fixed establishment on a quarterly basis and address discrepancies.
- Improving the Staff Performance Management System; review the policy, conduct audits and provide training in performance management.
- Ensure alignment of the Approved Post List and requests for the creation, activation and de-activation of posts with the filled and activated posts on the Department's staff establishment.

3.3.2 **Human Resource Development**

Refer to Programme 6.

3.3.3 **Labour Relations**

Purpose: To develop and maintain sound labour relations within the Province in accordance with the relevant legislation, policies and collective agreements.

The Directorate consists of three sub-directorates, namely:

- Collective Bargaining
- Labour Relations Support services

- Dispute Resolution and Advisory Services

The key focus of the Directorate is to:

- Provide support to executive and line management in the managing of labour relation matters through direct involvement and or training;
- Ensure an effective and efficient functioning of the provincial chamber to ensure consultation is taking place with organised labour to implement the Department's policies;
- Ensure effective functioning of Institutional Management Labour Committees (IMLCs) to operationalise human resource plans of the specific institution;
- Manage disputes (conflict management, grievances, conciliations and arbitrations);
- Maintenance of internal labour relations information management system to provide statistics to all the relevant stakeholders (e.g. for Annual Report, Public Service Commission, Department of Labour, National Department of Health, Department of Premier, etc.);
- Manage and co-ordinate the departmental response to strikes, protest actions and pickets;
- Co-ordinate Labour Court cases on various labour relation matters;
- Direct involvement in all national collective bargaining structures e.g. Public Health and Social Development Sectoral Bargaining Council.

3.3.3.1 **Challenges**

1) Maintain constructive collective bargaining processes;
2) Prompt dispute prevention and resolution of grievances.

3.3.3.2 **Priorities**

Key priorities include:

- Ensure effective consultation with organised labour to ensure the full implementation of the CSP organisational structure, managing excess staff and the Annual Performance Plan;
- Ensure effective and optimum functioning of provincial chamber and IMLCs to deal with matters of mutual interest and to prevent or minimise conflict;
- Prompt and effective management of grievances/disputes;
- Continue with development of line managers in labour relation matters through capacity building;
- Managing strikes and ensuring contingency plans are in place at all institutions.

3.3.4 Nursing Services

Purpose: To provide direction and to co-ordinate the nursing services, nursing education and nursing governance within the Western Cape.

The Directorate Nursing Services comprises of three sub-directorates, namely:

- Nursing Practice;
- Nursing Education and Training; and
- Western Cape College of Nursing.

The Directorate is the custodian of the Provincial Nursing Strategy and is responsible for its implementation via the afore-mentioned sub-directorates.

Focal areas of the Provincial Nursing Strategy are:

- Human Resources for Nursing Care;
- Nursing Education and Training;
- Nursing Leadership and Management;
- Nursing Practice.

The Directorate, by means of its core function, ensures attention to the above focal areas.

3.3.4.1 Challenges

1) Filling of lecturer posts due to a shrinking pool, as a result of nurse education being a qualification required to lecture as well as the impact of the Occupational Specific Dispensation (OSD);
2) Ring fencing community service posts and funding vacant posts to enable placement of bursary holders;
3) New Nursing Qualifications Framework with potential phasing out of legacy qualifications impact on the status of nursing schools/colleges;
4) The role of the South African Nursing Council (SANC), as an accrediting regulating body with regards to clinical placement sites, teaching sites and programs with other related registration matters;
5) Poor corporate image of nursing impacts on the view of the public.

3.3.4.2 Priorities

Key priorities emanating from the Provincial Nursing Strategy include:

- Co-ordination of the quality and improvement of nursing practice;
- Co-ordination of nursing related research and development;
- Marketing and promotion of the corporate image of nursing;
- Implementation of the integrated nursing education and training framework;

- Expanding of nurse education teaching sites, programs and sites for clinical placement of students with relevant co-ordination thereof;
- Co-ordination of formal and informal nurse training programmes and initiatives, in line with the Comprehensive Service Plan (CSP), required strategic focus and nursing education legislation;
- Harmonisation and integration of education and training with practice;
- Create mechanisms to expedite the filling of posts;
- Ensure the availability of funded posts to accommodate graduates with bursaries;
- Liaise with SANC to expedite the release of relevant regulations and scope of practices.

3.3.1 Transformation Unit

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

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

The key focus of the Unit is to:

- Implement and drive the Gender Mainstreaming Strategic Framework and Implementation Plan (2008 – 2012);
- Implement a programme(s) to communicate the outcomes of the Barret Values Survey to relevant employees and to address the outcomes of the survey;
- Manage the Coaching Programme aimed at empowering management with strategic leadership skills;
- Manage the Employee Health and Wellness Programme as prescribed by the Department of Public Service and Administration (DPSA);
- Manage the workplace HIV and AIDS / Sexually Transmitted Infection (STI) / Tuberculosis (TB) policy and programme, including on-site HIV counselling and testing;
- Manage employment equity and implement affirmative action programmes;
- Implement reasonable accommodation measures for employees with disabilities.

3.3.1.1 Challenges

1) Poor understanding of the concept gender mainstreaming;
2) Lack of co-ordination regarding Safety, Health, Environment Risk and Quality (SHERQ).
3) Deviations from employment equity targets.

3.3.1.2 **Priorities**

Key priorities include:

- Drive change management by strengthening the diversity management programme by simultaneous mainstreaming of human rights programmes (HIV, Gender Youth and disability); capacity building for senior and middle managers; awareness, education and popularisation of gender concepts; strengthen and capacitate the departmental Gender Forum;

- Intensify information and education around 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; upscale HIV counselling and testing in the workplace to contribute towards meeting provincial HCT targets;

- Establish a Safety, Health, Environment Risk and Quality forum/committee to implement policy as prescribed by the DPSA; roles, responsibilities and functions of role-players are to be identified;

- Conduct assessment audits of health facilities and implementation of reasonable accommodation measures;

- Strengthen employment equity measures.

3.4 STRATEGY AND HEALTH SUPPORT

Purpose: To facilitate strategic and annual planning within the Department; ensure alignment between the departmental policies and plans with that of the provincial and national government; monitor the implementation of annual plans and provide an annual report; to assess the long term impact of health service delivery; to provide a framework for and monitor the improvement of quality of health services.

The Chief Directorate consists of the following directorates:

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

3.4.1.1 Information Management

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

The key focus areas are to:

- Ensure and manage various information systems, communication networks and information technology resources to provide quality information for decision making;

- Develop and implement an effective quarterly monitoring and evaluation system;
- Produce the Annual Report of the Department;
- Provide an efficient central registry service.

3.4.1.2 **Professional Support Services**

Purpose: To provide professional support services.

The key focus areas are to:

- Render a medico legal service;
- Provide effective laboratory services which encompasses the monitoring and evaluation of service within the Province and the co-ordination of the control of services;
- Provide an advisory and co-ordinating service to the medical imaging profession;
- Ensure a comprehensive, efficient and cost-effective pharmaceutical service;
- Render a licensing and facility inspectorate service;
- Provide an advisory and co-ordinating service to therapeutic services;
- Manage the Cape Medical Depot, which procures medical and surgical sundries in bulk for the pharmaceuticals department.

3.4.1.3 **Strategic Planning and Co-ordination**

Purpose: To facilitate the legislative and strategic direction of the Department.

The key focus areas are to:

- Facilitate the drafting of legislation in support of health policies, and ensure all policies are aligned with departmental strategies;
- Develop a Service Transformation Plan that maps the strategies towards 2020;
- Develop the Annual Performance Plan of the Department.

3.4.1.4 **Health Impact Assessment**

Purpose: To determine the impact of the service delivery programmes on the population of the Western Cape as well as its effect on the burden of disease of its population.

The key focus areas are to:

- 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 on the health status of the population;
- Develop interventions to improve the patient experience and overall quality of care.

3.4.1.5 **Challenges**

1) Critical posts within the Chief Directorate remain vacant.
2) Building organisational cohesion within the newly created Chief Directorate.
3) Ensuring good quality data for management decision making at all levels of the service.
4) Ensuring adequate human resource capacity in Information Management at all levels of the Department.
5) The lack of technical skills within the Chief Directorate.

3.4.1.6 **Priorities**

Key priorities include:

1) Building the skills capacity in the directorates to undertake high quality technical work;
2) Strengthen the communication and working relationships between the directorates within the Chief Directorate as well as with other internal and external role players;
3) Putting in place adequate tools, processes and systems to manage performance information;
4) Securing adequate resources to strengthen information management capacity at all levels of the health service.
5) Expedite the filling of posts within the Chief Directorate.

4. SITUATION ANALYSIS AND PROJECTED PERFORMANCE FOR HUMAN RESOURCES AND ADMINISTRATION

Table 1.1: Situational analysis and projected performance for Human Resources [ADMIN 1]

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	2007/08	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. To provide sufficient staff with appropriate skills per occupational group.	1) Number of medical officers per 100 000 people	No	29.2	37	32.42	32.73	31.72	31.05	30.41	29.80	
			Numerator		1 787	-	1 808	1 844	1 787	1 787	1 787	1 787	
			Denominator		6 119 435	-	5 576 765	5 634 323	5 634 323	5 755 607	5 876 887	5 998 164	
			2) Number of medical officers per 100 000 people in rural districts	No	14.65	13	14.64	15.97	15.76	15.47	15.19	14.92	
			Numerator		301	-	286	305	301	301	301	301	
			Denominator		2 053 536	-	1 953 305	1 909 976	1 909 976	1 945 872	1 981 764	2 017 653	
			3) Number of professional nurses per 100 000 people	No	85.8	100	91.42	92.31	93.21	91.25	89.37	87.56	
			Numerator		5 252	-	5 098	5 201	5 252	5 252	5 252	5 252	
			Denominator		6 119 435	-	5 576 765	5 634 323	5 634 323	5 755 607	5 876 887	5 998 164	
			4) Number of professional nurses per 100 000 people in rural districts	No	77.91	70	80.73	82.93	83.77	82.22	80.74	79.30	
			Numerator		1600	-	1,577	1,584	1 600	1 600	1 600	1 600	
			Denominator		2 053 536	-	1 953 305	1 909 976	1 909 976	1 945 872	1 981 764	2 017 653	
			5) Number of pharmacists per 100 000 people	No	5.42	10	6.15	5.93	5.89	5.77	5.65	5.54	
			Numerator		332	-	343	334	332	332	332	332	
			Denominator		6 119 435	-	5 576 765	5 634 323	5 634 323	5 755 607	5 876 887	5 998 164	
			6) Number of pharmacists per 100 000 people in rural districts	No	5.35	8	5.63	5.71	5.76	5.65	5.55	5.45	
			Numerator		110	-	110	109	110	110	110	110	
			Denominator		2 053 536	-	1 953 305	1 909 976	1 909 976	1 945 872	1 981 764	2 017 653	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
			7) Vacancy rate for professional nurses	%	4.73%	28%	25%	5.56%	4.73%	4.73%	4.73%	4.73%	
			Numerator		261	-	-	-	261	261	261	261	
			Denominator		5 513	-	-	-	5 513	5 513	5 513	5 513	
			8) Vacancy rate for medical officers	%	7.93%	17%	16%	5.73%	7.93%	7.93%	7.93%	7.93%	
			Numerator		154	-	-	-	154	154	154	154	
			Denominator		1 941	-	-	-	1 941	1 941	1 941	1 941	
			9) Vacancy rate for medical specialists	%	11.35%	22%	22%	6.64%	11.35%	11.35%	11.35%	11.35%	
			Numerator		70	-	-	-	70	70	70	70	
			Denominator		617	-	-	-	617	617	617	617	
			10) Vacancy rate for pharmacists	%	12.40%	43%	28%	12.34%	12.40%	12.40%	12.40%	12.40%	
			Numerator		47	-	-	-	47	47	47	47	
			Denominator		379	-	-	-	379	379	379	379	

Note:

1. The number of employees per category of staff for 2009/10 is shown in Table 1.1
2. The same staffing level is maintained for the MTEF period due to the increasing pressure on the personnel budget as a result of the implementation of the OSD.
3. Vacancy rate indicated for the periods 2007/08 and 2008/09 is based on vacant funded and unfunded posts.
4. Vacancy rate indicated for 2009/10 until 2013/14 is based on vacant funded posts.
5. Strategic objective performance measures are highlighted in yellow.
6. Performance indicators prescribed by the National Department of Health are highlighted in blue.

Table 1.2: Performance indicators for Administration [ADMIN 2]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Ensure a sustainable income to provide the required health services.	1.1. Promote efficient financial resource use.	1.1.1. Promote sound financial governance and management to ensure the under/over spending of the annual equitable share is within 1% of the budget allocation.	1) Percentage expenditure of the annual equitable share budget allocation	%	100%	101.61%	99.6%	100.3%	100%	100%	100%	100%	
			Numerator		11 724 698	5 238 280	6 188 127	7 519 280	8 803 710	9 676 807	10 397 517	11 166 379	
			Denominator		11 724 698	5 155 077	6 163 668	7 489 777	8 803 710	9 676 807	10 397 517	11 166 379	
2. Develop and maintain a capacitated workforce.	2.1. Develop and maintain a comprehensive Human Resource Plan for the Department.	2.1.1. Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.	2) Amended Human Resource Plan submitted timeously to DPSA	Y/N	Yes	New Indicator	New Indicator	Yes	Yes	Yes	Yes	Yes	

Table 1.3: Quarterly targets for 2011/12 [ADMIN 3]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Ensure a sustainable income to provide the required health services.	1.1. Promote efficient financial resource use.	1.1.1. Promote sound financial governance and management to ensure the under/over spending of the annual equitable share is within 1% of the budget allocation.	1) Percentage expenditure of the annual equitable share budget allocation	Quarterly	100%	100%	100%	100%	100%
			Numerator		8 803 710	8 803 710	8 803 710	8 803 710	8 803 710
			Denominator		8 803 710	8 803 710	8 803 710	8 803 710	8 803 710
2. Develop and maintain a capacitated workforce.	2.1. Develop and maintain a comprehensive Human Resource Plan for the Department.	2.1.1. Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.	2) Amended Human Resource Plan submitted timeously to DPSA	Annually	Yes	No	Yes	No	No

5. RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND THE MTEF

Table 1.4: Summary of payment and estimates for Administration

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2007/08	Audited 2008/09	Audited 2009/10	Main appro-priation 2010/11	Adjusted appro-priation 2010/11	Revised estimate 2010/11	2011/12	% Change from Revised estimate 2010/11	2012/13	2013/14
1. Office of the Provincial Minister [a]	3 840	5 855	5 844	5 386	6 460	6 460	8 171	26.49	8 605	9 335
2. Management	201 493	243 249	260 866	392 136	343 383	343 383	437 051	27.28	462 760	508 740
Central Management [b]	191 379	233 528	250 010	392 136	343 383	343 383	437 051	27.28	462 760	508 740
Decentralised Management	10 114	9 721	10 856							
Total payments and estimates	205 333	249 104	266 710	397 522	349 843	349 843	445 222	27.26	471 365	518 075

[a] MEC total remuneration package: R1 491 514 with effect from 1 April 2010.

[b] 2011/12: Conditional grant: Health Professions Training and Development: R258 000 (Compensation of employees R221 000; Goods and services R37 000).

Note: Sub-programme 1.2.2 allocations from 2010/11 was shifted to sub-programme 4.1.

Table 1.5: Summary of provincial payments and estimates by economic classification

Economic classification R'000	Outcome						Medium-term estimate			
	Audited	Audited	Audited	Main appro-priation	Adjusted appro-priation	Revised estimate	% Change from Revised estimate			
	2007/08	2008/09	2009/10	2010/11	2010/11	2010/11	2011/12	2010/11	2012/13	2013/14
Current payments	190 418	228 741	247 171	361 901	329 056	329 053	412 517	25.36	437 351	480 663
Compensation of employees	81 317	96 213	110 116	150 070	131 540	131 537	175 032	33.07	187 432	199 618
Salaries and wages	71 259	84 683	96 644	133 562	117 341	117 338	155 840	32.81	166 876	178 573
Social contributions	10 058	11 530	13 472	16 508	14 199	14 199	19 192	35.16	20 556	21 045
Goods and services	109 101	132 528	137 055	211 831	197 516	197 516	237 485	20.24	249 919	281 045
of which										
Administrative fees	604	639	817	902	902	902	965	6.98	1 004	1 104
Advertising	8 923	20 747	10 366	14 642	14 642	14 642	15 815	8.01	16 523	18 136
Assets <R5 000	2 818	1 128	1 066	1 444	1 392	1 392	1 994	43.25	2 073	2 278
Audit cost: External	7 422	11 344	16 342	23 735	18 175	18 175	20 435	12.43	21 253	23 378
Catering: Departmental activities	321	384	383	445	435	435	508	16.78	531	584
Communication	5 495	4 803	5 490	5 893	5 892	5 892	6 348	7.74	6 600	7 263
Computer services	34 579	35 637	34 405	55 247	64 430	64 430	73 925	14.74	76 881	84 569
Cons/prof: Business and advisory service	23 710	34 765	46 798	50 627	43 399	43 399	64 666	49.00	70 110	83 289
Cons/prof: Infrastructure & planning	26									
Cons/prof: Laboratory service		6								
Cons/prof: Legal cost	4 562	3 982	3 588	6 023	5 023	5 023	5 937	18.20	6 174	6 792
Contractors	8 259	5 150	2 918	36 881	27 714	27 714	29 213	5.41	30 382	33 423
Agency and support/ outsourced services	1 833	739	1 235	1 228	992	992	478	(51.81)	498	548
Entertainment	99	76	57	78	78	78	93	19.23	96	111
Inventory: Food and food supplies		2	2	3	3	3	5	66.67	5	5
Inventory: Fuel, oil and gas		3								
Inventory: Materials and supplies	1	10	27	28	28	28	14	(50.00)	15	16
Inventory: Medical supplies		3	1	3	3	3	3		3	3
Inventory: Medicine	1									
Inventory: Other consumables	35	22	69	59	57	57	63	10.53	67	72
Inventory: Stationery and printing	2 572	2 822	2 762	2 914	2 865	2 865	3 000	4.71	3 118	3 431
Lease payments	711	757	742	892	892	892	1 002	12.33	1 043	1 147
Property payments	184	411	317	120	120	120	175	45.83	182	201
Transport provided: Departmental activity		1								
Travel and subsistence	5 429	6 546	8 135	7 853	7 675	7 675	9 372	22.11	9 745	10 720
Training and development	354	1 088	779	1 345	1 330	1 330	1 714	28.87	1 784	1 960
Operating expenditure	230	277	93	137	137	137	153	11.68	159	175
Venues and facilities	933	1 186	663	1 332	1 332	1 332	1 607	20.65	1 673	1 840
Transfers and subsidies to	7 921	9 028	10 561	23 148	17 511	17 511	21 948	25.34	22 826	25 109
Households	7 921	9 028	10 561	23 148	17 511	17 511	21 948	25.34	22 826	25 109
Social benefits	94	4 966	3 805	4 922	3 922	3 922	5 044	28.61	5 246	5 770
Other transfers to households	7 827	4 062	6 756	18 226	13 589	13 589	16 904	24.39	17 580	19 339
Payments for capital assets	6 908	11 192	8 960	12 473	3 276	3 276	10 757	228.36	11 188	12 303
Machinery and equipment	6 901	11 138	8 960	12 473	3 276	3 253	9 702	198.25	10 091	11 096
Transport equipment	1 941		386	240	240	240	720	200.00	750	822
Other machinery and equipment	4 960	11 138	8 574	12 233	3 036	3 013	8 982	198.11	9 341	10 274
Software and other intangible assets	7	54				23	1 055	4486.96	1 097	1 207
Payments for financial assets	86	143	18			3		(100.00)		
Total economic classification	205 333	249 104	266 710	397 522	349 843	349 843	445 222	27.26	471 365	518 075

6. PERFORMANCE AND EXPENDITURE TRENDS

6.1.1 Resource considerations

Programme 1 is allocated 3.32 per cent of the vote in 2011/12 in comparison to the 2.83 per cent allocated in the revised estimate of 2010/11. This amounts to a nominal increase of R95.379 million or 27.26 per cent.

The determination of the Programme 1 budget is based on staffing requirements and the latest expenditure trends. The programme budget includes:

- The expenditure of the chronic dispensing unit [CDU] which is a high volume, low cost dispensing process which alleviates workload at institutions, and significantly reduces the waiting time for patients to collect their medicines.
- The cost of medico legal claims,
- Health information systems which includes the roll out the Hospital Information System (HIS) to hospitals; and
- Other central costs such as audit and recruitment advertising fees.

The Cape Medical Depot is a central pharmaceutical depot which carries stock to the value of R100 million. Although under the central managerial responsibility of Professional Support Services in Programme 1, the working capital of the trading account is reflected in Sub-programme 7.5.

7. RISK MANAGEMENT

Risks	Measures to mitigate impact
1. Financial systems not compliant with the Generally Accepted Accounting Principles (GAAP);	1.1. Active engagement with National and Provincial Treasury to approve the acquisition of improved systems to report in accordance with GAAP adherence; 1.2. Appointment of suitably qualified staff proficient in the application of GAAP;
2. Incorrect application of the accrual accounting practices;	2.1. Increased staff training in respect of their understanding and reporting on accruals and commitments; 2.2. Monthly reporting and correction of erroneous entries in respect of accrual and commitment amounts as reported from data extracted from the underlying systems;
3. Timely payment of goods and services;	3.1. Increased staff training in respect of the timing of payments ; 3.2. Monthly monitoring and reporting on amounts not paid timeously;
4. Lack of human resource capacity and skilled workforce;	4.1. Staff development and training; 4.2. Improved retention and recruitment strategies;
5. Non-existence of an electronic attendance system;	5.1. Implementation of an attendance mechanism policy;
6. Slow procurement process of IT infrastructure and end-user hardware;	6.1. Make recommendations to the Central Information Technology Committee (CITCOM) for policy amendments;
7. Poor quality of data and information.	7.1. Facilitate implementation of revised policies, standard operating procedures and tools to improve data quality; 7.2. Roll-out of patient administration systems in hospitals and primary health care facilities. 7.3. Strengthen human resource capacity in Information Management.

PROGRAMME 2: DISTRICT HEALTH SERVICES

1. PROGRAMME PURPOSE

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

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 in respect of mother and child, health promotion, geriatrics, occupational therapy, physiotherapy, psychiatry, speech therapy, communicable diseases, mental health, etc.

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, abuse victims, 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 AND AIDS

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

2.7 SUB-PROGRAMME 2.7: NUTRITION

Rendering a nutrition service aimed at specific target groups and combines 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 district management structures were formalised during the 2008/09 financial year, i.e. the Cape Town Metro District and the five rural districts.

The City of Cape Town Metro District is the largest of the districts and has been further sub-divided into four management sub-structures, each consisting of two 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 districts and the location of the district offices are as follows:

1) City of Cape Town Metro District: Cape Town
   - Khayelitsha and Eastern sub-districts: Khayelitsha
   - Mitchell's Plain and Klipfontein sub-districts: Mitchells Plain
   - Northern and Tygerberg sub-districts: Parow
   - Southern and Western sub-districts: Retreat
2) Cape Winelands District: Worcester

3) Central Karoo District: Beaufort West

4) Eden District: George

5) Overberg District: Caledon

6) West Coast District: Malmesbury

The Provincial Government of the Western Cape has assumed responsibility for personal primary health care services (PPHC) in the rural districts. In the Cape Town Metro District there is a service level agreement between the Provincial Government, Department of Health and the City of Cape Town Municipality, for the provision of personal primary health care (PPHC) services, which are therefore provided jointly by both the provincial and local spheres of government in the Cape Town Metro District.

Environmental health care services are provided by the municipalities across all six districts.

The Western Cape District Health Councils Act, which will facilitate the establishment of the District Health Councils, was assented to on 29 November 2010. The District Health Councils will provide governance within the districts in accordance with the stipulations in the National Health Act.

3.1.2 Primary Health Care (PHC) facility-based services

Community health clinics (Sub-programme 2.2) and community day centres/community health centres (Sub-programme 2.3) are the entry points within the public health system. They also serve as referral points for patients who require services that are rendered at other levels of the health care system.

Community health clinics include fixed and non-fixed (satellites, mobiles and visiting points) clinics. Clinical nurse practitioners (CNPs) provide services in accordance with the national package of care, which includes child and adult curative, preventive and promotive services; antenatal, postnatal, family planning and other specialised services; mental health; TB, HIV and AIDS; chronic disease management and walk through services. There are 455 clinics (including local government clinics) in the Province of which 282 (62%) are fixed clinics and 173 are non-fixed clinics, i.e. satellite and mobile 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 CNPs, who are supported by full-time medical officers and pharmacists and patients have access to X-ray services. 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. Community health centres provide 24-hour emergency services and the South African Triage System (SATS) has been implemented to ensure appropriate care and prompt referral. Ten CDCs/CHCs in the City of Cape Town Metro provide a nurse-based package of services between the hours of 16h00 and 21h00 on weekdays, and between 08h00 and 13h00 over weekends and eleven CDCs/CHCs also provide 24-hour midwife obstetric services.

There were 1 715 professional nurses, 192 medical officers and 139 pharmacists employed across the PHC facilities in the Province, as at 31 March 2010 (Table 2.2). Approximately 59% of the professional nurses, 71.9% of the medical officers and 56.1% of the pharmacists were employed in the City of Cape Town Metro District. The City of Cape Town Municipality employed 24% (412) of the professional nurses, 11% (21) of the medical officers and 6% of the pharmacists.

3.1.3 Community-based Services

The Community Based Services (CBS) (Sub-programme 2.4) renders a full package of services at chronic, sub-acute and palliative care 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, and to strengthen facility-based services by providing healthcare directly to the community, and through actively empowering the community to participate in preventive and adherence health programmes.

Non-profit organisations (NPOs) are formally contracted to render the services, primarily through community care workers (CCWs). CCWs are required to conduct a minimum of five client visits per day during their 4.5 hour working day.

De-hospitalised care is provided to clients who have been discharged from acute hospitals, but require on-going personal clinical care:

1) **Sub-acute/step-down services:** For clients who are ill but who do not necessarily need to be in an acute hospital.
2) **Respite/Palliative centres:** For terminal/chronic clients in care of families where a short period of respite is needed.
3) **Chronic or life-long care:** For lifelong/long-term clients i.e. greater than six months, offered in one consolidated facility. (Life Esidimeni chronic care centre).
4) **Home-based care:** Integrated community home-based care. There are three service delivery streams i.e.: home-based care; community adherence support and prevention/health promotion.
5) **Community-Mental Health Centres:** 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 2010/11 [DHS1]

Health district[1]	Facility type	No.	2009/10 Uninsured Population[2,5]	Uninsured Population per fixed PHC facility[5]	PHC facilities headcounts	District hospital separations	Per capita (uninsured) utilisation[6]
City of Cape Town Metro District	Non fixed clinics[3]	26	2 845 401	17 896	9 819 995	108 749	3.5
	Fixed clinics[4]	87					
	CHCs	9					
	CDCs	37					
	Sub-total clinics + CHCs + CDCs	133					
	District hospitals	9					
CAPE WINELANDS	Non fixed clinics[3]	35	578 645	11 809	2 024 847	25 515	3.5
	Fixed clinics[4]	44					
	CHCs	0					
	CDCs	5					
	Sub-total clinics + CHCs + CDCs	49					
	District hospitals	4					
CENTRAL KAROO (Rural development node)	Non fixed clinics[3]	11	51 769	5 752	268 188	12 156	5.4
	Fixed clinics[4]	8					
	CHCs	0					
	CDCs	1					
	Sub-total clinics + CHCs + CDCs	9					
	District hospitals	4					
EDEN	Non fixed clinics[3]	36	469 699	11 183	1 911 801	38 119	4.2
	Fixed clinics[4]	35					
	CHCs	0					
	CDCs	5					
	Sub-total clinics + CHCs + CDCs	40					
	District hospitals	6					
OVERBERG	Non fixed clinics[3]	23	192 933	7 717	824 910	17 674	4.4
	Fixed clinics[4]	23					
	CHCs	0					
	CDCs	1					
	Sub-total clinics + CHCs + CDCs	24					
	District hospitals	4					
WEST COAST	Non fixed clinics[3]	42	257 848	9 209	999 232	35 872	4.0
	Fixed clinics[4]	27					
	CHCs	0					
	CDCs	0					
	Sub-total clinics + CHCs + CDCs	27					
	District hospitals	7					
PROVINCE	Non fixed clinics[3]	173	4 396 294	14 091	15 848 973	238 085	3.7
	Fixed clinics[4]	224					
	CHCs	9					
	CDCs	49					
	Sub-total clinics + CHCs + CDCs	282					
	District hospitals	34					

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

Table2.2 Situation analysis indicators for district health services [DHS3]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Type	Province wide value 2009/10	Cape Town District 2009/10	Cape Winelands District 2009/10	Central Karoo District 2009/10	Eden District 2009/10	Overberg District 2009/10	West Coast District 2009/10	National Average 2009/10
1. Manage the burden of disease.	1.1. Increase access to PHC services in the DHS in the Western Cape.	1.1.1. Achieve a PHC utilisation rate of 3.0 visits per person per annum by 2014/15.	1) Utilisation rate – PHC (total population)	No	3.0	2.8	2.8	4.7	3.7	3.8	3.5	2.44
			Numerator		15 848 973	9 820 426	2 024 416	268 188	1 911 801	824 910	999 232	
			Denominator		5 321 416	3 525 473	718 194	56 685	517 473	214 514	289 077	
			2) PHC total headcount	No	15 848 973	9 820 426	2 024 416	268 188	1 911 801	824 910	999 232	117,674,357
			3) Utilisation rate – PHC under 5 years	No	5.0	4.5	5.7	7.6	6.5	6.7	6.7	4.52
			Numerator		2 527 588	1 495 591	370 269	45 558	303 436	137 211	175 523	
			Denominator		497 995	333 711	64 998	5 993	46 542	20 536	26 215	
			4) PHC total headcount - under 5 years	No	2 527 588	1 495 591	370 269	46 558	303 436	137 211	175 523	22,882,694
			5) Fixed PHC facilities with a monthly supervisory visit rate	%	95.6%	93.8%	94.1%	100%	97.5%	100%	100%	
			Numerator		283	137	46	9	39	23	27	
			Denominator		296	146	51	9	40	23	27	
			6) Percentage of CHCs and CDCs with a resident doctor	%	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									
			Denominator									
			7) Number of NPO appointed home carers	%	2 491	1 402	249	70	300	202	268	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure access to and the sustained delivery of the full package of quality PHC services by 2014.	2.1.1. Achieve a primary health care (PHC) expenditure of R450 per uninsured person by 2015.	8) Provincial expenditure per PHC headcount	R	104	105	112	105	87	102	111	
			Numerator		1 589 545 770	1 006 816 837	219 512 048	26 319 090	156 811 671	81 400 590	100 202 919	
			Denominator		15 346 491	9 632 697	1 959 929	250 658	1 802 433	798 045	902 729	
			9) Provincial PHC expenditure per uninsured person	R	401	402	382	522	374	457	428	
			Numerator		1 589 545 770	1 006 816 837	219 512 048	26 319 090	156 811 671	81 400 590	100 202 919	
			Denominator		3 959 443	2 503 086	574 555	50 450	419 153	178 046	234 152	

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Type	Province wide value 2009/10	Cape Town District 2009/10	Cape Winelands District 2009/10	Central Karoo District 2009/10	Eden District 2009/10	Overberg District 2009/10	West Coast District 2009/10	National Average 2009/10
3. Improve the quality of health services.	3.1. Improve the experience of clients utilising the PHC services.	3.1.1. Achieve an 80% client satisfaction rate by 2015.	10) Percentage of complaints of users of PHC services resolved within 25 days	%	Not required to report	Not required to report	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		-	-	-	-	-	-	-	-
			Denominator		-	-	-	-	-	-	-	-
			11) Number of PHC facilities assessed for compliance against the core standards	%	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	Not required to report

Note:

Indicator 1: Including PHC headcount at district hospitals

Indicator 8: Excluding PHC headcount at district hospitals for costing purposes

3.1.4 **DHS performance indicators**

1) A total PHC headcount of 15 848 973 was recorded (against a target of 14 645 765) in 2009/10. This was an increase of 5.3% from the 2008/09 financial year. The City of Cape Town Metro accounted for 62% of this headcount, while the five rural districts accounted for 38% of the headcount.

2) The PHC utilisation rate per capita (total population) of 3.0 is higher than the target of 2.76. The PHC utilisation rate for the population under five increased from 4.9 in 2008/09 to 5.0 in 2009/10. The utilisation rates in Eden, Overberg, West Coast and Central Karoo districts are higher than the provincial average while the rates in City of Cape Town Metro and Cape Winelands District (which are the two most populous districts) are lower than the provincial average. This indicates a relative inequity of access in the more densely populated areas in the Province, especially where the population growth has been disproportionately high over a relatively short period of time.

3) The PHC supervision rate has increased from 43.8% in 2007/08 to 70.3% in 2008/09 to 95.6% in 2009/10 (126% increase over 2 years). The supervision rate has increased significantly across all six districts over this period, but there was confusion about the definition, which resulted in erroneously high rates in 2009/10. This has been corrected in 2010/11. The professional nurse (26 clients per day) and doctor (21 clients per day) clinical workload was relatively low across all districts. The data was lower and inconsistent in the earlier part of the financial year. The data in the last quarter was higher and more consistent after the introduction of the standard operating procedure for standardised data collection.

3.2 **CHALLENGES**

1) The continued provision of fragmented PPHC service delivery by the Provincial Government of the Western Cape (PGWC) and City of Cape Town Municipality in the City of Cape Town Metro is inefficient and compromises quality of care.

2) There is insufficient capacity in two rural district offices, Overberg and Central Karoo, and the four Metro sub-structure offices to fully execute decentralised management functions.

3) Greater access to PHC services is needed in the densely populated sub-districts of especially City of Cape Town Metro and Cape Winelands.

4) The productivity of professional nurses and doctors as evidenced by a relatively low clinical workload needs to be improved.

5) Prevention and promotion activities on the community-based services (CBS) service platform need to be scaled up, especially in sub-districts with higher burden of disease profiles.

3.3 PRIORITIES

3.3.1 Service delivery priorities

1) Provincialisation of City of Cape Town personal primary care services.

2) Improvement in utilisation rates, especially the under 5 year utilisation rates, in densely populated sub-districts in the City of Cape Town Metro and Cape Winelands.

3) Increased clinical workload for professional nurse and doctors.

4) Scaling up of prevention and promotion activities aimed at reducing the major causes of the burden of disease.

3.3.2 Clinical governance/ quality of care priorities

1) Institutionalise the clinical governance policy framework in all districts. The appointment of family physicians and family medicine registrars is a key strategy.

2) 2011 will be a watershed year in improving the patient experience at PHC facilities. Focused projects to enhance patient experience at reception areas; patient registration; patient flow and health education while waiting in facilities, will be implemented.

3) The resolution of patient complaints will be improved. Specific corrective measures will be implemented across PHC facilities in response to the analysis of the registered patient complaints and investigations.

4) Selected PHC facilities will be assessed for compliance against the national core standards during the course of the year. The assessments will form the basis for detailed service delivery improvement plans.

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

Table 2.3: Strategic objectives, indicators and annual targets for District Health Services [DHS 4 & 5]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Increase access to PHC services in the DHS in the Western Cape.	1.1.1. Achieve a PHC utilisation rate of 3.0 visits per person per annum by 2014/15.	1) Utilisation rate – PHC	No	3.0	2.4	2.8	3.0	2.8	2.8	2.8	2.8	3.5
			Numerator		18 722 105	-	-	15 848 973	16 322 170	16 291 503	16 535 876	16 783 914	
			Denominator		6 240 702	-	-	5 321 416	5 634 323	5 755 607	5 876 887	6 101 322	
			2) PHC total headcount	No		13 029 007	15 051 210	15 848 973	16 322 170	16 291 503	16 535 876	16 783 914	
			3) Utilisation rate – PHC under 5 years	No		4.9	4.9	5.0	4.6	4.7	4.8	4.9	5.5
			Numerator			-	2 436 479	2 527 588	2 424 307	2 531 063	2 639 194	2 749 586	
			Denominator			-	495 993	497 995	527 215	538 524	549 832	561 140	
			4) PHC total headcount - under 5 years	No		Not required to report	2 436 479	2 527 588	2 424 307	2 531 063	2 639 194	2 749 586	
			5) Fixed PHC facilities with a monthly supervisory visit rate	%		44%	70%	95.6%	85.6%	90%	95%	97%	100%
			Numerator			-	-	283	253	266	281	287	
			Denominator			-	-	296	296	296	296	296	
			6) Percentage of CHCs and CDCs with a resident doctor	%		Not required to report	Not required to report	Not required to report	87.0%	90%	95%	100%	100%
			Numerator			-	-	-	47	49	51	53	
			Denominator			-	-	-	54	54	54	54	
			7) Number of NPO appointed home carers	No	3 100	1 343	2 455	2 491	2 565	3 000	3 050	3 100	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure access to and the sustained delivery of the full package of quality PHC services by 2014.	2.1.1. Achieve a primary health care (PHC) expenditure of R450 per uninsured person by 2015 (in 2009/10 rands).	8) Provincial PHC expenditure per uninsured person	R	450	375	407	406	398	397	387	386	
			Numerator		2 190 743 550	1 575 858 053	1 751 220 546	1 786 006 483	1 787 758 158	1 822 176 822	1 811 958 890	1 842 318 532	
			Denominator		4 868 319	4 207 479	4 301 882	4 396 294	4 490 706	4 585 115	4 679 521	4 773 922	
			9) Provincial expenditure per PHC headcount	R	125	121	116	113	110	112	110	110	
			Numerator			1 575 858 053	1 751 220 546	1 786 006 483	1 787 758 158	1 822 176 822	1 811 958 890	1 842 318 532	
			Denominator			13 029 007	15 051 210	15 848 973	16 322 170	16 461 036	16 984 203	17 154 749	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
3. Improve the quality of health services.	3.1. Improve the experience of clients utilising the PHC services.	3.1.1. Achieve an 80% client satisfaction rate by 2015.	10) Percentage of complaints of users of PHC services resolved within 25 days	%	Not required to report	Not required to report	Not required to report	Not required to report	Not required to report	60%	70%	**80%**	
			Numerator		-	-	-	-	-	750	812	**864**	
			Denominator		-	-	-	-	-	1 250	1 160	**1 080**	
			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	Not required to report	Not required to report	9	32	**96**	

3.5 QUARTERLY TARGETS FOR DISTRICT HEALTH SERVICES

Table 2.4: Quarterly targets for District Health Services for 2010/11 [DHS6]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Increase access to PHC services in the DHS in the Western Cape.	1.1.1. Achieve a PHC utilisation rate of 3.0 visits per person per annum by 2014/15.	1) Utilisation rate – PHC	Quarterly	2.8	2.8	2.8	2.8	2.8
			Numerator		16 291 503	4 072 875	4 072 876	4 072 876	4 072 876
			Denominator		5 755 607	1 438 902	1 438 902	1 438 902	1 438 902
			2) PHC total headcount	Quarterly	16 291 503	4 072 875	4 072 876	4 072 876	4 072 876
			3) Utilisation rate – PHC under 5 years	Quarterly	4.7	4.7	4.7	4.7	4.7
			Numerator		2 531 063	632 765	632 766	632 766	632 766
			Denominator		538 524	134 631	134 631	134 631	134 631
			4) PHC total headcount - under 5 years	Quarterly	2 531 063	632 765	632 766	632 766	632 766
			5) Fixed PHC facilities with a monthly supervisory visit rate	Quarterly	90%	90%	90%	90%	90%
			Numerator		266	266	266	266	266
			Denominator		296	296	296	296	296
			6) Percentage of CHCs and CDCs with a resident doctor	Quarterly	90%	90%	90%	90%	90%
			Numerator		49	49	49	49	49
			Denominator		54	54	54	54	54
			7) Number of NPO appointed home carers	Annually	3 000	-	-	-	-
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure access to and the sustained delivery of the full package of quality PHC services by 2014.	2.1.1. Achieve a primary health care (PHC) expenditure of R450 per uninsured person by 2015 (in 2009/10 rands).	8) Provincial expenditure per PHC headcount	Quarterly	111	111	111	111	111
			Numerator		1 822 176 822	455 544 205	455 544 205	455 544 206	455 544 206
			Denominator		16 291 503	4 072 875	4 072 875	4 072 875	4 072 875

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			9) Provincial PHC expenditure per uninsured person	Quarterly	397	397	397	397	397
			Numerator		1 822 176 822	455 544 205	455 544 205	455 544 206	455 544 206
			Denominator		4 585 115	1 146 279	1 146 279	1 146 279	1 146 279
3. Improve the quality of health services.	2.1. Improve the experience of clients utilising the PHC services.	2.1.1. Achieve an 80% client satisfaction rate by 2015.	10) Percentage of complaints of users of PHC services resolved within 25 days	Quarterly	60%	60%	60%	60%	60%
			Numerator		750	188	187	188	187
			Denominator		1 250	313	312	313	312
			11) Number of PHC facilities assessed for compliance against the core standards	Annual	9				

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 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 children in-patient and out-patient care, and obstetric care. There is a varying quantum of general specialist services offered at the larger district hospitals to improve access, quality and cost efficiency.

There are 34 district hospitals in the Province. Nine of these hospitals are located within the City of Cape Town Metro, including the Khayelitsha and Mitchell's Plain hub hospitals based at Tygerberg and Lentegeur Hospitals respectively. The Khayelitsha and Mitchell's Plain Hospitals are both currently under construction. Four hospitals: Karl Bremer, GF Jooste, Helderberg and Victoria Hospitals, previously classified as regional hospitals, have been re-classified as district hospitals in the City of Cape Town Metro over the last three financial years. Three of these hospitals: Karl Bremer, GF Jooste, and Victoria Hospitals, still offer a significant quantum of general specialist services.

Cape Winelands, Overberg and Central Karoo have four district hospitals each, while Eden has six and West Coast seven. The sizes and the quantum of general specialist services offered vary across these hospitals. The population living in the George, Breede Valley and Drakenstein 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.

There were 983 professional nurses, 375 medical officers and 82 pharmacists employed across the 34 district hospitals as at 31st March 2010. Fifty-three per cent (524) of the professional nurses, 77.6% (524) of the medical officers and 63.4% (52) of the pharmacists were employed in the nine City of Cape Town Metro district hospitals.

Table 2.5: Situation analysis indicators for district hospitals [DHS7]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Type	Province wide value 2009/10	Cape Town District 2009/10	Cape Winelands District 2009/10	Central Karoo District 2009/10	Eden District 2009/10	Overberg District 2009/10	West Coast District 2009/10	National Average 2009/10
1. Manage the burden of disease.	1.1. Increase access to acute services /district hospital services in the DHS in the Western Cape.	1.1.1. Establish 2 673 acute district hospital beds in the DHS by 2014/15.	1) Number of district hospital beds	No	2464	1 133	260	120	404	193	354	
			2) Caesarean section rate in district hospitals	%	21.9%	28.5%	21.0%	20.3%	18.8%	21.7%	12.5%	16.2%
			Numerator		6 587	3 114	962	226	1 113	540	632	
			Denominator		30 078	10 919	4 579	1 116	5 909	2 494	5 061	
			3) Total separations in district hospitals	No	238 085	108 749	25 515	12 156	38 119	17 674	35 872	1 716 911
			4) Patient day equivalents [PDE] in district hospitals	No	986 481	502 799	99 973	45 345	150 628	67 509	120 227	10 740 610
			5) OPD total headcounts in district hospitals	No	504 673	290 411	45 003	9 394	72 688	30 744	56 433	7 486 845
			6) Average length of stay in district hospitals	Days	3.0	3.1	3.0	2.9	2.9	2.7	2.5	4.3
			Numerator		705 098	341 616	76 861	35 258	111 391	48 556	91 416	
			Denominator		238 085	108 749	25 515	12 156	38 119	17 674	35 872	
			7) Bed utilisation rate (based on usable beds) in district hospitals	%	78.4%	83%	81%	80.5%	75.5%	68.9%	70.7%	73.2
			Numerator		705 098	341 616	76 861	35 258	111 391	48 556	91 416	
			Denominator		899 360	413 545	94 900	43 800	147 460	70 445	129 210	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure access to the full package of quality district hospital services by 2014/15.	2.1.1. Achieve a district hospital expenditure of R1 650 per PDE by 2014/15 (in 2009/10 rands).	8) Expenditure per patient day equivalent [PDE] in district hospitals	R	R1 330	R1 247	R895	R769	R1 008	R852	R1 031	
			Numerator		1 312 166 000	626 990 000	89 475 000	34 870 305	151 833 000	57 517 668	123 954 000	
			Denominator		986 481	502 799	99 973	45 345	150 628	67 509	120 227	
3. Improve the quality of health services.	3.1. Improve the experience of clients utilising district hospital services.	3.1.1. Achieve an 80% client satisfaction rate by 2014/15.	9) Percentage of complaints of users of district hospital services resolved within 25 days	%	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		-	-	-	-	-	-	-	
			Denominator		-	-	-	-	-	-	-	

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Type	Province wide value 2009/10	Cape Town District 2009/10	Cape Winelands District 2009/10	Central Karoo District 2009/10	Eden District 2009/10	Overberg District 2009/10	West Coast District 2009/10	National Average 2009/10
			10) Percentage of district hospitals with monthly mortality and morbidity meetings	%	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		-	-	-	-	-	-	-	
			Denominator		-	-	-	-	-	-	-	
			11) District hospital patient satisfaction rate	%	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		-	-	-	-	-	-	-	
			Denominator		-	-	-	-	-	-	-	
			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	

4.1.2 District hospital performance indicators (refer Table 2.6)

- The caesarean section rate was 21.9% in 2009/10. The City of Cape Town Metro recorded a 28.5% rate. Only five of the nine Metro district hospitals deliver maternity services, and Karl Bremer Hospital is responsible for the bulk of these services. This rate in the rural districts hospitals varied from 12.5% in West Coast to 21.7% in Overberg. District hospitals in West Coast (12.5%) and Eden (18.8%) are responsible for 57% of the maternity caseload in the rural districts.
- The total number of separations for 2009/10 was 238 085, of which 45.7% was in the City of Cape Town Metro, 16% in Eden, 15.1% in West Coast and 10.7% in Cape Winelands. The total PDEs for 2009/10 was 986 481, of which 51% was in the City of Cape Town Metro, 15.3% in Eden, 12.2% in West Coast and 10.1% in Cape Winelands. The total outpatient department (OPD) headcount for 2009/10 was 504 673, of which 57.5% was in the City of Cape Town Metro, 14.4% in Eden, 11.2% in West Coast and 8.9% in Cape Winelands.
- The average length of stay in district hospitals was three days in 2009/10, varying from 2.5 days in West Coast to 3.1 days in the City of Cape Town Metro. The bed utilisation rate in district hospitals was 78.4% in 2009/10, varying from 68.9% in Overberg to 83% in the City of Cape Town Metro.

4.2 CHALLENGES

- Securing the full operational budget to fully commission Khayelitsha Hospital during the 2011/12 financial year.
- The limited range of services offered in many district hospitals leads to a sub-optimal response to the burden of disease in the respective drainage populations. The provision of maternal and neonatal care services is a specific challenge, in light of the MDG priorities. This further impact on the workload of the emergency medical services to transport patients to more distant sites to access the service.
- A relatively stagnant workload across the district hospitals. This varies significantly across institutions, with the smaller hospitals showing a relatively lower work output. There is a continued relatively low bed occupancy rate, especially in smaller rural hospitals.
- The administrative, i.e. finance, supply chain management, human resource management and information management, capacity at district hospitals to implement effective management controls within the hospitals and in their surrounding PHC facilities based on the hub-and-spoke arrangements.

4.3 PRIORITIES

4.3.1 Service delivery priorities

1) The full commissioning of Khayelitsha District Hospital during the 2011/12 financial year.
2) Increasing the packages of services offered across district hospitals in order to respond more effectively to the burden of disease of the drainage populations. A special focus is needed for the expansion of maternal and neonatal care service access at district hospitals.
3) Increasing the work outputs across district hospitals, with a special focus on the smaller district hospitals across the Province. These strategies will be co-ordinated within the geographic service areas (GSAs), through innovative deployment of resources across the entire service platform, to maximise service outputs. The expansion of the outputs at district hospitals will be facilitated by the setting of realistic targets for specific surgical procedures in GSA's.
4) Increasing the administrative management capacity across all district hospitals to implement effective management control within the hospitals and surrounding PHC facilities.

4.3.2 Clinical governance/ quality of care priorities

1) Institutionalise the clinical governance policy framework in all district hospitals. The appointment of family physicians and family medicine registrars is a key strategy.
2) Mortality and morbidity review meetings will be institutionalised.
3) Focus areas for quality assurance will be clinical governance and the six priorities of the core standards as required by the Office of Standards Compliance.

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

Table 2.6: Strategic objectives, indicators and annual targets for district hospitals [DHS 7 & 8]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Increase access to acute services /district hospital services in the DHS in the Western Cape.	1.1.1. Establish 2 673 acute district hospital beds in the DHS by 2014/15.	1) Number of district hospital beds	No	2 673	1 570	2 292	2 464	2 452	2 592	2 722	2 722	
			2) Caesarean section rate in district hospitals	%		20.6	20.6%	21.9%	21.9%	21.5%	21.0%	20.5%	15%
			Numerator			-	6 093	6 587	6 785	6 994	7 241	7 563	
			Denominator			-	29 648	30 078	30 980	32 529	34 481	36 895	
			3) Total separations in district hospitals	No		203 932	221 365	238 085	239 570	240 620	242 545	244 485	
			4) Patient day equivalents [PDE] in district hospitals	No		956 181	963 020	986 481	990 240	1 028 547	1 045 225	1 062 758	
			5) OPD total headcounts in district hospitals			515 501	840 179	504 673	496 317	510 150	535 860	560 915	
			6) Average length of stay in district hospitals	Days		3.3 days	3.1 days	3.0 days	2.9 days	2.9 days	2.9 days	2.9 days	3.5 days
			Numerator			-	682 960	705 098	705 333	707 423	710 657	716 341	
			Denominator			-	221 365	238 085	239 570	240 620	242 545	244 485	
			7) Bed utilisation rate (based on usable beds) in district hospitals	%		79.30%	80.90%	78.4%	78.5%	79%	80%	81%	75%
			Numerator			-	682 960	705 098	705 333	707 423	710 657	716 341	
			Denominator			-	843 880	899 360	898 170	895 472	888 321	884 372	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure access to the full package of quality district hospital services by 2014/15.	2.1.1. Achieve a district hospital expenditure of R1 650 per PDE by 2014/15 (in 2009/10 rands).	8) Expenditure per patient day equivalent [PDE] in district hospitals	Rand	R1 650	1 163	1 233	1 330	1 306	1 306	1 361	1 415	
			Numerator		1 824 456 150	1 111 589	1 187 760	1 312 166	1 317 716	1 343 488	1 422 156	1 504 191	
			Denominator		1 105 731	956 181	963 020	986 481	1 009 099	1 028 547	1 045 225	1 062 758	
3. Improve the quality of	3.1. Improve the experience of	3.1.1. Achieve an 80% client satisfaction rate by	9) Percentage of complaints of users of	%		Not required	**75.5%**	73.3%	68%	70%	75%	**80%**	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
health services.	clients utilising district hospital services.	2014/15.	district hospital services resolved within 25 days			to report							
			Numerator			-	283	498	383	420	450	**480**	
			Denominator			-	375	679	562	600	600	**600**	
			10) Percentage of district hospitals with monthly mortality and morbidity meetings	%		71.4%	62.5%	73.5%	50%	58.8%	67.6%	73.5%	
			Numerator			-	20	25	17	20	23	25	
			Denominator			-	32	34	34	34	34	34	
			11) District hospital patient satisfaction rate	%		Not required to report	Not required to report	Not required to report	86%	85%	85%	85%	
			Numerator			-	-	-	7 267	7 225	7 225	7 225	
			Denominator			-	-	-	8 491	8 500	8 500	8 500	
			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	2	9	27	

4.5 QUARTERLY TARGETS FOR DISTRICT HOSPITALS

Table 2.7: Quarterly targets for district hospitals for 2010/11 [DHS9]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Increase access to acute services / district hospital services in the DHS in the Western Cape.	1.1.1. Establish 2 673 acute district hospital beds in the DHS by 2014/15.	1) Number of district hospital beds	Quarterly	2 592	2 452	2 452	2 592	2 592
			2) Caesarean section rate for district hospitals	Quarterly	21.5%	21.5%	21.5%	21.5%	21.5%
			Numerator		6 994	1 748	1 748	1749	1 749
			Denominator		32 529	8132	8132	8132	8133
			3) Total separations in district hospitals	Quarterly	240 620	60 155	60 155	60 155	60 155
			4) Patient day equivalents [PDE] in district hospitals	Quarterly	1 028 547	257 136	257 137	257 137	257 137
			5) OPD total headcounts in district hospitals	Quarterly	510 150	127 537	127 537	127 538	127 538
			6) Average length of stay in district hospitals	Quarterly	2.9 days	2.9 days	2.9 days	2.9 days	2.9 days
			Numerator		707 423	176 855	176 856	176 856	176 856
			Denominator		240 620	60 155	60 155	60 155	60 155
			7) Bed utilisation rate (based on usable beds) in district hospitals	Quarterly	79%	79%	79%	79%	79%
			Numerator		707 423	176 855	176 856	176 856	176 856
			Denominator		895 472	223 868	223 868	223 868	223 868
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure access to the full package of quality district hospital services by 2014/15.	2.1.1. Achieve a district hospital expenditure of R1 650 per PDE by 2014/15 (in 2009/10 rands).	8) Expenditure per patient day equivalent [PDE] in district hospitals	Quarterly	1,306	1,306	1,306	1,306	1,306
			Numerator		1 343 488 460	335 872 115	335 872 115	335 872 115	335 872 115
			Denominator		1 028 547	257 136	257 137	257 137	257 137
3. Improve the quality of health services.	3.1. Improve the experience of clients utilising district hospital services.	3.1.1. Achieve an 80% client satisfaction rate by 2014/15.	9) Percentage of complaints of users of district hospitals resolved within **25** days	Quarterly	70%	70%	70%	70%	70%
			Numerator		420	105	105	105	105
			Denominator		600	150	150	150	150
			10) Percentage of district hospitals with monthly mortality and morbidity meetings	Quarterly	58.8%	58.8%	58.8%	58.8%	58.8%

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			Numerator		20	20	20	20	20
			Denominator		34	34	34	34	34
			11) District hospital patient satisfaction rate	Annually	85%	-	-	-	
			Numerator		7 225	-	-	-	
			Denominator		8 500	-	-	-	
			12) Number of district hospitals assessed for compliance with the 6 priorities of the core standards	Annually	2	-	-	-	

5. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND THE MTEF

Table 2.8: Summary of payments and estimates for District Health Services

Sub-programme R'000	Outcome			Main appro-priation	Adjusted appro-priation	Revised estimate	Medium-term estimate			
	Audited 2007/08	Audited 2008/09	Audited 2009/10	2010/11	2010/11	2010/11	2011/12	% Change from Revised estimate 2010/11	2012/13	2013/14
1. District Mangement a	103 010	164 641	212 080	242 509	260 292	260 292	288 047	10.66	306 606	328 895
2. Community Health Clinics [a]	430 608	649 969	760 215	871 457	888 092	888 092	978 983	10.23	1 029 979	1 109 028
3. Community Health Centres [a]	677 703	705 342	813 712	922 077	945 967	945 967	1 019 448	7.77	1 080 090	1 166 184
4. Community Based Services [a]	125 738	106 033	119 334	129 518	127 737	127 737	145 645	14.02	152 478	166 784
5. Other Community Services	52 414			1	1	1	1		1	1
6. HIV and Aids [b]	239 899	268 931	383 531	554 054	555 054	555 054	660 614	19.02	743 249	935 489
7. Nutrition	16 810	17 068	18 885	22 730	23 558	23 558	24 680	4.76	25 761	28 002
8. Coroner Services	122 266	83 538		1	1	1	1		1	1
9. District Hospitals [a]	854 454	1 030 902	1 312 167	1 469 943	1 504 167	1 504 167	1 642 713	9.21	1 848 283	2 071 801
10. Global Fund	84 676	113 376	102 606	10 713	107 139	107 139	166 462	55.37	203 009	209 388
Total payments and estimates	2 707 578	3 139 800	3 722 530	4 223 003	4 412 008	4 412 008	4 926 594	11.66	5 389 457	6 015 573

[a] 2011/12: Conditional grant: Health Professions Training and Development: R73 271 000 (Compensation of employees R46 015 000; Goods and services R27 256 000).

[b] Conditional grant: Comprehensive HIV and Aids: R660 614 000 (Compensation of employees R226 555 000; Goods and services R256 109 000, Transfers and subsidies R175 767 000 and Payments for capital assets R2 183 000).

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: The Forensic Services previously in sub-programme 2.8 has been transferred to sub-programme 7.3 with effect of 1 April 2009.

Table 2.9: Summary of provincial 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			
	2007/08	2008/09	2009/10	2010/11	2010/11	2010/11	2011/12	2010/11	2012/13	2013/14
Current payments	2 299 185	2 730 836	3 235 936	3 726 849	3 863 518	3 860 482	4 298 944	11.36	4 711 301	5 249 357
Compensation of employees	1 399 729	1 699 818	2 005 421	2 280 741	2 400 869	2 397 805	2 702 533	12.71	2 993 173	3 298 056
Salaries and wages	1 234 751	1 501 085	1 775 659	2 023 503	2 134 852	2 131 788	2 386 046	11.93	2 645 468	2 932 431
Social contributions	164 978	198 733	229 762	257 238	266 017	266 017	316 487	18.97	347 705	365 625
Goods and services	899 456	1 030 729	1 230 200	1 446 108	1 462 649	1 462 649	1 596 411	9.15	1 718 128	1 951 301
of which										
Administrative fees	8		2							
Advertising	3 001	783	578	5 064	3 610	3 610	18 248	405.48	20 550	26 112
Assets <R5 000	16 335	12 580	9 716	12 902	13 911	13 911	18 571	33.50	21 546	25 818
Audit cost: External	572	561	565		1 146	1 146	563	(50.87)	603	645
Catering: Departmental activities	1 239	1 786	1 342	1 425	1 797	1 797	2 161	20.26	2 267	2 553
Communication	19 485	20 577	20 910	22 298	22 656	22 656	24 607	8.61	25 613	28 218
Computer services	7 050	4 513	4 263	4 238	4 504	4 504	4 535	0.69	4 719	5 184
Cons/prof: Business and advisory service	5 101	4 522	3 520	2 614	4 893	4 893	25 677	424.77	27 379	32 351
Cons/prof: Infrastructure & planning	646		6							
Cons/prof: Laboratory service	117 715	145 907	187 705	210 057	224 871	224 871	206 501	(8.17)	223 872	254 917
Cons/prof: Legal cost	11	2	11	8	13	13	13		14	16
Contractors	21 212	19 396	25 095	25 022	25 523	25 523	27 439	7.51	28 538	31 400
Agency and support/ outsourced services	90 016	109 097	137 533	119 927	118 848	118 848	129 715	9.14	139 085	156 587
Entertainment	23	36	30	50	66	66	84	27.27	87	96
Inventory: Food and food supplies	22 563	26 436	33 677	45 750	47 016	47 016	48 237	2.60	53 451	63 291
Inventory: Fuel, oil and gas	9 207	8 828	10 857	12 267	12 179	12 179	12 958	6.40	13 475	14 819
Inventory: Materials and supplies	2 419	4 898	3 304	4 223	4 435	4 435	5 772	30.15	8 007	10 405
Inventory: Medical supplies	97 120	118 544	147 614	175 011	169 823	169 823	186 748	9.97	198 886	223 494
Inventory: Medicine	331 734	366 367	456 576	590 205	588 738	588 738	634 648	7.80	677 927	763 851
Inventory: Other consumables	18 585	21 952	30 163	34 484	35 026	35 026	37 361	6.67	38 900	42 884
Inventory: Stationery and printing	14 714	18 968	17 931	20 863	21 310	21 310	25 438	19.37	26 760	30 133
Lease payments	8 719	9 157	5 225	5 515	5 731	5 731	6 894	20.29	7 180	7 914
Property payments	57 467	73 898	80 894	92 913	94 828	94 828	109 997	16.00	125 271	147 339
Transport provided: Departmental activity	490	862	782	976	1 037	1 037	1 056	1.83	1 100	1 210
Travel and subsistence	34 340	40 596	40 305	42 542	44 092	44 092	45 858	4.01	47 828	52 704
Training and development	8 543	8 439	7 514	12 106	10 717	10 717	13 605	26.95	14 596	17 038
Operating expenditure	10 092	9 869	3 033	2 748	3 428	3 428	4 172	21.70	4 342	4 769
Venues and facilities	1 049	2 155	1 049	2 900	2 451	2 451	5 553	126.56	6 132	7 553
Interest and rent on land		289	315			28		(100.00)		
Interest		289	315			28		(100.00)		
Transfers and subsidies to	307 597	323 408	404 255	434 195	481 299	483 752	572 767	18.40	617 499	690 487
Provinces and municipalities	150 924	165 186	228 424	240 191	271 087	271 087	315 436	16.36	337 911	364 721
Municipalities	150 924	165 186	228 424	240 191	271 087	271 087	315 436	16.36	337 911	364 721
Municipalities	150 924	165 186	228 424	240 191	271 087	271 087	315 436	16.36	337 911	364 721
of which										
Non-profit institutions	154 685	155 029	170 521	190 573	206 721	206 721	253 690	22.72	275 799	321 606
Households	1 988	3 193	5 310	3 431	3 491	5 944	3 641	(38.74)	3 789	4 160
Social benefits	1 988	3 193	5 310	3 281	3 281	5 734	3 482	(39.27)	3 624	3 978
Other transfers to households				150	210	210	159	(24.29)	165	182
Payments for capital assets	99 998	85 069	81 570	61 959	67 191	67 191	54 883	(18.32)	60 657	75 729
Buildings and other fixed structures	49 609	48 754	40 314		5 405	5 413	6 140	13.43	7 675	15 131
Buildings	49 609	48 754	40 314		5 405	5 413	6 140	13.43	7 675	15 131
Machinery and equipment	50 352	36 307	41 037	61 959	61 786	61 778	48 369	(21.71)	52 591	60 168
Transport equipment	9 024	3 917	6 539	4 905	5 085	5 085	4 893	(3.78)	5 090	5 599
Other machinery and equipment	41 328	32 390	34 498	57 054	56 701	56 693	43 476	(23.31)	47 501	54 569
Software and other intangible assets	37	8	219				374		391	430
Of which: "Capitalised Goods and services" included in Payments for capital assets		48 558	43 754	4 967	10 059	10 067	9 443	(6.20)	11 108	18 909
Payments for financial assets	798	487	769			583		(100.00)		
Total economic classification	2 707 578	3 139 800	3 722 530	4 223 003	4 412 008	4 412 008	4 926 594	11.66	5 389 457	6 015 573

5.1 PERFORMANCE AND EXPENDITURE TRENDS

Programme 2, District Health Services, is allocated 36.78 per cent of the vote in 2011/12 in comparison to the 35.65 per cent allocated in 2010/11. This translates into a nominal increase of R514.586 million or 11.7 per cent.

Sub-programmes 2.1 – 2.3, Primary Health Care Services, is allocated a nominal increase of R192.127 million or 9.2 per cent in 2011/12 in comparison to the allocation in 2010/11.

District hospitals are allocated a nominal increase of R138.546 million or a 9.2 per cent increase in 2010/11.

5.1.1 **District health services:**

- A total PHC headcount of 16 322 170 is estimated for 2010/11. The target for PHC headcount decreases to 16 291 503 for 2011/12. This has to be viewed within the context of an increase in CBS headcounts and an increase in chronic scripts being delivered via the chronic dispensing unit (CDU), and the "reclassification of the PHC headcount" to OPD headcount in district hospitals as from 1st April 2011.

- The PHC utilisation rate per capita (total population) is estimated to be 2.8 for 2010/11 (8.1% below the target of 3.1). The target is to remain at 2.8 for 2011/12. The under 5 year utilisation rate is estimated to be 4.6 in 2010/11, and the target for 2011/12 is 4.7. The PHC supervision rate is estimated to be 85.6% for 2010/11.

5.1.2 **District hospitals**

- The total PDE is estimated to be 990 240 for 2010/11. The target for 2011/12 is a 4% increase to 1 028 547.

- The total separations is estimated to be 239 570 for 2010/11, against a target of 239 996. The target for 2011/12 is a 0.5% increase to 240 620.

- The total OPD headcount is estimated to be 496 317 for 2010/11. The target for 2011/12 is a 2.8% increase to 510 150.

5.2 **RISK MANAGEMENT:**

Risk	**Mitigating factors**
1. Funding for full commissioning of Khayelitsha District Hospital.	1.1. Top slice of total departmental budget for 2011/12.
2. Continued dual authority for PPHC services in the City of Cape Town Metro.	2.1. Political decision and additional funding being sought to provincialise the PPHC services in City of Cape Town Metro.
3. Insufficient administrative capacity (including information management capacity) in districts.	3.1. Additional staff to be appointed and standard operating procedures to be implemented.
4. Drug stock outs in facilities.	4.1. Improved management systems in the Cape Medical Depot and improved stock management systems at facility level.
5. Poor physical infrastructure in PHC facilities.	5.1. Donor funding (Global Fund) to be used to complete upgrades in PHC facilities.

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

6.1 SITUATION ANALYSIS

Sub-programme 2.6 aims to render health services in respect of HIV, AIDS, STI and TB care. The Province has committed itself to a comprehensive HIV and AIDS, and TB programme that, via all relevant departments of the provincial government and all sectors of society, addresses the various aspects of the HIV and AIDS and TB dual epidemics. The Provincial Cabinet endorsed the Provincial Strategic Plan 2007 – 2011, which is aligned with the National Strategic Plan and provides a roadmap for increased effort and commitment to contain the spread of HIV, with ambitious targets.

The primary aims of the HIV and TB programme in the Department of Health are to:

1) Reduce the number of new HIV infections by 50% by 2015.
2) Provide an appropriate package of treatment, care and support to 80% of all people diagnosed with HIV.
3) Implement care and support programmes for people living with HIV and AIDS.
4) Strengthen the implementation of the directly observed treatment strategy (DOTS) strategy through the expansion and enhancement of quality DOTS in high TB burden sub-districts and health facilities.
5) Address multi-drug resistant (MDR-TB) and extreme drug resistant (XDR-TB) to ensure the adequate treatment and management of these patients.
6) Ensure functional integration of TB and HIV activities at facility level.

The Department is committed to integrating the HIV and AIDS programme into the general health services in a manner in which additional resources enhance the general health system as opposed to further institutionalising the vertical HIV/AIDS/STI/TB (HAST) service delivery model. A progressive systematic implementation of this will commence with the implementation of an Integrated Adherence Support Strategy for HIV and TB co-infected clients. First contact ambulatory care for HIV infected clients and TB patients are provided at all community health centres and clinics, including appropriate counselling, specimen collection for laboratory testing and initiation of appropriate treatment for TB and/or opportunistic infections. HIV counselling and testing (HCT), male and female condoms and treatment for STI are also available at all PHC facilities in the Province.

From 1 July 2010 until 30 June 2011, the Western Cape Province is conducting the HCT campaign and aims to reach 1.1 million people. The Department of Health has entered into a Service Level Agreement (SLA) with Clicks and non-profit organisations (NPOs) as partners for this HCT campaign. A Joint Operations Centre (JOC) has been established within the Department as the co-ordinating body for the HCT campaign. All partners, public sector, private sector and NPOs, are represented on the JOC.

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

HIV and TB services are available at all district, regional and central hospitals for clients with complex HIV or TB disease and/or co-morbidity. Furthermore, HIV services are available at the six dedicated TB hospitals in the Province. Currently, there are ninety anti-retroviral treatment (ART) service points. Thirty-two multi-sectoral action teams (MSATs) ensure community mobilisation by bringing together relevant role-players (government departments, civil society organisations, local government and non-profit organisations) at a sub-district level in order to initiate local responses to the HIV epidemic. Life skills and HIV prevention interventions within schools is important for ensuring 'an HIV-free generation'.

Decanting of stable ART patients from Level 3 and Level 2 to PHC level is in progress. The implementation of the nurse-led, doctor supported service is monitored to ensure that the services of trained clinical nurse practitioners are retained and quality of service is maintained.

The Department was successful in sustaining funding from the Global Fund through the Rolling Continuation Channel (RCC) for an additional three year period commencing on 01 July 2010 and ending on 30 June 2013. An amount of R212 270 090 is available for the three year period. The majority of funding will be allocated to the ART programme. Peer education programmes, palliative care programmes and community based programmes will also be funded.

The focus on prevention in the HAST programme will be significantly enhanced in 2011 by strengthening the Advocacy, Communication and Social Mobilisation (ACSM) capacity in the Department. The main goal of this initiative will be to enhance active case finding and promote healthy lifestyles, including increasing access to medical male circumcision (MMC).

Table 2.10: Situation analysis indicators for HIV and AIDS, STI's and TB control [HIV 1]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Type	Province wide value 2009/10	Cape Town District 2009/10	Cape Winelands District 2009/10	Central Karoo District 2009/10	Eden District 2009/10	Overberg District 2009/10	West Coast District 2009/10	National Average 2009/10
1. Manage the burden of disease.	1.1. MDG Goal 6: Have halted and begun to reverse the spread of HIV and AIDS and TB by 2015.	1.1.1. Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15-24 years to 8% in 2015.	1) HIV prevalence in women aged 15 – 24 years	%	10.9	-	-	-	-	-	-	
			Numerator		545	-	-	-	-	-	-	
			Denominator		4405	-	-	-	-	-	-	
			2) Total number of patients (children and adults) on ART	No	75 002	56 487	7 699	510	6 306	2 137	1 863	
			3) Male condom distribution rate	No	38.8	47.6	11.8	33.8	25.9	17.7	38.8	12.4
			Numerator		74 153 181	60 387 456	3 027 498	639 038	4 780 394	1 360 700	3 958 095	
			Denominator		19 09 053	1 269 661	256 380	18 895	184 631	76 682	102 805	
			4) New smear positive PTB defaulter rate	%	8.2%	8.7	8.5	9.2	7.1	6.2	6.9	
			Numerator		1 322	771	217	22	170	47	95	
			Denominator		16 194	8876	2547	238	2411	755	1367	
			5) HCT testing rate	%	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	
			Numerator		-	-	-	-	-	-	-	
			Denominator		-	-	-	-	-	-	-	
			6) Percentage of HIV-TB co-infected patients placed on ART	%	40.9%	46.2%	29.2%	97.7%	37.7%	13.0%	15.5%	
			Numerator		6 948	5 506	537	44	654	87	120	
			Denominator		16 950	11 896	1 834	45	1 733	669	773	
			7) New smear positive PTB cure rate	%	79.4%	78.1	76.4	81.9	83.0	87.8	78.3	
			Numerator		12 853	6 936	1 947	195	2 002	663	1 070	
			Denominator		16 194	8 876	2 547	238	2 411	755	1 367	
			8) PTB two month smear conversion rate	%	72.1%	70.9	70.7	56.9	73.4	89.7	72.4	
			Numerator		11 263	5 986	1 840	119	1 636	687	995	
			Denominator		15 620	8 443	2 601	209	2 227	766	1 374	

6.2 CHALLENGES

1) Cutting back on the rate of new HIV infections. The Provincial HIV prevalence was 16.9% in 2009.

2) Integration of TB and HIV interventions at programmes and service level.

6.3 PRIORITIES

1) Scaling up combined prevention and promotion interventions to impact on the burden of HIV and TB.

2) Expand access to appropriate packages of treatment, care and support to individuals, families and communities affected by HIV and TB.

3) Implement integration strategies that will facilitate adherence support to co-infected clients.

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

Table 2.11: Strategic objectives, indicators and annual targets for HIV and AIDS, STI and TB control [HIV 2 and 3]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. MDG Goal 6: Have halted and begun to reverse the spread of HIV and AIDS and TB by 2015.	1.1.1. Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15-24 years to 8% in 2015.	1) HIV prevalence in women aged 15 – 24 years	%	8%	11.9	11.0	10.9	10.8	10	9.5	8.5	
			Numerator		360	-	-	545	493	450	428	383	
			Denominator		4 500	-	-	4 405	3 564	4 500	4 500	4 500	
			2) Total number of patients (children and adults) on ART	No		37 435	54 703	75 002	91685	116 345	133 018	147 358	159 688
			3) Male condom distribution rate	No		41.1	33.6	38.8	45.7	52	55	58	60
			Numerator			-	-	74 153 181	92 339 525	102 564 800	110 825 000	119 434 318	
			Denominator			-	-	1 909 053	2 021 542	2 015 000	2 057 599	2 100 196	
			4) New smear positive PTB defaulter rate	%		9.6%	9.2%	8.2%	6.76%	6.5%	6.0%	5.5%	5%
			Numerator			-	-	1 322	1 012	1,034	945	858	
			Denominator			-	-	16 194	14 961	15,915	15,755	15,595	
			5) HCT testing rate	%		Not required to report	95.6%	96.7%	95%	95%	95%	95%	95%
			Numerator			-	353 959	397 704	700 000	774 501	774 480	814 478	
			Denominator			-	370 306	411 411	736 842	815 265	815 242	857 346	
			6) Percentage of HIV-TB co-infected patients placed on ART	%		Not required to report	Not required to report	40.9%	46%	51.7%	57.1%	62.5%	
			Numerator			-	-	6 948	7 952	9 357	10 770	12 499	
			Denominator			-	-	16 950	17 138	17 995	18 895	19 839	
			7) New smear positive PTB cure rate	%		77.50%	77.80%	79.4%	80.4%	80.5%	81%	81.5%	
			Numerator			-	-	12 853	12 029	12 812	12 761	12 710	
			Denominator			-	-	16 194	14 961	15 915	15 755	15 595	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
			8) PTB two month smear conversion rate	%		71.20%	70.60%	72.1%	74.8%	75%	76%	77%	75%
			Numerator			-	-	11 263	10 517	11 936	11 973	12 008	
			Denominator			-	-	15 620	14 061	15 915	15 755	15 595	

6.5 QUARTERLY TARGETS FOR HAST

Table 2.12: Quarterly targets for HIV and AIDS, STI and TB control [HIV4]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. MDG Goal 6: Have halted and begun to reverse the spread of HIV and AIDS and TB by 2015.	1.1.1. Implement an effective HIV prevention strategy to decrease the HIV prevalence in the age group 15-24 years to 8% in 2015.	1) HIV prevalence in women aged 15 – 24 years	Annually	10	-	-	-	-
			Numerator		450	-	-	-	-
			Denominator		4 500	-	-	-	-
			2) Total number of patients (children and adults) on ART	Quarterly	116 345	101 461	106 422	111 383	116 345
			3) Male condom distribution rate	Quarterly	52	13	13	13	13
			Numerator		102 564 800	25 641 200	25 641 200	25 641 200	25 641 200
			Denominator		2 015 000	2 015 000	2 015 000	2 015 000	2 015 000
			4) New smear positive PTB defaulter rate	Quarterly	6.5%	6.5%	6.5%	6.5%	6.5%
			Numerator		1 034	259	259	259	259
			Denominator		15 915	3 979	3 979	3 979	3 979
			5) HCT testing rate	Quarterly	95%	95%	95%	95%	95%
			Numerator		774 501	193 625	193 625	193 625	193 625
			Denominator		815 265	203 816	203 816	203 816	203 816
			6) Percentage of HIV-TB co-infected patients placed on ART	Quarterly	51.7%	51.7%	51.7%	51.7%	51.7%
			Numerator		9 357	2 339	2 339	2 339	2 339
			Denominator		17 995	4 499	4 499	4 499	4 499
			7) New smear positive PTB cure rate	Quarterly	80.5%	80.5%	80.5%	80.5%	80.5%
			Numerator		12 812	3 203	3 203	3 203	3 203
			Denominator		15 915	3 978	3 978	3 978	3 978
			8) PTB two month conversion rate	Quarterly	75%	75%	75%	75%	75%
			Numerator		11 936	2 984	2 984	2 984	2 984
			Denominator		15 915	3 978	3 978	3 978	3 978

6.6 PERFORMANCE AND EXPENDITURE TRENDS

1) The projected MTEF allocation is aligned to the strategic objectives of the HAST programme.

2) The MTEF projections are adequate to facilitate the achievement of the targets as set.

3) 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.

6.7 RISK MANAGEMENT

Risk	Mitigating factors
1. Appointments: The human resource systems not sufficiently responsive, which results in recruitment and selection processes being delayed.	1.1. Collaborate with the human resource division to expedite appointments.
2. Infrastructure: As a result of old buildings, the burden of disease and the lack of long range planning the quality and volume of working space is insufficient to facilitate the roll-out of HIV and TB services.	2.1. Dependant on Capital Works to fast track the upgrading of facilities in preparation for increased case load and burden of disease. Department of Public Works and Transport?
3. The waiting list for TB hospital admission is the most important risk factor affecting the spread of drug-resistant TB.	3.1. Provide universal access to treatment for all drug-resistant patients by implementing decentralised management of MDR-TB.
4. Absence of early warning systems to alert the Department of the unavailability of TB drugs.	4.1. Implement systems to ensure an uninterrupted TB drug supply to health facilities.
5. Non-compliance of NPOs with respect to achieving targets as set.	5.1. Implement systems that will align NPOs to be compliant with Finance Instruction G54 of 2009.
6. HIV and TB data management and flow not aligned to the departmental policy for establishing a central repository for health information management.	6.1. Collaborate with Chief Directorate: Strategy and Health Support to resolve this by supporting the establishment of the central repository and aligning the current data flow to that of the data flow policy.

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

7.1 SITUATION ANALYSIS FOR MCWH AND N

Maternal, Child and Women's Health (MCWH) and Nutrition services are rendered at all facilities within the Province, including secondary, tertiary, specialised hospitals and within communities, including community outreach programmes. The MCWH and N component strives towards implementing evidence-based key interventions to contribute towards achieving Millennium Development Goals (MDG) 4 & 5.

Malnutrition is a major contributing factor to morbidity and mortality and thus the Integrated Nutrition Programme (INP) is implemented as one of the key strategies within health programmes to decrease these rates. 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 prevention, implementation of health programmes.

The MCWH and Nutrition aims 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.

MCWH and Nutrition services are rendered through existing human resources at all levels of care, i.e. by doctors, nurses, dieticians, pharmacists and other healthcare workers. Improving MCWH services is a key factor in achieving MDGs 4 and 5. These include access to antenatal services, intra-partum care, postnatal care, neonatal care and child health services at all levels. Staff members are continuously up-skilled through programmes such as Integrated Management of Childhood Illnesses (IMCI), infant feeding, Basic Antenatal Care (BANC) and Essential Steps in Management of Obstetric and Neonatal Emergencies (ESMOE).

Table 2.13: Situation analysis indicators for MCWH & N [MCWH1]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Type	Province wide value 2009/10	Cape Town District 2009/10	Cape Winelands District 2009/10	Central Karoo District 2009/10	Eden District 2009/10	Overberg District 2009/10	West Coast District 2009/10	National Average 2009/10
1. Manage the burden of disease.	1.1. MDG goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	1.1.1. Reduce the mortality in children under the age of 5 years to 30 per 1 000 live births by 2015.	1) Under-5 mortality rate	Rate		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			-	-	-	-	-	-	
			Denominator			-	-	-	-	-	-	
			2) Immunisation coverage under 1 year	%	100.2%	99.2%	96.9%	104.8%	107.9%	97.8%	109.1%	89.5%
			Numerator		98 622	66 054	12 185	1 199	9 675	4 002	5 507	
			Denominator		98 403	66 581	12 570	1 144	8 969	4 092	5 048	
			3) Vitamin A coverage 12 – 59 months	%	**38.5%**	28.3%	54.6%	58.0%	64.1%	54.5%	64.6%	31.3%
			Numerator		**307 267**	150 976	57 229	5 628	48 134	17 937	27 363	
			Denominator		**799184**	534 262	104 856	9 698	75 092	32 890	42 332	
			4) Pneumococcal vaccine (PCV) 3rd dose coverage	%	102.8%	102.0%	99.7%	105.4	109.8	99.1%	110.4	91.7%
			Numerator		101 154	67 934	12 538	1 205	9 848	4 055	5 574	
			Denominator		98 403	66 581	12 570	1 144	8 969	4 092	5 048	
			5) Rotavirus (RV) 2nd dose coverage	%	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		-	-	-	-	-	-	-	
			Denominator		-	-	-	-	-	-	-	
			6) Measles 1st dose under 1 year coverage	%	102.8%	102.0%	99.7%	105.4	109.8	99.1%	110.4	
			Numerator		101 154	67 934	12 538	1 205	9 848	4 055	5 574	
			Denominator		98 403	66 581	12 570	1 144	8 969	4 092	5 048	
			7) Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	%	3.6%	3.7%	3.5%	0%	3.2%	4.2%	2.8%	
			Numerator		404	303	40	0	31	20	10	
			Denominator		11 233	8 255	1 140	42	954	481	351	

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Type	Province wide value 2009/10	Cape Town District 2009/10	Cape Winelands District 2009/10	Central Karoo District 2009/10	Eden District 2009/10	Overberg District 2009/10	West Coast District 2009/10	National Average 2009/10
			8) Facility infant mortality (under 1) rate	No per 1 000	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	N/A
			Numerator		-	-	-	-	-	-	-	
			Denominator		-	-	-	-	-	-	-	
			9) Facility child mortality (under 5) rate	No per 1 000	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	N/A
			Numerator		-	-	-	-	-	-	-	
			Denominator		-	-	-	-	-	-	-	
			10) Diarrhoea incidence under 5 years	%	14.8%	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		73 389							
			Denominator		495 991							
			11) Pneumonia incidence under 5 years	%	8.6%	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		42 614							
			Denominator		495 991							
	1.2. MDG goal 5: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	1.2.1. Reduce the maternal mortality ratio to 90 per 100 000 live births by 2015.	12) Facility maternal mortality rate	No per 100 000	103	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		100							
			Denominator		97185							
			13) Cervical cancer screening coverage	%	5.7%	5.1%	6.1%	6.5%	7.8%	6.3%	7.6%	43.9%
			Numerator		70 345	41 758	9 822	805	9 545	328	5 127	
			Denominator		1 218 127	805 253	159 056	12 384	121 957	52 100	67 377	
			14) Delivery rate for women under 18 years	%	7.3%	6.6%	9.3%	7.9%	8.4%	8.2%	8.5%	8.8%
			Numerator		7 060	4 406	1 145	89	745	244	431	
			Denominator		96 907	66 496	159 056	1 116	8 888	2 972	5 061	
			15) Antenatal visits before 20 weeks rate	%	46.4%	38.4%	60.4%	58.9%	64.3%	59.1%	65.0%	32.5%
			Numerator		48 351	26 539	7 772	722	6 651	2 606	4 061	
			Denominator		104 256	69 177	12 858	1 226	10 337	4 408	6 250	

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Type	Province wide value 2009/10	Cape Town District 2009/10	Cape Winelands District 2009/10	Central Karoo District 2009/10	Eden District 2009/10	Overberg District 2009/10	West Coast District 2009/10	National Average 2009/10
			16) Couple year protection rate	%	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	31.9%
			Numerator		-	-	-	-	-	-	-	
			Denominator		-	-	-	-	-	-	-	

7.2 CHALLENGES

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

2) Prevention of future outbreaks of vaccine-preventable diseases (e.g. measles).

7.3 PRIORITIES

1) The launch of the Road to Health Booklets will be the key rallying tool to enhance the wellness of children, with a special focus on prevention. All key partners will be involved, including NPO's , universities and private sector.

2) Implementation of strategies and interventions to improve child health outcomes:

- Behaviour change interventions such as breast-feeding promotion, protection and support; complementary feeding and healthy eating ;
- Micro-nutrient programmes;
- Therapeutic feeding;
- Prevention of vaccine -preventable diseases through immunisation interventions;
- Implementation of Child Healthcare Problem Identification Programme (CHPIP);
- Early childhood development – with focus on screening for developmental disabilities and screening of school-going children.

3) Implementation of strategies and interventions to improve women's health outcomes:

- Provide quality Sexual and Reproductive Services;
- Quality obstetric care during antenatal, intra-partum and postnatal phases of pregenancy;
- Improving management of obstetric and neonatal emergencies.

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

Table 2.14: Strategic objectives, indicators and annual targets for MCWH and N [MCWH & N 2 AND 3]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. MDG goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	1.1.1. Reduce the mortality in children under the age of 5 years to 30 per 1 000 live births by 2015.	1) Under-5 mortality rate	Rate	30	38.8	38.6	38.6	37	35	33	31	
			Numerator		-	-	-	-	-	-	-	-	
			Denominator		-	-	-	-	-	-	-	-	
			2) Immunisation coverage under 1 year	%		100.5%	96.5%	100.2%	75%	95%	95%	95%	90%
			Numerator			-	94 540	98 622	89496	101 092	103 218	105 344	
			Denominator			-	98 008	98 403	104175	106 413	108 651	110 889	
			3) Vitamin A coverage 12 – 59 months	%		33.24 %	61.54 %	38.45 %	20.38 %	54%	63%	72%	80%
			Numerator			246 626	456 575	307 267	115 014	435 901	510 577	585 833	
			Denominator			741 900	741 900	799 184	846 080	807 224	810 440	813657	
			4) Pneumococcal vaccine (PCV) 3rd dose coverage	%		Not required to report	Not required to report	102.8%	95%	95%	95%	95%	90%
			Numerator					101 154	98 966	101 092	103 218	105 344	
			Denominator					98 403	104 175	106 413	108 651	110 889	
			5) Rotavirus (RV) 2nd dose coverage	%		Not required to report	Not required to report	Not required to report	95%	95%	95%	95%	90%
			Numerator						98 966	101 092	103 218	105 344	
			Denominator						104 175	106 413	108 651	110 889	
			6) Measles 1st dose under 1 year coverage	%		102.80%	100%	102.8%	95%	95%	95%	95%	90%
			Numerator			-	97 726	101 154	98 966	101 092	103 218	105 344	
			Denominator			-	98 008	98 403	104 175	106 413	108 651	110 889	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
			7) Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	%		5.2%	4.5%	3.6%	3%	3%	3%	3%	
			Numerator			-	487	404	355	420	432	444	
			Denominator			-	10 797	11 223	11 998	14 000	14 400	14 800	
			8) Facility infant mortality (under 1) rate	No per 1 000		10.6	Not required to report	Not required to report	Not required to report	16.2	14.8	13.4	
			Numerator							1 587			
			Denominator							98 799			
			9) Facility child (under 5) mortality rate	No per 1 000		15.5	Not required to report	Not required to report	Not required to report	23.5	21.5	19.5	
			Numerator							12 384			
			Denominator							527 215			
			10) Diarrhoea incidence under 5 years	%		2.3%		14.8%	12.3%	10.3%	8.3%	6.3%	
			Numerator			11 684		73 389	64 847	55 467	45 636	35 351	
			Denominator			508 016		495 991	527 215	538 524	549 832	561 140	
			11) Pneumonia incidence under 5 years	%		5.5%		8.6%	8.3%	7.5%	7.0%	6.5%	
			Numerator			27 940		42 614	41 396	40 389	38 488	36 474	
			Denominator			508 016		495 991	527 215	538 524	549 832	561 140	
	1.2. MDG goal 5: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	1.2.1. Reduce the maternal mortality ratio to 90 per 100 000 live births by 2015.	12) Facility maternal mortality rate	%	27	Not required to report	Not required to report	103	87	72	57	42	
			Numerator		27			100	85	71	56	42	
			Denominator		99 685			97185	97 685	98 185	98 685	99 185	
			13) Cervical cancer screening coverage	%		5.10%	52.0	57.7	66.2	102.0	104.0	106.0	40%
			Numerator			-	63,127	70,345	85,345	134,414	139,942	145,580	
			Denominator			-	121,322	121,813	128,998	131,779	134,560	137,340	
			14) Delivery rate for women under 18 years	%		7.5%	7.9%	7.3%	7.04%	6.7%	6.4%	6.1%	10
			Numerator			-	7 412	7 060	6 305	6 566	6 304	6 039	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
			Denominator			-	94 139	96 907	89 505	98 000	98 500	99 000	
			15) Antenatal visits before 20 weeks rate	%		39%	44.2%	46.4%	52.9%	68%	70%	72%	
			Numerator			-	43,413	48 351	55 531	85 782	97 135	109 904	
			Denominator			-	106 909	104 256	105 061	126 150	138 765	152 641	
			16) Couple year protection rate	%		65	Not required to report	Not required to report	Not required to report	60	62	64	
			Numerator			948 522				865 197	897 606	930 245	
			Denominator			1 459 266				1 441 995	1 447 752	1 453 509	

Table 2.15: Quarterly targets for MCWH&N for 2010/11 [MCWH4]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. MDG goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	1.1.1. Reduce the mortality in children under the age of 5 years to 30 per 1000 live births by 2015.	1) Under-5 mortality rate	Annually	35	-	-	-	-
			Numerator		-				
			Denominator		-				
			2) Immunisation coverage under 1 year	Quarterly	95%	95%	95%	95%	95%
			Numerator		101 092	25 273	25 273	25 273	25 273
			Denominator		106 413	26 604	26 603	26 603	26 603
			3) Vitamin A coverage 12 – 59 months	Quarterly	54%	54%	54%	54%	54%
			Numerator		435 901	108 975	108 975	108 975	108 975
			Denominator		807 224	201 806	201 806	201 806	201 806
			4) Measles 1st dose under 1 year coverage	Quarterly	95%	95%	95%	95%	95%
			Numerator		101 092	25 273	25 273	25 273	25 273
			Denominator		106 413	26 604	26 603	26 603	26 603
			5) Pneumococcal vaccine (PCV) 3rd dose coverage under 1 years	Quarterly	95%	95%	95%	95%	95%
			Numerator		101 092	25 273	25 273	25 273	25 273
			Denominator		106 413	26 604	26 603	26 603	26 603

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			6) Rotavirus (RV) 2nd dose coverage	Quarterly	95%	95%	95%	95%	95%
			Numerator		101 092	25 273	25 273	25 273	25 273
			Denominator		106 413	26 604	26 603	26 603	26 603
			7) Baby tested PCR positive six weeks after birth as a proportion of babies tested at six weeks	Quarterly	3%	3%	3%	3%	3%
			Numerator		420	105	105	105	105
			Denominator		14 000	3 500	3 500	3 500	3 500
			8) Facility infant mortality (under 1) rate	Annually	16.2	-	-	-	-
			Numerator		1 587	-	-	-	-
			Denominator		98 799	-	-	-	-
			9) Facility child mortality (under 5) rate	Annually	23.5	-	-	-	-
			Numerator		12 384	-	-	-	-
			Denominator		527 215	-	-	-	-
			10) Diarrhoea incidence under 5 years	Quarterly	10.3%	10.3%	10.3%	10.3%	10.3%
			Numerator		55 467	13 867	13 867	13 867	13 867
			Denominator		538 524	134 631	134 631	134 631	134 631
			11) Pneumonia incidence under 5 years	Quarterly	7.5%	7.5%	7.5%	7.5%	7.5%
			Numerator		40 389	10 097	10 097	10 097	10 097
			Denominator		538 524	134 631	134 631	134 631	134 631
	1.2. MDG goal 5: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	1.2.1. Reduce the maternal mortality ratio to 90 per 100 000 live births by 2015.	12) Facility maternal mortality rate	Annually	72	-	-	-	-
			Numerator		71	-	-	-	-
			Denominator		98 185	-	-	-	-
			13) Cervical cancer screening coverage	Quarterly	10.2%	10.2%	10.2%	10.2%	10.2%
			Numerator		134 414	33 604	33 604	33 603	33 603
			Denominator		1 317 790	329 448	329 448	329 448	329 448

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			14) Delivery rate for women under 18 years	Quarterly	6.7%	6.7%	6.7%	6.7%	6.7%
			Numerator		6 566	1 642	1 642	1 641	1 641
			Denominator		98 000	24 500	24 500	24 500	24 500
			15) Antenatal visits before 20 weeks rate	Quarterly	68%	68%	68%	68%	68%
			Numerator		85 782	21 445	21 445	21 446	21 446
			Denominator		126 150	31 537	31 537	31 538	31 538
			16) Couple year protection rate	Annually	60	-	-	-	-
			Numerator		865 197	-	-	-	-
			Denominator		1 441 995	-	-	-	-

7.5 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

7.6 PERFORMANCE AND EXPENDITURE TRENDS

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.

An additional amount of R1 122 million or 4.76 per cent, in nominal terms, has been allocated to Nutrition.

The Department took a policy decision to compile detailed projections for vaccine needs and ring-fence the budget for 2011/12.

7.7 RISK MANAGEMENT

Risk	Mitigating factors
1. Inconsistent supply and distribution of vaccines to the districts leading to low immunisation coverage (in some sub-districts).	1.1. Review the service level agreement with BIOVAC as a service provider. 1.2. Monitor contract management with BIOVAC.
2. Inadequate smears and missed opportunities for cervical cancer detection.	2.1. Implementation staff training programmes to improve the quality of smears. 2.2. Monitor laboratory expenditure trends for cervical smears.
3. Inadequate utilisation of health information trends for management decisions	3.1. Improve skills for monitoring and evaluation: accuracy, completeness and timeliness of data management. 3.2. Improve the culture of using information management for decision making.
4. Increased pressures on services arising from emerging and re-emerging infectious diseases.	4.1. Implementation of robust surveillance systems and appropriate disease preparedness plans.

8. DISEASE PREVENTION AND CONTROL

8.1 SITUATION ANALYSIS FOR DISEASE PREVENTION AND CONTROL

Environmental Health Services (EHS), which relate 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, which include a high volume cataract surgery site, refraction services, low vision and community-based services provide services within the districts. In addition, to the central hospitals, Eerste River Hospital has been identified as a high volume cataract surgery site.

The National Department of Health had initially set a cataract surgery rate target of 2 000/million which proved to be unattainable and has now been adjusted to 1 500/million.

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

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Type	Province wide value 2009/10	Cape Town District 2009/10	Cape Winelands District 2009/10	Central Karoo District 2009/10	Eden District 2009/10	Overberg District 2009/10	West Coast District 2009/10	National Average 2009/10
1. Manage the burden of disease.	1.1. Preparation for the dealing with epidemics and disasters.	1.1.1. Ensure that all districts have plans to deal with outbreaks and epidemics.	1) Malaria fatality rate (annual)	%	0	0	0	0	0	0	0	1.06
			Numerator		0	0	0	0	0	0	0	
			Denominator		62							
			2) Cholera fatality rate (annual)	%	0	0	0	0	0	0	0	89.5%
			Numerator		0	0	0	0	0	0	0	
			Denominator		1							
	1.2. Chronic disease management.	1.2.1. Increase cataract surgery rate	3) Cataract surgery rate (annual)	No / million popu-lation	1 132	1 352	777	812	1 043	410	76	
			Numerator		6 022	4 768	558	46	540	88	22	
			Denominator		5 321 416	3 525 473	718 194	56 685	517 473	214 514	289 077	

8.2 CHALLENGES

1) Prevention of future disease outbreaks due to emerging and re-emerging infectious diseases.
2) Prevention of blindness.

8.3 PRIORITIES

1) Implementation of provincial disease outbreak preparedness plans.
2) Implementation of high volume cataract surgery procedures at designated health facilities.
3) Strengthening of the healthy lifestyle programme.

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

Table 2.17: Strategic objectives, indicators and annual targets for disease prevention and control [DCP 3]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Preparation for the dealing with epidemics and disasters.	1.1.1. Ensure that all districts have plans to deal with outbreaks and epidemics.	1) Malaria fatality rate (annual)	%		0	0	0	1.9%	0	0	0	1.06
			Numerator			-	-	0	1	0	0	0	
			Denominator			-	-	62	71				
			2) Cholera fatality rate (annual)	%		0	0	0	0	0	0	0	
			Numerator			-	-	0	0	0	0	0	
			Denominator			-	-	1					
	1.2. Chronic disease management.	1.2.1. Increase cataract surgery rate.	3) Cataract surgery rate (annual)	No / million popu-lation	1 500 per million population	1 033	1 070	1 132	1 101	1 200	1 300	1 400	1 500 per million population
			Numerator			-	5 670	6 022	6 201	6 907	7 640	8 3987	
			Denominator			-	5 299 999	5 321 416	5 634 323	5 755 607	5 876 887	5 998 164	

8.5 QUARTERLY TARGETS FOR DISEASE PREVENTION AND CONTROL

Table 2.18: Quarterly targets for disease prevention and control for 2010/11 [DCP4]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Preparation for the dealing with epidemics and disasters.	1.1.1. Ensure that all districts have plans to deal with outbreaks and epidemics.	1) Malaria fatality rate (annual)	Annually	0	-	-	-	-
			Numerator		0	-	-	-	-
			Denominator			-	-	-	-
			2) Cholera fatality rate (annual)	Annually	0	-	-	-	-
			Numerator		0	-	-	-	-
			Denominator			-	-	-	-
	1.2. Chronic disease management.	1.2.1. Increase cataract surgery rate.	3) Cataract surgery rate (annual)	Annually	1 200	-	-	-	-
			Numerator		6 907	-	-	-	-
			Denominator		5 755 607	-	-	-	-

8.5 PERFORMANCE AND EXPENDITURE TRENDS

From 2007/08 to 2009/10, the cataract surgery performance has been steady with only a 10% increase over the four financial years. This indicates the need to inject more funding into Eerste River Hospital as the high volume cataract surgery centre to expand services. The Department will be undertaking a province-wide situational analysis to estimate future needs and resources required for expansion.

8.6 RISK MANAGEMENT

Risk	Mitigating factors
1. Emerging and imported disease outbreaks requiring strong partnerships with municipalities and other sectors.	1.1. Strengthen partnerships with key sectors to implement surveillance systems and outbreak preparedness plans.
2. Inadequate organisational capacity at implementation level to expand cataract surgery service.	2.1. Undertake a province-wide situational analysis to forecast future needs and resources required for expansion.
3. Inadequate multi-sectoral interventions to impact on the burden of diseases.	3.1. Implement the Advocacy, Communication and Social Mobilisation (ACSM) activities in collaboration with key sectors to improve healthy lifestyles.

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 centers).

3. SITUATIONAL ANALYSIS

There are 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 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 stations in five rural district EMS services and four Cape Town divisional EMS services with a fleet of 260 ambulances and 1 353 operational personnel and 122 supervisors (officers). Forty six per cent of the operational personnel are trained in Basic Life Support, forty three per cent in Intermediate Life Support and eleven per cent in Advanced Life Support.

The service performed 414 154 ambulance missions in 2009 transporting 461 940 patients with an urban priority 1 response performance of 40% within 15 minutes and rural priority 1 response performance of 79% within 40 minutes. The triage profile of patients transported according to the SATS triage score shows a distribution of 5% Red (critically ill), 60% Yellow (serious), 32% Green (minor) and 3% Blue (patients who have died).

EMS patient transport or HealthNET performs out-patient 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. HealthNET in Cape Town transports rural patients to surrounding rural areas and relieves the emergency service by transporting non-acute cases from clinics to hospitals in the City.

HealthNET has seventy six patient transporters which are either configured with thirteen seats, twenty two seats, two stretchers and two seats, 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 eighty six 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 which provides for the transfer of acutely ill or injured patients to referral hospitals. This service performed 842 missions in 2009 transporting 1 025 patients to secondary and tertiary care facilities. Eighty-five rescue missions resulted in 50 patients being rescued from wilderness areas or the sea.
- The Fleet Management Services ensures the provision of an operational vehicle fleet.
- The Information Communication Technology 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 Special Event Services which provides cover to many community events every year.
- The Facility Management Services which coordinate the delivery and maintenance of EMS building infrastructure throughout the Province.

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 undergraduate 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.

Table 3.1: Situation analysis indicators for EMS and patient transport [EMS1]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Type	Province wide value 2009/10	Cape Town District 2009/10	West Coast District 2009/10	Cape Winelands District 2009/10	Overberg District 2009/10	Eden District 2009/10	Central Karoo District 2009/10	National Average 2009/10
1. Manage the burden of disease.	1.1. Fully implement the Comprehensive Service Plan model for EMS by 2014.	1.1.1. To complete the implementation of the Comprehensive Service Plan by operationalising the EMS resources (542 vehicles, 54 bases and **2 366** personnel) necessary to the specified service levels of 156 rostered ambulances per hour in the CSP by 2014.	1) Rostered ambulances per 10 000 people	No	0.47	0.32	0.98	0.61	1.21	0.65	2.37	1.546
			Numerator		251	103	28	40	25	30	15	
			Denominator		5 513	3 639	305	741	228	540	60	
	1.2. Provide roadside to bedside definitive emergency care within defined emergency time frames within and across geographic and clinical service platforms.	1.2.1. To meet the response time performance for urban (90% P1 within 15 minutes) and rural (90% P1 within 40 minutes) clients and ensure the shortest time to definitive care by integrated management of pre-hospital and hospital emergency care resources by 2014.	2) Percentage of urban Priority 1 responses within 15 minutes	%	40.1	36.7	59.0	46.8	63.8	72.3	78.9	50.4%
			Numerator		39 320	27 161	2 192	3 725	2 067	2 711	964	
			Denominator		95 231	74 084	3 715	7 967	3 238	3 749	1 222	
			3) Percentage of rural Priority 1 responses within 40 minutes	%	79.2	33.3	81.4	80.5	78.6	82.2	64.2	55.1%
			Numerator		7, 050	9	1, 415	2, 970	882	1, 241	501	
			Denominator		8, 907	27	1, 739	3, 691	1, 122	1, 510	780	
			4) All calls with a response time within 60 minutes	%	78.5	71.3	92.7	81.3	93.8	96.6	95.0	67.7%
			Numerator		325 121	188 557	20 251	38 826	21 337	43 767	9 457	
			Denominator		414 154	264 480	21 853	47 741	22 743	45 300	9 950	

4. CHALLENGES

The challenges in EMS include the following:

4.1 COMMUNICATIONS

1) The absence of an National 112 Emergency Number System.
2) Inadequate technology to process emergency call demand.
3) Inadequate human resources quantitatively and qualitatively to process call demand.
4) Poor initial education and training in contact centre operations.
5) No professional remuneration structures for contact centre personnel.

4.2 HUMAN RESOURCES

1) An Occupational Specific Dispensation for EMS that is poorly constructed with poor remuneration structures and which fails in the stated objective of retaining and recruiting competent EMS professionals. EMS has lost eleven Advanced Life Support paramedics since implementing the OSD.
2) Poor development structures for supervisory and management cadres.
3) Accelerating loss of experienced Advanced Life Support personnel.
4) The significant vacancies in supervisory and operational posts need to be addressed.

4.3 OPERATIONAL PERFORMANCE

1) Achieving urban response time targets.
2) High demand for outpatient access to central hospitals.
3) Coordination of Emergency Care and Emergency Centres across the platform from primary to tertiary care facilities.
4) Hospital ownership of response time performance.
5) Medical Rescue of patients in entrapments by virtue of their environment.

5. PRIORITIES

5.1 COMMUNICATIONS

- Establishing appropriate Information Communication Technology and Systems to facilitate rational dispatch and achievement of response time targets.

5.2 OPERATIONAL PERFORMANCE

- Coordination between health facilities and EMS.
- Operational modelling to achieve response time efficiencies.
- Improving quality of care and the patients' experience of the service.

5.3 HUMAN RESOURCES

- Overcoming the human resource challenges in EMS.

6. STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR EMS

Table 3.2: Performance indicators for EMS and patient transport [EMS3]

Strategic Goal	Strategic Objective: Title	Strategic Objective: Statement	Performance Indicator	Type	Strategic Objective Target	Audited/Actual Performance			Estimated performance	Medium term targets			National Target
					2015	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Fully implement the Comprehensive Service Plan model for EMS by 2014.	1.1.1. To complete the implementation of the Comprehensive Service Plan by operationalising the EMRS resources (542 vehicles, 54 bases and **2 366** personnel) necessary to the specified service levels of 156 rostered ambulances per hour in the CSP by 2014.	1) Rostered ambulances per 10 000 people	No	0.25	0.39	0.43	0.47	0.25	0.22	0.21	0.21	1
			Numerator		156	-	230	251	141	126	126	126	611
			Denominator		611	-	540	551	563	575	587	599	611
			2) Total number of EMS emergency cases	No	456 000	392 395	387 436	461 940	419 904	429 000	438 000	446 000	-
	1.1. Provide roadside to bedside definitive emergency care within defined emergency time frames within and across geographic and clinical service platforms.	1.1.1. To meet the response time performance for urban (90% P1 within 15 minutes) and rural (90% P1 within 40 min) clients and ensure the shortest time to definitive care by integrated management of pre-hospital and hospital emergency care resources by 2014.	3) Percentage of urban Priority 1 responses within 15 minutes	%	65%	50%	43.6%	40.1%	49%	65%	65%	65%	80%
			Numerator		94 590	-	35 908	39 320	55 640	64 100	65 450	66 800	
			Denominator		105 000	-	82 410	95 231	114 299	98 600	100 700	102 800	
			4) Percentage of rural Priority 1 responses within 40 minutes	%	80%	69%	75.4%	79.2%	83%	80%	80%	80%	80%
			Numerator		7 272	-	7 607	7 050	8 243	6 860	7 008	7 150	
			Denominator		9 090	-	10 090	8 907	9 883	8 580	8 760	8 940	
			5) All calls with a response time within 60 minutes	%	80%	57%	79.3%	78.5%	74.6%	80%	80%	80%	100%
			Numerator		364 800	-	296 483	325 121	362 665	343 200	350 400	356 800	
			Denominator		456 000	-	373 940	414 154	486 121	429 000	438 000	446 000	
	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.	6) Percentage of ambulance patients transferred between facilities	%	10%	21%	20.8%	27.5%	31.5%	30%	25%	20%	
			Numerator		45 600	82 402	80 586	127 033	132 345	128 700	109 500	89 200	
			Denominator		456 000	392 395	387 436	461 940	419 904	429 000	438 000	446 000	

Strategic Goal	Strategic Objective: Title	Strategic Objective: Statement	Performance Indicator	Type	Strategic Objective Target	Audited/Actual Performance			Estimated performance	Medium term targets			National Target
					2015	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	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.	7) Number of outpatients transferred by HealthNET to regional and central hospitals	No	91 650	-	-	113 830	77 279	86 250	88 050	89 850	

Note:

Indicator 1: During the period from 2007/08 to 2009/10, the number of ambulances in the fleet was used for this indicator. From 2010/11 onwards, the number of rostered ambulances is used i.e. the average number of ambulances available per hour.

Table 3.3: Quarterly targets for EMS and patient transport for 2010/11 [EMS4]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1 Fully implement the Comprehensive Service Plan model for EMS by 2014.	1.1.1. To complete the implementation of the Comprehensive Service Plan by operationalising the EMRS resources (542 vehicles, 54 bases and **2 366** personnel) necessary to the specified service levels of 156 rostered ambulances per hour in the CSP by 2014.	1) Rostered ambulances per 10 000 people	Quarterly	0.22	0.22	0.22	0.22	0.22
			Numerator		126	126	126	126	126
			Denominator		575	575	575	575	575
	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.	2) Total number of EMS emergency cases	Quarterly	429 000	107 250	107 250	107 250	107 250
			3) Percentage of urban Priority 1 responses within 15 minutes	Quarterly	65%	65%	65%	65%	65%
			Numerator		64 100	16 025	16 025	16 025	16 025
			Denominator		98 600	24 650	24 650	24 650	24 650
			4) Percentage of rural Priority 1 responses within 40 minutes	Quarterly	80%	80%	80%	80%	80%
			Numerator		6 860	1 715	1 715	1 715	1 715
			Denominator		8 580	2 145	2 145	2 145	2 145
			5) All calls with a response time within 60 minutes	Quarterly	80%	80%	80%	80%	80%
			Numerator		343 200	85 800	85 800	85 800	85 800
			Denominator		429 000	107 250	107 250	107 250	107 250

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
	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,	6) Percentage of ambulance patients transferred between facilities	%	30%	30%	30%	30%	30%
			Numerator		128 700	32 175	32 175	32 175	32 175
			Denominator		429 000	107 250	107 250	107 250	107 250
	1.4 Efficiently and effectively manage chronic diseases	1.4.1. To meet the appropriate outpatient transfer needs per year through intra-district and trans district HealthNET Transport system ensuring that patients are managed at the appropriate level of care by 2014.	7) Number of outpatients transferred by HealthNET to regional and central hospitals	No	86 250	21 564	21564	21 561	21 561

7. RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND THE MTEF

Table 3.4: Expenditure estimates: Emergency Medical Services [EMS5]

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2007/08	Audited 2008/09	Audited 2009/10	Main appro-priation 2010/11	Adjusted appro-priation 2010/11	Revised estimate 2010/11	2011/12	% Change from Revised estimate 2010/11	2012/13	2013/14
1. Emergency Transport [a]	321 120	378 469	492 887	520 386	539 510	539 510	566 520	5.01	600 632	647 337
2. Planned Patient Transport	20 757	24 649	37 243	40 192	42 485	42 485	49 527	16.58	52 007	56 605
Total payments and estimates	341 877	403 118	530 130	560 578	581 995	581 995	616 047	5.85	652 639	703 942

[a] 2011/12: Conditional grant: Health professions training and development: R3 172 000 (Compensation of employees R2 746 000; Goods and services R426 000).

Table 3.5: Summary of provincial expenditure by economic classification for Emergency Medical Services

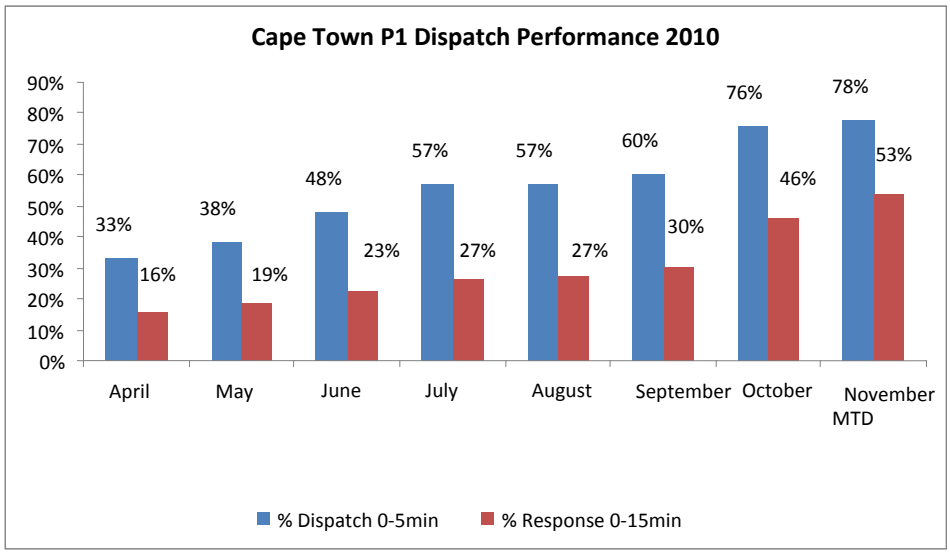
Economic classification R'000	Outcome			Main appro-priation	Adjusted appro-priation	Revised estimate	Medium-term estimate			
	Audited	Audited	Audited					% Change from Revised estimate		
	2007/08	2008/09	2009/10	2010/11	2010/11	2010/11	2011/12	2010/11	2012/13	2013/14
Current payments	300 344	371 842	470 719	504 837	535 580	535 130	565 754	5.72	600 334	646 406
Compensation of employees	204 437	259 484	315 071	323 197	360 064	359 614	378 835	5.34	405 672	432 042
Salaries and wages	175 298	223 654	271 863	287 646	314 705	314 255	325 923	3.71	349 012	377 828
Social contributions	29 139	35 830	43 208	35 551	45 359	45 359	52 912	16.65	56 660	54 214
Goods and services	95 907	112 329	155 626	181 640	175 516	175 516	186 919	6.50	194 662	214 364
of which										
Advertising	41				1	1	1		1	1
Assets <R5 000	4 485	2 446	3 533	3 696	4 545	4 545	3 063	(32.61)	3 186	3 504
Catering: Departmental activities	112	112	213	104	104	104	111	6.73	116	127
Communication	4 293	4 312	8 910	10 177	10 177	10 177	10 889	7.00	11 325	12 458
Computer services	306	415	268	682	682	682	230	(66.28)	239	263
Cons/prof: Business and advisory service	345	329	909	293	293	293	114	(61.09)	118	130
Cons/prof: Infrastructure & planning	21									
Cons/prof: Legal cost			1	2	2	2	2		2	2
Contractors	1 111	1 029	2 126	2 806	8 232	8 232	8 808	7.00	9 161	10 077
Agency and support/ outsourced services	121	174	566	236	236	236	253	7.20	263	289
Entertainment		1	1	4	4	4	14	250.00	15	16
Inventory: Food and food supplies		1								
Inventory: Fuel, oil and gas	1 463	2 161	3 995	3 175	3 175	3 175	4 087	28.72	4 251	4 676
Inventory: Materials and supplies	558	434	773	1 118	1 118	1 118	1 196	6.98	1 244	1 369
Inventory: Medical supplies	4 569	4 473	8 982	9 864	9 564	9 564	9 865	3.15	10 260	11 286
Inventory: Medicine	126	194	323	256	256	256	300	17.19	312	344
Inventory: Other consumables	3 243	329	5 836	6 706	5 256	5 256	6 423	22.20	6 681	7 350
Inventory: Stationery and printing	1 286	1 389	2 098	2 716	2 716	2 716	2 906	7.00	3 022	3 325
Lease payments	6 129	8 254	483	1 561	1 561	1 561	1 500	(3.91)	1 560	1 716
Property payments	1 706	2 353	2 542	3 217	3 517	3 517	4 760	35.34	5 212	5 967
Travel and subsistence	65 755	81 775	112 903	134 038	123 088	123 088	131 339	6.70	136 593	150 253
Training and development			819	718	718	718	768	6.96	799	879
Operating expenditure	54	1 779	335	263	263	263	281	6.84	293	322
Venues and facilities	183	369	10	8	8	8	9	12.50	9	10
Interest and rent on land		29	22							
Interest		29	22							
Transfers and subsidies to	18 930	20 972	29 264	37 128	37 128	37 128	39 355	6.00	40 930	45 023
Non-profit institutions	18 873	20 906	29 172	37 058	37 058	37 058	39 281	6.00	40 853	44 938
Households	57	66	92	70	70	70	74	5.71	77	85
Social benefits	57	66	92	70	70	70	74	5.71	77	85
Payments for capital assets	21 590	9 486	27 950	18 613	9 287	9 287	10 938	17.78	11 375	12 513
Machinery and equipment	21 590	9 479	27 780	18 613	9 287	9 287	10 938	17.78	11 375	12 513
Transport equipment	11 545	2 697	10 264	4 941	1 941	1 941	2 077	7.01	2 160	2 376
Other machinery and equipment	10 045	6 782	17 516	13 672	7 346	7 346	8 861	20.62	9 215	10 137
Software and other intangible assets		7	170							
Of which: "Capitalised Goods and services" included in Payments for capital assets			3 446	3 922	96	96	103	7.29	107	118
Payments for financial assets	1 013	818	2 197			450		(100.00)		
Total economic classification	341 877	403 118	530 130	560 578	581 995	581 995	616 047	5.85	652 639	703 942

8. PERFORMANCE AND EXPENDITURE TRENDS

Programme 3 is allocated 4.60 per cent of the vote in 2011/12 in comparison to the 4.70 per cent that was allocated in the revised estimate of 2010/11. This amounts to a nominal increase of R34.052 million or 5.85 per cent.

8.1 The Department has prioritized and increased investment in EMS over recent years. This was further boosted by increased allocations during the World Cup in 2010. This enabled, amongst others, the modernization of the ambulance fleet, augmented the equipping of vehicles, appointment of more staff, the setting up of modern communication centres and the strengthening of Healthnet, the setting up of Emergency Medicine as a discipline with the appointment of specialists and registrars and the strengthening and expansion of the Air Mercy Service.

8.2 Significant alterations to the dispatch model in the City of Cape Town and the application of overtime expenditure have resulted in a Priority 1 response time within 15 minutes improvement from **16% to 53%** from April to November 2010. Additional human resources and fleet will be required to further improve the response times.



Rural response time performance appears to be sustained at good levels and focus on improving performance must be in the City of Cape Town.

8.3 EMS has strategically built five core system structures through which to deliver emergency care:

1) Communications System
2) Ambulance System
3) Medical Rescue System
4) Patient Transport System
5) Air Medical System

The clinical governance and coordination of Emergency Medicine within EMS completes the link to hospital based emergency care.

8.4 These structures represent a solid foundation of the service but meeting performance targets will require increased investment if patient contacts cannot be resolved at the lowest level and transfers are required to higher or more distant levels of care. It is anticipated that the commissioning of the Khayelithsha and Mitchells Plain District Hospitals over the MTEF period will reduce the demand for ambulance transfers from these communities. Demand continues to rise with population increases where 8% of the population is transported by public sector EMS ambulances annually and 2% require HealthNET transport to facilities.

8.5 The cost of higher quality staff must be factored into progressive funding over the medium term. Human resource budgets do not accommodate improved qualification and remuneration with time resulting in a shrinking establishment.

8.6 Access through a three digit emergency number has not been achieved. Representation has been made to the national government in this regard. There is much to be done in respect of communication systems. The question is what role the private sector communications industry should be playing in relation to their licensing contracts.

8.7 EMS is funding the function of Emergency Number Systems that should be funded elsewhere in the national sphere of government whereas communications expenditure should be spent locally on improving response efficiency.

8.8 HealthNET (non-emergency transport) provides good access to outpatient appointments at hospitals but there is much to be done in the health system to rationalize and organize this access and improve equity. Transport to a centralized specialist service is calculated to be cheaper than providing decentralized services although the inconvenience to the patients must be recognized.

8.9 The need to transport patients between levels of care is not accurately calculated over time in relation to the evolution of the health system and the consequent clinic and hospital structures that are created. Planning of hospitals and clinics must incorporate planning for transport between these facilities and inform the budget process. HealthNET expenditure has increased in order to meet the demands of the health system.

8.10 There has been variable progress in implementing the acute emergency case load management policy at institutional level. Creating an ownership of responsibility amongst hospital staff for emergency patient care from the “roadside to bedside” is an ongoing challenge.

8.11 Planning for Emergency Medicine should be progressive and reflected specifically and explicitly in hospital budgets.

8.12 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.

8.13 The Air Mercy Service is a quality service that provides equitable access for any critically ill or injured patient in the province to secondary and tertiary care. The service also frees up ambulances in local towns and improves local access to emergency care. The strategic investment in this resource maintains rural performance. Health economics studies have demonstrated the value of this service.

Investment in maintaining this service over time, where costs escalate in relation to Euro/Dollar currencies (aircraft parts/service/fuel) at greater than 30% per annum, places massive pressure on the EMS budget. The EMS budget inflated at 5-7% across the service does not accommodate the progressive escalation in air transport costs. The application of discriminating inflationary indices across the spectrum of costs would be rational.

9. RISK MANAGEMENT

Risk	Mitigating factors
1. Failure to provide caller latitude and longitude with telephony data.	1.1. Discussion and negotiation with cellular providers to provide data.
2. Computer Aided Dispatch System failure.	2.1. Contract new CAD Service provider and design paper backup.
3. Social infrastructure inhibits prompt emergency response.	3.1. Navigation must not be dependent on social infrastructure (roads, signs and numbers).
4. Slow response times.	4.1. New CAD ICT solution and operational remodelling.
5. Poor Emergency Care quality.	5.1. Good competency development in foundation training. 5.2. Continuous personnel development programme. 5.3. Quality management structure and process with close cooperation by Emergency Medicine Specialists.

PROGRAMME 4: PROVINCIAL HOSPITALS

1. PROGRAMME PURPOSE

Delivery of hospital services, which are accessible, appropriate, and effective and provide general specialist services, including a specialized 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 of 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 for complicated dental patients and provide a platform for training and research.

3. SUB-PROGRAMME 4.1 GENERAL (REGIONAL) HOSPITALS

3.1 SITUATIONAL ANALYSIS

Sub-Programme 4.1 funds regional hospital services in New Somerset and Mowbray Maternity Hospitals in the Cape Town Metro District and Paarl, Worcester and George Hospitals in the rural districts. The reconfiguration and strengthening of these hospitals, 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.

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

The reporting of performance information for general specialist services in central hospitals was aligned with the allocation of funding and was reported in Sub-programme 4.1 for the period 2008/09 to 2010/11. From 2011/12, in line with the funding shift, the performance information for these services in central hospitals will be reported in Programme 5. Cognisance must be taken of these shifts when the data trends are analysed.

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

The focus areas for the regional hospitals are:

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

3.2 CHALLENGES

- Managing the acute caseload in general specialist hospitals.
- Improving access to specialist ambulatory care: Appropriate devolution of outpatient activities to primary health care.
- Improving infectious disease management.
- Improving quality of patient care.
- Financial management and compliance.
- Implementation of Functional Business Units (FBUs).

- Strengthening human resources and appointing staff in line with the affordable approved post list.
- Improving information systems and data reliability.

3.3 PRIORITIES

3.3.1 Service Delivery

Improving access to general specialist services:

1) The implementation of the Acute Emergency Case Load Management (AECLM) policy and improving the triage policy.
2) Improving theatre efficiencies.
3) Increased day surgery capacity.
4) The uniform implementation of the outreach and support system in all three of the rural regional areas.
5) Improving women's health:
   - Provision of specialist outreach services from level 2 gynaecology services.
   - Obstetric service specialists will provide 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) Continuing to improve responsiveness to the diarrhoeal season.
7) Identifying outpatients for devolution to primary care for follow up.
8) Improve infectious disease management:
   - Pending the finalisation of the ART decanting plan, the planning process has commenced to decant stable ART patients from regional hospitals to the community health centres in the Metro West area.
   - Implementation of TB control measures in general hospitals aims at prevention of intra-hospital spread of TB with a particular focus on the management of the occupational health risks posed to staff and other patients by patients with TB.
   - Improving infection prevention and control in all services.

3.3.2 Clinical governance and quality of care

1) Mortality and morbidity meetings result in improved management of clinical risks.
2) Adverse incidents and patient complaints are investigated and addressed. This leads to improved staff development, risk management and patient experience.
3) Assess the adherence to the six identified priorities extracted from the National Core Standards.

3.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR GENERAL (REGIONAL) HOSPITALS

Table 4.1: Strategic objectives, performance indicators and annual for general (regional) hospitals [PHS1 & 2]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Ensure access to general specialist hospital services.	1.1.1. Ensure access to regional hospitals services by providing 1 340 regional hospital beds by 2014.	1) Number of regional hospital beds	%	1 340	1 379	2 490	2 364	2 378	1 340	1 340	1 340	
			2) Total separations in regional hospitals	No		130 205	196 668	185 919	176 461	111 306	113 634	115 879	
			3) Patient day equivalents [PDE] in regional hospitals	No		636 992	1 122 369	1 051 150	1 041 026	569 019	581 666	593 156	
			4) OPD total headcounts in regional hospitals	No		362 960	718 131	628 931	608 124	262 799	268 673	273 720	
	1.2. Reduce facility maternal mortality.	1.2.1. Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies at a target of 35% by 2014.	5) Caesarean section rate for regional hospitals	%	35%	33%	33%	32.5%	35.6%	35%	35%	35%	>25%
			Numerator		5127	-	8 211	8 425	9 141	9 134	9 134	9 134	
			Denominator		14426	-	25 040	25 961	25 699	26 116	26 116	26 116	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality general specialist hospital services.	2.1.1. Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R2 100 per PDE by 2014. [Constant 2009/10 rand].	6) Expenditure per patient day equivalent [PDE] in regional hospitals	R	2 100	1 304	1 509	1 626	1 662	1 609	1 574	1 570	
			Numerator		1 164 058 000	830 762 114	1 693 684 682	1 709 636 442	1 730 042 197	915 427 153	915 658 625	931 453 904	
			Denominator		554 313	636 992	1 122 369	1 051 150	1 041 026	569 019	581 666	593 156	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1. Efficiently manage the allocated resources of regional hospitals to achieve a target bed utilisation rate of 85% and an average length of stay of 4 days by 2014.	7) Bed utilisation rate (based on usable beds) in regional hospitals	%	85%	91%	86%	86%	85.5%	89%%	91%	92%	75%
			Numerator		415 735	-	782 263	742 740	746 867	433 538	443 174	451 928	
			Denominator		489 100	-	908 850	862 860	873 413	489 100	489 100	489 100	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
			8) Average length of stay in regional hospitals	Days	4 days	3.4 day	4 days	4 days	4.2 days	4 days	4 days	4 days	4.8days
			Numerator		415 735	-	782 263	742 740	746867	433 538	443 174	451 928	
			Denominator		103 934	-	196 668	185 919	176461	111 306	113 634	115 879	
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. Implement quality assurance measures to minimise patients risk in regional hospitals by monthly mortality and morbidity meetings by 2014.	9) Percentage of regional hospitals with monthly mortality and morbidity meetings	%	100 %	100 %	100%	100%	100%	100%	100%	100%	
			Numerator		5	-	9	8	8	5	5	5	
			Denominator		5	-	9	8	8	5	5	5	
			10) Percentage of complaints of users of regional hospitals resolved within **25** days	%		Not required to report	100%	82.5%	83%	85%	85%	85%	
			Numerator			-	-	552	484	510	510	510	
			Denominator			-	-	669	583	600	600	600	
			11) Regional hospital patient satisfaction rate	%		Not required to report	Not required to report	Not required to report	75%	75%	75%	75%	
			Numerator			-	-	-	2 484	2 625	2 625	2 625	
			Denominator			-	-	-	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	Not required to report	1	3	5	

Note:
1. During the 2006/07 financial year Sub-programme 4.1 included: Somerset, Mowbray Maternity, Paarl, and Worcester, George, GF Jooste, Helderberg, Victoria and Karl Bremer Hospitals.
2. The level two services within central hospitals were included in this sub-programme as from 1 April 2008 and will reflect in Program 5 as from 1 April 2011.
3. Victoria Hospital shifted to Programme 2 from 1 April 2009.

Table 4.2: Quarterly targets for general (regional) hospitals for 2011/12 [PHS3]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Ensure access to general specialist hospital services.	1.1.1. Ensure access to regional hospitals services by providing 1 340 regional hospital beds by 2014.	1) Number of regional hospital beds	Quarterly	1 340	1 340	1 340	1 340	1 340
			2) Total separations in regional hospitals	Quarterly	111 306	27 827	27 827	27 827	27 827
			3) Patient day equivalents [PDE] in regional hospitals	Quarterly	569 019	142 255	142 255	142 255	142 255
			4) OPD total headcounts in regional hospitals	Quarterly	262 799	65 700	65 700	65 700	65 700
	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% in 2014.	5) Caesarean section rate for regional hospitals	Quarterly	35%	35%	35%	35%	35%
			Numerator		9 134	2 284	2 284	2 284	2 284
			Denominator		26 116	6 529	6 529	6 529	6 529
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality general specialist hospital services.	2.1.1. Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R2 100 per PDE by 2014. [Constant 2009/10 rand].	6) Expenditure per patient day equivalent [PDE] in regional hospitals	Quarterly	R1 609	R1 609	R1 609	R1 609	R1 609
			Numerator		915 427 153	228 856 788	228 856 788	228 856 788	228 856 788
			Denominator		569 019	142 255	142 255	142 255	142 255
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1. Efficiently manage the allocated resources of regional hospitals to achieve a target bed utilisation rate of 85% and an average length of stay of 4 days by 2014.	7) Bed utilisation rate (based on usable beds) in regional hospitals	Quarterly	89%	89%	89%	89%	89%
			Numerator		433 538	108 385	108 385	108 385	108 385
			Denominator		489 100	122 275	122 275	122 275	122 275
			8) Average length of stay in regional hospitals	Quarterly	4 days	4 days	4 days	4 days	4 days
			Numerator		433 538	108 385	108 385	108 385	108 385
			Denominator		111 306	27 827	27 8274	27 827	27 827
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. Implement quality assurance measures to minimise patients risk in regional hospitals by monthly mortality and morbidity meetings by 2014.	9) Percentage of regional hospitals with monthly mortality and morbidity meetings	Quarterly	100%	100%	100%	100%	100%
			Numerator		5	5	5	5	5
			Denominator		5	5	5	5	5

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			10) Percentage of complaints of users of regional hospitals resolved within **25** days	Quarterly	85%	85%	85%	85%	85%
			Numerator		510	127	127	128	128
			Denominator		600	150	150	150	150
			11) Regional hospital patient satisfaction rate	Annual	75%	-	-	-	
			Numerator		2 625	-	-	-	
			Denominator		3 500	-	-	-	
			12) Number of regional hospitals assessed for compliance with the 6 priorities of the core standards	Annual	1	-	-	-	

Note:
Victoria Hospital shifted to Programme 2 from 1 April 2009.

3.5 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND THE MTEF

Table 4.3: Summary of payments and estimates: Programme 4: Provincial Hospital Services

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2007/08	Audited 2008/09	Audited 2009/10	Main appro-priation 2010/11	Adjusted appro-priation 2010/11	Revised estimate 2010/11	2011/12	% Change from Revised estimate 2010/11	2012/13	2013/14
1. General Hospitals [a]	718 190	1 567 744	1 698 619	1 978 787	2 026 737	2 026 737	1 148 730	(43.32)	1 221 297	1 316 658
2. Tuberculosis Hospitals [a]	101 671	135 635	157 627	178 370	184 216	184 216	194 867	5.78	207 331	224 161
3. Psychiatric/Mental Hospitals [a]	344 390	391 902	448 401	502 620	530 785	530 785	569 950	7.38	609 729	655 241
4. Chronic Medical Hospitals [a]	79 888	99 317	110 461	122 168	126 578	126 578	136 024	7.46	143 755	155 777
5. Dental Training Hospitals [a]	61 888	66 052	85 980	94 286	97 983	97 983	102 900	5.02	109 494	117 434
Total payments and estimates	1 306 027	2 260 650	2 501 088	2 876 231	2 966 299	2 966 299	2 152 471	(27.44)	2 291 606	2 469 271

[a] 2011/12: Conditional grant: Health professions training and development: R71 951 000 (Compensation of employees R54 279 000; Goods and services R17 672 000).

Note: Contributing factors to the decrease of funding in this programme in 2007/08 are the allocation of GF Jooste, Hottentots Holland and Karl Bremer Hospitals from sub-programme 4.1 to sub-programme 2.9 and Nelspoort Hospital from sub-programme 4.4 to s

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 4.4: Summary of provincial 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			
	2007/08	2008/09	2009/10	2010/11	2010/11	2010/11	2011/12	2010/11	2012/13	2013/14
Current payments	1 292 089	2 243 275	2 478 921	2 838 714	2 928 782	2 928 670	2 127 715	(27.35)	2 265 860	2 440 952
Compensation of employees	877 609	1 553 809	1 746 601	1 952 746	2 048 220	2 048 099	1 520 829	(25.74)	1 628 555	1 734 414
Salaries and wages	775 403	1 381 181	1 557 298	1 737 945	1 828 128	1 828 007	1 349 400	(26.18)	1 444 982	1 551 737
Social contributions	102 206	172 628	189 303	214 801	220 092	220 092	171 429	(22.11)	183 573	182 677
Goods and services	414 480	689 388	732 320	885 968	880 562	880 562	606 886	(31.08)	637 305	706 538
of which										
Administrative fees			16	7	8	8	8		9	9
Advertising	996	37	71	98	108	108	113	4.63	118	129
Assets <R5 000	5 175	7 483	5 432	8 366	7 646	7 646	7 421	(2.94)	7 719	8 492
Audit cost: External	19	377								
Catering: Departmental activities	272	686	130	364	431	431	465	7.89	487	533
Communication	9 729	12 005	14 215	17 689	17 199	17 199	14 020	(18.48)	14 581	16 038
Computer services	1 206	1 279	1 638	2 051	1 985	1 985	1 821	(8.26)	1 891	2 082
Cons/prof: Business and advisory service	36 556	39 261	41 391	46 932	46 734	46 734	49 885	6.74	51 880	57 071
Cons/prof: Infrastructure & planning	506									
Cons/prof: Laboratory service	42 889	91 809	98 154	109 981	112 684	112 684	58 236	(48.32)	60 566	66 624
Cons/prof: Legal cost	3		2	2	1	1	1		1	1
Contractors	13 638	22 268	32 284	36 793	28 763	28 763	24 650	(14.30)	25 637	28 200
Agency and support/ outsourced services	64 541	103 917	93 692	84 883	76 619	76 619	55 418	(27.67)	57 636	63 397
Entertainment	2	1	1	3	10	10	25	150.00	25	30
Inventory: Food and food supplies	16 477	29 898	31 520	35 766	39 671	39 671	29 516	(25.60)	30 694	33 765
Inventory: Fuel, oil and gas	3 039	4 969	4 595	5 594	6 930	6 930	4 080	(41.13)	4 243	4 665
Inventory: Materials and supplies	3 286	7 281	8 229	11 910	12 214	12 214	8 266	(32.32)	8 593	9 455
Inventory: Medical supplies	90 508	162 190	182 609	245 790	233 111	233 111	137 304	(41.10)	142 796	157 078
Inventory: Medicine	41 692	69 139	69 655	107 978	103 396	103 396	64 291	(37.82)	66 861	73 544
Inventory: Other consumables	12 133	17 887	23 596	28 698	29 215	29 215	22 146	(24.20)	23 033	25 334
Inventory: Stationery and printing	6 131	8 127	8 367	11 120	9 854	9 854	9 296	(5.66)	9 666	10 635
Lease payments	4 638	5 475	2 940	4 595	5 047	5 047	3 811	(24.49)	3 963	4 360
Property payments	46 379	84 320	98 389	108 816	125 672	125 672	94 052	(25.16)	103 961	119 856
Transport provided: Departmental activity	1 059	1 095	421	696	1 481	1 481	1 542	4.12	1 603	1 764
Travel and subsistence	6 238	8 778	9 380	10 675	11 505	11 505	11 023	(4.19)	11 469	12 614
Training and development	2 788	4 202	4 352	5 798	8 663	8 663	7 973	(7.96)	8 290	9 120
Operating expenditure	4 565	6 828	1 193	1 288	1 488	1 488	1 410	(5.24)	1 466	1 613
Venues and facilities	15	76	48	75	127	127	113	(11.02)	117	129
Interest and rent on land		78				9		(100.00)		
Interest		78				9		(100.00)		
Transfers and subsidies to	2 686	4 863	4 116	4 132	4 132	4 123	2 885	(30.03)	3 001	3 299
Non-profit institutions	1 021	1 226								
Households	1 665	3 637	4 116	4 132	4 132	4 123	2 885	(30.03)	3 001	3 299
Social benefits	1 665	3 637	4 116	4 132	4 132	4 123	2 885	(30.03)	3 001	3 299
Payments for capital assets	10 965	12 337	17 914	33 385	33 385	33 385	21 871	(34.49)	22 745	25 020
Buildings and other fixed structures	11	588	69							
Buildings	11	588	69							
Machinery and equipment	10 948	11 738	17 839	33 385	33 385	33 385	21 813	(34.66)	22 685	24 954
Transport equipment		11	536	760	760	760	580	(23.68)	604	663
Other machinery and equipment	10 948	11 727	17 303	32 625	32 625	32 625	21 233	(34.92)	22 081	24 291
Software and other intangible assets	6	11	6				58		60	66
Of which: "Capitalised Goods and services" included in Payments for capital assets			242	329	329	329	182	(44.68)	189	208
Payments for financial assets	287	175	137			121		(100.00)		
Total economic classification	1 306 027	2 260 650	2 501 088	2 876 231	2 966 299	2 966 299	2 152 471	(27.44)	2 291 606	2 469 271

3.6 PERFORMANCE AND EXPENDITURE TRENDS

Programme 4 is allocated 16.07 per cent of the vote during 2011/12 in comparison to the 23.97 per cent that was allocated in the 2010/11 revised estimate. This amounts to a nominal decrease of R813.828 million or 27.44 per cent due to the shifting of the funds for Level 2 services in the central hospitals from Sub-programme 4.1 to Programme 5 from 1 April 2011.

Sub-Programme 4.1 is allocated 53.37 per cent of the Programme 4 budget in 2011/12 in comparison to the 68.33 per cent of the budget that was allocated in the 2010/11 revised estimate. This amounts to a nominal decrease of 43.32 per cent or R878.007 million.

3.6.1 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:

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.

3.7 RISK MANAGEMENT

Risk	Mitigating factors
1. **Financial management**: Financial constraints which are exacerbated by the increasing demand for services as a result of the increased burden of disease 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. 1.2. Cost containment strategies are being institutionalised. 1.3. Expenditure reports 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 staff as well as establishing the Devolved Internal Control Unit at the Regional Office to manage resources more effectively and efficiently towards financial compliance. 1.6. Contract management will be improved to ensure that service providers adhere to the output specifications. 1.7. Asset management will be strengthened to prevent the loss of assets.
2. **Human Resource Management** The human resource risk is 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 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,	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.

Risk	Mitigating factors
nosocomial infections, morbidity and mortality.	3.3. Clinical audit and mortality and morbidity meetings will be institutionalised. 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. Core standards in priority areas.
4. **Information Management** The lack of good quality data compromises the planning, monitoring and management of health service.	4.1. Standard operating procedures are being developed and implemented at all levels of the service. 4.2. The 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 committees in the major disciplines will enable better co-ordination and sharing of clinical experiences across the health service.

4. SUB-PROGRAMME 4.2: TB HOSPITALS

4.1 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 six TB hospitals in the Province which are located as follows:

1) Brooklyn Chest Hospital: Cape Town Metro
2) DP Marais Hospital: Cape Town Metro
3) Sonstraal Hospital: Paarl
4) Infectious Diseases Hospital: Malmesbury
5) Harry Comay Hospital: George
6) Brewelskloof Hospital: Worcester.

There are currently three designated drug resistant TB (DR-TB) units in the Western Cape namely Brewelskloof, Harry Comay and Brooklyn Chest Hospitals. DP Marais and Harry Comay were provincialised from the South African National Tuberculosis Association (SANTA) in recent years. In October 2010, Brooklyn Chest and DP Marias Hospital were 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.

4.2 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 phased implementation of 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.
3) The growing burden of drug resistant Tuberculosis and co-infected HIV/TB patients places a strain on human and financial resources at TB hospitals.
4) Providing a safe, infection controlled environment for the management of highly infectious patients

4.3 PRIORITIES:

1) Fill priority posts within the financial constraints and the CSP framework in TB hospitals.
2) Improve infection control and occupational health and safety surveillance.
3) Improve clinical treatment outcomes for the multi-drug resistant (MDR-TB) and XDR-TB programme.
4) Strengthen clinical governance in all TB hospitals.

4.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR TB HOSPITALS

Table 4.5: Strategic objectives, performance indicators and annual targets for TB hospitals [PHS 1 & 2]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Ensure access to TB hospital services.	1.1.1. Ensure access to the full package of TB hospital services by providing 1 284 TB hospital beds by 2014.	1) Number of TB hospital beds	No	1 284	1 008	1 040	1 016	1 033	1 040	1 040	1 115	
			2) Total separations in TB hospitals	No		3 759	3 725	3 684	4 107	3 796	3 841	3 903	
			3) Patient day equivalents [PDE] in TB Hospitals	No		300 307	304 302	305 833	311 779	316 171	323 789	331 408	
			4) OPD total headcounts in TB hospitals	No		2 942	1 818	3 208	7 631	3 308	3 388	3 468	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality TB hospital services.	2.1.1. Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R510 per PDE by 2014. [Constant 2009/10 rand].	5) Expenditure per patient day equivalent [PDE] in TB hospitals	R	R510	441	514	515	504	491	480	479	
			Numerator		187 396 525	132 294 534	156 272 827	157 626 336	157 248 549	155 290 227	155 444 923	158 580 010	
			Denominator		367 444	300 307	304 302	305 833	311 779	316 171	323 789	331 408	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1. Effectively manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 85 days by 2014.	6) Bed utilisation rate (based on usable beds) in TB hospitals	%	90%	81%	80%	82%	82 %	83%	85%	81%	
			Numerator		366 278	299 326	303 696	304 764	309 236	315 068	322 660	330 252	
			Denominator		406 975	367 920	379 600	370 840	376 248	379 600	379 600	406 975	
			7) Average length of stay in TB hospitals	Days	85 days	80 days	82 days	81 days	75 days	83 days	84 days	85 days	
			Numerator		366 278	299 326	303 696	304 764	309 236	315 068	322 660	330 252	
			Denominator		4 309	3 759	3 725	3 693	4 107	3 796	3 841	3 903	
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. Implement quality assurance measures to minimise patient risk in TB hospitals by monthly mortality and morbidity meetings by 2014.	8) Percentage of TB hospitals with monthly mortality and morbidity meetings	%	100%	50%	67%	67%	50%	67%	100%	100%	
			Numerator		6	3	4	4	3	4	6	6	
			Denominator		6	6	6	6	6	6	6	6	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
			9) Percentage of complaints of users of TB hospitals resolved within **25** days	%		Not required to report	100%	72.1%	72%	75%	75%	75%	
			Numerator			-	-	129	129	150	150	150	
			Denominator			-	-	179	179	200	200	200	
			10) TB hospital patient satisfaction rate	%		Not required to report	Not required to report	Not required to report	83%	85%	85%	85%	
			Numerator			-	-	-	506	510	510	510	
			Denominator			-	-	-	606	600	600	600	
			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	Not required to report	1	2	3	

4.5 QUARTERLY TARGETS FOR TB HOSPITALS

Table 4.5: Quarterly targets for TB hospitals for 2010/11 [PHS3]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Ensure access to TB hospital services.	1.1.1. Ensure access to the full package of TB hospital services by providing 1 284 TB hospital beds by 2014.	1) Number of TB hospital beds	Quarterly	1 040	1 040	1 040	1 040	1 040
			2) Total separations in TB hospitals	Quarterly	3 796	949	949	949	949
			3) Patient day equivalents [PDE] in TB hospitals	Quarterly	316 171	79 043	79 043	79 043	79 043
			4) OPD Total Headcounts in TB Hospitals	Quarterly	3 308	827	827	827	827
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality TB hospital services.	2.1.1. Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of **R510** by 2014. [Constant 2009/10 rand]	5) Expenditure per patient day equivalent [PDE] in TB hospitals	Quarterly	R491	R491	R491	R491	R491
			Numerator		155 290 227	38 822 557	38 822 557	38 822 557	38 822 557
			Denominator		316 171	79 043	79 043	79 043	79 043
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1. Effectively manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 85 days by 2014.	6) Bed utilisation rate in TB hospitals	Quarterly	83%	83%	83%	83%	83%
			Numerator		315 068	78 767	78 767	78 767	78 767
			Denominator		379 600	94 900	94 900	94 900	94 900
			7) Average length of stay in TB hospitals	Quarterly	83 days	83 days	83 days	83 days	83 days
			Numerator		315 068	78 767	78 767	78 767	78 767
			Denominator		3 796	949	949	949	949
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. Implement quality assurance measures to minimise patient risk in TB hospitals by monthly mortality and morbidity meetings by 2014.	8) Percentage of TB hospitals with monthly mortality and morbidity meetings	Quarterly	67%	67%	67%	67%	67%
			Numerator		4	4	4	4	4
			Denominator		6	6	6	6	6

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			9) Percentage of complaints of users of TB hospitals resolved within **25** days		75%	74%	74%	76%	76%
			Numerator		150	37	37	38	38
			Denominator		200	50	50	50	50
			10) TB hospital patient satisfaction rate		85%	-	-	-	
			Numerator		510	-	-	-	
			Denominator		600	-	-	-	
			11) Number of TB hospitals assessed for compliance with the 6 priorities of the core standards		1	-	-	-	

4.6 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Please refer to Tables 4.3 and 4.4 for the detailed financial information.

4.7 PERFORMANCE AND EXPENDITURE TRENDS

Sub-programme 4.2, TB Hospitals, is allocated 9.05. per cent of the Programme 4 budget in 2011/12 in comparison to the 6.21 per cent that was allocated in the revised estimate of 2010/11. This is a nominal increase of R10.651 million or 5.78 per cent.

The high HIV/TB co-infection rate, which is as high as 77% in some TB hospitals, means extra personnel and resources are needed to manage these complex, acutely ill patients. The provision of universal ART coverage for all HIV positive, DR-TB patients will favourably impact on the current trend.

The burgeoning DR-TB epidemic in the Western Cape, especially patients resistant to standard multi-drug resistant TB treatment, places a significant strain on the allocated budgets. The high cost of second line medication, laboratory costs and personnel costs are the three main cost drivers of this programme. Programme 2 will implement a decentralised DR-TB programme in a phased approach to ensure community access to DR-TB treatment. Skills and knowledge transfer through training and mentorship will help to facilitate earlier commencement of treatment, which will decrease transmission of DR-TB.

Due to the high mortality and poor treatment outcomes associated with DR-TB, the number of terminal patients requiring palliative care will continue to increase. A centralised unit has been commissioned at Nelspoort Hospital in the Central Karoo District. Four palliative care beds in the Eden District will address local patient needs. Where possible, addressing the upstream factors such as alcohol and substance abuse, food insecurity, overcrowding and poverty alleviation etc. will help to mitigate the current TB situation within the Western Cape.

4.8 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 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 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.

Risk	Mitigating factors
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.

Please refer to Programme 2.6: TB for additional downstream risk factors.

5. SUB-PROGRAMME 4.3 PSYCHIATRIC HOSPITALS

5.1 SITUATIONAL ANALYSIS

Sub-Programme 4.3 (Psychiatric Hospitals) consists of four hospitals all of which are located in the Cape Town Metro District:

1) Alexandra Hospital
2) Lentegeur Hospital
3) Stikland Hospital
4) Valkenberg Hospital
5) Two sub-acute facilities namely William Slater and New Beginnings.

5.1.1 The services provided are:

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

5.1.2 Mental Health Review Board

- In accordance with the Mental Health Care Act this Province has a single Mental Health Review Board with five members.

- The Board has established a benchmark for the country. The functions of the Board relate to protection of the rights of mental health care users and their families and they interface closely with the Cape High Court in this regard.

5.2 CHALLENGES

1) Hospital estate management and physical infrastructure remains a challenge.

2) Acute adult services remain under pressure.

3) The changing face of drug abuse (TIK, etc.) is placing an enormous burden on the services.

4) The serious impact of co-morbid infectious diseases, namely HIV and drug resistant TB on acuity of mental illness, complexity of treatment and length of hospital stay.

5) The waiting list for the male observation service, to awaiting trial prisoners, has remained constant at eighty patients for five to six months. This is a reduction on the nine to twelve months in the past. The service is run at maximum efficiency and will not be able to further reduce the waiting list without the Hospital Revitalisation Programme (HRP) provision of additional, safe infrastructure.

6) Mental health services must be integrated into all levels of general health care and to do this safely and with dignity, require both infrastructure and human resource capacity.

5.3 PRIORITIES

5.3.1 Service Delivery

1) **Ensure access to psychiatric hospital services**

A balanced provision for continuum of care requires growth in capacity for acute service management in primary health care and district hospitals, a growth in sub-acute residential and day programmes and particular growth in supported community residential options for both the mentally ill and the intellectually disabled people who cannot live independently.

- Commission 22 secure male admission beds at Valkenberg Hospital and strengthen the staffing of the acute services at Valkenberg to sustain current patient management efficiencies.
- Transfer 30 long term forensic patients from Valkenberg Hospital to Lentegeur Hospital.
- Discharge 45 long term patients from Lentegeur Hospital to the New Beginnings service.
- Discharge 20 long term patients from Stikland Hospital to New Beginnings service.

2) **Sub-Acute Services**

- Continue to manage the residential psychosocial rehabilitation programmes at William Slater and New Beginnings effectively and efficiently.
- Expand the New Beginnings service on Stikland Hospital premises to include an additional 65 residential placements for people difficult to place in community based group homes. Thus decommissioning these beds in the psychiatric hospitals.

3) **Support to District Hospitals**

- Maintain outreach and support from the psychiatric hospitals to the acute regional and district hospitals.
- Establish appropriate outpatient psychiatric services at all levels of care.

5.3.2 **Clinical Governance and Quality of Care**

1) Mortality and morbidity meetings result in improved management of clinical risks.
2) Adverse incidents and patient complaints are investigated and addressed to improve staff development, risk management and patient experience.
3) Assess the adherence to the six identified priorities extracted from the National Core Standards.

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

1) Appropriate management of bed utilisation.
2) Staff recruitment and retention strategies to be enhanced to support systems in areas such as finance, supply chain management, human resources, maintenance and information management.

5.3.4 **Allocate sufficient funds to ensure the sustained delivery of the full package of quality psychiatric hospital services**

1) Allocate sufficient funds to service delivery within psychiatric hospitals.
2) Ensure Department of Justice payment for forensic psychiatric observation services.
3) Encourage funding initiatives by the hospital boards.

5.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR PSYCHIATRIC HOSPITALS

Table 4.6: Strategic objectives, performance indicators and annual targets for psychiatric hospitals [PHS1 & 2]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Ensure access to psychiatric hospital services.	1.1.1. Ensure access to the full package of psychiatric hospital services by providing 1 528 psychiatric hospital beds by 2014.	1) Number of psychiatric hospital beds	No	**1 528**	1 924	1 934	1 792	1 738	**1 716**	**1 716**	**1 716**	
			2) Total separations in psychiatric hospitals	No		4 560	5 051	5 369	6 257	6 263	6 263	6 263	
			3) Patient day equivalents [PDE] in psychiatric hospitals	No		641 220	616 296	595 471	580 048	573 853	573 853	573 853	
			4) OPD total headcounts in psychiatric hospitals	No		21 403	23 955	34 521	31 485	30 440	30 440	30 440	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality psychiatric hospital services.	2.1.1. Allocate sufficient funds to ensure the delivery of the full package of psychiatric hospital services at a rate of R850 per PDE by 2014. [Constant 2009/10 rands).	5) Expenditure per patient day equivalent [PDE] in psychiatric hospitals	R	850	699	733	753	781	791	797	808	
			Numerator		435 297 467	447 936 000	451 532 000	448 360 000	453 083 000	454 195 000	457 140 000	463 542 000	
			Denominator		512 115	641 220	616 296	595 471	580 048	573 853	573 853	573 853	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1. Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 90 days by 2014.	6) Bed utilisation rate (based on usable beds) in psychiatric hospitals	%	**90%**	90%	87%	89%	88.7%	89%	87%	86%	
			Numerator		**501 948**	-	606 826	583 871	569 553	563 706	563 706	563 706	
			Denominator		**557 720**	-	698 883	654 080	641 809	626 340	626 340	626 340	
			7) Average length of stay in psychiatric hospitals	Days	**90**	139 days	118 days	109 days	91 days	90 days	90 days	90 days	
			Numerator		**501 948**	-	606 826	583 871	569 553	563 706	563 706	563 706	
			Denominator		**5 577**	-	5 051	5 369	6 257	6 263	6 263	6 263	
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. Implement quality assurance measures to minimise patients risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014.	8) Percentage of psychiatric hospitals with monthly mortality and morbidity meetings	%	100%	100%	100%	25%	100%	100%	100%	100%	
			Numerator		4	4	4	1	4	4	4	4	
			Denominator		4	4	4	4	4	4	4	4	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
			9) Percentage of complaints of users of psychiatric hospitals resolved within **25** days	%		Not required to report	100%	59.8%	60%	65%	70%	75%	
			Numerator			-	-	52	52	59	63	68	
			Denominator			-	-	87	87	90	90	90	
			10) Psychiatric hospital patient satisfaction rate	%		Not required to report	Not required to report	Not required to report	79%	80%	80%	80%	
			Numerator			-	-	-	467	480	480	480	
			Denominator			-	-	-	588	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	Not required to report	1	2	4	

Note:

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 monitoring and evaluation purposes, the costs of the PPP is divided between the sub-programmes in the table below

Table 4.7: Cost per PDE of Sub-programmes 4.3 and 4.4 adjusted in line with the distribution of the cost of the PPP

Sub-programme	Performance indicator	Audited/Actual Performance			Estimated performance	Medium term targets		
		2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
4.3. Psychiatric Hospitals	Expenditure per patient day equivalent [PDE] in psychiatric hospitals	740	773	793	820	831	836	848
4.4. Rehabilitation Hospital	Expenditure per patient day equivalent [PDE] in the rehabilitation hospital	1 525	1 625	1 525	1 633	1 800	1 797	1 831

Table 4.8: Quarterly targets for psychiatric hospitals for 2011/12 [PHS3]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Ensure access to psychiatric hospital services.	1.1.1. Ensure access to the full package of psychiatric hospital services by providing 1 528 psychiatric hospital beds by 2014.	1) Number of psychiatric hospital beds	Quarterly	**1 716**	**1 716**	**1 716**	**1 716**	**1 716**
			2) Total separations in psychiatric hospitals	Quarterly	6 263	1 566	1 566	1 566	1 566
			3) Patient day equivalents [PDE] in psychiatric hospitals	Quarterly	573 853	143 463	143 463	143 463	143 463
			4) OPD total headcounts in psychiatric hospitals	Quarterly	30 440	7 610	7 610	7 610	7 610
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality psychiatric hospital services.	2.1.1. Allocate sufficient funds to ensure the delivery of the full package of psychiatric hospital services at a rate of R850 per PDE by 2014. [Constant 2009/10 rand).	5) Expenditure per patient day equivalent [PDE] in psychiatric hospitals	Quarterly	791	791	791	791	791
			Numerator		454 195 000	113 548 812	113 548 812	113 548 812	113 548 812
			Denominator		573 853	143 463	143 463	143 463	143 463
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained support and strategic direction in the delivery of health services.	3.1.1. Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 90 days by 2014.	6) Average length of stay in psychiatric hospitals	Quarterly	90 days	90 days	90 days	90 days	90 days
			Numerator		563 706	140 927	140 927	140 927	140 927
			Denominator		6 264	1 566	1 566	1 566	1 566
			7) Bed utilisation rate (based on usable beds) in psychiatric hospitals	Quarterly	89%	89%	89%	89%	89%
			Numerator		563 706	140 927	140 927	140 927	140 927
			Denominator		626 340	156 585	156 585	156 585	156 585
4. Quality of health services.	4.1. Improve the quality of health services.	3.1.2. Implement quality assurance measures to minimise patients risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014.	8) Percentage of psychiatric hospitals with monthly mortality and morbidity meetings	Quarterly	100%	100%	100%	100%	100%
			Numerator		4	4	4	4	4
			Denominator		4	4	4	4	4

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			9) Percentage of complaints of users of psychiatric hospitals resolved within 25 days	Quarterly	65%	64%	68%	65%	65%
			Numerator		59	14	15	15	15
			Denominator		90	22	22	23	23
			10) Psychiatric hospital patient satisfaction rate	Annual	80%	-	-	-	
			Numerator		480	-	-	-	
			Denominator		600	-	-	-	
			11) Number of psychiatric hospitals assessed for compliance with the core standards	Annual	1	-	-	-	

5.5 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Please refer to Tables 4.3 and 4.4 for the detailed financial information.

5.6 PERFORMANCE AND EXPENDITURE TRENDS

Sub-Programme 4. 3, Psychiatric Hospitals, is allocated 26.48 per cent of the Programme 4 budget in 2011/12 in comparison to the 17.89 per cent that was allocated in 2010/11. This amounts to a nominal increase of R39.165 million or 7.38 per cent.

5.6.1 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 important therefore that the Department continue to focus on the de-institutionalisation of clients and the strengthening of acute, inpatient and outpatient services.

5.7 RISK MANAGEMENT

Risk	Mitigating factors
1. **Financial management**: Financial constraints which are exacerbated by the increasing demand for services as a result of the increased burden of disease 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. 1.2. Cost containment strategies are being institutionalised. 1.3. Expenditure reports 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 staff as well as establishing the Devolved Internal Control Unit at the Regional Office to manage resources more effectively and efficiently towards financial compliance. 1.6. Contract management will be improved to ensure that service providers adhere to the output specifications. 1.7. Asset management will be strengthened to prevent the loss of assets.
2. **Human Resource Management** The human resource risk is 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.

Risk	Mitigating factors
	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 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. 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 be institutionalised. 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. Core standards in priority areas.
4. **Information Management** The lack of good quality data compromises the planning, monitoring and management of health services.	4.1. Standard operating procedures are being developed and implemented at all levels of the service. 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 committees for mental health services will enable better co-ordination and sharing of clinical experiences across the health service.

6. SUB-PROGRAMME 4.4: SPECIALISED REHABILITATION SERVICES

6.1 SITUATIONAL ANALYSIS

6.1.1 Western Cape Rehabilitation Centre (WCRC):

- Programme 4.4 is made up only of Western Cape Rehabilitation Centre (WCRC), which provides rehabilitation services for people with physical disabilities and the Orthotic and Prosthetic Centre (OPC). The sub-programme has therefore been designated Specialised Rehabilitation Services.
- The WCRC, a 156-bed hospital, 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 / prosthetics where indicated.
- A clinical and functional outcome-based approach is followed, which demonstrates the positive impact of the service on re-integrating disabled clients back to their homes, communities and where appropriate, a return to productive activity.
- Specialised outpatient services are provided at urology-, orthopaedics-, plastics- and specialised seating clinics, for referred patients.
- Advanced outreach seating clinics will prioritise high risk clients.
- A number of persons with disabilities were trained as community-based peer supporters, as part of a long term project to strengthen the management and support of the patients in their community settings.
- The presentation of basic wheelchair seating training modules will continue to be provided at WCRC, as service delivery demands allow, to build the capacity of rehabilitation personnel. The WCRC will remain available as a teaching site for the presentation of the internationally accredited three-week basic Bobath and one-week advanced Bobath courses on neurological rehabilitation.
- Activities in the Health and Wellness Centre Project for persons living with a disability in the community have increased to include the promotion of participation in a broader spectrum of recreational- and sporting activities such as wheelchair tennis, blow darts and wheelchair basketball.

6.1.2 Management of the Orthotic and Prosthetic Services :

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

- With the exception of the Central Karoo and Eden Districts, where services have been outsourced since 2005, the OPC provides an accessible and responsive service to the remainder of the Western Cape. Alternative service design options such as further outsourcing of the service in the rural districts and retaining the in-house service in the Metro, will be considered to address the increasing demand.
- Planning continues for the relocation of the OPC from the Conradie site in Pinelands to a new down-scaled modern facility on the grounds of the WCRC.

6.1.3 **Management of the Public Private Partnership (PPP) contract:**

- There is a Western Cape Public Private Partnership for the provision of equipment, facilities management and all associated services at the WCRC and Lentegeur Hospital which is on the same site. The partnership was signed in December 2006 and full service commenced from 1 March 2007 for a period of twelve years.
- Managing this contract requires ongoing vigilance and stringent financial controls to ensure compliance with the Department's contractual obligations and to obtain the best value for money.
- The benefit of the PPP is that clinical staff is able to focus on their core business of service delivery, although administration and management of the PPP adds to the workload of the hospital manager and administrative staff.

6.2 **CHALLENGES**

1) To render "high intensity" rehabilitation as per the definition of 4-6 hours of interventions per day against a background of inadequate client: staffing ratios, higher acuity levels of clients that need to be admitted to reduce bed pressure in acute hospitals and a limited number of sub-acute beds on the platform.
2) Implementation of the modernisation of audiology service plan and address the backlog in hearing aids.
3) Loss of OPC data since migration to Clinicom resulting in an under-estimation of workload.
4) To eradicate the wheelchair / buggy backlog for mobility assistive devices.
5) The relocation of the orthotic and prosthetic services from the Conradie site to WCRC within the context of a PPP.

6.3 **PRIORITIES**

6.3.1 **Ensure access to specialised rehabilitation services**

1) Deliver inter-disciplinary outcome based rehabilitation services in line with the Rehabilitation and Disability Management Service Plan in the Comprehensive Service Plan.
2) Facilitate the implementation of appropriate 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 sufficient capacity to render comprehensive, individualised rehabilitation programmes to disabled clients.

4) Support the project to investigate and make recommendations on the modernisation of audiology services for the Western Cape.

5) Render on-site, off-site as well as outreach orthotic and prosthetic services to all districts in the Western Cape.

6) Facilitate the development and implementation of a modernised and quality orthotic and prosthetic service.

6.3.2 **Ensure and maintain organisational strategic management capacity and synergy**

1) Develop integrated support and management structures to render effective rehabilitation services.

2) Render services through a configuration of four inter-disciplinary teams as functional business units.

6.3.3 **Allocate sufficient funds to ensure the sustained delivery of the full package of quality rehabilitation hospital services**

1) Allocate sufficient funds to service delivery within rehabilitation.

2) Encourage funding initiatives by the hospital board.

6.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR REHABILITATION HOSPITALS

Table 4.9: Strategic objectives and annual targets for rehabilitation hospitals [PHS1 & 2]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Ensure access to rehabilitation services.	1.1.1. Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014.	1) Number of rehabilitation hospital beds	No	156	156	156	156	156	156	156	156	
			2) Total separations in rehabilitation hospitals	No		958	944	829	951	860	860	860	
			3) Patient day equivalents [PDE] in rehabilitation hospitals	No		50 654	54 940	56 801	53 584	48 762	48 762	48 762	
			4) OPD total headcounts in rehabilitation hospitals	No		5 856	16 227	25 107	31 178	25 004	25 004	25 004	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality rehabilitation hospital services by 2014.	2.1.1. Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R2 300 per PDE by 2014. [Constant R2009/10 rands].	5) Expenditure per patient day equivalent [PDE] in rehabilitation hospitals	R	2 300	2 052	2 083	1 945	2 069	2 281	2 268	2 319	
			Numerator		117 391 233	103 954 674	114 429 098	110 461 638	110 887 846	111 246 867	110 611 856	113 098 837	
			Denominator		51 040	50 654	54 940	56 801	53 584	48 762	48 762	48 762	
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained and strategic direction in the delivery of health services with well-defined efficiency targets towards improving quality of care.	3.1.1. Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilization rate of 75% and an average length of stay of 50 days by 2014.	6) Bed utilisation rate (based on usable beds) in rehabilitation hospitals	%	75%	87%	86%	85%	75.5%	70.7%	70.7%	70.7%	
			Numerator		42 705	-	49 176	48 431	43 191	40 262	40 262	40 262	
			Denominator		56 940	-	56 940	56 940	57200	56 940	56 940	56 940	
			7) Average length of stay in rehabilitation hospitals	Days	50 days	52 days	52 days	58 days	45.4 days	47 days	47 days	47 days	
			Numerator		42 705	-	49 176	48 431	43 191	40 427	40 427	40 427	
			Denominator		854	-	944	829	951	860	860	860	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
4. Quality of health services.	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.	8) Percentage of rehabilitation hospitals with monthly mortality and morbidity meetings	%	100%	100%	100%	0%	100%	100%	100%	100%	
			Numerator		1	1	1	0	1	1	1	1	
			Denominator		1	1	1	1	1	1	1	1	
			9) Percentage of complaints of users of rehabilitation hospitals resolved within 25 days	%		Not required to report	100%	86.7%	87%	88%	88%	88%	
			Numerator			-	-	13	13	14	14	14	
			Denominator			-	-	15	15	16	16	16	
			10) Rehabilitation hospital patient satisfaction rate	%		Not required to report	Not required to report	Not required to report	96%	95%	95%	95%	
			Numerator			-	-	-	176	190	190	190	
			Denominator			-	-	-	184	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	Not required to report	1	1	1	

Note:
Indicator 3: WCRC went on Clinicom in 20008/09 and all the service groups at OPD's are now included in the headcount as per the definitions.
Strategic objective 1.1.1 has been aligned with the performance indicators

Table 4.10: Quarterly targets for Rehabilitation Hospitals for 2011/12 [PHS3]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Ensure access to specialised 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	Quarterly	156	156	156	156	156
			2) Total separations in rehabilitation hospitals	Quarterly	860	215	215	215	215
			3) Patient day equivalents [PDE] in rehabilitation hospitals	Quarterly	48 762	12 190	12 190	12 190	12 190
			4) OPD total headcounts in rehabilitation hospitals	Quarterly	25 004	6 251	6 251	6 251	6 251
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality rehabilitation hospital services by 2014.	2.1.1. Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R 2 300 per PDE by 2014. [Constant R2009/10 rands].	5) Expenditure per patient day equivalent [PDE] in rehabilitation hospitals	Quarterly	2 281	2 281	2 281	2 281	2 281
			Numerator		111 246 667	27 812	27 812	27 812	27 812
			Denominator		48 762	12 190	12 190	12 190	12 190
3. Ensure and maintain organisational strategic management capacity and synergy.	3.1. Ensure that management provides sustained and strategic direction in the delivery of health services with well-defined efficiency targets towards improving quality of care.	3.1.1. Efficiently manage the allocated resources of rehabilitation services to achieve a target bed utilisation rate of 75% and an average length of stay of 50 days by 2014.	6) Bed utilisation rate (based on usable beds) in rehabilitation hospitals	Quarterly	70.7%	70.7%	70.7%	70.7%	70.7%
			Numerator		40 262	10 066	10 066	10 066	10 066
			Denominator		56 940	14 235	14 235	14 235	14 235
			7) Average length of stay in rehabilitation hospitals	Quarterly	47 days	47 days	47 days	47 days	47 days
			Numerator		40 427	10 107	10 107	10 107	10 107
			Denominator		860	215	215	215	215
4. Quality of health services.	4.1. Improve the quality of health services.	3.1.2. Implement quality assurance measures to minimise patients risk rehabilitation hospitals by monthly mortality and morbidity meetings by 2014.	8) Percentage of rehabilitation hospitals with monthly mortality and morbidity meetings	Quarterly	100%	100%	100%	100%	100%
			Numerator		1	1	1	1	1
			Denominator		1	1	1	1	1

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			9) Percentage of complaints of users of rehabilitation hospitals resolved within 25 days		88%	75%	75%	100%	100%
			Numerator		14	3	3	4	4
			Denominator		16	4	4	4	4
			10) Rehabilitation hospital patient satisfaction rate		95%	-	-	-	
			Numerator		190	-	-	-	
			Denominator		200	-	-	-	
			11) Number of rehabilitation hospitals assessed for compliance with the core standards		1	-	-	-	

Note:
Indicator 3: WCRC went on Clinicom in 20008/09 and all the service groups at OPD's are now included in the headcount as per the definitions

6.5 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Please refer to Tables 4.3 and 4.4 for the detailed financial information.

6.6 PERFORMANCE AND EXPENDITURE TRENDS

Sub-programme 4.4, Rehabilitation Hospitals is allocated 6.32 per cent of the 2011/12 allocation in comparison to the 4.27 per cent that was allocated in the revised estimate of 2010/11. This amounts to a nominal increase of R9.446 million or 7.46 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:

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.

6.7 RISK MANAGEMENT

Risk	Mitigating factors
1. **Financial management**: Financial constraints which are exacerbated by the increasing demand for services as a result of the increased burden of disease 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. 1.2. Cost containment strategies are being institutionalised. 1.3. Expenditure reports 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 staff as well as establishing the Devolved Internal Control Unit at the Regional Office to manage resources more effectively and efficiently towards financial compliance. 1.6. Contract management will be improved to ensure that service providers adhere to the output specifications. 1.7. Asset management will be strengthened to prevent the loss of assets.
2. **Human Resource Management** The human resource risk is 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. 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 be institutionalised. 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. Core standards in priority areas.
4. **Information Management** The lack of good quality data compromises the planning, monitoring and management of health services.	4.1. Standard operating procedures are being developed and implemented at all levels of the service. 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.

7. SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

7.1 SITUATION ANALYSIS

- 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.

7.2 CHALLENGES

1) Increasing theatre time remains a challenge.
2) Clinical sessions for students need to be increased.
3) The Oral Health Plan needs to be implemented.
4) Data collection needs to be improved.

7.3 PRIORITIES

1) Ensure access to an integrated oral health service and training platform.
2) Implementation of the oral health plan.

7.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND TARGETS FOR SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

Table 4.11: Strategic objectives and annual targets for dental training hospitals [PHS2]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Ensure access to dental training hospitals.	1.1.1. Ensure access to an integrated oral health service and training platform by providing for 185 454 patient visits per annum by 2014.	1) Number of oral health patient visits per annum	No	185 454	176 991	199 021	175 200	130 876	170 000	170 000	170 000	Not determined
		1.1.2. Performing maxillofacial surgery procedures during which one or more incisions are made to the head and neck area and is performed in a registered operating theatre that is equipped for anaesthesia and able to provide sterile conditions for surgical procedures with a target of 1 700 by 2014.	2) Number of oral health theatre cases per annum	No	1 700	1 016	1 523	1 578	1 297	1 556	1 556	1 556	
		1.1.3. Provide quality removable prosthetic devices to patients with a target of 4 108 by 2014.	3) Number of removable oral health prosthetic devices manufactured (dentures)	No	4 108	Not required to report	Not required to report	3 026	4 957	3 988	3 988	3 988	
		1.1.4. Provide a quality orthodontic service to dental patients with a target of 297 by 2014.	4) Number of new patients banded for orthodontic treatment (braces)	No	297	Not required to report	Not required to report	Not required to report	254	180	180	180	

Table 4.12: Quarterly targets for dental training hospitals for 2011/12 [PHS3]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Ensure access to dental training hospitals.	1.1.1. Ensure access to an integrated oral health service and training platform by providing for 185 454 patient visits per annum by 2014.	1) Number of oral health patient visits per annum	Quarterly	170 000	42 500	42 500	42 500	42 500
		1.1.2. Performing maxillofacial surgery procedures during which one or more incisions are made to the head and neck area and is performed in a registered operating theatre that is equipped for anaesthesia and able to provide sterile conditions for surgical procedures with a target of 1 700 by 2014.	2) Number of oral health theatre cases per annum	Quarterly	1 556	389	389	389	389
		1.1.3. Provide quality removable prosthetic devices to patients with a target of 4 108 by 2014.	3) Number of removable oral health prosthetic devices manufactured (dentures)	Quarterly	3 988	997	997	997	997
		1.1.4. Provide a quality Orthodontic service to Dental patients with a target of 297 by 2014.	4) Number of new patients banded for orthodontic treatment (braces)	Quarterly	180	0	0	0	180

7.5 RECONCILING PERFORMANCE TARGETS WITH THE BUDGET AND MTEF

Please refer to Tables 4.3 and 4.4 for the detailed financial information.

7.6 PERFORMANCE AND EXPENDITURE TRENDS

Sub-programme 4.5, Dental Training Hospitals, is allocated 4.78 per cent of the Programme 4 budget for 2011/12 in comparison to the 3.30 per cent that was allocated in the revised estimate of 2010/11. This amounts to a nominal increase of R4.917 million or 5.02 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:

Given the limited resources and many competing needs, only minor steps can be taken annually to implement the oral health plan. However, there will be a renewed focus on the fluoridation of water in 2011/12, which is a key upstream factor in the prevention of dental caries.

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.

There will be incremental implementation of the national core standards to improve the quality of care.

7.7 RISK MANAGEMENT

Risk	Mitigating factors
1. Inadequate budget	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 Resources	3.1 Recruit appropriate staff. 3.2 Prioritise critical posts in Approved Post List. 3.3 Organisational design. 3.4 Skills development plans. 3.4 Employee Assistance Programme to support staff. 3.5 Staff satisfaction survey.
4. Information management	4.1 Development of standard operation procedures. 4.2 Appointment of information management staff. 4.3 System developments and enhancements. 4.4 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.

PROGRAMME 5: CENTRAL HOSPITAL SERVICES

1. PROGRAMME

To provide central hospital specialist tertiary and quaternary health services, and to 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 specialized health services on a national basis and maintainting a platform for the training of health workers, as well as for research.

3. SITUATION ANALYSIS

The central hospitals are Groote Schuur, Tygerberg, and Red Cross War Memorial Children's Hospitals. Collectively these hospitals receive referrals from institutions in the Western Cape and beyond provincial boundaries.

Highly specialised services in 2010/11 were provided in 1 460 beds, related outpatient clinics, operating theatres and procedure rooms. These services require a multidisciplinary approach by a range of experts, as well as the support of various specialised diagnostic modalities. In addition, the central hospitals provide general specialist services, which were recorded in Programme 4.1 between 2008/09 and 2010/11. Table 5.1 below lists the range of services provided.

Table 5.1: Range of Central Hospital services delivered in 2010/11

Specialty	Sub-specialty service	Specialty	Sub-specialty service
Critical Care (Intensive Care)	Adult critical care		Paediatric Gastroenterology
	Paediatric and neonatal critical care		Paediatric Infectious Diseases
Obstetrics	Obstetrics		Paediatric Nephrology
	Maternal-Fetal Medicine		Paediatric Neurology
Gynaecology	Gynaecology		Paediatric Pulmonology
	Oncology	**Medicine**	Allergology
	Reproductive Medicine		Cardiology
	Uro-Gynaecology		Clinical Haematology/Oncology
Surgery	General Surgery		Dermatology
	Cardiothoracic Surgery		Emergency Medicine
	Neurosurgery		Endocrinology
	Ophthalmology		Gastroenterology
	Plastic and reconstructive surgery		General Medicine
	Urology		Geriatrics
	Ear, Nose and Throat		Hepatology
	Maxillo facial surgery		Infectious diseases
Orthopaedics	Orthopaedics		Nephrology
	Hand Surgery		Neurology
	Spinal Unit		Pulmonology
	Paediatric orthopaedics		Rheumatology
Paediatric Surgery	Paediatric Surgery	**Radiation Medicine**	Radiation Medicine
	Paediatric Cardiothoracic Surgery	**Psychiatry**	General Psychiatry
	Paediatric Neurosurgery		Forensic Psychiatry
	Paediatric Ophthalmology		Child and Adolescent Psychiatry
	Paediatric Otolaryngology		
	Paediatric Urology		
Paediatric Medicine	General Paediatrics		
	Paediatric Cardiology		
	Paediatric Clinical Haematology/Oncology		

3.1 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 for the Province:

- Adult Burns Unit, which includes critical care.
- Cochlear implantation.
- Dedicated academic infection prevention and control services.
- Craniofacial surgical services.

3.2 RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

Red Cross War Memorial Children's Hospital provides tertiary and quaternary services for children and is an important provincial, national and international clinical and academic resource for child health care.

The hospital is a referral centre for:

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

3.2.1 Maitland Cottage Home

Maitland Cottage Home is a provincially aided hospital which operates as an extension of Red Cross War Memorial Children's Hospital and renders specialist orthopaedic surgery, post-operative care and rehabilitation for children with orthopaedic conditions. The facility operates 85 beds and performs, on average, 564 operations per year.

3.3 GROOTE SCHUUR HOSPITAL

Groote Schuur Hospital provides a full package of adult tertiary services, and is the provincial 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.

4. CHALLENGES

4.1 DIFFERENTIATING SERVICES BY LEVELS OF CARE IN CENTRAL HOSPITALS

1) The departmental policy as reflected in the Comprehensive Service Plan is to differentiate central hospital services as general and highly specialised services. This service configuration improves efficiencies and provides an appropriate platform for training, and strengthens clinical governance.

2) Since 2008/09 this policy has been strengthened by separating the central hospital funding into Programme 5.1 (highly specialised services) and Programme 4.1 (general specialist services).

3) Structures were created and reporting systems were re-engineered to monitor expenditure and patient activity by differentiated service entity. The following challenges remained:

- Information systems cannot automatically differentiate between levels of care resulting in a range of manual processes required to completely separate clinical and financial data for reporting purposes. All records of manual calculations and processes must be retained for audit purposes.
- Accurate differentiation of expenditure for the respective programs proved challenging, specifically related to overhead costs, such as security, municipal accounts, management, engineering, building maintenance and administrative support. Accurately reflecting all differentiated costs by level of care was therefore not possible.
- In future planning the Department is therefore shifting the focus from individual levels of care, to packages of care per hospital.

4.2 ACUTE BED PRESSURES

Acute bed pressures are pronounced in critical care, neonatology, obstetrics and gynaecology, and medicine and are reflected in bed utilisation rates often exceeding 85%. Groote Schuur Hospital experienced marked pressure with the average utilisation rate exceeding 90% for the 2010/11 year. Note that hospitals are regarded as full at a bed utilisation rate of 85%. Seasonal pressures in child illnesses often increase the bed utilisation rates in paediatric services at Red Cross War Memorial Children's Hospital.

4.3 HUMAN RESOURCES

Challenges in recruitment and retention were experienced in the following staff categories:

- Professional nursing staff with post basic qualifications in theatre technique and intensive care, resulting in the inability of the hospitals to improve access to surgical procedures and critical care.
- Clinical technologists.

5. PRIORITIES FOR 2011/12

During 2011/12 the central hospitals will address key challenges, risks, departmental strategic goals, as well as contribute towards the progressive realisation of key priorities of the national Negotiated Service Delivery Agreement.

5.1 CENTRAL HOSPITALS

The programme will focus on the following priorities for the 2011/2012 year.

1) Manage the burden of disease.
   - Improve acute hospital services focussing on the following priority areas:
     - Strengthen general specialist services.
     - Improve maternal, child and women's health services.
     - Improve the management of bottleneck areas such as intensive care units (ICU), theatres, radiology.
   - Improve the patient experience in ambulatory and emergency care.
2) Ensure and maintain organisation strategic management capacity and synergy.
   - Strengthen clinical governance and clinical leadership across levels of care within geographic service areas together with district health services.
   - Improve service management effectiveness, monitoring and evaluation through Functional Business Units (FBUs) for each clinical discipline with decentralised decision making, monitoring and evaluation of resource allocation and service performance. These FBUs would form the key vehicles to effect the differentiation of services between general and highly specialised services.
3) Improve the quality of care
   - Enhance the capacity to improve the management and prevention of hospital acquired infections through the Best Care Always initiative.
   - Respond to the findings of the annual patient satisfaction survey.
4) Develop and maintain a capacitated workforce to deliver the required health services.
   - Finalise the organisational design process for each central hospital and initiate implementation.
   - Respond to the findings of staff satisfaction surveys.
5) Provide and maintain appropriate health technology and infrastructure.
   - Implement Picture Archiving Communication and Regional Information Systems (PACS/RIS) in each of the central hospitals.

5.2 GROOTE SCHUUR HOSPITAL

1) Manage the burden of disease towards an increased life expectancy and improved health outcomes for patients by strengthening acute hospital services by:
   - Supporting general specialist service by establishing three dedicated general orthopaedic and general surgery lists.
   - Strengthening general specialist outpatient services by commencing a general orthopaedic outpatient clinic.

- Improve the patient experience in and the delivery of emergency services by:
  - Concluding the infrastructure plan for the emergency centres.
  - Apply measurement instruments and tools to reduce waiting times in emergency centres.
- Improve the delivery of woman's health services by:
  - Supporting the expansion of colposcopy services at Victoria Hospital.
  - Improve maternal health by providing a comprehensive service to high risk cardiac and hypertension clinics.
- Bolster 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.
  - Commissioning five new operating theatre slates.
  - Piloting five operating theatre practitioners in the operating theatre environment.
  - Extend the scanning hours for Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) services.

2) Improve the quality of health services by adopting initiatives and transferring skills from Best Care Always to improve the management of central lines.

3) Establish and maintain sufficient health infrastructure and technology to support service delivery by implementing the Picture Archiving Communication and Regional Information Systems (PACS/RIS).

5.3 TYGERBERG HOSPITAL

1) Manage the burden of disease towards an increased life expectancy and improved health outcomes for patients by strengthening acute hospital services by:
   - Strengthening general specialist service by appointing a Head of General Medicine.
   - Improve the patient experience in and the delivery of emergency services by:
     - Commencing infrastructure work towards establishing the emergency centre.
     - Performing quarterly triage audits.
     - Allocate beds, governed by emergency medicine within the emergency centre unit.
   - Bolster the services rendered in bottleneck areas like theatres and critical care by:
     - Piloting five operating theatre practitioners in the theatre environment.
     - Sustainably operating 10 paediatric intensive care unit beds.

2) Improving the quality of health services
   - Through the Best Care Always Initiative ensure the transfer of skills and capacity and progressive adoption of tools and methods to better manage and prevent hospital acquired infections.

- Consolidate and organise the haematology services to protect neutropenic patients from hospital acquired infections.
- Establish and maintain sufficient health infrastructure to support service delivery installation of key specialised technology, which includes:
    - Commissioning of a new Cardiac Catheterisation Lab.
    - Commissioning of a Positron Emission Tomography (PET) scanner

5.4 RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

1) Manage the burden of disease towards an increased life expectancy and improved health outcomes for patients by strengthening acute hospital services by:
    - Strengthening general specialist service by providing outreach and support to general paediatric surgery and paediatric burns services.
    - Appointing and ensuring a sustained staffing model to provide access to the poison information centre.
    - Improve emergency centre services by commencing with upgrading of the emergency centre infrastructure according to provincial policy.
    - Bolster the services rendered in bottleneck areas like theatres and critical care by:
        - Continuously operate 22 intensive care unit beds and initiate the planning process for dedicated neonatal intensive care and high care beds.
        - Participate in conjunction with the Walter Sisulu Paediatric Cardiac Foundation to increase the number of cardiac operations performed.
        - Participate in conjunction with the Smile Foundation to increase the number of ear, nose and throat operations performed.
        - Reduce the number of theatre cancellations.
        - Ensure senior anaesthetist cover to the day surgery unit to improve patient safety.
2) Strengthen health system effectiveness through organisational synergy, co-ordination and support by:
    - Initiating and supporting a phased, collaborative plan to strengthen tracheostomy home care services.
3) Improving the quality of health services through the Best Care Always Initiative by adopting initiatives related to ventilator associated pneumonia.
4) Establish and maintain sufficient health infrastructure to support service delivery by:
    - Implementing PACS by appointing a PACS/RIS administrator.

Table 5.2: Performance indicators for Central Hospitals [CHS3]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in central hospitals	%	43%	37%	41%	44%	44%	44%	43%	43%	30%
			Numerator:		5 800	-	4 915	5 052	5 848	5 882	5 800	5 800	
			Denominator:		13 600	-	12 123	11 509	13 303	13 400	13 500	13 600	
	1.2. Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	1.2.1. Ensure access to central hospital services by providing 2 536 beds.	2) Number of operational beds in central hospitals	No	2 536	2 417	1 460	1 460	1 473	2 520	2 517	2 527	
			3) Total separations in central hospitals	No		123 495	70 000	68 231	69 307	135 593	137 982	138 828	
			4) OPD total headcounts in central hospitals	No		957 339	543 461	537 749	557 717	873 325	850 062	846 242	
			5) Patient day equivalents [PDE] in central hospitals	No		1 090 957	603 490	625 661	649 945	1 109 467	1 103 616	1 100 862	
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	6) Bed utilisation rate (based on usable beds) in central hospitals	%	84%	81%	79%	83%	86%	84%	84%	84%	75%
			Numerator		780 877		422 267	446 411	464 040	773 692	775 596	774 782	
			Denominator		925 640		532 900	535 820	540 100	919 800	918 705	922 355	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	2.1.1. Ensure the cost effective management of central hospitals at a target cost of R3 000 per patient day equivalent [Constant 2009/10 rands].	7) Expenditure per patient day equivalent [PDE] in central hospitals	R	3 000	2 793	3 741	3 733	3 507	2 804	2 821	2 878	
			Numerator		3 362 032 548	3 047 384 945	2 257 829 508	2 335 490 820	2 279 205 970	3 110 902 343	3 113 089 525	3 167 909 491	
			Denominator		1 120 678	1 090 957	603 490	625 661	649 945	1 109 467	1 103 616	1 100 862	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
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.	8) Average length of stay in central hospitals	Days	5.5	5.8	6.8	6.5	6.7	5.7	5.6	5.6	5.5
			Numerator		780 877	-	422 267	446 411	464 040	773 692	775 596	774 782	
			Denominator		140 749	-	70 000	68 231	69 307	135 593	137 982	138 828	
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) Number of central hospitals with monthly mortality and morbidity meetings	No	3	3	3	3	3	3	3	3	
			10) Percentage of complaints of users of central hospital services resolved within 25 days	%		Not required to report	88%	88%	90%	90%	90%	90%	
			Numerator			-	678	618	630	630	630	630	
			Denominator			-	768	704	700	700	700	700	
			11) Central hospital patient satisfaction rate	%		Not required to report	Not required to report	Not required to report	88%	90%	90%	90%	
			Numerator			-	-	-	2 936	2 970	2 970	2 970	
			Denominator			-	-	-	3 323	3 300	3 300	3 300	
			12) Number of central hospital assessed for compliance with core standards	No		Not required to report	Not required to report	Not required to report	Not required to report	1	2	3	

Notes:

1. Prior to 2008/09 the hospital outputs reflect the combined outputs of Programme 4.1 and Programme 5.1. From 2008/09 to 2010/11 the general specialist services outputs were reflected in Programme 4.1. As from 2011/12 all service activities in central hospitals will be reflected in Programme 5.1.
2. Indicator 1: The caesarean section rate indicated is for the central hospital services as a whole, including the L2 services.
3. Indicator 7: The expenditure per patient day equivalent for the period 2008/09 to 2010/11 reflects the highly specialised services in the central hospitals. As from 2011/12 the expenditure per patient day equivalent is for both the general specialised and the highly specialised services.

Table 5.3: Quarterly targets for central hospitals for 2011/12 [CHS6]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in central hospitals	Quarterly	**44%**	44%	44%	44%	44%
			Numerator		**5 882**	1 471	1 471	1 471	1 471
			Denominator		**13 400**	3 350	3 350	3 350	3 350
	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 central hospital services by providing 2 536 beds	2) Number of operational beds in central hospitals	Quarterly	**2 520**	**2 520**	**2 520**	**2 520**	**2 520**
			3) Total separations in central hospitals	Quarterly	**135 593**	33 939	33 974	33 858	33 822
			4) OPD total headcounts in central hospitals	Quarterly	**873 325**	218 446	218 703	218 217	217 959
			5) Patient day equivalents [PDE] in central hospitals	Quarterly	1 109 467	277 618	277 918	277 116	276 815
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	6) Bed utilisation rate (based on usable beds) in central hospitals	Quarterly	**84%**	84%	84%	83%	85%
			Numerator		**773 692**	193 636	193 851	193 210	192 996
			Denominator		**919 800**	229 320	231 840	231 840	226 800
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	2.1.1. Ensure the cost effective management of central hospitals at a target cost of **R3 000** per patient day equivalent. [Constant 2009/10 rands].	7) Expenditure per patient day equivalent [PDE] in central hospitals	Quarterly	2 804	2 804	2 804	2 804	2 804
			Numerator		3 110 902 343	777 725 586	777 725 586	777 725 586	777 725 586
			Denominator		1 109 467	277 367	277 367	277 367	277 367
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 hospital by 2014/15.	8) Average length of stay in central hospitals	Quarterly	**5.7**	5.7	5.7	5.7	5.7
			Numerator		**773 692**	193 636	193 851	193 210	192 996
			Denominator		**135 593**	33 939	33 974	33 858	33 822
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) Number of central hospitals with monthly mortality and morbidity meetings	Quarterly	3	3	3	3	3

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			10) Percentage of complaints of users of central hospital services resolved within 25 days	Quarterly	90%	90%	90%	90%	90%
			Numerator		630	157	157	158	158
			Denominator		700	175	175	175	175
			11) Central hospital patient satisfaction rate	Annually	90%				
			Numerator		2 970				
			Denominator		3 300				
			12) Central hospitals assessed for compliance with core standards	Annually	1				

Table5.4: Performance indicators for Groote Schuur Hospital [CHS5]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Groote Schuur Hospital	%		47%	51%	53%	55%	54%	53%	53%	30%
			Numerator:			-	2 587	2 861	4 047	4 032	4 000	4 000	
			Denominator:			-	5 094	5 452	7 347	7 400	7 500	7 600	
	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 2536 beds.	2) Number of operational beds in Groote Schuur Hospital	No		-	-	625	630	920	907	907	
			3) Total separations in Groote Schuur Hospital	No		42 977	33 785	33 293	33 085	50 916	50 704	51 802	
			4) OPD total headcounts in Groote Schuur Hospital	No		418 466	259 361	268 551	268 663	373 000	346 338	329 211	
			5) Patient day equivalents [PDE] in Groote Schuur Hospital	No		424 173	302 817	300 397	307 091	434 261	421 103	404 134	
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	6) Bed utilisation rate (based on usable beds) in Groote Schuur Hospital	%		82%	86%	92%	94%	88%	88%	85%	75%
			Numerator			-	216 308	210 880	217 537	296 928	292 657	281 397	
			Denominator			-	250 025	228 125	231 000	335 800	331 055	331 055	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	2.1.1. Ensure the cost effective management of central hospitals at a target cost of R3 000 per patient day equivalent [Constant 2009/10 rands].	7) Expenditure per patient day equivalent [PDE] in Groote Schuur Hospital	R		3 057	3 723	3 640	3 656	2 983	3 078	3 264	
			Numerator			1 296 729 605	1 127 507 235	1 093 531 419	1 122 727 123	1 295 286 429	1 296 051 877	1 319 117 194	
			Denominator			424 173	302 817	300 397	307 091	434 261	421 103	404 134	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
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.	8) Average length of stay in Groote Schuur Hospital	Days		6.3	6.4	6.3	6.6	5.8	5.8	5.4	5.5
			Numerator			-	218 308	210 880	217 537	296 928	292 657	281 397	
			Denominator			-	33 785	33 293	33 085	50 916	50 704	51 802	
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) Groote Schuur Hospital with monthly mortality and morbidity meetings	Y / N		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			10) Percentage of complaints of users of Groote Schuur Hospital resolved within 25 days	%		Not required to report	88%	84%	90%	90%	90%	90%	
			Numerator			-	448	385	432	432	432	432	
			Denominator			-	512	458	480	480	480	480	
			11) Patient satisfaction rate in Groote Schuur Hospital	%		Not required to report	Not required to report	Not required to report	89%	90%	90%	90%	
			Numerator			-	-	-	2 055	2 052	2 052	2 052	
			Denominator			-	-	-	2 302	2 280	2 280	2 280	
			12) Groote Schuur Hospital assessed for compliance with core standards	Y / N		Not required to report	Not required to report	Not required to report	Not required to report	No	Yes	Yes	

Notes:

1. Prior to 2008/09 the hospital outputs reflect the combined outputs of Programme 4.1 and Programme 5.1. From 2008/09 to 2010/11 the general specialist services outputs were reflected in Programme 4.1. As from 2011/12 all service activities in central hospitals will be reflected in Programme 5.1.
2. Indicator 1: The caesarean section rate indicated is for the central hospital services as a whole, including the L2 services.
3. Indicator 7: The expenditure per patient day equivalent for the period 2008/09 to 2010/11 reflects the highly specialised services in the central hospitals. As from 2011/12 the expenditure per patient day equivalent is for both the general specialised and the highly specialised services.

Table 5.5: Quarterly targets for Groote Schuur Hospital for 2011/12 [CHS6]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Groote Schuur Hospital	Quarterly	54%	54%	54%	54%	54%
			Numerator		4 032	1 008	1 008	1 008	1 008
			Denominator		7 400	1 850	1 850	1 850	1 850
	1.2. Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care	1.2.1. Ensure access to central hospital services by providing 2 536 beds	2) Number of operational beds in Groote Schuur Hospital	Quarterly	920	**920**	**920**	**920**	**920**
			3) Total separations in Groote Schuur Hospital	Quarterly	50 916	12 729	12 729	12 729	12 729
			4) OPD total headcounts in Groote Schuur Hospital	Quarterly	373 000	93 250	93 250	93 250	93 250
			5) Patient day equivalents [PDE] in Groote Schuur Hospital	Quarterly	434 261	108 565	108 565	108 565	108 565
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	6) Bed utilisation rate (based on usable beds) in Groote Schuur Hospital	Quarterly	88%	89%	88%	88%	90%
			Numerator		296 928	74 232	74 232	74 232	74 232
			Denominator		335 800	83 720	84 640	84 640	82 800
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	2.1.1. Ensure the cost effective management of central hospitals at a target cost of **R3000** per patient day equivalent. [Constant 2009/10 rands].	7) Expenditure per patient day equivalent [PDE] in Groote Schuur Hospital	Quarterly	2 983	2 983	2 983	2 983	2 983
			Numerator		1 295 286 429	323 821 607	323 821 607	323 821 607	323 821 607
			Denominator		434 261	108 565	108 565	108 565	108 565
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 hospital by 2014/15.	8) Average length of stay in Groote Schuur Hospital	Quarterly	5.8	5.8	5.8	5.8	5.8
			Numerator		296 928	74 232	74 232	74 232	74 232
			Denominator		50 916	12 729	12 729	12 729	12 729
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) Groote Schuur Hospital has monthly mortality and morbidity meetings	Quarterly	Yes	Yes	Yes	Yes	Yes

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			10) Percentage of complaints of users of Groote Schuur Hospital resolved within 25 days	Quarterly	90%	90%	90%	90%	90%
			Numerator		432	108	108	108	108
			Denominator		480	120	120	120	120
			11) Patient satisfaction rate in Groote Schuur Hospital	Annually	90%	-	-	-	
			Numerator		2 052	-	-	-	
			Denominator		2 280	-	-	-	
			12) Groote Schuur Hospital assessed for compliance with core standards.	Annually	**No**	**-**	**-**	**-**	

Table 5.6: Performance indicators for Tygerberg Hospital [CHS5]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Tygerberg Hospital	%		30%	33%	36%	30%	31%	30%	30%	30%
			Numerator:			-	2 328	2 191	1 801	1 850	1 800	1 800	
			Denominator:			-	7 029	6 057	5 955	6 000	6 000	6 000	
	1.2. Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	1.2.1. Ensure access to central hospital services by providing 2536 beds.	2) Number of operational beds in Tygerberg Hospital	No		-	-	608	608	1 310	1 310	1 310	
			3) Total separations in Tygerberg Hospital	No		59 237	18 548	22 611	23 655	62 974	66 078	68 152	
			4) OPD total headcounts in Tygerberg Hospital	No		370 123	203 643	187 654	204 683	360 895	367 269	380 883	
			5) Patient day equivalents [PDE] in Tygerberg Hospital	No		518 130	205 995	225 672	239 770	524 662	530 287	541 835	
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	6) Bed utilisation rate (based on usable beds) in Tygerberg Hospital	%		80%	70%	74%	77%	81%	82%	83%	75%
			Numerator			-	138 114	163 121	171 543	386 363	389 864	397 207	
			Denominator			-	196 370	221 920	222 933	478 150	478 150	478 150	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	2.1.1. Ensure the cost effective management of central hospitals at a target cost of R3 000 per patient day equivalent [Constant 2009/10 rands].	7) Expenditure per patient day equivalent in Tygerberg Hospital	R		2 593	3 838	3 949	3 367	2 662	2 637	2 625	
			Numerator			1 343 525 000	790 547 798	891 123 563	807 303 857	1 396 631 059	1 398 121 861	1 422 447 711	
			Denominator			518 130	205 995	225 672	239 770	524 662	530 287	541 835	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
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.	8) Average length of stay in Tygerberg Hospital	Days		6.2	7.5	7.2	7.3	6.1	5.9	5.8	5.5
			Numerator			-	138 114	163 121	171 543	386 363	389 864	397 207	
			Denominator			-	18 584	22 611	23 655	62 974	66 078	68 152	
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) Tygerberg Hospital has monthly mortality and morbidity meetings	Y / N		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			10) Percentage of complaints of users of Tygerberg Hospital resolved within 25 days	%		Not required to report	87%	94%	90%	90%	90%	90%	
			Numerator			-	158	202	180	180	180	180	
			Denominator			-	181	214	200	200	200	200	
			11) Patient satisfaction rate in Tygerberg Hospital	%		Not required to report	Not required to report	Not required to report	88%	90%	90%	90%	
			Numerator			-	-	-	385	387	387	387	
			Denominator			-	-	-	437	430	430	430	
			12) Tygerberg Hospital assessed for compliance with core standards	Y / N		Not required to report	Not required to report	Not required to report	Not required to report	No	No	Yes	

Notes:
1. Prior to 2008/2009 the hospital outputs reflect the combined outputs of Programme 4.1 and Programme 5.1. From 2008/09 to 2010/11 the general specialist services outputs were reflected in Programme 4.1. As from 2011/12 all service activities in central hospitals will be reflected in Programme 5.1.
2. Indicator 1: The caesarean section rate indicated is for the central hospital services as a whole, including the L2 services.
3. Indicator 7: The expenditure per patient day equivalent for the period 2008/09 to 2010/11 reflects the highly specialised services in the central hospitals. As from 2011/12 the expenditure per patient day equivalent is for both the general specialised and the highly specialised services.

Table 5.7: Quarterly targets for Tygerberg Hospital for 2011/12 [CHS6]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Tygerberg Hospital	Quarterly	31%	31%	31%	31%	31%
			Numerator		1 850	463	463	463	463
			Denominator		6 000	1 500	1 500	1 500	1 500
	1.2. Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	1.2.1. Ensure access to central hospital services by providing 2 536 beds.	2) Number of operational beds in Tygerberg Hospital	Quarterly	1 310	**1 310**	**1 310**	**1 310**	**1 310**
			3) Total separations in Tygerberg Hospital	Quarterly	62 974	15 802	15 802	15 685	15 685
			4) OPD total headcounts in Tygerberg Hospital	Quarterly	360 895	90 467	90 467	89 980	89 980
			5) Patient day equivalents [PDE] in Tygerberg Hospital	Quarterly	524 662	131 567	131 567	130 764	130 764
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	6) Bed utilisation rate (based on usable beds) in Tygerberg Hospital	Quarterly	81%	81%	80%	80%	82%
			Numerator		386 363	96 911	96 911	96 271	96 271
			Denominator		478 150	119 210	120 520	120 520	117 900
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	2.1.1. Ensure the cost effective management of central hospitals at a target cost of **R3000** per patient day equivalent. [Constant 2009/10 rands].	7) Expenditure per patient day equivalent [PDE] in Tygerberg Hospital	Quarterly	2 662	2 662	2 662	2 662	2 662
			Numerator		1 396 631 059	349,157,765	349,157,765	349,157,765	349,157,765
			Denominator		524 662	131 166	131 166	131 166	131 166
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 hospital by 2014/15.	8) Average length of stay in Tygerberg Hospital	Quarterly	6.1	6.1	6.1	6.1	6.1
			Numerator		386 363	96 911	96 911	96 271	96 271
			Denominator		62 974	15 802	15 802	15 685	15 685
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) Tygerberg Hospital has monthly mortality and morbidity meetings	Quarterly	Yes	Yes	Yes	Yes	Yes

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			10) Percentage of complaints of users of Tygerberg Hospital resolved within 25 days	Quarterly	90%	90%	90%	90%	90%
			Numerator		180	45	45	45	45
			Denominator		200	50	50	50	50
			11) Patient satisfaction rate in Tygerberg Hospital	Annually	90%	-	-	-	
			Numerator		387	-	-	-	
			Denominator		430	-	-	-	
			12) Tygerberg Hospital assessed for compliance with core standards.	Annually	No	-	-	-	

Table 5.8: Performance indicators for Red Cross War Memorial Children's Hospital [CHS5]

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in Red Cross War Memorial Children's Hospital [RCWMCH]	%		Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	30%
			Numerator:			-	-	-	-	-	-	-	
			Denominator:			-	-	-	-	-	-	-	
	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 2536 beds.	2) Number of operational beds in RCWMCH	No		-	-	235	235	290	300	310	
			3) Total separations in RCWMCH	No		21 281	10 222	12 327	12 567	21 703	21 200	18 874	
			4) OPD total headcounts in RCWMCH	No		145 639	80 457	81 544	84 371	139 430	136 456	136 148	
			5) Patient day equivalents [PDE] in RCWMCH	No		148 654	94 664	99 592	103 084	150 545	152 227	154 893	
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	6) Bed utilisation rate (based on usable beds) in RCWMCH	%		82%	82%	84%	87%	85%	85%	85%	75%
			Numerator			-	67 845	72 411	74 960	90 401	93 075	96 178	
			Denominator			-	82 855	85 775	86 167	105 850	109 500	113 150	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	2.1.1. Ensure the cost effective management of central hospitals at a target cost of R3 000 per patient day equivalent [Constant 2009/10 rands].	7) Expenditure per patient day equivalent [PDE] in RCWMCH	R		2 739	3 589	3 523	3 387	2 783	2 752	2 753	
			Numerator			407 130 341	339 774 475	350 835 838	349 174 990	418 984 855	418 915 787	426 344 586	
			Denominator			148 654	94 664	99 592	103 084	150 545	152 227	154 893	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
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.	8) Average length of stay in RCWMCH	Days		4	6.6	5.9	6.0	4.2	4.4	5.1	5.5
			Numerator			-	67 845	72 411	74 960	90 401	93 075	96 178	
			Denominator			-	10 222	12 327	12 567	21 703	21 200	18 874	
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) RCWMCH has monthly mortality and morbidity meetings	Y / N		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			10) Percentage of complaints of users of RCWMCH resolved within 25 days	%		Not required to report	96%	97%	90%	90%	90%	90%	
			Numerator			-	72	31	18	18	18	18	
			Denominator			-	75	31	20	20	20	20	
			11) Patient satisfaction rate in RCWMCH	%		Not required to report	Not required to report	Not required to report	85%	90%	90%	90%	
			Numerator			-	-	-	496	531	531	531	
			Denominator			-	-	-	584	590	590	590	
			12) RCWMCH assessed for compliance with core standards	Y / N		Not required to report	Not required to report	Not required to report	Not required to report	Yes	Yes	Yes	

Notes:
1. Prior to 2008/09 the hospital outputs reflect the combined outputs of Programme 4.1 and Programme 5.1. From 2008/09 to 2010/11 the general specialist services outputs were reflected in Programme 4.1. As from 2011/12 all service activities in central hospitals will be reflected in Programme 5.1.
2. Indicator 1: The caesarean section rate indicated is for the central hospital services as a whole, including the L2 services.
3. Indicator 6: The cost per PDE is adjusted to reflect 2009/10 prices.
4. Indicator 7: The expenditure per patient day equivalent for the period 2008/09 to 2010/11 reflects the highly specialised services in the central hospitals. As from 2011/12 the expenditure per patient day equivalent is for both the general specialised and the highly specialised services.

Table 5.9: Quarterly targets for Red Cross War Memorial Children's Hospital [CHS6]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the burden of disease.	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in RCWMCH	Quarterly	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
			Numerator		-	-	-	-	-
			Denominator		-	-	-	-	-
	1.2. Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care	1.2.1. Ensure access to central hospital services by providing 2 536 beds	2) Number of operational beds in RCWMCH	Quarterly	290	**290**	**290**	**290**	**290**
			3) Total separations in RCWMCH	Quarterly	21 703	5 408	5 444	5 444	5 408
			4) OPD total headcounts in RCWMCH	Quarterly	139 430	34 729	34 986	34 986	34 729
			5) Patient day equivalents [PDE] in RCWMCH	Quarterly	150 545	37 486	37 786	37 787	37 486
	1.3. Ensure optimal access to central hospital services to manage the burden of disease.	1.3.1. Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	6) Bed utilisation rate (based on usable beds) in RCWMCH	Quarterly	85%	85%	85%	85%	86%
			Numerator		90 401	22 493	22 708	22 708	22 493
			Denominator		105 850	26 390	26 680	26 680	26 100
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	2.1.1. Ensure the cost effective management of central hospitals at a target cost of **R3000** per patient day equivalent. [Constant 2009/10 rands].	7) Expenditure per patient day equivalent [PDE] RCWMCH	Quarterly	2 783	2 783	2 783	2 783	2 783
			Numerator		418 984 855	104 746 214	104 746 214	104 746 214	104 746 214
			Denominator		150 545	37 636	37 636	37 636	37 636
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 hospital by 2014/15.	8) Average length of stay in RCWMCH	Quarterly	4.2	4.2	4.2	4.2	4.2
			Numerator		90 401	22 493	22 708	22 708	22 493
			Denominator		21 703	5 408	5 444	5 444	5 408
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. To ensure appropriate mechanisms to measure improvement in quality of health services.	9) RCWMCH has monthly mortality and morbidity meetings	Quarterly	Yes	Yes	Yes	Yes	Yes
			10) Percentage of complaints of users of RCWMCH resolved within 25 days	Quarterly	90%	90%	100%	90%	100%
			Numerator		18	4	5	4	5
			Denominator		20	5	5	5	5

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
			11) Patient satisfaction rate in RCWMCH	Annually	90%	-	-	-	
			Numerator		531	-	-	-	
			Denominator		590	-	-	-	
			12) RCWMCH assessed for compliance with core standards.	Annually	Yes	-	-	-	

6. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND MTEF

Table 5.10: Expenditure estimates: Central hospitals [CHS 7]

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2007/08	Audited 2008/09	Audited 2009/10	Main appro-priation 2010/11	Adjusted appro-priation 2010/11	Revised estimate 2010/11	2011/12	% Change from Revised estimate 2010/11	2012/13	2013/14
1. Central Hospital Services [a,b]	2 349 884	1 970 686	2 347 345	2 595 971	2 683 266	2 683 266	3 953 753	47.35	4 204 724	4 533 910
Total payments and estimates	2 349 884	1 970 686	2 347 345	2 595 971	2 683 266	2 683 266	3 953 753	47.35	4 204 724	4 533 910

[a] 2011/12: Conditional grant: National tertiary services: R1 973 127 000.

[b] 2011/12: Conditional grant: Health professions training and development: R259 142 000 (Compensation of employees R201 211 000; Goods and services R57 931 000).

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 su

As from the 2011/12 year Sub-programme 4.1 (general specialist) and Sub-programme 5.1. (highly specialised services) are funded and reported from Sub-programme 5.1 under central hospital services. The Sub-programme 4.1 funding, separately allocated and reported since 2008/09, will be combined with the Sub-programme 5.1 funding. The increase in the budget allocation from 2011/2012 should therefore be interpreted, cognisant of this funding consolidation.

Table 5.11: Summary of Provincial expenditure estimates by Economic Classification: Health Facilities Management [HFM4]

Economic classification R'000	Outcome			Main appro-priation	Adjusted appro-priation	Revised estimate	Medium-term estimate			
								% Change from Revised estimate		
	Audited	Audited	Audited							
	2007/08	2008/09	2009/10	2010/11	2010/11	2010/11	2011/12	2010/11	2012/13	2013/14
Current payments	2 274 635	1 906 294	2 256 659	2 512 513	2 598 196	2 597 736	3 835 449	47.65	4 081 412	4 399 768
Compensation of employees	1 500 187	1 186 494	1 453 200	1 716 705	1 797 836	1 797 376	2 650 867	47.49	2 838 647	3 023 075
Salaries and wages	1 345 672	1 067 606	1 313 054	1 527 643	1 605 698	1 605 238	2 401 578	49.61	2 571 698	2 764 185
Social contributions	154 515	118 888	140 146	189 062	192 138	192 138	249 289	29.74	266 949	258 890
Goods and services	774 448	719 800	803 459	795 808	800 360	800 360	1 184 582	48.01	1 242 765	1 376 693
of which										
Administrative fees		1	1		1	1	1		1	1
Advertising	2 442	21	34	27	31	31	36	16.13	38	42
Assets <R5 000	3 861	6 015	5 878	5 505	6 916	6 916	6 050	(12.52)	6 291	6 922
Catering: Departmental activities	103	173	131	154	167	167	191	14.37	199	217
Communication	7 413	5 074	8 290	7 868	6 714	6 714	10 451	55.66	10 869	11 956
Computer services	172	120	938	517	306	306	868	183.66	904	994
Cons/prof: Business and advisory service	2 013	1 920	522	766	1 098	1 098	1 771	61.29	1 842	2 026
Cons/prof: Laboratory service	122 115	111 337	109 168	136 509	129 985	129 985	167 628	28.96	174 333	191 767
Cons/prof: Legal cost	37	3	1		1	1	1		1	1
Contractors	33 605	41 773	42 146	29 391	37 876	37 876	49 184	29.86	51 153	56 268
Agency and support/ outsourced services	76 265	57 564	62 669	32 649	40 366	40 366	67 682	67.67	70 389	77 428
Entertainment	9	8	4	3	14	14	15	7.14	15	17
Inventory: Food and food supplies	17 721	11 776	18 075	21 126	16 562	16 562	30 559	84.51	31 782	34 960
Inventory: Fuel, oil and gas	5 771	3 411	5 551	4 673	4 745	4 745	8 260	74.08	8 591	9 450
Inventory: Materials and supplies	5 550	9 695	8 667	9 236	10 592	10 592	18 059	70.50	18 782	20 660
Inventory: Medical supplies	275 089	266 161	307 691	299 799	307 733	307 733	450 199	46.30	468 207	515 031
Inventory: Medicine	120 929	114 209	134 934	130 677	129 031	129 031	184 364	42.88	191 738	210 912
Inventory: Other consumables	18 129	17 564	25 689	26 640	28 840	28 840	39 598	37.30	41 182	45 301
Inventory: Stationery and printing	6 544	7 830	8 039	8 176	8 870	8 870	11 165	25.87	11 611	12 772
Lease payments	5 301	6 043	4 080	1 755	3 170	3 170	3 143	(0.85)	3 269	3 596
Property payments	58 914	49 552	54 559	73 858	61 745	61 745	126 270	104.50	142 122	165 978
Transport provided: Departmental activity	363	153	94	148	100	100	150	50.00	156	171
Travel and subsistence	3 106	2 019	2 630	2 857	2 394	2 394	3 919	63.70	4 074	4 483
Training and development	2 003	1 641	2 672	2 644	2 355	2 355	3 867	64.20	4 021	4 424
Operating expenditure	6 848	5 649	768	534	478	478	694	45.19	720	794
Venues and facilities	145	88	228	296	270	270	457	69.26	475	522
Transfers and subsidies to	8 555	9 811	10 588	11 445	11 445	11 736	13 627	16.11	14 171	15 589
Non-profit institutions	4 825	5 812	7 232	7 695	7 695	7 695	8 157	6.00	8 483	9 331
Households	3 730	3 999	3 356	3 750	3 750	4 041	5 470	35.36	5 688	6 258
Social benefits	3 730	3 999	3 356	3 750	3 750	4 041	5 470	35.36	5 688	6 258
Payments for capital assets	65 819	54 318	79 726	72 013	73 625	73 625	104 677	42.18	109 141	118 553
Machinery and equipment	65 819	54 318	79 341	72 013	73 283	73 283	104 067	42.01	108 507	117 855
Transport equipment				100	100	100	30	(70.00)	31	34
Other machinery and equipment	65 819	54 318	79 341	71 913	73 183	73 183	104 037	42.16	108 476	117 821
Software and other intangible assets			385		342	342	610	78.36	634	698
Of which: "Capitalised Goods and services" included in Payments for capital assets				17	17	17	188	1005.88	196	215
Payments for financial assets	875	263	372			169		(100.00)		
Total economic classification	2 349 884	1 970 686	2 347 345	2 595 971	2 683 266	2 683 266	3 953 753	47.35	4 204 724	4 533 910

6.1 PERFORMANCE AND EXPENDITURE TRENDS

6.1.1 Expenditure trends

The budget of central hospital services in 2008/09 to 20010/11 was allocated in two financial programmes. The general specialist services were provided for in Programme 4.1 and the highly specialised services in Programme 5. The allocation and expenditure figures for the previous years are therefore not comparable.

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.

Programme 5 is allocated 29.52 per cent of the vote in 2011/12 in comparison to the 21.68 cent of the vote that was allocated in the adjusted estimate of 2010/11. This amounts to a nominal increase of R1.270 billion or 47.35 per cent. The increase is a result of the shift of funding for Level 2 services in the central hospitals which will revert to Programme 5 from Sub-programme 4.1.

The cost of compensation of employees increased, on average, by 15% year on year increase over the 2008/09 to 2010/11 period, largely due to ICS and the Occupational Specific Dispensation for nursing and medical staff.

Expenditure on goods and services increased by 4% year on year from 2008/09 to 2010/11.

The Modernisation of Tertiary Services [MTS] grant was utilised for implementing the Picture Archive Communication System and Radiological Imaging System [PACS/RIS] at Tygerberg Hospital and to commence the roll out at Groote Schuur Hospital. It was furthermore utilised to fund clinical engineers responsible for medical equipment maintenance.

It is unlikely that expansion of services will occur, if the budget allocation does not exceed medical inflation and the funding deficit of the Health Professional Training and Development Grant and National Tertiary Services Grant is not addressed.

6.1.2 **Performance trends**

The patient day equivalents outputs for Programme 5 have increased by 7.6% from 2008/09 to 2010/11. The bed utilisation rate for the central hospitals has increased from 79% in 2008/09 to a projected 86% in 2010/11. This is an indication of the service pressures experienced.

The combined caesarean section rate for Tygerberg and Groote Schuur Hospitals remain between 41% and 44%. The average length of stay of stay has remained between 6.5 and 6.8 days for the 2008/09 to 2010/11 period.

6.1.3 **Relating funding trends to strategic goals**

6.1.3.1 **Funding trends**

Conditional Grants constituted 73% of the 2010/11 budget. The conditional grants are the National Tertiary Service Grant (NTSG) and the Health Professional Training and Development Grant (HPTDG). The Programme receives an equitable share allocation which assists in funding the OSD for professional staff categories as well as the MTS for equipment in oncology, medical imaging and related modalities.

Table 5.12: Sources of funding for Programme 5

Source of funds (R'000)	2010/11	% contribution to total Programme 5.1 budget during 2010/2011
NTSG	R1 763 234	66%
HPTDG	R200 000	7%
Equitable Share	R714 541	26%
DDG	R5 491	0%
Total	R2 683 266	100%

Note:

Included in the Equitable Share allocation are all ICS and OSD improvements over time, as well as the MTS allocation for equipment in oncology, imaging and related modalities

6.1.4 Conditional grants

6.1.4.1 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.

Challenges:

- A comprehensive National Tertiary Health Plan that determines the distribution of services across the country is required.
- A costing study done in 2007 by Benguela Health Consulting to determine the actual expenditure incurred for the delivery of tertiary services in the Western Cape, reflected a calculated expenditure on tertiary services amounting to R2.473 billion. The NTSG allocation for the same period was R1.335 billion reflecting a R1.14 billion under-funding for tertiary services. The shortfall reiterated the ongoing funding pressures the Western Cape Provincial Department of Health experiences.
- As a result of the submissions by the Western Cape Department of Health to the NDOH there are minor adjustments to the NTSG allocation to the Western Cape for the 2010/11 which are welcomed but do not significantly address the full funding gap.

6.1.4.2 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.

Challenges:

- The grant allocation amount is not underpinned by a clear national plan or costing base.

- The funding levels of the grant have not matched inflation over time, or OSD implications. A costing study concluded in 2007 reiterated the grant under funding for that year amounting to be R468.4 million required to provide a service platform for teaching and training for students.

The Western Cape Department of Health has made submissions to the National Department of Health in this regard.

6.1.5 Resource considerations

Tables 5.10, 5.11 and 5.12 provide more detail on expenditure trends, further explained by the brief notes below

6.1.5.1 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 and doctors. The OSD for other categories of staff is in the process of being implemented.

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 sustained quantum of outputs. Personnel cost will remain one of the primary cost drivers in the programme.

6.1.5.2 Goods and services

Medical inflation, particularly for highly specialised health services, exceeds general inflation. A report from Statistics South Africa[1] indicated that medical inflation amounts to 8% for medical services and 5.9% for medical products. In general, the inflationary adjustments received, are less than medical inflation, resulting in the year-on-year reduction in purchasing capacity. 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.

Control measures for the purchasing of goods and services are in place to ensure decisions are based on the best value for money as well as to remain within the allocated budget.

[1] Statistics South Africa, Consumer price Index, September 2010, p6

7. RISK MANAGEMENT

Risk Identified for the Programme	Mitigation Strategies
1. Insufficient budget from the following sources: • Equitable share • Conditional grants: o National Tertiary Services Grant o Health Professionals Training and Development Grant	1.1. Motivate to the National Department of Health for additional funds in the conditional grants. 1.2. Continue to improve efficiencies. 1.3. Establish FBUs for decentralised decision-making and management controls.
2. Service demands continue to grow with the increasing population and escalating burden of disease.	2.1. Support the delivery of district health services through outreach, support and clinical governance.
3. Limitation in recruitment and retention of key health professionals and other staff categories.	3.1. Prioritise critical posts for filling and use bursary system to attract possible candidates for scarce categories. 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.
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 and improved training to staff involved in processes. 4.2. Staff performance management.
5. Major adverse clinical incidents with medico legal risk.	5.1. Have morbidity and mortality meetings for clinical disciplines. 5.2. Establish Provincial Clinical Co-ordinating Committees for each discipline to enhance clinical governance. 5.3. Prevent hospital acquired infections.

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

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

There have been no changes to the budget programme structure during the 2010/11 financial year.

The Department is required to recruit, train and retain the appropriate numbers of personnel with the appropriate competencies to address current and future service requirements across the levels of care.

Programme 6 resources provide education, training and development opportunities for actual and potential employees and for community members engaged in governance of or service delivery for the Department of Health.

The Human Resource Plan (HRP) and Workplace Skills Plan (WSP), which are based on the Comprehensive Services Plan (CSP), the key interdivisional priorities and service delivery imperatives, will address the scarce and critical skills gap through the appropriate interventions.

To increase the numbers of competent nurses the Department invests substantially in nursing education, training and development, marketing, recruitment and retention strategies based on the Provincial Nursing Strategy. The Nursing College (Sub-programme 6.1), nursing schools and higher education institutions (HEIs) are the major providers of nurse training.

Emergency Medical Services (EMS) will identify the shortfall of emergency care personnel being trained in order to meet current and future EMS patient care requirements. The PGWC College of Emergency Care, Sub-programme 6.2, is responsible for the emergency medical care training including the Emergency Care Technician Certificate which is a 2 year programme.

Ongoing analysis of education, training and development requirements for specific priority occupational groups has been undertaken. The Department provides bursaries as an incentive to train actual and potential employees to meet these needs. There is continuous engagement with all the appropriate higher education institutions in South Africa to ensure an appropriate supply of trained health workers.

The improvement and maintenance of competencies (iMOCOMP) of health professionals will be strengthened within a multi-disciplinary team based approach (Sub-programme 6.4).

The provision of skills development interventions for all occupational categories (Sub-programme 6.5) in the Department includes *inter alia* management development training and the Expanded Public Works Programme (EPWP). The EPWP strengthens the sustainability of community-based services at primary care level through the training of community care givers (CCGs) toward formal qualifications in ancillary health care and community health work. It contributes to creating employment opportunities and alleviating poverty through 'stipended' work opportunities and training of relief workers who are recruited from the community.

Learnership programmes for unemployed persons within nursing and the pharmaceutical services are also provided. Internship opportunities are offered through the EPWP funded 3 535 data capturer programme. The Assistant to Artisan (ATA) programme will be continued in 2011.

4. CHALLENGES

1) Lack of an integrated HR information system.
2) Funding to provide relief staff to enable full time staff the opportunity to train.
3) Recruitment and retention of scarce skills in rural areas.
4) Lack of adequate funding for:
    - Replacement costs especially nursing.
    - Ring fencing community service posts.
    - Funded vacant posts to place bursary holders.
5) The new Nursing Qualifications Framework affects the current status of the Nursing College and nursing schools.
6) Accreditation of additional programmes and clinical facilities by South African Nursing Council (SANC).
7) Matching and placement of excess enrolled nursing assistants.

5. PRIORITIES

1) Development of an integrated information HR system linked to PERSAL and HR Connect.
2) Development of Return on Training Investment Framework/ Model.
3) Capacity audit of relevant training providers to meet the Department's service delivery needs.
4) Strengthening the generic internship programme and learnership programmes.
5) Expansion of training providers to deliver on the Improvement and Maintenance of Competence Project (iMOCOMP Project).
6) Accreditation of additional clinical placement facilities across the Province with the South African Nursing Council (SANC) "cluster".
7) Co-ordination of formal and in-formal training programmes in line with CSP needs, the strategic focus of the Department.
8) Improve the skills and competence levels of health professionals.
9) Ensure the harmonisation and integration of education and training with practice.
10) Recruitment and retention of scarce skills (including rural areas).
11) Ring fencing community service posts.
12) Accreditation of additional programmes and clinical facilities by SANC.

6. STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND TARGETS FOR HEALTH SCIENCES AND TRAINING

Table 6.1: Performance indicators for health sciences and training [HST1 & 2]

Strategic goal	Strategic objective: Title	Strategic objective: statement	Indicator	Type	Strategic objective target 2014/15	Audited/actual			Estimate	MTEF Projection			National target
						2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	
1. Develop and maintain a capacitated workforce to deliver the required health services.	1.1 Develop, implement, monitor and evaluate a comprehensive Training Plan guided by the Human Resource Plan for health and support professionals in line with the Comprehensive Service Plan (CSP).	1.1.1 Number of basic nurse students graduating (output).	1) Intake of nurse students (HEIs and nursing colleges)	No	3 160	992	1 192	1 236	2 462	2 495	2 820	3 000	
			2) Students with bursaries from the province	No	4 540	2 117	2 848	3 055	4 714	3 674	3 980	4 200	
			3) Basic nurse students graduating	No	600	285	304	299	399	400	500	550	
		1.1.2 Ensure optimum competency levels of health and support professionals through education, training and development.	4) EMC intake on accredited HPCSA courses	No	150	Not required to report	Not required to report	250	297	132	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).	5) Number of Home Community Based Carers (HCBCs) trained	No	2 500	1 009	1 805	1 840	1 614	2 000	2 200	2 400	
		1.2.2 Increase the number of data capturer interns required at health care facilities.	6) Number of data capturer interns	No	160	Not required to report	280	192	120	140	140	150	
		1.2.3 Expand the number of pharmacy assistant basic and post-basic learnerships to meet the needs of health care facilities.	7) Number of pharmacy assistants in training	No	140	Not required to report	Not required to report	40	100	110	120	130	

Strategic goal	Strategic objective: Title	Strategic objective: statement	Indicator	Type	Strategic objective target 2014/15	Audited/actual			Estimate	MTEF Projection			National target
						2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	
		1.2.4 Increase the numbers of Assistant to Artisans (ATAs) interns to address the maintenance of health care facilities.	8) Number of Assistant to Artisans (ATAs) interns	No	120	Not required to report	Not required to report	147	100	120	120	120	
		1.2.5 Increase the number of human resource and finance interns.	9) Number of HR and finance interns	No	140	Not required to report	Not required to report	Not required to report	80	100	120	130	

Table 6.2: Quarterly targets for Health Sciences and Training for 2010/11 [HST3]

Strategic goal	Strategic objective: Title	Strategic objective: statement	Indicator	Reporting period	Annual Target 2011/12	Quarterly targets			
						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 Number of basic nurse students graduating (output).	1) Intake of nurse students [HEIs and nursing colleges]	Annual	2 495	2 495	-	-	-
			2) Students with bursaries from the province	Annual	3 674	3 674	-	-	-
			3) Basic nurse students graduating	Annual	400	400	-	-	-
		1.1.2 Ensure optimum competency levels of health and support professionals through education, training and development.	4) EMC intake on accredited HPCSA courses		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).	5) Number of Home Community Based Carers (HCBCs) trained	Annual	2 000	2 000	-	-	-
		1.2.2 Increase the number of data capturer interns required at health care facilities.	6) Number of data capturer interns	Annual	140	140	-	-	-

Strategic goal	Strategic objective: Title	Strategic objective: statement	Indicator	Reporting period	Annual Target 2011/12	Quarterly targets			
						Q1	Q2	Q3	Q4
		1.2.3 Expand the number of pharmacy assistant basic and post-basic learnerships to meet the needs of health care facilities.	7) Number of pharmacy assistants in training	Annual	110	110	-	-	-
		1.2.4 Increase the numbers of Assistant to Artisans (ATAs) interns to address the maintenance of health care facilities.	8) Number of Assistant to Artisans (ATAs) interns	Annual	120	-	120	-	-
		1.2.5 Increase the number of human resource and finance interns.	9) Number of HR and finance interns	Annual	100	-	-	100	-

7. RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 6.3: Summary of payments and estimates for Health Sciences and Training

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2007/08	Audited 2008/09	Audited 2009/10	Main appro-priation 2010/11	Adjusted appro-priation 2010/11	Revised estimate 2010/11	2011/12	% Change from Revised estimate 2010/11	2012/13	2013/14
1. Nursing Training College	32 117	35 767	39 191	49 464	50 527	50 527	51 501	1.93	54 785	59 029
2. Emergency Medical Services Training Colleges	6 152	7 156	7 631	9 117	9 292	9 292	12 784	37.58	13 632	14 660
3. Bursaries	52 178	31 249	60 155	66 306	67 586	73 363	71 713	(2.25)	74 582	82 040
4. Primary Health Care Training				1	1	1	1		1	1
5. Training Other [a]	43 259	62 457	87 647	92 078	90 878	85 101	97 467	14.53	101 490	111 487
Total payments and estimates	133 706	136 629	194 624	216 966	218 284	218 284	233 466	6.96	244 490	267 217

[a] 2011/12: Conditional grant: Social Sector EPWP Incentive grant to Provinces: R5 812 000 (Transfers and subsidies R5 812 000).

Table 6.4: Summary of provincial payments and estimates by economic classification for Health Sciences and Training

Economic classification R'000	Outcome			Main appro-priation	Adjusted appro-priation	Revised estimate	Medium-term estimate			
								% Change from Revised estimate		
	Audited 2007/08	Audited 2008/09	Audited 2009/10	2010/11	2010/11	2010/11	2011/12	2010/11	2012/13	2013/14
Current payments	69 224	77 980	105 113	115 959	115 467	110 928	128 764	16.08	135 598	147 437
Compensation of employees	25 243	30 917	36 096	44 354	45 672	45 672	49 478	8.33	52 984	56 428
Salaries and wages	22 076	27 098	31 648	39 475	40 699	40 699	43 201	6.15	46 262	49 811
Social contributions	3 167	3 819	4 448	4 879	4 973	4 973	6 277	26.22	6 722	6 617
Goods and services	43 981	47 063	69 017	71 605	69 795	65 256	79 286	21.50	82 614	91 009
of which										
Advertising	5	32	36	34	34	34	36	5.88	38	41
Assets <R5 000	406	761	184	433	433	433	464	7.16	482	530
Bursaries (employees)	3 850	4 581	7 365	7 218	7 218	7 218	7 723	7.00	8 032	8 835
Catering: Departmental activities	1 925	1 980	2 355	2 742	2 064	2 064	2 209	7.03	2 297	2 526
Communication	684	734	652	701	701	701	750	6.99	780	858
Computer services	29	145	14	32	32	32	34	6.25	36	39
Cons/prof: Business and advisory service	5 178	1 850	4 698	3 640	3 675	3 675	3 932	6.99	4 089	4 498
Cons/prof: Infrastructure & planning	102									
Contractors	25	2	12	9	9	9	10	11.11	10	11
Agency and support/ outsourced services	398	703	847	870	1 370	1 370	1 416	3.36	1 472	1 620
Entertainment	1	1								
Inventory: Food and food supplies	841	1 248	1 658	1 974	2 274	2 274	2 433	6.99	2 531	2 784
Inventory: Fuel, oil and gas	786	1 016	853	1 032	1 032	1 032	1 104	6.98	1 148	1 263
Inventory: Materials and supplies	584	449	304	327	327	327	350	7.03	364	400
Inventory: Medical supplies	6	18	46	59	59	59	63	6.78	66	72
Inventory: Other consumables	177	268	369	458	458	458	490	6.99	509	561
Inventory: Stationery and printing	329	663	601	1 140	942	942	1 058	12.31	1 100	1 210
Lease payments	391	534	522	737	737	737	789	7.06	821	902
Property payments	4 345	4 029	4 883	6 129	4 799	4 799	4 741	(1.21)	5 088	5 735
Travel and subsistence	3 395	7 137	10 329	8 097	8 173	8 173	8 693	6.36	9 041	9 944
Training and development	20 004	20 215	32 693	35 420	34 600	30 061	42 073	39.96	43 755	48 131
Operating expenditure	66	95	5	6	6	6	6		7	7
Venues and facilities	454	602	591	547	852	852	912	7.04	948	1 042
Transfers and subsidies to	63 746	57 750	89 198	100 386	102 196	106 734	103 827	(2.72)	107 982	118 779
Departmental agencies and accounts	2 169	2 795	2 997	3 189	3 189	3 189	3 880	21.67	4 036	4 439
Provide list of entities receiving transfers	2 169	2 795	2 997	3 189	3 189	3 189	3 880	21.67	4 036	4 439
SETA	2 169	2 795	2 997	3 189	3 189	3 189	3 880	21.67	4 036	4 439
Universities and technikons	1 400			1 817	1 817	1 817	1 926	6.00	2 003	2 203
Non-profit institutions	12 000	28 482	33 000	36 188	36 188	36 188	33 359	(7.82)	34 694	38 163
Households	48 177	26 473	53 201	59 192	61 002	65 540	64 662	(1.34)	67 249	73 974
Social benefits	3	43	590	104	634	634	672	5.99	699	769
Other transfers to households	48 174	26 430	52 611	59 088	60 368	64 906	63 990	(1.41)	66 550	73 205
Payments for capital assets	723	695	131	621	621	621	875	40.90	910	1 001
Machinery and equipment	723	695	131	621	621	621	875	40.90	910	1 001
Transport equipment							455		473	520
Other machinery and equipment	723	695	131	621	621	621	420	(32.37)	437	481
Payments for financial assets	13	204	182			1		(100.00)		
Total economic classification	133 706	136 629	194 624	216 966	218 284	218 284	233 466	6.96	244 490	267 217

8. PERFORMANCE AND EXPENDITURE TRENDS

Programme 6 is allocated 1.74 per cent of the vote in 2011/12 in comparison to the 1.76 per cent allocated in the adjusted estimate of 2010/11. This amounts to a nominal increase of R15.182 million or 6.96 per cent.

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.

9. 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. A fragmented human resource development information system.	2.1. Development of an integrated information HR system linked to PERSAL.

ROGRAMME 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 service to hospitals, care and rehabilitation centres and certain local authorities.

2.2 PROGRAMME 7.2: ENGINEERING SERVICES

Rendering a maintenance service to equipment and engineering installations, and minor maintenance to buildings.

2.3 PROGRAMME 7.3: FORENSIC PATHOLOGY SERVICE

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

2.4 PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

Rendering specialised orthotic and prosthetic services.

This service is transferred to 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.

3. SUB-PROGRAMME 7.1: LAUNDRY SERVICES

3.1 SITUATION ANALYSIS

Linen and laundry services are provided by large central laundries located at Tygerberg and Lentegeur Hospitals and in George. Tygerberg laundry has 170 personnel, Lentegeur has 72, and George laundry has 36. A number of rural district hospitals, such as Beaufort West, Bredasdorp, Caledon, Citrusdal, Clanwilliam, Ladismith, Laingsburg, Malmesbury, Murraysburg, Nelspoort, Prince Albert, Swellendam, Uniondale and Vredendal Hospitals, have small laundries on site.

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. Although outsourcing saves on costly overtime at in-house laundries, the capacity in the private sector is limited. It is also important from a strategic perspective to maintain in-house capacity.

3.2 CHALLENGES

Securing funding to replace aging and expensive laundry equipment is an on-going challenge.

The recent and projected increases in the cost of electricity, water and effluent highlights the need for effective and efficient laundry machinery and systems.

It would be cost effective to outsource a greater proportion of the laundry. This would spread the risk by reducing the Department's dependence on a limited number of suppliers but the private sector capacity is limited.

3.3 PRIORITIES

The priority is to increase the efficiency of in-house services. Large volumes of work are imperative for the central laundries to make them cost-competitive with the private sector. There is a plan to:

1) Upgrade and maximise the production capacity of the Lentegeur Laundry with funding from the Hospital Revitalisation Programme.
2) Replace ageing equipment at George Laundry.
3) Downscale the Tygerberg Laundry. This plan will enable significant savings in water, steam, electricity and chemical consumption.

3.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR LAUNDRY SERVICES

Table 7.1: 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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Provide and maintain appropriate health technology and infra-structure.	1.1. Provide an effective and efficient laundry service to all hospitals.	1.1.1. Provide all health facilities with the quantity of clean disinfected linen required to deliver quality healthcare.	1) Total number of pieces laundered	No	20.5m	20.06m	20m	20.05m	19 748 600	20.5m	20.5m	20.5m	
		1.1.2. Provide a laundry service using in-house laundries.	2) Total number of pieces laundered: in-house	No	15m	14.8m	14.5m	15m	13 369 864	15m	15m	15m	
		1.1.3. Provide a laundry service using outsourced laundries in the private sector	3) Total number of pieces laundered: outsourced	No	5.5m	5.26m	5m	5.5m	6 378 736	5.5m	5.5m	5.5m	
		1.1.4. Provide cost effective in-house laundry service.	4) Average cost per item laundered: in-house	R	R4.90	R1.91	R2.10	R1.90	R3.20	R3.60	R4.10	R4.90	
			Numerator			-	30 450 000-	28 500 000	48 000 000	54 000 000	61 500 000	73 500 000	
			Denominator			-	14 500 000	15 000 000	15 000 000	15 000 000	15 000 000	15 000 000	
		1.1.5. Provide cost effective outsourced laundry service.	5) Average cost per item laundered: outsourced	R	R5,20	R1.61	R1.75	R1.70	R3.30	R3.30	R3.60	R3,80	
			Numerator			-	8 750 000	9 350 000	18 150 000	18 150 000	19 800 200	20 900 800	
			Denominator			-	5 000 000	5 500 000	5 500 000	5 500 000	5 500 000	5 500 000	

3.5 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR LAUNDRY SERVICES

Table 7.2: Quarterly targets for Laundry Services for 2011/12 [SUP2]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
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	Quarterly	20.5m	4.75m	4.7m	5.55m	5.50m
		1.1.2. Provide a laundry service using in-house laundries.	2) Total number of pieces laundered: in-house	Quarterly	15m	3.30m	3.10m	4.30m	4.30m
		1.1.3. Provide a laundry service using outsourced laundries in the private sector.	3) Total number of pieces laundered: outsourced	Quarterly	5.5m	1.45m	1.60m	1.25m	1.20m
		1.1.4. Provide cost effective in-house laundry service.	4) Average cost per item laundered: in-house	Quarterly	R3.60	R3.50	R3.55	R3.65	R3.70
			Numerator		54 000 000	13 135 000	13 312 500	13 687 500	13 875 000
			Denominator		15 000 000	3 750 000	3 750 000	3 750 000	3 750 000
		1.1.5. Provide cost effective outsourced laundry service.	5) Average cost per item laundered: outsourced	Quarterly	3.30	3.20	3.25	3.35	3.40
			Numerator		18 150 000	4 400 000	4 472 500	4 607 500	4 675 000
			Denominator		5 500 000	5 500 000	5 500 000	5 500 000	5 500 000

3.6 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND MTEF

Please refer to paragraph 8 for the financial details for Programme 7.

Sub-programme 7.1 is allocated 25.75 per cent of the 2011/12 Programme 7 budget in comparison to the 24.62 per cent that was allocated in the revised estimate of 2010/11. This amounts to a nominal increase of R4.654 million or 7.76 per cent.

3.7 PERFORMANCE AND EXPENDITURE TRENDS

The budget allocations will assist the Directorate Engineering and Technical Support Services to fulfil the following critical services:

1) Provide all health facilities with an efficient, sustainable, quality, cost effective linen service.

2) Ensure that all hospitals have received regular supplies of clean, disinfected and useable linen.

3.8 RISK MANAGEMENT

Risk	Mitigating factors
1. The problem facing the laundry service is aging equipment that must be replaced at high cost.	1.1. An important exception is the upgrading of the Lentegeur Laundry as part of the Hospital Revitalisation Programme. This upgrading will result in the replacement of major high cost equipment.
2. Hospitals experience significant linen loses which is a problem as the institutions' funding to purchase new linen is limited.	2.1. In order to keep the linen service operational it has, in the past, been necessary for new linen to be purchased by Programme 7.1. 2.2. Laundry managers are assisting the institution management to strengthen existing control policies.
3. There has been a significant increase in the price of electricity, coal and water which has affected the cost of steam required for the laundry services.	3.1. Equipment is being purchased that will reduce the consumption of water, electricity and chemicals.
4. Availability of qualified laundry managers is of concern.	4.1. On-going training of laundry managers.

4. SUB-PROGRAMME 7.2 ENGINEERING SERVICES

4.1 SITUATION ANALYSIS

The policy is that each hospital must have an appropriately resourced workshop to provide for all routine maintenance at the hospital. The hospital workshops are expected to attend to all routine maintenance of buildings and equipment. The BAS system makes it difficult to establish the exact cost but an analysis of available data reveals that expenditure on routine maintenance is in the order of R70 million per annum.

In respect of the district hospitals, the policy is that the hospital workshop will be resourced to provide routine maintenance support for the primary health care facilities in the district. The quantum of the resources and the level of expertise depend on the size and sophistication of the facility.

The workshops of large central hospitals delivering tertiary level services are typically headed by a professional engineer and have a personnel establishment of more than one hundred persons. In contrast a small district hospital workshop may be headed by an artisan and have a personnel complement of three persons. Funding for the hospital workshops is provided as part of the relevant hospital's budget (Programme 2.9, 4 or 5).

The individual hospital workshops are assisted by central workshops at Bellville, Zwaanswyk and Vrijzee. The workshops at Bellville and Zwaanswyk provide advanced technical support to the individual hospital workshops. These two workshops are also known as the "Mobile Workshops" because they have been provided with adequate suitable vehicles to enable them to move personnel and equipment to wherever they are needed. The Goodwood (Vrijzee) 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 hospital workshops. Funding is provided in Programme 7.2.

Major outsourced maintenance projects are handled by the Department of Transport and Public Works using funding from Programme 8.

4.2 CHALLENGES

1) A history of inadequate funding for the maintenance of assets that has resulted in a maintenance backlog estimated to be R900 million.
2) Difficulty in recruiting and retaining qualified and experienced artisans and technicians.
3) Limited number of personnel to effectively manage all maintenance requirements due to the difficulty in recruiting and retaining qualified and experienced personnel.
4) No maintenance management system to enable effective maintenance planning, budgeting and decision making.
5) Insufficient funding over the MTEF period.

6) There is no up-to-date immovable asset register (IAR) for the Western Cape Department of Health.

4.3 PRIORITIES

1) Ensuring that the funding for the day-to-day maintenance activities is ring fenced for each institution.
2) Ensuring that maintenance funding is utilised efficiently, i.e. maximise value for money.
3) Continue to strive to fill all artisan and technician posts with qualified and experienced persons. It is hoped that the implementation of the OSD will assist in recruiting and retaining qualified and experienced technical personnel.
4) Extending the comprehensive maintenance management system that has been set up at George, Worcester, Paarl and Vredenburg including their satellite institutions for a period of two years from 01 May 2010 to 31 June 2012.

4.4 STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND ANNUAL TARGETS FOR ENGINEERING SERVICES

Table 7.3: 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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	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	No	13 500	11 234	11 817	13 000	19 535	13 200	13 200	13 500	
		1.1.2. Provide preventative maintenance to critical equipment.	2) Number of preventative maintenance jobs completed	No	2 100	1 818	1 945	2 200	1 877	2 100	2 100	2 100	
		1.1.3. Provide repairs and renovation to DoH infrastructure.	3) Number of repairs completed	No	11 400	9 416	9 872	10 800	17 505	11 100	11 100	11 400	

4.5 QUARTERLY TARGETS FOR ENGINEERING SERVICES

Table 7.4: Quarterly targets for Engineering Services for 2010/11 [SUP2]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
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	Quarterly	13 200	2 536	2 762	3 906	3 996
		1.2. Provide preventative maintenance to critical equipment.	2) Number of preventative maintenance jobs completed	Quarterly	2 100	525	525	525	525
		1.3. Provide repairs and renovation to DoH infrastructure.	3) Number of repairs completed	Quarterly	11 100	2 011	2 237	3 381	3 471

4.6 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND MTEF

Sub-programme 7.2 is allocated 30.06 per cent of the Programme 7 budget in 2011/12 in comparison to the 31.40 per cent that was allocated in the adjusted estimate. This is a nominal decrease of R1.057 million or 1.38 per cent.

4.7 PERFORMANCE AND EXPENDITURE TRENDS

The budget allocations will assist the Directorate Engineering and Technical Support Services to fulfil the following critical services:

1) Provide effective and economical maintenance service to all health facilities.
2) Ensure that the facilities comply with the Occupational Health and Safety (OHS) Act and Building Regulations.
3) Provide preventative maintenance to critical engineering plants including life support equipment, ensuring that this equipment is safe and reliable.
4) Appropriate maintenance improves the lifespan of equipment.

Based on the present cost of construction the replacement value of the buildings is estimated at R17.6 billion. Assuming a norm of 4% of replacement cost as an appropriate annual maintenance budget, the estimated expenditure on the maintenance of buildings should be in the region of R700 million per annum. The 2010/11 Programme 7 budget for allocated Engineering Services was R70 million and 2011/12 budget is R75 million showing a nominal increase of 7%. The 2010/11 Programme 8 maintenance budget for buildings was R134 million. The 2011/12 Programme 8 maintenance budget is R141 million showing a nominal increase of 5%. These increases will not address the significant backlog of maintenance, repair and rehabilitation work that is estimated to be in the region of R900 million.

The challenges created by the shortfall in maintenance funding are compounded by the take-over of the forensic pathology service (from the South African Police Service), the ambulance service (from local authorities) and the rural primary health care service (from local authorities). No additional personnel or funding is available to maintain these assets that have an estimated total replacement value of R1.8 billion.

4.8 RISK MANAGEMENT

Risk	Mitigating factors
1. Inadequate budget allocation for maintenance for additional services acquired, e.g. forensic pathology services, emergency medical service and primary health care facilities.	1.1. Human Resource Management is investigating a proposal to expand the engineering establishment.
2. Shortage of qualified and experienced technical and professional personnel.	2.1. The OSD for artisans and technicians is in the process of being implemented with the objective of facilitating the recruitment and retention of the required expertise.
3. Lack of maintenance management system.	3.1. The infrastructure delivery improvement programme (IDIP) process includes a user asset management plan [U-AMP].
4. Lack of preventative maintenance for the new facilities (e.g. Khayelitsha and Mitchell's Plain Hospitals).	4.1. Funding must be set aside for the setting up of the maintenance structure/workshop, daily repairs including preventative maintenance of equipment.

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 Metro, two academic departments of forensic medicine, three Referral FPS laboratories (M3) and smaller FPS laboratories and holding centres (M1 and M2) in the West Coast, Cape Winelands, Overberg, Eden and Central Karoo Districts.

Forensic pathology facilities are classified according to the number of cases that are managed at the facility.

Table 7.5: Forensic Pathology Services (FPS) facilities

Grading of Forensic Pathology 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, Mosselbay, Knysna
M3	500 - 999	Regional Referral Centres: Paarl, Worcester, George, Stellenbosch, Oudtshoorn
M4	1000 - 1499	None
M5	1500 - 1999	None
M6 (Academic)	> 2000	Salt River, Tygerberg

This Forensic Pathology Service includes 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.
- Safe custody of all forms of evidence.
- 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**.**

5.2 CHALLENGES

5.2.1 Funding

Sub-programme 7.3 is largely funded from conditional grant funding. The conditional grant allocation has not kept pace with the impact of inflationary pressures, improvement of conditions of service as well as the impact of the implementation of Occupation Specific

Dispensation for doctors. This resulted in fewer posts being able to be filled year on year (2009/10 – 267; 2010/11 – 256). The conditional grant allocation will phase out in the 2012/13 financial year.

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. Three new forensic pathology laboratories (Worcester, Paarl and Malmesbury) reached practical completion during the 2010/11 financial year, following on from the two facilities (George and Hermanus) that were completed during the 2008/09 financial year. This implies that thirteen 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. The property in Swellendam was purchased by the Department (not conditional grant funding) from private undertakers during 2009/10. This facility now requires some refurbishing and upgrading.

Planning and construction of the following new projects are prioritised and will be constructed during the MTEF period:

- The relocation of the Salt River (M6 academic) facility and the construction of a new M6 facility on the Groote Schuur Hospital premises.
- The construction of a new facility in Beaufort West (M1) to ensure adequate facilities to deal with the caseload and also to act as disaster response centre for the Central Karoo District.
- The construction of new M1 facilities in Riversdale. This facility is currently on private undertaker premises.

Feasibility evaluation will commence for the following projects:

- The expansion of the Tygerberg (M6 academic) facility to adequately deal with the caseload and also to act as the provincial disaster response centre.
- The construction of a new facility to replace the current facility in Stellenbosch (M3), which is inadequate to deal with the caseload.
- The construction of a new facility in Vredenburg (M1) which is currently on private undertaker premises.
- The construction of a new facility in Wolseley (M1) which is currently on private undertaker premises.

5.2.3 **Human resources**

The proposed human resource plan cannot be fully implemented as it is not fully funded which means that the number of posts to be filled year on year has been reduced. 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. Access to accredited training programmes that leads to a formal qualification is critical and no progress has been made with regard to this.

The institutionalisation of structured and dedicated employee wellness programmes within the Forensic Pathology Service remains a priority. The National Strategic Plan for FPS, (linked to that the Healthcare 2010 Plan) proposes 123 forensic pathologists (FP's) for South Africa (SA). There are approximately forty registered and practising forensic pathologists in SA at present. There are eight university training centres in South Africa, of which only six train post-graduate students.

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.
- Processing of toxicology and blood alcohol samples to inform the 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.

5.3 PRIORITIES

The priorities for 2011/12 remain as outlined in the five-year strategic plan namely:

1) Manage the burden of disease by ensuring access to the Forensic Pathology Service. This will be achieved through the management of response times as well as turnaround times of forensic pathology cases.

2) Integration of quality assurance into all aspects of the service through the implementation of standard operating procedures and quality improvement initiatives.

3) Financial management including compliance with financial prescripts.

4) Recruitment, retention, development and support of personnel.

5) Infrastructure and equipment that meets the service needs.

6) Adequate and responsive information technology through the implementation of enhancements to the Forensic Pathology business solution and expansion of electronic content management.

7) Continued interaction with stakeholders to ensure synergy and optimal service delivery.

8) Preparedness 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 7.6: Strategic objectives, performance indicators and annual targets for Forensic Pathology 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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Manage the con-sequences of the burden of disease.	1.1. Ensure access to a Forensic Pathology Service.	1.1.1. Provide an efficient Forensic Pathology Service through maintenance of average response times ≤ 40 minutes.	1) Average response time from dispatch to arrival of FPS on scene		≤ 40 minutes	54 minutes	39 minutes	37 minutes	34 minutes	≤ 40 minutes	≤ 40 minutes	≤ 40 minutes	
			Numerator		392 000	-	-	-	315 017	388 000	390 000	392 000	
			Denominator		9 800	-	-	-	9 273	9 700	9 750	9 800	
		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		≤ 3.5 days	3.17 days	3.26 days	3.55 days	3.3 days	≤ 3.5 days	≤ 3.5 days	≤ 3.5 days	
			Numerator		33 600	-	-	-	34 092	33 271	33 443	33 614	
			Denominator		9 604	-	-	-	9 523	9 506	9 555	9 604	
		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)		≤ 5.5 days	5.04 days	11.28 days	5.11 days	≤ 5.5 days	≤ 5.5 days	≤ 5.5 days	≤ 5.5 days	
			Numerator		46 464	-	-	-	46 426	46 521	46 761	47 000	
			Denominator		8 448	-	-	8 131	8 441	8 458	8 502	8 546	
2. Ensure and maintain organisational strategic management capacity and synergy.	2.1. Develop integrated support and management structures to render effective FPS.	2.1.1. Develop integrated support and management structures to render effective FPS service.	4) Number of unknown persons exceeding 90 days	No	≤125	120	197	111	110	≤125	≤125	≤125	

5.5 QUARTERLY TARGETS FOR FORENSIC PATHOLOGY SERVICES

Table 7.7: Quarterly targets for Forensic Pathology Services for 2010/11 [SUP2]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Manage the consequences of the burden of disease.	1.1. Ensure access to a Forensic Pathology Service.	1.1.1. Provide an efficient Forensic Pathology Service through maintenance of average response times ≤ 40 minutes.	1) Average response time from dispatch to FPS arrival on scene	Quarterly	≤ 40 minutes	≤40	≤40	≤40	≤40
			Numerator		388 000	97 000	97 000	97 000	97 000
			Denominator		9 700	2 425	2 425	2 425	2 425
		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	Quarterly	≤ 3,5 days	≤3,5 days	≤3,5 days	≤3,5 days	≤3,5 days
			Numerator		33 271	8 317	8 318	8 318	8 318
			Denominator		9 506	2 376	2 376	2 377	2 377
		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).	Quarterly	≤ 5,5 days	≤ 5,5 days	≤ 5,5 days	≤ 5,5 days	≤ 5,5 days
			Numerator		46 521	11 630	11 630	11 630	11 630
			Denominator		8 458	2 115	2 115	2 115	2115
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 unknowns by reducing the number of unknowns.	4) Number of unknown persons exceeding 90 days	Quarterly	≤125	≤125	≤125	≤125	≤125

5.6 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND MTEF

Sub-programme 7.3. is allocated 39.20 per cent of the Programme 7 budget in 2011/12 in comparison to the 39.13 that was allocated in 2010/11. This amounts to a nominal increase of R3.027 million or 3.03 per cent in nominal terms. This is largely due to the fact that the conditional grant allocation has not been adjusted to accommodate the implementation of the occupation specific dispensation for various categories of staff or the inflationary pressures as a result of the improvement in conditions of service.

5.7 PERFORMANCE AND EXPENDITURE TRENDS

Improvement to the physical infrastructure remains a largely unfunded priority. Thirteen of the eighteen forensic pathology laboratories still require either relocation or upgrading. The conditional grant will phase out at the end of the 11/12 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 256 out of an establishment of 306 in 2011/12 financial year. Incident response time will be maintained below an average of 40 minutes across the Province by ensuring sixty-six vehicles in active service on the road.

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 will be 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. Submissions and annual business plans highlighting the funding gap. 3.2. Implement the service within available budget only.
4. The implementation of the infrastructure plan is limited by the availability of funding.	4.1. Business cases will be submitted to obtain funding to proceed with prioritised projects.
5. The ability to respond to major incidents.	5.1. The implementation of local, district and provincial Major Incident Response Plans.

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.

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:

- Augmenting the working capital in the medicine trading account.
- 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.
- Ongoing 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 7.8: Strategic objective, performance indicator and annual target for Medicine trading account [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	2007/08	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 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.	1) Working capital in the medicine trading account	Rand	R84m	R50.0	R46.8m	R58.3m	R62.9m	R68.0m	R76m	R80.0m	

7.4.1 QUARTELRY TARGETS FOR THE MEDICINE TRADING ACCOUNT

Table 7.9: 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			
					2011/12	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.	1) Working capital in the medicine trading account	Annual	R68.0m	R68.0m	R68.0m	R68.0m	R68.0m

7.2 RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND MTEF

Please refer to paragraph 8 for the financial details.

Sub-programme 7.5 is allocated 4.99 per cent of the Programme 7 budget in 2011/12 in comparison to the 4.85 per cent of the Programme 7 budget that was allocated in the 2010/11 revised estimate. This amounts to a nominal decrease of R710 000 or 6.00 per cent. The reason for this is that there was a once off allocation of R10 million in the adjusted estimate of 2010/11 for the increased capital funding for the Cape Medical Depot (CMD) to fund the increased stock.

7.3 PERFORMANCE AND EXPENDITURE TRENDS

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.

7.4 RISK ASSESSMENT

Risk	Mitigating factors
1. Maintenance of the current CMD building to legislative norms and standards.	1.1. Tender for the replacement of a passenger lift awarded by the Department of Transport and Public Works, for installation in 2011/12. 1.2. Replacement of condemned large walk-in fridges for the storage of thermo labile medication. 1.3. 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 2011/12.
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 1.87 per cent of the vote in 2011/12 in comparison to the 1.97 per cent allocated in the 2010/11 adjusted estimate. This amounts to a nominal increase of R7.334 million or 3.01 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 7.10: Summary of payments and estimates: Health Care Support Services [SUP 3]

Sub-programme R'000	Outcome						Medium-term estimate			
	Audited 2007/08	Audited 2008/09	Audited 2009/10	Main appro-priation 2010/11	Adjusted appro-priation 2010/11	Revised estimate 2010/11	2011/12	% Change from Revised estimate 2010/11	2012/13	2013/14
1. Community Health Facilities [a,b]	28 400	28 026	24 236	86 760	95 584	93 084	66 773	(28.27)	101 908	121 708
2. Emergency Medical Rescue Services [b]	18 706	7 892	10 985	24 785	24 266	24 266	29 317	20.82	18 962	15 788
3. District Hospital Services [a,b]	55 281	132 460	210 005	388 071	427 722	403 222	423 517	5.03	410 236	258 956
4. Provincial Hospital Services [a,b]	201 568	176 875	274 398	262 822	259 892	259 892	166 795	(35.82)	154 635	284 771
5. Central Hospital Services [a,b]	52 320	41 775	79 959	88 281	93 192	93 192	93 265	0.08	86 597	114 539
6. Other Facilities [a,b]	15 403	12 680	11 419	25 929	52 339	47 839	36 813	(23.05)	98 434	74 910
Total payments and estimates	371 678	399 708	611 002	876 648	952 995	921 495	816 480	(11.40)	870 772	870 672

[a] 2011/12: Conditional grant: Hospital revitalisation: R481 501 000 (Compensation of employees R17 470 000; Goods and services R22 778; Machinery and Equipment R 104 488 000 and Buildings and other fixed structures R 336 765 000).

[b] 2011/12: Conditional grant: Health Infrastructure grant: R119 179 000 (Buildings and other fixed structures R119 179 000).

Table 7.11: Payments and estimates by economic classification: Health Care Support Services

Economic classification R'000	Outcome			Main appro-priation	Adjusted appro-priation	Revised estimate	Medium-term estimate			
	Audited	Audited	Audited					% Change from Revised estimate		
	2007/08	2008/09	2009/10	2010/11	2010/11	2010/11	2011/12	2010/11	2012/13	2013/14
Current payments	79 811	93 208	179 506	210 164	219 689	212 677	229 205	7.77	243 196	262 583
Compensation of employees	43 953	43 515	104 448	123 004	133 315	126 303	142 157	12.55	152 227	162 116
Salaries and wages	37 913	37 477	90 315	109 654	117 609	110 597	124 405	12.48	139 481	149 209
Social contributions	6 040	6 038	14 133	13 350	15 706	15 706	17 752	13.03	12 746	12 907
Goods and services	35 858	49 693	75 058	87 160	86 374	86 374	87 048	0.78	90 969	100 467
of which										
Advertising	214		2		3	3	5	66.67	5	5
Assets <R5 000	275	262	768	886	922	922	842	(8.68)	875	964
Catering: Departmental activities		1	103	120	119	119	95	(20.17)	99	108
Communication	461	433	1 670	2 129	1 970	1 970	1 950	(1.02)	2 030	2 234
Computer services		20	2 545	2 084	2 561	2 561	2 005	(21.71)	2 086	2 294
Cons/prof: Business and advisory service			220		10	10	11	10.00	11	12
Cons/prof: Infrastructure & planning	2									
Cons/prof: Laboratory service			684	821	2 866	2 866	726	(74.67)	755	830
Contractors	9 989	2 463	6 246	6 241	6 231	6 231	7 518	20.65	7 819	8 601
Agency and support/ outsourced services	2 332	4 014	6 871	7 303	7 311	7 311	7 340	0.40	7 633	8 396
Entertainment	3	2	5	9	9	9	9		10	10
Inventory: Food and food supplies	98	117	124	163	163	163	175	7.36	181	200
Inventory: Fuel, oil and gas	596	870	768	876	876	876	1 132	29.22	1 178	1 296
Inventory: Materials and supplies	5 328	6 420	9 598	10 478	10 448	10 448	11 099	6.23	11 542	12 697
Inventory: Medical supplies	4 461	2	757	821	807	807	879	8.92	915	1 007
Inventory: Other consumables	3 070	8 984	10 845	12 359	12 202	12 202	12 166	(0.30)	12 653	13 918
Inventory: Stationery and printing	487	551	1 405	1 556	1 666	1 666	1 622	(2.64)	1 685	1 854
Lease payments	229	130	1 150	977	722	722	636	(11.91)	661	728
Property payments	3 816	20 816	17 148	25 905	24 288	24 288	22 917	(5.64)	24 271	27 096
Travel and subsistence	4 122	4 354	13 421	12 820	12 461	12 461	15 095	21.14	15 701	17 273
Training and development	351	202	487	531	531	531	639	20.34	665	730
Operating expenditure	24	16	163	1 071	97	97	161	65.98	167	185
Venues and facilities		36	78	10	111	111	26	(76.58)	27	29
Transfers and subsidies to	1 554	1 657	2 881	2 219	12 219	12 219	12 953	6.01	13 471	14 817
Departmental agencies and accounts	1 411	1 573	1 715	1 825	11 825	11 825	12 535	6.00	13 036	14 340
Entities receiving transfers	1 411	1 573	1 715	1 825	11 825	11 825	12 535	6.00	13 036	14 340
CMD Capital Augmentation	1 411	1 573	1 715	1 825	11 825	11 825	12 535	6.00	13 036	14 340
Households	143	84	1 166	394	394	394	418	6.09	435	477
Social benefits	143	84	1 166	394	394	394	418	6.09	435	477
Payments for capital assets	399	1 203	15 164	3 561	11 785	18 785	8 869	(52.79)	9 220	10 144
Buildings and other fixed structures		385	12 486		8 702	15 702	5 140	(67.27)	5 346	5 880
Buildings		385	12 486		8 702	15 702	5 140	(67.27)	5 346	5 880
Machinery and equipment	399	818	2 678	3 561	3 083	3 083	3 729	20.95	3 874	4 264
Transport equipment			524	890	890	890	860	(3.37)	894	984
Other machinery and equipment	399	818	2 154	2 671	2 193	2 193	2 869	30.83	2 980	3 280
Of which: "Capitalised Goods and services" included in Payments for capital assets			12 020	20	8 722	15 722	5 162	(67.17)	5 368	5 905
Pavments for financial assets	21	82	54			12		(100.00)		
Total economic classification	81 785	96 150	197 605	215 944	243 693	243 693	251 027	3.01	265 887	287 544

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

1. PROGRAMME PURPOSE:

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

2. PROGRAMME STRUCTURE

0.1. SUB-PROGRAMME 8.1: COMMUNITY HEALTH FACILITIES

Construction of new Community Health Centres, Community Day–Care Centres, and Community Health Clinics, and the upgrading and maintenance of community health facilities.

0.2. SUB-PROGRAMME 8.2: EMERGENCY MEDICAL SERVICES

Construction of new Emergency Medical Service facilities, and the upgrading and maintenance of all emergency medical service facilities.

0.3. SUB-PROGRAMME 8.3: DISTRICT HOSPITAL SERVICES

Construction of new district hospitals, and the upgrading and maintenance of all district hospitals.

0.4. SUB-PROGRAMME 8.4: PROVINCIAL HOSPITAL SERVICES

Construction of new provincial hospitals, and the upgrading and maintenance of all provincial hospitals.

0.5. SUB-PROGRAMME 8.5: CENTRAL HOSPITAL SERVICES

Construction of new central hospitals, and the upgrading and maintenance of all central hospitals.

0.6. SUB-PROGRAMME 8.6: OTHER FACILITIES

Construction of other new health facilities, and the upgrading and maintenance of all other facilities.

3. SITUATION ANALYSIS

The Chief Directorate: Infrastructure Management within the Western Cape Department of Health (WCDoH) is responsible for the construction of new facilities and the upgrading and maintenance of existing facilities. This is done in line with the Construction Industry Development Board (CIDB) best practice guidelines and prescripts. In particular, WCDoH, referred to in the CIDB guidelines as the *Client Department,* is responsible for *Infrastructure Planning* and *Client Programme Management*, while the Western Cape Department of Transport and Public Works (WCDTPW), referred to as the *Implementing Department* or *ID,* is responsible for the *Programme Implementation* and *Project Delivery*. The latter was reinforced through a December 2009 Provincial Cabinet resolution that WCDTPW be the "preferred Implementing Agent" for the delivery of infrastructure within the Western Cape.

The process of establishing the Chief Directorate: Infrastructure Management, begun during May 2010, is now well underway, with personnel for the Directorate: Infrastructure Support currently being recruited. Once established, the Chief Directorate will have three components responsible for managing and implementing Programme 8, i.e. the Directorate: Hospital Revitalisation Programme (HRP), Directorate: Infrastructure Support, and Directorate: Engineering and Technical Support Services. The Chief Directorate is currently assisted by the Infrastructure Delivery Improvement Programme (IDIP) Technical Advisor. The IDIP is funded by National Treasury with the aim of addressing inadequate infrastructure delivery capacity and skills within the provincial departments of Health, Education and Public Works across the country.

4. CHALLENGES

The primary challenges for the delivery and maintenance of health care infrastructure include:

1) Ensuring the rapid establishment of the Chief Directorate: Infrastructure Management;
2) The limited internal and organisational capacity of the Implementing Department, the WC Department of Transport and Public Works;
3) Infrastructure backlog, especially in relation to Emergency Medical Service, Forensic Pathology Service, and Primary Health Care facilities;
4) Maintenance backlog primarily due to the transfer of rural PHC, EMS, and FPS. These services were transferred to the Provincial Government from Local Government and SAPS;
5) Lack of adequate facility maintenance for both existing and newly built health care infrastructure;
6) Sub-standard quality of construction, procurement and management of professional service providers and contractors, and costly delays in project implementation by WCDTPW;
7) Land availability and lengthy land acquisition processes for new facilities, particularly between the three spheres of government;

8) Ensuring cost-parity between government-built health facilities and those built by the private sector ;

9) Ensuring the timeous preparation of provincial space planning norms and standards, standard drawings and technical specifications, design guidelines, and cost norms;

10) Limited capacity of the building industry, especially SMMEs;

11) The current delivery management and procurement strategy (design-by-employer model is not efficient, effective nor economical).

5. PRIORITIES

The primary projects prioritised for implementation at the respective phases[1] in each of the Sub-Programmes are outlined below.

5.1 SUB-PROGRAMME 8.1: COMMUNITY HEALTH FACILITIES

- **Projects at Identification / Feasibility Phase**:
  Beaufort West new Clinic, Mitchell's Plain Weltevreden CDC; Strand Nonzamo Asanda Clinic, and District Six CDC;
- **Projects at Design / Tender Phase**:
  Knysna Witlokasie CDC, Table View Du Noon CHC (Community Health Centre), Hermanus new Community Day Centre (CDC), Delft Symphony Way CDC, and Rawsonville new Clinic;
- **Projects at Construction / Handover Phase:**
  Plettenberg Bay Kwanokahtula CDC, Grassy Park Clinic, Malmesbury Westbank CDC, and Grabouw CDC extension.

5.2 SUB-PROGRAMME 8.2: EMERGENCY MEDICAL SERVICES

- **Projects at Identification / Feasibility Phase:**
  De Doorns Ambulance Station, Heidelberg Ambulance Station, and Robertson Ambulance Station;
- **Projects at Design / Tender Phase:**
  Malmesbury Ambulance Station, Piketberg Ambulance Station, and Tulbagh Ambulance Station;
- **Projects Construction / Handover Phase**:
  Ceres Ambulance Station, Plettenberg Bay - Kwanokathula Ambulance Station and Vredendal Ambulance Station.

[1] Note: The phases as outlined here are aligned with the milestones as included in the Infrastructure Reporting Model (IRM), as required by National Treasury

5.3 SUB-PROGRAMME 8.3: DISTRICT HOSPITAL SERVICES

- The two major priorities for this sub-programme are the construction of Khayelitsha and Mitchell's Plain Hospitals. Both projects are currently under construction. Khayelitsha Hospital will be completed by the end of June 2011 (six months ahead of schedule), while Mitchell's Plain at the end of October 2012.
- Other priorities are the upgrading and extension of the Emergency Centre at Karl Bremer, Hermanus, Ceres, and Knysna Hospitals, the final phase of Riversdale Hospital upgrade, and the completion of the Vredenburg Hospital revitalisation.

5.4 SUB-PROGRAMME 8.4: PROVINCIAL HOSPITAL SERVICES

- **Rural Regional Hospitals**:
  Completion of the upgrading for George, Paarl, and Worcester hospitals, part of the Hospital Revitalisation Programme;
- The revitalisation of Valkenberg and Brooklyn Chest Hospitals are due to start during the MTEF period.

5.5 SUB-PROGRAMME 8.5: CENTRAL HOSPITAL SERVICES

- The main priority for this sub-programme is the replacement of Tygerberg Hospital registered as a mega project with National Treasury. During the MTEF a feasibility study will be prepared focussing on the needs and options analysis, value assessment, economic valuation and procurement plan.
- Other priorities are the upgrade of the Emergency Centre at Red Cross War Memorial Children and Groote Schuur Hospitals.

5.6 SUB-PROGRAMME 8.6: OTHER FACILITIES

- The relocation of the Salt River Forensic Pathology Laboratory near to the Groote Schuur Hospital estate is the main priority for this sub-programme.

6. PROVINCIAL STRATEGIC OBJECTIVES, PERFORMANCE INDICATORS AND targets for health facilities management

Table 8.1: Strategic objectives, performance indicators and annual targets for Health Facilities Management [HFM1 &2] !

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
1. Provide and maintain appropriate health technology and infrastructure	1.1. Fund, construct and commission new health care facilities and upgrade and maintain all health facilities to ensure access to the integrated comprehensive health platform	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%	3.61%	3.4%	4.78%	8%%	6%	6%	5.6%	
			Numerator	R"000	1 010	271	295	473	953	816	871	871	
			Denominator	R'000	16 840	7 498	8 555	9 893	11 963	13 395	14 390	15 666	
			2) Equitable share capital programme as percentage of total health expenditure	%	0.54%	0.21%	0.21%	0.47%	0.25%	0.54%	0.56%	0.54%	
			Numerator	R'000	90	16	18	50	30	73	80	84	
			Denominator	R'000	16 840	7 498	8 555	10 556	11 963	13 395	14 390	15 666	
			3) Expenditure on facility maintenance as percentage of total health expenditure	%	1.12%	1.12%	1.28%	1.04%	1.13%	1.07%	1.10%	1.12%	
			Numerator	R'000	188	84	105	110	135	143	158	176	
			Denominator	R'000	16 840	7 498	8 555	10 556	11 963	13 395	14 390	15 666	
			4) Hospitals funded from the revitalisation programme	%	21%	13%	13%	13%	13%	16%	19%	21%	
			Numerator	No	12	7	7	7	7	9	11	12	
			Denominator	No	58	53	53	53	56	56	57	58	
			5) Average backlog of service platform in fixed PHC facilities	%	23%				50%	42%	34%	28%	
			Numerator	R'000l	400				500	480	450	420	
			Denominator	R'000	1 750				1000	1150	1323	1520	
		1.1.1. Ensure and maintain appropriate access per 1000 uninsured population to acute hospital beds by 2014/15	6) Level 1 (district hospital) beds per 1 000 uninsured population	No.	0.55		0.54	0.57	0.57	0.58	0.59	0.58	
			Numerator		2 673		2 292	2 464	2 485	2 592	2 722	2 722	
			Denominator		4 868		4 207	4 302	4 396	44 91	4 585	4 679	

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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
			7) Level 2 (regional hospital) beds per 1 000 uninsured population	No.	0.28		0.59	0.55	0.54	0.30	0.29	0.29	
			Numerator		1 340		2 490	2 364	2 387	1 340	1 340	1 340	
			Denominator		4 868		4 207	4 302	4 396	4 491	4 585	4 679	

Note: Indicator 6 : Reduction in the numerator between 2010/11 and 2011/12 is the result of the shift of Level 2 beds from Sub-Programme 4.1 to Programme 5.

Table 8.2: Quarterly targets for Health Facilities Management for 2011/12 [HFM3]

Strategic goal	Strategic objective: Title	Strategic objective: Statement	Performance Indicator	Reporting period	Annual target	Quarterly targets			
					2011/12	Q1	Q2	Q3	Q4
1. Provide and maintain appropriate health technology and infrastructure	1.1. Fund, construct and commission new health care facilities and upgrade and maintain all health facilities to ensure access to the integrated comprehensive health platform	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.	Quarterly	6%	1.5%	3%	4.57%	6%
			Numerator		816	204	408	612	816
			Denominator		13 395	13 395	13 395	13 395	13 395
			2) Equitable share capital programme as percentage of total health expenditure	Quarterly	0.54%	0.13%	0.28%	0.41%	0.54%
			Numerator		73	18	37	55	73
			Denominator		13 395	13 395	13 395	13 395	13 395
			3) Expenditure on facility maintenance as percentage of total health expenditure	Quarterly	1.06%	0.27%	0.53%	0.80%	1.06%
			Numerator		142	35.5	71	106.5	142
			Denominator		13 395	13 395	13 395	13 395	13 395
			4) Hospitals funded from the revitalisation programme	Quarterly	16%	12.5%	12.5%	14.3%	16%
			Numerator		9	7	7	8	9
			Denominator		56	56	56	56	56
			5) Average backlog of service platform in fixed PHC facilities	Annually	42%				
			Numerator		480				
			Denominator		1 150				
		1.1.1. Ensure and maintain appropriate access per 1000 uninsured population to acute hospital beds by 2014/15	6) Level 1 (district hospital) beds per 1 000 uninsured population	Annual	0.56				
			Numerator		2 453				
			Denominator		4 378				
			7) Level 2 (regional hospital) beds per 1 000 uninsured population	Annual	0.31				
			Numerator		1 340				
			Denominator		4 378				

7. RECONCILING THE PERFORMANCE TARGETS WITH THE EXPENDITURE TRENDS

Table 8.3: Expenditure estimates: Health Facilities Management [HFM4]

	Sub-programme R'000	Outcome						Medium-term estimate			
		Audited 2007/08	Audited 2008/09	Audited 2009/10	Main appro-priation 2010/11	Adjusted appro-priation 2010/11	Revised estimate 2010/11	2011/12	% Change from Revised estimate 2010/11	2012/13	2013/14
1.	Community Health Facilities [a,b]	28 400	28 026	24 236	86 760	95 584	93 084	66 773	(28.27)	101 908	121 708
2.	Emergency Medical Rescue Services [b]	18 706	7 892	10 985	24 785	24 266	24 266	29 317	20.82	18 962	15 788
3.	District Hospital Services [a,b]	55 281	132 460	210 005	388 071	427 722	403 222	423 517	5.03	410 236	258 956
4.	Provincial Hospital Services [a,b]	201 568	176 875	274 398	262 822	259 892	259 892	166 795	(35.82)	154 635	284 771
5.	Central Hospital Services [a,b]	52 320	41 775	79 959	88 281	93 192	93 192	93 265	0.08	86 597	114 539
6.	Other Facilities [a,b]	15 403	12 680	11 419	25 929	52 339	47 839	36 813	(23.05)	98 434	74 910
	Total payments and estimates	371 678	399 708	611 002	876 648	952 995	921 495	816 480	(11.40)	870 772	870 672

[a] 2011/12: Conditional grant: Hospital revitalisation: R481 501 000 (Compensation of employees R17 470 000; Goods and services R22 778; Machinery and Equipment R 104 488 000 and Buildings and other fixed structures R 336 765 000).

[b] 2011/12: Conditional grant: Health Infrastructure grant: R119 179 000 (Buildings and other fixed structures R119 179 000).

Earmarked allocations:

Included in Programme 8 is an earmarked allocation amounting to R41 361 000 (2011/12), R47 128 000 (2012/13) and R49 720 000 (2013/14) for the purpose of maintaining current infrastructure funding.

Included in Programme 8 is an earmarked allocation amounting to R169 289 000 (2011/12), R176 672 000 (2012/13) and R180 132 000 (2013/14), for the purpose of Maintenance and Capital.

Included in Programme 8 is an earmarked allocation amounting to R5 150 000 (2011/12), R3 000 000 (2012/13) and R10 320 000 (2013/14), for Donations for Red Cross Hospital.

Included in Programme 8 is an earmarked allocation amounting to R11 465 000 000 (2012/13) and R20 465000 (2013/14), for Preventative maintenance.

Table 8.4: Summary of Provincial Expenditure Estimates by Economic Classification: 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		
	2007/08	2008/09	2009/10	2010/11	2010/11	2010/11	2011/12	2010/11	2012/13	2013/14
Current payments	103 856	104 490	137 659	165 586	163 020	163 020	**182 887**	12.19	209 754	223 688
Compensation of employees	6 290	6 021	9 198	18 976	19 526	19 526	**17 470**	(10.53)	15 678	14 165
Salaries and wages	6 111	5 875	8 664	17 449	17 999	17 999	**16 433**	(8.70)	14 621	13 329
Social contributions	179	146	534	1527	1527	1527	**1037**	(32.09)	1057	836
Goods and services	97 566	98 469	128 461	146 610	143 494	143 494	**165 417**	15.28	194 076	209 523
of which										
Advertising	40	5		4	2	2		(100.00)		
Assets <R5 000	752	5 915	5 663	4 693	4 933	4 933	**17 503**	254.81	31447	31751
Catering: Departmental	18	119	78	128	138	138	**121**	(12.32)	115	76
Communication	25	4	23	48	50	50	**50**		46	46
Computer services	30	5	43							
Cons/prof: Business and advisory service	2 768	3 076	3 561	5 356	4 617	4 617	**3 568**	(22.72)	2 775	511
Cons/prof: Infrastructure & planning		4 425	2 909							
Contractors	9 084	719	4 623		11	11	**84**	663.64	180	
Agency and support/ outsourced services	7 953	1298	617		395	395	**65**	(83.54)	50	50
Entertainment	2		2	5	5	5	**6**	20.00	6	6
Inventory: Food and food	3			3	2	2		(100.00)		
Inventory: Materials and	383	1355	8 880				**100**			
Inventory: Medical supplies	101	4	36		35	35		(100.00)		
Inventory: Other consumables	544	143	789	9	232	232	**100**	(56.90)	61	31
Inventory: Stationery and	71	66	157	105	148	148	**140**	(5.41)	137	77
Lease payments	450	500	439							
Property payments	74 754	79 676	98 683	134 733	130 699	130 699	**142 667**	9.16	158 389	176 204
Transport provided: Departmental activity					140	140		(100.00)		
Travel and subsistence	291	343	687	320	771	771	**404**	(47.60)	365	278
Training and development	241	773	1075	856	1081	1081	**454**	(58.00)	350	343
Operating expenditure	10		99							
Venues and facilities	46	43	97	350	235	235	**155**	(34.04)	155	150
Transfers and subsidies to				7 000	9 900	9 900	**5 150**	(47.98)	3 000	10 320
Households				7 000	9 900	9 900	**5 150**	(47.98)	3 000	10 320
Other transfers to households				7 000	9 900	9 900	**5 150**	(47.98)	3 000	10 320
Payments for capital assets	267 822	295 218	473 343	704 062	780 075	748 575	**628 443**	(16.05)	658 018	636 664
Buildings and other fixed structures	247 850	278 392	440 748	657 752	740 415	708 915	**523 955**	(26.09)	582 889	588 335
Buildings	247 850	278 392	440 748	657 752	740 415	708 915	**523 955**	(26.09)	582 889	588 335
Machinery and equipment	19 972	16 809	32 595	46 310	39 660	39 660	**104 488**	163.46	75 129	48 329
Other machinery and equipment	19 972	16 809	32 595	46 310	39 660	39 660	**104 488**	163.46	75 129	48 329
Software and other intangible assets		17								
Of which: "Capitalised Compensation" included in			141							
Of which: "Capitalised Goods and services" included in Payments for capital assets		278 393	440 607	657 752	740 415	708 915	**523 955**	(26.09)	582 889	588 335
Total economic classification	371678	399 708	611002	876 648	952 995	921495	**816 480**	(11.40)	870 772	870 672

8. PERFROMANCE 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 most certainly not be met. However, it is important to note that, in reality, the current allocations are not reducing the provincial health

infrastructure backlog in a meaningful way: Current estimations put the capital infrastructure backlog at between about R6 billion and R8 billion, while the maintenance backlog is estimated to be about R1 billion. Now, while backlogs undoubtedly remain moving targets in a developing country such as South Africa, it would be important to significantly reduce the backlogs, or at the very least, ensure stability in these numbers. A substantial increase in MTEF allocations would therefore be required. However, were these increases to be granted, the ability of the department to effectively and efficiently spend the allocation would need to increase through:

- Increasing the capacity of the Department's Chief Directorate: Infrastructure Management in terms of both its Infrastructure Planning and its Client Programme Management role;
- Increasing the capacity of WCDTPW as Implementing Agent;
- Increasing the capacity of WCDTPW as Custodian and as Property Manager;
- Streamlining procurement processes within WCDTPW;
- Implementing alternative procurement strategies to that of "design-by-client" (e.g. targeted procurement through the NEC3 Engineering and Construction Contract);
- Improved quality of service from Professional Service Providers;
- Improved management of Professional Service Providers and contractors by WCDTPW;
- Re-structuring the manner in which WCDoH manages, implements, monitors and reports on its immovable asset maintenance programme;
- Standardisation based on approved space planning norms and standards, cost norms, standard drawings and technical specifications, and standard designs;

Programme 8 is allocated 6.10 per cent of the vote in 2011/12 in comparison to the 7.45 per cent that was allocated in the 2010/11 revised estimate. This translates into a nominal decrease of R105.015 million or 11.40 per cent.

8.1 RESOURCE CONSIDERATIONS

The implementation of Programme 8 is managed by the Chief Directorate: Infrastructure Management. However, the establishment of this Chief Directorate, begun in May 2010, has not yet been fully completed. As a result, the capacity within the Chief Directorate to effectively and efficiently ***plan*** the implementation of the Department's infrastructure programme, as well as ***programme manage*** its implementation, is lacking. It is, however, anticipated that all relevant posts within the Chief Directorate will be filled within the current financial year and a considerable improvement should thus be realized within the forthcoming financial year.

In so far as the actual project implementation is concerned, capacity constraints have also been identified within the Department's Implementing Agent (Western Cape Department of Transport and Public Works). These constraints, along with others pertinent to the Department of Health, are being addressed through collaborative efforts of both

departments, assisted by the Infrastructure Delivery Improvement Programme (IDIP), see also Section 8 above and Section 9 below.

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.	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.
2. Capacity deficiencies continue in WCDTPW.	2.1. The Provincial HR Strategy has a particular focus on WCDTPW – the intention of which is to address capacity deficiencies within the department.
3. Management of Professional Service Providers (PSP's) and contractors by WCDTPW remains poor.	3.1. The contractual documentation managing the relationship between WCDTPW and PSP's is currently being reviewed.
4. Poor quality of service from Professional Service Providers impacts upon quality of infrastructure delivered as well as inflated costs.	4.1. The contractual documentation managing the relationship between WCDTPW and PSP's is currently being reviewed.
5. The management of the immovable asset maintenance programme of the department is too fragmented.	5.1. Re-structuring the manner in which WCDoH manages, implements, monitors and reports on its immovable asset maintenance programme.
6. Non-standardisation leads to over-design, "re-inventing the wheel", inefficiencies.	6.1. Standardisation based on approved space planning norms and standards, cost norms, standard drawings and technical specifications, and standard designs is currently underway.
7. Streamlining procurement processes within WCDTPW.	7.1. Working with WCDTPW, WCDoH will ensure that alternative procurement strategies to that of "design-by-client" are implemented (e.g. targeted procurement through the NEC3 Engineering and Construction Contract)
8. Increasing the capacity of WCDTPW as Custodian and as Property Manager.	8.1. The Provincial HR Strategy has a particular focus on WCDTPW, the intention of which is to address capacity deficiencies within WCDTPW, including its role as Custodian and Property Manager.

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:	Public Works have received the brief from 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 IA (DTPW) equivalent to start of design/stage
Completion date:	Final Account concluded and signed off
Total Budget Available	Project cost all included (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 Feb 2011	Project Duration Months	Start Date	Completion Date	Total Project Cost	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's
1	IGP	Mitchell's Plain CHC	City of Cape Town	EC & Pharmacy	Retention	36	Apr-07	May-10	39 500	919	10 713	15 031	100				
2	IGP	Grassy Park Clinic	City of Cape Town	New clinic	Construction/ hand over	38	Apr-08	Jun-11	19 000	34	940	10 626	7 400				
3	IGP	Malmesbury - Wesbank CDC	West Coast	New CDC	Construction/ hand over	36	Apr-08	Sep-11	27 336	238	1 248	14 355	11 495				
4	IGP	Melkhoutfountein Clinic	Eden	Clinic Replacement	Construction/ hand over	15	Sep-10	Dec-11	3 000			500	2500				
5	HRP	Paarl TC Newman CHC	Cape Winelands	Community health center upgrade	Construction/ hand over	69	Apr-06	Mar-11	21 649	99		20 000	550		-	-	-
6	IGP	Plettenberg Bay Kwanakathula CDC	Eden	New CDC	Construction/ hand over	36	Apr-08	Mar-11	29 457	109	1 425	27 523	400				
7	PES	Delft Symphony Way CDC	City of Cape Town	New CDC	Design/ tender	48	Apr-10	Mar-16	27 000			200	1 500				
8	PES	District Six	City of Cape Town	New CDC	Design/ tender	48	Apr-10	Aug-14	45 000			50	1 500	4 500	34 000		
9	IGP	Du Noon CHC	City of Cape Town	New CHC	Design/ tender	48	Apr-10	Mar-14	70 000			500	1 500	21 000	41 500	5 500	
10	PES	Grabouw CDC	Overberg	Upgrade & extension (co-sponsor French Government)	Design/ tender	30	Sep-09	Apr-12	14 000					2 109			
11	PES	Hermanus CDC	Overberg	New CDC	Design/ tender	32	Apr-10	Oct-12	30 000			100	3 500	25 000	1 900		
12	PES	Knysna - Witlokasie CDC	Eden	New CHC	Design/ tender	53	Apr-09	Sep-13	35 000			800	15 761	12 519	5 920		
13	IGP	Rawsonville Clinic	Cape Winelands	New clinic	Design/ tender	37	Apr-10	May-13	8 050			50	1 000	6 500	500		
14	IGP	Strand Nonzamo: Asanda Clinic	City of Cape Town	New clinic	Design/ tender	36	Apr-10	Apr-13	11 800			50	1 000	8 500	2 250		
15	IGP	Beaufort West Clinic	Central Karoo	Extenstion of van Schalkwyk street Clinic	Identified/ feasibility	36	Apr-11	Mar-14	5 000				50	150	4 000	800	
16	IGP	Beaufort West Clinic	Central Karoo	New clinic	Identified/ feasibility	24	Apr-13	Mar-15	7 000						150	6 000	850
17	IGP	Bergsig Clinic	Cape Winelands	Extension	Identified/ feasibility	24	Apr-14	Mar-16	5 700							500	5 000
18	IGP	Bonnievale Clinic	Cape Winelands	New Clinic	Identified/ feasibility	24	Apr-13	Mar-16	10 000						100	9 200	700
19	IGP	Caledon Clinic	Overberg	New Clinic	Identified feasibility	24	Apr-14	Mar-17	8 000							100	7 500
20	IGP	Ceres CDC	Cape Winelands	New CDC	Identified/ feasibility	36	Apr-13	Mar-16	25 000						500	17 000	7 000

No	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage Feb 2011	Project Duration Months	Start Date	Completion Date	Total Project Cost	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's
21	IGP	De Doorns Clinic	Cape Winelands	Extension	Identified/ feasibility	24	Apr-15	Mar-17	5 900								500
22	IGP	Elsies River CHC	City of Cape Town	CHC upgrade and renovation	Identified/ feasibility	48	Apr-15	Mar-19	30 000								2 500
23	IGP	Fisante Kraal Clinic	City of Cape Town	New Clinic	Identified/ feasibility	24	Apr-15	Mar-17	15 000								500
24	IGP	George Centre Clinic	Eden	New clinic	Identified/ feasibility	24	Apr-15	Mar-17	10 000								1 000
25	IGP	Hannover Park CHC	City of Cape Town	Clinic Replacement	Identified/ feasibility	36	Apr-15	Mar-18	18 000								100
26	IGP	Houtbay CDC	City of Cape Town	New CDC	Identified/ feasibility	36	Apr-15	Mar-18	27 000								400
27	IGP	Kalbaskraal Clinic	West Coast	New Clinic	Identified/ feasibility	24	Apr-15	Mar-17	8 000								500
28	IGP	Khayelitsha Swartklip Clinic	City of Cape Town	New clinic	Identified/ feasibility	24	Apr-15	Mar-17	15 000								500
29	IGP	Knysna Town clinic	Eden	Clinic Replacement	Identified/ feasibility	24	Apr-15	Mar-17	8 000								500
30	IGP	Mbekweni CDC	Cape Winelands	New clinic	Identified/ feasibility	36	Apr-15	Mar-18	20 000								500
31	IGP	Mitchell's Plain Weltevedren CDC	City of Cape Town	New CDC	Identified/ feasibility	36	Apr-13	Mar-16	27 000						500	26 000	500
32	IGP	Mossel Bay ASLA Park CDC	Eden	New CDC	Identified/ feasibility	36	Apr-14	Mar-17	27 000							200	5 000
33	PES	Napier Clinic	Overberg	Clinic Replacement	Identified/ feasibility	36	Apr-12	Mar-15	10 000				100	2 000	7 900		
34	IGP	Oudtshoorn Clinic	Eden	New Clinic (Property Acquisition)	Identified/ feasibility	12	Apr-11	Mar-12	1 400				1 300				
35	IGP	Prince Alfred Hamlet Clinic	Cape Winelands	Clinic Replacement	Identified/ feasibility	36	Apr-12	Mar-15	8 000						100	6 000	1 900
36	IGP	Sandhills Clinic	Cape Winelands	New clinic	Identified/ feasibility	24	Apr-15	Mar-17	10 000								100
37	IGP	Vredenberg CDC	West Coast	New CDC	Identified/ feasibility	48	Apr-13	Mar-17	30 000						500	15 000	11 000
38	IGP	Wolseley Clinic	Cape Winelands	New Clinic	Identified/ feasibility	24	Apr-13	Mar-15	8 000						100	5 000	2 900
39	IGP	Worcester Avian Park Clinic	Cape Winelands	New clinic	Identified/ feasibility	36	Apr-13	Mar-16	10 000						100	3 600	6 300
40	IGP	Worcester CDC	Cape Winelands	Extension for Dental clinic	Identified/ feasibility	24	Apr-14	Mar-16	1 326							538	788
						TOTAL							49 656	82 278	100 020	95 438	56 538

Schedule 2: Sub-Programme 2 Emergency Medical Services

No	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage Feb 2011	Project Duration Months	Start Date	Completion Date	Total Project Cost	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's
1	IGP	Lamberts Bay Ambulance	West Coast	Ambulance station Extension	Construction/ hand over	36	Apr-08	Mar-11	1 770	5	64	1 591					
2	IGP	Leeu Gamka Ambulance Station	Central Karoo	New Ambulance station	Construction/ hand over	36	Apr-08	Mar-11	13 250	20	403	3 327	9 000	500			
3	IGP	Plettenberg Bay Kwanokuthula Ambulance	Eden	New Ambulance station	Construction/ hand over	36	Apr-08	Mar-11	8 036		296	7 363	377				
4	Eq Share	Malmesbury Hospital	West Coast	New Ambulance station and extension to EC	Design/ tender	27	Apr-10	Jun-12	11 250			250	5 500	4 500	500		
5	Eq Share	Piketberg Ambulance Station	West Coast	New Ambulance station	Design/ tender	36	Apr-10	Mar-13	6 900			300		6 000	600		
6	Eq Share	Tulbach Ambulance Station	West Coast	New Ambulance station	Design/ tender	36	Apr-10	Mar-13	5 500			715	4 000	785			
7	Eq Share	Barrydale Ambulance Station	Overberg	New Ambulance station	Identified/ feasibility	18	Apr-13	Mar-15	4 000						500	3 200	200
8	Eq Share	Bonnievale Ambulance Station	Cape Winelands	Convert the existing clinic into ambulance station	Identified/ feasibility	18	Apr-14	Mar-16	3 500							200	3 300
9	IGP	Caledon Hospital	Overberg	EMS Communication centre	Identified/ feasibility	24	Apr-11	Mar-13	1 500				500	1 000			
10	Eq Share	Darling Ambulance Station	West Coast	New Ambulance Station	Identified/ feasibility	24	Apr-15	Mar-17	4 000								1 000
11	Eq Share	De Doorns ambulance station	Cape Winelands	New Ambulance station	Identified/ feasibility	12	Apr-13	Mar-14	5 500						800	4 500	300
12	Eq Share	Gansbaai Ambulance Station	Overberg	New Ambulance Station	Identified/ feasibility	24	Apr-13	Mar-17	3 000						559		2 441
13	Eq Share	Heidelberg ambulance station	Eden	New Ambulance station	Identified/ feasibility	6	Apr-11	Mar-15	4 000				100		200	3 700	
14	Eq Share	Jacobs Bay Ambulance Station	West Coast	New Ambulance Station	Identified/ feasibility	36	Apr-13	Mar-16	3 000						100	500	2 400
15	Eq Share	Murraysburg Ambulance Station	Central Karoo	New Ambulance station	Identified/ feasibility	24	Apr-13	Mar-15	1 500						100	1 400	
16	Eq Share	Napier Ambulance Station	Overberg	New Ambulance Station	Identified feasibility	36	Apr-13	Mar-16	5 000						50	469	4 481
17	IGP	Pinelands EMS	City of Cape Town	New Ambulance station	Identified feasibility	36	Apr-14	Mar-17	20 000							1 000	10 000
18	Eq Share	Porterville Ambulance Station	West Coast	New Ambulance station	Identified feasibility	12	Apr-13	Mar-13	1 490						1 490		
19	Eq Share	Rawsonville Ambulance Station	Cape Winelands	New Ambulance Station	Identified feasibility	12	Apr-13	Mar-18	5 000						1 000		

No	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage Feb 2011	Project Duration Months	Start Date	Completion Date	Total Project Cost	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's
20	Eq Share	Robertson Ambulance Station	Cape Winelands	New Ambulance station	Identified feasibility	36	Apr-11	Mar-14	6 000				487	2 239	3 274		
21	Eq Share	Sedgefield Ambulance Station	Eden	New Ambulance Station	Identified feasibility	24	Apr-15	Mar-17	4 000								1 297
22	Eq Share	Uniondale Ambulance Station	Central Karoo	New Ambulance station	Identified feasibility	24	Apr-13	Mar-15	4 000						800	3 200	
23	Eq Share	Villiersdorp Ambulance Station	Overberg	New Ambulance station	Identified feasibility	18	Apr-14	Mar-16	4 400							400	4 000
24	Eq Share	Wellington Ambulance Station	Overberg	New Ambulance Station	Identified feasibility	24	Apr-15	Mar-17	5 000								1 000
						TOTAL							19 964	15 024	9 973	18 569	30 419

Schedule 3: Sub-Programme 8.3 District Health Services

No	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage Feb 2011	Project Duration Months	Start Date	Completion Date	Total Project Cost	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's
1	IGP	Ceres Ambulance Station	Cape Winelands	New Ambulance Station	Retention	32	Apr-08	Dec-10	9 650	124	1 102	8 424	100				
2	IGP	Eerste River : Hospital	City of Cape Town	New Emergengy Centre	Retention	39	Apr-07	Jul-10	30 139	7 339	16 163	5 800	100				
3	IGP	Ceres Hospital	Cape Winelands	New Emergency Centre	Construction hand over	24	Apr-09	Mar-11	10 000			1 500	8 000	500			
4	IGP	Hermanus Hospital	Overberg	EC, new wards, OPD and Administration	Construction hand over	48	Apr-09	Mar-13	66 224		2 130	6 000	25 000	29 224	3 870		
5	HRP	Khayelitsha hospital	City of Cape Town	New hospital and ambulance station	Construction hand over	72	Apr-05	Jun-11	480 000	24 500	111 000	250 864	72 865	1 000			
6	HRP	Mitchell's Plain hospital	City of Cape Town	New hospital	Construction hand over	84	Apr-05	Oct-12	480 000	18 000	15 600	108 500	175 876	106 069	2 000		
7	IGP	Riversdale Hospital	Eden	Phase 3 upgrade	Construction hand over	24	Apr-09	Aug-11	10 140			3 760	6 380				
8	HRP	Vredenburg hospital	West Coast	Upgrading phase 2A	Construction hand over	56	Apr-06	May-11	37 000	700	15 300	16 000	4 600		-	-	-
9	IGP	Vredendal Hospital	West Coast	New Ambulance Station	Construction hand over	36	Apr-08	Aug-11	10 000	16	234	3 350	6 400				
10	IGP	Caledon Hospital	Overberg	Upgrade - Disa ward phase 2	Design tender	48	Apr-09	Mar-13	9 000			750	1 000	6 550	700		
11	IGP	Karl Bremer Hosp	City of Cape Town	New Emergency Centre and Main Store	Design tender	60	Apr-09	Mar-14	44 600			500	2 000	19 600	21 100	1 400	
12	IGP	Knysna Hospital	Eden	New emergency Centre and OPD	Design tender	60	Apr-09	Mar-14	25 000			600	1 000	15 000	7 400	1 000	
13	IGP	Robertson Hospital	Cape Winelands	New Bulk Store	Design tender	18	Apr-11	Oct-12	4 000			250	2 000	1 500	250		
14	HRP	Vredenburg hospital	West Coast	Upgrading phase 2B	Design tender	84	Apr-07	Mar-14	138 000	2 000	2 400	5 000	20 000	83 192	25 000	408	
15	IGP	Eerste River Hospital	City of Cape Town	Safe Ward	Identified feasibility	12	Apr-15	Mar-16	750								500
16	HRP	Helderberg Hospital	City of Cape Town	Hospital Replacement	Identified feasibility	36	Apr-12	Mar-16	350 000					5 000	38 000	120 000	100 000
17	HRP	Manenberg: GF Jooste Hospital	City of Cape Town	Hospital Replacement	Identified feasibility	36	Apr-12	Mar-17	480 000					5 000	20 386	44 000	
18	HRP	Mossel Bay Hospital	Eden	Hospital Replacement	Identified feasibility	24	Apr-11	Mar-16	250 000			-		1 200	25 192	100 000	90 000

No	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage Feb 2011	Project Duration Months	Start Date	Completion Date	Total Project Cost	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's
19	IGP	Oudtshoorn Hospital	Eden	New Emergency Centre	Identified feasibility	24	Apr-14	Mar-16	8 000							1 000	7 000
20	IGP	Robertson Hospital	Cape Winelands	New EC and new wards	Identified feasibility	48	Apr-15	Mar-19	60 000								500
21	IGP	Stellenbosch Hospital	Cape Winelands	New Emergency Centre	Identified feasibility	24	Apr-14	Mar-16	8 500							600	8 000
22	IGP	Swellendam Hospital	Overberg	New Emergency Centre	Identified feasibility	28	Apr-14	Mar-16	10 000							600	9 000
23	Eq Share	Tygerberg EMS Training College	City of Cape Town	Teaching facilities and practical labs upgrade	Identified feasibility	36	Apr-13	Mar-16	11 400						1 200	6 000	4 200
24	HRP	Victoria hospital	City of Cape Town	Hospital Replacement	Identified feasibility	30	Apr-15	Mar-20	400 000			-	-	-	-		100
25	IGP	Victoria hospital	City of Cape Town	New Emergency Centre	Identified feasibility	36	Apr-12	Mar-15	22 600					100	1 500	21 000	1 500
26	HRP	Khayelitsha hospital	City of Cape Town	Health Technology	In Progress							834	75 765	62 650	30 000		
27	HRP	Khayelitsha hospital	City of Cape Town	OD and QA	In Progress							3 638	4 612	3 638	3 638		
28	HRP	Mitchell's Plain hospital	City of Cape Town	Health Technology	In Progress									40 000	40 000		
29	HRP	Mitchell's Plain hospital	City of Cape Town	OD and QA	In Progress				-	-		3 613	3 428	3 613	3 376		
30	HRP	Vredenburg hospital	West Coast	Health Technology	In Progress				-	-	-	1 224	676	2 000	5 000		
31	HRP	Vredenburg hospital	West Coast	OD and QA	In Progress				-	-	-	1 299	1 671	1 300	1 300		
								TOTAL					411 473	387 136	229 912	296 008	220 800

Schedule 4: Sub-Programme 8.4 Provincial Hospital Services

No	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage Feb 2011	Project Duration Months	Start Date	Completion Date	Total Project Cost	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's
1	IGP	Somerset Hospital	City of Cape Town	2010 Enabling Work	Retention	12	Apr-09	Mar-10	32 058	369	29 439	2 150					
2	HRP	Worcester Hospital	Cape Winelands	Phase 3 Upgrade	Retention	80	Apr-01	Dec-08	260 000	38 700	6 500	4 000	200	-	-		
3	HRP	George hospital	Eden	Hospital upgrade phase 3	Construction hand over	48	Apr-08	Feb-12	75 000	2 500	18 800	30 280	18 924	5 400			
4	Eq Share	George: Harry Comay TB Hospital	Eden	Upgrade	Construction hand over	27	Apr-09	Jul-11	5 000			1 770	3 000	230			
5	IGP	Lentegeur Hospital	City of Cape Town	Relocation of Lifecare	Construction hand over	5	Jan-11	Jun-11	11 000			9 000	2 000				
6	HRP	Paarl hospital	Cape Winelands	Hospital upgrade	Construction hand over	132	Apr-00	Mar-11	450 000	77 800	119 130	81 000	3 000			-	-
7	IGP	Somerset Hospital	City of Cape Town	Lift Upgrade	Construction hand over	24	Apr-09	Nov-11	5 640			640	5 000				-
8	Eq Share	Stikland Hospital	City of Cape Town	Wards 1, 6, 7 & 11 Upgrade	Construction hand over	27	Apr-09	Jul-11	8 000			4 900	3 100			-	-
9	HRP	Worcester hospital phase 4	Cape Winelands	Hospital upgrade phase 4	Construction hand over	36	Apr-08	Mar-11	45 000		4 912	30 000	9 000			-	-
10	Eq Share	Brooklyn Chest TB hospital	City of Cape Town	New MDR & XDR wards	Design tender	48	Apr-09	Mar-13	25 000			1 070	5 000	15 000	3 930		-
11	Eq Share	Paarl Sonstraal TB Hospital	Cape Winelands	UV Lights & extraction	Design tender	24	Apr-10	Mar-12	3 413			1 150	2 263				
12	HRP	Valkenberg hospital	City of Cape Town	Hospital upgrading	Design tender	96	Apr-09	Mar-17	900 000			2 500	26 850	50 533	190 000	150 000	230 000
13	HRP	Brooklyn Chest Hospital	City of Cape Town	Extensions & Upgrades	Identified feasibility	84	Apr-12	Mar-19	700 000					5 000	40 000	30 000	30 000
14	HRP	Paarl hospital	Cape Winelands	New Psychiatric Unit	Identified feasibility	9	Apr-11	Mar-13	12 000			-	1 401	10 000			
15	HRP	Worcester Hospital phase 5	Cape Winelands	Hospital upgrade phase 5	Identified feasibility	18	Apr-11	Mar-14	32 000			-	2 500	25 000	4 500		
16	HRP	George hospital	Eden	Health Technology	In Progress				-	-	-	11 844	12 017	-	-	-	-
17	HRP	George hospital	Eden	OD and QA	In Progress				-	-	-	2 701	1 661	500	-	-	-
18	HRP	Paal Hospital	Cape Winelands	OD and QA	In Progress				-	-	-	22 499	1 839	1 000	-	-	-
19	HRP	Paarl hospital	Cape Winelands	Health Technology	In Progress				-	-	-	3 545	16 332	-	-	-	-
20	HRP	Worcester Hospital	West Coast	Health Technology	In Progress				-	-	-	8 175	17 000	-	5 000	-	-

No	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage Feb 2011	Project Duration Months	Start Date	Completion Date	Total Project Cost	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's
21	HRP	Worcester Hospital	Cape Winelands	OD and QA	In Progress				-	-	-	2 543	1 476	3 748	-	-	-
22	HRP	Valkenberg hospital	City of Cape Town	Health Technology	Inception				-			-	-	-	-	-	-
						TOTAL							132 563	116 411	243 430	180 000	260 000

Schedule 5: Sub-Programme 8.5 Central Hospital Services

No	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage Feb 2011	Project Duration Months	Start Date	Completion Date	Total Project Cost	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's
1	IGP	Groote Schuur Hospital	City of Cape Town	Relocation of Engineering Workshop	Retention	42	Apr-07	Dec-10	7 193		730	6 463	100				
2	IGP	Groote Schuur Hospital	City of Cape Town	Security upgrade Ph 1	Retention	24	Apr-08	Mar-10	12 500	373	6 013	2 000	100				
3	IGP	Groote Schuur Hospital	City of Cape Town	Upgrade pharmacy	Construction hand over	29	Apr-08	Sep-11	11 600	12	950	4 834	5 804				
4	IGP	Groote Schuur Hospital	City of Cape Town	Ward E16 Respiratory Clinic Mechanical Ventilation Upgrade	Construction hand over	36	Apr-08	Mar-11	2 140		150	1 940	50				
5	IGP	Groote Schuur Hospital	City of Cape Town	NMB fire detection ph 2	Construction hand over	38	Apr-09	Jun-12	5 000			1 200	2 000	1 750	50		
6	Eq Share	Red Cross Hospital	City of Cape Town	Various Upgrade Projects	Construction hand over	72	Apr-10	Mar-16	43 945			10 225	5 150	3 000	10 320	5 150	10 100
7	PES	Tygerberg Hospital	City of Cape Town	EC Upgrade	Design tender	48	Apr-09	Mar-13	13 200			1 140	11 000				
8	IGP	Groote Schuur Hospital	City of Cape Town	E-floor upgrading	Identified feasibility	24	Apr-15	Mar-17	8 000								2 500
9	IGP	Groote Schuur Hospital	City of Cape Town	Fire Detection Phase 3	Identified feasibility	24	Apr-15	Mar-17	6 500								500
10	PES	Groote Schuur Hospital	City of Cape Town	Master Plan	Identified feasibility	36	Apr-11	Mar-14	400				1 000				
11	IGP	Groote Schuur Hospital	City of Cape Town	Upgrade of the Emergency Centre	Identified feasibility	36	Apr-11	Mar-14	8 000				100	2 000	5 500	400	
12	Eq Share	Red Cross Hospital	City of Cape Town	Upgrade Emergency Centre	Identified feasibility	36	Apr-11	Mar-15	16 496				200	1 000	9 296	6 000	
13	IGP	Tyberberg Hospital	City of Cape Town	Upgrade security (electronic surveillance system) phase 1	Identified feasibility	12	Apr-14	Mar-15	3 200							1 000	2 200
14	Eq Share	Tygerberg Hospital	City of Cape Town	PET/SCAN Infrastructure Installation	Identified feasibility	12	Apr-11	Mar-12	3 000				3 000				
15	HRP	Tygerberg Hospital	City of Cape Town	Replacement Hospital	Identified feasibility	48	Apr-10	Apr-20	1 500 000				-	12 203	20 000	20 334	14 642
16	HRP	Tygerberg Hospital	City of Cape Town	Health Technology	Inception					-	-	180	180	180	-		
17	HRP	Tygerberg Hospital	City of Cape Town	OD and QA	Inception					-	-	1 820	1 820	1 820	850		
18	HRP	Valkenberg hospital	City of Cape Town	OD and QA	Inception				-			-	-	-	-	-	-
								TOTAL					30 504	21 953	46 016	32 884	29 942

Schedule 6: Sub-Programme 8.6 Other Facilities

No	Fund Source	Facility	District	Type of Infrastructure	Current Project Stage Feb 2011	Project Duration Months	Start Date	Completion Date	Total Project Cost	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's	2013/14 R000's	2014/15 R000's	2015/16 R000's
1	IGP	Malmesbury FPS	West Coast	New Forensic Laboratory	Retention	54	Apr-06	Oct-10	14 300	7 300	272	5 500					
2	IGP	Paarl FPS	Cape Winelands	New Forensic Laboratory	Retention	54	Apr-06	Oct-10	17 300	950	1 093	5 700					
3	IGP	Worcester FPS	Cape Winelands	New Forensic Laboratory	Retention	54	Apr-06	Oct-10	18 500	12 200	821	6 180					
4	IGP	Beaufort West Hospital	Central Karoo	New Forensic Pathology Laboratory	Construction hand over	36	Apr-09	Mar-12	10 800			3 440	6 823	537			
5	IGP	Mitchell's Plain	City of Cape Town	Sub district office	Construction hand over	13	Jun-10	Jul-11	8 000			6 000	2 000				
6	IGP	Groote Schuur	City of Cape Town	Forensic mortuary	Design tender	72	Apr-10	Mar-16	67 668			200	1 000	15 000	47 668	3 800	
7	PES	Khayelitsha Office Accom.	City of Cape Town	New Shared Service Centre	Design tender	18	Jun-10	Dec-11	12 000			4 000	7 000	1 000			
8	IGP	Riversdale FPS	Eden	Forensic Pathology Laboratory	Design tender	36	Mar-09	Mar-12	8 000			400	5 600	2 000			
9	HRP	Mitchell's Plain hospital	City of Cape Town	Regional laundry replacement (including equipment)	Identified feasibility	15	Apr-11	Mar-13	76 500			-	1 000	65 000	10 500		
10	IGP	Stellenbosch FPL	Cape Winelands	New FPL	Identified feasibility	36	Apr-15	Mar-18	25 000								100
11	IGP	Tygerberg FPS	City of Cape Town	Forensic laboratory: additional refrigeration, dissection and accommodation	Identified feasibility	36	Apr-14	Mar-17	38 000							2 000	30 000
12	IGP	Vredenburg FPS	West Coast	New Forensic Laboratory	Identified feasibility	36	Apr-13	Mar-16	10 000						200	8 500	1 300
13	IGP	Wolseley FPL	Cape Winelands	New FPL	Identified feasibility	24	Apr-15	Mar-17	10 000						100	900	9 000
14	HRP	HRP Unit	City of Cape Town	Head Office	In Progress							5 500	6 258	6 050	6 655	6 655	6 655
						TOTAL							29 681	89 587	65 123	21 855	47 055

PART C

LINKS TO OTHER PLANS

PART C: LINKS TO OTHER PLANS

1. LINKS TO THE LONG-TERM INFRASTRCUTURE AND OTHER CAPITAL PLANS

Table C1: Links to the long-term infrastructure plan

NO	PROJECT NAME	PROG.	MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
1	**New and replacement assets** (R 'thousand)												
	Piketberg Ambulance Station	8.2	Bergrivier	New Ambulance station			300				6,000	600	
	Tulbach Ambulance Station	8.2	Witzenberg	New Ambulance station			715	4,000			785		
	Barrydale Ambulance Station	8.2	Swellendam	New Ambulance station								500	3,200
	Darling Ambulance Station	8.2	Swartland	New Ambulance Station									
	De Doorns ambulance station	8.2	Breede Valley	New Ambulance station								800	4,500
	Gansbaai Ambulance Station	8.2	Overstrand	New Ambulance Station								559	
	Heidelberg ambulance station	8.2	Swellendam	New Ambulance station				100				200	3,700
	Jacobs Bay Ambulance Station	8.2	Saldanha Bay	New Ambulance Station								100	500
	Murraysburg Ambulance Station	8.2	Central Karoo Districts	New Ambulance station								100	1,400
	Napier Ambulance Station	8.2	Cape Augalhas	New Ambulance Station								50	469
	Porterville Ambulance Station	8.2	Bergrivier	New Ambulance station								1,490	
	Rawsonville Ambulance Station	8.2	Breede Valley	New Ambulance Station								1,000	
	Robertson Ambulance Station	8.2	Breede Rivier/ Winelands	New Ambulance station				487			2,239	3,274	
	Sedgefield Ambulance Station	8.2	Bitou	New Ambulance Station									
	Uniondale Ambulance Station	8.2	Oudtshoorn	New Ambulance station								800	3,200
	Villiersdorp Ambulance Station	8.2	Theewaterskloof	New Ambulance station									400
	Wellington Ambulance Station	8.2	Drakenstein	New Ambulance Station									
	Khayelitsha hospital	8.3	Cape Town	New hospital and ambulance station	24,500	111,000	250,864	72,865			1,000		
	Mitchell's Plain hospital	8.3	Cape Town	New hospital	18,000	15,600	108,500	175,876			106,069	2,000	
	Mitchell's Plain hospital	8.6	Cape Town	Regional laundry replacement (including equipment)				1,000			65,000	10,500	
	Tygerberg Hospital	8.5	Cape Town	Replacement Hospital							12,203	20,000	20,334
	Helderberg Hospital	8.3	Cape Town	Hospital Replacement							5,000	38,000	120,000
	Manenberg: GF Jooste Hospital	8.3	Cape Town	Hospital Replacement							5,000	20,386	44,000
	Mossel Bay Hospital	8.3	Mossel Bay	Hospital Replacement							1,200	25,192	100,000
	Khayelitsha hospital	8.3	Cape Town	Health Technology			834	75,765			62,650	30,000	
	Khayelitsha hospital	8.3	Cape Town	OD and QA			3,638	4,612			3,638	3,638	
	Mitchell's Plain hospital	8.3	Cape Town	Health Technology							40,000	40,000	

NO	PROJECT NAME	PROG.	MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
	Mitchell's Plain hospital	8.3	Cape Town	OD and QA			3,613	3,428			3,613	3,376	
	Malmesbury FPS	8.6	Swartland	New Forensic Laboratory	7,300	272	5,500						
	Paarl FPS	8.6	Drakenstein	New Forensic Laboratory	950	1,093	5,700						
	Worcester FPS	8.6	Breede Valley	New Forensic Laboratory	12,200	821	6,180						
	Beaufort West Hospital	8.6	Beaufort West	New Forensic Pathology Laboratory			3,440	6,823			537		
	Grassy Park Clinic	8.1	Cape Town	New clinic	34	940	10,626	7,400					
	Leeu Gamka Ambulance Station	8.2	Prince Albert	New Ambulance station	20	403	3,327	9,000			500		
	Malmesbury - Wesbank CDC	8.1	Swartland	New CDC	238	1,248	14,355	11,495					
	Melkhoutfountein Clinic	8.1	Hessequa	Clinic Replacement			500	2,500					
	Plettenberg Bay Kwanakathula CDC	8.1	Bitou	New CDC	109	1,425	27,523	400					
	Plettenberg Bay Kwanokuthula Ambulance	8.2	Bitou	New Ambulance station		296	7,363	377					
	Vredendal Hospital	8.3	Matzikama	New Ambulance Station	16	234	3,350	6,400					
	Du Noon CHC	8.1	Cape Town	New CHC			500	1,500			21,000	41,500	5,500
	Rawsonville Clinic	8.1	Breede Valley	New clinic			50	1,000			6,500	500	-
	Riversdale FPS	8.6	Hessequa	Forensic Pathology Laboratory			400	5,600			2,000		
	Strand Nonzamo: Asanda Clinic	8.1	Cape Town	New clinic			50	1,000			8,500	2,250	
	Beaufort West Clinic	8.1	Beaufort West	New clinic								150	6,000
	Bonnievale Clinic	8.1	Breede Rivier/ Winelands	New Clinic								100	9,200
	Caledon Clinic	8.1	Theewaterskloof	New Clinic									100
	Ceres Ambulance Station	8.3	Witzenberg	New Ambulance Station	124	1,102	8,424	100					
	Ceres CDC	8.1	Witzenberg	New CDC								500	17,000
	Fisante Kraal Clinic	8.1	Cape Town	New Clinic									
	George Centre Clinic	8.1	George	New clinic									
	Hannover Park CHC	8.1	Cape Town	Clinic Replacement									
	Houtbay CDC	8.1	Cape Town	New CDC									
	Kalbaskraal Clinic	8.1	Swartland	New Clinic									
	Khayelitsha Swartklip Clinic	8.1	Cape Town	New clinic									
	Knysna Town clinic	8.1	Knysna	Clinic Replacement									
	Mbekweni CDC	8.1	Drakenstein	New clinic									
	Mitchell's Plain Weltevedren CDC	8.1	Cape Town	New CDC								500	26,000
	Oudtshoorn Clinic	8.1	Oudtshoorn	New Clinic (Property Acquisition)				1,300					
	Pinelands EMS	8.1	Cape Town	New Ambulance station									1,000

NO	PROJECT NAME	PROG.	MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
	Prince Alfred Hamlet Clinic	8.2	Witzenberg	Clinic Replacement								100	6,000
	Sandhills Clinic	8.1	Breede Valley	New clinic									
	Stellenbosch FPL	8.1	Stellenbosch	New FPL									
	Vredenberg CDC	8.6	Saldanha Bay	New CDC								500	15,000
	Vredenburg FPS	8.1	Saldanha Bay	New Forensic Laboratory								200	8,500
	Wolseley Clinic	8.6	Breede Valley	New Clinic								100	5,000
	Wolseley FPL	8.1	Breede Valley	New FPL								100	900
	Worcester Avian Park Clinic	8.6	Breede Valley	New clinic								100	3,600
	Delft Symphony Way CDC	8.1	Cape Town	New CDC			200	1,500					
	District Six	8.1	Cape Town	New CDC			50	1,500			4,500	34,000	
	Hermanus CDC	8.1	Overstrand	New CDC			100	3,500			25,000	1,900	
	Khayelitsha Office Accom.	8.1	Cape Town	New Shared Service Centre			4,000	7,000			1,000		
	Knysna - Witlokasie CDC	8.6	Knysna	New CHC			800	15,761			12,519	5,920	
	Napier Clinic	8.1	Cape Augalhas	Clinic Replacement				100			2,000	7,900	
Total new and replacement assets					**63,367**	**133,332**	**462,478**	**421,389**			**333,453**	**288,385**	**405,503**
2	**Upgrades and additions** (R thousand)												
	George: Harry Comay TB Hospital	8.4	George	Upgrade			1,770	3,000			230		
	Stikland Hospital	8.4	Cape Town	Wards 1, 6, 7 & 11 Upgrade			4,900	3,100					
	Brooklyn Chest TB hospital	8.4	Cape Town	New MDR & XDR wards			1,070	5,000			15,000	3,930	
	Malmesbury Hospital	8.2	Swartland	New Ambulance station and extension to EC			250	5,500			4,500	500	
	Paarl Sonstraal TB Hospital	8.4	Drakenstein	UV Lights & extraction			1,150	2,263					
	Red Cross Hospital	8.5	Cape Town	Upgrade Emergency Centre				200			1,000	9,296	6,000
	Tygerberg EMS Training College	8.3	Cape Town	Teaching facilities and practical labs upgrade							-	1,200	6,000
	Tygerberg Hospital	8.5	Cape Town	PET/SCAN Infrastructure Installation				3,000					
	Ceres Ambulance Station	8.3	Witzenberg	New Ambulance Station	124	1,102	8,424	100					
	Eerste River : Hospital	8.3	Cape Town	New Emergengy Centre	7,339	16,163	5,800	100					
	Groote Schuur Hospital	8.5	Cape Town	Relocation of Engineering Workshop	-	730	6,463	100					
	Groote Schuur Hospital	8.5	Cape Town	Security upgrade Ph 1	373	6,013	2,000	100					
	Mitchell's Plain CHC	8.1	Cape Town	EC & Pharmacy	919	10,713	15,031	100					
	Somerset Hospital	8.4	Cape Town	2010 Enabling Work	369	29,439	2,150	-					
	Ceres Hospital	8.3	Witzenberg	New Emergency Centre			1,500	8,000			500		
	Groote Schuur Hospital	8.5	Cape Town	Upgrade pharmacy	12	950	4,834	5,804					
	Groote Schuur Hospital	8.5	Cape Town	Ward E16 Respiratory		150	1,940	50					

NO	PROJECT NAME	PROG.	MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
				Clinic Mechanical Ventilation Upgrade									
	Groote Schuur Hospital	8.5	Cape Town	NMB fire detection ph 2			1,200	2,000			1,750	50	
	Hermanus Hospital	8.3	Overstrand	EC, new wards, OPD and Administration		2,130	6,000	25,000			29,224	3,870	
	Lamberts Bay Ambulance	8.2	Cederberg	Ambulance station Extension	5	64	1,591						
	Lentegeur Hospital	8.4	Cape Town	Relocation of Lifecare			9,000	2,000					
	Mitchell's Plain	8.6	Cape Town	Sub district office			6,000	2,000					
	Riversdale Hospital	8.3	Hessequa	Phase 3 upgrade				6,380					
	Somerset Hospital	8.4	Cape Town	Lift Upgrade			640	5,000					
	Caledon Hospital	8.3	Theewaterskloof	Upgrade - Disa ward phase 2			750	1,000			6,550	700	
	Groote Schuur	8.6	Cape Town	Forensic mortuary			200	1,000			15,000	47,668	3,800
	Karl Bremer Hosp	8.3	Cape Town	New Emergency Centre and Main Store			500	2,000			19,600	21,100	1,400
	Knysna Hospital	8.3	Knysna	New emergency Centre and OPD			600	1,000			15,000	7,400	1,000
	Robertson Hospital	8.3	Breede Rivier/ Winelands	New Bulk Store			250	2,000			1,500	250	
	Beaufort West Clinic	8.1	Beaufort West	Extenstion of van Schalkwyk street Clinic			-	50			150	4,000	800
	Bergsig Clinic	8.1	Langeberg	Extension			-	-					500
	Caledon Hospital	8.2	Theewaterskloof	EMS Communication centre				500			1,000		
	De Doorns Clinic	8.1	Breede Valley	Extension									
	Eerste River Hospital	8.3	Cape Town	Safe Ward									
	Elsies River CHC	8.1	Cape Town	CHC upgrade and renovation									
	Groote Schuur Hospital	8.5	Cape Town	E-floor upgrading									
	Groote Schuur Hospital	8.5	Cape Town	Fire Detection Phase 3									
	Groote Schuur Hospital	8.5	Cape Town	Upgrade of the Emergency Centre				100			2,000	5,500	400
	Oudtshoorn Hospital	8.3	Oudtshoorn	New Emergency Centre									1,000
	Robertson Hospital	8.3	Breede Rivier/ Winelands	New EC and new wards									
	Stellenbosch Hospital	8.3	Stellenbosch	New Emergency Centre									600
	Swellendam Hospital	8.3	Swellendam	New Emergency Centre									600
	Tyberberg Hospital	8.5	Cape Town	Upgrade security (electronic surveillance system) phase 1									1,000
	Tygerberg FPS	8.6	Cape Town	Forensic laboratory: additional refrigeration, dissection and accommodation									2,000
	Victoria hospital	8.3	Cape Town	New Emergency Centre							100	1,500	21,000

NO	PROJECT NAME	PROG.	MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
	Worcester CDC	8.1	Breede Valley	Extension for Dental clinic									538
	Grabouw CDC	8.1	Theewaterskloof	Upgrade & extension (co-sponsor French Government)							2,109		
	Tygerberg Hospital	8.5	Cape Town	EC Upgrade			1,140	11,000					
	Groote Schuur Hospital	8.5	Cape Town	Master Plan			-	1,000					
Total upgrades and additions					**9,017**	**66,352**	**76,729**	**98,347**			**115,213**	**106,964**	**46,638**
3	**Rehabilitation, renovations and refurbishments (R thousand)**												
	Worcester Hospital	8.4	Drakenstein	Phase 3 Upgrade	38,700	6,500	4,000	200					
	George hospital	8.4	George	Hospital upgrade phase 3	2,500	18,800	30,280	18,924			5,400		
	Paarl hospital	8.4	Drakenstein	Hospital upgrade	77,800	119,130	81,000	3,000					
	Paarl TC Newman CHC	8.1	Drakenstein	Community health center upgrade	99		20,000	550					
	Vredenburg hospital	8.3	Saldanha Bay	Upgrading phase 2A	700	15,300	16,000	4,600					
	Worcester hospital phase 4	8.4	Breede Valley	Hospital upgrade phase 4		4,912	30,000	9,000					
	Valkenberg hospital	8.4	Cape Town	Hospital upgrading		-	2,500	26,850			50,533	190,000	150,000
	Vredenburg hospital	8.3	Saldanha Bay	Upgrading phase 2B	2,000	2,400	5,000	20,000			83,192	25,000	408
	Brooklyn Chest Hospital	8.4	Cape Town	Extensions & Upgrades							5,000	40,000	30,000
	Vredenburg hospital	8.3	Saldanha Bay	Health Technology			1,224	676			2,000	5,000	
	Vredenburg hospital	8.3	Saldanha Bay	OD and QA			1,299	1,671			1,300	1,300	
	Worcester Hospital	8.4	Breede Valley	Health Technology			8,175	17,000				5,000	
	Tygerberg Hospital	8.5	Cape Town	OD and QA			1,820	1,820			1,820	850	
	Valkenberg hospital	8.4	Cape Town	Health Technology									
	Valkenberg hospital	8.4	Cape Town	OD and QA									
	Worcester Hospital	8.4	Breede Valley	OD and QA			2,543	1,476			3,748		
	Paarl hospital	8.4	Drakenstein	New Psychiatric Unit				1,401			10,000		
	Mitchells Plain	8.6	Cape Town	Laundry Upgrade				1,000			65,000	10,500	
	Worcester Hospital phase 5	8.4	Breede Valley	Hospital upgrade phase 5				2,500			25,000	4,500	-
	George hospital	8.4	George	Health Technology			11,844	11,938					
	George hospital	8.4	George	OD and QA			2,701	1,740			500		
	HRP Unit	8.6	Cape Town	Head Office			5,500	6,258			6,050	6,655	6,655
	Paal Hospital	8.4	Drakenstein	OD and QA			22,499	1,839			1,000		
	Paarl hospital	8.4	Drakenstein	Health Technology			3,545	16,332					
	Tygerberg Hospital	8.5	Cape Town	Health Technology			180	180			180		
Total rehabilitation, renovations and refurbishments					**121,799**	**167,042**	**250,110**	**148,955**			**260,723**	**288,805**	**451,063**

NO	PROJECT NAME	PROG.	MUNICIPALITY	OUTPUTS	OUTCOME			MAIN APPRO PRIATION	ADJUSTED APPRO PRIATION	REVISED ESTIMATE	MEDIUM TERM ESTIMATES		
					2008/09	2009/10	2010/11	2011/12			2012/13	2013/14	2014/15
4	**Maintenance and repairs**												
	(R thousand)												
	Schedule Maintenance												
	Community Health facilities	8.1		Maintain Serviceability				17,117			17,630	18,688	18,688
	Emergency Medical Services	8.2		Maintain Serviceability				2,853			2,938	3,115	3,115
	District Hospitals	8.3		Maintain Serviceability				18,543			19,099	20,245	20,245
	Provincial Hospitals	8.4		Maintain Serviceability				34,233			35,260	37,376	37,376
	Central Hospitals	8.5		Maintain Serviceability				62,761			64,644	68,523	68,523
	Other Facilities	8.6		Maintain Serviceability				7,132			7,347	7,786	7,786
	Maintenance Preventative for new health facilities												
	Community Health facilities	8.1		Maintain Serviceability							2,000	3,000	3,000
	Emergency Medical Services	8.2		Maintain Serviceability							1,000	1,500	1,500
	District Hospitals	8.3		Maintain Serviceability							4,000	10,000	10,000
	Provincial Hospitals	8.4		Maintain Serviceability							2,965	3,965	3,965
	Central Hospitals	8.5		Maintain Serviceability									
	Other Facilities	8.6		Maintain Serviceability							1,500	2,000	2,000
Total Maintenance and repairs								**142,639**			**158,383**	**176,198**	**176,198**
Infrastructure Transfers Capital													
	Red Cross Hospital	8.5	Cape Town	Various Projects			10,225	5,150			3,000	10,320	5,150
Total Infrastructure Transfers Capital							10,225	5,150			3,000	10,320	5,150

CONDITIONAL GRANTS

Table C2: Conditional grants

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Outputs
Infrastructure Grant to Provinces	To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in education, roads, health and agriculture; to enhance the application of labour intensive methods in order to maximise job creation and skills development as encapsulated in the Expended Public Works Programme (EPWP) guidelines; and to enhance capacity to deliver infrastructure.	Delivery of infrastructure in accordance with the Schedules provided for Programme 8	Quality and quantity of serviceable education, health and roads infrastructure Comprehensive 5-10 year Infrastructure Plans and User Asset Management Plans (U-AMPs) Comprehensive monthly and quarterly reports showing progress on infrastructure projects
Hospital Revitalisation Grant [HRP]	To provide funding to enable provinces to plan, manage, modernise, rationalise and transform the infrastructure, health technology, monitoring and evaluation of hospitals; and to transform hospital management and improve quality of care in line with national policy objectives.	Delivery of infrastructure in accordance with the Schedules provided for Programme 8	All hospital projects shall be implemented according to the approved annual Project Implementation Plan
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.	Number of NTSG funded clinical tertiary services provided	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.	Number of Higher Education Institutions receiving accesses the health platform with service costs funded by the HPTDG to train health science students.	Three HEI's (US, UWC, UCT)
Comprehensive HIV and AIDS	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 cots and health system strengthening.	Number of facilities operating as Antiretroviral treatment (ART) service points	175
		Number of registered ART patients	116,345
		Number of new ART patients	26,658
		Percentage of hospitals offering Post exposure Prophylaxis services	100%
		Prevention of Mother to Child Transmission rate	3.0%
		Programme Management: Number of quarterly output reports submitted in time	4
		Regional Training Centre: Number of quarterly output reports submitted in time	4
		Number of usable beds at Step Down Units	304
		Percentage of clients tested for HIV to those counselled (excluding antenatal)	91%

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Outputs
Forensic Pathology services Grant	To establish a Forensic Pathology Service that is effective, efficient and rendered in accordance with the statutory requirements by implementing a new Forensic Pathology Service as per policy and legal requirements (Code and Regulations).	Average Turn-around time from receipt of body to hand-over in days	≤5,50 days
		Average response time from receipt of call to arrival on scene in minutes	≤40 minutes
		Average Turn-around time from admission to post-mortem done in days	≤3,50 days
		Number of response vehicles	44
		Maintain the number of unidentified persons exceeding 90 days below 125	≤125
		Achieve 97.5% of approved posts filled	97.5%
		Number of facilities upgraded, under construction or built	6

Note:
UCT: University of Cape Town
US : University of Stellenbosch
UWC: University of the Western Cape

2. PUBLIC PRIVATE PARTNERSHIPS

Table C.3: 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 Help Desk, 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.	46 408	28 February 2019	Partnership Management Plan; Governance Structures; PPP agreement; Performance indicators; Patients and other stakeholder satisfaction; Knowledge management systems

ANNEXURES

ANNEXURE A

UPDATED STRATEGIC OBJECTIVES PER PROGRAMME

PROGRAMME 1: ADMINISTRATION

1. 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 removed 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	Baseline			Justification	Links
			Strategic Objective Baseline Measure	2009/10	2014/15		
Ensure and maintain organisational strategic management capacity and synergy.	To have an effective and efficient and skilled workforce.	To provide sufficient staff with appropriate skills per occupational group.	Number of medical officers per 100 000 people Numerator: Denominator:	32.73 1 844 5 634 323	29.2 1 787 6 119 435	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
			Number of professional nurses per 100 000 people Numerator: Denominator:	92.31 5 201 5 634 323	85.8 5 252 6 119 435		
			Number of pharmacists per 100 000 people Numerator: Denominator:	5.93 334 5 634 323	5.42 332 6 119 435		
1. Ensure a sustainable income to provide the required health services.	1.1. Promote efficient financial resource use.	*1.1.1. The development and maintenance of a financial efficiency programme to ensure under/over spending is within 1% of the annual allocated budget throughout the reporting periods.*	1) *Percentage under /over spending of the annual allocated budget*	*1%* *10. 556 bn / 10. 463 bn*	*1%* *13. 424bn/ 13. 559 bn*	*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*
		Promote sound financial governance and management to ensure the under/over spending of the annual equitable share is within 1% of the budget allocation.	Percentage expenditure of the annual equitable share budget allocation Numerator: Denominator:	100.3% 7 519 280 7 489 777	100% 11 724 698 11 724 698	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

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Strategic Objective Baseline Measure	2009/10	2014/15		
2. Develop and maintain a capacitated workforce	*2.1.* Develop and maintain a comprehensive human resource plan for the Department.	*2.1.1. To determine the educational qualifications and experience of 98% of the current staff by conducting a skills analysis by 2014/15.*	*2) Percentage of occupational skills analysis completed for all staff.*	*31%* *8 883/ 28 656*	*98%* *28 082/ 28 656*	*The assessment of whether staff are in possession of the necessary skills and competencies to successfully perform the functions linked to their post and for managers to have a common understanding of the set of competencies and skills that are core to the department.*	*DPSA - HR Plan* *Ten Point Plan:* • *Improve Human Resources* *Maximising health outcomes* *Comprehensive Service Plan*
		Strengthen human resource capacity to enhance service delivery by implementing, reviewing and amending the departmental Human Resource Plan on an annual basis.	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
	2.2. Ensure optimal staffing levels within the finance components at Head Office.	*2.2.1. Ensure a 97% filled post rate within the finance components at Head Office throughout the reporting periods.*	*3) Percentage of filled finance posts at head office.*	*88 %*	*97 %*	*To increase capacity within the finance components to support sound financial management practices.*	
3. *Ensure organisational strategic management capacity and synergy.*	*3.1. To implement and maintain the organisational post structures of the CSP.*	*3.1.1. Ensure the implementation and maintenance of 147 organisational and post structures aligned to the CSP by 2014/15.*	*4) Number of organisational and post structures implemented by 2014/15.*	*65*	*147*	*To ensure greater accountability, organisational and managerial effectiveness.*	*Ten Point Plan:* • *Provision of strategic leadership;* • *Overhauling the health system* *Guidelines of the Medical Control Council* *PFMA* *National Treasury Regulations* *Provincial Treasury Instructions*
	3.2. An effective and viable departmental website.	*3.2.1. Revitalisation and maintenance of the official website to increase optimal usage of site by 2014/15.*	*5) Number of Chief Directorates' policies and practices posted on the department's official website.*	*0*	*8*	*To ensure an effective and viable departmental website to serve as the primary source of communication and departmental information, policies and practices.*	
	3.3. Provide an effective financial compliance reporting tool.	*3.3.1. Ensure that 63 institutions report monthly on the financial compliance to the departmental predetermined list which addresses the shortcomings identified by the Auditor-General.*	*6) Number of institutions submitting monthly finance compliance reports.*	*40*	*63*	*To ensure adherence to the legislative requirement imposed on the department.*	*Preferential Procurement Policy Framework Act* *Comprehensive Service Plan*

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Strategic Objective Baseline Measure	2009/10	2014/15		
	3.4. Ensure optimum pharmaceutical stock levels.	*3.4.1. Maintain a 93% stock availability rate at Cape Medical Depot {CMD] during each reporting period.*	*7) Percentage of pharmaceutical stock availability at the CMD.*	*93%*	*93%*	*To ensure pharmaceutical stock levels meet demand.*	
	3.5. Raise Supply Chain Management to a level 3 compliance.	*3.5.1. Ensure the policy maintenance of the Accounting Officers System (AOS) by end April of each reporting period.*	*8) Provision of the Accounting Officers System policy.*	*1*	*1*	*To ensure all institutions are in possession of the departmental procurement and provisioning policy*	
		3.5.2. Development and maintenance of a Procurement Plan for minor and major assets by end April of each reporting period.	*9) Provision of a Procurement Plan.*	*1*	*1*	*To align the procurement of minor and major assets to the budget and programme deliverables.*	
		3.5.3. Ensure that the 59 sites registered on the LOGIS or SYSPRO system account for all assets by performing monthly reconciliation reports throughout the reporting periods.	*10) Number of registered sites performing asset reconciliation reports.*	*59*	*59*	*To ensure all sites are in possession of an up-to-date asset register and all expenditure on assets is recorded.*	
	3.6. Co-ordinate, integrate and provide health information to the department.	*3.6.1. Improve the integrity of performance data by ensuring a 99% submission rate of prioritised data by 2014/15.*	*11) Data submission rate of prioritised data used.*	*85% (11 760/ 13 836)*	*99% (13 698/ 13 836)*	*Optimal use of information and information technology to effectively support the strategic objectives of the department.*	*Ten Point Plan:* • *Overhaul the health system and improve its management*
4. *Ensure the provision of infrastructure that meets the needs of current and future development.*	*4.1. Infrastructure to support workforce development.*	*4.1.1. 98% implementation of the Health Information System (HIS) at all contracted hospitals by 2014/15.*	*12) Percentage of hospitals where the HIS has been implemented.*	*68% (28/41)*	*98% (40/41)*		
5. *To improve the quality of health services.*	*5.1. The institutionalisation and integration of Quality Improvement (QI) at all levels of care in line with National and Provincial Departmental objectives and initiatives.*	*5.1.1. The institutionalisation and integration of QI across all levels of care reflected by the timeous submission of composite reports on consumer and technical quality.*	*13) Number of organisational structures (APH, central hospitals, districts, CD: Regional Hospitals and EMS) submitting composite QI reports.*	*6*	*12*	*To ensure an improved quality of service at health facilities.*	*Ten Point Plan:* • *Improve the quality of health services*

Table 1.1: REVISED 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.	1) Number of medical officers per 100 000 people	32.73	29.2	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		
			Denominator:	5 634 323	6 119 435		
			2) Number of professional nurses per 100 000 people	92.31	85.8		
			Numerator:	5 201	5 252		
			Denominator:	5 634 323	6 119 435		
			3) Number of pharmacists per 100 000 people	5.93	5.42		
			Numerator:	334	332		
			Denominator:	5 634 323	6 119 435		
2. Ensure a sustainable income to provide the 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	11 724 698		
			Denominator:	7 489 777	11 724 698		
3. Develop and maintain a capacitated workforce	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

4. 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 removed 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 Title	Strategic Objective Statement	Baseline			Justification	Links
			Strategic Objective Baseline Measure	2009/10	2014/15		
1. Manage the burden of disease.	1.1. Increase access to PHC services in the DHS in the Western Cape.	*1.1.1. Achieve a PHC utilisation rate of 3.84 visits per person per annum by 2014/15.*	*1) Utilisation rate – PHC*	*2.96 headcounts per person per annum*	*3.84 headcounts per person per annum*	*This is in line with the Comprehensive Service Plan to ensure that 90% of all first contacts are seen in the District Health System.*	*MTSF Focus area:* • *Increase life expectancy* • *HIV and AIDS* • *TB caseload* *NDOH Ten Point Plan:* • *Improve quality of health services* • *Mass mobilistation for the better health of the people.* *Provincial priority:* • *Maximise health outcomes.*
		Achieve a PHC utilisation rate of 3.0 visits per person per annum by 2014/15.	Utilisation rate – PHC Numerator: Denominator:	3.0 1 844 5 634 323	3.0 1 787 6 119 435		
	1.2. Ensure access to acute services/district hospitals.	1.2.1 *Establish 2 673 acute district hospital beds in district hospitals in the DHS by 2014/15.*	*2) Number of beds in district hospitals*	*2 452 beds in district Hospitals*	*2673 beds in district hospitals the DHS*		
	Increase access to acute services /district hospital services in the DHS in the Western Cape.	Establish 2 673 acute district hospital beds in the DHS by 2014/15.	Number of beds in district hospitals	2 464	2673		
	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.	*3) HIV prevalence in women aged 15 – 24 years*	*15% in 2004 (peak)*	*8%*	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.
			HIV prevalence in women aged 15 – 24 years Numerator Denominator	10.9% 545 4 405	8% 360 4 500		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Strategic Objective Baseline Measure	2009/10	2014/15		
	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*	*38.8 per 1 000 live births (2007)*	*30 per 1 000 live births (1990 baseline to verified)*	*Children and youth are priority vulnerable groups.*	*MDG to reduce child mortality* *MTSF Focus area:* • *Reduce child mortality* *NDOH Ten Point Plan: 7:* • *Mass mobilisation for better health of the population.* *Provincial priority:* *Maximise health outcomes*
			Under-5 mortality rate	38.6 per 1 000 live births (2007)	30 per 1 000 live births (1990 baseline to verified)		
			Numerator:	334	332		
			Denominator:	5 634 323	6 119 435		
	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.	5) *Maternal mortality rate*	*98 per 100 000 live births*	*90 per 100 000 live births (1990 baseline to be verified)*	Women are s priority vulnerable group.	MDG to improve maternal health MTSF Focus area: • Decrease the maternal mortality ratio. NDOH Ten Point Plan: 7: • Mass mobilisation for better health of the population. Provincial priority: Maximise health outcomes
			Public health facility maternal mortality rate	103 per 100 000 live births	27 per 100 000 live births		
			Numerator	100	27		
			Denominator	97 185	99 685		
	1.6 Preparation for the dealing with epidemics and disasters.	1.6.1 Ensure that all districts have plans to deal with outbreaks and epidemics.	Malaria fatality rate (annual)	0%	0%		
			Numerator	0	0		
			Denominator	62			
	1.7 Chronic disease management	1.7.1 Increase cataract surgery rate.	Cataract surgery rate (annual)	1 132 per 1 million population	1 500 per 1 million population		
			Numerator	6 022	9 361		
			Denominator	5 321 416	6 240 702		
2. Ensure a sustainable income to provide the required District Health Services	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 R950 per uninsured person by 2015 (in 2008/09 rands).*	6) *Provincial PHC expenditure per uninsured person*	*R850*	*R950*	Allocation of sufficient funds is required to ensure the delivery of the full package of PHC services.	MTSF Focus area: • Health system effectiveness Provincial priority: • Maximising health outcomes. Department: • Aligned with the CSP.

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Strategic Objective Baseline Measure	2009/10	2014/15		
		Achieve a primary health care (PHC) expenditure of R450 per uninsured person by 2015 (in 2009/10 rands).	Provincial PHC expenditure per uninsured person Numerator Denominator	R406 1 786 006 483 4 396 294	R450 2 190 743 550 4 868 319		
	2.2 *Allocate sufficient funds to ensure access to and the sustained delivery of the full package of quality District Hospital Services by 2014*	2.2.1 *Achieve a provincial district hospital expenditure of R365 per uninsured person by 2015 (in 2008/09 rands).*	7) *Expenditure per patient day equivalent [PDE] in district hospitals*	R271	R365	Allocation of sufficient funds is required to ensure the delivery of the full package of DH services.	
	Allocate sufficient funds to ensure access to the full package of quality district hospital services by 2014/15.	Achieve a district hospital expenditure of R1 650 per PDE by 2014/15 (in 2009/10 rands).	Expenditure per patient day equivalent [PDE] in district hospitals Numerator Denominator	R1 330 1 312 166 986 481	R1 650 1 824 456 150 1 105 731		
3. Ensure quality assurance	3.1 *Improve clinical governance in all six districts by employing Family Medicine Specialists and Family Medicine Registrars.*	3.1.1 *Employ 37 Family Medicine Specialists and 80 Family Medicine Registrars to work within the district health system.*	8) *Family medicine specialists and family medicine registrars appointed*	*16 Family Physicians and 50 Registrars*	*37 Family Physicians and 80 Registrars*	*Continuous improvement in the quality of care provided on the DHS platform.*	*MTSF Focus area:* • *Health system effectiveness* *NDOH Ten Point Plan, 3:* • *Improve the quality of health services* *Provincial priority:* • *Maximising health outcomes.* *Department:* *Aligned with the CSP.*
4. Improve the quality of health services.	4.1 Improve the experience of clients utilising district hospital services.	4.1.1 Achieve an 80% client satisfaction rate by 2014/15.	9) Percentage of district hospitals with monthly mortality and morbidity meetings. Numerator Denominator	73.5% 25 34	100% 34 34		

Table 2.2: REVISED 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.	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.	1) Utilisation rate – PHC Numerator Denominator	3.0 15 848 973 5 321 416	3.0 18 722 105 6 240 702	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.	2) Number of beds in district hospitals	2 464	2 673	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.	3) HIV prevalence in women aged 15 – 24 years Numerator Denominator	10.9% 545 4 405	8% 360 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.
	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.	5) Public health facility maternal mortality rate Numerator Denominator	103 per 100 000 live births 100 97 185	27 per 100 000 live births 27 99 685	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	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 Preparation for the dealing with epidemics and disasters.	1.6.1 Ensure that all districts have plans to deal with outbreaks and epidemics.	6) Malaria fatality rate (annual) Numerator Denominator	0% 0 62	0% 0		
	1.7 Chronic disease management	1.7.1 Increase cataract surgery rate.	7) Cataract surgery rate (annual) Numerator Denominator	1 132 per 1 million population 6 022 5 321 416	1 500 per 1 million population 9 361 6 240 702		
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1 Allocate sufficient funds to ensure access to and the sustained delivery of the full package of quality PHC services by 2014.	2.1.1 Achieve a primary health care (PHC) expenditure of R450 per uninsured person by 2015 (in 2009/10 rands).	8) Provincial PHC expenditure per uninsured person Numerator Denominator	406 1 786 006 483 4 396 294	450 2 190 743 550 4 868 319	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.
	Allocate sufficient funds to ensure access to the full package of quality district hospital services by 2014/15.	a. Achieve a district hospital expenditure of R1 650 per PDE by 2014/15 (in 2009/10 rands).	9) Expenditure per patient day equivalent [PDE] in district hospitals Numerator Denominator	1 330 1 312 166 986 481	R1 650 1 824 456 150 1 105 731	Allocation of sufficient funds is required to ensure the delivery of the full package of DH services.	
3. Improve the quality of health services.	3.1 Improve the experience of clients utilising district hospital services.	3.1.1 Achieve an 80% client satisfaction rate by 2014/15.	10) Percentage of district hospitals with monthly mortality and morbidity meetings. Numerator Denominator	73.5% 25 34	100% 34 34		

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

1. 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 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	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
1. Manage the burden of disease.	*1.1 Integration of quality assurance into all levels of care*	*1.1.1 To improve quality and decrease adverse patient incidents to 10 per annum by the institution of staff surveys, patient surveys, adverse incident reporting and a quality management structure by 2014.*	*1) Number of adverse incidents per annum*	*>20*	*10*	*Quality patient care is a fundamental outcome of the service and quality improvement can only be effected if quality measurement is in place.*	***NDOH Ten Point Plan*** • *Improving the Quality of Health Services*
	1.2 Fully implement the Comprehensive Service Plan model by 2014.	*1.2.1 To complete the implementation of the Comprehensive Service Plan by operationalising the EMRS resources (542 vehicles, 54 bases and 2366 personnel) necessary to the specified service levels of 156 rostered ambulances per hour in the CSP by 2014.*	*2) Number of rostered ambulances*	*126*	*156*	*Service levels specified in the CSP can only be met by the implementation of the full resource complement.*	***NDOH Ten Point Plan*** • *Overhauling the Healthcare System and improve its management*
			Numerator	*2 207 520*	*2 733 120*		
			Denominator	*17 520*	*17 520*		
			Rostered ambulances per 10 000 people	0.47	0.25		
			Numerator	251	156		
			Denominator	551	611		
	1.3 Manage all patients at the appropriate level of care within the appropriate packages of care	*1.3.1 To meet the patient response, transport and inter hospital referral needs of the Department in line with the 90:10 CSP Model by realigning the configuration (proportion of emergency versus non emergency resources) of the EMRS Service by 2014*	*3) Percentage of ambulance patients transfer facilities*	461 940	*10%*	*In order to support service levels of the CSP patients must be managed at the appropriate level of care and have access to required levels of care.*	***NDOH Ten Point Plan*** • *Overhauling the Healthcare System and improve its management*
	1.4 Efficiently and effectively manage chronic diseases.	*1.4.1 To meet the appropriate outpatient transfer needs of 10 000 patients through the intra-district and trans-district HealthNET Transport System ensuring that patients are managed at the appropriate level of care by 2014.*	*4) Number of patients transferred to tertiary level hospitals per annum.*	*36000*	*10000*	*All clients must have access to appropriate levels of care and be assured of access in appropriate time frames.*	***NDOH Ten Point Plan*** • *Overhauling the Healthcare System and improve its management*

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
	1.5 Provide roadside to bedside definitive emergency care within defined emergency time frames within and across geographic and clinical service platforms.	1.5.1 To meet the response time performance for urban (90% P1 Within 15 Min) and rural (90% P1 within 40 min) clients and ensure the shortest time to definitive care by integrated management of pre-hospital and hospital emergency care resources by 2014.	5) Percentage of urban Priority 1 responses within 15 minutes	40.1%	65%	Emergency Care is a Constitutional and legal imperative.	Millenium Development Goals • Reduce Child Mortality • Improve Maternal Health • Emergency Care is a Constitutional and legal imperative Provincial priority**:** • Maximise health outcomes
			Numerator	39 320	94 590		
			Denominator	95 231	105 000		
			6) Percentage of rural Priority 1 responses within 40 minutes	79.2%	80%		
			Numerator	7 050	7 272		
			Denominator	8 907	9 090		
	1.6 Institute Trauma and Violence Prevention Programs	*1.6.1 To initiate a trauma and violence prevention program in Cape Town and each of the five rural Districts by 2014.*	*7) Number of prevention programs initiated.*	*0*	*6*	*Trauma and violence is the greatest proportion of disease burden and cost in the Western Cape*	
	1.7 Manage all patients at the appropriate level of care within the appropriate packages of care.	1.7.1 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,	8) Percentage of ambulance patients transferred between facilities	27.5%	10%	Monitor measures introduced to facilitate improved access to health services.	Millenium Development Goals • Reduce Child Mortality • Improve Maternal Health Negotiated Service Delivery Agreement: • Increasing life expectancy • Decreasing maternal and child mortality • Strengthening health system effectiveness. Provincial priority: Increasing wellness.
			Numerator	127 033	45 600		
			Denominator	461 940	456 000		
	1.8 Efficiently and effectively manage chronic diseases.	1.8.1 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,	9) Number of outpatients transferred by HealthNET to regional and central hospitals	113 830	91 650		
2. Ensure and maintain organizational strategic management capacity and synergy	*2.1 Develop integrated support and management structures to render effective clinical service.*	*2.1.1 To ensure the integrated management of emergency clients through competent EMRS and Support Managers and the institution of 5 geographic cooperative emergency care management structures by 2014.*	*10) Number of Emergency Medicine Specialist led cooperative geographic structures operational out of 5 geographic areas*	*2*	*5*	*Competent and effective management is fundamental to effective and efficient delivery of services*	***NDOH Ten Point Plan*** • *Overhauling the Healthcare System and improve its management* • *Improvement of Human Resources* • *Provision of Strategic Leadership and the creation of Social Compact for better Health outcomes*
		2.1.2 To achieve a qualification of Certificate in Management for 100 shift and station managers by 2014.	*11) Number of supervisors with a certificate in management.*	*0*	*100*	*Management and Supervisory Capacity is fundamental to the coordination of the dispersed EMS resources*	

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
		2.1.3 To achieve an HRM Clerk, Finance Clerk, Reception Clerk, Information Clerk and Admin clerk in each of 9 District/Divisional structures by 2014.	12) *Number of support clerks appointed out of 36.*	*9*	*36*	*Administrative support of EMS structures is fundamental to administrative process.*	
	2.2 Ensure efficient and cost effective procurement	*2.2.1 To complete the institution of EMRS Supply Chain Management structures and systems (LOGIS, personnel, administration, training) necessary to the continuous supply and maintenance of EMRS equipment by 2014,*	13) *Number of districts that can electronically requisition goods and services.*	*0*	*6*	*An efficient Supply Chain in support of clinical services is essential.* *Audit and control is facilitated by SCM Systems.*	
3. Develop and maintain a capacitated workforce to deliver the required health services.	*3.1 Implement the Human Resource Plan*	*3.1.1 To recruit, train and deploy all 2366 staff necessary to achieving service levels in the CSP by 2014.*	14) *The percentage of CSP personnel out of 2366 Appointed*	*73%*	*100%*	*People make up 68% of expenditure in EMRS and quality of care depends on motivated personnel.* *Performance targets can only be achieved by appropriate staffing levels.*	***NDOH Ten Point Plan*** • *Improvement of Human Resources*
	3.2 Become the employer of choice in the health sector by creating an environment for a satisfied workforce.	*3.2.1 To develop a positive attitude and motivation in 80% of operational staff by instituting the good quality facilities, squad system, providing squad leadership, quality uniforms, training and development, quality equipment and vehicles, acknowledgement and rewards by 2014,*	15) *Percentage of personnel surveyed with a positive attitude and motivation.*	*0*	*80%*	*Salaries and the working environment are important to the retention of staff.*	***NDOH Ten Point Plan*** • *Improvement of Human Resources*
		3.2.2 To imbed an Occupational Health and Safety Structure in EMS with a dedicated OHS Officer in each of the 9 Districts/Divisions by 2014,	16) *Number of OHS Officers appointed*	*0*	*9*	*Safety is the First Rule of Emergency Response*	
4. Provide and maintain appropriate health technology and infrastructure.	*4.1 To provide responsive and appropriate information technology for the Department*	*4.1.1 To institute a comprehensive Information Communication Technology Solution for EMRS in Cape Town and the Five Rural Districts integrated with Hospital Emergency Centres to provide reliable, real time and accurate data in order to meet target emergency care outcomes (response times) by 2014.*	17) *Number of districts out of six with fully functional ICT solution.*	*0*	*6*	*Management information is essential to inform changes to improve efficiency and effectiveness*	***NDOH Ten Point Plan*** • *Research and Development*

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
5. Ensure a sustainable income to provide the required health services according to the needs	*5.1 Augment the funding streams for health services*	*5.1.1 To institute 6 sponsorship, branding and business relationships that provide additional funding streams for EMRS in order to achieve quality service levels by 2014.*	18) *Number of projects delivering sponsorship.*	*0*	*6*	*Current levels of equitable share funding do not meet the needs of the CSP and therefore collateral income streams are required.*	***NDOH Ten Point Plan*** • *Improving the Quality of Health Services.*

Indicator 2: 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. Manage the burden of disease.	1.1. Fully implement the Comprehensive Service Plan model for EMS by 2014.	1.1.1. To complete the implementation of the Comprehensive Service Plan by operationalising the EMRS resources (542 vehicles, 54 bases and **2 366** personnel) necessary to the specified service levels of 156 rostered ambulances per hour in the CSP by 2014.	1) Rostered ambulances per 10 000 people	0.47	0.25	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	156		
			Denominator	551	611		
	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.	2) Percentage of urban Priority 1 responses within 15 minutes	40.1%	65%	Emergency Care is a Constitutional and legal imperative.	
			Numerator	39 320	94 590		
			Denominator	95 231	105 000		
			3) Percentage of rural Priority 1 responses within 40 minutes	79.2%	80%		
			Numerator	7 050	7 272		
			Denominator	8 907	9 090		
	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.	4) Percentage of ambulance patients transferred between facilities	27.5%	10%	Monitor measures introduced to facilitate improved access to health services.	
			Numerator	127 033	45 600		
			Denominator	461 940	456 000		
	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.

PROGRAMME 4: PROVINCIAL HOSPITALS

1. 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 removed 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	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
1. Manage the burden of disease.	1.1 Ensure access to general specialist hospital services.	*1.1.1 Ensure access to regional hospital services by providing 2 384 regional hospital beds by 2014.* *[Sub-programme 4.1]*	*1) Number of regional hospital beds*	*2 362*	*2 384*	• 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.	National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Maximising health outcomes Departmental priority: Comprehensive Service Plan
		Ensure access to regional hospitals services by providing 1 340 regional hospital beds by 2014.	Number of regional hospital beds	2 364	1 340		
	1.2 Ensure access to TB hospital services.	*1.1.2 Ensure access to the full package of TB hospital services by providing 1 284 TB hospital beds by 2014.* *[Sub-programme 4.2]*	*2) Number of TB hospital beds*	*1 020*	*1 284*	• 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.
		Ensure access to the full package of TB hospital services by providing 1 284 TB hospital beds by 2014.	Number of TB hospital beds	1 016	1 284		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
	1.3 Ensure access to psychiatric hospital services.	*1.1.3 Ensure access to the full package of psychiatric hospital services by providing 1 528 psychiatric hospital beds by 2014. [Sub-programme 4.3]*	3) *Number of psychiatric hospital beds*	*1 745*	*1 528*	• 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: Maximising health outcomes Departmental priority: Comprehensive Service Plan
		Ensure access to the full package of psychiatric hospital services by providing 1 528 psychiatric hospital beds by 2014.	Number of psychiatric hospital beds	1 792	1 528		
	1.4 Ensure access to rehabilitation services.	*1.1.4 Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014. [Sub-programme 4.4]*	4) 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 Provincial priority: Maximising health outcomes Departmental priority: Comprehensive Service Plan
		Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014.					
		1.1.5 Ensure access to an integrated oral health service and training platform by providing for 185 454 patient visits per annum by 2014 [Sub-programme 4.5]	5) *Number of oral health patient visits per annum*	*179 120*	*185 454*	• 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.	
		Ensure access to an integrated oral health service and training platform by providing for 185 454 patient visits per annum by 2014	Number of oral health patient visits per annum	175 200	185 454		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
	1.2 Reduce maternal mortality.	*1.2.1 Perform appropriate clinically indicated caesarean sections in regional hospitals to ensure improved outcomes and safety for mothers and babies*	6) *Caesareans section rate for regional hospitals (Number of Caesarean sections/ Deliveries)*	*35%*	*35%*	• Ensure an improved health outcome for mothers and babies.	Millennium development goal 5 (MDG):Improve maternal health National Department of Health Ten Point Plan: • Improve the quality of health services Provincial priority: Maximising health outcomes
	Reduce facility maternal mortality.	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.	Caesarean section rate for regional hospitals Numerator Denominator	32.5% 8 425 25 961	35% 5 127 14 426		
	1.3 Provide roadside to bedside definitive emergency care	*1.3.1 Improve access to emergency services and improving the quality of care and the interface between the emergency services and the admitting hospital*	7) *Casualty/ Emergency Trauma headcount*	*296 716*	*312 332*	• *Ensure compliance with the Acute Emergency Case Load Management Policy (AECLM) with specific focus on bed management improving the throughput in the emergency centres to definite care.* • *Emergency care is a national constitutional provision and therefore has to be prioritised.*	*National Department of Health Ten Point Plan:* • *Improve the quality of health services* *Provincial priority: Maximising health outcomes*
	1.4 Improve quality of care at all levels of care	*1.4.1 Implement and maintain quality assurance measures in regional and specialist hospitals to minimize patient risk by performing monthly mortality and morbidity meetings to monitor the quality of hospital services as reflected in the acuity of diseases, adverse events and proportion of deaths for the reporting period.*	8) *Case fatality rate in regional hospitals for surgery separations (Number of surgical separations/ Number of surgical deaths)*	*3.9%*	*3.5%*	*Ensure the maintenance and constant improvement of the quality of health services by:* • *The appropriate care and treatment to patients.* • *Correct clinical outcomes are achieved, complications are minimized and protocols are enhanced for preventable events.* • *Treatment of patients with dignity and respect.* • *Creating an environment conducive to patient safety.* • *Assess how our patients experience the health services and improve on complaints/ consider their suggestions.*	*National Department of Health Ten Point Plan:* • *Improve the quality of health services* *Provincial priority: Maximising health outcomes*
		1.4.2 Perform and analyze one standardized patient satisfaction survey per annum to measure patient satisfaction in the General, TB, Psychiatric, Specialized Rehabilitation and Dental Hospitals.	9) *Percentage of regional hospitals with patient satisfaction survey using DOH template*	*100%*	*100% (8/8)*	*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: Maximising health outcomes*

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
			10) *Percentage of TB hospitals with patient satisfaction survey using DOH template*	*100%*	*100% (6/6)*		
			11) *Percentage of Psychiatric hospitals with patient satisfaction survey using DOH template*	*100%*	*100% (4/4)*		
			12) *Percentage of Rehabilitation hospitals with patient satisfaction survey using DOH template*	*100%*	*100% (1/1)*		
		1.4.3 Implement quality assurance measures to minimize patients risk in the Regional, TB, Psychiatric, Specialized Rehabilitation and Dental Hospitals by monthly mortality and morbidity meetings.	13) *Percentage of regional hospitals with mortality and morbidity meetings every month*	*100%*	*100% (8/8)*		
2. Quality of health services.	2.1 Improve the quality of health services.	2.1.1 Implement quality assurance measures to minimise patients risk in regional hospitals by monthly mortality and morbidity meetings by 2014.	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		
			14) *Percentage of TB hospitals with mortality and morbidity meetings every month*	*100%*	*100% (6/6)*		
		2.1.2 Implement quality assurance measures to minimise patient risk in TB hospitals by monthly mortality and morbidity meetings by 2014.	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		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	**2009/10**	**2014/15**		
			15) *Percentage of psychiatric hospitals with mortality and morbidity meetings every month*	*100%*	*100% (4/4)*		
		2.1.3 Implement quality assurance measures to minimise patients risk in psychiatric hospitals by monthly mortality and morbidity meetings by 2014.	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: Maximising health outcomes
			16) *Percentage of rehabilitation hospitals with mortality and morbidity meetings every month*	*100%*	*100% (1/1)*		
		2.1.4 Implement quality assurance measures to minimise patients risk rehabilitation hospitals by monthly mortality and morbidity meetings by 2014.	Percentage of rehabilitation hospitals with monthly mortality and morbidity meetings Numerator Denominator	0% 0 1	100% 1 1	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: Maximising health outcomes
2. Ensure a sustainable income to provide the required health services according to the needs.	*2.1 Allocate sufficient funds to ensure the sustained delivery of quality general specialist hospital services.*	*2.1.1 Allocate sufficient funds to ensure the effective and efficient delivery of regional hospital services at a rate of R2 629 per PDE [Constant 2008/09 rand]*	17) *Expenditure per PDE in regional hospitals*	*R1 653*	*R2 629*	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
	Allocate sufficient funds to ensure the sustained delivery of the full package of quality general specialist hospital services.	Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R2 629 per PDE by 2014. [Constant 2009/10 rand].	Expenditure per patient day equivalent [PDE] in regional hospitals Numerator Denominator	R1 626 1 709 636 442 1 051 150	R2 100 1 164 058 000 554 313		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
		2.1.2 Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R750 per PDE. [Constant 2008/09 rand]	18) *Expenditure per PDE in TB hospitals*	*R 509*	*R 750*	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.
	Allocate sufficient funds to ensure the sustained delivery of the full package of quality TB hospital services.	Allocate sufficient funds to ensure the delivery of the full package of TB hospital services at a rate of R750 per PDE by 2014. [Constant 2009/10 rand].	Expenditure per patient day equivalent [PDE] in TB hospitals Numerator Denominator	R515 157 626 336 305 833	R750 187 396 525 367 444		
		2.1.3 Allocate sufficient funds to ensure the effective and efficient delivery of the full package of psychiatric hospital services at a rate of R977 per PDE. [Constant 2008/09 rand]	19) *Expenditure per PDE in psychiatry hospitals*	*R 667*	*R 977*	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
	Allocate sufficient funds to ensure the sustained delivery of the full package of quality psychiatric hospital services.	Allocate sufficient funds to ensure the delivery of the full package of psychiatric hospital services at a rate of R977 per PDE by 2014. [Constant 2009/10 rands).	Expenditure per patient day equivalent [PDE] in psychiatric hospitals Numerator Denominator	R753 448 360 000 595 471	R850 435 297 467 512 115		
		2.1.4 Allocate sufficient funds to ensure the effective and efficient delivery of the full package of rehabilitation hospital services at a rate of R1 667 per PDE. [Constant 2008/09 rand]	20) *Expenditure per PDE in rehabilitation hospitals*	*R1 193*	*R1 667*	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
	Allocate sufficient funds to ensure the sustained delivery of the full package of quality rehabilitation hospital services by 2014.	Ensure the cost effective management of rehabilitation hospitals at a target expenditure of R1 667 per PDE by 2014. [Constant R2009/10 rands].	Expenditure per patient day equivalent [PDE] in rehabilitation hospitals Numerator Denominator	R1 945 110 461 638 56 801	R2 300 117 391 233 51 040		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
		2.1.5 *Allocate sufficient funds to ensure the effective and efficient delivery of integrated oral health services at a rate of R23.64 per uninsured person. [Constant 2008/09 rands]*	21) *Allocation per capita.[uninsured]*	*R19.79*	*R23.64*	*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*
3. *Develop and maintain a capacitated workforce to deliver the required health services.*	3.1 *Become the employer of choice in the health sector by creating an environment for a satisfied workforce*	3.1.1 *Perform and analyze one annual standardized staff satisfaction survey to measure workforce satisfaction in the General, TB, Psychiatric, Specialized Rehabilitation and Dental Hospitals.*	22) *Percentage of regional hospitals with annual staff satisfaction survey completed*	*100%*	*100% (8/8)*	• *Ensure workforce capacity across the platform to provide the planned services as reflected in the package of care* • *A satisfied and motivated staff compliment at all facilities will enhance quality of patient care*	*National Department of Health Ten Point Plan:* • *Improve the quality of health services.* • *Overhauling the health system and improving its management.* • *Improve human resources* *Provincial priority: Maximising health outcomes*
			23) *Percentage of TB hospitals with annual staff satisfaction survey completed*	*100%*	*100% (6/6)*		
			24) *Percentage of psychiatric hospitals with annual staff satisfaction survey completed*	*100%*	*100% (4/4)*		
			25) *Percentage of rehabilitation hospitals with annual staff satisfaction survey completed*	*100%*	*100% (1/1)*		
		3.1.2 *Ensure optimum staffing levels for all facilities by ensuring that 97.5% of affordable staff establishment remains filled.*	26) *The percentage of regional hospitals that have 97.5% of affordable staff establishment filled*		*100% (8/8)*		
			27) *The percentage of TB hospitals that have 97.5% of affordable staff establishment filled*	*Not reported*	*100% (6/6)*		
			28) *The percentage of psychiatric hospitals that have 97.5% of affordable staff establishment filled*	*Not reported*	*100% (4/4)*		
			29) *The percentage of rehabilitation hospitals that have 97.5% of affordable staff establishment filled*	*Not reported*	*100% (1/1)*		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
4. Ensure and maintain organisational strategic management capacity and synergy.	*4.1 Ensure that management provides sustained support and strategic direction in the delivery of health services: -* • *By the development of annual performance plans that align and integrates the Departmental objectives* • *With well defined efficiency targets.* • *Create structures across levels of care to ensure organizational synergy.*	4.1.1 Efficiently manage the allocated resources of regional hospitals to achieve a target bed utilisation rate of 85% and an average length of stay of 4 days.	30) *Bed utilisation rate in regional hospitals*	*85%*	*85%*	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence. • Minimize patient transfers between institutions.	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
	Ensure that management provides sustained support and strategic direction in the delivery of health services.		Bed utilisation rate (based on usable beds) in regional hospitals	86%	85%		
			Numerator	742 740	415 735		
			Denominator	862 860	489 100		
			31) *Average length of stay in regional hospitals*	*4 days*	*4 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: Maximising health outcomes
			Average length of stay in regional hospitals	4 days	4 days		
			Numerator	742 740	415 735		
			Denominator	185 919	103 934		
		4.1.2 Establish functional business units within provincial hospitals as a key supportive structure in ensuring that resources are adequately utilised within cost centres.	32) *Number of hospitals with fully Functional Business Units*	*Not reported*	*5*	*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* *Departmental policy*

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
		4.1.3 Efficiently manage the allocated resources of TB hospitals to achieve a bed utilisation rate of 90% and an average length of stay of 85 days.	33) *Bed utilisation rate in TB hospitals*	*78%*	*90%*	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence • Minimize patient transfers between institutions	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
			Bed utilisation rate (based on usable beds) in TB hospitals	82%	90%		
			Numerator	304 764	366 278		
			Denominator	370 840	406 975		
			34) *Average length of stay in TB hospitals*	*86 days*	*85 days*	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	
			Average length of stay in TB hospitals	81 days	85 days		
			Numerator	304 764	366 278		
			Denominator	3 693	4 309		
		4.1.4 Efficiently manage the allocated resources of psychiatric hospitals to achieve a bed utilisation rate of 85% and an average length of stay of 110 days.	35) *Bed utilisation rate in psychiatric hospitals*	*86%*	*85%*	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence • Minimize patient transfers between institutions	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
			Bed utilisation rate (based on usable beds) in psychiatric hospitals	89%	90%		
			Numerator	583 871	501 948		
			Denominator	654 080	557 720		
			36) *Average length of stay in psychiatric hospitals*	*115 days*	*90 days*	Ensure that health resources are appropriately, efficiently and effectively applied to improve the health status of patients to ensure sustainability of services.	
			Average length of stay in psychiatric hospitals	109 days	90 days		
			Numerator	583 871	501 948		
			Denominator	5 369	5 577		
		4.1.5 Efficiently manage the allocated resources of rehabilitation hospitals to achieve a bed utilisation rate of 85% and an average length of stay of 50 days.	37) *Bed utilisation rate in rehabilitation hospitals*	*85%*	*85%*	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence • Minimize patient transfers between institutions	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
			Bed utilisation rate (based on usable beds) in rehabilitation hospitals	85%	75%		
			Numerator	48 431	42 705		
			Denominator	56 940	56 940		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
			38) *Average length of stay in rehabilitation hospitals*	*52 days*	*50 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: Maximising health outcomes
			Average length of stay in rehabilitation hospitals	58 days	50 days		
			Numerator	48 431	42 705		
			Denominator	829	860		
5. Provide and maintain appropriate health technology and infrastructure.	*5.1 Ensure the provision of infrastructure that meets the needs of current and future development.*	*5.1.1 Ensure the establishment of PCU's at all institutions*	39) *Percentage of hospitals with PCU's 4.1 (5/5); 4.2 (6/6); 4.3 (4/4); 4.4 (1/1)*			*Ensure that health infrastructure is 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*
		5.1.2 Ensure 5 year plan per institution	40) *Percentage of hospitals with 5 year infrastructure plan 4.1 (5/5); 4.2 (6/6); 4.3 (4/4); 4.4 (1/1)*	*Not reported*	*100%*		

Table 4.1: REVISED 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.	1.1. Ensure access to general specialist hospital services.	1.1.1. Ensure access to regional hospitals services by providing 1 340 regional hospital beds by 2014.	1) Number of regional hospital beds.	2 364	1 340	• 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.	2) Caesareans section rate for regional hospitals	32.5%	35%	• Ensure an improved health outcome for mothers and babies.	Millennium development goal 5 (MDG): Improve maternal health.
			Numerator	8 425	5 127		
			Denominator	25 961	14 426		
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality general specialist hospital services.	2.1.1. Allocate sufficient funds to ensure the effective and efficient delivery of the full package of regional hospital services at a rate of R2 100 per PDE by 2014. [Constant 2009/10 rand].	3) Expenditure per patient day equivalent [PDE] in regional hospitals	R1 626	R2 100	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		
			Denominator	1 051 150	554 313		
3. Ensure and maintain or-ganisational strategic manage-ment 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.	4) Bed utilisation rate (based on usable beds) in regional hospitals	86%	85%	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		
			Denominator	862 860	489 100		
			5) Average length of stay in regional hospitals	4 days	4 days		
			Numerator	742 740	415 735		
			Denominator	185 919	103 934		

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.	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 4.2: 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. Manage the burden of disease.	1.1. Ensure access to TB hospital services.	1.1.1. Ensure access to the full package of TB hospital services by providing 1 284 TB hospital beds by 2014.	1) Number of TB hospital beds	1 016	1 284	• 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.	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].	2) Expenditure per patient day equivalent [PDE] in TB hospitals	R515	R510	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		
			Denominator	305 833	367 444		
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.	3) Bed utilisation rate (based on usable beds) in TB hospitals	82%	90%	• 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		
			Denominator	370 840	406 975		
			4) Average length of stay in TB hospitals	81 days	85 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		
			Denominator	3 693	4 309		
4. Quality of health services.	4.1. Improve the quality of health services.	4.1.1. Implement quality assurance measures to minimise patient risk in TB hospitals by monthly mortality and morbidity meetings by 2014.	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: 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. Manage the burden of disease.	1.1. Ensure access to psychiatric hospital services.	1.1.1. Ensure access to the full package of psychiatric hospital services by providing 1 528 psychiatric hospital beds by 2014..	1) Number of psychiatric hospital beds	1 792	1 528	• 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
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate sufficient funds to ensure the sustained delivery of the full package of quality psychiatric hospital services.	2.1.1. Allocate sufficient funds to ensure the delivery of the full package of psychiatric hospital services at a rate of R850 per PDE by 2014. [Constant 2009/10 rands).	2) Expenditure per patient day equivalent [PDE] in psychiatric hospitals	R753	R850	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		
			Denominator	595 471	512 115		
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	3) 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	**501 948**		
			Denominator	654 080	**557 720**		
			4) Average length of stay in psychiatric hospitals	109 days	**90 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	**501 948**		
			Denominator	5 369	5 577		

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.	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.	5) 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: 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. Manage the burden of disease.	1.1. Ensure access to rehabilitation services.	1.1.1. Ensure access to the full package of rehabilitation hospital services by providing 156 rehabilitation hospital beds by 2014.	1) Number of rehabilitation hospital beds	156	156	• 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.	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].	2) Expenditure per patient day equivalent [PDE] in rehabilitation hospitals	1 945	2 300	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	117 391 233		
			Denominator	56 801	51 040		
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.	3) Bed utilisation rate (based on usable beds) in rehabilitation hospitals	85%	75%	• Improve inpatient and outpatient services at the appropriate health sites, creating opportunities for clinical coherence. • Minimize patient transfers between institutions.	
			Numerator	48 431	42 705		
			Denominator	56 940	56 940		
			4) Average length of stay in rehabilitation hospitals	58 days	50 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	42 705		
			Denominator	829	854		
4. Quality of health services.	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 4.5: 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		
1.1. Manage the burden of disease.	1.2. Ensure access to dental training hospitals.	1.1.1 Ensure access to an integrated oral health service and training platform by providing for 185 454 patient visits per annum by 2014.	1) Number of oral health patient visits per annum	175 200	185 454	• 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.	

PROGRAMME 5: CENTRAL HOSPITAL SERVICES (HIGHLY SPECIALIZED)

3. 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 removed 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	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
1. Manage the burden of disease	1.1. Reduce maternal mortality due to complications during delivery.	*1.1.1. Perform appropriate 44% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.*	1) *Caesarean section rate in central hospitals*[1]	*44%* *(5 058/ 11 527)*	*44%* *(6 055/ 13 690)*	Ensure an improved health outcome for mothers and babies.	MDG 5: Improve maternal health. MTSF Focus area: • Increase life expectancy: Decrease the maternal mortality ratio NDOH Ten Point Plan, 8: • Mass mobilisation for the better health of the population. Provincial priority: • Maximising health outcomes.
		Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	Caesarean section rate in central hospitals[1] Numerator Denominator	44% 5 052 11 509	43% 5 800 13 600		
	1.2. Ensure the delivery of tertiary services to manage the burden of disease at the appropriate level of care	*1.2.1. Ensure access to tertiary services by providing 1460 tertiary beds.*	2) *Number of designated tertiary beds in central hospitals.*	*1 460*	*1 460*	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	MTSF Focus area: • Health system effectiveness NDOH Ten Point Plan: • Overhauling the health care system and improving its management. Provincial priority: • Maximising health outcomes.
	Ensure the delivery of central hospital services to manage the burden of disease at the appropriate level of care.	Ensure access to central hospital services by providing 2 536 beds.	Number of operational beds in central hospitals.	1 460	2 536		
	1.3. Ensure optimal access to highly specialised services to manage the burden of disease.	*1.3.1. Manage bed utilisation to achieve a bed utilisation rate of 85% in Central Hospitals by 2014/2015.*	3) *Bed utilisation rate (based on usable beds) in central hospitals*	*84%* *(450 000/ 1 460/ 365)*	*85%* *(460 836/ 1 460/365)*	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	
	Ensure optimal access to central hospital services to manage the burden of disease.	Efficiently manage resources to achieve the target bed occupancy rate of 84% by 2014/2015.	Bed utilisation rate (based on usable beds) in central hospitals Numerator Denominator	83% 446 411 535 820	84% 780 877 925 640		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
	1.4. Integration of quality assurance into all levels of care.	*1.4.1. Implement quality assurance measures to minimise patient risk in the 3 Central Hospitals by performing monthly morbidity and mortality meetings to monitor the quality of hospital services by 2014/15.*	*4) Number of central hospitals conducting monthly morbidity and mortality reviews*	*3*	*3*	Ensure the maintenance and constant improvement of the quality of health services.	MTSF Focus area: • Health system effectiveness NDOH Ten Point Plan: • Improve quality of health services. Provincial priority: • Maximising health outcomes.
Quality of health services.	Improve the quality of health services.	To ensure appropriate mechanisms to measure improvement in quality of health services.	Number of central hospitals with monthly mortality and morbidity meetings	3	3		
		1.4.2. Perform and analyse one annual survey to measure patient satisfaction in each of the Central Hospitals by 2014/15.	*5) Number of central hospitals that performed and annual patient satisfaction survey*	*3*	*3*	*Ensure the maintenance and constant improvement of the quality of health services.*	
		1.4.3. Implement quality assurance measures to minimise patients risk in the Central Hospitals by monthly monitoring of the surgical deaths (mortality) for the reporting period and maintaining a mortality rate of less than 4.0% for Tertiary surgical services by 2014/15.	*6) Case fatality rate in central hospitals for surgery separations*	*3.8% (806/ 21 182)*	*4.0% (920/23 100)*	*Ensure the maintenance and constant improvement of the quality of health services.*	*MTSF Focus area:* • *Health system effectiveness* *NDOH Ten Point Plan:* • *Improve quality of health services.* *Provincial priority:* • *Maximising health outcomes*
2. Ensure a sustainable income to provide the required health services according to the needs.	*2.1. Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, highly specialised services.*	*2.1.1. Increase the ICD coding of inpatient activities to 80% in central hospitals by 2014/15.*	***SO Baseline measure:*** *7) ICD 10 coding rate of 80% for inpatient activities in central hospitals by 2014/15.*	*Not reported on*	*80% 61 445/ 76 805*	*Ensure a generation of income to fund sustainable health services.*	*MTSF Focus area:* • *Health system effectiveness* *Provincial Cabinet Programmes and Priorities nr. 2*
		2.1.2. Ensure the cost effective management of central hospitals at a target cost of R5 534 per patient day equivalent by 2014/15. [Constant 2008/09 rands]	*8) Expenditure per patient day equivalent in central hospitals*	*R3 392*	*R5 534*	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: • Maximising health outcomes
	Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	Ensure the cost effective management of central hospitals at a target cost of R3 000 per patient day equivalent [Constant 2009/10 rands].	Expenditure per patient day equivalent in central hospitals Numerator Denominator	R3 733 2 335 490 820 625 661	R3 000 3 362 032 548 1 120 678		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
3. Develop and maintain a capacitated workforce to deliver the required health services.	*3.1. Have a human resource development plan in place to deliver the required package of care and manage its resources.*	*3.1.1. Ensure each central hospital has a skills development plan to develop and maintain key skills to render effective and quality health services and manage its resources by 2014/15.*	*9) Number of central hospitals with an approved annual skills development plan.*	*3*	*3*	*Develop and maintain a capacitated workforce adequately skilled to deliver the required health services*	*NDOH Ten Point Plan:* • *Improve human resources* *Provincial priority:* • *Maximising health outcomes*
	3.2. Become the employer of choice in the health sector by creating an environment for a satisfied workforce.	*3.2.1. Perform, analyse and respond to the findings of one annual standardised staff satisfaction survey to measure workforce satisfaction in the each of the central hospitals by 2014/15.*	*10) Number of central hospitals that performed a staff satisfaction survey.*	*3*	*3*	*Ensure that an appropriately skilled and capacitated workforce is sustained as a key success factor for delivering health services.*	*NDOH: Ten Point Plan,.5:* • *Improve human resources* *Provincial priority:* *Maximising health outcomes*
4. Ensure and maintain organisational strategic management capacity and synergy.	*4.1. Establish a Drug and Therapeutic committee to ensure compliance with Provincial Drug policies and participate in the review of drug policy*	*4.1.1. Ensure that a drug and therapeutic committee is established at each central hospital by 2014/15.*	*11) Number of central hospitals with an appointed Drug and Therapeutic committee.*	*3*	*3*	*Ensure the review, uniform implementation and compliance with Provincial drug policy*	*NDOH: Ten Point Plan 9:* • *Review of the drug policy.* *Provincial priority:* • *Maximising health outcomes*
	4.2. Establish a health facility board as a key supportive governance structure.	*4.2.1. An appointed, functional health facility board serves as a key interface with the community at each central hospital by 2014/15.*	*12) Number of central hospitals with an appointed health facility board*	*3*	*3*	*Improve the nation's health status and ensure cohesive and sustainable communities.*	*NDOH:Ten Point Plan 1;* • *Provision of strategic leadership and creation of a social compact for better health outcomes.* *Provincial priority:* • *Maximising health outcomes*
	4.3. Management provides sustained strategic direction in the delivery of sustained health services with well defined efficiency targets for Tertiary services.	*4.3.1. Effectively mange allocated resources to achieve the Comprehensive Service Plan target average length of stay of 6 days for central hospitals by 2014/15.*	*13) Average length of stay in central hospitals.*	*6.6 days* *(450 000/ 69 000)*	*6 days* *460 836/ 76 806*	Ensure the optimal utilisation of hospital resources.	NDOH Ten Point Plan: • Overhauling the health care system and improving its management.. Provincial priority: • Maximising health outcomes
Ensure organisational strategic management capacity and synergy.	Management provides sustained strategic direction in the delivery of sustained health services with well-defined efficiency targets for central hospital services.	Effectively manage allocated resources to achieve the target average length of stay of 5.5 days for central hospitals by 2014/15.	Average length of stay in central hospitals. Numerator Denominator	6.5 days 446 411 68 231	5.5 days 780 877 140 749		

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
5. Provide and maintain appropriate health technology and infrastructure	*5.1. Ensure the provision of infrastructure that meets the needs of current and future development*	*5.1.1. Ensure that a functional planning and commissioning unit is appointed at each central hospital to perform key planning and monitoring activities to ensure that current and future infrastructure needs are met by 2014/15.*	14) *Number of hospitals with an appointed and functioning planning and commissioning unit.*	*3*	*3*	*Ensure the adequate provision and maintenance of infrastructure in geographical regions suitable to house the provision of quality services.*	*NDOH Ten Point Plan:* • *Revitalisation of infrastructure.*

Note:

Indicator 1: The ceasarian section rate indicated is for the central hospital services. The ceasarian section rate would change once the Comprehensive Service Plan service shifts and differentiation between Level 2 and Level 3 services in terms of ceasarian sections has been completed.

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. Manage the burden of disease	1.1. Reduce maternal mortality due to complications during delivery.	1.1.1. Perform appropriate 43% clinically indicated caesarean sections to ensure improved outcomes and safety for mothers and babies by 2014/15.	1) Caesarean section rate in central hospitals[1] Numerator Denominator	44% 5 052 11 509	43% 5 800 13 600	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.	2) Number of operational beds in central hospitals.	1 460	2 536	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.	3) Bed utilisation rate (based on usable beds) in central hospitals Numerator Denominator	83% 446 411 535 820	84% 780 877 925 640	Fulfil the Constitutional mandate for the Western Cape and beyond. Play a key role in health system strengthening.	
2. Ensure a sustainable income to provide the required health services according to the needs.	2.1. Allocate, manage and generate sufficient funds to ensure sustained delivery of the full package of quality, central hospital services.	2.1.1. Ensure the cost effective management of central hospitals at a target cost of R3 000 per patient day equivalent [Constant 2009/10 rands].	4) Expenditure per patient day equivalent in central hospitals Numerator Denominator	R3 733 2 335 490 820 625 661	R3 000 3 362 032 548 1 120 678	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.	5) Average length of stay in central hospitals. Numerator Denominator	6.5 days 446 411 68 231	5.5 days 780 877 140 749	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.	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.

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

1. 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 removed 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	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	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 HRP (BP: 1) for health & support professionals (BP 2, 3, 4 & 5) in line with the packages of care within the Comprehensive Service Plan (CSP).*	*1.1.1 Increase the availability of health science students to address scarce skills.*	*1) Total number of health science students graduating.*	*542*	*900*	Increase the critical mass of health science students to address scarce skills.	*MTSF: Focus area:* • *Health system effectiveness* *NDOH Ten Point Plan for 2009 - 2014, priority 5:* • *Improve human resources* *Provincial strategic plan:* • *Maximising health outcomes*
	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).	Number of basic nurse students graduating (output).	Basic nurse students graduating	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 health and support professionals through education, training and development to render optimum accessible packages of care in line with CSP by 2014.	*2) Total number of health and support professionals trained and developed through formal and informal training.*	*2 520*	*2 970*	*Integrated health professional and health support professional including EMS training to address the CSP needs and current health and support professional shortages by maximizing the training opportunities and available resources.*	

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
		Ensure optimum competency levels of health and support professionals through education, training and development.	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
	1.2 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).	Number of Home Community Based Carers (HCBCs) trained	1 840	2 500	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.	Number 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.	Number of pharmacy assistants in training	40	140	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.	Number 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.	Number of HR and finance interns	0	140	HR and Finance functionaries are viewed as critical and scarce skills within the HR Plan.	
2. Ensure and organisational strategic management capacity and synergy.	*2.1 Develop, maintain and implement a training plan for managers based on the result of a skills audit of senior management and facilities management.*	*2.1.1 Ensure senior management and facilities' management have the required management competencies to deliver quality health services*	*3) Number of bursaries awarded to managers for formal Leadership & Management training toward a qualification*	*48*	*86*	*The predominant profile of managers in the health care sector is that of a healthcare professional that has migrated into management with no formal management qualification. This intervention is based on the needs and experiences of managers which will train them to provide leadership and which will lead to a sustainable improvement in the quality of health care.*	*MTSF: Focus area:* • *Health system effectiveness* *NDOH Ten Point Plan for 2009 - 2014, priority 1&4:* • *Provision of Strategic leadership and creation of social compact for better health outcomes.* • *Overhauling the health care system and improving its management.* *Provincial strategic plan:* • *Maximising health outcomes*

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
3. Improve the quality of health services	*3.1 Develop and implement an iMOCOMP training plan in alignment with the Clinical Governance Framework (CGF) to support quality assurance through the provision of training*	*3.1.1 Ensure optimum improvement and maintenance of competencies (iMOCOMP) of health and support professionals to address integrated health care including DHS burden of disease priorities*	4) *Number of health and support professionals receiving clinical training at the various levels of care on interdivisional burden of disease priorities*	*2 200*	*2 400*	*The improvement and maintenance of competence of health professionals strives to strengthen primary health care level service delivery through the continual improved capacity of healthcare professionals.* *Support quality assurance through the provision of training*	*MTSF: Focus area:* • *Health system effectiveness* *NDOH Ten Point Plan for 2009 - 2014, priority 3, 4,5 & 8:* • *Improving quality health services.* • *Overhauling the health care system and improving its management.* • *Improved human resource planning, development and management.* • *Mass mobilisation for better health of the population.* *Provincial strategic plan:* • *Maximising health outcomes*
		3.1.2 Ensure the integration of quality assurance into all levels of care	5) *Number of front line personnel on salary level 1 - 6 trained on Batho Pele principles*	600	998		
4. Manage the burden of disease	*4.1 Efficiently and effectively manage the dehospitalisation of patients and health promotion and prevention in the home and community.*	*4.1.1 Expand community-based care services through the optimum training and development of Home based Carers as part of Expanded Public Works Programme (EPWP).*	6) *Number of Home community- Based Carers trained.*	*2 000*	*2 800*	*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.*	

Table 6.2: REVISED Strategic objectives and expected outcomes for 2010 – 2015

Strategic Goal	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).	1) Basic nurse students graduating	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).	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).	3) Number of Home Community Based Carers (HCBCs) trained	1 840	2 500	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
		1.3.2 Increase the number of data capturer interns required at health care facilities.	4) Number 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.	5) Number of pharmacist's assistants in training	40	140	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.	6) Number 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.	7) Number 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

1. 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 removed 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	Baseline			Justification	Links
			Baseline Measure	2009/10	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.	**MTSF: Focus area** • 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 the State is not only 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.	
		1.1.6. Ensure effective and efficient utilisation of the linen stock: In-house laundries	6) *Turnaround time for laundered linen: In-house*	*24 hour weekday* *72 hour weekend*	*24 hour weekday* *72 hour weekend*	*A quick turnaround is essential to ensure the availability of clean linen and keep linen stock to a minimum.*	
		1.1.7. Ensure effective and efficient: out-sourced laundries utilisation of the linen stock	7) *Turnaround time for laundered linen: Outsourced*	*24 hour weekday 72 hour weekend*	*24 hour weekday 72 hour weekend*	*A quick turnaround is essential to ensure the availability of clean linen and to keep the linen stock to a minimum.*	

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. Provide and maintain appropriate health technology and infrastructure.	1.1 Provide an effective and efficient laundry service to all hospitals.	1.1.8. 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.
		1.1.9. 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.	
		1.1.10. 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.	
		1.1.11. 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.	
		1.1.12. 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.	

2. 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 removed 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	Baseline			Justification	Links
			Baseline Measure	2009/10	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.	MTSF: Focus area • **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	*2 000* 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	*10 800* 11 400	An effective repair service will reduce the impact of breakdowns and deterioration of assets through age.	
		1.1.4 Provide a service to deal with all infrastructure emergencies at institutions	4) *Number of emergencies handled*	*200*	*300*	*In the healthcare sector a rapid response to infrastructure emergencies is essential to ensure patient safety and prevent disruption of clinical care.*	
		1.1.5 Provide efficient engineering installations	5) *Average cost of utilities per bed*	*7 300*	*R10 800*	*With the rapidly rising cost of electricity, fuel, water, gas, etc. it is essential to monitor utilities cost and be proactive in increasing efficiency to reduce expenditure.*	
		1.1.6 Ensure compliance with the Occupational Health and Safety [OHS] Act	6) *Number of reportable incidents*	*160*	*95*	*Compliance with the OHS Act promotes safety in the workplace and protects personnel, patients and the public.*	

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. 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.	

3. 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 removed are highlighted in grey and in italic font. The revised Table 7.4 is subsequently reflected.

Table 7.4: 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 burden of disease.	1.1 Ensure access to Forensic Pathology services.	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*	*≤ 40 minutes*	*≤ 40 minutes*	Management of response times is an indicator of the quality of service being rendered. This also measure equity, access and efficiency.	**MTSF: Focus area** • Health system effectiveness. **National Ten Point Plan Priority 6:** • Improve the quality of health services **Provincial Strategic Plan:** • **Maximising health outcomes.** **Departmental Strategic Goals:** • Manage the burden of disease. Batho Pele Principles
Manage the con-sequences of the burden of disease			Average response time from dispatch to arrival of FPS on scene	37 minutes	≤ 40 minutes		
			Numerator	-	392 000		
			Denominator	-	9 800		
		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.*	*≤ 3.5 days*	*≤ 3.5 days*	The Forensic Pathology Service contributes to the development of a just society through the medico-legal investigation of death	
			Average turnaround time from admission to examination done.	3.55 days	≤ 3.5 days		
			Numerator	-	33 600		
			Denominator	-	9 604		
		1.1.3 Ensure an efficient Forensic Pathology Service through maintenance of turnaround from admission to release of deceased to ≤ 5,5 days (excluding unidentified persons).	*3) Average turnaround time from admission to release of deceased (Excluding unidentified persons).*	*≤ 5.5 days*	*≤ 55 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.	
		Manage the turnaround time from admission to release of deceased (excluding unidentified persons) to below 5,5 days.	Average turnaround time from admission to release of deceased (Excluding unidentified persons)	5.11 days	≤ 5.5 days		
			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		
	1.2 Integration of quality assurance into all levels of care	*1.2.1 Implement and maintain standard operating procedures across all 20 Forensic pathology facilities.*	*4) The percentage of Standard operating procedures implemented across all facilities*	*70%*	*100%*	*Ensure the maintenance and constant improvement of the quality of forensic pathology service by:* • *The appropriate management of each FPS case* • *Treatment of FPS cases and next of kin with dignity and respect.* • *Creating an environment conducive to staff safety.*	
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 unknowns by reducing the number of unknowns ≥ 90 days*	*5) Number of unknown persons exceeding 90 days*	*150*	*125*	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	
		Develop integrated support and management structures to render effective FPS service	Number of unknown persons exceeding 90 days	111	≤125		
3. Develop and maintain a capacitated workforce.	*3.1 Implement the Human Resource Plan*	*3.1.1 Maintain the percentage of filled posts at 97.5% of the funded establishment.*	*6) % of funded posts filled*	*90*	*97.5*	*Ensure adequate skilled capacity to deliver on the mandate and contribute to the development of a just society through the medico-legal investigation of death*	***MTSF: Focus area*** • *Health system effectiveness.* ***National Ten Point Plan Priority 5:*** • ***Improve human resources*** ***Departmental Strategic Goals:*** • *Manage the burden of disease.* *Batho Pele Principles;*
	3.2 Become the employer of choice in the health sector by creating and environment for a satisfied workforce.	*3.2.1 Pilot, implement and analyze one annual standardized staff satisfaction surveys to measure workforce satisfaction in all FPS facilities by 2014*	*7) Annual staff satisfaction survey completed.*	*None*	*Yes*	*Ensure adequate skilled capacity to deliver on the mandate and contribute to the development of a just society through the medico-legal investigation of death*	

Table 7.4: REVISED 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.	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		
		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		
		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		
2. Ensure and maintain organisational strategic management capacity and synergy.	2.1 Develop integrated support and management structures to render effective FPS.	2.1.1 Develop integrated support and management structures to render effective FPS service	4) Number of unknown persons exceeding 90 days	111	≤125	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	

4. SUB-PROGRAMME 7.5 MEDICINE TRADING ACCOUNT

Table 7.5 below is reflected on page 126 of the Strategic Plan 2010 – 2014 and remains unchanged.

Table 7.2: 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.	1) Working capital in the medicine trading account	R58,3 m	R84 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.

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 removed 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	Baseline			Justification	Links
			Baseline Measure	2009/10	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 sufficient capital funding to ensure the infrastructure backlog is significantly reduced between 2010/11 and 2014/15.*	1) *Programme 8 capital funding as a percentage of total health expenditure*	*0.6%* *R599m/ R9,893*	*0.6%* *R800/ R13,200*	The Programme 8 capital budget provides funding to construct new facilities and to substantially upgrade existing facilities. Quality healthcare requires facilities that are fit for purpose and many of the existing facilities do not meet this criterium.	**MTSF: Focus: Health system effectiveness:** • Improved physical infrastructure for healthcare delivery, National Ten Point Plan Priority 6: • Revitalisation of Infrastructure Provincial priority: • Maximising health outcomes Departmental Strategic Goals: • Manage the burden of disease. • Provide and maintain appropriate health technology and Infrastructure.
	Fund, construct and commission new health care facilities and upgrade facilities to ensure access to the integrated comprehensive health care platform.	Allocate 6% of the total health budget to Programme 8 capital funding by 2014/15.	Programme 8 capital funding as a percentage of total health expenditure Numerator Denominator	6% R599m R9 893m	6% R800 R13 200		
		1.1.2. Complete the 10 PHC projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	2) *Number of capital projects completed in PHC facilities that are funded by the Programme 8 capital budget.* *[Sub-programme 8.1]*	*New indicator*	*10*	*The Clinics and Community healthcare facilities are the first point of contact for ± 90% of patients.* *Providing appropriate treatment at this level is the most cost effective way to provide an accessible health service.* *Most of the existing facilities are not suited for purpose and require upgrading or replacement.*	
		1.1.3. Complete the 9 ambulance station projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	3) *Number of ambulance stations projects completed funded by the Programme 8 capital budget.* *[Sub-programme 8.2]*	*0*	~~9~~	*An efficient and effective emergency medical service plays a pivotal role in appropriate access to health services.* *Many of the existing ambulance stations are not fit for purpose which impacts negatively on personnel morale and the ability to render an effective and efficient service.*	

Strategic Goal	Strategic Objective Title	Strategic Objective Statement	Baseline			Justification	Links
			Baseline Measure	2009/10	2014/15		
		1.1.4. Complete the 14 district hospital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	4) *Number of capital projects completed in district hospitals funded by the Programme 8 capital budget.* *[Sub-programme 8.3]*	*0*	*14*	*Appropriate district hospital infrastructure is essential for the implementation of the CSP.* *Currently many of the district hospitals require upgrading*	
		1.1.5. Complete the 9 provincial hospital capital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	5) *Number of capital projects completed in provincial hospitals funded by the Programme 8 capital budget.* *[Sub-programme 8.4]*	*0*	*9*	*Appropriate provincial hospital infrastructure is essential for the implementation of the CSP.* *Currently many of the provincial hospitals require upgrading.*	
		1.1.6. Complete the 8 central hospital capital projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	6) *Number of Capital projects completed in central hospitals funded by the Programme 8 capital budget.* *[Sub-programme 8.5]*	*0*	*8*	*Appropriate central hospital infrastructure is essential for the implementation of the CSP.* *Currently central hospitals require upgrading.*	
		1.1.7. Complete the 6 forensic mortuary and other projects funded from the Programme 8 capital budget between 2010/11 and 2014/15.	7) *Number of projects completed in forensic mortuaries and other projects funded by the Programme 8 capital budget.* *[Sub-programme 8.6]*	*0*	*6*	*The Forensic Service was taken over from the SAPS.* *Much of the infrastructure is deficient and is in need of replacement*	

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. 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 Numerator Denominator	6% R599m R9,893m	6% R800 R13,200	The Programme 8 capital budget provides funding to construct new facilities and to substantially upgrade existing facilities. Quality healthcare requires facilities that are fit for purpose and many of the existing facilities do not meet this criterium.	NDSA: Strengthening health system effectiveness • Improved physical infrastructure for healthcare delivery, 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

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) Number of 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 on the last day 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) Number of 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 on the last day 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) Number of 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 on the last day 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) Number of 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 on the last day 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) Number of 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 on the last day 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) Number of 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 on the last day 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 on the last day 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 medical officers	Percentage of vacant funded medical officer posts on last day of the reporting period.	Tracks the number of vacant funded medical officer posts to monitor availability of human resources.	Numerator: Personnel records Denominator: Personnel records	Numerator: PERSAL Denominator: PERSAL	Numerator: Vacant funded medical officer posts on the last day of the reporting period Denominator: Funded 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 on the last day 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 on the last day 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

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 the department spent. 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: Projected annual expenditure. Denominator: Total BAS annual equitable share budget allocation.	100 (%)	Dependant on realistic projected expenditure.	Output	Percentage	Quarterly	No	The over/under spending of the annual equitable share does 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 was 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 Report	Submission of the Amended Human Resource Report	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	Yes	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 prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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
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

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 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) Denominator: Fixed PHC facilities X number of months in the period under review	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: Facility Semi-permanent Data 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.	Service Level Agreement between the Department and the NPO	NPO home carer 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
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 and 2.3) 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 and 2.3) 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

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
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	Yes	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.	Assessment tool to be provided by NDoH	Assessment tool to be provided by NDoH	PHC facilities assessed against the core standards	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 PHC facilities.	DHS Programme Manager

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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	Useable 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	Usable beds in district hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	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
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	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

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) 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 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 usable bed days in district hospitals (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 5.1) 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
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	Yes	Higher percentage suggests better management of complaints in district hospitals.	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
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: DHIS Denominator: DHIS	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	Yes	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.	Assessment tool to be provided by NDoH	Assessment tool to be provided by NDoH	District hospitals assessed against the core standards	100 (%)	Implementation plan and assessment tool to be provided by National Department of Health.	Quality	Percentage	Annual	Yes	Higher number indicates better compliance with the core standards in district hospitals.	DHS Programme Manager

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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	Yes	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 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	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.	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 tested for HIV Denominator: HCT clients pre-test counselled	100 (%)	Dependant on accuracy of data from reporting facilities.	Process	Percentage	Quarterly	Yes	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	Yes	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	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 clients registered	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 prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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) Under-5 mortality rate	The number of children who have died between birth and their fifth birthday, expressed per thousand live births as determined by the South African Demographic and Health Survey (SADHS).	Monitoring child deaths on a routine basis is very important to monitor progress towards MDG.	Numerator: SADHS Denominator: SADHS	Numerator: SADHS Denominator: SADHS	Numerator: Children less than 5 year old who die in one year Denominator Live births during that year	1 000	Empirical data is provided by the SADHS every 5 years.	Outcome	Rate	Annual	Yes	Lower infant mortality rates are desired.	MCWH Programme Manager
2) 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 Denominator: Population data	Numerator: SINJANI Denominator: StatsSA Denominator: StatsSA	Numerator: Immunised fully under 1 year Denominator: Population 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
3) 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
4) 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

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) 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	Yes	Higher percentage indicates better rotavirus vaccine coverage.	EPI Programme Manager
6) 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
7) 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 tested positive for HIV Denominator: PMTCT baby tested for HIV	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
8) 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)	Yes	Lower incidence indicates a healthy community.	MCWH Programme Manager
9) 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)	Yes	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
10) 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
11) 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	100 (%)	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
12) 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
13) 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
14) 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
15) 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
16) 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	Yes	Higher percentage indicates higher prevalence of contraceptive methods.	MCWH Programme Manager

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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 fatality rate (annual)	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 (annual)	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 (annual)	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

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Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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 Report 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 (annualised)	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 Report Denominator: Efficiency Report	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 the service volumes and demand relative to capacity.	Efficiency Report	Efficiency Report	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) Percentage of urban Priority 1 responses within 15 minutes	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 15 minutes or less.	Monitors response times to emergencies within the national urban target.	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Efficiency Report Denominator: Efficiency Report	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 coordination of the EMS system in order to achieve better response times in urban areas.	EMS Manager
4) Percentage of rural Priority 1 responses within 40 minutes	Percentage of rural (farming areas outside of a town or built up area) responses classified as priority 1 (P1) or emergencies by the Emergency Call Centre agent where the response time is 40 minutes or less.	Monitor response times to emergencies within national rural target.	Numerator: Efficiency Report Denominator: Efficiency Report	Numerator: Efficiency Report Denominator: Efficiency Report	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 coordination of the EMS system in order to achieve better response times in rural 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
5) All calls with a response time within 60 minutes	Percentage of all 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 Report Denominator: Efficiency Report	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 coordination 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 Report 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
7) Number of outpatients transferred by HealthNET to regional and central hospitals	The number of outpatients transferred by the patient transport service, HealthNET, within and across districts to regional and/or central hospitals for consultations with specialists.	Monitors the demand and capacity of HealthNET and the efficiency of the District Health System.	Efficiency Report	Efficiency Report	Outpatients transferred from districts to regional and/or central hospitals for specialist outpatient appointments	None (no)	Dependant on accuracy of data received from EMS stations.	Efficiency	Sum for period under review	Quarterly	Yes	Outpatient referrals appropriate to the CSP and levels of care. The % should be 10% of the outpatient headcounts at district and regional hospitals.	EMS Managers Hospital Managers District Health Directors

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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	Useable 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	Usable beds in regional hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	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	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 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 usable bed days in regional hospitals (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	Yes	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: DHIS Denominator: DHIS	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	Yes	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.	Assessment tool to be provided by NDoH	Assessment tool to be provided by NDoH	Regional hospitals assessed against the core standards	100 (%)	Implementation plan and assessment tool to be provided by National Department of Health.	Process	Percentage	Annual	Yes	Higher number indicates better compliance with the core standards in regional hospitals.	Provincial Hospital Services Programme Manager

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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	Useable 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	Usable beds in TB hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	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	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 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 usable bed days in TB hospitals (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	Yes	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: DHIS Denominator: DHIS	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	Yes	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.	Assessment tool to be provided by NDoH	Assessment tool to be provided by NDoH	TB hospitals assessed against the core standards	100 (%)	Implementation plan and assessment tool to be provided by National Department of Health.	Process	Percentage	Annual	Yes	Higher number indicates better compliance with the core standards in TB hospitals.	TB Hospital Services Programme Manager

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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	Useable 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	Usable beds in psychiatric hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	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	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 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 usable bed days in psychiatric hospitals (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	Yes	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: DHIS Denominator: DHIS	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	Yes	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.	Assessment tool to be provided by NDoH	Assessment tool to be provided by NDoH	Psychiatric hospitals assessed against the core standards	100 (%)	Implementation plan and assessment tool to be provided by National Department of Health.	Process	Percentage	Annual	Yes	Higher number indicates better compliance with the core standards in psychiatric hospitals.	APH Programme Manager

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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	Useable 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	Usable beds in rehabilitation hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	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	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 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 usable bed days in rehabilitation hospitals (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	Yes	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: DHIS Denominator: DHIS	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	Yes	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.	Assessment tool to be provided by NDoH	Assessment tool to be provided by NDoH	Rehabilitation hospitals assessed against the core standards	100 (%)	Implementation plan and assessment tool to be provided by National Department of Health.	Process	Percentage	Annual	Yes	Higher number indicates better compliance with the core standards in rehabilitation hospitals.	CEO Western Cape Rehabilitation Centre

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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.	Oral Health Centre Tygerberg / UWC Patient Visit Form	Clinicom for Tygerberg and UWC Oral Health Centres. Patient record card for other oral health clinics (out-reach clinics).	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 ate the oral health centres.	Monitoring the service volumes of theatre cases in the oral health centres.	Theatre register	Theatre Register.xls	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).	Job card for prosthetic unit (dentures)	Laboratory Register.xls	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).	Appointment register for orthodontic clinic	Orthodontic Devices.xls	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 prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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 operational beds in central hospitals	Designated tertiary beds (useable beds) in central hospitals are beds actually available for use within the central 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	Usable beds in central hospitals	None (no)	Dependant on accuracy of data from reporting facilities.	Input	Cumulative	Quarterly	No	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	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 usable 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 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 usable bed days in central hospitals (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	Yes	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: DHIS Denominator: DHIS	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	Yes	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 for quality assurance.	Tracks the levels of compliance against the 6 priority areas of the core standards for quality assurance.	Assessment tool to be provided by NDoH	Assessment tool to be provided by NDoH	Central hospitals assessed against the core standards	100 (%)	Implementation plan and assessment tool to be provided by National Department of Health.	Process	Percentage	Annual	Yes	Higher number indicates better compliance with the core standards in central hospitals.	Central Hospital Services Programme Manager

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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 operational tertiary beds in Groote Schuur Hospital	Designated tertiary beds (useable 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	Usable beds in Groote Schuur Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Input	Cumulative	Quarterly	No	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	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 usable 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 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 usable bed days in Groote Schuur Hospital (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 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).	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	Yes	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: DHIS Denominator: DHIS	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	Yes	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	Groote Schuur Hospital 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.	Assessment tool to be provided by NDoH	Assessment tool to be provided by NDoH	Central hospitals assessed against the core standards	(Y/N)	Implementation plan and assessment tool to be provided by National Department of Health.	Quality	Compliance (Yes / No)	Annual	Yes	Yes indicates better compliance with the core standards in Groote Schuur Hospital.	CEO Groote Schuur Hospital

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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 operational tertiary beds in Tygerberg Hospital	Designated tertiary beds (useable 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	Usable beds in Tygerberg Hospital	None (no)	Dependant on accuracy of data from reporting facility.	Input	Cumulative	Quarterly	No	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	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 usable 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 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 usable bed days in Tygerberg Hospital (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 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).	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	Yes	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: DHIS Denominator: DHIS	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	Yes	Higher percentage indicates better levels of satisfaction in Tygerberg Hospital services.	CEO Tygerberg Hospital
12) Tygerberg Hospital assessed for compliance with core standards	Tygerberg Hospital 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.	Assessment tool to be provided by NDoH	Assessment tool to be provided by NDoH	Central hospitals assessed against the core standards	(Y/N)	Implementation plan and assessment tool to be provided by National Department of Health.	Quality	Compliance (Yes / No)	Annual	Yes	Yes indicates better compliance with the core standards in Tygerberg Hospital.	CEO Tygerberg Hospital

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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 operational tertiary beds in RCWMCH	Designated tertiary beds (useable 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	Usable beds in RCWMCH	None (no)	Dependant on accuracy of data from reporting facility.	Input	Cumulative	Quarterly	No	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	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
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

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) Bed utilisation rate (based on usable beds) in RCWMCH	Patient days in RCWMCH during the reporting period, expressed as a percentage of the sum of the daily number of 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 usable bed days in RCWMCH (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
9) RCWMCH conducts monthly morbidity and mortality meetings	RCWMCH conducts 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).	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

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
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	Yes	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: DHIS Denominator: DHIS	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	Yes	Higher percentage indicates better levels of satisfaction in RCWMCH services.	CEO RCWMCH
13) RCWMCH assessed for compliance with core standards	RCWMCH 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.	Assessment tool to be provided by NDoH	Assessment tool to be provided by NDoH	Central hospitals assessed against the core standards	(Y/N)	Implementation plan and assessment tool to be provided by National Department of Health.	Quality	Compliance (Yes / No)	Annual	Yes	Yes indicates better compliance with the core standards in RCWMCH.	CEO RCWMCH

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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 (HEIs and nursing colleges)	Number of student nurses entering the first year of nursing college.	Tracks the training of nurses.	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) 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 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
3) Basic nurse students graduating	Number of students who graduate from the basic nursing course.	Tracks the production of nurses with a basic nursing qualification.	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) 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	EPWP Web based system: database	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
5) Number of Home Community Based Carers (HCBCs) trained	Number of Home Community Based Carers (HCBCs) in training.	Tracks the training of Home Community Based Carers (HCBCs) on the various NQF levels.	Home Community Based Carers registration lists	EPWP Web based system: 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 numbers of Home Community Based Carers receiving National Diplomas means an increase in the number of qualified Home Community Based Carers 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
6) Number of data capturer interns	Number of data capturer interns.	Tracks the number of data capturer interns.	Signed internship agreements	EPWP Web based system: database	Intake of data capturer interns	None (no)	Dependant on accuracy of record keeping by the Provincial DoH.	Input	Cumulative	Annual	No	Higher numbers of data capturer interns means an increase in the numbers of data capturer interns that are available for assimilation into posts at healthcare facilities leading to improved data management.	HRD Programme Manager
7) Number of pharmacy assistants in training	Number of pharmacist's assistants in training at basic and post basic level.	Tracks the training of pharmacist's assistants at a basic and post basic level.	Signed learnership agreements	EPWP Web based system: 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 numbers of pharmacist's assistants in training means an increase in the numbers of pharmacist's assistants that are available to address scarce skills.	HRD Programme Manager
8) Number of Assistant to Artisans (ATAs) interns	Number of Assistant to Artisans (ATAs) interns.	Tracks the number of Assistant to Artisans (ATAs) interns.	Signed learnership agreements	EPWP Web based system: database: Municipal Information System for Infrastructure (MIS)	Intake of Assistant to Artisans (ATAs) interns	None (no)	Dependant on accuracy of record keeping by the Provincial DoH	Input	Cumulative	Annual	No	Higher numbers of Assistant to Artisans (ATAs) interns means an increase in the numbers of ATAs that are available to address maintenance needs of healthcare facilities.	HRD Programme Manager
9) Number of HR and finance interns	Number of HR and Finance interns.	Tracks the number of HR and finance interns.	Signed internship agreements	EPWP Web based system: database	Intake of HR and Finance interns	None (no)	Dependant on accuracy of record keeping by the Provincial DoH	Input	Cumulative	Annual	No	Higher numbers of HR and finance interns means an increase in the numbers of HR and finance interns to address scarce skills.	HRD Programme Manager

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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. Total number of pieces laundered	The actual number of linen pieces processed or laundered by both in-house and outsourced laundries.	To ensure that clean and disinfected linen is supplied to all provincial hospitals.	• Laundry linen count • Private contractor accounts	In-house: Laundry returns.xls Outsourced: Private laundry returns.xls	Sum of: • Items laundered in-house • Items laundered outsourced	None (no)	Dependant on the submission of information and accuracy of records kept by in-house laundries and private contractors.	Output	Sum for period under review	Quarterly	No	Higher workload indicates greater demand on the service.	Laundry manager (Directorate: Engineering and Technical Support)
2. Total number of pieces laundered: in-house	The actual number of linen pieces processed or laundered by large central in-house laundries located at Tygerberg, Lentegeur and George Hospitals.	To ensure that in-house laundries are providing clean and disinfected linen in areas where private sector laundries are unable to provide a service.	Laundry linen count	Laundry returns.xls	Items laundered in-house	None (no)	Dependant on the accuracy of records kept by in-house laundries.	Output	Sum for period under review	Quarterly	No	Higher workload indicates greater demand on the service.	Laundry manager (Directorate: Engineering and Technical Support)
3. Total number of pieces laundered: outsourced	The actual number of linen pieces processed or laundered by outsourced laundries in the private sector	To ensure that private laundries are providing clean and disinfected linen as per the agreed contract.	Private contractor accounts	Private laundry returns.xls	Items laundered outsourced	None (no)	Dependant on the submission of information and the reliability of records kept at private laundries.	Output	Sum for period under review	Quarterly	No	Higher workload indicates greater demand on the service.	Laundry manager (Directorate: Engineering and Technical Support)
4. 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)
5. 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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Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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. Number of maintenance jobs completed	The number of jobs completed by clinical engineering or hospital engineering workshops as well as outside contractors. Jobs include repairs, renovations, upgrades, etc.	Monitor maintenance done by the Department to maximise the lifespan of equipment, reduce breakdowns and ensure safety.	Engineering workshop requisitions	Job card system	Maintenance jobs completed	None (no)	Dependant on accuracy of record keeping at the reporting facility.	Output	Sum for period under review	Quarterly	No	Higher numbers indicate more maintenance of assets resulting in improved condition of health facilities and equipment.	Director: Engineering and Technical Support
2. Number of preventative maintenance jobs completed	Number of preventative maintenance jobs to critical equipment that has been completed.	Monitor preventative maintenance done by the Department to reduce breakdowns, promote safety and lengthen the lifespan of equipment.	Engineering workshop requisitions	Job card system	Preventative maintenance jobs completed	None (no)	Dependant on accuracy of record keeping at engineering workshops.	Output	Sum for period under review	Quarterly	Yes	Higher numbers indicate more preventative maintenance done which should lead to improved condition and lifespan of equipment.	Director: Engineering and Technical Support
3. Number of repairs completed	Number of repairs and renovations to buildings, plant and equipment that has been completed.	Monitor repairs done by the Department to reduce the impact of breakdowns and deterioration of assets through age.	Engineering workshop requisitions	Job card system	Repairs completed	None (no)	Dependant on accuracy of record keeping at engineering workshops.	Output	Sum for period under review	Quarterly	Yes	Higher numbers indicate more repairs completed and should result in improved condition of health facilities and equipment. However, it may also indicate poor condition of facilities and equipment, i.e. greater need for preventative maintenance.	Director: Engineering and Technical Support

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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) Average response time from dispatch to arrival of FPS on scene	Average Forensic Pathology Service (FPS) response time from receipt of call to arrival on scene.	Monitor response times and therefore the efficiency of the Forensic Pathology Services.	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: Total number of minutes from receipt of call to arrival on all FPS related Death Scenes Denominator: Total number of forensic pathology scenes attended (body receipt and deferral)	None (no)	Dependent on accuracy of data from FPS laboratories.	Quality	Average	Quarterly	No	Lower response times indicate greater efficiency.	Forensic Pathology Services (FPS) Programme Manager
2) Average turnaround time from admission to examination done	Average Forensic Pathology Service turnaround time from the admission of a deceased until the post-mortem examination is done.	Monitor turnaround times and therefore the efficiency as well as available resources in Forensic Pathology Services.	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: Total turnaround time of all Forensic Pathology cases from admission to post-mortem Denominator: Total number of forensic pathology cases examined during the reporting period	None (no)	Dependent on accuracy of data from FPS laboratories.	Quality	Average	Quarterly	Yes	Lower turnaround times indicate greater efficiency and improved resource allocation.	FPS Programme Manager
3) Average turnaround time from admission to release of deceased (excluding unidentified persons)	Average Forensic Pathology Service turnaround time from the admission of a deceased until the time that the deceased is released for burial – excluding unidentified persons.	Monitor turnaround times and therefore the efficiency as well as available resources in Forensic Pathology Services, 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: Total number of days all the released bodies were stored at the facility (excluding unidentified persons) Denominator: Total number of bodies released (excluding paupers)	None (no)	Dependent on accuracy of data from FPS laboratories.	Quality	Average	Quarterly	Yes	Lower turnaround times indicate greater efficiency and improved resource allocation.	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) Number of unknown persons exceeding 90 days in FPS	Number of deceased within the Forensic Pathology Service 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 the Forensic Pathology Service as well as within external stakeholders such as the SAPS and Home Affairs.	FPS R003 FPS 002	FPS R003 Index Register	Cases still unidentified after 90 days have elapsed	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 prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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
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

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Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

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) Programme 8 capital funding as a percentage of total health expenditure	Capital expenditure on buildings, including conditional grants, as a percentage of the total provincial health expenditure.	Tracks total expenditure on health infrastructure.	Numerator: Financial data Denominator: Financial data	Numerator: BAS Denominator: BAS	Numerator: Capital expenditure on buildings upgrade renovation and construction Denominator Total expenditure by provincial DoH	100 (%)	Dependant on the accuracy of financial data on BAS.	Input	Percentage	Annual	Yes	Higher percentage shows additional funding allocated but is also a reflection of the poor condition of health facilities and infrastructure backlog.	Health Facilities Management Programme Manager
2) Equitable share capital programme as percentage of total health expenditure	Capital expenditure on buildings and equipment from the provincial equitable share allocation (i.e. excluding conditional grants) as a percentage of the total provincial health expenditure.	Tracks equitable share expenditure on health infrastructure and equipment.	Numerator: Financial data Denominator: Financial data	Numerator: BAS Denominator: BAS	Numerator: Capital expenditure (equitable share) on buildings upgrade, renovation and construction Denominator Total expenditure by provincial DoH (equitable share)	100 (%)	Dependant on the accuracy of financial data on BAS.	Quality	Percentage	Annual	No	Higher percentage shows additional funding allocated but is also a reflection of the poor condition of health facilities and infrastructure backlog.	Health Facilities Management Programme Manager
3) Expenditure on facility maintenance as percentage of total health expenditure	Programme 8's expenditure on maintenance of health buildings as a percentage of the total provincial health expenditure.	Tracks expenditure on the maintenance of health facilities.	Numerator: Financial data Denominator: Financial data	Numerator: BAS Denominator: BAS	Numerator: Programme 8 expenditure on building maintenance Denominator: Total expenditure by Provincial DoH	100 (%)	Dependant on accuracy of financial data on BAS and costing of maintenance expenditure.	Input	Percentage	Annual	No	Higher percentage shows additional funding allocated but is also a reflection of the poor condition of health facilities and maintenance backlog. Desired performance is 4% of total health expenditure.	Health Facilities Management Programme Manager
4) Hospitals funded from the revitalisation programme	Number of hospitals with funding from the Hospital Revitalisation Grant. Only hospitals that have been funded for planning, construction or both must be included. Approved business cases that have not been funded should be excluded.	Tracks progress with the revitalisation of hospitals to improve service delivery.	Numerator: Hospital Revitalisation Programme Project Implemen-tation Plans (HRP PIPs) and approval letter from NDoH Denominator: Facility list	Numerator: Hospital Revitalisation Programme Project Implemen-tation Plans (HRP PIPs) and approval letter from NDoH Denominator: Facility list	Numerator: Hospitals funded from the Revitalisation Grant Denominator: Number of public hospitals	None (no)	Dependant on the accuracy of records on the status of hospital revitalisation projects.	Input	Sum	Annual	No	Higher number of hospitals funded reflects progress with the revitalisation of hospitals.	Health Facilities Management 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) Average backlog of service platform in fixed PHC facilities	Expenditure required to bring all fixed provincial health clinics, community day centres (CDCs) and community health centres (CHCs) up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose) as a percentage of the total replacement cost for all fixed PHC facilities.	Tracks the quality (condition) of health facilities and expenditure required to render them 'fit for purpose'.	Numerator: Estimate by Health Facilities Planners Denominator: Estimate by Health Facilities Planners	Numerator: NHI Infrastructure backlog.xls Denominator: NHI Infrastructure backlog.xls	Numerator Expenditure required for fixed PHC facilities to reach maintenance standard Denominator Replacement cost for all fixed PHC facilities	100 (%)	Dependant on accuracy of costing and assessment of the condition of health facilities.	Quality	Percentage	Annual	No	Lower average backlog is desirable. Higher average backlog of service platform reflects poor condition of health facilities. In some instances, it might even be more cost-effective to replace than to repair the facility.	Health Facilities Management Programme Manager
6) Level 1 (district hospital) beds per 1 000 uninsured population	Usable beds in district hospitals per 1 000 uninsured population.	Tracks the provision and availability of district hospital beds in the province.	Numerator: Hospital Throughput Form Denominator: Population data	Numerator: SINJANI Denominator: Stats SA	Numerator: Usable beds in district hospitals Denominator: Total uninsured population	1 000	Dependant on accuracy of data from reporting facility and population estimates from Stats SA.	Outcome	Number per 1 000 uninsured population	Annual	No	A higher number of district hospital beds suggests that the need for district hospital beds is being met. but bed occupancy rates must also be assessed to develop an informed judgement.	Health Facilities Management Programme Manager
7) Level 2 (regional hospital) beds per 1 000 uninsured population	Useable beds in regional hospitals per 1 000 uninsured population.	Tracks the provision and availability of regional hospital beds in the province.	Numerator: Hospital Throughput Form Denominator: Population data	Numerator: SINJANI Denominator: Stats SA	Numerator: Usable beds in regional hospitals Denominator: Total uninsured population	1 000	Dependant on accuracy of data from reporting facility and population estimates from Stats SA.	Outcome	Number per 1 000 uninsured population	Annual	No	A higher number of regional hospital beds suggests that the need for regional hospital beds is being met, but bed occupancy rates must also be assessed to develop an informed judgement.	Health Facilities Management Programme Manager

Note: Indicators prescribed by the National Department of Health are highlighted in blue.
Indicators used as performance measures in the Strategic Plan 2010 – 2014 are highlighted in yellow.

ANNEXURE C

LIST OF FACILITIES

LIST OF FACILITIES AS AT FEBRUARY 2010

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 **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 Kleinvlei Clinic Kuyasa Clinic Luvuyo Clinic Macassar Clinic Male Clinic (C) Mayenzeke Clinic Nolungile Clinic Russel's Rest Clinic Sarepta Clinic Sir Lowry's Pass Clinic Site B Youth Clinic Site C Youth Clinic Somerset West Clinic Town 2 Clinic Wesbank (Oostenberg) Clinic Zakhele Clinic	Driftsands Satellite Clinic Fagan Street Satellite Clinic Hillcrest (Kuils River) Satellite Clinic Kuilsriver (Carinus Street) Satellite Clinic	Macassar Mobile
1 + 9 + 3	**20**	**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 Inzame 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	Hazendal Satellite Clinic Honeyside Satellite Clinic Mandalay Satellite Clinic Newfields Satellite Clinic Nyanga Junction RH Satellite Clinic	None
3 + 6 + 3	**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	Adriaanse Clinic	Bellville Reprod Health Sat Clinic	Durbanville Mobile
Delft CHC	Bellville South Clinic	Chestnut Satellite Clinic	
Elsies River CHC	Bishop Lavis Clinic	Fisantekraal Satellite Clinic	
Kraaifontein CHC	Bloekombos Clinic	Groenvallei Satellite Clinic	
Community Day Centres	Bothasig Clinic	Leonsdale Satellite Clinic	
Bellville South CDC	Brackenfell Clinic		
Bishop Lavis CDC	Brighton Clinic		
Durbanville CDC	Delft South Clinic		
Goodwood CDC	Durbanville Clinic		
Parow CDC	Elsies River Clinic		
Ravensmead CDC	Goodwood Clinic		
Reed Street CDC	Harmonie Clinic		
Ruyterwacht CDC	Netreg Clinic		
Scottsdene CDC	Northpine Clinic		
St Vincent CDC	Parow Clinic		
Midwife Obstetric Units	Ravensmead Clinic		
Bishop Lavis MOU	Scottsdene Clinic		
Elsies River MOU	St Vincent Clinic		
Kraaifontein MOU	Uitsig Clinic		
	Valhalla Park Clinic		
	Wallacedene Clinic		
3 + 10 + 3	**21**	**5**	**1**

1.1.4 Southern and Western Sub-districts

Community Health Centres (CHCs); Community Day Centres (CDCs)	Clinics	Satellite Clinics	Mobiles
Community Health Centres	Albow Gardens Clinic	Alphen Satellite Clinic	Redhill Mobile
Retreat CHC	Chapel Street Clinic	Pelican Park Satellite Clinic	Melkbosstrand Mobile
Vanguard CHC	Claremont Clinic	Pella Satellite Clinic	Witsand Mobile
Community Day Centres	Diep River Clinic	Pinelands Satellite Clinic	
Albow Gardens CDC	Du Noon Clinic	Schotscheskloof Satellite Clinic	
Grassy Park CDC	Factreton Clinic	Simon's Town Satellite Clinic	
Green Point CDC	Fish Hoek Clinic	Table View Satellite Clinic	
Hout Bay Harbour CDC	Grassy Park Civic Centre Clinic		
Kensington CDC	Hout Bay Harbour Clinic		
Lady Michaelis CDC	Hout Bay Main Road Clinic		
Lotus River CDC	Klip Road Clinic		
Maitland CDC	Langa Clinic		
Mamre CDC	Lavender Hill Clinic		
Ocean View CDC	Lotus River Clinic		
Robbie Nurock CDC	Maitland Clinic		
Woodstock CDC	Masiphumelele Clinic		
Midwife Obstetric Units	Melkbosstrand Clinic		
Retreat MOU	Muizenberg Clinic		
Vanguard MOU	Parkwood Clinic		
	Philippi Clinic		
	Protea Park Clinic		
	Retreat Clinic		
	Saxon Sea Clinic		
	Seawind Clinic		
	Spencer Road Clinic		
	Strandfontein Clinic		
	Westlake Clinic		
	Wynberg Clinic		
2 + 12 + 2	**28**	**7**	**3**

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
Community Day Centres	Bella Vista Clinic	Hexberg Satellite Clinic	Botha/Brandwacht Mobile
Ceres CDC	Bergsig Clinic	Maria Pieterse Satellite Clinic	Dal / E de Waal Mobile
Cloetesville CDC	Breerivier Clinic	Newton Satellite Clinic	De Wet Mobile
TC Newman CDC	Cogmanskloof Clinic	Overhex Satellite Clinic	Devon Valley Mobile
Wellington CDC	Dalevale Clinic	Rhodes Fruit Farm Satellite Clinic	Franschhoek Mobile
Worcester CDC	De Doorns Clinic	Somerset Street Satellite Clinic	Gouda Mobile
	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 + 5	**44**	**8**	**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 + 1	**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 Plettenberg Bay CDC Thembalethu CDC	Albertinia 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 Kwanokathula Clinic Ladismith (Nissenville) Clinic Lawaaikamp Clinic New Horizon Clinic Oudtshoorn Clinic Pacaltsdorp Clinic Parkdene Clinic Riversdale Clinic Rosemoor Clinic Sedgefield Clinic Still Bay Clinic Toekomsrus Clinic Herold Clinic Uniondale (Lyonsville) Clinic Wit Lokasie Clinic Zoar Clinic	Amalienstein Satellite Clinic Avontuur Satellite Clinic Brandwacht Satellite Clinic Dana Bay Satellite Clinic Friemersheim Satellite Clinic Hartenbos Satellite Clinic Herbertsdale Satellite Clinic Karatara Satellite Clinic Melkhoutfontein Satellite Clinic Slangrivier Satellite Clinic Touwsranten Satellite Clinic Van Wyksdorp Satellite Clinic Wittedrift Satellite Clinic	Albertinia Mobile Calitzdorp Mobile De Rust Mobile Diepkloof&Geelhoutboom Mobile Haarlem Mobile Heidelberg Mobile Herold Mobile Keurhoek Mobile Knysna Mobile Kraaibos 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 Van Wyksdorp Mobile Wilderness Mobile
0 + 5	**35**	**13**	**23**

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 Malgas Satellite Clinic Onrus Satellite Clinic Pearly Beach Satellite Clinic Protem 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 Mob 4 Grabouw Mobile 1 Grabouw Mobile 2 Grabouw Mobile 3 Ruens Mobile 5 Swellendam Mobile 4 Villiersdorp Mobile 1 Villiersdorp Mobile 2
0 + 1	**23**	**9**	**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 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 Vredendal Central 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 Wupperthal Mobile
0 + 0	**26**	**24**	**19**

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 Groote Schuur L2 Red Cross War Memorial ChildrenL2 Tygerberg L2	Paarl Worcester	-	George	-	-	
2 + 3	**2**	**0**	**1**	**0**	**0**	**8**

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
Alexanddra 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 L3 Red Cross War Memorial Children L3 Tygerberg L3	-	-	-	-	-	
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
St Luke's Hospice Baphumelele Eagle's Rest Special Lifecare Helderberg Hospice Ithemba Labantu Living Hope Trust Themba Care Booth Memorial Conradie Care Centre Sarah Fox St Joseph's Home	Boland Hospice Bram Care Luthando Stellenbosch Hospice Ceres Step Down	Cornerstone	Bethesda Knysna Sub-acute @ Peace Palliative Uniondale	Overstrand Care Themba Care	LAPA Munnik Siyabonga	
12	**5**	**1**	**4**	**2**	**2**	**26**

2.2.2 Psychiatric step-down facilities

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
William Slater New Beginnings	-	-	-	-	-	
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
Eastern Northern Southern Western	Bonnievale Ceres De Doorns Montague Paarl Robertson Stellenbosch Touws River Tulbagh Worcester	Beaufort West Laingsburg Leeu Gamka Murraysburg Prince Albert	Calitzdorp Dysselsdorp George Heidelberg Knysna Ladismith Mossel Bay Oudtshoorn Plettenberg Bay Riversdale Uniondale	Barrydale Bredasdorp Caledon Grabouw Hermanus Riviersonderend Swellendam Stanford Villiersdorp	Bitterfontein Clanwilliam Citrusdal Lamberts Bay Malmesbury Mooreesburg Piketberg Porterville Van Rhynsdorp Vredenburg Vredendal	
4	**10**	**5**	**11**	**9**	**11**	**50**

3.2 Forensic Pathology Laboratories (Mortuaries)

Cape Town	Cape Winelands	Central Karoo	Eden	Overberg	West Coast	Total
Salt River Tygerberg	Paarl Stellenbosch Wolseley Worcester	Beaufort West Laingsburg	George Knysna Mossel Bay Oudtshoorn Riversdale	Hermanus Swellendam	Malmesbury Vredenburg Vredendal	
2	**4**	**2**	**5**	**2**	**3**	**18**

ABBREVIATIONS

ABBREVIATIONS

ACSM	Advocacy, communication and social mobilisation
ACT	Assertive community teams
AECL(M)P	Acute emergency case load (management) policy
AIDS	Acquired immune deficiency syndrome
AOS	Accounting officers system
APL	Approved post list
ART	Antiretroviral treatment
ARV	Antiretroviral
ASSA	Actuarial Society of South Africa
ATA	Assistant to Artisan
AZT	Azidothymidine / Zidovudine
BANC	Basic antenatal care
BAS	Basic Accounting System
BMI	Budget management instrument
BOD	Burden of disease
CAD	Computer aided dispatch
CBS	Community-based services
CCG	Community care giver
CCW	Community care worker
CDC	Community day centre
CDU	Chronic dispensing unit
CHC	Community health centre
CHS	Central hospital services
CI	Confidence interval
CIDB	Construction Industry Development Board
CMD	Cape Medical Depot
CNP	Clinical nurse practitioner
CPIX	Consumer price index
CSP	Comprehensive Service Plan
CT	Computed tomography
DDG	Deputy Director General
DH	District hospital
DHIS	District Health Information System
DHS1	District health services
DOTS	Directly observed treatment short course
DPSA	Department of Public Service and Administration
DRG	Diagnostic related group
DTaP-IPV/Hib	Diphtheria, Tetanus, acellular Pertussis, inactivated polio vaccine and *Haemophilus influenza* type B combined
EC	Emergency centre
ECD	Early child development
EHS	Environmental health services
EMRS	Emergency medical rescue service
EMS	Emergency medical services
EPWP	Expanded Public Works Programme
Eq	Equitable
ESMOE	Essential steps in the management of obstetric emergencies
EXCO	Executive committee
FBU	Financial business unit
FPL	Forensic pathology laboratory
FPS	Forensic pathology services
FP	Forensic pathologist
GAAP	Generally Accepted Accounting Principles
GSA	Geographic service area
H1N1	Subtype of Influenza Type A category virus (H1N1 – Haemagglutinin type 1 and Neuraminidase type 1)
HCT	HIV counselling and testing
HEI	Higher education institution

HFM	Health facilities management
HIS	Hospital Information System
HIV	Human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
HPTDG / HPT & D grant	Health professions training and development grant
HR	Human resource
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	Implementing department
IDIP	Infrastructure delivery improvement programme
IGP	Infrastructure grant to provinces
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
IRM	Infrastructure reporting model
IT	Information technology
JOC	Joint operations centre
LG	Local government
LOGIS	Logistic Information Management System
MCWH & N	Maternal, child, and women's health & nutrition
MDG	Millennium development goal
MDR	Multi-drug resistant
MMC	Medical male circumcision
MMR	Maternal mortality rate
MOU	Midwife obstetric unit
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
NDOH	National Department of Health
NEC3	New engineering contract
NHI	National Health Insurance
NMB	New main building
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	Out-patient department
OSD	Occupational specific dispensation
P1	Priority 1
PACS	Picture Archive Communication System
PACS/RIS	Picture Archive Communication System and Radiological Imaging System
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

PGWC	Provincial Government Western Cape
PHC	Primary health care
PHS	Primary health services
PMTCT	Prevention of mother-to-child transmission
PPHC	Personal primary health care services
PPP	Public private partnership
PPT	Planned patient transport
PSP	Professional service providers
PTB	Pulmonary tuberculosis
QA	Quality assurance
RCC	Rolling continuation channel
RIS	Radiological Imaging System
RTI	Road traffic injuries
SA	South Africa
SADHS	South African Demographic and Health Survey
SANC	South African Nursing Council
SANTA	South African National Tuberculosis Association
SAPS	South African Police Service
SATS	South African Triage System
SCM	Supply chain management
SHERQ	Safety, health, environment risk and quality
SLA	Service level agreement
SM	Saving mothers
SMMEs	Small, medium and micro enterprise
SO	Strategic objective
SP	Strategic plan
STI	Sexually transmitted infections
TB	Tuberculosis
U5MR	Under 5 mortality rate
U-AMP	User asset management plan
UCD's	Intra-uterine contraceptive devices
WCCN	Western Cape College of Nursing
WCDoH	Western Cape Department of Health
WCRC	Western Cape Rehabilitation Centre
WHO	World Health Organisation
WSAR	Wilderness search and rescue system
WSP	Workplace skills plan
XDR	Extreme drug resistant

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