



Western Cape
Government

Health



Healthcare 2030

The Road to Wellness

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The Road to Wellness**

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March 2014

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ABBREVIATIONS

ALS	Advanced life support
APL	Approved post list
ART	Antiretroviral treatment
ARV	Antiretroviral
ASR	Air sea rescue
BI	Business intelligence
BLS	Basic life support
BMI	Budget management instrument
CAD	Computer-aided dispatch
CBO	Community-based organisation
CBS	Community-based services
CCG	Community care giver
CCW	Community care worker
CDC	Community day centre
CEI	The Centre for e-innovation
CDU	Chronic dispensing unit
CHC	Community health centre
CHW	Community health worker
CMI	Compliance management instrument
CI	Confidence interval
CNP	Clinical nurse practitioner
COCT	City of Cape Town
COO	Chief Operating Officer
CSP	Comprehensive Service Plan
DHS	District health services / system
DoE	Department of Education
DITCOM	Departmental IT Committee
DPSA	Department of Public Service Administration
DRG	Diagnostic-related group
DSD	Department of Social Development
DTaP-IPV/Hib	Diphtheria, Tetanus, acellular Pertussis, inactivated polio vaccine and Haemophilus influenza type B combined
DTPW	Department of Transport and Public Works
ECD	Early childhood development
ECM	Enterprise content management
ECT	Emergency care technician
EEV	Emergency equipment vehicle
EFAR	Emergency first aid response
EMS	Emergency medical services
ENT	Ear Nose and Throat
FBS	Facility-based services
FBU	Functional business unit
FPL	Forensic pathology laboratory
FPS	Forensic pathology services

ABBREVIATIONS

FTE	Full-time equivalent
GIAMA	Government Immovable Asset Management Act
GBV	Gender-based violence
GSA	Geographic service area
Ha	Hectare
HCBC	Home community-based carers
HR	Human resources
HRM	Human resource management
HSRC	Human Sciences Research Council
HCT	HIV counselling and testing
ICD10	International classification of disease coding
ICS	Improved conditions of service
ICT	Information and communications technology
ICU	Intensive care unit
IDMS	Infrastructure delivery management system
IDS	Intellectually disabled services
IFR	Institute for Futures Research
IHI	Institute for healthcare improvement
IMR	Infant mortality rate
ILS	Intermediate life support
IPV	Intimate partner violence
IT	Information technology
IUSS	Infrastructure Unit Systems Support
L1	Level 1
L2	Level 2
L3	Level 3
MDG	Millennium Development Goal
MDR TB	Multi-drug-resistant TB
M&E	Monitoring and evaluation
MIMMS	Major Incident Medical Management System
MMR	Maternal mortality rate
MRC	Medical Research Council
MTEF	Medium-term expenditure framework
NCD	Non-communicable disease
NDP	National Development Plan
NEC	New engineering contract
NHI	National Health Insurance
NHS	National Health Service
NHS	National Health System
NPC	National Planning Commission
NPO	Non-profit organisation
NSDA	Negotiated Service Delivery Agreement
NSRI	National Sea Rescue Institute
OHC	Oral health centre
OHSA	Occupational Health and Safety Act

ABBREVIATIONS

OT	Occupational therapist
OSD	Occupation-specific dispensation
P1	Priority 1
P2	Priority 2
PACS	Picture archives and communication systems
PAC	Provincial AIDS Council
PCE	Person-centred experience
PDA	Personal Digital Assistant
PDE	Patient Day Equivalent
PERO	Provincial Economic Review and Outlook
PFMA	Public Finance Management Act
PHC	Primary health care
PLWID	People living with intellectual disabilities
PMTCT	Prevention of mother-to-child transmission
PN	Professional Nurse
PSA	Public Service Act
PTMS	Provincial transversal management system
RCW	Rehabilitation care worker
RIS	Radiology information systems
RTI	Road traffic injuries
SAAF	South African Airforce
SANAC	South African National Aids Council
SHERQ	Safety, Health, Environment, Risk and Quality Management
SITA	State information technology agency
TB	Tuberculosis
U-AMP	User asset management plan
UNDP	United Nations Development Programme
VPUU	Violence Prevention through Urban Upgrade
WCDoH	Western Cape Department of Health
WCDTPW	Western Cape Department of Transport and Public Works
WCG	Western Cape Government
WCIDMS	Western Cape Infrastructure Delivery Management System
WCRC	Western Cape Rehabilitation Centre
WCL	Weighted case load
WH	Women's health
WHO	World Health Organization
WMA	World Medical Association
WSAR	Wilderness Search and Rescue
XDR TB	Extensively drug-resistant TB

Minister's Message: Healthcare 2030

It gives me great pleasure to release the Healthcare 2030 vision of the Western Cape Government, which has been endorsed by the provincial cabinet. The Department of Health is to be congratulated on the in-house development of this document, which reflects a cohesive and powerful vision for the future of health care in this province. I would like to sincerely thank the many individuals and organisations that took the time to make significant inputs into this process. It is my wish that the vision of Healthcare 2030 is shared and owned by the broader communities of the Western Cape.

The publication of Healthcare 2030 is the start of a new journey in health care reform in the Western Cape. It is important that all parties in the province and beyond engage in a dialogue to deepen our understanding and build a common commitment to the vision, values and principles of Healthcare 2030 in order to improve the health and wellness of our citizens.

Healthcare 2030 signals an important shift from illness to wellness. The conventional approach of health services with the focus on curative health care is not sustainable or desirable in the face of the increasing burden of disease. The community at large must own the responsibility for health and wellness. Wellness cannot be delivered by a health service to people who remain passive recipients of the process. Thus a "whole of society" approach to improving wellness is a key pillar of Healthcare 2030 and an important strategic objective of the Western Cape Government.



I therefore call on all parties to work closely with the Western Cape Government to bring this vision to fruition. We can only do better together!

A handwritten signature in black ink, appearing to be 'Theuns Botha'.

Theuns Botha
Provincial Minister of Health
Western Cape Government
March 2014

Foreword

Reflection on the achievements of and lessons learned from the 2010 Comprehensive Service Plan acknowledged that the Department, while making many positive organisational changes, had not focused adequately on many “people issues”, related both to patients as well as to the staff. For this reason since 2010, the patient experience and a person-centered approach to health care have become a focus of the Department. Following extensive consultation the vision of Healthcare 2030 emerged as “access to person-centered quality care”. The process of achieving a shared understanding of the vision, values and principles of Healthcare 2030 amongst staff and strategic partners will continue over the forthcoming period.

The Department has recognised that person-centered quality care can only become a reality if staff is dedicated to serve, committed to the vision, feel engaged and passionate about their work and feel happy and proud to work in the Department.

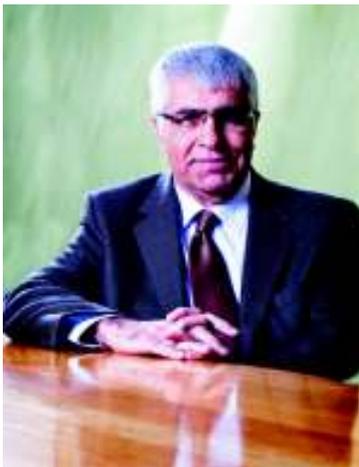
While the department is a large organisation with currently over 30 000 employees, quality care is delivered at the clinical interface between health workers and patients. Thus the Department will shift focus and effort to the support of the staff and management working at the service-rendering coalface.

Visible and responsive management and leadership at all levels of the organisation will be critical to the successful implementation of what is outlined in the Healthcare 2030 document. Championing the vision and principles of Healthcare 2030 amongst the staff as well as with our strategic partners will be key to success.

While the Department performs well within a South African context, Healthcare 2030 creates an exciting opportunity to sustain the good practices that have been built over the years as well as to be innovative and take the organisation to another level over the next two decades. Planning for the long term necessitates that the strategic intent is demonstrated through the vision, values and principles, but also to be flexible to adapt to changes in the internal and external environment.

The measure of successful implementation of Healthcare 2030 will lie in the achievement of time-bound targets. The Department will use flexible planning tools, based on the principles of Healthcare 2030 to determine the specific service needs for institutions and geographic areas. The priorities will need to be based on the affordability limits of the Department. Five-year and annual plans will translate Healthcare 2030 into implementable bites with defined indicators and targets to measure progress.

The achievement of the noble and indeed far-sighted vision of Healthcare 2030 requires collective commitment from our staff, partners and stakeholders as well as the cohesive functioning of all parts of the organisation. Unity of purpose to deliver a comprehensive quality health service and achieve optimal health and wellness outcomes amongst the best in the world will be key to success. The impact of the social determinants of disease on health outcomes is well documented and to address this requires a broader whole of society approach to improving health and wellness. The Department will need to play an important catalytic role to focus the attention of the broader community on these issues.



As I prepare to leave the department after more than a decade at its helm, I am reassured that the road map is now clear to take the department forward well into the 21st century. I have no doubt that the leadership and staff of the Western Cape Department of Health has what is needed to make this organisation one of the best of its kind in the world!

A handwritten signature in black ink, appearing to read 'C. Househam', written over a light-colored background.

Professor Craig Househam
Head of Department: Health
Western Cape Government
March 2014

EXECUTIVE SUMMARY

Introduction

Given the changing environment, uncertainties and assumptions, long term planning for the future necessitates a regular revisiting of the strategic thinking and basic parameters. The Western Cape Government: Health has finalised the Health Care 2030 framework, after considering the substantial verbal and written comments received on earlier drafts. It has been endorsed in principle by the provincial cabinet. The process of developing the 2030 strategy has already begun to energise, excite and engage our staff and strategic partners.

The document sets out the vision, values and principles guiding the Department to 2030. The document also presents a strategic framework for the Department together with a set of planning parameters and tools that will be incrementally applied. The 2030 strategy represents the third wave of health reform in the Western Cape since the Health Plan of 1995 and the Healthcare 2010. This document is divided into 10 sections and each section is discussed briefly below.

Background Context

Development of the 2030 strategy took into account changes in the external environment, which include demography, socio-economic determinants of health, burden of disease and its associated risk factors, climate change, advances in technology, and limited resources.

The changing policy environment and policy imperatives such as the Millennium Development Goals (MDGs), the 2030 National Development Plan (NDP), the priority National Health outcomes and the provincial strategic objective to improve wellness were also taken into account. The full implications of the National Health Insurance (NHI) policy have not been detailed to date and the 2030 strategy will need to be adjusted accordingly over time.

The Department will build on the strong foundation, direction and many other achievements of the Comprehensive Service Plan (CSP) and learn from the lessons in its planning and implementation towards 2030.

The two main focus areas that provide a compelling context for change are firstly, continuous improvement in the patient experience and the provision of quality health services on a sustainable basis to meet the escalating burden of disease and achieve wellness and secondly, the fact that we cannot achieve this without caring and better engagement of our staff.

Approach to Wellness :

Wellness is defined as not merely the absence of disease but the ability to maximise personal potential in all spheres of life. The World Health Organization (WHO) framework is used to think about an approach to Wellness. The five pillars of this framework include socio-economic context, differential exposure to risk factors, differential vulnerability, differential health care outcomes and differential consequences.

The Government of the Western Cape is committed to increasing the wellness of the people of the Province through a whole of society approach. The Department will strengthen its advocacy role through wide engagement with other departments and stakeholders outside of government.

The priority focus areas for intervention include:

1. Reducing Infectious diseases such as HIV/TB
2. Improving healthy lifestyles
3. Preventing injuries and violence
4. Improving maternal and child health
5. Strengthening women's health
6. Improving Mental Health

The Department wants to conceptually move away from an all consuming curative paradigm of treating illness and disease to one of prevention, promotion and wellness. This is in keeping with the World Health Organization's definition of Health being not merely the absence of disease but a complete state of physical, mental and social wellbeing. It's about fulfilling one's full potential in life.

From Health Service Delivery to Person-Centred Care

The crux of a re-imagined future in 2030 is the focus on person-centredness. This focus is woven throughout the document from the vision, values and principles to the service platform reconfiguration and quality.

The four conceptual pillars of person-centred care are: a person-centred approach, integrated provision of care, continuity of care, and a life course approach.

Vision, Values and Principles

Vision

The 2030 vision for the Western Cape Department of Health is: Access to person-centred, quality care. There are multiple perspectives to this vision. These perspectives include those of patients, staff, the community, the Department, spheres of government and strategic partners. To bring the vision for 2030 to life at a physical, intellectual and emotional level, we have attempted to describe in detail what the achievement of the vision will feel like for a range of role players, from patients to other stakeholders.

Values

The values of the Department are caring, competence, accountability, integrity, responsiveness and respect. The challenge of the Department is how to make these values a living reality for each staff member across the Department as we move towards our vision for 2030. The leadership will lead this process by example. Values are important in building a cohesive organisation and must be embedded in the organisational culture of the Department.

Principles

The principles underlying our vision and values are as follows:

1. Striving for person-centred quality of care
2. Adopting an outcomes-based approach
3. Commitment to the primary health care (PHC) philosophy
4. Strengthening the district health system model
5. Promoting equity
6. Operating with efficiency
7. Developing strategic partnerships

The development of a shared meaning and a rich, common understanding of these principles will evolve through a series of dialogues with staff and partners over time.

The evolution of a shared meaning and rich, common understanding of these principles will happen through a series of dialogues with staff and partners over time. The principles will inform the strategies to give effect to Healthcare 2030.

Leadership and Governance

Leadership

An essential requirement to communicate and build commitment to the vision of Healthcare 2030 is a dynamic and distributed leadership across the management, clinical and administrative ranks of the Department. Leadership is about inspiring change, providing strategic direction, building cohesion and motivating people. Steps to strengthen leadership and facilitate transformational action will be taken. Reciprocal accountability which is a shift from top down to mutual accountability is an important culture change that will help to cement a cohesive commitment to common objectives.

Leadership will demonstrate and embody prevailing organisational values, have highly developed inter-personal skills, encourage innovation, draw on the capability of all employees and be visibly collaborative with staff and partners.

A competitive values framework for organisational effectiveness identifies the tensions between the need to collaborate and the emphasis on competing for results, as well as the need to be creative and the requirements to control and comply. The key is to acquire the appropriate balance between these competing tensions for a specific situation.

Governance

According to the United Nations Development Programme, good governance is accountable, transparent, responsive, equitable and inclusive, effective and efficient, participatory, consensus oriented and follows the rule of law.

There is a rich legal and policy architecture that underpins the provision of public sector services in general and health services in particular. This includes the Public Finance Management Act, the National Health Act, the Western Cape Facilities Board Act and the Western Cape District Health Councils Act.

Greater effort will be made to make the statutory structures more functionally effective as conduits of community perspectives. This will include more effective communication and information sharing, capacity development within these structures and deepening of the trust and respect between them and the Department. Notwithstanding the complexity of community involvement, the Department will strive to increase community involvement in the design of health services.

Transparency, responsiveness and information sharing are important prerequisites for accountability. Greater effort will be made to communicate departmental plans and reports to the public, in a user-friendly format.

Clinical accountability will be embedded within the Department in line with the departmental clinical governance policy framework.

Service Platform

The shape of the envisioned 2030 service platform retains the original configuration of 2010 with a strengthening of primary health care (PHC) and district hospitals. The essence of the change is on how we do business within this service platform. The focus is on person-centred quality care, integrated provisioning, and continuity of care throughout the life course of the patient.

This strategic document focuses on the general health service platform and does not deal with any specific disciplines or sub-specialities. Special reference is made to tuberculosis (TB), rehabilitation, mental health and oral health in order to provide context to the re-alignment of these services from specialised hospitals to the mainstream health service.

The four tenets of the planning methodology are using the dependent population as a base, the smallest geographic entity for which there is good data, household income as a proxy for inequity and creation of norms and planning tools for application within specific service settings.

Primary Health Care Services

The PHC service component of the health system is the most critical component, as it serves as the entry point into the care continuum, and it caters for the vast majority of patient contacts. It comprises three distinct but inter-related service delivery platforms:

- Home and community-based care (HCBC),
- Primary care services (PCS) at health facilities, and
- Intermediate care.

Collectively these settings will provide a comprehensive array of preventive, promotive, curative, rehabilitative and palliative interventions.

Home and Community based care (HCBC)

HCBC is geared towards prevention and health promotion, with a complementary capacity for curative, rehabilitative and palliative care. It will support the actions people take to maintain health and well - being; prevent illness and accidents; care for minor ailments and long-term conditions; and recover from periods of acute illness and hospitalisation.

The core primary care team in HCBC comprises community care workers (CCWs) and a professional nurse. The service model is population-based and organised per electoral ward in the metro and per sub-district in rural areas. These teams will be entrusted with the responsibility of the health of a defined population. It does not depend on individual- or community-initiated access, thus maximising opportunities for preventive care and health promotion.

PHC services rendered in schools, crèches, old-age homes, the workplace and prisons will be governed by service level agreements between the Department and the custodian of these sites.

Counselling is an essential part of a health care provider's work, from encouraging adherence to supporting behaviour change, and has an important role in increasing the preventive and promotive aspects of the clinical encounter. The Department will further explore how, where and by whom counselling can be provided, what training and other resources will be required and how it could be implemented in a phased manner.

Primary care services

A comprehensive range of curative and preventive services are provided for with a complementary capacity for rehabilitative and palliative care at primary health care facilities.

The Clinical Nurse Practitioner, supported by a medical officer will provide the core of this front line service. There will be additional capacity to target amongst others, clinical support services, maternity care, eye care, Ear, Nose and Throat (ENT) services, oral health, nutrition, rehabilitation and chronic diseases. The specific circumstances within a geographic area – such as the burden of disease, access, economies of scale and efficiencies – will need to be considered to determine the provision of limited after-hour emergency services and labour ward facilities for the delivery of babies.

Intermediate care

Intermediate care refers to inpatient transitional care enabling patients to regain skills and abilities in daily living, with the ultimate discharge destination being home or an alternate supported living environment. Intermediate care involves post-acute-, rehabilitative- and end-of-life care. It allows for a seamless transition between acute care and the living environment, particularly where the person's ability to self-care is significantly compromised. Intermediate care is essential to alleviating the pressure on acute hospital beds.

Intermediate care teams will work in close collaboration with home-based care teams. Rehabilitation care workers (RCWs), working under the direction and clinical supervision of professional therapists, will deliver the bulk of required therapy. The introduction of a rehabilitation care worker is a major development in this service and will significantly improve access to rehabilitation.

Rehabilitation will be available for all impairment groups, including mental ill-health and intellectual disability. Support groups, adult day care facilities, supported living environments and occupational enrichment programmes are all part of the fabric of wholesome rehabilitation.

Acute hospital services

A well-functioning PHC service, as well as an efficient patient transport system are critical to the efficient functioning of acute hospitals. The international trends in the utilisation of hospitals and strategic parameters to guide the technical planning of acute hospitals are identified.

A home-grown set of norms for admission rates and average length of stay have been developed. The landscape of service provision will be dramatically different from the current reality after modernising and commissioning fully functional Khayelitsha-, Mitchells Plain-, GF Jooste-, Victoria-, Karl Bremer- and Helderberg hospitals.

The district hospital will provide a family-physician-driven service. The larger district hospitals will also provide a varying quantum of general specialist services depending on, amongst other things, the burden of disease and available infrastructure. These specialist services will not be departmentalised by clinical discipline in district hospitals. A detailed package of care for the large district hospital is being developed.

The regional hospitals will be general-specialist-led services that will also provide a district hospital service to the population in the immediate vicinity.

The central hospitals will be sub-specialist led, but will also provide a general specialist service to the population in their immediate vicinity. The National Department of Health is developing a tertiary services plan for the country, which will also inform the technical planning for central hospitals services. There will also be an enhanced capability to render specific rehabilitative care activities, psychiatric care and specific oral health service activities in the regional and central hospital.

Specialised hospitals

Mental health and psychiatric hospitals

There is strong evidence that mental illness is on the increase. This is further aggravated by societal stressors such as socio-economic deprivation, violence, poor family structures, as well as co-morbidly with chronic diseases, substance abuse and HIV. There are large proportions of unmet need. Importantly, there is emerging evidence that a significant proportion of patients can recover from their mental illness.

The introduction of the Mental Health Care Act has created a statutory obligation to improve access to mental health care by mainstreaming and integrating mental health services in the general health services. The key components of the package of care to be provided at all levels of the service are summarised. This section must be read in conjunction with the rest of the service delivery platform sections of the document. The hospital services plan that will be developed after the 2030 framework has been adopted, will include beds required for psychiatric services across the service platform.

The Department believes that the majority of people living with intellectual disabilities require supported living arrangements and not medical institutionalisation. The medical treatment should be provided on a needs basis by the Department of Health. The supported living arrangements should be the responsibility of the Department of Social Development (DoSD). An integrated approach by the whole of government should ensure that the needs of this vulnerable community are addressed.

Rehabilitation services and the Western Cape Rehabilitation Centre

In line with the departmental approach to improving the person centred experience and to providing integrated health care, rehabilitation services will be accessible at all levels of care. Acute services will be provided in health facilities such as district hospitals and PHC facilities, whereas non-acute services will be provided from a community-based platform. The major investment towards 2030 is to mainstream and strengthen these services within the general health service platform. A community rehabilitation care worker has been piloted with very positive results for broader application.

The Western Cape Rehabilitation Centre will continue to provide high-intensity-, specialised comprehensive, and multi-disciplinary inpatient and outpatient rehabilitation services. An integral aspect of the rehabilitation service will include the provision of the required mobility- and other assistive devices, orthotics and/or prosthetics, to facilitate full re-integration of persons with disabilities back into the community.

Tuberculosis services and TB hospitals

Ninety percent of TB is currently managed within the PHC platform and strengthening PHC services will improve efficiencies within TB hospitals. A PHC-based model for the treatment of multi-drug-resistant TB has been successfully piloted and will be rolled out.

A TB hospital will make provision for acute, sub-acute and chronic care beds for the proportion of patients who will be transferred from acute hospitals. The patient information system will also be improved to allow for the efficient continuity of care and referrals across the service platform. This will be a critical success factor in the effective management of the TB patient.

Oral health and oral health centres

Oral conditions are important public health concerns because of their high prevalence, their severity, their impact on the quality of life and the public demand for services.

The oral health service platform will be strengthened across all levels, with the largest investment in PHC services. The focus will shift from curative care to integrated health prevention and promotion – including education, advocacy for tooth brushing and fissure sealant programmes. Specialised services for complex conditions will be provided at the central hospitals and the oral health centres, which will also provide outreach and support to the district health services.

Specialised services

Emergency medical services (EMS)

Access to emergency care is a constitutional right in South Africa and is prioritised within the 2030 vision for

person-centred quality care. Emergency medical services has set ambitious targets for 2030, which may have to be adjusted within the available resources.

The EMS has five important components including communications, ambulance service, medical rescue, aeromedical and non-emergency patient transport. The province is geographically divided into six districts, each with an emergency contact centre, which also doubles as a disaster risk management centre in the rural districts. The communication centre will receive a modernised software application to enhance its operations. This will also enable better management reporting in real time and improved communication with the emergency centres in hospitals. A bed bureau will also be developed to monitor the availability of acute beds in all the major hospitals.

The aeromedical service will continue to play a vital role in the emergency transfer of complex patients to the referral hospitals.

The non-acute patient transport service will also be strengthened as a key component for access to services (especially for rural patients) and will improve efficiencies of acute hospitals by facilitating only those patients that have difficulty with transport out of these hospitals.

Forensic pathology services

The forensic pathology service (FPS) is a specialised service rendered by forensic pathologists, supported by forensic pathology officers. Access is also required to other sub-specialists such as histo-pathologists, odontologists and toxicologists. The FPS will continue to be provided via 18 forensic pathology laboratories and two departments of forensic medicine supported by a central management and administration component. The potential for consolidation of services between laboratories will also be explored. The laboratories are graded between M1 to M6 depending on the workload capacity and complexity to be managed.

A model has been developed that considers a number of factors including population estimates, burden of disease and its impact on caseload, workload, case mix, case complexity, direct case contact time as well as the optimal configuration of services. Affordable targets and staffing levels will be developed through the application of the model within defined budget allocations.

Quality of Care

The essence of Healthcare 2030 is "access to person-centred quality care". This vision needs to be rekindled with renewed vigour. The Department needs to deepen the daily conversation around quality and to make meaning of what terms like quality care and superior patient experience actually mean, what will it require to make it happen, how do we give effect to it in practice and make it a part of our being in our daily work.

The amended National Health Act, the National Core Standards and the establishment of the Office of Health Standards Compliance provide a legislative framework and mechanisms to ensure quality improvement. In parallel to the statutory obligation to comply with the national core standards, the Department intends to build sustainable commitment to continuous improvement through its local person-centred experience (PCE) strategies.

The vision for quality of care within the 2030 strategy will focus on person-centred experience, technical quality and caring for the carer. Caring for and engaging staff is central to achieving optimal PCE and is a theme that is picked up in several parts of the 2030 strategy.

Support Services

The process of developing a new vision and strategic framework for 2030 has created an opportunity for critical reflection and review of Support Services. There will be a cohesive alignment and common commitment of both line function services and support services to the shared vision, set of values and principles of Healthcare 2030. The organisational culture of working together and continuous improvement will be embedded in the Department.

The leadership at all levels will systematically create and nurture the space to allow for new and more effective ways of doing business within the department. The launch of Healthcare 2030 provides renewed energy and opportunity for innovation. Building strong and trustful relationships, the free flow of information and ideas, effective communication across boundaries and divisions and working in cross functional and diverse teams, will enhance the culture of learning and innovation.

The Department has a decentralised management model within which the roles, responsibilities, powers and functions and the levels of accountability are well defined. There will be three tiers of management viz. at the service entity, district or regional and provincial levels. Over the next few years, the focus is going to be on developing the clinical and administrative leadership and management capacity at institutional level that is directly responsible for service delivery and quality of care.

Support Services are defined as those that are not direct patient facing. The client of support services is therefore primarily the line function manager and its key purpose is to enable service delivery. Support services include financial management, human resources management, appropriate infrastructure, medical technology, availability of consumables, information management and ICT, communication as well as health programmes and clinical support services (e.g. pharmacy services, radiography, laboratories and bloods). The substance and form of these support services are centrally informed by the service delivery imperatives.

Clinical support services

Certain of the support services are more closely aligned to direct patient care and have been clustered as clinical support services. This includes, amongst others, laboratory services, provision of blood products, pharmacy services, imaging and radiography, and nursing. These services are critical to the efficient and effective delivery of patient care. The health professionals that perform these functions within the service rendering facilities are an integral part of the team at the local level.

The Clinical Support Services will revise their priorities and policies, in collaboration with the line function service, to align with the vision and principles of Healthcare 2030.

Human resources

Notwithstanding the envisaged changes in the system and opportunities that advances in technology will create, the people factor will be central to the successful achievement of the strategic objectives of Healthcare 2030. The biggest challenges to achieving the objective of a person-centred service are: re-energising the staff and building renewed commitment to the principles, vision and values of 2030 and creating an organisation where staff have a deep sense of belonging.

Leading and managing the people within the Department is a distributed responsibility at all levels of the organisation, and not the sole preserve of human resource management. The day-to-day listening to staff and effectively communicating, providing meaningful support, uplifting morale, managing performance for results and leading by example is the function of the line manager.

The 2030 Strategic Human Resources (HR) approach will focus on :

- » developing capability in HR analytics and research to provide the workforce intelligence that informs workforce planning, development and monitoring and evaluation (M&E);
- » an integrated HR policy and planning framework ;
- » Executing the HR priorities which include :
 - People management (bringing back the "human" in HRM),
 - Employee Wellness,
 - Scarce Skills,
 - implications for Task Shifting/ Sharing,
 - Leadership and management development.

Implementation support will include efficient and creative addressing of HR operational management challenges, performance management and productivity, capacity building and provision of systems, tools and support.

From a M&E perspective, the Department will have effective systems and a set of metrics in place to assess progress against the objectives of Healthcare 2030.

Financial management

There will always be an inevitable tension between effectively balancing the demand for health services against limited resources. The allocation of budgets, financial management and the procurement of supplies are a major support function that is central to the effective and efficient functioning of the Department and the achievement of the objectives of Healthcare 2030.

Gathering good financial intelligence to inform the planning and resourcing of services is key. Financial policy priorities include appropriate decentralisation with devolved accountability, building financial accountability into performance management and declaring war on red tape. Integrated planning and priority setting will inform budget allocations. A standard medical and surgical consumables and equipment list will simplify procurement and improve efficiencies.

Implementation support to the services will include automation, improved procurement and stock management, better communication and relationships across all levels of the service, staff recruitment and development.

The Department will closely monitor expenditure against its budget allocation, measuring efficiency and cost effectiveness and monitor compliance with financial prescripts to ensure that it receives an unqualified audit.

Infrastructure and technology

The modernisation, management, and maintenance of health infrastructure and technology continue to remain one of the cornerstones for enabling the health service in 2030. The process for the delivery and maintenance of health infrastructure and technology also needs to be economical, efficient, effective, and take cognisance of the continuous development of medical technology.

The approach to policy and planning of Infrastructure will continue to be governed by the 5L's : Long life (sustainability), Loose fit (flexibility and adaptability), Low impact (reduction of the carbon footprint), Luminous healing space (enlightened healing environment), Lean design and construction (collaborative and integrated).

The following priority areas have been identified: PHC facilities, Emergency Centres at Hospitals, District hospital replacements, the New Tygerberg Hospital, a focus on maintenance of facility infrastructure.

Monitoring and Evaluation will focus on maintenance and capital projects, physical condition of the health infrastructure and technology and learning lessons from post-occupancy evaluations of newly commissioned facilities.

This Integrated Delivery Management System provides tools, systems, and processes for improved management of infrastructure programmes and project

Information communication technology (ICT)

One of the most exciting developments is the realisation of the centrality of Information Communication and Technology (ICT) as an enabler and the opportunities it presents in achieving the vision and objectives of 2030. ICT will be mainstreamed within the generic processes of planning, budgeting, risk management, implementation, monitoring and evaluation in the department. This has served to systematically elevate the importance and focus of ICT in the minds of managers.

Business Intelligence (BI) with good-quality information is an important prerequisite for the planning, implementation and M&E of the 2030 plan. The strength of BI lies in its ability to integrate information from various systems and provide meaningful reports for better management. Integrated information at a clinical level will advance the cause of person-centredness and continuity of care, improve clinical management and automated coding will facilitate effective data mining.

Data Harmonization refers to the agreement, synchronization, and coordination of eHealth initiatives in the department to be able to inter-operate more effectively to achieve the goals of Healthcare 2030. The project focuses on Financial Business Intelligence and Clinical Business intelligence

ICT Policy and Planning will prioritise ICT Governance including risk management, producing annual implementation and project plans to give effect to the objectives in the ICT strategic plan, developing a system for technology refresh, creating organisational arrangements to encourage and respond to IT innovation and using the potential of mobile technology to advance health care delivery.

Implementation support will focus on data harmonisation at a patient level that will enable better and

integrated patient management, use of integrated information for research and health services management, the electronic Continuity of Care Record (eCCR) which is intended to foster and improve continuity of care across institutions and health professionals, and the availability of skilled technical capability. A range of ICT opportunities are identified at various levels i.e citizen, home and community based platform, health facility, management, support services.

The ICT M&E process will monitor progress on the roll-out of ICT projects.

Monitoring and Evaluation (M&E)

The Department will apply the Triple AIM framework, which identifies key dimensions for “optimising health system performance”. These dimensions include population health outcomes, health services (acceptability, appropriateness, access, quality, equity, effectiveness, and person-centeredness) and cost efficiency in service delivery. A set of potential indicators to measure each of these dimensions is proposed. The National Development Plan indicators will also be incorporated into the M&E framework.

The culture of monitoring and evaluation and continuous improvement which is important for health system strengthening, will be developed through improving the quality of information, deepening capacity, ensuring leadership and accountability and the widespread sharing of good practices. The purpose of M&E is to improve decision - making and support the process of whole system change and must allow for real-time learning and feedback i.e. move beyond the mere monitoring of variances from targets to meaningful dialogue to better understand and address the underlying challenges of the system and service.

Health research is critical to understanding the well-being of the population, the burden of disease, its associated risk factors and populations at highest risk as well as the performance of the health system with regards to access, quality, efficiency and impact.

Conclusion

Healthcare 2030 is a substantial piece of work built on the preliminary thinking, vision, principles and values circulated in earlier drafts, the extensive and valuable input received from staff and external stakeholders and the further evolution of conceptual thinking and technical work to date.

The thinking and principles of 2030 have begun to infiltrate the daily language and conversations in the department. The journey to 2030 has begun in parallel to the process of finalising the 2030 framework.

The process of consultation and engagement and coalescing of the multiple perspectives of people within and outside of the Department into a cohesive document is always a challenge. The Department believes that this final version is a fair reflection of the collective thinking and its strategic intent to date.

The provincial cabinet has endorsed Healthcare 2030 in principle. The work will now shift to converting this broad strategic direction to more specific details by applying the models and approaches to specific services and geographic areas. This will include, amongst others, identifying the priorities for incremental implementation through five year and annual plans within the affordability limits of allocated budgets.

Healthcare 2030 as a strategic compass will have to be regularly revisited to be able to titrate its intention and assumptions with the changing realities of the next two decades.

History will judge us by the degree to which we have been able to put in place the various plans and processes we have outlined in this document and its actual implementation to improve the health status of our citizens.

The provincial cabinet has endorsed Healthcare 2030 in principle. The work will now shift to converting this broad strategic direction to more specific details by applying the models and approaches to specific services and geographic areas. This will include, amongst others, identifying the priorities for incremental implementation through five year and annual plans within the limits of allocated budgets.



SECTION A:

THE CONTEXT OF HEALTHCARE 2030

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SUMMARY POINTS

1. This is the third wave of health reform in the Western Cape since 1995.
2. The Department appreciates the extensive comments on the earlier drafts of 2030, which were generally positive and the criticisms constructive.
3. Given the uncertainty of the environment and the need for flexibility to adapt, the Department has chosen to develop a high-level strategic framework that provides the vision, values and principles of 2030 with a set of planning parameters and tools that can be locally and incrementally applied within a specific context.
4. The 2030 planning process is as important as the end product. It has already served to energise, excite and engage our staff and strategic partners.

Introduction and Background

2030 is about plotting the path to a re-imagined future health service over the next two decades. This framework has been developed after having considered four main areas:

- » Changes, including opportunities and threats in the external environment;
- » Distilling key lessons from the Comprehensive Service Plan (CSP) of 2010;
- » Fresh thinking about a re-imagined future; and
- » Significant comments that have been submitted on both drafts

These areas have provided a compelling context for change and created an exciting opportunity to take the Department to new heights in this third wave of health reform in this province since the 1995 Health Plan and the CSP of 2010.

The Department's preliminary thinking was shared in a draft document circulated for public comment in 2012 and again in December of 2013. Facilitated dialogue sessions were convened with a range of external stakeholders and staff through specially convened sessions by the geographic service area management structures. Many submissions were received on both occasions and colleagues raised interesting, relevant and creative ideas during the dialogue sessions. All comments were considered and the written comments were individually responded to.

The values, vision and principles of 2030 were generally supported. The absence of a formal evaluation of the 2010 plan was noted and a substantial section has been included in this document to remedy this for 2030. Some of the major omissions from the earlier drafts, such as the impact of climate change and the potential role of advances in information and communications technology (ICT) in health, have been addressed in this final version. Many of the specific technical comments have either been addressed in the service delivery platform or support services section or will be addressed when the service plans emanating from 2030 framework is further developed in detail.

The Department recognises the high levels of uncertainty and complexity associated with planning for the long term. Examples of these include: the size of the financial envelope available to provide health services beyond the medium term; the cost of human and other resources required in health services; and the potential impact of National Health Insurance (NHI) on the organisational, functional and service delivery arrangements between the public and private sectors. The Department has therefore chosen to develop a high-level strategic framework that provides the vision, values and principles of 2030 with a set of planning parameters and tools that can be locally and incrementally applied within specific contexts. Healthcare 2030 is meant to show long term strategic intent which must be constantly revisited to allow for flexibility and adjustments for the kind of changes mentioned above.

The 2030 planning process is as important as the end product. It has already served to energise, excite and engage our staff and strategic partners. Work has already begun to embed the principles, vision and values of 2030 within the language of the Department and plant the seeds within the hearts and minds of our staff.

SUMMARY POINTS

1. Changes in the environment include demography, socio-economic determinants of health, politics, burden of disease and its associated risk factors, climate change, advances in technology and limited resources.
2. 2030 takes into account the changing political environment, which includes the MDGs, the National Development Plan, priority national health outcomes, the NHI, and provincial strategic objectives.
3. The Department will build on the strong foundation, direction and many other achievements of the Comprehensive Service Plan (CSP) and learn from the lessons in its planning and implementation towards 2030.
4. A baseline assessment against national core standards identifies several areas for improvement in the quality of care. Surveys have identified significant numbers of staff that do not feel engaged in the organisation.
5. The two main focus areas that provide a compelling context for change are the continuous improvement in the patient experience and the provision of quality of health services on a sustainable basis to meet the escalating burden of disease and achieve wellness and the fact that we cannot achieve this without caring and better engagement of our staff.

External Environment

Account has to be taken of the on-going changes in the environment. These include, amongst others, demography, socio-economic determinants of health, political contexts, burden of disease and the associated risk factors, advances in technology, and the global, national and provincial policy environment. Some of the main determinants of this context are described below.

Demography: The Census 2011 data was released in November 2012. According to the State of the Cities report, the City of Cape Town had the highest growth rate at 20.91% between 2001 and 2007. Migration and urbanisation are important factors in this regard. The Western Cape population is estimated to be 5,8 million currently. Some of the important trends are: life expectancy slowly increasing; population growth continuing until 2030; population ageing, a changing racial mix; and the continuation of urbanisation and migration.

Burden of disease: The provincial population is afflicted with a quadruple burden of disease that has been well documented. A more detailed summary is found in Annexure A. The level of trauma from interpersonal violence and road traffic accidents, the escalating burden of chronic diseases (including mental ill health and its associated risk factors), the twin burden of HIV with TB and the conditions associated with maternal and child health form the bulwark of the quadruple burden that the health service must effectively respond to. There are also changes in the cause of mortality that must be taken into account in the way we respond. For example, HIV that used to be the number one cause of death of children under five years of age several years ago has been significantly addressed through the prevention of mother-to-child transmission (PMTCT) and antiretroviral (ART) programmes.

The incidence of non-communicable diseases which consist mainly of cardiovascular diseases, cancers, respiratory diseases, diabetes and mental illness and its associated risk factors such as smoking and obesity is on the increase in the Western Cape. Large proportions of these patients are undiagnosed, untreated or poorly controlled on treatment. This is one of the most significant risks in the forthcoming decades and requires not only a comprehensive approach by the Department of Health but a full frontal assault by the whole of society similar to that undertaken to control HIV and AIDS.

Socio-economic conditions: It is well documented that socio-economic factors are important upstream determinants of health. The National Development Plan identifies poverty, inequality and unemployment as the key triad of socio-economic challenges facing South Africa. Notwithstanding the higher level of development and living standards in the Western Cape, these challenges are as relevant to the Western Cape as they are to the rest of the country. According to the Provincial Economic Review and Outlook (PERO), in quarter two of 2012, the Western Cape had an unemployment rate of between 24,9 percent and 33,5 percent depending which definition

was used. The Gini coefficient, which is a measure of inequality, was 0,63 for the province in 2008 with one representing complete inequality and zero representing complete equality. Also in 2008, 22.3% of the population lived below the poverty line of R6 302 per annum. Associated socio-economic challenges are a lack of basic services such as clean water and sanitation, electricity and housing. These challenges are compounded by the pace and scale of migration and urbanisation in relation to the ability of government to provide these services. The situation is aggravated by the low levels of numeracy and literacy and other skills within significant sections of the population. This situation exists notwithstanding the significant gains made by government in the delivery of basic services to date.

Health outcomes: Despite the fact that the WC provincial health outcomes are good, they still lag behind what is required by the MDG targets. Notwithstanding the 2015 deadline for the MDG goals, achieving these targets has now become one of the key drivers of the strategy for 2030 and the revised targets will continue to drive our vision in a post-2015 development agenda. Outcomes for significant challenges not included in the current MDGs such as chronic diseases, mental health and trauma will also be addressed.

Public expectations and accountability: There is a growing awareness and demand for the right to good-quality health care. Public expectations are high and there is an increased demand for public accountability and responsiveness of government. This is evidenced by the increasing frequency of social protest action by communities.

Sustaining and improving good practice: While the Department currently performs well on many fronts including improving health outcomes and consistently achieving an unqualified audit over the last ten years, there is a need to embed and institutionalise good practice to sustain and improve its performance. The culture of organisational learning and continuous improvement and capacity to change will be strengthened to raise the performance bar even higher.

Limited resources: Tension between limited resources and growing health needs is inevitable and requires that the Department constantly stretch and optimise the value of the health rand. It is important to ensure that priorities are identified and that scarce resources are allocated to the most cost-effective interventions. Productivity and operational efficiency must be addressed on an on-going basis. Assumptions will be made with regards to the available funding envelope to plan for in the medium to long term. This is difficult to predict and will be impacted upon by factors such as the growth of the economy and the pooling of resources through National Health Insurance.

Climate Change: Climate change is predicted in some quarters to be the biggest global health threat of the 21st century. Climate change, water scarcity and extreme weather events are all identified in the top ten risks in the Global Risks 2014 Report of the World Economic Forum. The increased emission of greenhouse gases and the consequent climate change effects are significant and growing realities that must be addressed. South Africa contributes about 39 percent of the greenhouse gases (GHG) on the African continent. From assessments of other countries, health services are an important contributor to greenhouse emissions.

Climate change policy and adaptation plans have been developed by the National Department of Health and the Western Cape Government (WCG). These provide a useful framework within which the Department will develop and action its strategies.

The impact of climate change is predicted to be wide ranging and will, amongst other things, include: water scarcity and food insecurity; extreme events such as fires, floods and disasters; and the outbreak of infectious diseases. The poorest communities remain the most vulnerable.

The health service thus needs to be in a state of readiness to address the public health consequences of climate change. This will include improved surveillance and disease outbreak management capacity, better disaster management and rescue responsiveness in collaboration with other departments and strengthened emergency services within health.

The Department will put in place tools to measure its own contribution to GHG, set targets and implement cost-effective mitigation measures to systematically reduce its GHG contributions. This will include a range of interventions from better infrastructure design to more environmentally friendly operational policies such as the Green Procurement Policy of the WCG. The four focus mitigation areas are currently water usage, electricity consumption, waste management and distances travelled.

The Department has created a climate change committee (CCC), convened by a senior manager, to systematically start to address both the mitigation and adaptation aspects. Work is currently in its infancy. Disaster preparedness in the Department is being systematically supported by the emergency medical services. The CCC will also be the liaison point for engaging with other sectors and spheres of government in this regard. Khayelitsha and Lentegeur hospitals have been identified as flagship projects as part of the Premier's 110% Green campaign. Local initiatives by institutions in the Department are being encouraged and the expertise, technical knowledge and research within the Higher Education Institutions (HEIs) are being harnessed by the Department.

Medical Technology and Information and Communication Technology: Rapid advances in technology raise unlimited opportunities for improving patient care, increasing efficiencies and doing business differently. These opportunities must be optimised within our available resources to obtain best value for the health rand.

Legislative and Policy Environment

This section provides an overview of the national legislative and policy framework within which the Department functions.

Table 1 Summary of key policy and legislative frameworks guiding development of Vision 2030

International	<p>Millennium Development Goals</p> <p>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. A table that summarises the goals, targets and indicators of the MDGs is contained in Annexure B. The specific health-related MDGs are goals four, five and six, which relate to child mortality, maternal mortality and HIV/TB/Malaria respectively. The MDGs are being currently reviewed by the UN.</p> <p>UN Convention on the Rights of People with Disabilities</p> <p>This was signed in 2007 and is a wide ranging international treaty of human rights to protect the rights and dignity of persons with disabilities. The principles include respect and individual autonomy, non – discrimination, full and effective participation and inclusion in society, equality of opportunity and accessibility.</p> <p>Article 25 makes specific provision for persons with disabilities to attain the highest standards of health without discrimination.</p>
Constitutional	<p>The Constitution of the Republic of South Africa, Act No. 108 of 1996</p> <p>The rendering of health services is a national and provincial legislative competence in terms of Schedule 4, Part A of the Constitution of the Republic of South Africa, 1996. The Constitution places the following obligations upon the Department:</p> <ul style="list-style-type: none"> » Section 27(1)(a) obliges the Department to provide access to health services, including reproductive health care; » Section 27(3) provides that no-one may be refused emergency medical treatment; and » Section 28(c) prescribes that every child has the right to basic health care.
National	<p>Negotiated Service Delivery Agreement (NSDA)</p> <p>The National Government continues to follow an outcomes-based approach and has identified 12 targeted outcomes against which the respective national ministers have signed performance agreements with the President. The health outcome is: improve healthcare and life expectancy among all South Africans. The key outputs of the NSDA between the National Minister of Health and the President are:</p> <ol style="list-style-type: none"> 1. Increasing life expectancy; 2. Decreasing maternal and child mortality; 3. Combating HIV and AIDS and decreasing the burden of disease from TB; 4. Strengthening health system effectiveness, with a particular focus on: <ul style="list-style-type: none"> » Revitalisation of primary health care; » Health care financing and management; » Human resources for health; » Quality of health and the accreditation of health establishments; » Health infrastructure; and » Information, communication and technology and health information systems.

National	<p>National Development Plan (NDP)</p> <p>The NDP charts a new path for South Africa and seeks to eliminate poverty and reduce inequality by 2030. In terms of the plan, by 2030 the health system should provide quality health care to all, free at point of service, or paid for by publicly provided or privately funded insurance. The NDP identifies the following areas in the public health system for reform:</p> <ul style="list-style-type: none"> » Improved management, especially at institutional level; » More and better trained health professionals; » Greater discretion over clinical and administrative matters at facility level, combined with effective accountability; and » Better patient information systems supporting more decentralised and HBC models. <p>The section on health also identifies the following key targets and actions</p> <ul style="list-style-type: none"> » By 2030, life expectancy should reach at least 70 for both men and women; » The under-20 age group should largely be an HIV-free generation; » The infant mortality rate should decline from 43 to 20 per 1 000 live births and the under-five mortality rate should be less than 30 per 1 000 from the 104 it is today; » Maternal mortality should decline from 500 to 100 per 100 000 live births; » All HIV-positive people should be on treatment and preventive measures such as condoms, and microbicides should be widely available, especially to young people; » Non-communicable diseases should reduce by 28% and deaths from drug abuse, road accidents and violence by 50%; and » Everyone should have access to an equal standard of basic health care regardless of their income.
National Department of Health	<p>National Health Act No. 61 of 2003</p> <p>This Act provides the framework for a structured uniform health system taking into account the obligations imposed by the Constitution and other laws within the national, provincial and local governments spheres with regard to health services.</p> <p>Ten Point Plan</p> <p>This is a key policy document which serves as a roadmap to consolidate Government's response to health system challenges. It includes:</p> <ol style="list-style-type: none"> 1. Provision of strategic leadership and creation of a social compact for better health outcomes. 2. Implementation of a National Health Insurance (NHI) Plan. 3. Improving quality of health services. 4. Overhauling the health care system and improving its management. 5. Improving HR planning, development and management. 6. Revitalisation of physical infrastructure. 7. Accelerated implementation of the HIV and AIDS and sexually transmitted infections National Strategic Plan 2007-11 and increased focus on TB and other communicable diseases. 8. Mass mobilisation for better health for the population. 9. Review of the drug policy. 10. Strengthening of research and development.

Human Resource Strategy for the Health Sector 2012/13 – 2016/17

This strategy deals with the supply of health professionals and equity of access; education, training and research; and the working environment of the health workforce. Eight priorities were identified which form the framework for the HRH strategy:

- » Leadership, governance and accountability;
- » Health workforce information and health workforce planning;
- » Re-engineering of the workforce to meet service needs;
- » Upscaling and revitalising education, training and research;
- » Creating infrastructure for workforce and service development - academic health complexes and nursing colleges;
- » Strengthening and professionalising the management of human resources and prioritising health workforce needs;
- » Ensuring professional, quality care through oversight, regulation and continuing professional development;
- » Improving access to health professionals and health care in rural and remote areas.

Green Paper on National Health Insurance (NHI)

NHI will be introduced to South Africa over a 14 year period. The strategic intent is to build social solidarity and provide universal coverage of health care. The NHI reforms will focus on:

- » Strengthening of district health structures, not only in terms of the re-engineered PHC approach but establishing the District Health Authorities that would need to contract with the NHI Fund and with accredited private providers;
- » Comprehensive quality improvement, assurance and compliance by all providers;
- » Increasing human resources in the health system (including increasing the capacity of training facilities for various health professionals);
- » Piloting the system in 10 selected health districts (initially funded by an NHI conditional grant);
- » Completion of an assessment of existing health infrastructure;
- » Implementing hospital management reforms in relation to governance reforms, financial management, autonomy and accountability;
- » Developing the necessary purchasing and procurement processes;
- » Developing processes for population registration;
- » Refinement of the "financial resource envelope" and the "revenue mobilisation strategy and pooling systems" (including alignment with the Road Accident Fund, Compensation for Occupational Diseases and Injuries, Compensation Commission for Occupational Diseases and the Occupational Diseases in Mines and Works Act);
- » Refinement of the "provider payment mechanisms";
- » Development of an integrated health information system; and
- » Review of existing legislation and creation of an enabling legislative framework (including legislation to establish the NHI Fund, initially at a national level and later at sub-national levels).

Footnote : The Western Cape Government supports elements of the NHI policy and has concerns with others that will be addressed at a political level. (Also see section on provincial policy).

Primary Health Care Re-engineering

This is a major policy development, which aligns with the 10 Point Plan objective of overhauling the health care system and improving its management. PHC re-engineering is key to the success of the NSDA implementation process and seeks to shift the PHC system from a largely passive, curative, vertically and individually oriented system to one with a more proactive, integrated and population-based approach. The core principles of PHC re-engineering are:

- » to attain a population-orientation to health care, focused on meeting priority health needs of geographically coherent populations in a comprehensive manner, including prevention, promotion and good quality, essential care;
- » to focus on health outcomes aimed at reducing mortality and morbidity from the major causes of ill-health;
- » to develop integrated, efficient and well-supported PHC teams, guided by and accountable to communities;
- » to establish a well-functioning DHS; and
- » to pay closer attention to those factors outside of the health sector that impact on health, namely the social determinants of health.
- » Three PHC streams are envisaged:
 - » multi-disciplinary teams of clinically competent professionals in which nurses play a critical role;
 - » community municipal ward-based multi-disciplinary health teams with nurses again playing a critical role; and
 - » effective implementation of national school-based PHC system led by nurses.

Office of Health Standards Compliance (OHSC)

This office has come into effect through the passing of the National Health Amendment Act and will be headed by a qualified Executive Director and supported by competent personnel including Health Officers. The OHSC will oversee the development and compliance with the national core standards, and ensure that complaints received from health care users or the public (patients and families) are properly and independently investigated. The OHSC is also expected to pave the way for the implementation of the National Health Insurance as the provision of quality care will be one of the core requirements for the NHI.

The Provincial Strategic Plan

The Provincial Strategic Plan has 12 strategic objectives that have been identified to facilitate the achievement of the vision of creating an 'open opportunity society for all'. These objectives are closely aligned with national outcomes, particularly in relation to concurrent functions such as health. The health-specific strategic objective for which the Department takes the lead is increasing wellness.

One of the mechanisms to give effect to the achievement of the strategic objectives is the Provincial Transversal Management System (PTMS), which provides political support for effective inter-sectoral collaboration within the provincial government.

Footnote : The Department has adapted the PHC re-engineering strategy to local conditions in the Western Cape.

Provincial Strategic Objective: Increasing wellness

Upstream factors contributing to the burden of disease are frequently the result of socio-economic deprivation, such as unemployment, poverty, poor housing and sanitation.

The wellness of the people of the Western Cape is undermined by the growing burden of disease. The strategic objective of increasing wellness contains a two-pronged approach to address this.

Firstly, the Department has a responsibility to manage the burden of disease through disease prevention, health promotion, and early detection of disease, treatment and rehabilitation – i.e. the provision of comprehensive health services.

Secondly, the Department is working with stakeholders, such as other departments, academia and non-profit organisations through the mechanism of the PTMS, to address the upstream factors that contribute to the burden of disease.

Aligned with the quadruple burden of disease and the MDGs, the Department has identified the following focus areas within the PTMS:

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

Universal Health Care for All

The WCG developed the Universal Health care for All policy as a response to the Green paper on the NHI. The NHI will be implemented in phases over a 14 year period. The vision of Healthcare 2030, which centres around access to quality care is completely aligned with the underlying strategic intent of the NHI. The WCG supports several parts of the NHI proposal especially in the early phases of the process. These include the strengthening of the District Health Services and PHC re-engineering, leadership and management development, the focus on quality improvement and compliance with the national core standards, and the strengthening of information and other management systems and processes.

However, the WCG also has major concerns with the NHI proposals that will be taken up with National Health at a political level. These include:

1. NHI may be unconstitutional as it erodes provincial authority.
2. The true cost and affordability of the NHI is unclear.
3. The country lacks the human resources to implement NHI.
4. Centralisation of healthcare funding will be bureaucratic and inefficient.
5. NHI does not address accountability for service delivery.
6. The private sector is not responsible for the poor quality outcomes in the public sector.

Universal Health Care for All proposes high quality care that is accountable, affordable, efficient and effective based on the Western Cape experience:

1. The National Department of Health must create an enabling environment through the setting of norms and standards.
2. Provincial Departments of Health must be strengthened for better health service delivery.

3. The autonomy of health providers and facilities must be supported.
4. Health care standards need to be monitored by independent bodies.
5. Patients must be protected financially.
6. The private sector should be regulated through national guidelines.
7. Public-private cooperation should be promoted.
8. Human resources must be capacitated to meet growing needs.

The Western Cape Health Facility Boards Act, 7 of 2001

This Act provides for the establishment, functions, powers and procedures of health facility boards. This legislation will be amended to more appropriately accommodate clinic committees at a PHC level.

The Western Cape District Health Councils Act, 5 of 2010.

This Act provides for matters relating to District Health Councils to give effect to section 31 of the National Health Act, 2003. This Act allows for the structured engagement between Local Government and other local representatives with the Department around district health services.

Internal Environment

Comprehensive Service Plan 2010 – Lessons learned and achievements

The 2010 Comprehensive Service Plan (CSP) has guided the health reform process within the province in the last decade.

The detailed engagement that preceded the development of the CSP paid many positive dividends. The technical work for the CSP was undertaken in-house, which ensured the ownership of the process and the product. There was robust engagement between the Department and stakeholders, significant interaction between clinicians and management, and extensive formal and informal comment that was individually considered. These elements of the planning process contributed to the intellectual rigour and a greater understanding of the complexities and challenges in reforming the health service. Flexibility in the translation of a strategic plan into an operational reality was an important lesson.

Achievements

A formal evaluation of the achievements and challenges in the implementation of the CSP has not been undertaken. This is acknowledged as a serious limitation. However, at a departmental review session in July 2010, there was general agreement that the overall configuration of the health service proposed by the CSP remained sound and that the major building blocks envisaged by the 2010 CSP have, or are being implemented.

» **Some of the main achievements of the CSP over the past few years include:**

a. District Health Services

- » Implementation of the district health system, including the unbundling of the Metro PHC service into more manageable sub-structures;
- » Strengthening the district health service by the appointment and training of family medicine specialists and expansion of the CNP cadre; and
- » Improvement in access to health care by expansion of the community-and home-based services.

b. Acute hospitals

- » General specialist services in rural regional and central hospitals have been strengthened.
- » The appointment of General Specialist heads and Family Medicine specialists strengthened clinical governance in the health system.
- » The package of care for acute hospitals was defined.

c. Mental hospitals

- » Chronic psychiatric and intellectually disabled patients have been dehospitalised;
- » Several mental health care policies have been developed and a Mental Health Review Board that provides oversight is well established; and
- » The Mental Health Care Act required the mainstreaming of the management of mentally ill patients. While there were and continue to be significant challenges in implementing the Act, significant progress has been made, especially at district and regional hospitals.

d. Infrastructure

- » Major progress in the revitalisation of the physical infrastructure of the rural regional hospitals, some district hospitals, several ambulance stations and forensic mortuaries;
- » Upgrading and building of a number of PHC facilities;
- » Constructing a state of the art Western Cape Rehabilitation Centre (WCRC) to replace an out-dated rehabilitation service facility at Conradie and Karl Bremer hospitals; and
- » Building and commissioning the new Khayelitsha and Mitchells Plain Hospitals.

e. Emergency medical services (EMS)

- » The communication centres in EMS have been modernised; a significant number of vehicles in the ambulance fleet have been replaced, the staff complement has been expanded and strengthened and 'one man ambulances' have been done away with. Infrastructure at ambulance stations is being incrementally upgraded.

f. Provincialisation

- » A range of services was transferred to the provincial Department of Health. These included the provincially aided hospitals; PHC services provided by local government in rural districts; TB hospital services provided by SANTA and local government; forensic pathology services from SAPs; and EMS provided by local government.
- » The Department is in discussion with the City of Cape Town and a formal political process to investigate options for a single authority within the Cape Metro district is currently underway.

Lessons Learned from the CSP 2010

The successes listed above do not fully reflect the rich experience and valuable lessons learnt through the implementation of the CSP. There were certain aspects of the CSP that proved to be over-ambitious and could not be successfully implemented.

These include the following:

- » Much was learnt about the complexity of implementing service shifts across institutions. The health system consists of inter-connected parts. Change in one area of the health system has ripple effects across a range of institutions in the system.
- » The complete physical separation of level 2 services from level 3 services within the central hospitals proved challenging. The services, resources and processes were so closely intertwined that they proved over-ambitious to separate.
- » While some of the historically classified regional hospitals were reclassified as district hospitals under the CSP, we have recognised that these hospitals provide a quantum of specialist services that adds important value and it makes service sense for the specialist services to remain in these hospitals. This has therefore become the norm for large district hospitals and will be more systematically addressed in the service planning for Healthcare 2030.
- » The CSP made provision for intensive care beds only in the central hospitals. In practice, from a service perspective, the serious need for critical care beds across regional hospitals and at times in the larger district hospitals was recognised. This will also be reviewed within the service planning for Healthcare 2030.
- » The effort required for the development of detail in planning for a long-term horizon needs to be balanced against the uncertainty and the need for flexibility to adapt to changing circumstances. For example, the detailed staff numbers developed in the black book of the CSP in many instances was unaffordable within the allocated budgets. The introduction of the Occupation-Specific Dispensation (OSD) was unforeseen and significantly raised the cost of hiring health professionals and rendered the staff numbers in the CSP unaffordable.
- » The CSP was useful in laying the foundation of the organisation of health services within the Department, including detailed staff establishments and infrastructure. The human side of the service, which is often regarded as comprising softer issues, both within staff and between staff and patients, families and communities was not adequately focused upon in the CSP.
- » The organisational structures we created have unintentionally fragmented the Department and promoted siloism and divisions. The national budget programme structure has also entrenched these divisions. This has undermined the effectiveness of the health service from functioning as a cohesive health system.
- » Technological advances and modern clinical practice in diagnostics led the department to create CT scanning capacity in regional hospitals. This was not foreseen in the CSP.

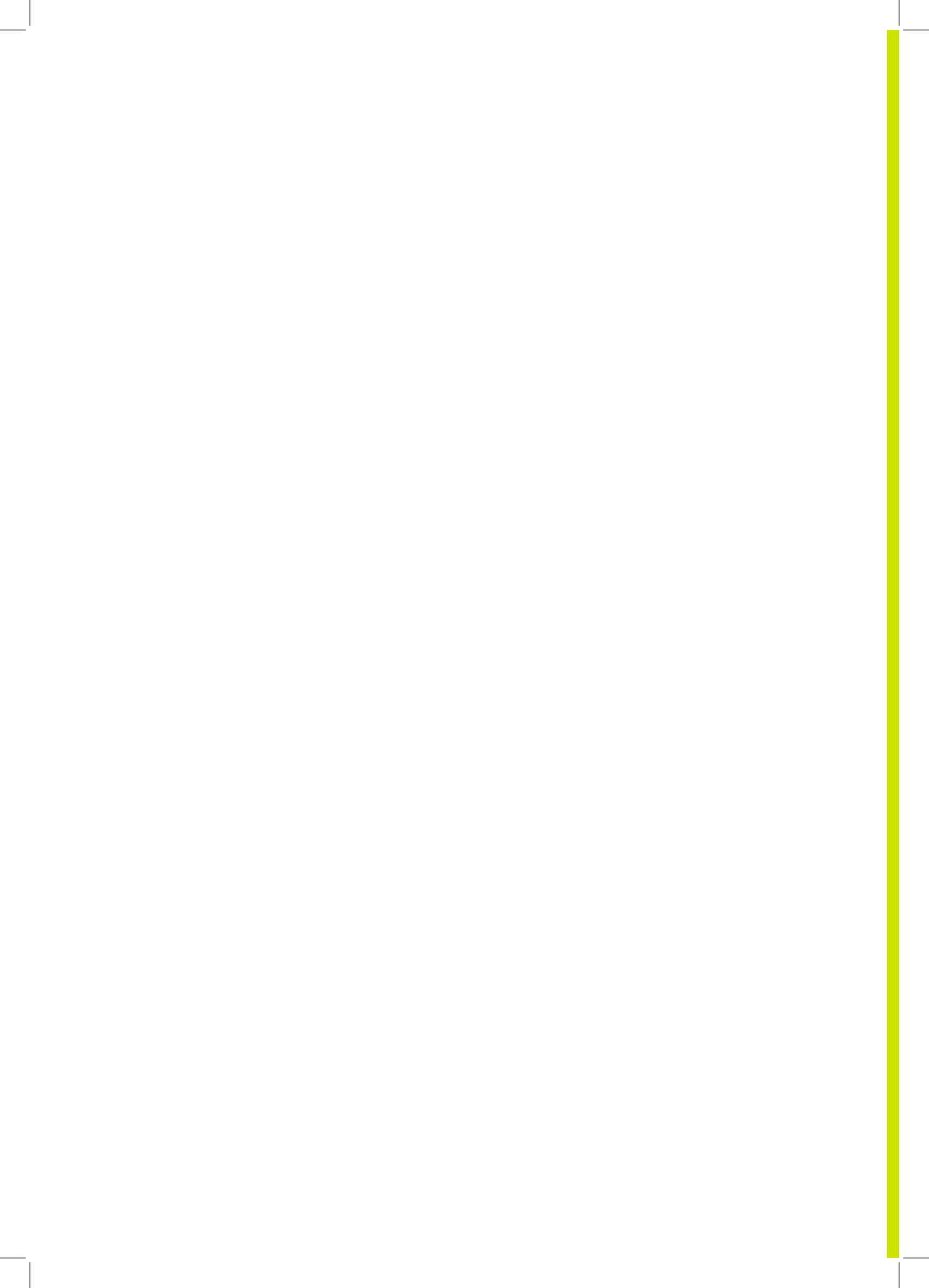
From this brief analysis it has become clear that the province can build on the strong foundation, direction and many other achievements of the CSP and learn from the lessons in its planning and implementation towards 2030.

Quality of care

The National Department of Health has produced a comprehensive set of core standards to assess quality of health services. Notwithstanding the teething problems in the development and application of the tools, the baseline assessment identifies several areas for improvement. These are more significant in the PHC facilities. An analysis of patient complaints identifies waiting times and staff attitudes to be major challenges.

The staff satisfaction surveys identify a sizable proportion of staff that do not feel valued or listened to in the organisation. A survey of metro doctors identified staff burnout in a stressful working environment as a major challenge. The Barret's surveys conducted over the previous two years had identified the limiting values to be, amongst others, cost consciousness, bureaucracy, hierarchy, and confusing messages.

The above observations and findings form a significant basis for the renewed thinking within Healthcare 2030.





SECTION B: **OUR APPROACH TO WELLNESS**

SECTION B: OUR APPROACH TO WELLNESS

SUMMARY POINTS

1. The Government of the Western Cape is committed to increasing the wellness of the people of the Province. Wellness is defined as not merely the absence of disease but the ability to maximise personal potential in all spheres of life.
2. The WHO proposes a framework that identifies five parameters that impact on wellness and health outcomes. These are: socio-economic context, differential exposure, differential vulnerability, differential health outcomes and differential consequences.
3. The Provincial Transversal Management System provides a structured opportunity to mobilise role players outside of the health department to address social determinants of health. This system has been prioritised by the provincial cabinet, giving political weight to inter-sectoral collaboration through this initiative.
4. The Cape Town Declaration on Wellness of 2011 launched the “whole of society” approach to achieving wellness.
5. The six priority focus areas that have been identified (and which could be adjusted over time) include:
 - a. Decreasing the incidence of infectious diseases
 - b. Preventing violence and road injuries
 - c. Promoting a healthy lifestyle
 - d. Improving Women’s Health
 - e. Improving Maternal and Child Health
 - f. Strengthening Mental Health

Introduction and Background

The Government of the Western Cape is committed to increasing the wellness of the people of the Province. Wellness is defined as not merely the absence of disease but the ability to maximise personal potential in all spheres of life. Wellness is not a state of being but a proactive process of increasing knowledge and agency for making healthier lifestyle choices and for adapting to changing circumstances towards realising, maximising and mobilising the fullest potential (physically, psychologically, financially, spiritually and socially, including role expectations) of self and others. The dynamic process of achieving reciprocal wellness resonates with the African philosophical principles of Ubuntu, which states that “I am what I am because of who we all are” (Marais 2013). The Department will advance the need for a philosophical and practical paradigm shift amongst healthcare workers from health “providers” to health “facilitators/enablers” in order to promote co-responsibility for increasing and sustaining wellness. This is important to remove the notion of dependency on health providers and to promote individual/community capacity and responsibility for the health and care of self and others – embracing a “whole of society approach” and “whole of government approach”.

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Wellness is defined as not merely the absence of disease but the ability to maximise personal potential in all spheres of life.

The approach to increasing wellness in the Western Cape is based on the framework developed by the WHO Commission for Social Determinants of Health. The basis for this framework is that the structural issues and conditions of daily life such as income distribution, access to and quality of education, environmental conditions such as housing, social spaces, urban vs. rural area dynamics, access to and quality of health services, and work and leisure directly influence health outcomes and wellness. The WHO framework highlights five factors of importance that are described below.

Socio-economic context and position

People’s social class, gender, ethnicity, education, health literacy, occupation and income levels are a critical risk factor in wellness. These issues are often driven by policies outside of the health sector, yet are central to ensuring wellness. In South Africa, for example, the infant mortality rate (IMR) of those in the poorest quintiles is three times more than of those in the richest quintiles; twice as much in children of mothers who do not have matric compared to those with matric; and twice as much in those from rural areas compared to urban areas.

Differential exposure

The exposure to most risk factors (behavioural, societal, and environmental) is inversely related to one's socio-economic position. It is, for example, more difficult to have a healthy lifestyle within a poor community because healthy foods are more expensive and less readily available. There is also limited access to safe open spaces to exercise. Similarly poor communities tend to live in houses that are not well-designed and in unhealthy environments with poor water and sanitation and thus are more likely to contract infectious diseases like diarrhoea and pneumonia.

Differential vulnerability

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

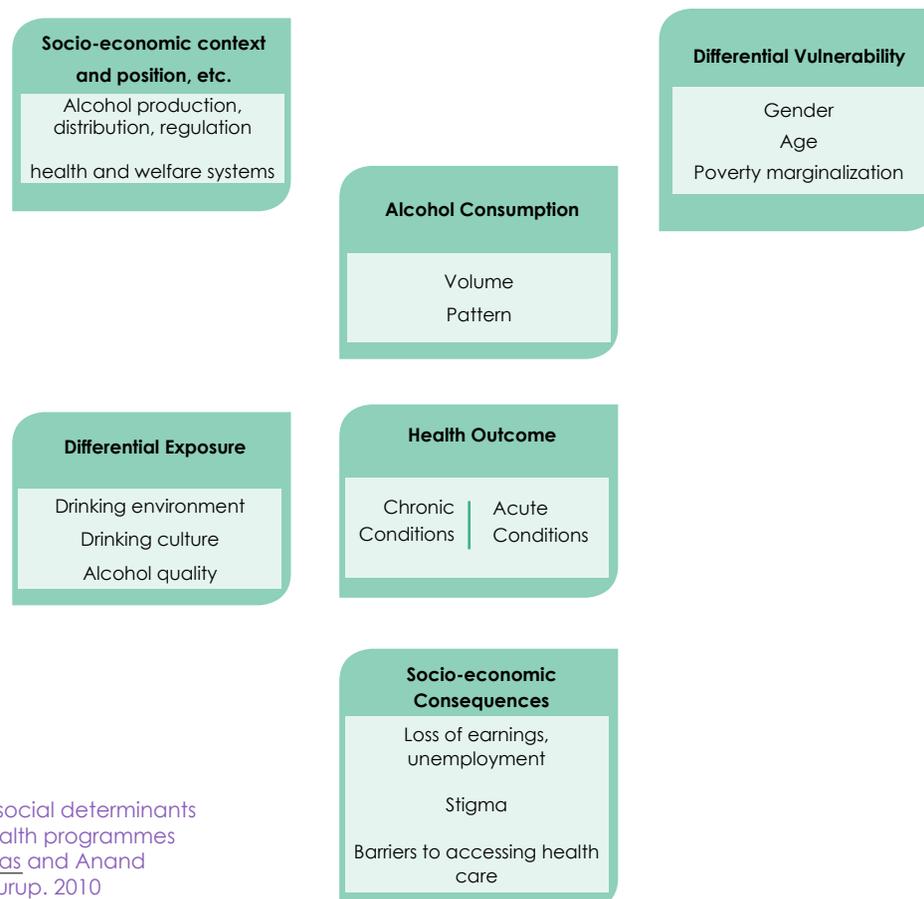
Differential health care outcomes

The attainment of health outcomes and wellness is influenced by the socio-economic and environmental context and the resulting differential exposure and vulnerability to disease as discussed above.

Differential consequences

Poor health outcomes may have social and economic consequences such as inability to work and earn a living and as a result deepening poverty with a reduced ability to afford basics such as food or transport to access health services and their medicines. While advantaged population groups are better protected – for example, in terms of job security and health insurance – for the disadvantaged, ill health might result in further socio-economic degradation, crossing the poverty line and accelerating down a downward spiral that further damages health. Figure 1 below uses alcohol to further explain this framework.

Figure 1: Priority public health conditions analysis¹



1. WHO. Equity, social determinants and public health programmes / editors Erik Blas and Anand Sivasankara Kurup. 2010

Importantly, managing the existing burden of disease and improving health outcomes also require focus on “downstream” health services factors such as biomedical interventions. For example, the provision of ARVs to pregnant women has decreased the transmission of HIV from mother to child. In 2000 in the Western Cape, more than 1 in five children under five years (20%) were dying of HIV²; in 2009 only about 7 percent died from HIV³.

Thus wellness could be increased by adopting an integrated health promotion strategy (including empowerment, community building and social change approaches) which combines structural (upstream) and biomedical (downstream) interventions to promote health and prevent disease at both the individual and population levels. The overarching goal is to strengthen individual and community capacity and responsibility for the health and care of self and others, and to address the social determinants of health in order to reduce exposure and vulnerability to disease.

The Department of Health is mandated by the National Health Act to provide quality health services that address mostly downstream factors focused on the individual. As such, HealthCare 2030 is a health-system-transformation strategy that is focused on delivering a superior patient experience of quality health services that result in the desired outcomes. To achieve the promotion of health and the prevention of disease, comprehensive integrated health promotion strategies that address individual factors (such as lifestyle behaviour and health literacy) and socio-economic factors (such as education, poverty, and housing) together with improved health services are required for improved outcomes and increased wellness.

However, the required joint planning and responsibility across departments, municipalities and sectors in collaboration with the affected communities to ensure contextually appropriate, accessible, well coordinated, and targeted interventions in order to facilitate superior health outcomes and increase wellness is lacking. The approach, therefore, that the province has taken to address this challenge is to create the Provincial Transversal Management System.

The Provincial Transversal Management System (PTMS)

The PTMS provides a structured opportunity to mobilise role players outside of the health department to address social determinants of health. This system has been prioritised by the provincial cabinet, giving political weight to inter-sectoral collaboration through this initiative. The philosophy is that of thinking and acting in a united and coordinated way around a common set of objectives as a “whole of society” and a “whole of government”.

The strategic objectives for the PTMS are clustered into three sectors – human development; economic and infrastructural; and administrative and inter-governmental. Each of the strategic objectives has a steering group which co-ordinates the work groups that function within the strategic objective.

The following are the 12 strategic objectives prioritised for inter-sectoral collaboration:

Table 2: Twelve provincial strategic objectives

Strategic Objective 1:	Creating opportunities for growth and jobs
Strategic Objective 2:	Improving education outcomes
Strategic Objective 3:	Increasing access to safe and efficient transport
Strategic Objective 4:	Increasing wellness
Strategic Objective 5:	Increasing safety
Strategic Objective 6:	Developing integrated and sustainable human settlements
Strategic Objective 7:	Mainstreaming sustainability and optimising resource use efficiency
Strategic Objective 8 & 9:	Promoting social inclusion and reducing poverty
Strategic Objective 10:	Integrating service delivery for maximum impact
Strategic Objective 11:	Increasing opportunities for growth and development in rural areas
Strategic Objective 12:	Building the best-run provincial government in the world.

2. Bradshaw D et al. South African national Burden of Disease Estimates of Provincial Mortality. Cape Town : South African medical Research Council, 2004

3. Groenewald P, Berteler M, Bradshaw D, Coetzee D, Cornelius K, Evans J, Jacobs C, Neethling I, Msemburi W, Matzopoulos R, Naledi T, Shand L, Thompson V, Visser M, Western Cape Mortality Profile 2010. Cape Town: South African Medical Research Council, 2013.

In line with the quadruple burden of disease and the MDGS, the Department has identified six priority areas for increasing wellness (additional emerging priority areas may be added over time):

- a. Decreasing the incidence of infectious diseases (HIV and TB);
- b. Preventing violence and road injuries;
- c. Advocating healthy lifestyles to address non-communicable diseases;
- d. Emphasising women's health;
- e. Emphasising antenatal- and child health; and
- f. Emphasising mental health.

The Strategy to Address the Six Priorities to Increase Wellness

The WHO defines wellness as an optimal state of health of individuals and groups. This definition focuses on rights and responsibilities - the right to realise one's physical, psychological, social, spiritual and economic potential, together with the individual's responsibility to fulfil their expected roles in the family, community, place of worship, workplace and other settings.

The success of the 12 strategic objectives referred to in Table 2 will result in a significant improvement in the socio-economic status of people and, in this way, will reduce individual vulnerabilities and consequences of the burden of disease and improve health outcomes and wellness. The Department of Health, therefore, will be strengthening its capacity to advocate for the six priority areas within the strategic objectives in order to deepen the understanding of the health implications of the broader interventions. For example, the implications of minimum standards for low-cost housing and the materials used in the building of houses for its occupants; the urban design and how that facilitates or discourages living healthy lifestyles like increasing physical activity; and the design of roads and how it influences road traffic injuries.

In addition, the Department of Health will work with other sectors, including targeted communities, to design, pilot and evaluate key interventions to increase wellness.

The Department will advocate for the PTMS system to be replicated at district level to give effect to local inter-sectoral collaboration.

Strengthening the Advocacy Role of the Department of Health

In order to improve its advocacy role the Department should:

- » Provide mortality and morbidity information that identifies the communities most affected by the burden of disease and its associated risk factors;
- » Establish early warning systems for important risk factors;
- » Provide the evidence for interventions that have proven to work successfully in similar contexts
- » Work with other role players, including geographically targeted communities, to identify and support the design of these interventions locally;
- » Adopt a community building approach which includes the mapping of and building on existing community assets such as structures, skills, intelligence and resources;
- » Emphasise an inclusive population approach to increasing wellness which integrates the conditions, needs and assets of people living with disabilities;
- » Provide a system to monitor and evaluate progress towards addressing all (down-, mid- and upstream) risk factors and the associated diseases and providing recommendations on further action to be taken;
- » Encourage the establishment of sustained platforms to facilitate community communication and participation in the identification, implementation and evaluation of evidence-based interventions which are contextually appropriate, accessible and beneficial to the target group. This includes measures to ensure effective inter-generational and cross-cultural communication;
- » Advocate for the development, implementation and evaluation of an integrated health promotion strategy (including biomedical, education, empowerment, community building and social change approaches) to increase wellness.

To perform this role the Department has invested in a Strategy and Health Support Chief Directorate that includes planning, health impact assessment, IT and M&E to provide the intelligence to the department and other role players. This unit consists of both technocrats and academics and has strategic partnerships with local universities and research institutions such as the Medical Research Council (MRC) and the Human Science

Research Council (HSRC). In addition, the unit partners with a range of community-based non-governmental organisations in the design, implementation and evaluation of interventions.

The Cape Town Declaration on Wellness

On 8 November 2011, the Premier hosted a summit on reducing the burden of disease, which focused on infectious diseases, child health, women's health, violence and road injuries, and non-communicable diseases. The summit was attended by over 250 people from government, the private sector, civil society and academia, and succeeded in:

- » Reviewing the latest available data on the burden of disease;
- » Providing the space for multi-sectoral dialogue on the technical strategy to respond to the burden of disease by all levels of government and role players outside of government in the private sector and civil society;
- » Identifying an action agenda for implementation, designed to advance the collective effort of all role players to reduce the burden of disease; and
- » Getting a broad range of delegates to commit to undertakings in the Cape Town Declaration on Wellness;

The Declaration outlined the priority actions for all sectors. (See Table 3). The Summit was a watershed event to launch a renewed commitment by the whole of society to take responsibility for their wellness.

Table 3: Priority Actions arising out of the Cape Town Declaration on Wellness

1. Inter-sectoral action to address the root causes of ill health, injuries and inequity
2. Gender equality and the education of all children, as well as adult education
3. Creating safe & stimulating environments that promote wellness for children and adults
4. Address the structural, legislative and behavioural constraints and mobilise the whole of society to make the right choice to:
 - » Eat healthy foods
 - » Promote breastfeeding
 - » Increase physical activity
 - » Stop smoking and not start smoking in the first place
 - » Not do harmful drugs
 - » Test for HIV and having safe sex
 - » Drink alcohol safely
 - » Drive safely
 - » Stop violence
 - » Immunise against infectious diseases
 - » Responsibly use medicines
5. Take responsibility for the wellness of our children.
6. Maximise the wellness of pregnant women and give special attention to the care of newborn babies.
7. Promote early childhood nutrition through breastfeeding and effective early childhood development.
8. Support long-term adherence to medication and chronic disease management at individual and community level.
9. Ensure interventions are informed by evidence and appropriate research.
10. Ensure a strong health system to detect and manage disease and their risk factors early and treat it effectively.

The Summit was a watershed event to launch a renewed commitment by the whole of society to take responsibility for their wellness.

Priority Interventions

Decreasing the incidence of infectious diseases (HIV and TB)

The five main priority areas to reduce HIV and TB through social mobilisation are:

- » Promote HIV testing through the HIV counselling and testing campaign (HCT);
- » Promote the use of condoms in males and females;
- » Promote male medical circumcision;
- » Change behaviour to reduce early sexual debut, concurrency, multiple partners, alcohol misuse and drug abuse and increase condom use;
- » Be more active in early TB case finding, early initiation on treatment, promote good adherence to treatment provide isoniazid preventive therapy to children under 5 and all eligible HIV positive adults and children and implement effective infection control measures to prevent the transmission of tuberculosis.
- » The strategy to deliver on the priority areas will include:
 - » Maximise the wide network of partnerships fostered in HIV and AIDS within other departments in the public sector, the many civil society and community organisations and groups, and academia etc. to promote uptake of interventions and change behaviour.
 - » Strengthen the multi-sectoral Provincial AIDS Council (PAC) to provide strategic leadership.
 - » Establish a technical committee of the PAC to coordinate the evidence-based joint planning, implementation, monitoring and evaluation of the multi-sectoral response.
 - » In the future establish district Inter-sectoral committees that are technical committees to locally coordinate interventions for wellness and not just for HIV and AIDS.
 - » Advocate for an integrated health promotion strategy to decrease the incidence of infectious diseases.

Preventing violence and road injuries

Violence is complex and multifactorial in its causation, is widespread and affects all segments of the population. The Department has therefore decided to be more focussed initially and target its energies and limited resources on alcohol as a risk factor and certain high risk geographic areas. The projects will grow over time in their focus as well as its geographic location.

Alcohol is one of the key risk factors for injuries and we know that this risk is concentrated in areas of high deprivation, with 50% of alcohol-related deaths occurring in five areas. The objective is thus to reduce alcohol-related injury harms. In the Western Cape, 60% of all deaths caused by road traffic injuries and homicide were alcohol-related. Nearly 80% of these injury-related deaths occurred among males, particularly in the 20 to 34 year age group. Five high-risk areas to deliver inter-sectoral alcohol-related violence-reduction interventions have been identified. The lessons from these areas will be rolled out to the rest of the province.

The strategy will include:

- » **Reducing supply of alcohol** and creating safer drinking environments through the implementation of the Western Cape Liquor Act led by the Department of Economic Development and Tourism;
- » **Reducing alcohol demand** through a TV campaign based on BoozaTV, which is an entertaining and provocative documentary mini-series consisting of six 24-minute episodes, which challenge the misperceptions that South Africans have about alcohol, alcohol abuse, and how to reduce alcohol-related harm.
- » **Piloting brief motivational interviews** in two trauma units aimed at testing the feasibility and effectiveness of conducting brief interventions for alcohol and drug abusers at a 'teachable moment' in the trauma wards.

Violence prevention policy

The causes and risk factors for violence and injuries are multi-faceted. An integrated provincial policy is therefore required to institutionalise a consistent, long-term commitment to safety promotion and violence and injury prevention. This is consistent with international best practice, as echoed at the 5th Milestones Meeting in the Global Campaign for Violence Prevention that was hosted by the WCG Health in Cape Town on 6 to 7

September 2011 in collaboration with the World Health Organization and the National Department of Health.

The aim of the integrated provincial violence and injury prevention policy will be to ensure adherence to the key attributes of successful violence and injury prevention approaches, namely:

- » An intervention approach driven by an accessible evidence base and reliable injury surveillance data;
- » The strategic and systematic deployment of prevention resources to target high-risk times, places and groups ;
- » The on-going monitoring of outcomes and risk factors for refinement and improvement; and
- » Balancing programmatic and policy interventions likely to reduce violence in the short term (such as those that reduce access to lethal means, e.g. firearms, and the use of drugs associated with violence and aggressive behaviour, e.g. alcohol) and making use of interventions that affect sustained long-term change to the social environment and societal norms that support violence (such as infrastructure for improved early childhood development and positive parenting);
- » The establishment of a review and consultation process across relevant departments to align existing performance priorities and deliverables;
- » On-going consultation with state- and non-state actors across the political spectrum as well as community organisations and stakeholders; and
- » The institutionalisation of an inter-sectoral framework that supports and sustains multi-dimensional prevention strategies over a long period, to protect them from political vicissitudes.

The strategy to deliver on the priority areas will be:

- » To advocate for the adoption of the integrated violence and injury prevention policy by the provincial government and ensure sustained multi-dimensional prevention strategies that include:
 - » Investing in early interventions;
 - » Increasing positive adult involvement;
 - » Strengthening individuals and communities;
 - » Changing cultural norms;
 - » Reducing income inequality; and
 - » Improving criminal justice and social welfare.
 - » Promoting the role of men as responsible, equal and caring citizens.
- » In addition to providing quality emergency medical services, the Department of Health will strengthen screening for risk factors (especially alcohol misuse), provide brief motivational interventions, integrate health promotion approaches including the use of Booza TV, and deliver quality rehabilitation services.
- » To establish a robust injury surveillance system in the emergency and forensic pathology services and provide geocoded data to influence decision making for targeted multi-dimensional prevention strategies such as the City of Cape Town Mayoral Urban Regeneration Initiative and the the Department of Economic Development and Tourism (DEDAT) high streets model where an economic hub would be developed and the relocation of shebeens will be encouraged.
- » To strongly align with the City of Cape Town Mayoral Urban Regeneration Initiative aimed at uplifting former neglected, dysfunctional areas that are regressing rapidly, and to improve safety, quality of life and the socio-economic situation, with a particular focus on the shared/public environment. This initiative is implemented using the strategy from the organisation Violence Prevention through Urban Upgrade (VPUU). The strategy includes a baseline survey and a prioritisation process in collaboration with community members and their representative bodies. The Department will provide the evidence for effective interventions and support the development of a community-level observatory to provide outcome data that can support targeting of interventions by government, civil society and communities.

Promoting a healthy lifestyle

The key priorities in promoting healthy lifestyles that affect cardiovascular diseases and some cancers in

particular include:

- » Encouraging healthy eating
- » Increasing physical activity
- » Reducing smoking

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

- » The school
- » The workplace
- » The community

The Department will be instituting a robust system of cancer surveillance and undertaking a more systematic approach to cancer epidemiology and its risk factors to inform prevention and promotion strategies. It will work with agencies such as the African Cancer Institute, the National Cancer Registry and the Cancer Association of South Africa.

i) School Setting

- » A school health programme is currently under development and will include the following:
 - » Advocacy and capacity development of school leadership;
 - » Baseline audits of current healthy-lifestyle interventions in schools;
 - » Collaborative development of appropriate interventions that promote wellness using the integrated school health policy; and
 - » Piloting and evaluation of the interventions.

ii) Workplace Setting

A workplace programme for provincial government staff in collaboration with the employee wellness sub-group in strategic objective 12: building the best-run provincial government in the world, is being developed. The Department will advocate for at least all large workplaces in the province to have wellness programmes.

iii) Community Setting

- » Community Wellness Centres aimed at promoting awareness and prevention of chronic diseases, the provision of information and resources (not financial) to access early screening and treatment, to facilitate behavior change and to build capacity for improved self-management of chronic disease, will be piloted. The key principles for these wellness centres will be to :
 - » Provide a package of health checks;
 - » Provide health promoting information and resources;
 - » Prioritise people living in under-resourced communities;
 - » Position outside of the health services within communities;
 - » Locate in well frequented places in communities such as shopping centres;
 - » Establish strategic partnerships with local pharmacies and other service provider groups;
 - » Target younger people;
 - » Ensure strong referral linkages with the health sector; and
 - » Monitor and evaluate the performance of the wellness centres.

The strategy to deliver on the priority areas will be to :

- » Support the Western Cape Integrated School Health Implementation Framework within the departments of Health and Education, which includes ensuring schools are health promoting;
- » Establish partnerships with academic institutions to support the design, implementation and M&E of healthy lifestyles interventions in schools, workplaces and communities;
- » Establish partnerships with private, non-governmental and community-based organisations to use their infrastructure to deliver the aforementioned interventions, which include wellness centres;
- » Explore and pilot innovative communication and behaviour change strategies; and
- » Advocate for an integrated health promotion strategy to promote healthy lifestyles.

Improving Women's Health

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

- » The development of a policy on responding to gender-based violence (GBV) within health care settings;
- » Incorporating anti-gender-based violence programmes into specific services (sexual, reproductive, maternal health, HIV);
- » Providing IPV screening and services;
- » Training and support of health care workers to improve the quality of care of birthing practices (addressing abuse of women in labour and re-igniting caring and compassionate health care workers);
- » Developing effective models of psycho-social counselling to address the huge mental health burden and improving the quality of counselling services (standards, training level); and
- » Investing in programme/projects that work with young boys and young girls to address gender and social norms by working in close collaboration with the Department of Education.

To implement recommendations ii-v the Department is piloting the IPV project in PHC facilities in the Cape Wine-lands and Northern/Tygerberg substructure.

The strategy to deliver on the priority areas will be to:

- » Integrate IPV screening, acute management and referral into the health services;
- » Partner with the Department of Education to work with young boys and young girls to address gender and social norms;
- » Advocate for GBV interventions in the Mayoral Urban Regeneration Initiative;
- » Advocate for gender economic empowerment initiatives in strategic objectives 1, 8 and 9;
- » Advocate for increased positive male involvement – promoting the role of men as responsible and equal carers, partners, husbands and fathers; and
- » Advocate for an integrated health promotion strategy to increase women's health.

Improving maternal and child health

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

- » Engage parents to promote a "well family concept";
- » Focus on perinatal area (health of child begins from pre-conception);
- » Promote exclusive breastfeeding;

- » Invest in the Home and Community Based Care programme; and
- » Invest in Early Childhood Development (ECD).

This is in keeping with the prioritisation of the 1000 days of life which has a huge impact on the life of the child and the mother.

The strategy to deliver on the priority areas will be two pronged. The first will be to focus on health sector interventions that include:

- » Prioritising perinatal and maternal health within health services;
- » Ensuring all health facilities are mother-and-baby friendly and encourage breastfeeding;
- » Strengthening the HCBC programme to move towards geographic coverage;
- » Undertake research to develop an evidence-based breastfeeding restoration policy that takes into account social determinants and provides recommendations for inter-sectoral action; and
- » Continuing to improve the quality and universal coverage of child health services such as immunization; and
- » Promoting and integrating the role of men as responsible and equal carers, partners, husbands and fathers.

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

- » Continue to collaborate with Strategic Objective 8 and advocate for an approach that strengthens families and promotes a “well Family concept” through the provision of the evidence to inform this;
- » Continue to collaborate with Strategic Objective 8 on ECD and particularly around nutritional support; and
- » Advocate for particular vulnerable communities with adverse child and maternal health outcomes on the basis of the mortality and morbidity surveillance system.
- » Advocate for increased positive male involvement
- » Advocate for the building of parenting skills; and
- » Advocate for an integrated health promotion strategy to improve maternal and child health.

Strengthening Mental health

The life course approach will be employed to address mental health and focus on the following four periods:

» The perinatal period

Improving perinatal mental health has been shown to yield very high returns in health outcomes of women and children. These outcomes are very sustainable with long-term effects on the child that can be identified even in adulthood. Currently there is very high coverage and frequency of contact for the antenatal period. Intervening at this stage is likely to yield a very high impact over the medium- to long term.

» Childhood

ECD also has a very high return on investment and has been shown to be effective even up to 27 years post-intervention.

» Adolescence

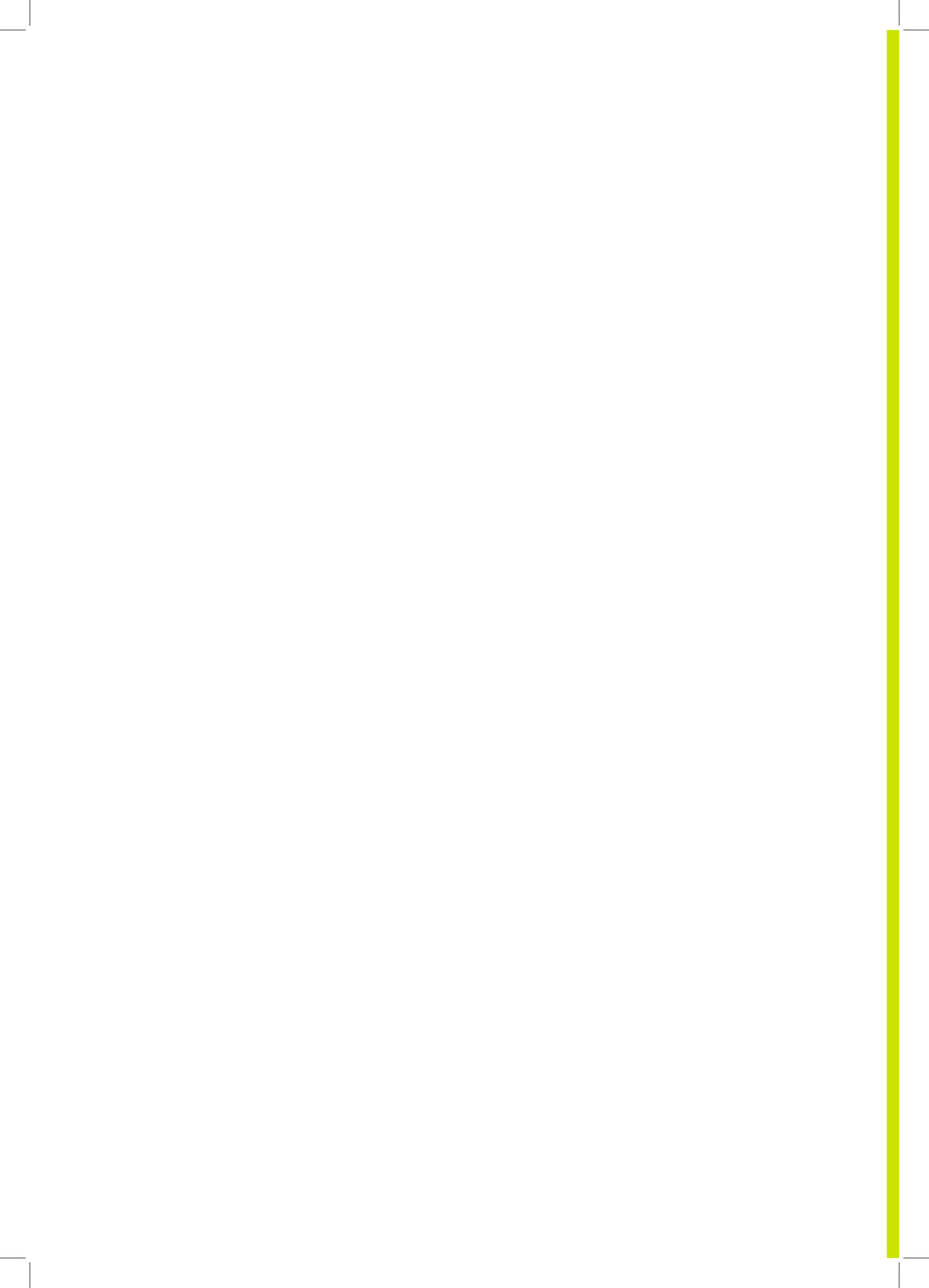
Mental health programmes in schools indicate that nearly half of grade 10 to 12 year olds have mental health problems, with substance abuse – particularly alcohol – being the major problem.

» Adulthood

Mental health integration into PHC, HIV and chronic disease health services will address about half the adults with these co-morbidities.

The strategy to deliver on the priority areas will include:

- » Promoting awareness of mental health and the availability of information and resources to access early support, screening and treatment, to facilitate behaviour change and to build capacity for improved self-management of mental health disorders;
- » Integrating screening for mental illness, acute management and referral into perinatal, PHC, chronic and HIV services;
- » Collaborating with the substance abuse workgroup to strengthen community-based adolescent services to prevent mental illness;
- » Collaborating with the Department of Social Development (DSD) and Department of Education (DoE); and
- » Advocating for an integrated health promotion strategy to strengthen mental health.





SECTION C:
FROM HEALTH SERVICE DELIVERY TO
PERSON-CENTRED CARE

SECTION C: FROM HEALTH SERVICE DELIVERY TO PERSON-CENTRED CARE

SUMMARY POINTS

1. The crux of a re-imagined future in 2030 is the focus on the person-centredness. This focus is woven throughout the document from the vision, values and principles to service platform reconfiguration and quality.
2. The four conceptual pillars of person-centred care are:
 - a. Person-centred approach
 - b. Integrated provision of care
 - c. Continuity of care
 - d. Life course approach

Introduction and Background

In this third wave of health reform in the Western Cape, the focus will be on the patient experience and outcomes – i.e. person centeredness. This re-imagined future is described in the vision and principles of 2030 and requires conceptual clarity on the elements of being person centred. This attempt at defining the elements will be further refined through the comments we receive on this version of 2030, as well as the facilitated dialogues that will be held to develop a shared vision of 2030. This section should be read in conjunction with the section on quality that explores this area even further and provides more detail on how the Department intends to give effect to these concepts. The four elements of this approach are shown in Figure 2.

Figure 2: Key conceptual pillars of person-centred care

Person-centred Approach

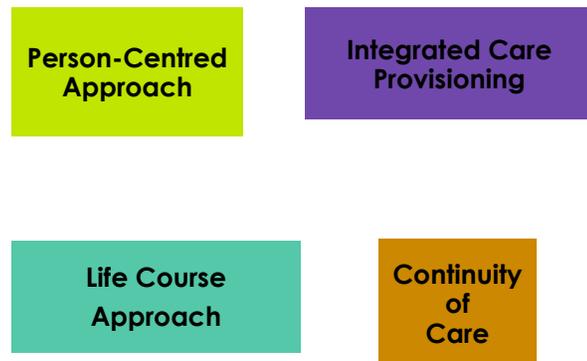
The organisation of care that has a person perspective instead of an organisational perspective requires patients and their accompanying relatives to be treated with dignity and respect, to be listened to and provided with information that they can understand, and to be involved and empowered in making informed choices and determining their treatment options. In this context, clinical staff manage their patients holistically, by locating the illness within a broader personhood, family and community context, understanding the socio-economic and other contextual factors, and refraining from adopting a technocratic clinical approach to the management of the patient.

Understanding and addressing a patient's concerns enables appropriate and effective management of the condition. A person-centred approach, built on a relationship of trust, leads to increased compliance, improved quality of care and, ultimately, better health outcomes.

Integrated Care Provisioning

Integrated care is central to having a better understanding of the needs of a population and builds greater trust in the system. We therefore need to redouble efforts to overcome historical approaches based on a specific set of problems or a specific disease or group of diseases that fragment the system and provision of care.

Inter-disciplinary teams will be deployed to develop care pathways for specific patient groups that reference all aspects of care. All stakeholders need to work with a single assessment and care planning process as the patient's journey crosses the entire service platform. There will be shared authority in care provisioning as a result of inter-professional collaboration.



Continuity of Care

The aim of the continuity of care processes is to provide seamless care in a consistent manner. There needs to be continuity of care for patients who need to utilise services from more than one level of care or facility if they are to achieve the desired health outcomes and goals. The referral and discharge processes are key opportunities in the patient's journey where health care providers can contribute to continuity of care. An effective process of discharge planning or referral from hospital has the potential benefits of reducing re-admissions and the average length of stay and empowering patients with useful information for self-care.

Comprehensive record keeping, access to medical records, efficient transfer of medical information between health care professionals and adequate provision of suitably skilled staff are essential to ensuring that patients receive a continuum of care. Advances in technology will enable these requirements. Strengthening communication and the relationship between health professionals within and between institutions also helps the smooth referral of patients and continuity of care.

Life Course Approach

A life course is not a series of clearly defined steps. It resembles an integrated continuum of exposures, experiences and interactions. These occurrences in earlier life can shape adult health. The Life Course Approach offers a framework to better understand the underlying biological, behavioral and psychological processes that operate across the life-span of a person, in relation to future health. It is applied more universally to understand factors that can help people attain optimal health and development trajectories over a lifetime and across generations. A Life Course Approach enables the identification of chains of risk that can be broken and opportune times to intervene that may be especially effective.



SECTION D: **VISION, VALUES AND PRINCIPLES**

SECTION D: VISION, VALUES AND PRINCIPLES

SUMMARY POINTS

1. The vision for 2030 is:
Access to person-centred, quality care.
2. A narrative that captures multiple perspectives of this vision is described. These perspectives include those of patients, staff, the community, the Department, spheres of the government and strategic partners.

VISION

The Department is excited about developing a shared vision of a re-imagined future health service with the staff and our strategic partners. This is a meaningful and energising process that has already started and will continue over the forthcoming period.

The strategic planning process provides an opportunity to redefine the departmental vision for 2030. The objective is to deliver an improved, quality patient experience to the people of the Western Cape within a world-class public sector health service.

The vision should motivate the population of the province to take responsibility for their health and for the Department to achieve amongst the best health outcomes in the world.

The heart of the vision for 2030 is access to person-centred, quality care. To bring the vision for 2030 to life, we have attempted to describe in detail what achievement of the vision will feel like for a range of role players, from patients to other stakeholders.

In order to change behaviour, the expanded vision statement seeks to resonate with audiences on a physical, intellectual and emotional level.

The Expanded Vision Statement

Preamble

Access to health care is a constitutional human right in South Africa that needs to be progressively realised. Achieving optimal health outcomes of the population requires robust upstream interventions by the whole of society and a high-quality, comprehensive health service. We will strive to achieve excellence in delivering health care by 2030. This will be achieved in partnership with caring, competent and committed staff, aided by modernised health systems, infrastructure and technology and in collaboration with all stakeholders and partners.

The narrative below describes what the experience of the Western Cape Department would be like in 2030 if the vision was achieved.

What does it mean for patients?



A patient comes to the health service because he or she has an appointment (unless this is an emergency) and is greeted on entrance by a staff member, who is friendly, helpful, empathetic and caring. The staff are equipped to respond to any queries of the patient or family member and to direct the patient to the relevant sections of the facility. Patients will not wait longer than is reasonably acceptable. Their file will be available because the patient will have an appointment for a planned visit. Patient files will be stored electronically, which reduces the incidence of lost folders and production of duplicates, reduces the physical space for storage of folders and, most importantly, reduces the waiting times for patients at facilities. The electronic record will be available across facilities and will help in the communication and referral between health professionals and the provision of continuity of care throughout the life course of patients.

The patient will move smoothly through the well-signposted facility without unnecessary delays at any service point. Patients will feel listened to, their needs and concerns understood and feel part of shaping their care plans. The one-to-one relationship between the patient and staff will build trust and confidence. Patients are respectful of health workers and the facility. Patients will take responsibility for treatment adherence and assume responsibility for their health by leading a healthy lifestyle.

Facilities will be well maintained, clean and neat at all times. In addition, through appropriate design and construction, the facility will be environmentally friendly and efficient.

The patient will leave the facility satisfied with the service received and the clinical treatment provided. They will feel that they have been accorded dignity, respect and care. Patients will express confidence in the Western Cape Health Department.

What does it mean for staff?



Staff will be proud of what they do and to be employed in the public health service. Staff are recognised, respected and appreciated for their service by management as well as patients and communities.

The staff is motivated, creative and will exercise initiative. The attitude and actions of staff towards patients is one of caring and clinical competence. Staff is empathetic, not only towards the immediate illness that the patient faces, but also to the broader context and challenges faced by patients, their family and community. Clinical staff will endeavour to develop a meaningful relationship with patients based on trust and understanding. Staff will feel a part of the local community and will be encouraged to participate in local activities.

Staff will be fully engaged and will feel valued, will feel empowered to use their judgement to make the lives of their patients better, and will be willing to go the extra mile in their jobs. They feel supported by their peers, supervisors and management. Staff will work together as coherent teams to provide an optimal service. They will feel 'heard' and their problems will be efficiently addressed. Staff will feel safe in their workplace.

Systems will be created to ensure that staff have access to knowledge networks. They will be eager to learn and improve their knowledge and skills on an on-going basis.

What does it mean for the community?



The health service operates in a way that ensures the community trusts and has confidence in the service and in the health workers.

Communities are well organised and can represent their interests by engaging with health management. The community takes 'ownership' of health facilities and services. There will be efficient structures to enable effective communication with

the community. The Department, as part of a developmental state and through its intention to give stronger voice to the community, will endeavour to build capacity and deepen this relationship and the mechanisms of communication and accountability through the legislative provisions of the district councils, facility boards and clinic committees. These structures will be strengthened to monitor the performance of the health service.

There will be a full team of community care workers (CCWs). They have access to every household in the community. They are a direct link between the family, community and the health service and carry the message of healthy living to the people. They ensure that pregnant mothers attend the antenatal clinic, babies are immunised and patients take their medication regularly and correctly. They also provide health care advice on a range of issues including health prevention and promotion. Patients are referred to the clinic when necessary or managed at home. CCWs identify social problems and liaise with local social services, when necessary. CCWs live in the same area in which they work and have a good working relationship with the staff of their local clinic. They will develop a solid relationship with each of the families they are responsible for and will form a critical bridge based on trust and empathy between the health service and families in the community.

The community takes responsibility for its health by adopting healthy lifestyles. Opportunities will be available to promote wellness and for the community to be screened for the early detection of chronic diseases. Patients will also feel supported as community members will help them take their medication and attend their health facility when required.

Access to the public health service provides a strong social safety net for the poorest of the poor and prevents catastrophic health spending that plunges poor families into deeper poverty. The public confidence in the Department's health service is an important contribution to strengthening social capital in the province.

The community is healthy and happy and levels of unemployment are low. There is good-quality housing with electricity, clean water and sanitation. The schools provide effective education; roads are well lit and local businesses create wealth and economic opportunities. People feel it is safe to walk on the streets during the day or night because there is little or no crime. Good recreational and sporting facilities and libraries with Internet connectivity raise the quality of life. Public transport is affordable and accessible.

The community takes responsibility for its health by adopting healthy lifestyles. Opportunities will be available to promote wellness and for the community to be screened for the early detection of chronic diseases.

What does it mean for the Western Cape Department of Health?



The Department will have a reputation as the best health department on the continent, rendering a health service that is regarded as amongst the best public sector health services in the world. This reputation will be built primarily on the delivery of good quality health services that are accessible to all in the Western Cape. The Department advocates for a healthy and responsible lifestyle amongst the population both through direct engagement with patients and the community as well as through mobilising other sectors to mitigate the social and economic determinants of health.

The Department is responsive to the needs of the population; it is a learning organisation, and is innovative in developing new models of care. The Department operates a well-functioning health system that is coherent, co-ordinated and focused on the delivery of a superior patient experience and optimal health and organisational outcomes.

Over and above the personal health care that is rendered within the health service facilities, the Department will be proactively engaging families and communities through community-based services and other mechanisms. This is a significant development to address population health more broadly. Building resilient mechanisms between the health service and the community will stand the province in good stead to address eventualities such as disease outbreaks and the consequences of climate change including floods and fires. Good inter-sectoral collaboration at various levels with other stakeholders will be strengthened.

The organisation operates efficiently within its budget and renders a service that is financially sustainable. It receives unqualified and clean audits as a matter of course. The Department has clear strategic and operational plans, with definitive targets and is publicly accountable for results that are based on accurate and reliable information. The Department has institutionalised efficient systems and processes.

It is a corruption-free and well-governed organisation. The Department is sought after by employees as an employer of choice, because people see health workers as inspiring, well rewarded and respected. Employees are recognised and have opportunities to grow within the organisation. The leadership and staff of the Department live the values of the organisation in their daily practice, which is: caring, competence, accountability, integrity, responsiveness and respect.

What does it mean for our stakeholders and strategic partners?



We enjoy strong, vibrant, mutually respectful relationships with our partners, who share the common vision of Healthcare 2030. There is open and regular communication with all of our partners. There is a strong co-operative relationship with local government, particularly within the district health service.

Our staff, as members of well-organised unions, consider their interests as workers to be protected. There is a good relationship between organised labour and the Department, which results in labour stability and promotes good-quality essential patient care.

A synergistic relationship with universities is intrinsic to delivering an effective health service. Well-trained, competent and caring health professionals with a shared vision and value system are essential to providing a quality, person-centred experience. The training provided by our partners as well as within the Department must be aligned to meet the skills required by the health service. The Department has an important role in the whole production pipeline of health professionals from influencing career choices in schools, to providing a clinical platform for teaching and training to the induction of these professionals into the working world during internship and community service to becoming the employer of choice. Research is necessary to better understand the complex health service and improve clinical care. Interventions need to be evaluated so that lessons can be learned. Best practices will be shared. The relationship with universities will be used to access the technical expertise and knowledge to improve the performance of the Department in an on-going manner. This relationship will extend beyond health sciences to supportive disciplines like social sciences, information and communication technology, medical technology and architecture.

The Department will have all of its fixed health facilities connected and provided with the basic information systems that enable better patient care and auditable, effective monitoring, reporting and evaluation of performance. Electronic content management systems will enable better patient record management throughout the Department. The availability of mobile technology amongst the general public provides enormous opportunity to interact with patients and the community differently. The Centre for e-Innovation (CEI) within provincial government and SITA will provide effective leadership and support to facilitate progress in this regard.

The future vision is that the Department of Transport and Public Works is an effective implementing agent, which will consequently provide and promote modernised, well-constructed and maintained facilities that are adequately equipped.

There will be a strong contractual relationship with non-profit organisations (NPOs) to improve access to basic health services, especially at a community level and based on an agreed funding formula. There is an extensive network of NPOs that operate in a variety of specific focus areas as well as geographic areas that are well embedded in communities that the Department will partner with.

The partnership with the private sector is essential in the interests of improving access to and the quality of patient care. The Department will also have other mechanisms such as a Health Foundation that will enable the private sector to meaningfully contribute to the development of the public health service. The Department is one of the largest procurers of goods and services from the private sector and remains in a strong position to give effect to the policies such as Black Economic Empowerment and Green procurement policies. Suppliers are paid on time and the mutually dependent relationship is strong.

There will be a strong contractual relationship with non-profit organisations to improve access to basic health services, especially at a community level and based on an agreed funding formula.

What does it mean for government?



The provincial government is responsible for mobilising all the departments, other spheres of government, civil society and the business sector to improve the wellness of the whole of society. The provincial government has appropriate and effective strategies and mechanisms for inter-sectoral action for health and wellness. This will be extended from provincial level to district level.

Health is regarded as an important prerequisite for development within the province and is consequently adequately resourced.

The Western Cape Department of Health will give tangible effect to delivering a superior patient experience, optimal health outcomes as per the Millennium Development Goals and effective and efficient health system performance. While the provincial department will operate within the legislative and policy parameters of the national department, it will also be a dynamic laboratory for innovation and a testing ground for proof of concept and learning lessons from implementation within the South African context.

The province will provide leadership in health development. It will also be strongly collaborative with sister provinces and the national department as a two-way learning and support process.

At a local level, district health management will liaise and work with local government to ensure co-ordinated planning and delivery of services. Inter-sectoral collaboration is most effective at the local level.

VALUES

SUMMARY POINTS

1. The values of the Department are caring, competence, accountability, integrity, responsiveness and respect.
2. The challenge of the Department is how to make these values a living reality for each of the staff members throughout the Department as we move towards our vision for 2030.

The Department renders a large and complex service every day of the year and the clinical environment is often stressful. Staff attitudes are a common source of complaints within this challenging environment. A key issue is how greater commitment and engagement from our staff can be promoted on a daily basis, so that we can move towards a more person-centred service with a greater focus on quality improvement.

Values are important in building a cohesive organisation. The provincial government has adopted a values-driven approach. The five core values of the provincial government have been identified as caring, competence, accountability, integrity and responsiveness. After an internal reflection the Department has also added "respect" to the list.

Potentially limiting departmental values were identified as bureaucracy, hierarchy, control, long hours and confusing messages. There was a general consensus among all staff on the desired set of values for the department.

The challenge of the Department is how to make the desired values a living reality for each of the staff members across the Department as we move towards our vision for 2030. The senior management of the Department will need to lead by example. The Department will be embarking upon a structured initiative to engage staff in this process. Building commitment to values is a long term process that must be embedded within the organisational culture of the Department.

SUMMARY POINTS

1. The principles of 2030 are:
 - a. Person-centred quality of care
 - b. Outcome-based approach
 - c. PHC philosophy
 - d. District health system model
 - e. Equity
 - f. Efficiency
 - g. Strategic partnerships
2. The evolution of a shared meaning and rich, common understanding of these principles will happen through a series of dialogues with staff and partners over time.
3. The principles will inform the strategies to give effect to Healthcare 2030.

PRINCIPLES

Each of the principles that inform 2030 are described in detail below to ensure that the meaning of each principle is fully understood and interpreted in the same way. The evolution of a shared meaning and rich, common understanding of these principles will happen through a series of dialogues with staff and partners over time.

Person-centred Quality of Care

The quality of care, with a focus on patient experience, lies at the heart of 2030. Excellence in clinical quality of care and the need for superior patient experience must inform every effort of the public health sector in the Western Cape. Patients must be treated with dignity and respect within a safe and clean environment. Waiting times should be acceptable and essential medicines must be available at all times. The Department will strive to meet the core standards developed by the National Department of Health.

A Move Towards an Outcomes-based Approach

The Department will focus on improving health outcomes, which will include improving life expectancy and reducing maternal and child mortality. Targets will be guided by the MDGs. Evidence-based interventions that have the largest impact on the desired outcomes will be prioritised. This also implies a more rigorous approach to disease

prevention and promotion. A strong culture and system of monitoring, evaluation and learning will be embedded at all levels of the organisation to ensure we deliver on these targets.

The Primary Health Care Philosophy

The PHC philosophy refers to the provision of a comprehensive service that includes preventive, promotive, curative and rehabilitative care. The primary care service is the point of first contact for the patient. These primary-level services are supported and strengthened by other levels of care, including acute and specialised referral hospitals and an efficient patient transport service. The philosophy is also premised on the understanding that wellness cannot be promoted in isolation from the social, economic and political environment. A central tenet of the PHC philosophy is community involvement in health. This implies that the community not only takes ownership and responsibility for its own health care at a personal level but, as a community, is also actively involved in the governance of health services.

Strengthening the District Health System Model

The DHS model gives a district manager and his or her team responsibility and authority for achieving the health outcomes targeted for a specific geographical area demarcated as a health district. The district manager will be accountable and play a stewardship role in securing and accessing the support of other levels of the service as well as working in partnership with the private sector. Health will be delivered within well-defined sub-district and district boundaries in the province. All public sector health services will be provided by a single authority. This is already the case for the rural districts. The district model will be further strengthened to ensure the desired health outcomes of 2030.

Equity

Serious inequity continues to exist in post-apartheid South Africa as confirmed by the NDP. These inequities exist between provinces and within the province of the Western Cape. Inequity exists between rural and urban areas, within the urban areas between formal and informal communities, as well as between the public and private health sectors. Equity is an internationally recognised principle of social justice. While this is a broader issue for government, the Department will need to address equitable allocation of resources, supervise the provision of services and monitor health outcomes.

Efficiency

The Department will advocate for adequate resources for the provision of health care. However, once the budget has been allocated the Department will need to operate responsibly within its budget allocation. Cost-effective priorities will have to be set and regularly reviewed to address the mismatch between escalating health needs and limited resources. The Department will strive to optimise efficiencies to obtain best value for the health rand. The Department will plan and function in a cost-effective and sustainable manner for the future.

Building Strategic Partnerships

It is essential that the provincial government seeks out and builds creative partnerships with role players in the private sector, civil society, higher education, labour movement, other spheres of government and internationally.

Improving the health status of the population requires a 'whole of society' approach. The capacity and resources within the private sector need to be engaged, given the disparity between what is spent versus the population coverage in the public and private sectors.

The production of competent and caring health professionals is an essential requirement to enable the Department to deliver on its 2030 mandate. Research will play an important role in improving the performance of the Department. It is important that the partnerships between the Department and universities are strengthened.

Local labour stability is vital to the efficient and effective delivery of health services. Good structural arrangements already exist at both local and provincial levels to foster a healthy working relationship. This will be sustained.

The provision of environmental health is an important component of PHC and the Department will work with municipalities to ensure a cohesive approach.

The promulgation of the Districts Health Councils Act in the province provides a statutory framework for working with local government.

Over recent years, NPOs and community-based organisations (CBOs) have become increasingly important as providers of community-based services. There will be major expansion and strengthening of these services towards 2030. Good structural and contractual arrangements and strong collaborative management is key to success in this area.

The WC Ministry of Health has already started an exciting engagement with the private sector, which has shown a willingness to invest in the public sector. Commercial opportunities are being investigated that can be mutually beneficial. A public-private health forum exists and a Health Foundation has been recently created, which provides a structured opportunity for engagement with the private sector.



SECTION E:

LEADERSHIP AND GOVERNANCE

SECTION E: LEADERSHIP AND GOVERNANCE

LEADERSHIP

SUMMARY POINTS

1. An essential requirement to communicate and build commitment to the shared vision of Healthcare 2030 is dynamic and distributed leadership across the ranks of management, clinicians and administration.
2. Leadership is about inspiring change, providing strategic direction, building cohesion and motivating people. Management is essentially about delivering on objectives and getting results. Managers are usually formally appointed into their positions and derive their authority accordingly. Leaders do not necessarily have formally appointed positions and leadership can be displayed at all levels of the organisation.
3. Leadership should embody the organisational values, use their interpersonal skills, encourage innovation, draw on the capability of all employees and be visibly collaborative with staff and partners.
4. Reciprocal accountability which is a shift from top down to mutual accountability is an important culture change that will help to cement a cohesive commitment to common objectives.
5. A competing values framework for organisational effectiveness identifies the tensions between the need to collaborate and the emphasis on competing for results, as well as the need to be creative and the requirements to control and comply.

The development of the vision, values, principles and strategic framework of Healthcare 2030 has created an exciting opportunity to think anew and afresh, to re-examine and re-imagine how we do business, to energise and excite both the staff within the organisation and our strategic partners as we build commitment to a shared future. An essential requirement to communicate and build commitment to the shared vision of Healthcare 2030 is dynamic and distributed leadership.

The Department also recognises that it requires a strong focus on transformation in the light of its hierarchical and bureaucratic nature. The intention is to develop leadership from its management, clinical and administrative ranks who:

- » Embody organisational values in the behaviors on a daily basis;
- » Depend on interpersonal forms of power, as opposed to power based on a position in the hierarchy;
- » Nurture creativity to enable innovation;
- » Draw on the inherent and potential capabilities of all employees in the Department; and
- » Are visibly collaborative and supportive in their relationships with staff and external stakeholders.

The key challenge will be to create a work environment that harnesses the relationships, skills and capabilities of individuals in the system. Managers at all levels need to be visible at the coalface to support the frontline staff, listen to their issues, needs and ideas and address the challenges with creative solutions. Frontline staff need to be acknowledged and recognised for their efforts, dedication and commitment to person-centred care. Managers need to be receptive to constructive criticism and be accountable when they fail to accept such input.

The development of the vision, values, principles and strategic framework of Healthcare 2030 has created an exciting opportunity to think anew and afresh, to re-examine and re-imagine how we do business, to energise and excite both the staff within the organisation and our strategic partners as we build commitment to a shared future.

Leadership and management are probably one of the most written about subjects in the literature. In essence, leadership is about inspiring change, providing strategic direction and motivating people. The generic functions of management include planning, priority setting, implementation, controlling and monitoring and evaluation. Management is essentially about delivering on objectives and getting results. Clearly, both are critical to the organisation and both functions can reside optimally within the same individual. Managers are usually formally appointed into their positions and derive their authority accordingly. Leaders do not necessarily have formally appointed positions and leadership can be displayed at all levels and in various situations irrespective of formal status. Ideally, leadership should be widely distributed and include all managers and much more.

Distributed Leadership

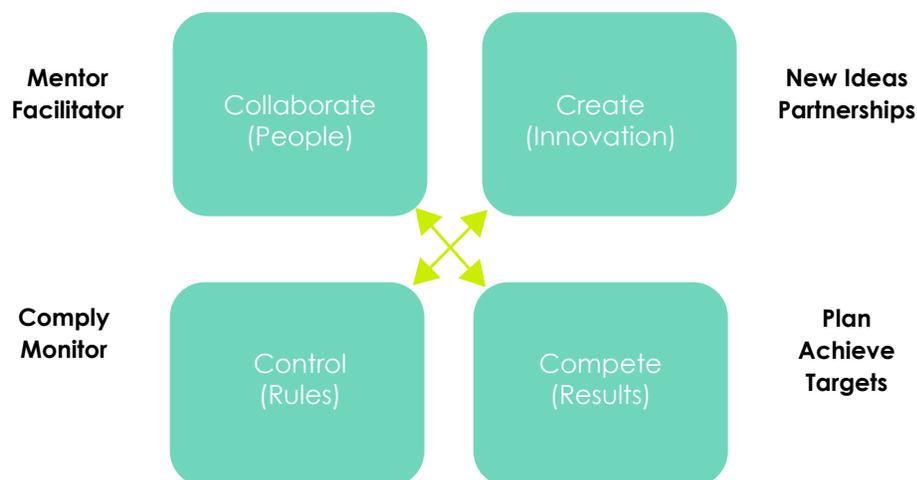
Health systems are complex and patient care is multi-disciplinary. Health professions have their own norms, professional groups and hierarchies. This together with the complex layering of the current health system means that distributed leadership is not only optimal but also necessary for the envisaged large-scale transformative change to take place.

Competing Values framework

The competing values framework is a useful management model, as it is designed to develop the capabilities of managers and clinicians to lead and manage effectively. The application of the model is a balancing act that must be context- and situation specific. The Department will use this framework to improve its organisational effectiveness.

The competing values framework (See Figure 3) draws on the four domains of organisational effectiveness. Each domain has a perceptual opposite. The “people domain” stands in contrast to the “results domain”. In the “people domain”, people are inherently valued, but in the “results domain” people are of value only if they contribute greatly to the attainment of targets. The “innovation domain” runs counter to the “rules domain”. While the “innovation domain” is concerned with adapting to the continuous change in the environment, the “rules domain” is concerned with maintaining stability and continuity inside the system.

Figure 3: Competing values framework



Source: Fearman SR, Quinn RE, Thompson MP. *Becoming a Master Manager: A Competing Values Approach*. 5th ed. Hoboken: Wiley; 2010.

Reciprocal Accountability

The concept of reciprocal accountability is a major shift from the convention where higher-order structures in the Department hold the facilities that deliver services accountable for results, to where the facilities also hold the higher structures accountable for the enabling support they need to provide to the facilities. This shift from top down to mutual accountability is an important culture change that will help to cement a cohesive commitment to common objectives.

The Department will invest in developing the prerequisite capabilities of leadership and management amongst middle- and senior management as well as clinical and administrative staff members. This is an essential requirement in the increasingly complex and challenging current environment as well as to drive the change envisaged by Healthcare 2030. The Department will source expertise in this regard from our strategic partners such as the HEIs or private agencies.

GOVERNANCE

SUMMARY POINTS

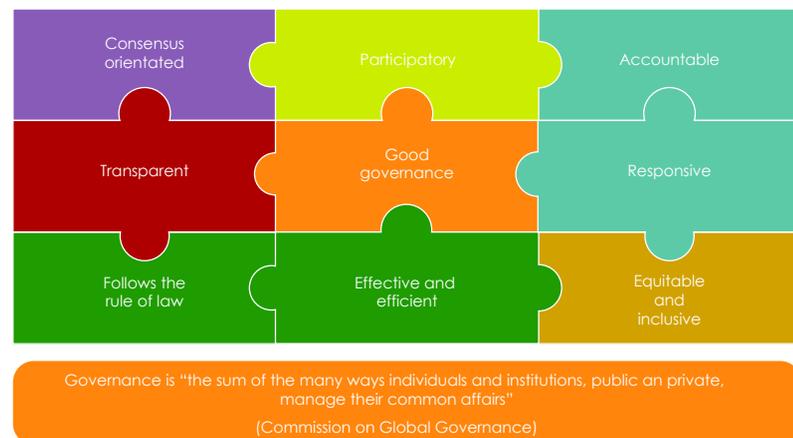
1. The Commission on Global Governance defines governance as "the sum of many ways individuals and institutions, public and private, manage their affairs. It is a continuing process through which conflicting or diverse interest may be accommodated " through compliance and/or cooperation and through formal or informal means".
2. According to the UNDP, good governance is accountable, transparent, responsive, equitable and inclusive, effective and efficient, participatory, consensus oriented and follows the rule of law.
3. There is a rich legal and policy architecture that underpins the provision of public sector services in general and health services in particular. Thus includes the PFMS, National Health Act, the Facilities Broad Act and the District Councils Act.
4. Greater efforts will be made to make the statutory structures more functionally effective as conduits of community concerns. This will include more effective communication and information sharing, capacity development within these structures and deepening of the relationships between them and the department based on trust and mutual respect.
5. Transparency, responsiveness and information sharing are important prerequisites for accountability. Greater effort will be made to communicate Departmental plans and reports to the public, in a user-friendly manner.
6. Clinical accountability will be developed in line with the clinical governance policy framework of the Department.

The Commission on Global Governance defines governance as:

the sum of the many ways individuals and institutions, public and private, manage their common affairs. It is a continuing process through which conflicting or diverse interests may be accommodated and cooperative action may be taken. It includes formal institutions and regimes empowered to enforce compliance, as well as informal arrangements that people and institutions either have agreed to or perceive to be in their interest.

According to the United Nations Development Programme, good governance is accountable, transparent, responsive, equitable and inclusive, effective and efficient, participatory, consensus-oriented and follows the rule of law.

Figure 4: UNDP principles of good governance



Source: UNDP; 1997

The outcome of good governance will be a public health system in the Western Cape that produces the desired outcomes, especially in terms of meeting the expectations of the people it serves. The 2030 vision narrative describes multiple perspectives and implies the roles and responsibilities of various parties in striving to achieve this vision. The Department commits itself to the UNDP principles of good governance. It is therefore imperative to create the enabling conditions to allow for good governance, which should be contextualised within our local setting and conditions. We therefore require effective mechanisms for meaningful oversight of the policy development, institutional arrangements, authority- and decision-making arrangements in the provision of health services in the Western Cape. Some of these mechanisms are elaborated on below as well as under the section on 2030 principles.

Legislation and the Rule of Law

There is a rich legal and policy architecture that underpins the provision of public sector services in general and health services in particular. The National Health Act is the main legislation that provides the overarching legislative framework for health services.

The District Health Council Act and the Health Facility Boards Act provide the legislative framework for governance structures in the Western Cape health system. The Health Facility Boards Act will be amended as a priority to make statutory provision for PHC facility committees.

It is imperative that the legislative framework allow for effective oversight at individual facility level and decentralised geographic areas, as much as at centralised levels.

Public Participation

Public participation and true local community involvement are integral parts of the 2030 principle of the PHC philosophy. Greater efforts will be made to make the statutory structures more functionally effective as conduits of community concerns. This will include more effective communication and information sharing, capacity development within these structures and deepening of the relationships between them and the Department, based on trust and mutual respect.

Communities are not homogenous entities and include a range of forces and vested groups that operate within them at any point in time. Thus, the dynamics of effective community involvement can be complex.

2030 envisages public participation and local community involvement with the Department to improve the health status of the population. This could range from an active role in the governance of health facilities to encouraging community campaigns around healthy lifestyles. The extensive network of CBOs and NGOs will be engaged as part of this process. Creative ways to have patients and communities involved in the designing of the health service as partners and contributors, as opposed to being passive recipients, will be explored.

The investment in community-based services and the fact that community care workers are engaging with families within their homes provides a basis for increased understanding of the many inter-related factors impacting on health. The interaction between health workers and patients must be seen as opportunities to build trust, confidence, and the sharing of information as well as opportunities for effective health promotion and prevention.

Accountability

Transparency, responsiveness and information sharing are important prerequisites for accountability.

The Public Finance Management Act (PFMA) and the Public Service Act (PSA) provide the legal framework for the efficient management of resources and ascribes accountability to officials at various levels within the Department. There are statutory processes for the tabling of annual plans and reports on performance to the legislature by the executive authority (provincial Minister of Health) and the accounting officer (Head: Health). Greater effort will be made to communicate these plans and reports to the public in a user-friendly manner. District health councils and facility boards provide important local vehicles for communication and accountability.

The formal audit process and the Office of the Auditor-General, who reports independently to the legislature, ensure compliance with legal prescripts.

Clinical accountability will be embedded within the Department in line with the departmental clinical governance policy framework. (See Section : Quality Improvement : Clinical Governance)



SECTION F:

SERVICE DELIVERY PLATFORM

SECTION F: SERVICE DELIVERY PLATFORM

SUMMARY POINTS

1. The structure of the envisaged 2030 service platform retains the original configuration of 2010 with a strengthening of PHC including home and community based care and district hospitals.
2. The essence of the change is how we do business within this service platform.
3. The focus is on person-centred quality care, integrated provisioning and continuity of care throughout the life course of the patient.
4. This section focuses on the mainstream general health service platform and does not deal with specific disciplines or subspecialties.
5. Special reference is made to TB, rehabilitation, mental health and oral health to provide context to the realignment of these services from the specialised hospitals to within the mainstreamed health service.
6. The four tenets of the planning methodology are using the dependent population as a base for planning, the smallest geographic entity for which there is good data, household income as a proxy for inequity and creation of norms and planning tools for application within specific service settings.

Introduction and Background

2030 centres on the re-orientation of the health system toward person-centred care; it recognises patients as partners in managing their own health and that of the broader community. It aims to create a health system that is designed around the needs and expectations of the people it serves, ultimately creating care that is more socially relevant and responsive. This requires a service delivery model oriented towards health and wellness rather than disease, which necessitates a rethink of how services are offered and the development of new ways of working that would enable person centredness, comprehensiveness, integrated care provisioning and continuity. The intention is the development of a delivery model with close-to-patient interdisciplinary teams responsible for a defined geographical area, with greater capability for prevention and health promotion. It is important that the delivery model is able to keep pace with the varying needs of patients as they progress along their life course trajectory.

The service delivery platform as envisaged in the 2030 document retains its 2010 structure, but has two important differences. There will be a significant investment in the expansion and strengthening of primary health care services and the manner in which we render services. We will move from a mind-set of delivering services mechanically and often impersonally to person-centred care at all levels of the service.

The model to the service platform is illustrated in Figure 5.

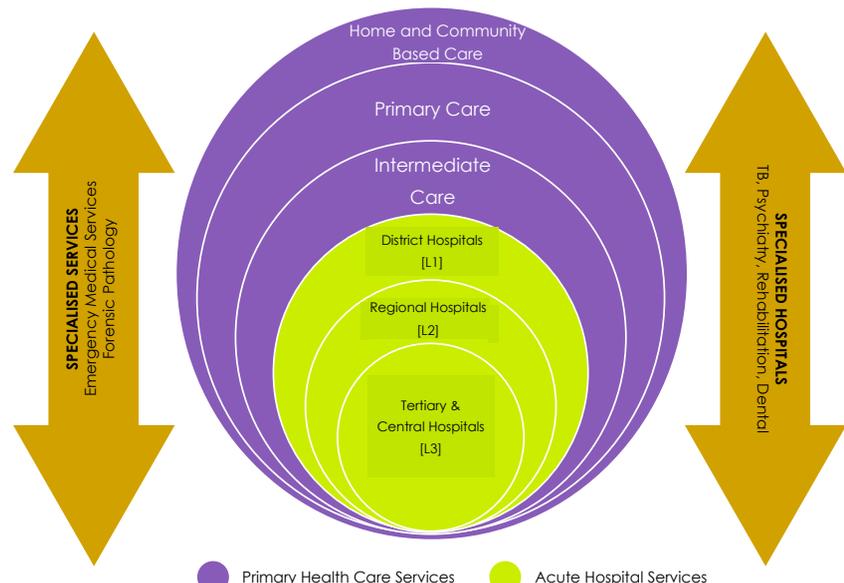
The 2030 envisioned delivery model retains the original configuration of 2010. Primary Health Care services will comprise of 3 care settings; Home and Community Based Care (HCBC), Primary Care and

PHC approach, as defined under the section on Principles of Health-care 2030, refers to an all encompassing philosophy of a balanced health service with PHC services supported by other levels of care; that is comprehensive i.e. preventive, promotive, curative and rehabilitative and includes community involvement and inter-sectoral collaboration. The PHC service refers to the service components described above i.e. home and community based care, primary care and intermediate care.

Intermediate Care. Collectively these settings will provide a comprehensive array of preventive, promotive, curative, rehabilitative and palliative interventions.

Acute hospital care is predominantly rendered from the hospital platform with three levels of care, in the form of the district hospital (L1), the regional hospital (L2) and the tertiary and central hospital (L3). In addition there are hospitals with more targeted specialist services like TB, psychiatric care, rehabilitation and dental care. EMS is integral to facilitating access to emergency medical care and patient transitioning between levels of care. The intention is to maintain ninety percent of patient contacts occurring within district health services (i.e. PHC and district hospitals) as we aim to deliver the

Figure 5: Service delivery platform for 2030



"right care, at the right time, in the right setting, every time" on an on-going basis.

The planning for the re-organisation of the health services will need to take into account the changes of one section and its impact on other sections of the platform.

In addition to the focus on the human side of patient care, the Department will also focus on improving the technical quality and system of health care delivery. This will include, amongst others, systematic triaging of patients, better discharge planning, improve all the elements that impact of effective referrals from discharge summaries, to communication with patients and their families as well as between institutions and health professionals and efficient transport.

The services will also need to consider the specific needs of segments of the population and will be organised in a child -, or women - or adolescent- or elderly - friendly manner. This will require more detailed thinking in the service planning phase and will range from considerations within infrastructure and services in emergency centres, to wards and OPD care, to ambulance services. For example, we need to plan the service that allows for every child that will be accompanied with one or both parents or an adult relative.

Rehabilitation Services has been historically under-developed, with limited access, mainly provided within hospitals and specialised centres by a range of trained health therapists. Healthcare 2030 will redesign and mainstream the provision of rehabilitation services at all levels of care. This will significantly increase the responsiveness of the whole health system to the need for rehabilitation and optimise its potential in improving the quality of care and well being of the patients that require this service. This service includes physical, psychosocial and vocational rehabilitation for both adults and children.

Care Co-ordination

Care pathways

The focus in 2030 is on strengthening the primary care providers' role as co-ordinators of patient care pathways across the health system, which has specific implications for the capacity of CNPs, as they become the key mediators between the community and the other levels of care in the health system. The CNP takes on the role of gatekeeper, helping patients navigate the labyrinth of care continuums in the system. This co-ordination function provides an institutional framework that enables collaboration with the broader health and social care networks beyond the boundaries of the Department itself, which is particularly relevant to the PNs operating on the HCBC platform. Care pathways are of particular value where people have multiple morbidities and an array of interventions is required to support self-management.

Continuum of care

Care pathways are individualised, non-linear and are a combination of service elements that are unique to a specific patient and cut across levels of care and sectors. Continuums tend to be more linear and represent how care is organised for a particular condition or group of conditions at each level of care within the health system. The co-ordination of a care continuum is vested in clinicians with the relevant expertise in a particular area; for example, the mental health nurse and the psychiatrist for psychiatric conditions, the midwife and the obstetrician for maternity care and the dietician for nutritional care. The family physician will play a critical co-ordination role in the care continuum in conjunction with the heads of the general specialties.

The approach can be extended to ensure continuity across departments and sectors for example in the care of children with autism or cerebral palsy there needs to be collaboration between the rehabilitation service in health and the education sectors.

The Department will also explore the possibility of chronic patients being able to see the same CNP or medical officer over time to enable building of stronger relationships and trust which impacts on the quality of care and clinical outcomes.

Planning Methodology

The parameters and methodology used for the planning of the health service in 2030 is a major advance on that used for 2010 and is based on four major tenets:

- » Using a population base and the notion of a dependent population;
- » Using the smallest geographic entity for which reliable health and socio-economic data is available;
- » Using an equity measure with household income as a proxy that weights the distribution of health resources

towards the poorest households; and

- » Establishing norms and creating planning tools for different aspects of the health service that allows for its application to specific geographic areas. The tools used in one section of the health service takes into account the impact of developments in other sections of the service; in this way the health service is viewed as an integrated health system.

The general tenets are further described in Annexure D and the specific application to various aspects of the health service platform is described under the service components.

The model makes assumptions and there are variables that can be adjusted - for example the proportion of lower middle income households that will depend on the public sector service.

Strengthening of the HCBC will be significantly expanding access to care and has major potential to influence the health status and wellbeing of families.

PRIMARY HEALTH CARE SERVICES

The primary health care (PHC) service component of the health system is the most critical component, as it serves as the main entry point into the care continuum, and caters for the vast majority of health care needs. It comprises three distinct but inter-related service delivery platforms (See Figure 6):

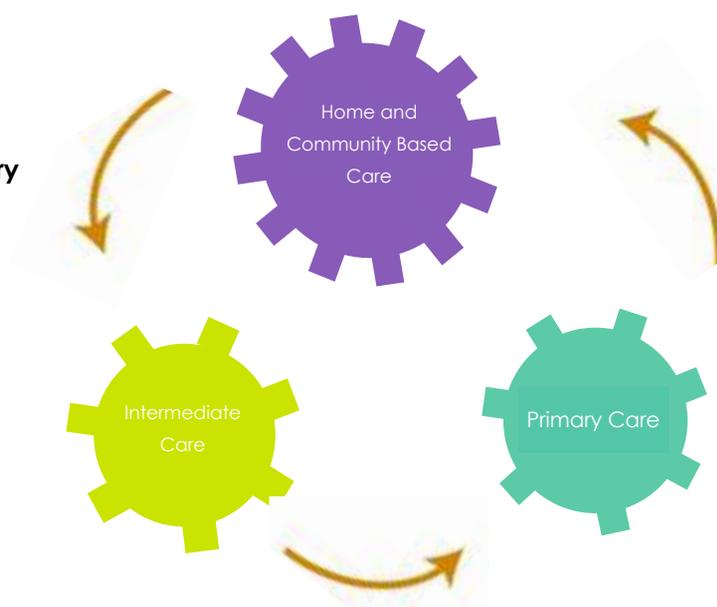
- » Home-and community- based care (HCBC);
- » Primary care services (PCS) at health facilities, including NPO sites or General Practitioner surgeries where a quantum of prevention, curative and rehabilitative services are offered; and
- » Intermediate care.

The social dimensions of disease create the need for continuity, coupled with more comprehensive and person-centred approaches to care. These necessitate PHC services that:

- » Cater for a range of health risks and illnesses;
- » Recognise people as partners in designing and managing their own health and that of the broader community; and
- » Re-orientate care around people's needs and expectations, making care more socially relevant to producing better health outcomes.

The 2030 principles require the PHC services to have significantly greater capability for health promotion and prevention. The re-design of the HCBC CBS platform creates this capability, enabling a more responsive health system as households are pro-actively engaged on matters that impact on their wellness.

Figure 6: Inter-related PHC service delivery platforms



SUMMARY POINTS

1. Home and Community based care (HCBC) is embedded in the local context and is innately designed to foster stable, long-term personal relationships with households, which build understanding, empathy and trust. The service model is population based and organised per electoral ward in the metro and per sub-district in rural areas.
2. The HCBC model provides for poorest households having greatest access to CCWs. There will be 270 households per CCW and 10 CCWs per professional nurse. CCWs will work an eight hour day. The model provides for 30 minutes per household visit on average and allocates fifty percent of the CCWs' employed time for direct patient care.
3. Intermediate care, which involves post acute, rehabilitative and end-of-life care, is essential for alleviating the pressure on acute hospital beds.
4. Intermediate care teams will work in close collaboration with HCBC teams. Rehabilitation care workers, working under the direction and clinical supervision of professional therapists, will deliver the bulk of required therapy.
5. Rehabilitation on the HCBC platform will be available for all impairment groups, including mental ill health and intellectual disability. Supported living environments and occupational enrichment programmes are all part of the fabric of wholesome rehabilitation.
6. Counselling is an essential part of a health care provider's work, from encouraging adherence to supporting behaviour change, and has an important role in increasing the preventive and promotive aspects of the clinical encounter. The Department will further explore how, where and by whom counselling can be provided, what training and other resources will be required and how it could be implemented in a phased manner. The Department is committed to creating a generic counselor that is trained to function in a range as settings as opposed to the historical situation of having specific counselors for different disease conditions or services. The role, responsibilities and availability of psychologists in this regard will also be reviewed.
7. Health services are also rendered in schools, crèches, old age homes, the workplace and prisons as part of the community based platform. This will be governed by service level agreements between the Department and the custodian of these sites.

2030 Service Configuration of PHC services

Home and Community based care (HCBC)

HCBC is rendered in the living, learning, working, and social and/or play spaces of the people we serve. It is geared towards prevention and health promotion with a complementary capacity for curative, rehabilitative and palliative care. CBS is embedded in the local context and is innately designed to foster stable, long-term personal relationships with households that build understanding, empathy and trust. This is pivotal to continuity and person-centred care.

Description of service

HCBC recognises people's capacity for self-help and involves a comprehensive range of context-sensitive interventions that positively influence environmental and personal factors such as psychosocial abilities, coping abilities, lifestyle issues, behaviour patterns and habits. It is a collection of activities that support the actions people take to maintain health and well-being, prevent illness and accidents, care for minor ailments and long-term conditions, and recover from periods of acute illness and hospitalization. A complementary capacity for rehabilitative and palliative care will be introduced into HCBC to further enhance the comprehensiveness of the care provided on the platform.

There is a need to strengthen the capability for early detection and treatment, the reduction of risky behaviour and ability to address underlying social determinants of health. The delivery model for HCBC is therefore population based and organised in accordance with the geographical boundaries of the electoral ward (urban context) or sub-districts (rural context). The core team in HCBC comprises Community Care Workers (CCWs) and a professional nurse (PN) who are responsible for a specified number of households per ward, bringing care closer to people and making primary health care directly and permanently accessible. The model entrusts these teams with the responsibility of the health of a defined population in its entirety, the sick and the healthy, those who choose to use services and those who do not. It does not depend on individual- or community-initiated access, maximizing opportunities for preventive care and health promotion. HCBC is designed to create an interface between the population and their health services that builds an enduring relationship. This is not merely a question of establishing trust in the health system and improving patient satisfaction but an investment proven to enhance quality and better health outcomes.

A focus on functioning, participation and social inclusion in HCBC promotes recovery, prevents hospital admissions, reduces re-admissions and interrupts downward social drift. It is especially true for people with mental illness.

Health activities on this platform are concentrated around the aspects of the package that enable primary and secondary prevention. An example would be the screening initiatives that identify children for immunisation or people who display early signs of a mental health condition. 2030 also encompasses a particular focus on tertiary prevention such as:

» Provision of accessible information on the relevant chronic

Recovery can be viewed as being clinical and personal in nature. Clinical recovery is associated with rehabilitation and focuses on objective intervention outcomes such as symptom reduction and return to previous levels of functioning. It aims to avoid relapse and re-admission, reduce risk and shorten hospitalisation. Personal recovery involves a subjective, non-linear journey of developing illness self-management strategies based on active choice, self-empowerment, hope and a search for meaning. These initiatives are identified by the person who needs to recover and are based on his or her current life circumstances, opportunities and aspirations.

conditions, treatment options, medication and crisis management (e.g. electronic access, group education, crisis plans for people with a psychiatric condition);

- » Equipping individuals and the families with strategies to prevent relapse and hospitalisation;
- » Mobilising support networks that enable living, learning, working and socialising arrangements that support wellness (e.g. support groups for parents of children with an intellectual disability);
- » Mechanisms that enhance coping with persistent symptoms and stress; and
- » Enabling health-promoting lifestyle choices (e.g. motivational interviewing and coaching).

The focus of rehabilitation interventions in the HCBC platform will be on the human functioning that relate to difficulties in executing activities (activity limitations) and problems in involvement in life situations (participation restrictions). Disinterest in meal preparation, poor self-care and grooming when clinically depressed are all examples of activity limitations. A participation restriction refers, for example, to the challenges a child with juvenile arthritis would experience as a learner in the absence of appropriate assistive technology and/or the necessary reasonable accommodation. HCBC includes strategies that support personal recovery, more specifically the development of self-management strategies to mitigate likely secondary complication of an impairment (tertiary prevention); and the mobilisation of agency at an individual, household and community level (health promotion).

The rehabilitation service within HCBC will be augmented by the introduction of the Rehabilitation Care Worker (RCW) who will be supported by professional therapists that include physiotherapists and occupational therapists and by dietitians and speech therapists and others where necessary.

The Department will develop a policy and detailed package of services to be rendered within HCBC that will further inform the structures, skills and levels of supervision required by CCWs as well as the systems and processes to implement this service efficiently and effectively.

Elements of HCBC services are also rendered in schools, crèches, old age homes, the workplace and prisons. The intention is to establish a policy framework and governance arrangements that provide the necessary parameters to clearly define and manage health activities performed by the Department in these establishments. The relationship will be formalised by a service level agreement between the Department and the custodians of the non-health entity. These activities will be factored into the resource allocation tools.

School health services have been prioritised by the National Department and the coverage will be incrementally improved over time starting with schools in the poorest quintiles, with the main focus being on prevention, promotion and early detection through screening.

Rehabilitation:	" . . . a goal-orientated and time limited process aimed at enabling impaired persons to reach an optimum mental, physical or social functional level" (National Health Act)
Primary Prevention:	is creating an environment where certain challenges to health are eliminated, and thus no further preventative interventions are necessary.
Secondary Prevention:	The prevention of clinical illness through early and asymptomatic detection and remediation of certain diseases and conditions that, if left undetected, would become clinically apparent and harmful.
Tertiary Prevention:	The prevention of disease progression and additional disease complications after clinical diseases are manifest.
Health Promotion:	The process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Counselling

The aim of counselling is to emphasise the strengths and resources of the person to bring about effective behaviour change and well-being. Health care workers often want to help their patients bring about change to improve their health status, and counselling is both an inherent part of the health care encounter itself and a useful referral resource when more extensive counselling is deemed necessary.

Counselling can assist in addressing many risk behaviours that lead to high burden diseases as well as in decreasing their complications. Its effectiveness has been shown in a wide range of areas including reducing cardiovascular risk factors by improving lifestyle habits such healthy eating and exercise, reduction in substance abuse and harmful drinking, improved adherence and knowledge in pregnant teenagers. The STRIVE study showed that identifying patients with harmful drinking and substance use patterns is feasible in emergency centres in the Western Cape, and counselling interventions.

Counselling is an essential part of a health care provider's work, from encouraging adherence to supporting behaviour change, and has an important role in increasing the preventive and promotive aspects of the clinical encounter. Counselling will be available through the primary care and community-based care platforms, allowing more extensive counselling for those with common mental disorders, as well as those requiring further assistance or encouragement in behaviour change, across a range of risk factors and common diseases.

The Department will further explore how, where and by whom counseling can be provided, what training and other resources will be required and how it could be implemented in a phased manner. The Department is committed to creating a generic counselor that is trained to function in a range as settings as opposed to the historical situation of having specific counselors for different disease conditions or services. The role, responsibilities and availability of psychologists in this regard will also be reviewed.

SUMMARY POINTS

1. A comprehensive range of curative and preventative services are provided with a complementary capacity for rehabilitative and palliative care (one stop service) at PHC facilities.
2. The CNP, supported by a medical officer, provides the core of this frontline service. This additional capacity particularly targets maternity care, eye care, hearing and ENT, Oral health, Nutrition, rehabilitation and mental health and clinical support services.
3. CNPs will become the key mediators between the community and the other levels of care in the health system as co-ordinators of the patient care pathway.
4. To improve access and efficiency, medical officers, Mental health and midwifery nurses will be allocated to clinic level.

Primary care services

A comprehensive range of curative and preventative services are provided with a complementary capacity for rehabilitative and palliative care i.e. a one - stop service for patients.

Primary care services are ambulatory in nature, rendered in a combination of generalist primary care centres (i.e. clinics including mobiles and satellites), community day centres and community health centres). There is sufficient evidence available to demonstrate the benefits of generalist ambulatory care in terms of the prevention of ill health and death, and improved health equity. It is particularly the case where services are organised in a dense network of small close-to-patient service points. The Department envisages a single authority managing PHC services in the City of Cape Town by 2030. The WCG and City of Cape Town have committed to a mediated process (via the Inter-governmental Committee) to arrive at an appropriate governance option for PHC services in the Cape Metro Health District within the foreseeable future.

Description of service

Primary care services are nurse driven and build on the HCBC platform – particularly as it relates to prevention, diagnosis, treatment and recovery. Likely activities include amongst others: neonatal screening for deafness in the midwife obstetric units, immunisation, counselling for victims of trauma and violence and the management of illnesses of women and children as well as clients with chronic diseases such as unstable diabetes, hypertension or mental illness. The Primary care service will be strengthened to manage the majority of patients with HIV, TB, mental health and oral health problems. An inter-disciplinary team will further augment the capacity for diagnoses, treatment and recovery, in line with the reviewed primary care package as illustrated in Figure 7.

The professional nurses responsible for the co-ordination and supervision of home-based care will play a prominent role in determining the care pathways of patients and therefore work closely with the primary care facility.

To improve access and efficiency the intention is to optimally allocate the following health professionals to clinic level where feasible:

- » Medical officers
- » Professional nurse: mental health
- » Professional nurse: maternity

Emergency services will be provided at fully equipped and adequately staffed emergency centres in acute hospitals. The specific circumstances within each geographic area will have to be taken into account when a decision is made on the provision of emergency services at primary care facilities. Some facilities will have extended after-hour services.

In this setting, rehabilitation thus encompasses activities that deal more with problems in body structure and function (impairments) that are ideally treated in a generalist ambulatory environment. A typical example is the patient who presents to physiotherapy with "sprains and strains" which are resolved relatively quickly with no long-term functional loss. Clinical recovery is the focus of rehabilitation services on this platform with the expressed purpose of minimising activity limitations and participation restrictions for those patients with functional loss. This may require provision of assistive technology like mobility aids. While the nurse practitioner and medical officer in primary care will have some basic knowledge and skills in rehabilitation, they will be supported by therapists and therapy assistants in a range of areas that includes physiotherapy, speech therapy, occupational therapists, audiologists and dieticians.

Intermediate Care

SUMMARY POINTS

1. Intermediate Care refers to in-patient transitional care for children and adults, which facilitates optimal recovery from an acute illness or complications of a long-term condition; enabling users to regain skills and abilities in daily living.
2. Intermediate care, which involves post acute, rehabilitative and end-of-life care, is essential for alleviating the pressure on acute hospital beds.

Intermediate Care refers to in-patient transitional care for children and adults, which facilitates optimal recovery from an acute illness or complications of a long-term condition; enabling users to regain skills and abilities in daily living. The ultimate discharge destination is home or an alternative supported living environment. It involves post-acute-, rehabilitative- and end-of-life care, and includes comprehensive assessment, a structured care plan, active therapy, treatment and/or an opportunity to recover.

Intermediate care allows for a seamless transition between acute care and the living environment; particularly where the person's ability to self-care is significantly compromised a supported discharge becomes crucial to a successful recovery process. The focus of this service element is on improving people's functioning so that they can resume living at home and enjoy the best possible quality of life. The service will be supported by therapists and therapy assistants in a range of areas that includes physiotherapy, speech therapy, occupational therapists, audiologists and dieticians where deemed appropriate.

Health promotion initiatives on the platform necessitate collaboration across a sector that is enabled by making primary care teams responsible for the health of a well-defined population. This arrangement forces them to consider the broader social determinants of health and creates the impetus to mobilise resources to address these issues.

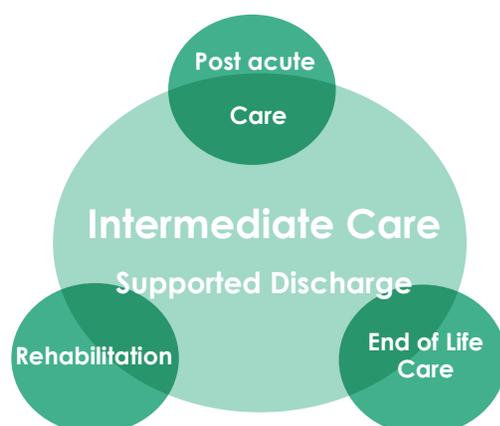
Figure 7: Primary Care package of care



Clinical support services that includes pharmacy, imaging services (radiography and ultrasound), laboratory services that are essential to the rendering of a comprehensive primary care service, will also be provided for at this level.

Professional Nurses are well positioned to mobilise a range of resources, beyond the confines of the health sector, to tackle the broader social determinants that precipitate and perpetuate ill health.

Figure 8: Types of Intermediate Care



Service Modelling

Home-and community-based care (HCBC)

	Persons with income below R76 400	Persons with income between R76 401-R153 800	Persons with income between R153 801 - R614 400	R614 400+
CBS coverage of households	90%	75%	40%	5%
Average size of households:	4			
Households per Community Care Worker				270
Number of Community Care Workers per Professional Nurse				10

The Department has used its discretion in the percentage of households covered by the HCBC programme. The norm of households per CCW and the ratio between the professional nurse and CCW are consistent with national norms, as well as the technical work undertaken by the University of the Western Cape. The application of the model to a sub-district is shown in the Table 4.

Table 4: Worked example showing application of above model to a sub-district

	Persons with income below R76 400	Persons with income between R76 401- R153 800	Persons with income between R153 801 - R614 400	R614 400+
Distribution of 2001 population	70.1%	26.7%	2.8%	0.3%
Households 2030	91 045	34 709	3 659	392
HCBC coverage	90.0%	75.0%	40.0%	5.0%
HHs per CCW	270 = Input variable			
Number of CCW required	303	96	5	0
Number of prof nurses required	30	11		

A workload calculator has been developed that enables the model to quantify the number of home visits that can be managed per day aggregated per annum. The model assumes that there will be full-time CCWs working eight hours a day for five days a week and that each visit will take 30 minutes on average and that each CCW will spend about fifty percent of their time directly in the homes of clients. The remaining fifty percent allows for travel between homes, which usually happens on foot, and administrative tasks such as reporting, problem solving with other agencies and consulting the professional nurse. These variables are adjustable and will have consequent resource implications.

The professional nurse will be responsible for the overall supervision and support, mentoring and on-the-job training, quality of care and problem solving – including navigating referrals through the system. The professional nurses will spend forty-five percent of their time directly doing home visits for the more complex clients and undertaking some of the above mentioned tasks.

Administrative support for each of the teams of 10 CHWs and a professional nurse in the ward is also provided to prevent the carers and nurses from inappropriately being consumed with administrative work and having their time diverted from seeing clients.

Table 5: Worked example showing application of workload calculator to determine the HCBC teams allocated to a sub-district

Post description	Working days per FTE per annum	Minutes/day	Direct patient care factor	Minutes/direct patient contact	Contacts per FTE/day	Contacts per FTE per annum (221 days)	FTEs (221 days per FTE per annum)
Community Care Worker (CCW)	221	450	50%	30	7.5	1 658	405
Prof Nurse: Co-ordinators/ Supervisors (CBS)	221	450	45%	30	6.75	1 492	41
Total visits by CHWs per annum by 2030				671 490			
Total visits by professional nurses per annum by 2030				61 172			

Appropriate adjustments to the model may be required for rural districts. For example, the distances to travel between homes may be larger and, therefore, the time for direct patient care will be adjusted accordingly.

Primary care services

In determining the optimal staff establishment to deliver the full package of PHC services, the aim was to create a balance between the various categories of staff and their optimal utilisation. The ratios between categories of staff must therefore be such that all staff are optimally used. Another important consideration was ensuring that sufficient management, administrative and pharmacy staff are provided so that clinical staff can use their available time optimally for clinical work. The high population density in the urban areas enhances opportunities for economies of scale. An example is the expansion of the catchment area of a clinic to 30 000 people without compromising access.

To ensure that socio-economically deprived communities receive proportionally more resources to address the higher burden of disease, allowance was made for weighted utilisation rates. This results in a greater allocation of health professionals to serve more deprived communities. In the example below the equity measure is applied to a sub-district in the Cape Town metro with regard to the utilisation of services rendered by CNPs.

Table 6: Sub-district application of the equity measure regarding clinical nurse practitioner services

	Persons with income below R76 400	Persons with income between R76 401 - R153 800	Persons with income between R153 801 - R614 400
Utilisation rate	2	1.6	1.28
Head count	102 780	98 021	10 224
CNP FTEs required	15.57	14.85	1.55

The PHC workload and utilisation calculator

An electronic PHC workload and utilisation calculator was developed to integrate utilisation and workload variables. A description of this process and methodology is contained in Annexure E.

Intermediate care

The model for intermediate care is based on the following assumptions:

- » Differentiated admission rate per household income;
- » Bed occupancy rate of 90%; and
- » Average length of stay of 42 days.

The implementation of rehabilitative home-based care should contribute significantly towards shortening the length of stay within intermediate facilities.

Table 7: Admission rate to intermediate care weighted according to household income

Weighted admissions per 1000: Intermediate Care Beds				
Admission rate	Persons with income below R76 400	Persons with income between R76 401 - R153 800	Persons with income between R153 801 - R614 400	R614 400+
	3.46	2.88	2.4	2

Given the life span of hospitals, the model can use the above assumptions and estimated population growth to project the intermediate beds required for 2030 as well.

The assumptions applied in determining the workload and full-time equivalents (FTEs) of rehabilitation workers and therapists required to render services in intermediate care facilities are listed below. These assumptions can be adjusted and will have the necessary consequent effects on staff numbers. This service may be provided by NGOs and the roles and responsibilities between the Department and the NGO will be defined through a service level agreement.

Each patient will receive a 45 minutes therapy session for 5 days per week (total of 225 minutes);

1. The therapy will be provided by rehabilitation care workers, as well as a range of therapists including physiotherapists, occupational therapists and speech therapists.
2. Social worker: 45% of patients will receive therapy once a week; and
3. Doctors are required on a part-time basis to address medical problems.

Because of the close collaboration between the home-based care teams and the intermediate care teams, a ratio between CHWs and RCWs was used to calculate the number of RCWs require for home-based care: (This does not mean that the CCWS will report to the RCW)

Number of CHWs per RCW:	8
Number of RCWs per therapist (occupational therapy and physiotherapy only):	6

RCW is a new category of mid-level worker and issues such as their registration, career progression and supervision will need to be addressed.

ACUTE HOSPITAL SERVICES

SUMMARY POINTS

1. A well-functioning community and primary care service and an efficient patient transport system is critical to the efficient functioning of hospitals providing acute services.
2. More detailed PHC and hospital service plans will be developed after the 2030 framework has been finalised. This will include planning for specific clinical disciplines.
3. International trends point to a decreasing dependency on hospital beds with a strengthening of CBS, PHC and inter-mediate services and the use of advances in technology.
4. A home-grown set of norms for admission rates and average length of stay have been developed.
5. The district hospital will provide a family physician-driven service. The larger district hospitals will also provide a varying quantum of general specialist services depending on, amongst other factors, the burden of disease and available infrastructure. The specialist services will not be departmentalised by clinical discipline.
6. The regional hospitals will provide general specialist-led services. They will also provide a district hospital service to the population in their immediate vicinity.
7. The central hospitals will be sub-specialist led but also provide a general specialist service to the population in their immediate vicinity.
8. There will also be an enhanced capability to render specific rehabilitative care activities, psychiatric care and oral health service activities.
9. Strategic parameters are identified to guide the planning of acute hospitals. Spatial planning considerations such as human settlement, transport routes, and economic activity, also influence the mapping of catchment areas and siting of hospitals. The rural hospital planning will be further weighted for the disadvantage of distance and low population densification.
10. The technical model weights variables such as the admission rates and average length of stay in favour of the wards with the larger proportion of poorest households.

A well-functioning PHC service and clinical support service and an efficient patient transport system are critical to the efficient functioning of acute hospitals, as a vital component of the care continuum for patients.

The acute hospitals include district-, regional-, tertiary- and central hospitals. The planning model adopts a similar approach to all

of them but, more importantly, the inter-dependency between these hospitals is significant. There is also the current and proposed reality of regional and district

beds being housed within the same institution and regional and tertiary beds being housed within the central hospitals.

Given the life span of hospitals and lead-time required to construct new hospitals, the long-term vision extends to 2030.

International trends point to a decreasing dependency on hospital beds – mainly linked to improving technology and the strengthening of associated services outside of acute hospitals. Whilst the complexities of managing large hospitals are recognised, there is no consensus on the optimally sized hospital.

The intention is to rebuild several of the hospitals in the Cape Town metro district. The landscape of service provision will be dramatically different from the current reality after modernising and making Khayelitsha-, Mitchells Plain-, GF Jooste-, Victoria-, Karl Bremer- and Helderberg hospitals fully functional.

Planning Considerations

The following factors were taken into consideration in the proposed technical modelling process:

Change in hospital utilisation trends

Internationally the trends in hospital utilisation are changing as a result of:

- » Decreasing average length of stay;
- » Reduced hospital admissions;
- » Increased admissions as day cases, day surgery and increased ambulatory care;
- » Improved technology;
- » Complementary use of associated service platforms such as home community-based care, intermediate care and facility-based PHC; and
- » The increased need for intensive care and high-care beds.

Optimal size of hospitals

Economies of scale vary between different types of hospitals. While there is recognition of the complexity involved in managing very large hospitals, there does not seem to be consensus on the optimal size hospital. Given the range of factors that need to be considered, it would be safe to assume that one size does not fit all situations.

Sizes of hospitals in terms of the Regulations published in terms of the National Health Act are:

District hospitals:	Beds:
Small	50 – 150 beds
Medium	150 – 300 beds
Large	300 – 600 beds
Regional hospitals	200 – 800 beds
Tertiary hospitals	400 – 800 beds
Central hospitals	maximum 1 200 beds

Strategic Parameters

The strategic parameters informing the 2030 technical planning process included the following principles:

- » District and regional hospitals should optimally provide a comprehensive package of care.
- » District hospitals should be most accessible and available within each of the sub-districts in the province, where feasible. Not only will this address accessibility to first-line acute hospital services, but it will also maintain the coherence of the district health system model.
- » All large district hospitals will provide some specialist services. The type and quantum of specialist services at large district hospitals will depend on the local burden of disease and the available infrastructure, technology and human resources within the affordable limits of the budget.
- » Some regional beds have also been located within the larger district hospitals. The number of regional beds has varied according to the available infrastructure in current hospitals or the potential opportunity in new ones. The package of care to be provided at these hospitals will be determined by the needs of the local population and the pragmatic feasibility of rendering services within the available beds.
- » The future of small district hospitals needs to be reviewed.
- » Regional hospitals are referral hospitals and should be optimally distributed and accessible along the major transport routes to facilitate emergency inter-facility transfers.
- » The geographic service areas (GSAs) structures are functional arrangements to co-ordinate the district health services and regional hospital services.
- » Regional Hospitals will also be responsible for rendering a district hospital service package to the population within the immediate vicinity of the hospital, if these services are not available locally.
- » Central Hospitals will provide a mix of regional and tertiary hospitals services.

Description of Services

The Western Cape Department of Health L1/L2/L3 acute hospital packages of care, 2009 provide the framework for the clinical services to be provided in district-, regional- and central/tertiary hospitals. Further technical work is being undertaken to recommend the mix of services (district hospital and general specialist services) that will be provided specifically in large district hospitals. This will also require customisation according to local circumstances as the local situation may be different between geographic areas and the specific institutions. Hospital services includes emergency care, outpatient, inpatient and day patient care. The subsequent service plan will provide further details of the reconfiguration of the various components of acute hospital services. The general trend is to strengthen ambulatory services and day care/day surgery as a more efficient and cost effective option whenever appropriate.

Figure 9: District hospital package of care



District hospital

District hospitals provide first-line hospital access and geographical ease of access for patients is important. District hospitals will optimally provide a full package of care. This will correct an important historical anomaly for several district hospitals and local communities: such as Victoria Hospital not providing obstetric services; GF Jooste not providing paediatric and obstetric services; and Karl Bremer not providing trauma and orthopaedic services.

The proposed 2030 service configuration allows for a family-physician-driven L1 acute hospital package of care. In response to the burden of disease, and in the interest of person-centred care, provision to varying levels will be made for a range of generalist specialist services (across the eight general specialist disciplines and the minor specialities), especially in the larger district hospitals. The general specialist services will not necessarily be configured in separate specialist departments. In certain instances general specialists will render these services on the establishment of the district hospitals and in other cases this will be provide through outreach and support. There will also be an enhanced capability to render rehabilitative care activities, psychiatric care and specific oral health service activities. To give full effect to this package of care, an appropriate inter-disciplinary team (with the prerequisite skills mix) will be provided. (See Figure 9)

Development of district hospital norms

A home-grown set of norms for admission rates and average length of stay has been developed. The hospital model uses differentiated admission rates and average length of stay in favour of the most deprived populations to address equity. This approach is used for district, regional and central hospitals.

The equity measure was applied to each ward to determine the admission rate and average length of stay weighted for each income group and, therefore, the number of beds required. There will be additional weighting built into the rural bed planning parameters to allow for distance and population dispersion.

Table 8: Weighted admissions for district hospitals

	Persons with income below R76 400	Persons with income with income between R76 401 - R153 800	Persons with income with income between R153 801 - R614 400
Admissions/1000	65.60	55.76	49.20
ALOS	2.90	2.61	2.47
Bed utilisation	0.85	0.85	0.85
Beds required/1000	0.61	0.47	0.39

Regional hospital

The proposed 2030 service configuration allows for a general specialist-driven L2 acute hospital package of care. In specific regional hospitals, provision will be made for the delivery of the L1 acute hospital package of care for the population in the immediate geographic drainage area that does not have access to a district hospital. The services will be configured in distinct and separate specialist departments (See Figure 10). There will also be an enhanced capability to render rehabilitative care activities, psychiatric care and specific oral health service activities. To give full effect to this package of care, an appropriate inter-disciplinary team (with the prerequisite skills mix) will be provided.

The regional hospital will provide outreach and support to district hospitals to ensure adequate clinical capacity and optimal quality of care.

Regional and central hospitals are referral hospitals and therefore less geographically accessible than district hospitals. There will be additional weighting built into the rural bed planning parameters to allow for distance and population dispersion.

Figure 10: Regional hospital package of care

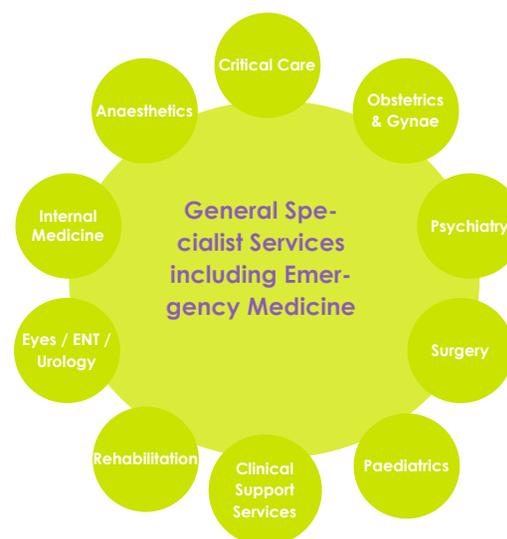


Table 9: Weighted admissions for regional hospitals

	Persons with income below R76 400	Persons with income between R76 401 - R153 800	Persons with income between R153 801 - R614 400
Admissions/1000	26.24	22.30	19.68
ALOS	3.9	3.51	3.32
Bed utilisation	0.85	0.85	0.85
Beds required/1000	0.33	0.25	0.21

Central/Tertiary hospital

The proposed 2030 service configuration allows for a sub-specialist driven L3 acute hospital package of care. It also allows for the provision of a general specialist-driven L2 acute hospital package of care for the population in the immediate geographic drainage area that does not have access to a regional hospital.

The central hospitals are an integral part of the overall service platform. The Department will continue to advocate for adequate funding through the conditional grants for these hospitals. There will also be an enhanced capability to render specific rehabilitative care activities, psychiatric care and specific oral health service activities. To give full effect to this package of care, an appropriate inter-disciplinary team (with the prerequisite skills mix) will be provided.

The National Department of Health has embarked on a technical process to develop a national tertiary services plan, in which the Department is participating. The proposed vision for tertiary services is:

“Equitably accessible efficient, high quality and cost effective tertiary health services provided to all South Africans as part of the national health system, in a manner that is both affordable and sustainable in the medium and long term, appropriately resourced, and that offers a platform for appropriate training and research.”

The national process has categorised tertiary services into tertiary service (T1), central referral (T2) and national referral (T3) based amongst others, increasing sub – specialisation and complexity of the service, highly skilled and scarce staff required, complicated and more expensive medical equipment required. The national process will also inform the planning of central hospitals within the province.

SPECIALISED HOSPITALS

SUMMARY POINTS

1. There is strong evidence that mental illness is on the increase. This is further aggravated by societal stressors such as socio-economic deprivation and violence, as well co-morbidly with chronic diseases, substance abuse and HIV. There are large proportions of unmet need. Importantly, there is emerging evidence that a significant proportion of patients can recover to varying degrees from their mental illness.
2. The introduction of the Mental Health Care Act has created a statutory obligation for the mainstreaming and integration of mental health services within the general health services to improve access. This is a global trend. This is further supported by the national (and provincial) mental health summits held in 2012, the national mental health policy framework, and the Ekurhuleni Declaration.
3. The service plan for the Department that will be developed after the 2030 framework has been adopted will include the psychiatric service platform.
4. The Department believes that the majority of PLWID require supported living arrangements and not medical institutionalisation.

Specialised Hospitals

The Department has historically had specialised hospitals for psychiatry, rehabilitation, TB and dental services. The future of these hospitals towards 2030

cannot be looked at in isolation from the broader general health service. 2030 explicitly intends to strengthen the general health service at all levels based on a PHC philosophy and the DHS model and to move from programmatic, disease specific approaches of the past to that of integrated provision of care. Thus the mainstreaming and integration of mental health services, rehabilitation and dental and TB services will be the key focus towards 2030. The success of these processes will result in a significant strengthening of these specific services.

The success of mainstreaming and integrating these services will result in improved access and significant strengthening.

Mental Health and Psychiatric Hospitals

Introduction and Background

There is strong evidence that the burden of mental illness is on the increase both globally and locally. The burden has been aggravated by high levels of co-morbidity with the epidemics of substance abuse, chronic diseases and HIV, as well as the other stressors, which include challenging socio-economic conditions of the majority of the population and the high levels of violence. Importantly, there is emerging evidence that a significant proportion of patients can recover from their mental illness.

The introduction of the Mental Health Care Act has created a statutory obligation for the main streaming and integration of mental health services within the general health services to improve access. This is a global trend. While notable progress has been made in this regard in the province, much remains to be done to strengthen mental health provision, especially at HCBC and primary care levels within the DHS and in the district and regional hospitals. The service planning process that follows the adoption of Healthcare 2030 will need to address the detail in, amongst others, what we mean by integrated mental health service, giving voice to the mental health patient, preventing stigma, what capacity and training is required at different levels, and what is the inter-relationship between levels of care and institutions to ensure continuity of care for the patient.

The National Mental Health Summit held in 2012 with the Ekurhuleni Declaration (See Annexure C) and the National Mental Health Policy provide a useful framework for the development of mental health services in the province.

Description of services

The focus of Health Care 2030 for mental health is on the integration of mental health services into PHC- and acute hospital platforms and service delivery. Only those services requiring a more specialised level of intervention will be treated within the specialist hospital platform.

PHC Platform

HCBC

The HCBC platform will include home care programmes, residential care programmes, group homes as well as day centres. The intention of all of these services is to provide support to patients within their communities. This support will include treatment adherence support, family support, as well as attending to appropriate psycho-social rehabilitative support as needed. Patients will also be able to participate in peer support groups and learn how to improve their adherence.

The CCWs and rehabilitation care workers who will be functioning at this level, need to be adequately capacitated and will be supported by professional nurses and community mental health nurses.

Mental health promotion and prevention programmes are also critical aspects of any community-based intervention. There is an increasing body of evidence that supports the efficacy of mental health promotion and prevention programmes, focusing on childhood and adolescence stages of development. This is where most of our preventive efforts should be targeted as we move towards 2030.

Primary Care service platform

The primary care service platform, together with the HCBC platform forms the base of the health care system. These levels will be supported by the district hospital within each sub-district. Mental health services will therefore form part of this integrated comprehensive PHC system. There needs to be a significant investment in terms of building capacity at PHC level to provide a quality health service for mental patients.

Preventive measures for mental illness are included in all PHC services such as antenatal-, infant-, child-, reproductive health and other services.

It is envisaged that the community mental health nurses at the larger centres, will support the PHC team of nurses, medical officers and allied health professionals on the service platform. The PHC team, including the mental health nurse will provide outreach support to the smaller clinics and the HCBC platform.

Services provided at this level of care will include: assessing new patients; reviewing chronic stable patients; and the early detection and appropriate management or referral of patients at risk of relapse to the nearest district hospital. The primary care services will also provide treatment for psychiatric conditions that do not require a higher level of intervention.

Intermediate Care

The intermediate psychosocial rehabilitation service will aim to:

- » Relieve pressure in the acute psychiatric services by providing a continuum of care from acute hospital settings to community-based residential services;
- » Provide within these facilities, an intensive psychosocial rehabilitation service for residents requiring a longer stay in a semi-institutional, structured environment; and
- » Complement and assist the functions of the CCW in the HCBC programme in optimising the management of high-frequency mental health users by either facilitating step up directly from the community or step down.

It is envisaged that the intermediate service would be part of the recovery-based rehabilitation care pathway of patients and would play a crucial role in ensuring that patients receive high-quality service.

District hospital psychiatric services

The provision of psychiatric services will be significantly enhanced through the strengthening of the district hospital service. The strengthening of the DHS should result in eighty to ninety percent of psychiatric services being provided at that level of the service platform. The remaining ten percent to twenty percent of services will be provided on the specialist service platform.

Patients will be assessed within the emergency centre of the district hospital and, once organic causes for a suspected mental illness have been excluded, they will be referred for a 72 hour assessment. Given the high burden of psychiatric morbidity anticipated for the foreseeable future, most of the larger district hospitals will have attached and dedicated units to assist with the 72-hour assessments of patients. Developing appropriate infrastructure and having competent staff to manage these patients within district hospitals will be an important priority towards 2030.

District hospitals in general will provide care for those people with severe psychiatric morbidity, including: the evaluation and management of attempted suicide; the management of substance intoxication, withdrawal and delirium; the admission and initial treatment of patients with psychoses; as well as the referral of medium-term admissions to psychiatric hospitals. In addition district hospitals should be able to: screen for, diagnose and manage acute mild to moderate, uncomplicated psychiatric illness; exclude medical causes of psychiatric symptoms; manage and stabilise all aspects of acute and ongoing violent, agitated or disruptive patients and refer those complex patients that require specialist treatment; and screen, diagnose and manage patients presenting in other disciplines with co-morbid psychiatric conditions.

District hospitals will have mental health nurses as part of the mental health team, with district psychiatrists providing the specialist-level support to the medical officers and family physicians.

The district team should also provide support and outreach to the PHC service platform.

Specialist Psychiatric Hospitals

The specialist psychiatric hospitals will provide the full range of treatment for the following: general adult psychiatric services; substance abuse and addiction treatment; child and adolescent services; neuropsychiatry; old-age psychiatry; as well as complications like challenging behaviour of PLWID.

The specialist psychiatric hospitals will have the full team of dedicated professionals that will include general nurses and mental health nurses, physiotherapists, occupational therapists, social workers, psychologists, medical officers, registrars, psychiatrists, as well as psychiatrists trained in specific areas such as forensic psychiatry, psycho-geriatric care etc.

» Child and Adolescent services

Services for children and adolescents have been historically under-developed. Against a backdrop of an escalating burden in the future, serious attention will need to be paid to developing this service. Separation of child and adolescent services from adult psychiatric services as well as strengthening the capacity within the general service platform will be two priority areas.

» Forensic Psychiatric Services

The number of state patients has quadrupled over the last 15 years. This situation is not sustainable. There will be an increase in observation beds at the revitalised Valkenberg Hospital. Separate facilities for the forensic observation of child and adolescents needs to be developed. However, there needs to be serious consideration to changing the service model, which requires an inter-governmental engagement and possible changes to the current legislation. Provision needs to be made for the observation of state patients within communities, regular review and discharge of state patients where appropriate. In certain instances observation of state patients could be managed within the general psychiatric services.

Psychiatric services at designated units within regional and central hospitals

Patients entering via the emergency centre of a regional hospital would follow a similar journey to the one described for a district hospital. In addition the designated regional units would be able to manage those patients referred for more specialised interventions, as well as continuing involuntary care beyond 72 hours when clinically appropriate.

Each general specialist hospital would provide psychiatric services in line with the general psychiatric package of care. These services would include the following: diagnose and manage complicated general psychiatric conditions that cannot be managed at district hospital level and require the attention of a general psychiatrist; diagnose and manage acute moderate to severe or complicated psychiatric illness; exclude and manage medical conditions that may be co-morbid or may cause or exacerbate psychiatric illness; manage all aspects of acute and on-going violent, agitated or disruptive patients; admit involuntary psychiatric patients for 72 hour assessment and continue treatment beyond 72 hours; provide appropriate ambulatory services; provide appropriate child and adolescent services; and provide appropriate old-age psychiatric services.

Psychiatric services at regional hospitals will be provided by mental health teams including mental health nurses, medical officers, registrars, psychiatrists, psychologists, social workers and occupational therapists.

The general specialist and other health professionals from the regional hospital will provide support and outreach to the district service platform.

There will be a category of patients that cannot be accommodated on the specialist psychiatric hospital platform. These services will be accommodated within the central/tertiary hospitals and will include, for example: services for patients with medical conditions and co-morbid psychiatric illness; managing the more complex old-age psychiatric conditions; as well as managing the more complex child and adolescent psychiatric illnesses.

Services for People living with Intellectual Disabilities (PLWID)

The service for PLWID has historically been a sizeable portion of the platform within the specialised psychiatric hospitals. A firm strategy within the CSP has been to de-institutionalise these patients. This was an ambitious objective and, in reality, most of the patients were de-hospitalised into more cost-effective institutions.

The Department recognises that the PLWID form a vulnerable group of patients that need to be cared for and that this group has a higher incidence of mental health problems. However, with 2030 in mind,

The Department believes that the majority of PLWID require supported living arrangements and not medical institutionalisation. The medical treatment should be provided on a needs basis by the Department of Health.

the Department believes that most of the patients in the main will require supported living arrangements and not medical institutionalisation. The medical treatment should be provided on a needs basis by the Department of Health. A small proportion of the PWLID will require inpatient care within specialised psychiatric hospitals. The supported living arrangements should be the responsibility of the Department of Social Development. However, the Department recognises that this is a complex discussion and process that transcends departments, legislative provisions and policies, historical practice, patient-, family-, and community expectations. Appropriate engagement with all relevant role players will be important in re-designing this service.

Considerations in developing a normative bed model for the psychiatric service platform

Further technical work will be undertaken to plan for mental health services across the health service delivery platform. The planning for psychiatric hospitals cannot happen in isolation from technical planning for HCBC, primary care services and acute hospitals. As mentioned above, the strengthening of this service lies in expanding the services outside of the psychiatric hospitals. There are several factors to consider in this process that includes the escalating burden of mental illness, the impact of the related burden of substance abuse, configuration of services across the platform and the impact of each level on other parts of the platform, the balance between inpatient and outpatient services within hospitals, the nuances of specific specialist areas such forensic psychiatry, child and adolescent services etc.

The approach to IDS technical planning will be subject to, amongst others, getting agreement within government on the roles and responsibilities of the various relevant departments.

The provincial planning will be informed by the national Mental Health Care Act as well as other national policy and planning frameworks.

SUMMARY POINTS,

1. In line with the departmental approach to improving the patient experience and to providing integrated health care, rehabilitation services will be accessible at all levels of care. Acute services will be provided in health facilities such as district hospitals and PHC facilities whereas non-acute services will be provided rehabilitation care workers from a community - based platform supported by therapists.
2. The Western Cape Rehabilitation Centre will continue to provide high-intensity, specialised comprehensive, multi-disciplinary inpatient and outpatient rehabilitation services. The centre also provides outreach and support to other levels of the service platform.
3. An integral aspect of the rehabilitation service will include the provision of the required mobility- and other assistive devices, orthotic and/or prosthetics to facilitate full reintegration of people with disability back into the community.

Rehabilitation Services and Western Cape Rehabilitation Centre (WCRC)

Currently rehabilitation services are concentrated within the L3 service platform and the WCRC. A limited capacity for rehabilitation exists within the District Health Service. The 2030 principles and vision of person centred, integrated continuity of care necessitate a re-think on how rehabilitation services are rendered on this platform.

Acute services will be provided in health facilities such as district hospitals and PHC facilities, whereas non-acute services will be provided through the HCBC platform. from a community-based platform.

In order to improve the accessibility to rehabilitation services, use will be made of Rehabilitation Care Workers (RCWs) on the HCBC and Intermediate care platform.

The PHC service will be supported by a range of therapists.

Complex patients requiring specialised physical rehabilitation services will be referred to the WCRC. The stronger the rehabilitation capacity within the DHS platform, the earlier the patients could be discharged into their communities for follow up at a local PHC facility or through the home-based care programme.

PHC platform

HCBC

The developed HCBC platform provides a huge opportunity to expand and augment the rehabilitation service. CCWs will be able to provide the basics in physical and mental rehabilitation. They will be supported by the more skilled RCW, who will mentor CCWs as well as

help in the management of more complex patients. The focus of HCBC will be helping patients in their personal recovery through the development of self-management strategies to overcome their activity limitations as well as their participation restrictions from their impairments.

Primary Care Services

In this setting, rehabilitation involves clinical recovery from impairments, which are resolved relatively quickly with no long-term functional loss and that are ideally treated in a generalist ambulatory environment. This may require provision of assistive technology like mobility aids. While the nurse practitioner and medical officer in primary care will have some basic knowledge and skills in rehabilitation, they will be supported by therapists and therapy assistants in a range of areas that includes physiotherapy, speech therapy, occupational therapists, audiologists and dieticians.

Intermediate Care

Intermediate Care refers to in-patient transitional care for children and adults, which facilitates optimal recovery from an acute illness or complications of a long-term condition enabling users to regain skills and abilities in daily living. The ultimate discharge destination is home or an alternative supported living environment. It involves post-acute-, rehabilitative- and end-of-life care and includes comprehensive assessment, a structured care plan, active therapy, treatment and/or an opportunity to recover.

Intermediate care allows for a seamless transition between acute care and the living environment particularly where the person's ability to self-care is significantly compromised, a supported discharge becomes crucial to a successful recovery process. The focus of this service element is on improving people's functioning so that they can resume living at home and enjoy the best possible quality of life.

The interface between acute hospitals, intermediate care and primary health care including home and community based care needs to be carefully managed with flexibility to accommodate the specific patient's needs.

Acute hospital service platform

The attention of rehabilitation in acute hospitals is on problems of body structure and function (impairment) and their impact on the patient's ability to execute a task or action (activity limitation). Examples of impairments include thought disorder, psychomotor agitation and blunted affect. Participation restrictions and the recovery aspects that link to environmental and personal factors are important considerations in addressing impairments and its consequent activity limitations; they are however not the focus of clinical recovery in this service component.

The package of services provided by the different types of hospitals will determine the case mix and the rehabilitative needs of patients and the appropriate skills required to render this service.

At L2 and L3 facilities the rehabilitation therapists, including physiotherapist, occupational- and speech therapists, will add value to the work of work with general medical specialists, rehabilitation nurses, occupational therapists, clinical psychologists and social workers in an inter-disciplinary manner to provide integrated co-ordinated care. The patients have complex conditions with disabilities that require a high level of skill, clinical expertise and experience and also require the support of medical specialists. Examples of such services are provided in:

- » Burns/intensive care units;
- » Spinal cord injury units;
- » Acute psychiatric units;
- » Departments of orthopaedics, neurology, cardiovascular-, maxillo-facial and hand surgery;
- » Memory clinics;
- » Specialised rehabilitation units;
- » Stroke/neurological-rehabilitation units;
- » Work assessment units; and
- » Cochlear implant units.

Patients requiring a higher level intensity of rehabilitation (i.e. four to six hours of rehabilitation per day) will generally attend the specialised rehabilitation facilities (including at L2 and L3 and WCRC) should be adequately staffed to ensure that patients receive appropriate treatment.

Western Cape Rehabilitation Centre (WCRC)

The 156-bed Western Cape Rehabilitation Centre will continue to provide specialised comprehensive, inter-disciplinary in-patient rehabilitation services to persons with physical disabilities. Primary reasons for admission include rehabilitation management of people with long-term, permanent disabilities, such as:

- » Spinal cord afflictions (quadriplegia/paraplegia), due to trauma, TB or HIV and AIDS, other neurological causes;
- » Cerebrovascular accidents due to hypertension, HIV and AIDS;
- » Traumatic brain injury;
- » Amputations;
- » Neurological conditions (Guillain Barre, multiple sclerosis, motor neuron disease, Parkinson's, cerebral palsy etc.);
- » The WCRC will provide high-level rehabilitation expertise, consultancy services and support to other levels of care to facilitate the provision of quality rehabilitation services for people with physical disabilities;
- » The WCRC, in turn, will be supported by specialists from the tertiary hospitals or employed on their establishment , e.g. plastic surgery, orthopaedics, urology/radiology;
- » The WCRC rehabilitation programmes focus on clinical outcome levels 1 to 3 (primarily); i.e. the aim is to achieve physiological (medical) stability, physiological maintenance (outcome of basic rehabilitation) and eventually home or residential re-integration (outcome of intermediate rehabilitation); and
- » In select, good prognostic cases (and especially in the case of children, youth and employed adults) the WCRC will manage patients through Outcome levels 4 to 5 to facilitate a return to work or school.

The Department will develop an approach to improve access to assistive devices across the service platform.

Provision of assistive devices

An integral aspect of the rehabilitation service will include the provision of the required mobility- and other assistive devices, orthotics and/or prosthetics, to facilitate full reintegration of people with disabilities back into the community. The greatest possible independence for persons with disabilities will be achieved through the provision of affordable, quality mobility aids, devices and assistive technologies.

The Department will develop a comprehensive approach to assistive devices and its associated services (e.g. seating service), which can range from wheelchairs to hearing aids. The approach will be based on the principles and vision of Healthcare 2030, alignment with the service delivery platform, cost effectiveness and affordability to best meet the needs of the population. This will include exploring service delivery models for the orthotic and prosthetic service and learning lessons from the outsourced model in the Eden district and the in-house service located in the metro. The approach will define the level of provision at the various levels of care across the platform, the skills and competencies and the human and other resources required as well as the roles, responsibilities and relationships between the service rendering entities. The underlying ethos must be person - centred and equitable access to quality care with the ultimate objective of functional re-integration of the patient whenever feasible. Consideration will also be given to earmarked funds in certain instances to prevent funds for assistive devices being diverted to competing priorities.

Tuberculosis Services and Hospitals

SUMMARY POINTS

1. The most significant change in disease burden in recent years is the contemporaneous increase in co-morbid HIV infection and the rise of multi-drug resistant TB and extensively drug-resistant TB.
2. Almost all (90%) of TB is managed from the PHC platform. Strengthening CBS and PHC services will improve efficiencies within TB hospitals.
3. The increase in drug-resistant TB cannot be sustainably managed through the admission of all patients to TB hospitals. A PHC-based model

The role of the TB hospitals needs to be located within the context of the projected burden of disease, the vision and principles of 2030 and the focus of overall health system strengthening. The majority of the TB workload will be managed in the DHS.

The Western Cape has always had a TB burden that is disproportionately large compared to other provinces in South Africa. Nevertheless, the burden and nature of TB has changed considerably since TB hospitals were first designed and built.

The most significant change in TB disease burden in recent years is the contemporaneous increase in co-morbid HIV infection and the rise of MDR TB and XDR TB. The HIV-infected patients with TB are much more severely and acutely ill and more complex to diagnose and treat than their HIV uninfected counterparts. A significant proportion of these patients are sputum negative, which has been the main method of diagnosis in pulmonary TB to date. These patients and those suspected of extra pulmonary TB require more sophisticated and expensive modes of investigation such as gene sequencing technology, blood cultures, ultrasound, X-rays and biopsies to make the diagnosis.

for the treatment of MDR TB has been successfully piloted.

4. The patient information system will also be improved to allow for the efficient continuity of care and referrals across the service platform.
5. A TB hospital will make provision for acute, sub-acute and chronic care beds for the proportion of patient who will be discharged from acute hospitals.

Drug-resistant TB necessitates stringent infection control measures and specialised medicines and medicine delivery strategies. The severity of the clinical condition of these patients varies from been quite well and ambulant to acutely ill. These patients have prolonged lengths of stay, are expensive to treat and often have a poor prognosis. The co-morbidity is further aggravated by other chronic diseases such as diabetes and hypertension, chronic obstructive airways disease, malnutrition and substance abuse.

The increase in drug-resistant TB cannot be sustainably managed through the admission of all patients to TB hospitals. Models of care in which drug-resistant TB

The increase in drug-resistant TB cannot be sustainably managed through the admission of all patients to TB hospitals. A PHC-based model for the treatment of MDR TB has been successfully piloted.

patients have been treated through a community-based treatment delivery system have been piloted with success in recent years. A proportion of drug-resistant patients is clinically stable and well and can be managed on an ambulatory basis. The biggest challenges in this group of patients are, one, compliance with treatment over a prolonged period given that they feel well and, two, the risk of transmission to family and community.

A critical success factor in the management of the TB patient is the efficient communication and continuity of care between service rendering entities across the platform from HCBC to the TB hospital as well as the effective engagement with the community through home visits.

TB management on the HCBC platform including MDR/XDR

The responsibilities of the HCBC platform are three-fold: raising community awareness of TB, case finding and case holding. Community awareness means ensuring that simple messages about TB are widely disseminated – the signs and symptoms of TB, the transmission risks, what to do if one suspects one has TB, etc. Also, engagement with relevant role players in high-risk areas and situations – like taxis and taxi ranks, shebeens and schools.

Case finding implies active case finding and refers both to contact tracing of known TB cases (especially known drug-resistant TB cases) as well as more general out-of-facility screening in high-burden areas.

Case holding refers to adherence support for people on the ambulatory (PHC) TB programme as well as those TB patients who have been discharged from hospital but who need on-going ambulatory treatment.

The health service needs to create community "safety nets" into which a hospital clinician will feel comfortable discharging the drug-resistant (and drug-sensitive) patient. Such "safety nets" will need to borrow from existing models of community care for drug-resistant patients and, as such, will likely include a dedicated professional nurse and a team of CCWs, as well as home visits and home "infectiousness" assessments. Making these links to care is seen as an increasingly important part of driving down the TB epidemic.

The relationship between the TB hospital and the receiving sub-district/facility can be facilitated by simple changes to existing networked software, so that a discharge from the TB hospital is automatically registered as an "expected case" at the appropriate facility and loss-to-programme is minimised. Mechanisms to introduce the hospital patient to the respective CCW prior to discharge will also be developed to ensure the continuity of care.

TB management on the PHC platform

The period of individual infectiousness within a community must be reduced. Delays in diagnosis and time to initiation of treatment must be addressed. These can be achieved through the widespread adoption of newer diagnostic technologies and improving health system efficiencies. Systems must be instituted so that HIV-infected people, who are at particular risk of acquiring TB, routinely receive high-quality screening for TB. Particular attention must be given to early identification of drug-resistant cases and appropriate channelling of such cases to the correct treatment regimens and strengthened community adherence support. Mechanisms to detect and follow up defaulters early in the process must be developed and strengthened.

TB management in acute hospitals

With the increasing risks of drug-resistant TB, care must be taken to prevent health institutions from becoming sources of nosocomial infection – both for health care workers and other patients. Infection control strategies will be reviewed and improved. All acute admitting institutions must have appropriate infection control measures to the extent that they would be comfortable to retain a drug-resistant case for 24 to 72 hours – since this duration of stay is a reality of being a first-line admission point. Diagnostic delays must be reduced through the use of appropriate technology.

TB management in specialised hospitals

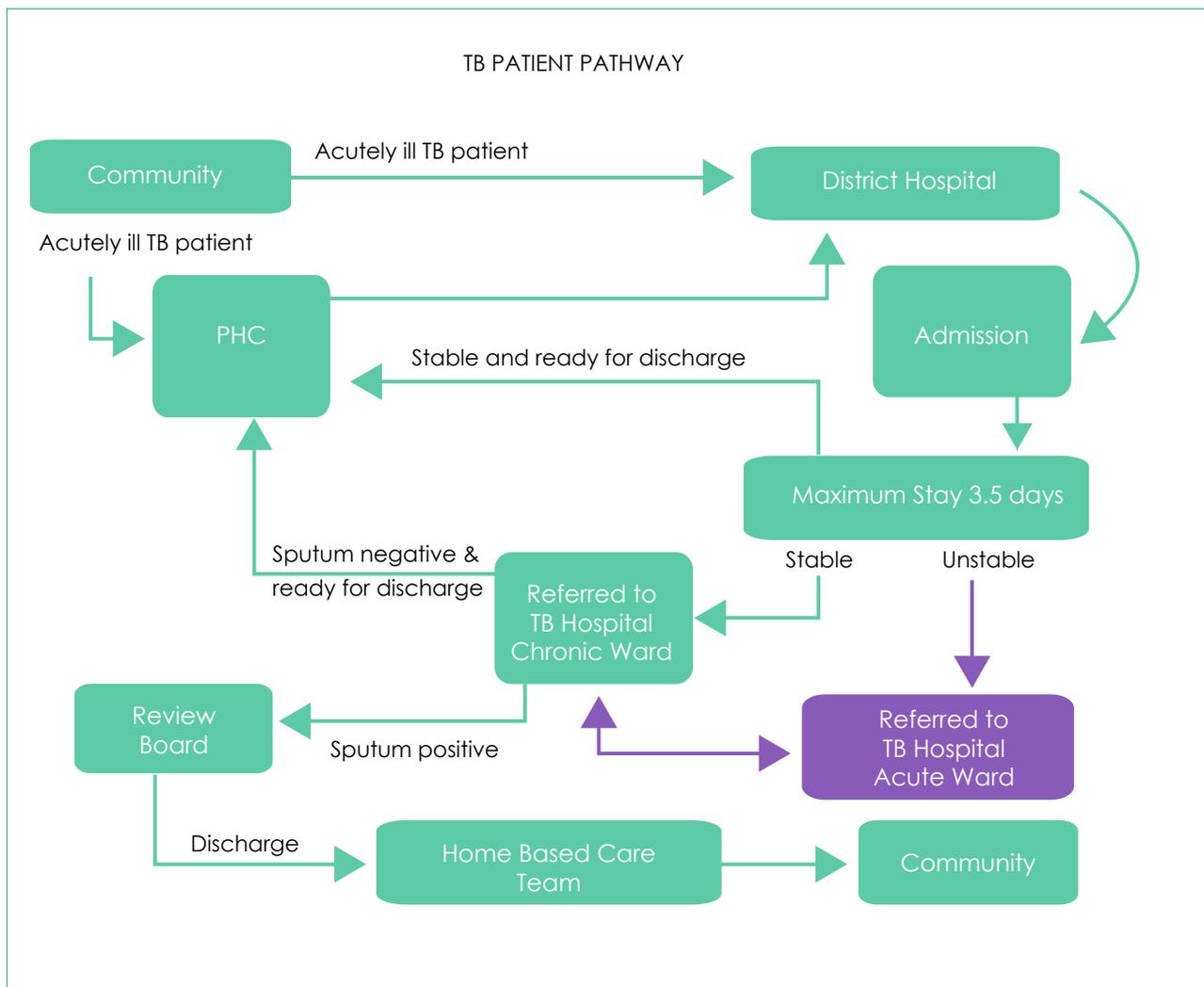
TB hospitals need to be resourced according to their needs and this will require being able to manage the acutely complex patient. TB hospitals themselves will also need to become centres that attract and retain the right kind of staff. Ways of doing this might include making TB hospitals:

1. Centres of inquiry at the “cutting edge” of the epidemic;
2. Centres of training, outreach and skills transfer; and
3. Nodes for community involvement.

The first and second points can be facilitated by improving the individual patient information captured at hospital level. The TB hospital in 2030 will be able to provide the health system with individualised data for each patient with regard to, at the very least: demographics, reason for admission, interventions, investigations and treatment received, and health outcome. Such data if it were routinely available would transform knowledge about the state of the TB epidemic in the province. (See Figure 11.)

Treatment of M(X)DR tuberculosis is lengthy and involves second/third-line, reserve drugs which are less effective and have more side effects than first-line tuberculosis drugs. Unfortunately not all patients will be cured with M(X)DR-treatment. A certain percentage of patients will fail treatment and become chronic excretors and or chronic defaulters and it may not be advisable to continue treatment in these patients. These clients must be referred to the specialized MDR/XDR-TB Review Committee who will evaluate each case and make recommendations with regard to the discontinuation of treatment and discharge of these patients on home isolation or to a palliative care unit. Currently the Department only has one palliative care unit in Central Karoo for XDR-TB clients who have failed treatment and remain infectious. The need for more long-term palliative care beds will be investigated.

Figure 11: A TB patient's care pathway



Oral Health and Oral Health Centres

Oral Health Centres (Dental Hospitals) have historically provided a high-end oral health service within the province and in the main have been responsible for the training of dental professionals and research. A review of their role and recasting their future within the context of 2030 cannot happen in isolation from examining the broader oral health strategy towards 2030.

SUMMARY POINTS

1. Oral conditions are important public health concerns because of their high prevalence, their severity, their impact on the quality of life and the public demand for services.
2. The oral health service platform will be strengthened across all levels with the largest investment in PHC services.
3. The focus will shift from curative care to integrated health prevention and promotion including education, advocacy for tooth brushing, and fissure sealant programmes.
4. The specialised services for complex conditions are provided at the central hospitals and the oral health centres (OHCs).
5. The OHC will also provide outreach and support to the District Health service.

Introduction

Poor oral health contributes to problems with general health and for this reason the high prevalence of early childhood caries is a serious concern to this province and the country as a whole. Most oral diseases are not life threatening, but affect almost every individual during his or her lifetime. Poor growth, cognitive and general development, poor appetite, interference with sleep, poor school behaviour including absenteeism, and negative self-esteem may result from oral diseases. Oral conditions are important public health concerns because of their high prevalence, their severity, their impact on the quality of life and the public demand for services.

A national survey conducted in 2003 showed that the dental caries rate for certain specific age groups in the Western Cape was double that found as a national mean.

The prevalence of partial and complete edentulousness is the highest in the Western Cape compared to the rest of the country. Approximately thirty to forty percent of 12 year olds in the Western Cape need definitive orthodontic treatment.

Certain general health conditions have an impact on oral health and vice versa. Patients with HIV and AIDS present with candidiasis (thrush) in the mouth and various types of ulcers. The dentist could be the first to pick up these observations during oral examinations. The dentist could also pick up early signs of cancer in the mouth. Diabetic patients have been shown to be prone to mouth ulcers, as well as periodontal conditions. The escalating epidemic of chronic diseases including cancers will increase the burden of oral conditions.

Oral health service platform

Community-based services and primary health care

The HCBC service will focus on promotion and prevention. This will include an Integrated school health programme (e.g. life skills) in partnership with the Department of Basic Education, supervised daily tooth brushing with fluoride toothpaste programmes at early childhood centres, crèches and selected primary schools, the promotion of good oral health habits with a focus on mothers and children. CCWs will demonstrate the correct and essential use of a toothbrush during home visits. The Department will continue to advocate nationally for water fluoridation, which will require legislative changes, as it remains one of the most cost effective oral health strategies.

The primary care facilities will provide a basic oral health service that will include alleviation of pain, treatment of oral infections, extractions and simple fillings and emergency denture repairs.

A service level agreement is in place that governs the provision of very basic dental services at prisons. It is envisaged that the Department will continue to render these services in the future. The Department of Correctional Services pays for these services.

Acute Hospitals

The acute hospitals will normally receive referral from and will provide general support to CHCs and PHC clinics. The hospitals will manage more complex patients such as maxillo - facial trauma, patients with complex co-morbidity, and the provision of theatre facilities to offer general anaesthetic and conscious sedation for dental extractions for pre-school children and patients with special needs.

Specialist oral health services

Specialist oral health services will be provided within the health service platform at appropriate facilities such as the oral health centres and central hospitals. This will include, amongst others, the management of complicated fractures, difficult impactions, oral oncology, forensic odontology, complicated periodontology, Orthodontics and Prosthodontics.

The oral health professionals and specialists from acute hospitals will provide outreach and support to the primary care platform to strengthen the skills base and improve the quality of care at this level.

SPECIALISED SERVICES

Emergency Medical Services

Introduction and Background

SUMMARY POINTS

1. Access to emergency care is a constitutional right in South Africa and is prioritised within the 2030 vision for patient centred quality care.
2. EMS has set ambitious targets for 2030, which may have to be reconsidered within the available resources These include:
 - » All 10177 calls from the public to be answered within three rings.
 - » Ambulance response time for Priority 1 calls in urban areas is 90 % within 8 minutes and rural areas 90% within 40 minutes.
 - » Medical rescue response will be 90% within 15 minutes in urban areas and 90% within 60 minutes in rural areas.
 - » Non-acute patient transport requests will be responded to on the same day if booked before 10 am and within 24 hours if booked after 10 am.
3. EMS district managers will closely support district health managers by providing EMS-related data for monitoring and evaluation and, by their availability, for immediate problem solving. Management of EMS is divided into strategic management in Cape Town and tactical management in health districts.
4. The province is geographically divided into six districts each with an emergency contact centre. In rural districts these centres double as disaster risk management centres.
5. A model to calculate the fleet and staffing requirements for the ambulance service has been developed. The model assumes that ten percent of the population will use the service. Eighty percent of staff will be emergency care technicians and twenty percent advanced life support or paramedics. The basic life support cadre is being phased out by the HPCSA.
6. The aeromedical service will continue

The imperative for emergency care is established through the Constitution of South Africa and the National Health Act both of which ensure the universal right to access to Emergency Care explicit in Chapter 2, section 27(3) of the Constitution and Chapter 2 section 5 of the National Health Act.

Emergency medical services (EMS) in the Western Cape will follow the guiding principles of 2030:

- » Response to telephonic calls for emergency care within tightly measured response times will ensure access to quality care.
- » Measuring and recording clinical parameters at the start and through the progress of the patient journey and adjusting care based on evidence will move the service towards an outcomes-based approach.
- » Advocacy for prevention of illness and injury in communities which endorses the PHC philosophy.
- » Geographically well-distributed response units across the province and a full range of communications, patient transport, ambulance, rescue and aeromedical services it will provide equitable access to all communities. Cooperation with the private sector will ensure that the Department's resources are dedicated to the indigent and poor. Allocation of ambulances will match the demands of the service.
- » Constant performance monitoring and management of all aspects of the service will ensure efficiency. The deployment of ambulances will match the peaks and troughs of the service demand.
- » The nature and position of EMS within the pre-hospital environment necessitates efficient and effective strategic partnerships with health and other emergency services to ensure optimal patient outcomes. Co-operation with the private sector will also enable more efficient use of resources.

EMS includes the following necessary components:

- » Communications services;
- » Ambulance services;
- » Medical rescue services;
- » Aeromedical services;
- » Disaster medicine;

to play a vital role in the emergency transfer of complex patients to the referral hospitals.

7. The non-acute patient transport service will also be strengthened as a key component for access to services, especially for rural patients, as well as for improving efficiencies of acute hospitals by facilitating the transport of certain discharged patients out of these hospitals.
8. The communication centre will use a modernised software application to enhance its operations. Call taking and dispatch is a central component of an efficient EMS operation. This will also enable better management reporting in real time and improved communication with the Emergency Centres in hospitals.
9. A bed bureau will also be developed to monitor the availability of acute bed in all the major hospitals.

- » Emergency Medicine; and
- » Patient transport services.

International benchmarking and best practice establishes that EMS is best delivered as a provincial service rather than a local service.

In this context EMS in the Western Cape is best managed as a provincial service with strong links to the district health service and large acute hospitals. Management of EMS is divided into strategic management in Cape Town and tactical management in health districts, which matches MIMMS command structures, which require bronze, silver and gold command levels based on a geographic model. EMS management structures match governance boundaries of local districts. EMS district managers will closely support district health managers by providing EMS-related data for monitoring and evaluation and by their availability for immediate problem solving and being part of the district management scheduled meetings where appropriate. This relationship needs to be monitored on an ongoing basis to ensure an integrated, cohesive and co-ordinated service delivery model.

Aeromedical services, medical rescue services, education and training have provincial management components while ambulance services, medical rescue and patient transport services (HealthNET) are managed directly at district level. For the second group of services, there will be a close working relationship with the district management teams. Current administration for fleet, finance, supply chain management and human resource management within EMS is centred in Cape Town.

The provincial model has huge strengths which include, amongst others, standardised fleet and equipment procurement and management, uniform education and training standards for staff, universal standard operating procedures; standardised management systems, processes and procedures and more efficient ability to deploy resources across boundaries especially highly skilled staff and expensive equipment.

Service description

Communications services

EMS must receive and process telephonic 10177 requests for assistance from the general population. The Department is exploring the possibility of simplifying the number to call for emergency services.

The province is geographically divided into six districts, each with an emergency contact centre as follows:

Table 10: Location of Emergency Contact Centres in the Western Cape

Location of Emergency Contact	District
Cape Town	Cape Town
Eden	George
Central Karoo	Beaufort West
Overberg	Bredasdorp (Caledon)
West Coast	Mooreesburg
Cape Winelands	Worcester

These calls must be answered within three rings and take 120 seconds to process to dispatch. The calls are prioritised based on the information received from the caller at the scene and then processed to the dispatch section.

Dispatchers receive calls from the computer-aided dispatch (CAD) system and manage up to ten resources (ambulances, rescue vehicles) per dispatcher in a defined geographic area, which drains towards a hospital in the centre of in the geographic area.

Supervisors are required for each function within a contact centre, i.e. inbound communication (call taking),

outbound communication (dispatching), incident management, shift management and centre management.

The Contact centre will operate within the metrics stated in the table below :

Call answer time	3 rings
Call process time	120 seconds
Dispatch time	5 minutes
Call abandonment rate	<5%

The contact centre will have sophisticated systems that enable detailed reports to monitor the quality of the service as well as the service demands at any point in time. The contact centre is optimally located to provide that "helicopter view" of the service pressures within a geographic area. A bed bureau, connected to the network of hospitals, will also be located at the contact centre and provide regular status reports on the availability of beds in hospitals. This will improve the efficiency of EMS in transporting patients to facilities.

These centres are emergency contact centres but also double as disaster risk management centres in the rural districts. Traffic services will also coordinate actions from these rural centres. An ideal model would see all emergency services (police, traffic, fire, and ambulance) operating from the same public service point.

Ambulance services

Ten percent of the population use ambulance services annually as calculated from historical performance. While the ten percent figure is used at a macro level to calculate the resources required in EMS, the allocation of resources to the areas with the greatest need will occur at a daily operational level. In rural areas ten percent of patients delivered by EMS are referred up a level of care to a regional or central hospital. In Cape Town 40 percent of EMS acute transfers are between facilities. The Department will strive to reduce inappropriate inter-facility transfers.

EMS personnel work 12-hour shifts day or night or day shift only (straight shift). The allocation of staff and vehicles will be titrated with the patterns of workload envisaged both in terms of geographic origin of calls as well as time of day.

The Ambulance service will operate within the metrics stated in the table below. These response times are ambitious and will depend on the availability of adequate resources.

Ambulance Priority 1: Urban Response Times	90% within 8 minutes
Ambulance Priority 1: Rural Response Times	90% within 40 minutes
Ambulance Priority 2: Urban Response Times	90% within 30 minutes
Ambulance Priority 2: Rural Response Times	90% within 60 minutes

Mission times are dependent on the geographic drainage area, but in Cape Town, the measured average mission time is 60 minutes.

The staff mix required is eighty percent emergency care technician (ECT) or intermediate life support (ILS) and twenty percent B.Tech Paramedic or advanced life support (ALS). Basic life support (BLS) training has been discontinued by the Health Professions Council of South Africa. Attrition will gradually erode the BLS component of the service.

The model for ambulance services in the City of Cape Town uses ten percent of the total population to determine the number of clients that EMS will service for the specified period. This demand at a macro level has been consistent over the last decade. Notwithstanding the interventions directed at upstream factors impacting on health, the increasing ageing of the population, continued urbanisation within and migration to the province

and the escalating epidemic of a spectrum of chronic diseases has made one conservatively use the ten percent figure for modelling. Provision for obstetric emergencies and new-born babies will also need to be factored in. The current percentage proportion contribution for Priority 1 calls are calculated at 36 percent of all calls and sixty-four percent for Priority 2 calls.

A mission time of 60 minutes is used to determine the number of hours needed to service the projected number of clients. With the hours calculated, the model then calculates the number of vehicles and staff required to provide a service within a given response time. The model will also factor in inter-facility transfers.

Medical rescue services

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

Medical rescue services are modelled on demand in the City of Cape Town and in a geographic proximity model along major traffic routes in rural districts. Cape Town experiences 10 751 traffic-related accidents annually, with a patient entrapment (patients trapped by the wreckage that then have to be freed with the 'jaws of life') rate of 1 018/10 000 accidents and a P1 under-15 minute-performance of eighty-one percent with ninety-two percent of these incidents dispatched within five minutes. Cape Town therefore requires eight rescue units 24 hours a day, including Atlantis, to create the geographic proximity for response within the necessary response time.

Medical rescue will meet the following metrics by 2030. These ambitious targets depend on the availability of adequate resources.

Response Time Urban Areas	90% within 15 minutes
Response Time Rural Areas	90% within 60 minutes
Time to release Urban Areas	90% within 30 minutes
Time to release Urban Areas	90% within 75 minutes

In addition Cape Town supports aquatic rescue through missions with the South African Airforce (SAAF) to provide air sea rescue (ASR) (of medical casualties recovered from ships at sea under the authority of SAMSA and MRCC), a diving rescue squad, swift water rescue, National Sea Rescue Institute (NSRI) rescue and in-shore rescue with the NSRI through the aeromedical programme. Cape Town must have confined space, trench and collapsed structure capability to support disaster risk-management capacity in the event of earthquakes or major structural collapse.

Disaster medicine and mass casualty response with a mobile medical unit and emergency equipment vehicles (EEVs) with large amounts of medical equipment to treat trauma victims is also provided.

Finally, the Cape Town district provides resources and support to Wilderness Search and Rescue (WSAR) to perform base management, communications, and technical rope rescue responses.

Intermediate motor vehicle rescue units and trailers are required along national routes on the N7, N1 and N2 highways and service approximate regional and municipal routes from those locations.

Aeromedical services

Aeromedical services are operated on a contracted-out model to an aviation medical service provider.

The services provided include acute primary scene response for mainly traffic accidents and WSAR incidents and acute inter-facility responses up to 200km and from 200km to 500km.

One fixed-wing aircraft adequately services inter-facility transfers from locations between 200km and 500km from Cape Town.

Helicopters in Oudtshoorn and Cape Town service a radius of 200km from those bases and drain towards George Regional Hospital, Worcester Regional Hospital, Paarl Regional Hospital and the three central/tertiary hospitals (including Red Cross War Memorial Children's Hospital).

Disaster medicine

This component plays a key role in disaster preparedness within the Department as a whole as well as at the local institutional level. Technical support is provided to institutions to develop their disaster preparedness plans, which are also regularly reviewed. The resilience and responsiveness of the Department as well as government as a whole in such instances is a critical capacity to develop. The risks from terror, extreme weather and other such events are very real. This also requires very good collaboration with other Departments, spheres of government and other stakeholders. This component is also responsible for the planning, provision and co-ordination of the EMS response to events such as the Argus Cycle Tour, the Two Oceans Marathon and many other sporting and community events.

Emergency medicine

Emergency medicine is relatively new discipline within the country and has come to play a central role in the health service. This speciality has been located within EMS as it plays a key inter-connecting role between the emergency medical services outside of health facilities and the emergency centres within hospitals. The Department has identified Emergency Centres as an important priority and been systematically addressing it over recent years in a phased manner. This includes modernising the infrastructure and equipment, strengthening the staffing especially the appointment of Emergency Medicine specialists in large district and regional hospitals. Emergency Centres are the entry point to hospitals and their efficient and effective management impacts on the functioning of the whole hospital as well as on the clinical outcomes. EM specialists therefore play a key role in this regard.

This component also plays an important oversight role in improving the quality of emergency care across the health service continuum i.e. from the roadside to the bedside. Analysis of specific patient incidents that are managed across the service platform provide important learnings to strengthen and improve the quality of services.

Patient transport services

HealthNET will continue to provide outpatient transport locally within sub-districts, regionally within geographic service areas (GSAs) and provincially along national routes to Cape Town.

Each geographic unit must have the capacity to book transport electronically, schedule patient movement and provide transport in suitable vehicles. Each District HealthNET component needs dedicated management.

The configuration of vehicles includes seats, stretchers and wheelchair capacity. Seated vehicles have a capacity of up to 23 seats; wheelchair vehicles are configurable to two wheelchairs and four seats; stretcher vehicles are configurable to two stretchers or one stretcher and six seats.

HealthNET operates five days a week for incoming referrals and seven days a week for outgoing repatriations. HealthNET takes patients only to their personal residence if they are in a wheelchair, on a stretcher, on renal dialysis or over 60 years old. HealthNET collects only renal dialysis and wheelchair patients from home only. Vehicles travelling greater than 200km to a referral centre need two drivers for safety reasons.

Patient transport services must meet the booking demands of the DHS and the geographic service area for the transport of outpatient or non-acute health clients between facilities up or down levels of care.

All discharge requests must be met both in Cape Town and rural districts as follows:

- » The same day if booked before 10 am;
- » Within 24 hours if booked after 10 am.

SUMMARY POINTS

1. The Forensic Pathology Service is a specialised service rendered by forensic pathologists, and supported by forensic pathology officers. Access is also required to other sub-specialists such as histopathologists, odontologists and toxicologists.
2. The Forensic Pathology Service is mandated to perform the medico-legal investigation of death in all cases where death is or appears to be due to unnatural causes.
3. A model has been developed that considers a number of factors, including population estimates, burden of disease and its impact on caseload, workload, case mix, case complexity, direct case contact time as well as the optimal configuration of services.
4. Affordable targets and staffing levels will be developed through application of the model within defined budget allocations.
5. The Forensic Pathology Service will continue to be provided via 18 forensic pathology laboratories and two departments of forensic medicine supported by a central management and administration component. The forensic pathology labs are graded between M1 and M6 depending on the workload capacity and the complexity to be managed.

Forensic Pathology Services

Introduction

The Forensic Pathology Service (FPS) is a specialised service rendered by forensic pathologists, supported by forensic pathology officers. Access is also required to neuropathologists, histopathologists, paediatric pathologists, odontologists, toxicologists, molecular scientists, entomologists and anthropologists to ensure a comprehensive quality service.

The Forensic Pathology Service is mandated to perform the medico-legal investigation of death in all cases where death is or appears to be due to unnatural causes. Since the transfer of the service from the South African Police Service to the Department of Health in April 2006, the provincial post-mortem rate per 1 000 population has varied between 1.8 post-mortems per 1 000 population and 1.63 per 1 000 population, with a greater variance experienced at district level. The post-mortem rate projected for 2030 is 1.74 per 1 000 population.

The impact of various interventions on the burden of disease and injury is unknown. This information is important for informing policy, planning services, as well as targeting interventions and monitoring the impact of interventions. The modelling tool is sufficiently robust to allow for adjustments year on year.

Service Description

The Forensic Pathology Service is a specialised service rendered by forensic pathologists and forensic pathology officers. As a scarce resource the service is configured to ensure access, whilst at the same time ensuring the quality of the medico-legal investigation process. Forensic pathology facilities are historically classified according to caseload. The classification ranges from M1 to M6, dependent on the number of cases managed at the facility. There are currently 18 facilities across the province.

The forensic service is classified according to levels of complexity and skills required. Level one includes call taking, property and scene management, specimen management, death scene investigation, evidence and exhibit administration, case administration (including chain of evidence), and visual identification and final release. The Level two service will include, in addition to the above, death scene attendance and comprehensive reporting, dissection, including specialised dissection techniques, special investigations, consultations, court appearances, inquests, and provision of docket opinions. The Level three/four service is highly specialised and includes a range of sub specialities such as Neuropathology, Histopathology, Paediatric Pathology, Odontology, Toxicology, Molecular science; Entomology; and Anthropology or any other functions related to case admission.

The operational geographical service is largely aligned with that of the South African Police Services (SAPS) and National Prosecution Agency (NPA) as key strategic partners, with an operational forensic pathology service manager responsible for each area, while clinical unit managers have the responsibility of ensuring clinical governance in each of their respective drainage areas.

The service will continue to be provided via 18 forensic pathology laboratories and two academic departments of forensic medicine supported by a central management and administration component. Potential consolidation of services between laboratories will also be explored. The facilities will over time and according to priority be relocated off existing SAPS premises and be replaced with fit-for-purpose facilities. The Forensic Pathology Service in the Cape Town metro district will be strengthened by the commissioning of the Observatory Forensic Pathology Service, which will replace the Salt River facility, and by the expansion of the Tygerberg facility to enable the facility to manage the Helderberg caseload.

The forensic pathology service area managers and responsible pathologists (clinical unit managers) will closely

support district health managers by providing forensic-pathology-service-related data for monitoring and evaluation and by being available for immediate problem solving and being part of the district management scheduled meetings. The forensic pathology service will further report on trends with regard to burden of disease and hospital case management as managed by the service.

Planning methodology and principles

The overarching principles and approach of Healthcare 2030 will guide the development of the forensic service over the next two decades. A model is being developed as a planning tool that makes assumptions and considers a number of factors including population estimates, burden of disease, and its impact on caseload, workload, case mix, case complexity, direct case contact time and the optimal configuration of services. The estimated caseload has been projected on the basis of historic information (post-mortem/1 000 population) and then adjusted year on year to allow for changes in population growth.

In developing staffing norms model it is clear that the modelling cannot be done merely on caseload or cases admitted to the forensic pathology service, but that the actual "case contact time" has to be considered.

It should further be noted that the 'care-pathway' for a forensic pathology case begins when the call for response is received and ends when the case is concluded by the judicial system. Case contact time defines per facility the amount of time spent per case and includes death scene attendance and investigation, facility admission and receipt, identification, Autopsy (including travel time), referral, release; forensic pathology administrative processes, management of general enquiries, Specimen and exhibit management.

The only existing norm for the determination of pathologist staffing requirements is that of 'NAME', which indicates a criterion of 250 cases to pathologist per annum. The current caseload of a forensic pathologist is 539 cases per annum. From the modelling, it is clear that the norm of 250 cases per annum would most probably not be achievable by 2030 in a resource-constrained environment. Affordable norms will be developed through application of the model within defined budget allocations. Alternate more cost effective service delivery models will also need to be explored.



SECTION G: QUALITY IMPROVEMENT

SECTION G: QUALITY IMPROVEMENT

SUMMARY POINTS

1. The essence of Healthcare 2030 is "access to person centred quality care". This vision needs to be rekindled with renewed vigour. The Department needs to deepen the daily conversation around quality. Management and staff need to make meaning of what terms like quality care and superior patient experience actually mean, what will it require to make it happen, how do we give effect to it in practice and make it a part of our being in our daily work.
2. The amended National Health Act, the National Core Standards and the establishment of the Office of Health Standards Compliance provide a legislative framework and mechanisms to ensure quality improvement.
3. In parallel to the statutory obligation to comply with the National Core Standards, the Department wants to build sustainable commitment to continuous improvement through its local person centred experience (PCE) strategies.
4. The vision for quality of care within the 2030 strategy can be divided into three dimensions:
 - » To improve patient centred experience
 - Voice of the patient
 - Involvement of family and friends
 - » To improve technical quality
 - National core standards
 - Reception services
 - Clinical governance
 - Infection prevention and control
 - Continuity of care
 - » Caring for the Carers
5. Caring for and engaging staff is central to achieving optimal PCE.
6. Building a culture of continuous improvement to quality will be a deliberate and systematic process.

Introduction

Over the years there have been policies developed within the Public Service generally and in Health specifically to improve the quality of care. There has been limited success in implementation for a variety of reasons.

The essence of Healthcare 2030 is "access to person-centred quality care". This vision needs to be rekindled with renewed vigour. The Department needs to deepen the daily conversation around quality. Management and staff need to make meaning of what terms like quality care and superior patient experience actually mean, what will it require to make it happen and how do we give effect to it in practice and make it a part of our being in our daily work.

Delivering quality and safe health services is both a national and a provincial priority. The Batho Pele principles of consultation, setting service standards, increasing access, ensuring courtesy, providing information, openness and transparency, redress and value for money provides a national guide of the key elements of quality service delivery in the public sector more generally.

The amended National Amendment Health Act (12 of 2013), providing for the establishment of the National Core Standards and the Office of Health Standards Compliance provide a legislative framework and mechanisms to ensure that quality of health service standards are met. The main purpose of the National Core Standards as articulated in the national policy is to:

1. Develop a common definition of quality care, which should be found in all health establishments in South Africa as a guide to the public and to managers and staff at all levels;
2. Establish a benchmark against which health establishments (public and private) can be assessed, gaps identified and strengths appraised; and
3. Provide for the national certification of compliance of health establishments with mandatory standards.

The department produced a policy in 2002, which identified the following three focus areas:

- » To improve consumer quality
- » To improve technical quality and
- » Caring for the Carers

These three areas of focus are still deemed to be critical areas except that consumer quality has now been changed to Person centered experience.

Person-centred Experience (PCE)

A person-centred health service is one that ensures that our patients have a superior experience when accessing health services in the Western Cape by 2030. The superior experience is one where people are treated with dignity and respect, providers communicate complete and unbiased information in ways that are affirming and useful, patients and family members build on their strengths by participating in experiences that enhance control and independence. Collaboration amongst communities, patients, family members and providers occurs in policy and programme development, professional education and design and delivery of care.

The three focus areas of quality are:

1. *To improve person-centred experience*
2. *To improve technical quality*
3. *Caring for the carer*

The Department has developed a framework to guide the establishment of a person-centred health service in the Western Cape. This framework in particular compliments the first four domains of the National Core Standards. This framework enhances the national core standards by placing the patient at the centre of everything to result in not only the desired health outcome but also one accompanied by a superior experience of a complete patient journey as perceived by the patient. To have a superior person-centred experience means that our patients feel that they⁴:

- » Receive effective treatment delivered by staff that they can trust;
- » Are involved in decisions and that their preferences are respected;
- » Have fast access to reliable health care advice;
- » Have clear, comprehensible information and support for self-care;
- » Have physical comfort and a clean, safe environment;
- » Receive empathy and emotional support;
- » Have the opportunity to involve family and friends in their care; and
- » Have continuity of care and smooth transitions throughout the health system.

Involvement of family and friends

Illness can cause anxiety and fear in patients and it is important to recognise that patient perspectives are dependent on values, beliefs and culture, and is informed by family, friends and community. These factors influence health-seeking behaviour, adherence to health care advice and interventions and self-care.

As deemed appropriate by the patient, there will be collaboration between communities, patients, family members and providers to ensure that appropriate support is given to the patient to ensure appropriate health-seeking behaviour, adherence to interventions and appropriate self-care. Patients will therefore be provided the opportunity to involve family and friends in their health-related decisions and plans. Non-governmental organisations will be essential to provide support to the patients and caregivers in their communities and the department would assist the patient and his/her family to make these linkages.

Our approach to increasing wellness also emphasises an inclusive population approach, which integrates the conditions, needs and assets of people living in a particular community to ensure that they are adequately empowered to meaningfully participate in the reduction of the Burden of Disease.

⁴Balik B, Conway J, Zipperer L, Watson J. Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)

The Voice of the Patient

The aim of developing a person-centred service is to place the patient at the centre of service delivery and a recognition that their perspectives and opinions no matter how diverse, matter. This firstly involves meaningfully engaging the patient during each visit to the health service, listening to their concerns, needs and perspectives and trying to accommodate this as much as is possible. Staff need to develop their ability to be mindful and being present during each encounter with a patient. This is difficult when clinical colleagues are faced with huge numbers of patients day in and day out at the health facilities.

The Department has institutionalised an annual patient satisfaction survey, mechanisms for written, oral or telephonic complaints and compliments and will be implementing regular rapid surveys to hear the voice of the patient from a qualitative point of view. These mechanisms will be used as a key yardstick to measure how well the Department is meeting expectations of patients with regard to being person - centered and provide the basis for on-going improvement. Patient feedback including complaints must be seen as constructive learning opportunities to improve the service.

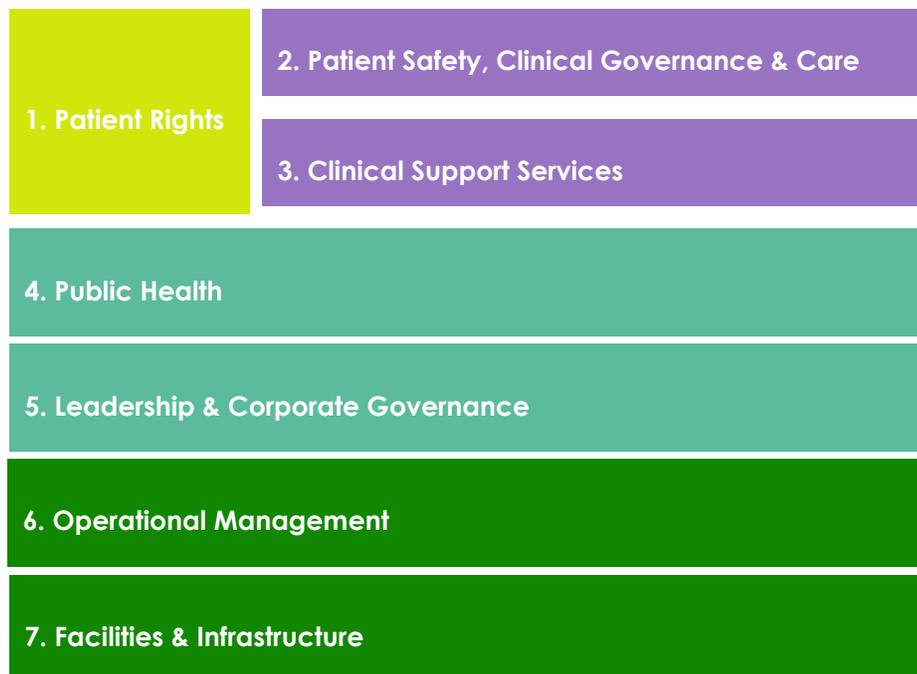
Improving technical quality

Technical quality refers to the objective and tangible elements provided by the health system to ensure quality services that result in improved health outcomes, minimise waste and are safe for our patients. These elements include meeting national core standards, clinical governance, infection prevention and control, systems and processes to ensure continuity of care.

National Core Standards

The seven domains of the National Core Standards (See Figure 12) provide the minimum legislated standards set for the health system to deliver quality health services that result in the desired health outcomes.

Figure 12: The seven domains of the National Core Standards



In addition to progressively moving towards National Core Standards compliance, the department has also prioritised the manner in which we deliver services in ways that minimise waste, are effective and patient-centred. The department will develop incremental internal capacity to implement process re-engineering strategies such as lean management to reach these objectives.

Managers will be expected to “manage by walking about” and get first-hand experience of service challenges by observing and listening to staff and patients and to respond to them as quickly as possible. Interventions to minimise waste, improve outcomes and the patient experience will be systematically monitored and evaluated and incremental targets will be set to ensure continuous improvement. System efficiency will be further evaluated as described in the monitoring and evaluation section of this document.

Reception Services

It is recognised that the manner in which a facility or a department within a facility ‘presents itself’ to a patient and the manner in which the patient’s needs are efficiently identified and handled play a large role in the patient’s perception of the quality of that service. The patient’s clinical folder that is neat and tidy, well annotated, up-to-date and always accessible is considered inviolable and is symbolic of respect for the patient’s dignity during their journey through the health services.

The following has been prioritised for action.

A welcoming protocol that ensures patients and their families feel welcome in the facility from when they enter the premises and through their entire journey of the facility.

This will include the courteous attitude of security guards at the gates of facilities even if they are from out sourced companies. They should also have assistance to direct them to where they need to be either through a patient service officer or manager and/or very clear signage of where the services patients require are situated. Staff should also be identifiable with name-tags, and facility organograms with photographs and contact details of the managers should be visible. Information on patient rights and responsibilities, the service charter and compliment and complaints procedures should also be visible.

Environmental ambience is related to clean facilities including toilets, availability of adequate seating in waiting areas, availability of drinking water, and an environment that is safe and minimises the transmission of diseases. In addition, there is adequate natural light and ventilation, minimum noise, especially in inpatient wards and the setting is generally aesthetically pleasing and environmentally friendly.

Triaging and risk profiling ensures the sickest patients or those that have limited mobility are prioritised and seen by the most appropriate health worker.

Patient registration that ensures each patient has a unique patient number that can be accessible at any provincial or City of Cape Town health facility and that can be retained throughout their life course.

Folder management that ensures folders are managed effectively with all the required and updated administrative and clinical information that can be easily retrieved when required. The most essential data should be captured for monitoring and evaluation purposes.

An appointment system that ensures patients do not wait for unnecessarily long periods to receive services

Clinical Governance

The Department has developed a policy framework for clinical governance. In this policy framework clinical governance is defined as: “a framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards, through creating an environment in which excellence in clinical care can flourish”.

Clinical leadership and technical expertise are central to facilitating clinical governance. This leadership will ensure that:

- » Clinical accountability is established with clear clinical and professional standards against which actual performance of health workers is measured;

- » Effective teamwork with inter-disciplinary co-operation;
- » Comprehensive service packages are defined for various level of care;
- » Clinical effectiveness results from the implementation of evidence-based clinical interventions;
- » Clinical risk management is achieved through continuous monitoring and improvement of:
 - individual health outcomes,
 - adverse incidents
 - adherence to clinical standards and guidelines; and
- » Continuous professional development

In addition to health workers providing effective health services, the manner in which they interact with patients must subscribe to the key principles of a person-centred experience described above.

Management plays an important role in ensuring that clinical governance remains central to clinical service delivery by partnering with clinical leaders to ensure that the required resources to perform clinical governance processes are provided for. In addition, both managers and clinical leaders have to instil a management culture based on on-going learning and development that ensures delivery of optimal clinical outcomes.

The creation of functional business units within larger hospitals will also allow for decentralised management and local responsibility and accountability for quality health services and efficient use of resources.

Infection Prevention & Control

"The National Infection Prevention and Control Policy and Strategy" document defines Infection Prevention and Control (IPC) as "measures, practices, protocols and procedures aimed at preventing and controlling infections in health care settings". Transmission of infections in health care facilities is of major concern in all health care environments. The increasing prevalence of antibiotic resistant organisms is a growing problem and aggravates the threat of such infections. Strengthening of IPC programmes is a national priority and the national core standards incorporates a number of standards related to IPC.

Infections within health facilities may be transmitted by patients, visitors or health care staff to each other or may be contracted via the environment. Protection of health service staff and patients is an important component of IPC and currently this may not be optimal despite various efforts and projects. To improve IPC the department will:

- » Ensure accountability for IPC by management, all clinical staff and other relevant staff;
- » Ensure appropriate IPC policies, guidelines and manuals are developed and used;
- » Use administrative procedures, environmental controls and personal protective equipment (PPE);
- » Ensure antibiotic stewardship is further developed and practised;
- » Ensure that there are adequately trained personnel to address IPC as current staff training and staff allocations may be inadequate;
- » Ensure new buildings/ infra-structure and planned renovations of existing buildings will be designed with IPC in mind; and
- » Ensure effective surveillance to maximise awareness and management of infections and to track trends.

Continuity of Care

The "care pathway" for patients in the health system describes the patient's journey through the health system which is planned to meet the needs of the individual patient as they progress through the various stages of life from birth to death.

As part of enhancing the person-centred experience, there will be continuity of care for patients who need to utilise services from different facilities at different stages of their life course. The referral and discharge processes are key opportunities in the patient's journey where health care providers can contribute to continuity of care through the capturing of vital information about the patient encounter on the patient record. This record will be electronically available across institutions and accessed through a unique patient identifier number. The record will improve clinical care through the easy availability of relevant information by all clinicians working in the system.

In order to achieve this, there are two critical elements that the department will be focusing on:

Hardware issues that ensure effective continuity of care

- » A standardised patient record and record management system that can maintain records throughout the life course from birth to death;
- » A standardised continuity of care record for discharge and referral;
- » Service point and drainage area directories for ease of referral;
- » Updated area - specific resource materials that are used for inductions of all new staff;
- » Institutionalized ICD-10 coding guidelines, tools and standard operating procedures to capture burden of disease information;
- » Availability of integrated appointment systems;
- » Easily accessible communication tools such as telephones, faxes, and e-mail; and
- » Closed loop communication that ensures that referring health providers receive feedback on the clinical outcomes of the patients they referred.

Software issues that ensure effective continuity of care

The key message of Healthcare 2030 is that the department is one cohesive organisation, driven by a shared vision and set of values with the single purpose of providing access to quality care. This intent must translate into positive relationships between staff and patients and amongst staff in the same or between different institutions and a shared responsibility for the attaining the patient's desired health outcomes and goals.

Caring for the carer

Staff play a critical role in PCE as they are responsible for the patient and provider interaction that is at the centre of PCE. It would be impossible to provide patient-centred quality care without a high-quality workforce and there is increasing evidence that staff satisfaction is directly related to improved patient satisfaction. Thus part of the 2030 strategy is geared to ensure that employees are engaged, empowered and happy to be at work that will in turn generate better outcomes for patients. Staff will be encouraged to be more innovative, effective and efficient.

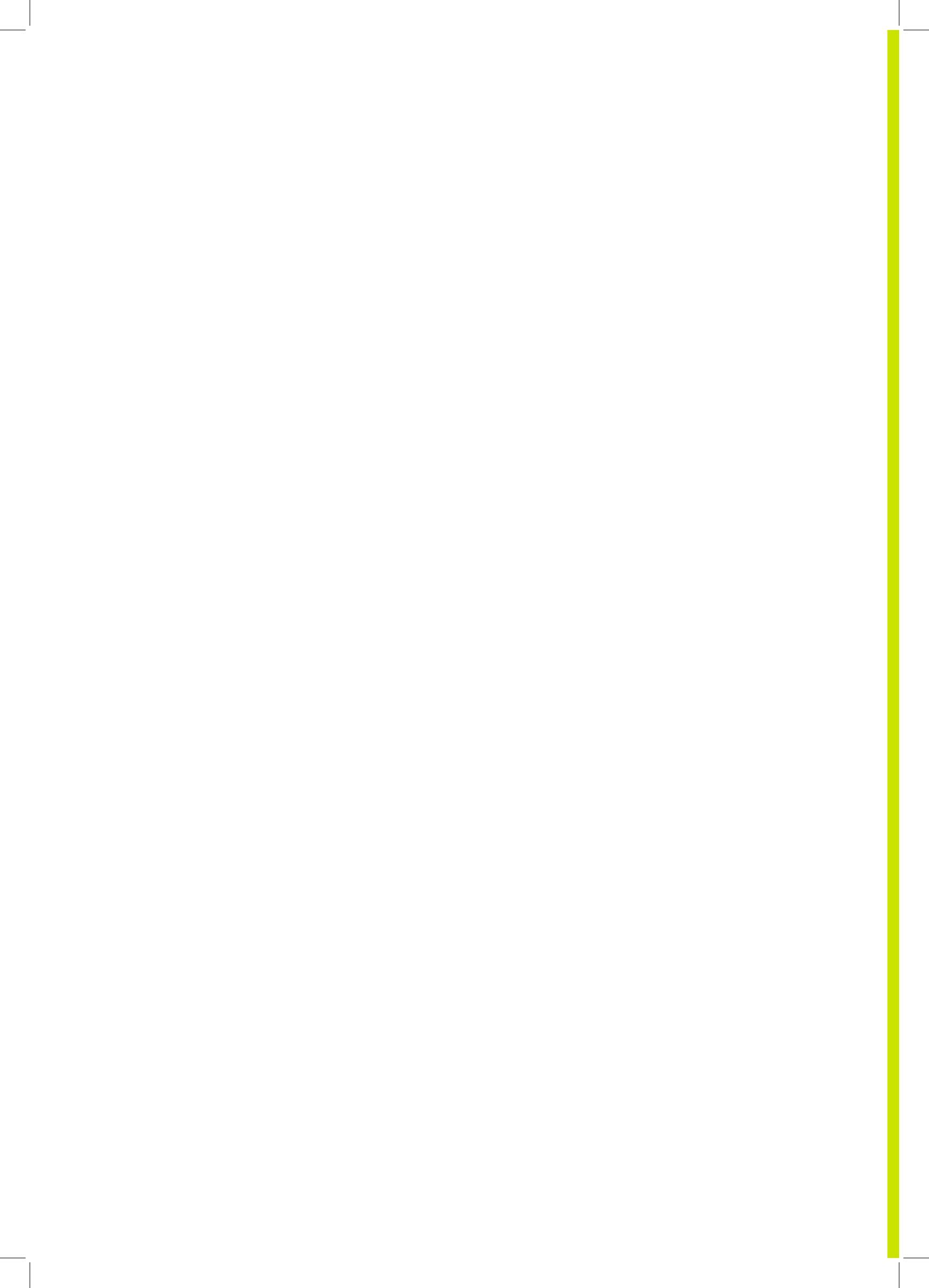
In a recent staff satisfaction survey, staff in the Department generally reported to be dedicated to their profession, committed and keenly engaged with their actual work. However, a proportion of staff also experienced dissatisfaction with the people-management skills of their line managers and do not believe that they are valued, feel listened to or cared for by the organisation and thus have limited engagement with the organisation. Furthermore high levels of burnout have been identified in staff as a result of heavy workloads and a stressful working environment. The Department has taken serious note of these findings and strategies to address them form an integral part of Healthcare 2030. (See Chapter on Support Services : Human Resources - section on Employee Wellness)

When employees are engaged, empowered and happy to be at work that will in turn generate better outcomes for patients.

Building a Culture of Continuous Quality Improvement

Continuous quality improvement means that there would be incremental improvement over time. This would be a proactive approach of establishing systems and processes to incrementally improve health outcomes based on specified measures in the three focus areas of PCE, technical quality and caring for the carer. Ensuring a culture of continuous improvement in the department is dependent on the following:

- » Leadership commitment;
- » Establishment of governance and co-ordination structures within facilities, districts, and head office for quality improvement that incorporates all three focus areas including occupational health and safety;
- » The involvement of staff in the identification of areas requiring improvement, setting targets and implementing the changes required;
- » Capacitation of staff in key principles of quality improvement;
- » Simple information systems to measure the baseline state and resultant changes and their impact on health outcomes;
- » Continuous monitoring, feedback and responsiveness to the feedback; and
- » Incentives and rewards for staff, facilities and districts.





SECTION H: **SUPPORT SERVICES**

SECTION H: SUPPORT SERVICES

SUMMARY POINTS

1. The process of developing a new vision and strategic framework for 2030 has created an opportunity for critical reflection and review of Support Services
2. There needs to be a cohesive alignment and common commitment of both line function services and support services to the shared vision, set of values and principles of Healthcare 2030. The organisational culture of working together and continuous improvement needs to be embedded.
3. The leadership at all levels must strive to systematically create and nurture the space to allow for new and more effective ways of doing business within the department. The launch of Healthcare 2030 provides renewed energy and opportunity for innovation. Building strong and trustful relationships, the free flow of information and ideas and effective communication across boundaries and divisions will enhance the culture of learning and innovation.
4. The Department is also committed to a decentralised management model within which the roles, responsibilities, powers and functions and the levels of accountability are well defined. There will be three tiers of management viz. service entity, district or regional and provincial.
5. Support Services are defined as those that are not direct patient facing. The client of support services is therefore primarily the line function manager and its key purpose is to enable service delivery.
6. Support services include financial management, human resources management, appropriate infrastructure, medical technology, availability of consumables, information management and ICT, communication as well as health programmes and clinical support services (eg pharmacy services, radiography, labs and bloods). The substance and form of these support services are centrally informed by the service delivery imperatives.
7. The four tenets of a re-invented support service is client centredness, integrated support services, continuity of support and a life course perspective.
8. The generic elements of a Support Service are informed by the components of a planning cycle ie :
 - » Organisational intelligence (information management, situational analysis, surveillance of the external and internal environment)
 - » Policy and Planning (including priority setting, risk management, budgeting)
 - » Implementation Support (including capacity building, provision of products (systems and tools) and services)
 - » Monitoring, evaluation and research

The process of developing a new vision and strategic framework for 2030 has created an opportunity for critical reflection on Support Services. This allows for developing a common understanding of the basics including what is meant by Support Services, who are the clients of Support Services, the purpose and value add of Support Services as well as how Support Services should respond in the light of the vision, values and principles of Healthcare 2030. The department is a large organisation. The development of prescripts, policies and ensuring administrative compliance has historically been a strong point. Healthcare 2030 calls for a responsiveness that has a greater sense of urgency, is more flexible and finds the creative space within existing rules.

The process of developing a new vision and strategic framework for 2030 has created an opportunity for critical reflection on Support Services.

There is sufficient consensus on the departmental vision, values and principles of Healthcare 2030. Both line function services and support services will therefore work towards giving effect to the overall general framework illustrated (see figure 13).

Synergy within Support Services and between Support and Line function Services

A critical success factor is cohesion within support services as well as between support services and line function delivery. This will require alignment to a common vision, commitment to shared values and principles, provision of a cohesive policy framework, strengthening relationships, effective communication, building trust and joint action. The Department is also committed to a decentralised management model within which the roles, responsibilities, powers and functions and the levels of accountability are well defined. This is further described below.

Building Cohesion

Once the framework for 2030 has been finalised, it would be important for the Department to ensure alignment of its structures, policies and practices to give cohesive effect to this strategic direction both from a planning and an M&E perspective. Structures and mechanisms to provide the key interconnectivity between the various support functions and service delivery functions will be created. This will ensure structural and functional alignment, a cohesive organisational focus on the patient experience and desired outcomes, appropriate prioritisation and consequent allocation of resources, and the M&E of progress towards achieving the identified outcomes. The integrated functioning of strategic planning, information management and health impact assessment as well as the meaningful engagement with the line function services, health programmes and other support functions (such as finance, human resources and infrastructure) is critical to providing this alignment, co-ordination and cohesion both at a provincial- and district or institutional level. A key thrust of Healthcare 2030 is systems thinking where one is continuously focusing on the system as a whole and paying great attention to maintaining the inter-connectivity between the parts. This approach is central to the overall health system strengthening and resilience that is required in the face of increasing demand and limited resources.

Culture of Learning and Innovation

A culture of learning and improvement will be fostered in the Department. This will be done through the encouragement of on-going, regular reflection on performance and developments and the sharing of lessons and experiences within the Department. In-service training, various management and clinical meetings must become an opportunity for learning, continuous improvement and innovation.

The Department will implement a change management strategy, aided by external expertise, to foster the culture of continuous improvement and doing things differently to improve the service. This will include embracing methods such as lean management.

The strongly regulatory and compliance driven environment in the public service can discourage innovation and risk taking. The leadership at all levels must strive to systematically create and nurture the space to allow for new and more effective ways of doing business within the regulated environment of government. The launch of Healthcare 2030 provides renewed energy and opportunity for innovation.

Building strong and trustful relationships, the free flow of information and ideas and effective communication across boundaries and divisions as well as a reduced fixation with rigidly defined job descriptions, linear reporting relationships within the Department will begin to create an environment that encourages innovation.

Decentralised management model

The Department of Health strives towards a decentralised management model which supports seamless and holistic service delivery, with person-centeredness as a focal point. This position is based on the belief that the greatest impact on the vision of Healthcare 2030 i.e. access to quality care, is made at point of contact with the patient. The challenge is to ensure that the service outcomes at this level is maximised. This approach implies management autonomy at the coalface, but directed by policy frameworks from the centre to ensure cohesion, consistency and

unity of purpose. The higher level management tiers and functional experts provide implementation support to service delivery entities in an integrated manner. The envisaged model should aim to promote sound and quick decisions and effective results at the point of patient care.

The model envisages centralised decision making with regard to departmental policies, norms and standards and resource allocation within which decentralised decision making at service delivery level will occur. To be effective, it is important that the service entities and districts are adequately capacitated both clinically as well as administratively and given the space to creatively manage and address the service challenges and bring the vision of Healthcare 2030 alive at the clinical coalface where it matters most.

Given the nature and extent of the health function, such a decentralised management model should provide for:

- » Policies, norms and standards;
- » A delineation of roles, responsibilities, powers and functions and levels of accountability across departmental management tiers;
- » A decision making and reporting framework;
- » A feedback mechanism to ensure accountability; and
- » Functional implementation support and enablement.

It is important to define the terms accountability and responsibility within a decentralised model. Accountability is the ultimate ownership for the completion of a task or function and its results i.e. "where the buck stops" and usually resides with one person and cannot be delegated. Responsibility is who will do the work, and can be a shared responsibility.

The Department will build a culture of reciprocal accountability which is a two way process whereby health facilities are accountable for services, their outputs and outcomes and upper tiers of management for providing the enablement and support.

Three tiers of the decentralised management model

Against this background the proposed decentralised management model allows for a three tiered approach, namely, service entity level, district level as well as provincial/head office level. The roles and responsibilities at the various levels will be as follows:

Accountability is the ultimate ownership for the completion of a task or function and its results i.e. "where the buck stops" and usually resides with one person and cannot be delegated. Responsibility refers to who will do the work and can be a shared function.

- » Service Entity level:
 - Accountable to maximise service delivery outcomes; and
 - Accountable to district Managers.
- » District level:
 - Facilitate, coordinate and enable implementation of policy and programmes at service entity level;
 - Integrate management information for decision making; and
 - Accountable to provincial level.
- » Provincial level:
 - Develop policies, norms and standards; strategic objectives; allocation of resources;
 - Functional implementation support (including development of appropriate management and other supportive systems, tools and processes, capacity building);
 - General oversight and impact assessment; and
 - Overall public accountability.

The Department has begun a process of creating Functional Business Units (FBUs) within the large entities that allows for authority to be delegated to the local clinicians in an institution. The aim of the Functional Business Units (FBU) is to allow for the local team of clinicians and management to manage their allocated budgets as well as the service outputs and outcomes through clinical governance processes like mortality and morbidity reviews. FBUs will thus become a key mechanism for local decentralised management.

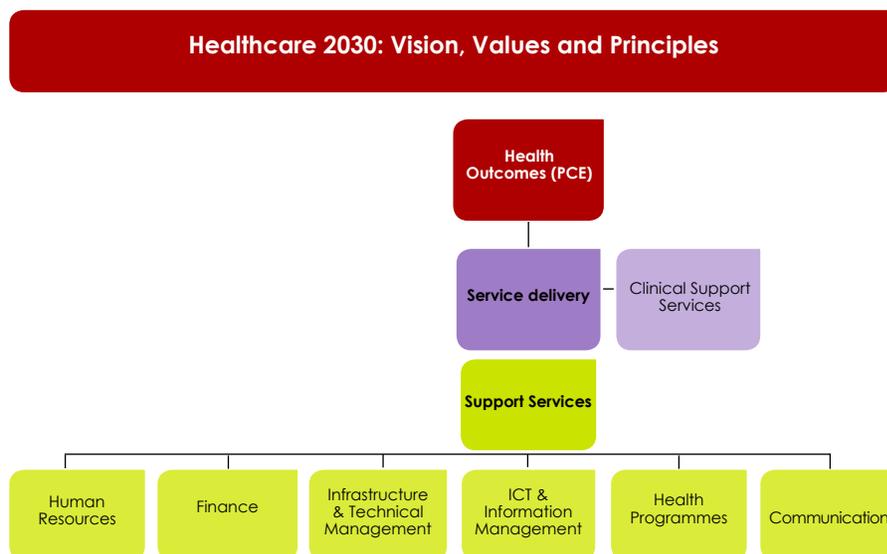
While the department is committed to a decentralised management model, in certain instances it would be more cost efficient to centralise certain functions such as the bulk procurement of items that can achieve large discounts. Decentralisation can also be costly and the skills may not be readily available in some cases and it may therefore not be prudent to decentralise certain functions to small facilities. Thus, the department will take a pragmatic view to shaping the finer details of this model.

Defining Support Services

This section describes the main broad functions within support services and does not discuss the specific role of all structures within Support Services.

The Department's core purpose and raison d'etre is to improve population based health outcomes through comprehensive health service delivery. Efficiency and effectiveness of service delivery forms the basis for assessing the value of all efforts within the Department. Support services can be simply defined as providing those services that are "not direct patient facing" to enable efficient and effective service delivery to patients.

Figure 13: Conceptual Structure of the Departmental functions



Clinical Support Services

The Department has recognised that certain functions that historically operated within support services are more closely aligned with service delivery and could therefore be located more appropriately within the service delivery arm of the Department. (See Section on Clinical Services)

Support Services Re-invented

Given the basic understanding of Support Services described above, support service will transform the ethos, philosophy and modus operandi of these functions in the department from a historically dominant mode of administrative compliance and control to one of creating value through effective management and administrative systems. A key thrust of Healthcare 2030 is systems thinking where one is continuously focusing on the system as a whole and paying great attention to maintaining the inter-connectivity between the parts.

a) Who is the client in Support Services?

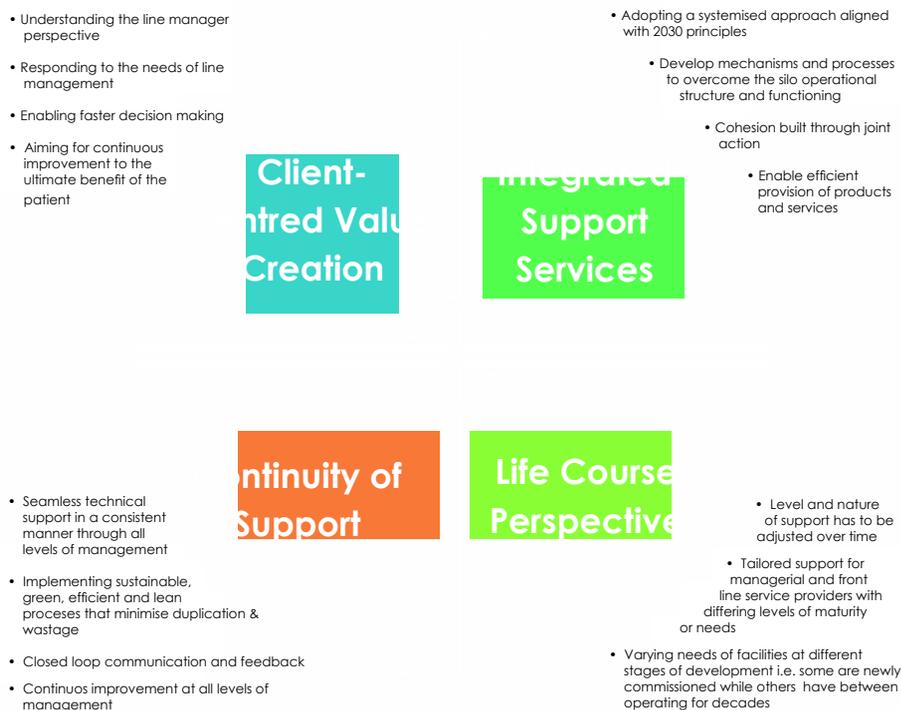
Given that the primary function of Support Services is to enable efficient and effective service delivery within a decentralised management system, the clients of Support Services are the local line function management teams at all levels of care.

The clients of Support Services are the local line function management teams at all levels of care.

b) What is the conceptual thinking underlying a re-invented support service?

The four tenets that underlie the thinking of a re-invented support service are shown in the Figure 14 and discussed below.

Figure 14: Conceptual approach of client-centred support services



Creating client centred value

To create value for the client it is important to understand their needs and perspectives. Responsiveness to their needs become the primary determinant of the value added by support services. Support services will work closely and be in constant communication with the line function to understand them as a client and what their needs are. Support Services also need to understand and be responsive to the urgency of line function management and colleagues working at the coal face of service delivery.

A culture of questioning every step in every process and “what value it is adding to the client” will be developed. Activities should always be necessary and value adding. However operating in a strongly regulatory government environment where compliance is essential some activities may be necessary but not value adding. Joint problem solving will minimise those activities that are not necessary and not value adding for effective delivery.

Integrated support services

It is important to develop mechanisms to overcome the silos that exist within support services. Structures, processes and collaboration across boundaries will be developed to ensure cross functional teams. Support Services will provide practical, integrated and easy to use tools to enable line management to carry out its functions efficiently. The cohesion within support services will only be built through joint planning, action and evaluation. Building trustful relationships and strengthening communication and the free flow of information across entities will be key requirements for more effective functioning.

Continuity of Support

The vastness of health services in the province requires seamless technical support processes in a consistent manner at all levels of management. This should be sustainable, green, efficient and lean to minimise duplication and wastage. Closed loop communication and feedback between support services and line management will result in continuous improvement at all levels of management.

Building trusting relationships and strengthening communication and the free flow of information across entities are will be key requirements for more effective functioning.

Building trust, collaboration and strengthening of the relationships between line- function and support services requires:

- » A culture of information sharing
- » Reciprocal accountability whereby local management is given the authority, delegations, autonomy and support to operate within a decentralised system but they operate within the statutory, policy and strategic frameworks and boundaries as set by the Department.

Life course approach

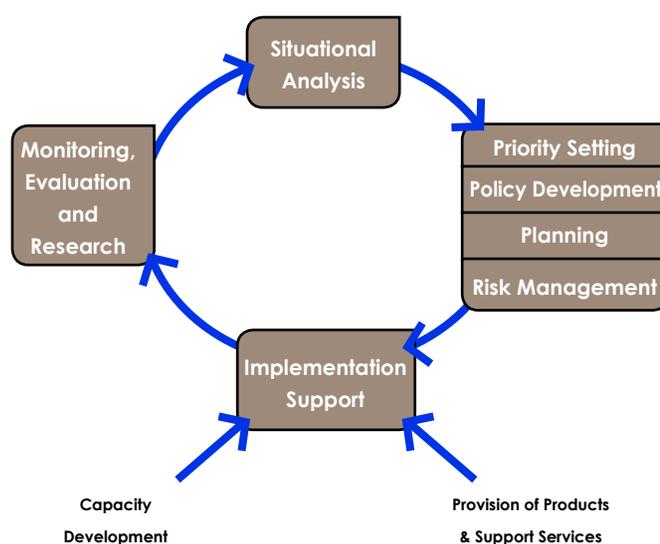
There is a recognition that service delivery entities are at different stages of development i.e. some are newly commissioned and others have been operating for decades. The support provided has to be titrated to the local and varying needs of the facility and adjusted over time.

Similarly staff that are either managers or front line service providers are also at differing levels of development. Support services need to ensure that their level of support, capacity development and decision making takes this into account

c) What are the generic elements of support service ?

The generic elements of support services are informed by the planning cycle shown below.

Figure 15: Generic Elements of Support Services



1. Organisational Intelligence (Situational Analysis):

A key role is obtaining, digesting and processing of organisational intelligence that informs the planning and management of health services in the Department. Scanning of the broader external environment for relevant developments globally and locally and being aware of the dynamics, performance, stresses and strains within the internal environment of the Department are critical to the functioning of Strategy and Support. Organically embedded mechanisms between the support functions, service delivery entities and external partners are critical to enable this functionality. Tapping into the body of knowledge generated by research as well as accessing the technical expertise within higher education institutions (HEIs) and other organisations is also important. Robust forms of surveillance of disease patterns and risk factors will inform the planning and responsiveness of the Department.

Information management: An important enabler to address the strategic direction of 2030, is the timely availability of good quality data and information to make decisions that impact on the health service at all levels. This requires the building of an organisational culture that values and uses information and the strengthening of information management systems. The latter requires ensuring proper policies and processes, supportive information technology with optimal use of the opportunities that rapid advances in this area provide, and the strengthening of human resources competency and capacity.

Good-quality information is an important prerequisite for the planning, implementation and M&E of the 2030 plan. Annual institutional, district and provincial plans will be developed that will contain incremental steps and targets to give effect to 2030. A core set of indicators is suggested to measure and report progress. Building the capacity to regularly evaluate health programmes and services will be important in improving overall performance at various levels of the service.

A clean audit on predetermined objectives (Information) is an important organisational objective. Institutionalising system improvements to address the audit findings will result in an overall improvement in the quality of data and information.

2. Policy and Planning:

Policy Development: Policy is any “course or principle of action adopted by an organization intended to address a particular issue”. Policy can emanate from national, provincial and institutional level and includes instruments such as legislation, policy framework documents, etc. The support service role at provincial level is to interpret national policy for the provincial context; develop provincial policies as well as facilitate and monitor its implementation in collaboration with line function services. Policies should be synergistically aligned across the different components of support services.

Several areas of improvement will be addressed to optimise the policy process:

- » A central repository of all policies which will be digitally available to all in the health services;
- » A more systematic and regular process of policy review;
- » More effective ways of communicating policies and developing a common understanding amongst staff;
- » More effective implementation of policies;
- » Monitoring the implementation and evaluating policy outcomes and impact; and
- » Involvement of all role players at all stages of policy development is an important prerequisite to the successful implementation of policies.

The technical capacity to support these processes will be strengthened. This will include building expertise to clearly define the problems to be addressed, source the evidence to support policy options, and cost the resources required to implement these options. Expertise will also be required to evaluate the impact after implementation and to conduct a review of the lessons learned from this experience.

Integrated planning: Strategic and operational planning must ensure an alignment of goals, objectives and priorities with the vision, values, principles and strategic intent of Healthcare 2030. The integrated planning process must collectively harness the human, financial, infrastructure, IT and other resources required for the achievement of the defined priorities.

The commitment to a district-based health service in 2030 implies a geographic and population-based approach to planning and the management of health services. The promulgation of the District Health Councils Act makes it a statutory obligation to have district health plans with targets that the district management will be accountable for. The collection of data from facilities and the building of targets from the bottom will ensure consistency and alignment between district and the provincial health plans. This also lays the foundation for a meaningful monitoring and evaluation process at both levels. The provincial centre will ensure that there is an alignment between district plans and institutional plans and the strategic priorities of national and provincial government.

Priority Setting: Given the reality of limited resources compared to the health needs of the population, the setting of priorities and the targeted allocation of resources become increasingly important. Within this context, 2030 calls for a focus on health outcomes which requires harnessing the most cost-effective interventions based on sound evidence. Steps will also be taken to access the strong research capacity located within the province more effectively.

Risk management: The Department has recently started to embrace risk management more formally and systematically. The risk management process will be developed and deepened at various levels of the organisation. This process will be institutionalised within the planning and M&E cycles of the Department and all managers will take responsibility for the implementation of mitigation measures in their areas of jurisdiction. Risk management will call for a strengthening of systems and processes, training and support, monitoring of compliance with prescripts, performance management and embedding accountability at all levels. Risk management will be a dynamic process where it is regularly reviewed and constantly addressed. Specific risks are therefore not described in this long term framework.

The risk management process will be developed and deepened at various levels of the organisation. Specific risks are therefore not described in this long term framework.

3. Implementation Support:

Implementation is essentially about the provision of technical expertise and skills, products and services to inform and support the implementation of service delivery. This might include the development of systems, tools and processes that enable health service management and the implementation of policies and plans.

Capacity building: ensures the appropriate competencies to perform specified roles and functions in the service. This will include formal and informal training and mentoring. Building and strengthening capacity at various levels is an important prerequisite to effective decentralised management and distributed leadership. Over the next few years, the focus will be on developing the clinical and administrative leadership and management capacity at institutional level that is directly responsible for service delivery and quality of care.

Provision of service/products: these are deliverables such as infrastructure, medical equipment and technology, medicines and consumables, maintenance.

4. Monitoring, evaluation and research.

Developing and fulfilling a relevant research agenda will improve service delivery and assess the impact of health services on health outcomes. We will provide the expertise and tools to monitor and evaluate performance in the short, medium and long term.

CLINICAL SUPPORT SERVICES

SUMMARY POINTS

1. Certain of the support services are more closely aligned to direct patient care and have been clustered as clinical support services. This includes, amongst others, laboratory services, provision of blood products, pharmacy services, radiography, and nursing. These services are critical to the efficient and effective delivery of patient care. The staff that perform these functions within the service rendering facilities are an integral part of the team at the local level.
2. The Clinical Support Services will revise their priorities and policies, in collaboration with the line function service, to align with the vision and principles of Healthcare 2030. The early thinking towards 2030 and some of the main priority areas are summarised:

2.1 Pharmacy Services:

- a. Chronic Dispensing
- b. Modernisation of the Cape Medical Depot
- c. Rational Medicine Use
- d. Antibiotic stewardship at all levels of care
- e. E-prescribing integrated IT System
- f. Automated dispensing services
- g. Clinical pharmacist posts
- h. Ward Pharmacy
- i. Enhanced role of Pharmacy Support Personnel

INTRODUCTION

The Department has recognised that certain functions that historically operated within support services are more closely aligned with service delivery and could therefore be located more appropriately within the service delivery arm of the Department (SEE FIGURE --). These services would be clustered as Clinical Support Services and include, amongst others, laboratory services, provision of blood products, pharmacy services, radiography, and nursing.

These services are critical to the efficient and effective delivery of patient care. The staff that perform these functions within the service rendering facilities are an integral part of the line function teams at the local level. The components at the provincial level render a key support role that includes policy development, planning, implementation support (including the provision of certain products and services and capacity building) and monitoring and evaluation. The responsiveness of the provincial components are primarily informed by the needs of the services and secondly by the national and provincial legislation, policy and strategic frameworks.

The Clinical Support Services will revise their priorities and policies to align with the vision and principles of Healthcare 2030. A short description of preliminary thinking within clinical support services follows. This will be further elaborated within the more detailed service plans that will emanate from Healthcare 2030 framework.

The Clinical Support Services will revise their priorities and policies to align with the vision and principles of Healthcare 2030.

2.2 Laboratory Services

The National Health Laboratory Services (NHLS) is an important strategic partner that provides lab services to the Department. Their vision is to support better clinical decision making through the right result, to the right patient, at the right time and at the right costs.

- » NHLS Roadmap Principles include :
 - » A responsive and quality service to enable clinical decision making in a seamless integrated clinical platform;
 - » A service that is affordable and sustainable;
 - » A reimbursement model that is simpler and encourages joint risk sharing;
 - » Teaching and research agendas that drive innovation and improved service; and
 - » A norms based employee model that ensures the laboratories position the right staff, in the right place ,with the right skills.

2.3 Blood Transfusion Service

The Western Province Blood Transfusion Service (WPBTS) is a provincial organisation formed by an association of voluntary blood donors, dedicated to providing an efficient service with the safest blood products and within the highest professional and ethical standards. WPBTS will align its strategy to respond to the Western Cape DoH 2030 Vision and provide an efficient and cost effective service by means of:

- » Continually assess and amend its safety strategy
- » Research and implementation of new technologies
- » Monitor usage to ensure responsible and rational use
- » Implement strategies to reduce inappropriate blood usage.
- » Expand Education programs
- » Establishing on site Blood Banks and ensure emergency access to O-pos and O-neg blood units

Preliminary thoughts on Healthcare 2030 :

Pharmacy Services

Chronic Dispensing

Chronic Diseases will form the bulk of the burden of disease in the next two decades and the consequent majority of patients seeking health services. Rational medicine management processes in this area including the efficient dispensing of medicines at sites close to patients, and improved adherence with medication by patients and monitoring of clinical outcomes will be key focus areas. The current project by the Chronic dispensing unit will be well-established across the province in the short to medium term.

Modernisation of the Cape Medical Depot

The procurement and delivery of medicines from Suppliers to the facilities within the Department and the role of the Depot will be critically evaluated. This will include end to end medicine management processes, modernised infrastructure and IT systems to improve the efficiency and quality of this important service. The IT system will be able to alert management with early warnings of possible medicine stock outs.

Rational medicine use

Rational medicine use is defined by WHO (1985): "Patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community"

Rational medicine use is central to quality of patient care, and must be linked to clinical governance to encourage effective clinical practice. This will minimise the risk of medication errors and to ensure optimal use of available funds. Pharmacy and Therapeutics Committees must play a pivotal role in the monitoring and evaluation of prescribing trends, thereby contributing to a culture of responsible use of medicines.

A shift in the role of the pharmacist is required, with greater emphasis on clinical pharmacy and direct patient care to enable them to promote rational medicine use.

Antibiotic stewardship at all levels of care

Multi-disciplinary antibiotic stewardship teams will be established to ensure appropriate use of antibiotics, thereby minimizing the risk of antimicrobial resistance, nosocomial infection and prolonged hospital stays.

E-prescribing of medicines and a single integrated Pharmacy IT System

Redesigning processes and using computer technology will allow prescribers to have access to accurate information about the medication and medical history of the patient. Built-in computerised warning and alert systems enhance the prescribing process by providing support systems for clinical decisions. Built-in formularies and system rules prevent incorrect or inappropriate prescribing, thereby

2.4 Nursing

Nurses form the largest category of clinical staff in the health service, are an integral part of the health team and form the backbone of providing good quality care. The Department has therefore created a dedicated Directorate to provide, amongst others, the leadership, develop strategic priorities, formulate policies, co-ordinate the training and support the services.

Some of the strategic priority areas that have been identified include:

- » Reviewing the structures, roles and responsibilities as well as the location of the Directorate : Nursing in the context of Healthcare 2030 and the emanating re-organisation and service priorities generally.
- » Developing a comprehensive nursing strategy in the light of Healthcare 2030 that will include:
 - i Gathering intelligence around nursing in the Department and beyond to inform planning;
 - ii Developing staffing norms, models and workforce planning tools;
 - iv Education and training;
 - v Research;
 - vi Recruitment and retention strategies;
 - vii Address changes in nursing required to support service priorities such as home and community based care, clinical nurse practitioners at primary care, school health;
 - viii To investigate and address the implications for and impact on nursing in lieu of task shifting and the creation of various categories of mid level workers;
 - ix Developing effective strategies to address scarce skills in nursing especially specialist nurses;
 - x Strengthen collaborative partnerships with the HEIs and other relevant role players; and
 - xi Enhancing nursing leadership and development.

promoting rational medicine use and decreasing patient harm.

Hand-written prescriptions contribute to medication errors since they may be illegible or incomplete, make use of ambiguous abbreviations or be subject to transcription errors. Electronic prescribing provides legible information and allows for seamless prescription transfers between levels of care. E-prescribing will also reduce the workload since the renewal authorisation can be an automated process.

E-Prescribing which is linked to ICD10 codes (diagnosis) allows for improved surveillance.

The automated analytical reports provide valuable information on medicine use and enable desktop audits to aid with the monitoring and evaluation of medicine use. The feasibility of E-prescribing will be explored

Automated dispensing services

This will enhance the patient experience by reducing patient waiting times and reducing risk of medication errors. By relieving pharmacy staff from repetitive and time consuming tasks, they are enabled to contribute more fully to patient care. The feasibility of a pilot at the Central Hospitals will be explored.

Clinical pharmacist posts at selected hospitals: a registered sub-speciality of pharmacists

Clinical pharmacy provides pharmaceutical expertise to patients by ensuring that medicines are used in a way to maximise efficacy and minimise toxicity. Their function must also encompass a teaching role for pharmacy students in a clinical setting.

Ward pharmacy

Pharmacists must be placed closer to the patients in the in-patient setting, for pro-active involvement in direct patient care, to promote rational medicine use and to anticipate and prevent medication errors. Their functions must include patient medication review on admission, ensuring use of patients' own medicines where applicable and to serve as members on the hospitals' antibiotic stewardship teams.

Enhance the role of Pharmacy Support Personnel (Pharmacists' Assistants/Pharmacy Technicians)

The training of pharmacy support personnel to support the Departmental goals as they relate to the patient based experience and provision of healthcare at all levels of care

Laboratory Services

The National Health Laboratory Service (NHLS) is an important strategic partner that provides an essential diagnostic service to enable good quality patient care. They are also responsible for production of sera for anti-snake venom, reagents and microbiology culture media ; research to keep abreast of the advances in the field and teaching and training to produce the technical and specialist expertise for the country.

2.5 Imaging and Radiographic Services

- » Advances in Imaging Technology
 - » The advances in imaging technology has exploded over recent years. This has made imaging a key adjunct to clinical services in especially diagnostics. The Department will have to rethink the provision of these services and the availability of the necessary technology at different levels of the service
- » Picture Archiving System (PACS)/ Radiology Information System (RIS)
 - » The Department has already started to implement the Picture Archiving System (PACS)/ Radiology Information System (RIS) in central hospitals and intends to roll this out to the large hospitals in the medium term. This will improve the quality of the service and improve efficiencies.
- » Ultrasound Services:
 - » The importance of ultrasound as a diagnostic aid has grown in recent years. It has become a necessity in important services such as antenatal care and managing TB. The Department will therefore need to review the capacity and skills and address the scope of practice issues, to provide this important service especially within the District Health Service.

The NHLS was established in 2000 by amalgamating a number of fragmented laboratory service providers and is the sole provider of diagnostic pathology services to the public sector in South Africa, consisting of approximately 268 laboratories and 7300 employees nationally with 18 labs and 789 staff within the province.

NHLS Roadmap

The NHLS will be engaged to align its strategy to respond to the vision and principles of Healthcare 2030. It is important that NHLS plans and prioritises its offering in conjunction with the service platform in the Department. The NHLS road map outlines principles to ensure that it supports better clinical decision making through the right result, to the right patient, at the right time and at the right costs.

- » A responsive and quality service to enable clinical decision making in a seamless integrated clinical platform;
- » A service that is affordable and sustainable;
- » A reimbursement model that is simpler and encourages joint risk sharing;
- » Teaching and research agendas that drive innovation and contribute to the delivery of improved service strategies
- » A norms based employee model that ensures the laboratories position the right staff, in the right place ,with the right skills.

Alignment with Healthcare 2030

The laboratory services component together with the NHLS will explore new ways to align with Healthcare 2030 to ensure a good quality pathology service that is responsive and clinically relevant. To enable clinical relevance, it is important that constant upgrades and innovations are implemented. This will include:

- » Small on-site laboratories to process urgent specimens;
- » Appropriate point of care solutions to support clinicians at the bed side;
- » A more stream-lined super laboratory footprint with an excellent logistic system to move specimens around in the shortest turn-around times to high throughput centres of excellence;
- » A relevant Information Technology infrastructure (TrakCare LIS) to ensure distribution of test results electronically. The LIS allows for retrieval of patient results as patients are referred or migrate through districts and will allow for consistent gate keeping against unnecessary testing and reduce wasteful expenditure;
- » Use of smart phone, tablet and sms printer solutions to provide real-time information to clinicians, and patients;
- » Secure storage of patient data on a central database, allowing data retrieval for surveillance, research, patient management, epidemiology etc;
- » Pathologist's role is evolving to a more frontline interaction with clinicians and sometimes directly with the patient, this puts the focus on managing care as well as diagnosis with a greater influence on health outcomes; and
- » Ensure effective cost management that will include dash boards with utilisation data to clinical managers.

Blood Transfusion Service

The Western Province Blood Transfusion Services (WPBTS) is another important strategic partner rendering an essential service to the Department. It is a community based regional health care organisation formed by an association of voluntary blood donors, dedicated to providing an efficient service with the safest blood products and within the highest professional and ethical standards.

The Service is demand-driven and in order to supply sufficient blood products, the donor base will be increased in a similar ratio to the population increase. Apart from increasing the numbers of active blood donors, the focus will be on improving donor safety such as the impact of recurrent donation on donor health and client satisfaction including better communication and organising the service for the convenience of donors.

Alignment with Healthcare 2030:

- » WPBTS will align its strategy to respond to the Western Cape DoH 2030 Vision and provide an efficient and cost effective service by means of:
 - Continually assess and amend safety strategy in order to provide the safest blood products to the community.
 - Research and implementation of new technologies that will improve the patient outcome:
 - Pathogen reduction technology;
 - Electronic crossmatch systems;
 - Automated component production;
 - Genotyping of blood donors and recipients; and
 - Expand testing arrays for multiple transfusion transmissible diseases.
 - Ensure that blood is used responsibly and rationally by means of monitoring usage;
 - Implement Patient blood management and restrictive blood transfusion strategies to reduce inappropriate blood usage;
 - Expand Education programs; and
 - Establishing on site Blood Banks and providing emergency blood banks "fridges stocked with O- pos and O-neg blood units" as per service requirements.

Nursing

Nurses form the largest category of clinical staff in the health service, are an integral part of the health team and form the backbone of providing good quality care. The Department has therefore created a dedicated Directorate to provide, amongst others, the leadership, develop strategic priorities, formulate policies, co-ordinate the education and training and support the services.

Some of the strategic priority areas that have been identified include:

- » Reviewing the structures, roles and responsibilities as well as the location of the Directorate : Nursing in the context of Healthcare 2030 and the emanating re-organisation, service and training priorities generally.
- » Developing a comprehensive nursing strategy in the light of Healthcare 2030 that will include:
 - Gathering intelligence around nursing in the Department and beyond to inform planning
 - Developing staffing norms, models and workforce planning tools
 - Education and training
 - Recruitment and retention strategies
 - Address changes in nursing required to support service priorities such as home and community based care, clinical nurse practitioners at primary care, school health.
 - To investigate and address the implications for and impact on nursing in lieu of task shifting and the creation of various categories of mid level workers.
 - Developing effective strategies to address scarce skills in nursing especially specialist nurses.
 - Strengthen collaborative partnerships with the HEIs and other relevant role players.
 - Enhancing nursing leadership and development.

Imaging/Radiographic Services:

Advances in Imaging Technology

The advances in imaging technology has exploded over recent years. This has made imaging a key adjunct to clinical services in especially diagnostics. The Department will have to rethink the provision of these services and the availability of the necessary technology at different levels of the service. Some of the technology that used to be seen as a scarce and expensive resource to be used sparingly such as the CT scanner is now perceived to be a basic diagnostic aid that should be available much more widely.

Picture Archiving System (PACS)/ Radiology Information System (RIS):

The Department has already started to implement the Picture Archiving System (PACS)/ Radiology Information System (RIS) in central hospitals and intends to roll this out to the large hospitals in the medium term. This will improve the quality of this service, improve efficiencies, enable images to be digitally moved between health professionals and across institutions and facilitate the remote reporting of complex images by radiologists. More cost effective variations of this development will be considered for smaller facilities. This also requires a fundamental change in the way this service will be rendered within and across institutions.

Ultrasound Services

The importance of ultrasound as a diagnostic aid has grown in recent years. It has become a necessity in important services such as antenatal care and managing TB especially with the large quantum of sputum negative patients that require other means of making the diagnosis. The Department's policy requires each pregnant mother to have an ultrasound scan before 20 weeks. The Department will therefore need to review the capacity and skills and address the scope of practice issues, to provide this important service especially within the District Health Service.

SUMMARY POINTS

1. Notwithstanding the envisaged changes in the system and opportunities that advances in technology will create, the people factor will be central to the successful achievement of the strategic objectives of Healthcare 2030. The biggest challenges to achieving the objective of a patient-centred service are: re-energising the staff and building renewed commitment to the principles, vision and values of 2030 and creating an organisation where staff have a deep sense of belonging.
2. Leading and managing the people within the Department is a distributed responsibility at all levels of the organisation, and not the sole preserve of Human Resource management. The day to day listening to staff and effectively communicating, providing meaningful support, uplifting morale, managing performance for results and leading by example is the function of the line manager.
3. The 2030 Strategic HR approach will focus on:
 - a. Workforce Intelligence
 - » Develop capability in HR analytics and research to provide the workforce intelligence that informs workforce planning, development and M&E.
 - b. HR Policy Framework
 - c. Integrated Planning (Demand and Supply)
 - d. Priority Setting
 - » People management (bringing back the "human" in HRM)
 - » Employee Wellness
 - » Scarce Skills
 - » Task Shifting/ Sharing
 - » Leadership and management development
 - e. Implementation Support
 - » Operational HR management
 - » Performance Management and Productivity
 - » Capacity Building
 - » Provision of systems, tools and support
 - f. Monitoring, Evaluation and Research
 - » Develop more robust and systematic ways of keeping the

Notwithstanding the envisaged changes in the system and opportunities that advances in technology will create, the people factor will be central to the successful achievement of the strategic objectives of Healthcare 2030. Effective healthcare delivery is highly dependent on the one to one interaction between the health professional and the patient and likely to be so in the foreseeable future. Thus the adequate availability of competent and caring staff is a key success factor. The biggest challenges to achieving the objective of a patient-centred service are: re-energising the staff and building renewed commitment to the principles, vision and values of 2030 and creating an organisation where staff have a deep sense of belonging.

Leading and managing people within the Department is a distributed responsibility at all levels of the organisation, and not the sole preserve of Human Resource Management. For the Department to become an employer of choice, the day-to-day operational management of staff and the role of the HR manager at each level of the service will be re-crafted. Human Resource Management (HRM) as a support function will provide an enabling professional service to achieve this outcome. This service will include creating a supportive working environment and professional HR administrative service to ensure the basics are in place. The day to day listening to staff and effectively communicating, providing meaningful support, uplifting morale, managing performance for results and leading by example is the function of the line manager. The combined efforts of the line manager and HR component is an organisation that people can be proud to be part of – an employer of choice.

To give effect to Healthcare 2030, HR will mainly focus on the areas described below.

Workforce Intelligence

The management will be in constant touch with the heartbeat of its workforce, to understand how the staff feel and perceive the organisation. This workforce intelligence will form the basis for an on-going review and development of HR policies and plans. The Department will be developing its capability in HR analytics and research as well as systematic instruments to provide the intelligence that informs workforce planning, development as well as M&E against a set of metrics to assess progress in achieving key strategic objectives.

Policy and Planning

Policy development

An HR policy framework will be developed and regularly reviewed to be responsive to the critical needs of staff and aligned to national policy prescripts. The policy framework will also address issues that will enhance the ability of the Department to become an employer of choice. For example, the majority of staff in the Department are women who have specific challenges. Creative solutions such as job sharing and flexitime will be explored to enable better work/family life balance. This framework will provide the guidelines, boundaries and delegations within which management at various levels could operate within a decentralised Department. The framework will

finger on the pulse of the staff and to be responsive accordingly.

- » Develop a set of metrics to assess progress against the objectives of Healthcare 2030.

introduce best practice, good governance, innovative products and services and will be developed in collaboration with HR's support service counterparts at all levels of the organisation as well as line function management.

The policy framework will have clear implementation guidelines.

There will be a clear focus on a range of strategies which will include:

- » Recruitment and retention strategies;
- » Performance management;
- » Education and training;
- » Leading and managing change;
- » Employee wellness;
- » Occupational Health and Safety;
- » Sound labour relations; and
- » Collective bargaining.

Integrated planning

Health workforce planning to ensure the right number of people with the right skills at the right time is required to enable the achievement of health outcomes. Workforce planning addresses demand and supply forecasting through environmental scanning and workforce analysis.

i) Demand

The demand for health workers for the different categories of staff, the specific skills and staff numbers required will be determined by the health service platform configuration and service delivery levels of 2030, which are required to address the burden of disease and achieve the desired health outcomes, including wellness of the population at large.

The 2030 framework does not include detailed staffing numbers and competencies required for every level of care or institution as appeared in the 2010 planning process. However, planning tools such as workload calculators and service models will be developed to enable the required staffing levels to be quantified. These tools will be then be applied, in consultation with local management and clinical staff, to specific sections of the health service to work out the human- and other resource requirements for 2030. Assumptions will be made about the available funding levels and affordability of staff. These assumptions will be reviewed against reality over time.

ii) Supply

The supply of health workers, especially health professionals, is from three main sources – universities and colleges, from other provinces and countries, and internal training and development.

The demand and supply of health workers is in dynamic flux as there is continuous movement of staff between the various sources and also between the private and public sectors. There is a range of push and pull factors that impact on this movement of staff. Some of the recognised push factors include stressful working environments, breakdown in relationships with immediate supervisors, and broader societal factors such as crime and insecurity. Some of the pull factors include better remuneration packages in the private sector and overseas, better and less stressful working environments, and the opportunity to travel and gain broader experience.

The creation and implementation of specific strategies to address push and pull factors within the control of the Department can have a significant impact on recruitment and retention of skilled staff. Collaboration with internal and external stakeholders, particularly the higher education institutions is pivotal in this regard.

Priority Setting

HR priorities will be aligned with the needs of services. Some of the main preliminary priorities that emerge from Healthcare 2030 include scarce skills, task shifting/sharing, leadership development and education and training.

i) People Management (The 'human factor' in human resources management)

The Department is a large organisation with about 30 000 staff that attend to millions of patients annually within a stressful, busy and resource-constrained environment. It is easy to understand how especially staff working at the clinical coalface can become mechanistic in the way they do their work, slip into a mentality of clearing crowds, and treating patients as cases on a daily basis. The biggest unintentional casualty is the human and caring factor in the service.

There will be a complete re-think on how we strengthen relationships, build trust and confidence and meaningful and effective communication in all directions between clinical staff and patients, between members of the multi-disciplinary teams, between staff at different institutions, between management and clinical staff, between line function and support service staff and between the Department and the strategic partners and stakeholders.

There will be greater alignment between the values of the individual staff and the stated values of the organisation. This is a long term process that will require an on-going investment from the leadership at all levels. Building a values based organisation will require values being incorporated into processes such as recruitment and performance.

The Department will invest resources in securing expertise to facilitate and implement interventions that address the above-mentioned challenges with the primary objective of becoming more patient-centred in the way we deliver our service at all levels of the organisation. A secondary objective will be to become an employer of choice for staff in the province and beyond.

ii) Scarce skills

The retention of scarce skills in the areas of specialised nursing, pharmacy, clinical psychology, radiography, prosthetics and orthotics, clinical technology, clinical engineering, forensic pathology and emergency care (technicians and paramedics) continues to compromise the ability of the Department to perform optimally. There is a range of strategies that the Department will continue to use and strengthen, which include:

- » The use of bursaries to train staff in identified areas;
- » The provision of relief staff to free up individuals for training;
- » Implementation of the occupation-specific dispensation to provide better remuneration to attract and retain staff;
- » Improving the working environment to retain talented staff with scarce skills;
- » Developing a reputation of being the employer of choice and marketing the Department accordingly to attract staff;
- » Using innovative ways to advertise posts; and
- » Undertaking task shifting to free up the existing staff with scarce skills to be optimally used.

The OSD for health professionals has generally been positive in providing competitive salary packages and retaining staff in the public service within the Western Cape. Skills shortages in certain categories, such as advanced midwives, operating theatre-trained nurses, advanced psychiatric nurses, critical care, paediatric nurses, pharmacists, clinical technologists, continue.

iii) Task shifting

The Department will further its attempts at task shifting as a mechanism to optimally use the health professionals we employ. The training of theatre technicians to overcome the shortage of professional nurses that are theatre trained has recently started and shows promise. The 2030 framework includes rehabilitation care workers and home-based carers who will be able to do some of the basic functions in the homes of patients that have been previously conducted within facilities.

Lay care workers will be employed in hospital wards to assist with basic patient care that can free up professional nurses to do what they are qualified to do. The creation of mid-level workers such as dental assistants must be

supported by adequate and appropriate training.

Task shifting or in some cases task sharing will be supported by adequate training and mentoring, supervision and monitoring.

iv) **Leadership and management development**

Committed and competent leadership distributed at all levels of the organisation is a key prerequisite for the strategic and operational management of staff and other resources in the health service towards 2030.

Health systems strengthening should not only be based on competency development of managers at all levels of health care. The transformative role of management as 'change champions' is fundamentally important as well. The role of HR is to develop leadership and management skills with a specific focus at facilities within sub-district and district level.

The area of clinical leadership has been historically under-emphasised in the Department. With the introduction of functional business units and the centrality of quality in the 2030 vision, the role of clinical leadership becomes very important. Strategies to develop this area will be put in place.

v) **Employee wellness**

Effective caring for patients requires caring for the carer (See also Chapter on Quality Improvement) . There is an inseparable connection and two-way impact between the working lives and personal lives of employees that is not unique to health.

The current Employee Health and Wellness Framework is based on four functional pillars. (Wellness management, Health and Productivity management, HIV and AIDS, STIs and TB management, and SHERQ management)

The key interventions to improve staff experience and employee wellness include:

- » A facilitated change management process that will assist in the transformation of organisational culture to be in line with 2030 values of "Caring, competence, accountability, integrity, responsiveness and respect". The key focus here will be to strengthen local facility capacity to be more responsive to problem solving, improve leadership at all levels; encourage innovation, improve communication and develop positive change agents within the frontline staff. Similar institutions will compete against each other on a league table and prizes will be awarded to winners.
- » Making staff part of the solution through the implementation of lean projects to improve service delivery and the provision of innovation awards to drive continuous improvement through the development of new ideas to reach departmental goals;
- » A staff development programme that includes induction, training and mentoring
- » A staff recognition system which will acknowledge and reward excellence through a variety of financial and non-financial rewards;
- » The Department is committed to developing a safe working environment for staff, employee wellness and the provision of quality care. A Safety, Health, Environment, Risk and Quality Management (SHERQ) policy has been developed within the national legislative framework and international conventions. The provisions of the Occupational Health and Safety Act (OHSA) are also incorporated into the policy. The policy aims to promote a safe working environment and reduce risks, prevent occupational injuries and diseases, and promote healthy lifestyles of employees. There is some overlap between this policy and the infection control and quality of care initiatives, which are being addressed within the Department. The challenge is to now take the required action towards systematic and sustainable implementation of the policy at various level of the health service. Support and counselling services will be provided for mental, financial and spiritual issues – wellness programmes, occupational health, campaigns and sports days to attain staff health objectives.
- » Conducting staff satisfaction surveys to constantly monitor staff engagement with the organisation.

Notwithstanding the specific initiatives mentioned above, the daily effective communication and meaningful engagement between management and staff at all levels is critical so that staff can feel heard, supported and acknowledged. This is central to building organisational esteem and a sense of belonging. A place of work that staff can feel proud to be part of.

Implementation Support

i) Operational HR Management

For the Department to become an employer of choice, the day-to-day operational management of staff will be improved.

The Department has been a long history in the development of prescripts and policies and ensuring administrative compliance. At this point in time however, the challenge for the HR function within the Department is to become more responsive to the needs of the service and the staff and to find creative space to function within existing rules, while still responding with greater urgency and flexibility.

The Department has created instruments that have been institutionalised to operationally manage the filling of all posts (permanent and contract). The approved post list (APL) identifies priority posts for filling at the beginning of the year within the allocated budget per entity. The APL is an important control mechanism to manage the personnel expenditure, as no post can be filled if it has not been authorised through the APL. The system allows for any change in the posts to be filled during the course of the year provided that costs of the old post and those of the new post(s) balance each other out and the source of funding can be identified. This allows flexibility yet firm control of the expenditure. The APL is a tried and tested control instrument that will hold the Department in good stead in the future especially within a resource constrained environment.

Recruitment processes will continue to be refined and improved. Innovative methods of electronic advertising and web-enabled application processes will be introduced. The Department will continue to reduce the period taken to fill posts over and above current average of 60 days. Tighter targets are being set to further improve in this regard. Creative retention strategies for staff will be explored and developed.

ii) Performance management and productivity

Steps will be taken to improve the manner in which the current performance management system is used and applied. This includes finding creative ways of using the existing system, exploring the use of non-financial methods to recognise staff performance and ensuring that there is a stronger alignment between the individual performance agreement of employees and the overall objectives and deliverables of the Department. Successful implementation of Healthcare 2030 calls for a strongly collaborative approach and incentives to reward working in teams should be explored.

iii) Capacity Building

Competent health practitioners are required to deliver health care that is responsive to the needs, preferences and expectations of people accessing health services. Through strategic and collaborative partnerships, HR will ensure a high performance culture by supporting all levels of staff to realise their full potential through the development of knowledge, skills and attitudes.

The Department will also focus on building a values consciousness and the softer skills required by staff to be more person centred in their daily work. This will include, amongst others, listening with empathy and communication skills and inter-personal skills.

An integrated training and development plan, which ensures the appropriate numbers and competency mix of staff per level of care, is imperative to achieve our desired outcomes. The training plan will include strengthening strategic partnerships with HEIs and professional councils to ensure that the Department's needs in terms of numbers of staff with the right competencies and values are produced on an on-going basis. The Department will engage with the HEIs to ensure appropriate curriculum content and a close inter-relationship and alignment between training, service and research. The teaching capacity within nursing colleges and the EMS training college will be addressed. The Department will ensure equitable and adequate access to the service platform for teaching and training of health professionals within the available resources.

The training and development plan, will focus on , amongst others, leadership and management development, training of mid-level workers, leading change management, training in service improvement methods such as lean management.

iv) Provision of products and services

In addition to what has been described elsewhere, HR will develop innovative tools and services to assist line function services. This will include ,amongst others, the following:

- » HR toolkit basic HR policies, delegations, best practices, good governance;
- » Tools to manage staffing levels and filling of posts within budgets;
- » Status reports on key HR indicators by district and/or large institution;
- » Performance standards for HR services;
- » Ongoing In house training of HR practitioners on policies and practice; and
- » Development or amendments to staff establishments according to changing needs of the organisation.

Monitoring, Evaluation and Research

More systematic ways to be in touch with the pulse of the people in the organisation as well as to monitor and evaluate the HR function will be developed. This will happen through formal and informal ways. Managers proactively asking for feedback and ideas and being available to listen on a daily basis is a vital source of workforce intelligence. More formal ways will include the Barrett's and staff satisfaction surveys, a robust analysis of exit interviews to understand why employees leave the organisation to routine indicators such as vacancy rates for different categories of staff, personnel expenditure per outputs such as patient day equivalent and average time to fill posts. Improved HR information systems will be implemented better monitor the HR function in the Department.

FINANCE AND SUPPLY CHAIN MANAGEMENT

SUMMARY POINTS

1. There will always be an inevitable tension between effectively balancing the demand for service against limited resources.
2. The allocation of budgets, financial management and the procurement of supplies are a major support function that is central to the effective and efficient functioning of the Department and the achievement of the objectives of Healthcare 2030.
3. The strategic focus areas for finance will include:
 - a. Financial Intelligence
 - b. Policy Development:
 - » Appropriate decentralisation
 - » Devolved accountability
 - » Alignment of financial management with Geographic based structures (GSAs)
 - » Financial Accountability built into Performance management
 - » Declare war on Red Tape

There will always be an inevitable tension between effectively balancing the demand for service against limited resources. The allocation of budgets, financial management and the procurement of supplies are a major support function that is central to the effective and efficient functioning of the Department and the achievement of the objectives of Healthcare 2030. In order to address this tension, getting better value from the existing health rand, more effective targeting of resources and improving systems, processes and capacity are the major focus areas for the forthcoming period.

There are a range of specific improvements to financial and supply chain systems and processes described below that the Department would address towards 2030. The purpose of these interventions is to deliver the right goods and services at the right place and time, and at the lowest possible cost, reduce errors and work load and to enable efficient and effective service delivery.

Financial Intelligence

The Department is a large organisation with thousands of transactions occurring on a daily basis across hundreds of entities within the health service. The Department will be investing time and resources in creating systems to obtain better quality financial data including historical trends, unit costs, costs against health service outputs and outcomes. Making sense and providing meaningful reports to the management at various levels is a critical success factor for the efficient functioning of the Department.

- c. Integrated planning
 - » a. Budget allocations
 - » b. Standard Medical and Surgical consumables and equipment
- d. Implementation Support:
 - » Automation
 - » Procurement and stock management
 - » Improve Communication and Relationships
 - » Staff Recruitment and Development
- e. Monitoring and Evaluation:
 - » Budget Expenditure
 - » Measuring efficiency and cost effectiveness
 - » Monitoring Compliance

Policy and Planning

Policy Development

i) *Appropriate decentralisation*

The Department is committed to decentralised management where appropriate. It results in a higher level of responsiveness to local needs. The financial framework (including delegations) within which decentralised management operates will be regularly reviewed. This will be coupled with training, tools and robust engagement between the central support service and local districts or entities.

The Department must be mindful that in some instances the risk of errors and inefficiency due to a lack of controls and the economy of scale increases. A greater extent of automation will allow the department to centralise selected functions without forfeiting service delivery or local responsiveness, resulting in improved compliance and efficiency. Procurement is a function that could be optimally centralised in certain instances, while provisioning (buying from centrally determined contracts), should remain a local function.

For example, payment of municipal services is a function that may be beneficial to centralise. It is a major expense to the department, and late and non-payment of these accounts have serious consequences. Centralisation of these payments would also allow better analysis and control of usage and tariffs, potentially resulting in significant cost reductions.

ii) *Devolved accountability*

An integral part of decentralised management is devolved accountability to the local management. The department has a large number of small facilities and a small number of large facilities, each with a separate budget.

The department will strive towards improved automated information systems that can provide integrated information as a foundation for an improved system of accountability.

Functional Business Units (FBUs) are an important local mechanism within hospitals for effective decentralised management.

iii) *Alignment with Geographical Services Areas (GSAs)*

Healthcare 2030 is committed to a geographic, district based health service as a principle. Management structures that are functional arrangements have been created to allow for co-ordinated management of services rendered by all entities (irrespective of the budget programme they belong), within a geographic area. The strategic intent is to provide a cohesive and seamless service to patients. In order to analyse health outputs and outcomes against the resources spent per geographic area, budgets and expenditure can be regrouped for all entities within the respective area.

iv) *Improved Performance Management*

The Department will include various aspects of financial and supply chain management within the performance agreements of regional and institutional managers, and assess performance on a continuous basis to ensure the high standards of financial management are achieved.

v) **Red Tape**

Red tape is not the same as bureaucracy. Red tape is understood here as unnecessary processes, or processes that are unnecessarily complex. The department has declared war against Red Tape and will continue to identify and eliminate red tape from the financial and supply chain management processes.

Integrated planning

i) **Budget allocations**

It is difficult to predict the financial envelope that will be available for Health in 2030. This depends on a range of factors including economic growth rates and the implementation of the NHI. Assumptions will be made which will need to be reviewed regularly. Currently, Government uses a three year medium term budgeting cycle.

Budget allocation is a powerful form of strategic decision making. To decide which services will be funded from the limited resources is a continuous challenge. To ensure best value from the health rand, the Department will continue to improve its budgeting processes by more effective targeting of resources to the most cost-effective interventions, that will optimally impact on health outcomes.

Finance, together with Information management, line management and other role players will develop and implement Diagnostic Related Groups (DRGs) which will assist with the fair distribution of resources in relation to case mix and workload. The budget allocation process therefore needs to be an integrated process that works collaboratively with, amongst others, strategic planning, information management, health impact assessment (public health), health programmes and the line function service management.

ii) **Standard medical and surgical consumables and equipment**

The department uses an "Essential Medicine List" (EML) for medicines. The EML is actively managed and limits the medicines allowed for use in the department. The department will develop a similar list of standard medical and surgical consumables and equipment. A higher level of standardisation will result in cost savings through volume discounts, a reduction in work load and errors due to centralised procurement, improved budget estimates as it will assist with the calculation of budgets and also improved service delivery, as standardisation will assist clinical staff to be more familiar with the supplies and equipment.

Implementation Support

i) **Automation**

This department is allocated about 35% of the provincial budget, but it processes about 70% of the province's accounting transactions. Owing to the decentralised nature of this department, it also manages about 70% of the province's accounting offices. Its budget is divided into a large number of allocations due to the level of decentralisation and variety of services in this department. Budget Administration is therefore a massive task. Furthermore, Treasury and management continually require additional analyses and reports with respect to budget and other financial data.

Unfortunately, the current transversal government computer systems are inadequate given the need for information. Consequently the department's budget is administered by means of Excel and other PC based tools, which results in a lack of integration and duplication of effort.

The department will therefore progressively increase the extent of automation of the financial processes, ensuring that even processes at service level, such as a nurse requesting medicines or supplies, are automated. Using Budget Administration again as an example, such automated systems must:

- » allow decentralised offices to access the central budget database, to capture or alter budgets and to capture projections;
- » calculate the annual and adjustment budgets automatically with the use of input parameters;

- » update BAS automatically with calculated budgets;
- » replace the current Excel based BMI (Budget Management Instrument) with an integrated online application;
- » allow Treasury access for investigation and analysis of the budget databases; and
- » Requests for changes to the Approved post list (APL) will be automated as well as the maintenance of the APL, and the comparisons of the APL with PERSAL.

Integration of automated systems: BAS, PERSAL and LOGIS are integrated, but SYSPRO, the Electronic Procurement System (EPS) and some other systems are not integrated with the transversal systems. Lack of integration necessitates the capturing of the same data more than once, increasing work load and the risk of errors. Furthermore, stand-alone systems are also often not properly supported by the formal IT support structures of the provincial government. The department will therefore strive towards a higher level of integration and resist the introduction of non-integrated stand-alone systems.

Implementation of integrated and comprehensive computer systems has the potential not only of reducing workload, but also an improved flow of information to management and other users, resulting in improved decisions.

ii) Procurement and Stock Management

Ensuring adequate supplies of consumables and medicines is an essential function within the Department, with an annual budget of billions of rands. The annual audit by the Auditor General continues to raise queries regarding compliance (adherence to rules) within the procurement process. The recruitment and retention of experienced procurement staff also remain an on-going challenge. Many institutions retain high stock levels to reduce the risk of stock outs.

The Supply Chain Process will be reviewed in its entirety. This includes:

- » Automation of all processes into an integrated computer system, to eliminate duplicate data capturing, errors and waiting time;
- » Management of the stock of the department as a single virtual store, by means of a transversal integrated computer system, which will allow goods to be moved as programmatically determined on the basis of re-order levels and quantities on hand;
- » "Just in time" procurement with direct deliveries from the supplier to the institution, and even to components within institutions;
- » The central procurement office for the department to optimise discounts through bulk purchasing and prevent irregular procurement;
- » Contracts to exist for a very high percentage of products to minimise buy outs. This would require a continuous and comprehensive system of procurement planning;
- » Reduce the onerous responsibility of clerks by simplifying processes such as SCOA or other codes;
- » Improved contract and relationship management of suppliers, and
- » Review and modernise the medicine management processes of the Cape Medical Depot and the Department at large.

iii) Improve Communication and Relationships

To ensure a higher level of efficiency and compliance with financial prescripts, the communication and relationship between the Financial Administration and Supply Chain Management staff at institutions, regional offices and head office must be improved. Easy to read and concise circulars and Standard Operating Procedures and regular meetings to discuss developments, challenges and share lessons and experiences will be important mechanisms to improve functioning in the Department.

iv) Staff Recruitment and Development

The recruitment, retention and development of staff are some of the most important challenges. Recruitment processes will be improved by ensuring that appropriate applications are received through an improved marketing approach, including the maintenance of a database of promising applicants.

Minimum standards when employing staff is important. Formal qualifications and technical skills should not be allowed to outweigh ownership, responsiveness and accountability.

On-going training of staff is important to keep staff up to date with the latest developments.

Monitoring and Evaluation

i) Budget expenditure

The Department will be committed to operating within its allocated budget on an annual basis. The current systems, processes and tools and practices will be enhanced to institutionalise fiscal discipline at all levels of the health service. Spending patterns will be regularly monitored and inform actions to control expenditure.

ii) Measuring Cost efficiency and Cost effectiveness

The measurement of cost-efficiency, such as the cost per patient, of the cost per mean, will be improved. The measurement of cost-efficiency is extremely complex due to the divergent nature of the department's services. Even similar facilities treat patients with different levels of acuity due to socio-economic profiles of the areas they service and the distances to facilities that provide more specialised services.

Systems such as Diagnostic-related Groups (DRG's) or equivalent methodologies may assist the department in improving the measurement of patient workload, to address inequities in resource allocation between districts, sub-districts and entities. The department is in the process of developing systems to capture ICD 10 codes and other details of patients for this purpose. DRG's will also prepare the institutions of the department for the envisaged NHI (National Health Insurance).

Given the focus of the Healthcare 2030 on health outcomes, it is also important to develop methodologies to measure cost effectiveness against defined health outcomes indicators.

iii) Monitoring Compliance

The Department is committed to sustain its proud track record of an unqualified audit over the last ten years. Tools such as the Compliance Monitoring Instrument (CMI) and processes will be reviewed to monitor compliance with financial prescripts. The intention is to create the least onerous and most effective mechanisms in this regard.

HEALTH INFRASTRUCTURE AND HEALTH TECHNOLOGY

SUMMARY POINTS

1. The modernisation, management, and maintenance of health infrastructure and technology continue to remain one of the cornerstones for enabling the health service in 2030. The process for the delivery and maintenance of health infrastructure and technology also needs to be economical, efficient, effective, and take cognisance of the continuous development of medical technology.
2. Health care infrastructure should be conducive to the healing process, while at the same time remaining sustainable, flexible, energy efficient and within the financial and environmental constraints. The delivery of appropriate, well-designed and affordable facilities in the right location facilitates the provision and access to quality health services.
3. The approach to policy and planning of Infrastructure will continue to be governed by the 5L's Agenda:
 - » Long life (sustainability)
 - » Loose fit (flexibility and adaptability)
 - » Low impact (reduction of the carbon footprint)
 - » Luminous healing space (enlightened healing environment)
 - » Lean design and construction (collaborative and integrated)
4. The management of information has become an increasingly prominent component in the running of healthcare facilities. For this reason, ICT systems have to be part of the infrastructure design from the inception phase.
5. The following priorities have been identified:
 - PHC facilities
 - Emergency Centres at Hospitals
 - District hospital replacements
 - New Tygerberg Hospital
 - Focus on maintenance
6. Effective and efficient implementation requires rigorous and well-institutionalised structures, systems, and best practice, based on a consistent, effective, and agreed upon service delivery model, with clearly defined mandates, roles and responsibilities. All of these must be underpinned by appropriate and optimally placed personnel capacity, experience and skills. Infrastructure Delivery Management System (IDMS). This IDMS provides tools, systems, and processes for improved management of infrastructure programmes and projects.
7. Monitoring and Evaluation will focus on :
 - Maintenance and capital projects
 - State of the health infrastructure and technology
 - Learning lessons from post occupancy evaluations

In line with person centredness, healthcare infrastructure should be conducive to the healing process, while, at the same time, remaining sustainable, flexible, energy efficient and affordable, and within the financial and environmental constraints. The delivery of appropriate, well-designed and affordable facilities in the right location facilitates the provision and access to quality health services. This can be achieved by adhering to various principles during the planning and delivery of new infrastructure and the maintenance thereof.

In the Western Cape, the modernisation, management, and maintenance of health infrastructure and technology continue to remain one of the cornerstones for enabling the health service in 2030. Health infrastructure and technology support productive workflows, operational protocols and procedures, improves staff efficiency and morale, provides a healing as well as a safe working environment, and strives to be "future proof" by allowing for future service delivery changes.

The integration of the requirements of staff, alignment of processes, consideration of existing and future protocols and procedures, yet also considering the status of particular facilities is pivotal in ensuring an efficient provision of health infrastructure and respective medical technology. The varied nature of infrastructure and respective users, being patients (e.g. children, elderly), clinicians, as well as support and administrative staff, needs to be taken into account. For example, the separation of children from adults in the Emergency centres to protect them from being exposed to the "blood and guts" of trauma. The support rendered and health infrastructure built or maintained must be guided by the aim to enable efficient and effective service delivery to patients.

The process for the delivery and maintenance of health infrastructure and technology also needs to be economical, efficient, effective, and take cognisance of the continuous development of medical technology. The healthcare space must be used as a shared resource and not as a territory, efficiently utilised and respected by staff, patients and the broader community. Lastly, infrastructure projects must be delivered through an integrated and collaborative process; this implies continuous feedback loops from users of facilities informing an improved provision of health infrastructure and medical technology. The provision of health infrastructure and medical technology must be intimately linked to its utilization in order to ensure the best use of scarce resources.

Infrastructure Intelligence

The infrastructure unit requires information from a range of sources to inform its planning and implementation. This includes, amongst others, the needs and experiences of users (staff and patients), the physical condition of the buildings and equipment at any point in time, advances and experiences in infrastructure design elsewhere, changes in national and provincial policies. Thus processes and mechanism need to be put in place to ensure such information is constantly accessed.

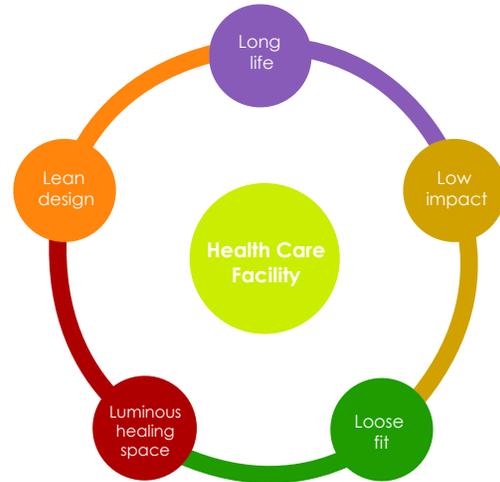
Policy and Planning

The 5L's Agenda

The Department's approach to health infrastructure and technology management is, and will continue to be, governed by the 5L's Agenda listed below:

1. Long life (sustainability)
2. Loose fit (flexibility and adaptability)
3. Low impact (reduction of the carbon footprint)
4. Luminous healing space (enlightened healing environment)
5. Lean design and construction (collaborative and integrated)

Figure 16: The 5L's Agenda



Long life

Rigorous health infrastructure and technology planning processes are required for enabling the health service at all levels. This is currently done through the drafting of the User Asset Management Plan (U-AMP), as required in terms of the Government Immovable Asset Management Act. The plan covers two budget cycles (six years) and provides a list of facilities to be built, replaced, upgraded, extended, and maintained. One of the new priorities in Government is to increase the focus on the maintenance of existing facilities and to limit new and/or replacement infrastructure. A considerable portion of the infrastructure budget is therefore to be utilised for the routine, day-to-day, and scheduled maintenance of facilities.

An integral part of sustainable infrastructure management is ensuring its affordability and the application of "green building" technology.

Lifecycle costing

Lifecycle costing is the estimation – at the planning stage – of all of the costs of an asset, including the cost of acquisition, operation, maintenance and disposal of that asset. New health facilities are planned for their entire lifecycle. A building maintenance plan is prepared with the aim of implementing it throughout the entire lifespan of the facility. Accordingly, an appropriate budget for maintenance must be ring-fenced for the facility and approval of new capital investment should only be granted if an appropriate lifecycle budget has been allocated. Balancing once-off capital costs and on-going operational savings is seen as an important factor in determining the value for money of an infrastructure investment. It is important to note that it is estimated that for every R1 spent on design and construction of a building, R5 must be set aside for maintenance through the estimated 60 years of the building's life – while between R50 to R100 must be for available for operational costs.

Affordability

One of the primary aims of the Infrastructure Delivery Management System (IDMS) is to create a more informed and capacitated Client Department (WCGH). WCGH will ensure a balance between the desire to build state-of-the-art, world-class facilities, and appropriateness in terms of the provincial context and affordability. Standardisation of design, technical specifications, and cost and planning norms are currently under development through the Infrastructure Unit Systems Support (IUSS). The main objective is to optimise the acquisition and management of public healthcare infrastructure throughout its entire lifecycle. The cost of infrastructure will be calculated for its entire lifecycle, with the intention of reducing its operational costs.

New PHC facilities will be designed and built using standardised design and technology, wherever suitable. A well-conceived standard design will cost less to procure and take shorter time to implement, while offering a

dignified working environment for staff and patients. The plan is to develop a few design types for PHC facilities, which can then be applied and adapted as required to suit a particular context, such as urban or rural, etc.

Finally, using integrated project delivery will ensure that facilities are built faster, cheaper and are of better overall quality.

Green building

Scientific research has demonstrated that a better indoor quality environment increases work productivity. The focus on green building design is therefore not only required for the reduction of energy and water consumption, thereby reducing operational costs, but also for improving the working environment and patient experience, ultimately leading to better health outcomes. The intention is thus to “retrofit” existing buildings with appropriate green technology. Such green retrofits would form part of all upgrades at existing facilities and would include, for example, improving energy and environment performance, reducing water use, and improving the comfort and quality of the space in terms of natural light, air quality, and noise.

Green building departmental policies are currently being developed in relation to the following:

- » Technology for cooling/heating – e.g. use of heat pumps, room motion sensors, geothermal installations;
- » Awareness of and education for saving electricity and water;
- » Management and usage – e.g. water and electricity meters; and
- » Utility project with the aim of reducing the consumption and expenditure for water and electricity in the next three years.

Loose fit

Buildings are systems composed of different components, and each component is made up of different elements. “Flexibility and adaptability” refers to the capacity of a building element, component, or the system itself, to change in response to external stimuli, such as the users, technology and the environment.

Healthcare buildings must be flexible and adaptable and used as space, not as territory. The design of health facilities needs to respond to changing needs, workloads, healthcare policies, protocols, and medical technologies. Spaces must be universally designed to accommodate a range of related functions. As long-term investments, buildings must be adaptable to changes, as replacement is not always a feasible option. This can be achieved by:

- » Creating a universal size room to be adapted to different functions;
- » Acuity adaptability patient room;
- » Standardisation of functional layouts;
- » Appropriate technology – e.g. light steel structure;
- » Design of “buffer” zones for allowing future expansion – e.g. adjacent to an imaging department;
- » Modular design and construction;
- » Office accommodation in accordance with the National Public Works Guidelines; and
- » Interstitial floors where feasible.

A hospital is a good example of a facility that continuously requires to be modified to suit changing demands. Flexibility and adaptability should therefore be essential aspects of their design.

Standardisation will also apply to health technology, which brings the following benefits:

- » Economical, due to the bulk procurement;
- » Limited number of consumables and type of medical equipment;

- » Facilitates maintenance, due to the inter-changeability of accessories and parts;
- » Reduces usage errors, due to the staff familiarity with fewer equipment types; and
- » Fewer training requirements.

Low impact

With a “cradle-to-grave” approach, the health infrastructure and technology value chain means considering all aspects of design, construction, usage and disposal, with the aim of reducing the overall carbon emissions. International experience shows that health facilities can be a significant contributor to greenhouse gas emissions. There is no reason to believe that the WCGH situation is any different.

The existing infrastructure portfolio will be assessed and baselines established for green retro-fitting projects aimed to reduce energy consumption. For new and upgraded infrastructure, the focus will be on the following:

- » Reviewing the origin and selection of raw materials;
- » Considering the construction phase emissions; and
- » Considering the design itself – passive design strategy, use of natural ventilation, use of alternative sources of energy, and energy-efficient equipment.

For health technology, the proposal is to use suppliers that offer low carbon products as well as those that can demonstrate a consideration for both the direct and indirect environmental impact of their products and services. However, it should be emphasised that users' behavioural change is also a fundamental component in reducing the carbon footprint of facilities (e.g. switching off lights, equipment, air-conditioning units, etc.).

Luminous healing space

A patient's interest in the physical environment is the first sign that healing has started. Over the past 30 years, scientific research has demonstrated that the physical environment affects the healing process. Better clinical outcomes can also be linked to the quality of the space where the patient is treated. The physical working environment also impacts on the wellbeing of health care workers. As the needs of various user and patient groups may differ, these differences need to be acknowledged and addressed in the design of health facilities.

Health facilities can thus be seen as healing environments where the building itself is part of the therapeutic setting and process. Healing environment elements are:

- » Access to external views;
- » Natural light and ventilation;
- » Reduction of noise;
- » Clear way finding;
- » Access to nature; and
- » Environmentally friendly materials.

A luminous healing space is a space where physical stressors for patients and staff are reduced to a minimum. This is all the more relevant given the stressful working conditions in the public health sector.

Lean design and construction

Sustainable and efficient health care infrastructure is only achievable through an integrated and collaborative design and construction process. Lean design and construction are the result of such a collaborative and integrated approach in infrastructure delivery. Lean is a management philosophy based on three tenets: continuous process improvement, reducing waste, and respect for people. In the design and construction of health facilities, activities, connections, pathways, and continuous improvements will be carefully considered.

Through the Infrastructure Delivery Management System (IDMS) it will be possible to apply lean design and construction principles in the delivery of healthcare infrastructure. Healthcare facilities will be built to increase patient and staff safety, while eliminating waste, reducing travel and waiting and lowering operational costs.

Applying lean thinking in a structured way to facility design can result in an environment that promotes continuous improvement, efficiency, safety, and better flow of information, supplies and services, keeping the emphasis on processes that add value to the patient experience.

Integration with ICT

The management of information has become an increasingly prominent component in the running of healthcare facilities. For this reason, clinical, safety and security, and other communication systems have to be part of the infrastructure design from the inception phase. Communication systems must be integrated into the design and construction for improving efficiencies and reducing redundancies, avoiding ad-hoc decisions in choosing between the different available technologies. This requires a more collaborative approach between the ICT component and the infrastructure unit.

Priority Setting

Infrastructure priorities will be informed by the service plans of Healthcare 2030. Structured mechanisms will be created in the Department to define capital and maintenance priorities and the sequencing of their implementation within the affordable limits of the budgets. This process will include infrastructure, other relevant support services such as strategic planning and the line function service managers.

Implementation Support

The portfolio of healthcare infrastructure in the Western Cape is vast and varied. Differing types of facilities, ranging from small rural clinics to Central Hospitals, need to be built, maintained, equipped, and at times decommissioned. Public sector infrastructure management and infrastructure delivery is a complex and multi-faceted set of processes and activities, conducted in an environment characterised by the scarcity of skills within an ever-changing mix of legislation and policies. Effective and efficient implementation requires rigorous and well-institutionalised structures, systems, and best practice, based on a consistent, effective, and agreed upon service delivery model, with clearly defined mandates, roles and responsibilities. All of these must be underpinned by appropriate and optimally placed personnel capacity, experience and skills.

The Western Cape Government Health infrastructure and technical management component has started the journey for improving the infrastructure and medical technology service through the implementation of the IDMS. This IDMS provides tools, systems, and processes for improved management of infrastructure programmes and projects.

Provincial Treasury Instructions 16b – Chapter 16B Supply Chain Management for the Delivery and Maintenance of Infrastructure – was issued on 01 April 2012 to regulate the implementation of the Standard for an Infrastructure Delivery Management System and the Standard for a Construction Procurement System. This is a seminal piece of legislation in that it recognises that procurement of capital and maintenance infrastructure projects requires different rules and regulations from goods and services.

The IDMS is structured around the following three core processes:

- i) Portfolio management which comprises the iterative process of identifying objectives, planning and grouping projects into infrastructure programmes and monitoring and controlling the roll-out of these programmes or projects;
- ii) Project management which involves the implementation of the projects identified in the planning processes; and Maintenance & Operations which comprises the maintenance and operation of assets through their life cycle and ultimate disposal.

iii) A control process – the “Infrastructure Gateway System” – provides a number of control points (gates) in the infrastructure life cycle where a decision is required before proceeding from one stage to another. Such decisions need to be based on information that is provided during the infrastructure life cycle.

The provision of infrastructure and technology will also be positioned as part of the integrated support services package to support service delivery aligned to 2030. There will be three main areas of focus: capital projects, maintenance of existing infrastructure and establishment of health technology to support patient-centred quality of care.

Monitoring and Evaluation

i) Monitoring of Capital and Maintenance projects

Infrastructure projects need to be tightly monitored for costs, quality of work and progress against timelines.

ii) Physical State of Infrastructure

Regular surveys will continue to be conducted to assess the state of the physical infrastructure in the Department. The findings will inform the priority setting for both maintenance and capital projects.

iii) Post Occupancy Evaluation

Continuous improvement will be ensured by the implementation of the post-occupancy evaluation process, which allows for improvement in the design and construction process and product, from both a technical as well as a functional point of view and, ultimately, informs how to “do better” in the next project. The continuous improvement process will also guarantee the pursuit for innovation in striving for operational efficiency and a better healing environment. The standard design will be regularly challenged and interrogated, and, where appropriate, updated to incorporate new ideas and fresh thinking.

Lessons learned from the design and construction of Khayelitsha and Mitchell's Plain hospitals, through the post-occupancy evaluation process, will be implemented for future projects. Health processes and workflows need to be understood fully, before casting the concrete, for enhancing the patient-centred care approach, as well as for efficiency and value for money. Organisational learning and continuous improvement through feedback by users are seen as key interventions for ensuring adequate provision of infrastructure.

SUMMARY POINTS

1. One of the most exciting developments is the realisation of the centrality of ICT as an enabler and the opportunities it presents in achieving the vision and objectives of 2030.
2. ICT will be mainstreamed within the generic processes of planning, budgeting, risk management, implementation, monitoring and evaluation in the department. This has served to systematically elevate the importance and focus of ICT in the minds of managers.
3. Business Intelligence:
 - » Good-quality information is an important prerequisite for the planning, implementation and M&E of the 2030 plan.
 - » Data Harmonization refers to the agreement, synchronization, and coordination of eHealth initiatives in the department to be able to inter-operate more effectively to achieve the goals of Healthcare 2030. The project focuses on Financial Business Intelligence and Clinical Business intelligence
4. Policy and Planning:
 - » ICT Governance : the Department will operate within the national provincial frameworks. ICT risks will be managed within the generic risk management processes of the Department.
 - » ICT Plans : There will be annual implementation and project plans to give effect to the objectives in the ICT strategic plan.
 - » Technology Refresh : Like all other infrastructure and technology, a systematic and affordable system and plan to refresh and maintain computers and associated hardware as well as disposal of old hardware in an environmentally responsible way, needs to be developed and implemented.
 - » IT Innovation : will transform the way we do business and needs to be encouraged and nurtured. Organisational arrangements need to be created that enables adequate responsiveness exploit the potential of innovation.
 - » Mobile Health : has enormous potential to advance the vision of Healthcare 2030 and the Department will undertake incremental steps to experiment in this regard.
5. Implementation Support:
 - » Data harmonisation at a patient level will enable better and

One of the most exciting developments is the realisation of the centrality of ICT as an enabler and the opportunities it presents in achieving the vision and objectives of 2030. ICT will play an important role in enhancing the integration of patient data and facilitating the continuity of care of patients across facilities in the system as well as over the life course of the patient. These developments give effect to the nub of the vision of 2030 i.e. improving the patient experience. By 2030, the generation of health workers will be very “techno savvy” and ICT will be an essential tool like the pen and paper of yester year.

There has been a renewed focus at the highest levels of the organisation to examine the challenges the department faces in this regard, the opportunities that advances in ICT present for Health and to develop a roadmap of priorities to 2030. To undertake this exercise, the department embarked on an ICT strategic planning session which marked an important milestone in the department. This was the first such session involving senior management and technical persons from the department, our partners such as Centre for e-Innovation (CEI), State Information Technology Agency (SITA) and the Universities.

The Department has recognised that ICT has been functioning in a parallel process without the due attention and systematic focus of management at various levels of the department. To remedy this situation, ICT will be mainstreamed within the generic processes of planning, budgeting, risk management, implementation, monitoring and evaluation in the department. This has served to systematically elevate the importance and focus of ICT in the minds of managers.

The National Department of Health is also strategically refocusing on ICT. A national eHealth strategic framework and the norms and standards that have been developed which provides useful pointers and guidelines to developing the provincial ICT strategy.

The rapid advances in ICT provide opportunities to significantly transform the way we do business in almost every section of the department and for the broader public in achieving the vision of 2030.

Business Intelligence

i) Good quality data

An important enabler to address the strategic direction of 2030, is the timeous availability of good quality data and information to make decisions that impact on the health service at all levels. This requires the building of an organisational culture that values and uses information and the strengthening of information management systems. The latter requires ensuring proper policies and processes, supportive information technology with optimal use of the opportunities that rapid advances in this area provide, and the strengthening of human resources competency and capacity.

Good-quality information is an important prerequisite for the planning, implementation and M&E of the 2030 plan. Annual institutional, district and provincial plans will be developed that will contain incremental steps and targets to give effect to 2030. A

integrated patient management, use of intergrated information for research and health services management.

- » Range of ICT opportunities identified at various levels i.e citizen,home and community based platform, health facility, management, support services
- » The electronic Continuity of Care Record (eCCR) is intended to foster and improve continuity of care across institutions and health professionals , reduce medical errors and ensure a minimum standard of securely shared health information.
- » The availability of skilled human resources is a prerequisite for the success of an eHealth project. The department will develop a strategy to ensure adequate human resource capacity and ICT technical capability.

6. The ICT M&E process, that will monitor progress on the roll out of ICT projects, will be institutionalised and mainstreamed in the Department.

core set of indicators is suggested to measure and report progress.

A clean audit on predetermined objectives (Information) is an important organisational objective. Institutionalising system improvements to address the audit findings will result in an overall improvement in the quality of data and information.

ii) Data harmonisation

However, there is a growing concern in the department that existing and new developments in eHealth are resulting in uncoordinated systems, duplicated efforts and unrealised potential. Interoperability and co-ordination is therefore urgently needed. The department is developing a framework of comprehensive policies and strategies to harmonize and consolidate eHealth in the province. Harmonization refers to the agreement, synchronization, and coordination of eHealth initiatives in the department to be able to inter-operate more effectively to achieve the goals of Healthcare 2030.

The project is built around two teams: Financial Business Intelligence and Clinical Business intelligence. The business intelligence focuses on aggregated reporting coming from different source systems (See diagram below).

Figure 17: WCDoh business intelligence framework

The department has further aligned the technologies and processes with the provincial ICT and BI Strategy in order to achieve the set goals by the Department. This means the project is robust and scalable and will allow a seamless integration with provincial systems.

Policy and Planning

i) ICT Governance

The Department will operate within ICT governance framework and policies of the national and provincial government.

The Department has revised the structure and function of the Departmental IT Committee (DITCOM). The Chairperson and Deputy Chairperson are senior managers who also represent the Department within the Central IT Committee of the WCG. Senior representatives from the line function services and strategic partners such as CEI and SITA are also represented. The main focus of the DITCOM is to provide strategic leadership and governance/ oversight of the ICT function within the health service. The DITCOM will provide regular feedback to the HOD and make recommendations for decision making.

The Directorate: Information Management provides the technical support to the DITCOM and manages the operational ICT function at a provincial level. This includes management and support of the various ICT projects, engagement with the line function services, as well as liaison with the partners (CEI and SITA). The district and facility managers are responsible for the ICT function within their jurisdiction.

ICT risks are managed within the general risk management processes of the Department.

ii) ICT Strategic and Operational Planning

The Department has developed an ICT strategic plan. This was amended in the light of the vision and principles and priorities of 2030. Given the recognition of the increasing centrality of ICT to health services and the ownership by management at various levels, the planning, budgeting, risk management, implementation and monitoring and evaluation of IT in health will be systematically incorporated into these generic processes within the Department. This will ensure that ICT secures its due attention and focus towards 2030. There will be annual implementation and project plans to give effect to the strategic objectives in the ICT strategic plan.

iii) Technology Refresh

Computers have become a basic tool to do one's work at all levels of the organisation. Like all other infrastructure and technology, a systematic and affordable plan to refresh and maintain our computers and associated hardware need to be developed and implemented. The WCG has adopted a policy position that all computers older than five years should be replaced.

The department needs to put in place an integrated system that connects the DITCOM approval, procurement and payment and asset register systems to enable an institutionalised database that identifies the hardware that requires replacement at each institution/section annually and allow for proper planning, budgeting and replacement.

A systematic process also needs to be put into place for the responsible disposal of old hardware.

iv) IT Innovation

ICT is one of the most rapidly developing fields of our time and has the capacity to transform the way we do business in Health. Innovations are being developed within increasing frequency both within the Department as home-grown solutions to service challenges, as well as by external parties.

The Department needs to have its vision for the ICT enabled health service consolidated that provides a compass against which innovations can be assessed. Organisational arrangements need to be created that enable adequate responsiveness to exploit the potential of innovation. This should include amongst others, appropriate structures, technical capacity, systems and processes and criteria to screen, assess and make recommendations to the Department on which innovations would be cost effective to adopt.

Important aspects such as security and confidentiality of patient data, implications for the network and bandwidth, cost implications, inter-operability all need to be robustly investigated. Notwithstanding these challenges, innovations will be encouraged within these parameters given its potential to improve efficiency, effectiveness and the quality of care.

Other Priorities

i) Mobile Health Technology

Mobile technology commonly used for cellular communication has evolved considerably over the years from providing capability for just a voice communication between two cellular phones to creating a mobile device able to carry & transfer large volumes of data, providing instant access to the World Wide Web, providing instant messaging and Global Positioning System (GPS) capabilities. Mobile Technology now ranges from smart cellular phones, tablets, iPads, Personal Digital Assistants (PDAs). The penetration of mobile technology, especially cell phones, within all sections of the South African population is estimated close to 90%. This development has created massive opportunities for m-Health, which is defined as the use of mobile technology in Health, especially as it aligns directly with the key vision of a patient centred approach and the delivery of quality health care for all.

Various pilot projects and studies internationally have shown the potential application of M-health technology in a range of areas. These include, amongst others:

- » Creating public health education and awareness through messaging;
- » Remote Access to health training materials;
- » More efficient data capturing and reporting;
- » Enabling patient complaints and feedback in real-time;
- » Promotion of public health campaigns; and
- » Sharing of health and patient related information between health professionals.

The Department looks forward to optimising the use of M-Health in achieving the vision of Healthcare 2030

The WCG has conducted a pilot to learn lessons in the management of mobile devices within the public sector and is in the process of finalising a provincial policy in this regard. The policy will provide a framework within which Departments could use this exciting opportunity. It will cover a range of issues such as data security, patient confidentiality, roles and responsibilities, access to government networks, options such as government owned devices and privately owned authorised for business use.

The Department has already embarked upon pilots and small scale projects using m-Health and social media. The Department has a Facebook page and Twitter account. More recently, a project has been launched to enable patients to complain about the service in real time to a central line. A substantial proportion of the complaints were satisfactorily resolved within hours and feedback provided to patients. This project will be rolled out.

Implementation Support

i) Integrated patient data

The department will use an enterprise patient master index (PMI) to maintain consistent, accurate and current demographic and essential medical data on the patients seen and managed within its various clinical domains. The patient is assigned a unique identifier that is used to refer to this patient across the department. The objective is to ensure that each patient is represented only once across all the software systems used within the department. The essential patient data includes name, gender, date of birth, race and ethnicity, ID number, current address and contact information, insurance information (if applicable), current diagnoses, most recent date of hospital admission and discharge, etc.

PMI will also solve the common problem where multiple systems across the department gradually became inconsistent with respect to the patient's most current data when the patient's information changes, and only one system is updated, i.e., the changes are not propagated to the others.

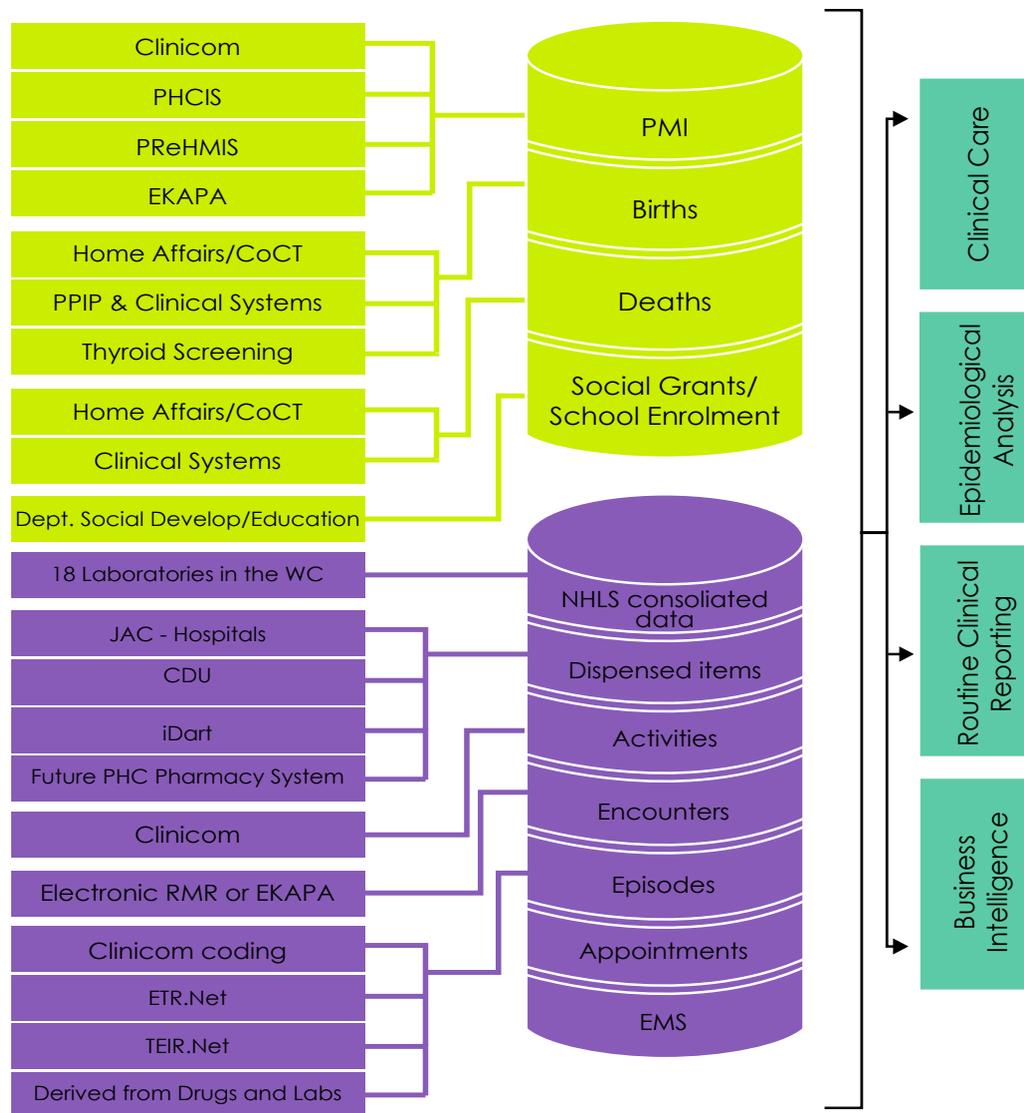
By correctly matching patient records from disparate systems and different clinical domains, a complete view of a patient may be obtained. A summary of all pertinent patient data will be available in one place to support the continuity of care. At a minimum, the single patient view will include demographics, vital signs, a problem list (including current and past conditions), a medication list, past laboratories and other diagnostic tests for the patient, vaccinations and immunizations, risk factors, other relevant measures (e.g. number of cigarette packs smoked per day), consults and education, referrals, notes, and reminders. These data items will be densely displayed so that they fit into one screen (without the need to scroll) or onto one piece of paper.

With this complete view, numerous benefits may be realised including:

- » Integrated clinical data from different systems will allow for better patient care across institutions by different health professionals;
- » Provides one consistent and accurate identifier, which links all disparate identifiers;
- » Standardises patient demographic data by providing one authoritative central reference point;
- » Improves response times when searching for patients;
- » Reduces duplicate records and shared identifiers; and
- » Historical care related information can be obtained from across the department.

The diagram below depicts the ideal state for all patient level data that will in essence enable the following reporting structure: Clinical Care Viewer, Epidemiological Analysis, and Routine Clinical Reporting. All of this will then feed into the Business Intelligence layer which is aggregated by cost centre code for further corporate reporting: Functional Business Unit, Monitoring and Evaluation, Quarterly Performance Reporting, Annual Reporting, National data submission, Enterprise Project Management, etc.

Figure 18: Data harmonisation - integration of patient level data



ii) ICT Opportunities to achieve person-centred care

Advanced information technology provides the department with the opportunity to improve patient care by streamlining clinical processes and creating a seamless flow of information. Currently, some facilities in the province are still using paper-based records to record a patient's receipt of health care services. Unfortunately, the use of such records leads to the inadequate documentation of the care-giving process, a severe disruption in the flow of patient related information, and a substantial delay in the delivery of health care services. Advanced information technologies - such as computer-based patient records, mobile devices, and expert information systems - alter this situation by providing clinicians with real-time access to patient information at the point of care.

Some of the main opportunities provided by advances in ICT and e-Health are listed below:

Opportunities to become citizen-centric

- » A health services directory that provides basic information on services and facilities throughout the province will be available on the internet and therefore mobile phones.
- » A Health help line could be created to assist with basic enquiries and first aid advice.
- » The emergency call numbers for ambulances, fire, police etc. will be made available more widely and be easily accessible or integrated on cell phones.
- » The GPS location of the original call could assist the Emergency services with getting to the address of person requiring help. This is particularly useful in the informal settlements where street lighting, street names and house numbers are often poorly developed.
- » The plans and performance reports of the Department could be made available in a user-friendly language to enable broader consultation and accountability.
- » Vacancies and tenders could be advertised on the web and the public could similarly submit their applications electronically.

Opportunities within Home and Community based care

- » The community care worker (CCW) could have access to patient records which are password protected to be able to effectively engage with the household members. This will also assist with referrals both to and from the facilities where the referral or discharge summary could be available on a mobile device. The unique patient number (PMI) is key to enabling this functionality. This enables the continuity of care across the service platform that is a key element of person-centered experience.
- » There would be easier storage and retrieval of CCW's own notes when visiting a household.
- » All the data of the CCW's home visits could be loaded directly onto their cellphone and transmitted to their supervisor. This will drastically cut down time spent on administration and free up more time for direct patient care. It will also provide auditable tracking of data and make for easier and quicker reporting.
- » Clinical algorithms on their mobile devices could assist the CCW with making decisions in their management of patients.
- » There would be more efficient communication between the professional nurse supervisor and the CCWs.

Opportunities within Health facilities

- » A summary of all pertinent patient data will be available in one place to support the continuity of care. (See Integrated patient data above)
- » If data have to be entered in manually in one database, they should never have to be entered again. All or most health *ICT systems will be interoperable across the health platform using the unique patient identifier* to enable primary care to connect to emergency medical services, emergency centres, general hospitals and vice versa. There is a clear need for having data from the continuum of care available for the effective management of patients.

- » The referral and discharge processes are key opportunities in the patient's journey where health care providers can contribute to continuity of care, as well the recording and capturing of vital information about the patient encounter, such as the ICD codes. A *standardised electronic record for discharging and referring* patients from hospital will be developed.
- » An electronic document system namely *Enterprise Content Management (ECM)* offering clinical documentation including clinical notes, care plans, clinical correspondence, and discharge information will be rolled out. This is intended to provide an electronic version of the historic paper records. This will enable safer storage and easier retrieval of patient folders as well as enable the communication of patient notes between health professionals and different facilities.
- » Out partners in the NHLS are implementing a new tracker system for lab results that will be inter-operable with Clinicom and PHCIS that will enable the efficient digital flow of lab results of a patient across the platform.
- » The Department will be modernising its radiology and imaging service starting in the larger hospitals with implementation of the Picture Archive and Communication Systems (PACS) and Radiology Information Systems (RIS). This will enable the efficient flow of digital images across institutions, easier storage of and access to images and doing away of x-ray films and the need for darkroom development. A radiologist could now centrally provide reports to more remotely placed referring institutions.
- » The Pharmacy System is currently built around a stock management system for the Pharmacy Department. The Department will be testing the feasibility and affordability of electronic patient-level prescribing and administration. The system will, amongst others, overcome illegible handwriting of prescribers, provide back-up systems to alert the prescriber to potential drug interactions, provide clinical audit trails of who and what was prescribed and dispensed which will be captured as part of the single view of the patient record described above.
- » There are a range of other smaller systems operating within hospitals such as theatre management and maternity that will be reviewed to ensure inter-operability and consistency within the broader ICT strategy to enable 2030.

Opportunities within Support Services

- » *Functional Business Units (FBU)* is a system of decentralised management at hospital level within the department. Establishing a FBU system is a strategic imperative of the department as is the creation of a central capacitated support structure in order to assist hospital management with the implementation and maintenance of this system. There will be ICT systems that will enable timeous and standardised reports to all relevant FBU managers. Utilising Business Intelligence will allow for reporting of financial, performance and efficiency data in line with the performance plan for the hospitals at FBU level.
- » Various budget *administrative and financial management processes will be automated and decentralised* to improve local management and accountability, better efficiency and reporting. This will include instruments such as the Budget Management Instrument (BMI) and the Approved Post List (APL) that will continue to be improved upon and firmly institutionalised to ensure that optimal control of expenditure within the allocated budgets at a decentralised level.
- » ICT will enable the *HR intelligence* required for effective strategic human resource management. Collecting, processing, and managing HR data and information will facilitate strategic decisions for forecasting, planning, recruiting, promotion, evaluation, and developing key human resources at all levels of the department.
- » ECM can improve the efficiency with the corporate and administrative functions of the Department.

iii) Continuity of care

The department has piloted an electronic Continuity of Care Record (eCCR) in response to the need to organise and make transportable a set of basic information about a patient's health care that will be accessible to clinicians. The eCCR is intended to foster and improve continuity of care across institutions and health professionals, reduce medical errors and ensure a minimum standard of securely shared health information.

The eCCR is a patient health summary or a way to create flexible documents that contain the most relevant and timely core health information about a patient, and to send these electronically from one caregiver to another. It contains various sections (such as patient demographics, insurance information, diagnosis and problem list, medications, allergies, care plan, etc.) that represent a "snapshot" of a patient's health data that can be useful, even lifesaving, if available when patients have their next clinical encounter. The eCCR was designed to permit easy creation by a clinician using an electronic health record software program at the end of an encounter. The eCCR also has the ability to be printed out in user-friendly paper formats, such as PDF and Microsoft Word.

It is very important that eCCR used in doctors' offices are able to "talk to" one another and share important clinical information: otherwise each doctor's office or clinic is simply an island of data without the means of accessing or exchanging the stored patient information it contains. Patients do not gain much from the use of eCCR if their personal health information cannot travel with them from care setting to care setting. Hence the eCCR needs to be both portable and interoperable to make it useful for clinical staff.

The main benefit of the widespread use of the eCCR will be the improvement in the quality of care that results from summary patient health information being accessible when treatment and diagnostic decisions need to be made. Safety of care will also be improved, as patients and doctors benefit from immediate access to patients' lists of medications and dosages, allowing all parties to avoid the sometimes very dangerous duplication of medications and other kinds of errors associated with illegible or incomplete medicine information. Finally, the department feels that the eCCR will have a significant impact on efficiency, as errors due to missing or incomplete health information can be costly to patients, providers and funders.

iv) ICT Human Resource Capacity

The availability of skilled human resources is a prerequisite for the success of an e-Health project. e-Health is not simply about equipment and telecommunications - it is people who make the difference.

The department will develop a strategy to ensure adequate human resource capacity and ICT technical capability. For new projects being developed and implemented, business analyst and ICT project management skills are essential. A key function of the project manager, over and above managing all aspects of the project itself, is the ability to manage the interface in a user friendly manner between the ICT vendor or partners such as CEI/SITA and the health providers within the Department.

Development of new programmes and enhancements of current software applications and systems is another critical capacity that requires strengthening within the WCG at large. While client departments are not allowed to employ their own programmers, the ability of CEI to respond to the needs of the health service is important.

Existing systems will have a system administrator, controller and owner that manage the maintenance of the system. The department will explore the possibilities of pooling these resources across systems to acquire efficiencies. An institutionalised system of ICT support per district will also be explored with CEI.

Training of staff within the health service on an on-going basis is important to be able to manage the basic challenges and support the systems especially at local level. All healthcare professionals should have access to basic ICT training facilities to improve their skills and foster positive attitudes towards information technology.

The Department will also strengthen its relationship with CEI and SITA. Clear deliverables will be identified annually and included in a service level agreement with our partners. This will enable better planning, allocation of resources and accountability for results

Monitoring and Evaluation

ICT has become one of the most important priorities that can enable the vision of Healthcare 2030. The projects to roll out of various systems and software applications need to be closely monitored from a cost, quality and progress against timelines point of view. Tools such as dashboards will be created to give effect to this. The ICT M&E process will also be institutionalised and mainstreamed in the Department.

HEALTH PROGRAMMES

SUMMARY POINTS

1. Health Programmes focus on a number of priority health conditions that cause a significant burden of disease in the Western Cape Province. They provide strategic and technical support to the health service delivery platform so as to optimise the health sector response to this burden.
2. The priority programmes that have been identified in the short to medium term are HIV, TB, Child Health, Women and Maternal Health, Mental Health and Chronic Diseases. These priorities will be reviewed over time.
3. Health Programmes must work closely with other support services such as information management, strategic planning, health impact assessment, line function services and external partners to be able to effectively add value and carry out its mandate.
4. Policy development: This will focus on the priority areas identified above. Policies will be developed within the province or translate national (or international) policies and adapting them to local circumstances, which might include differences in the burden of disease, resource constraints, conflicting local priorities, etc.
5. Planning: The specific Health Programme Plans will have objectives, targets, outputs and often earmarked funds relevant to the defined programme priority. There is an important need to achieve cohesive thinking and alignment between the health programme planning and the various other planning processes in the Department.
6. Implementation Support : The need for and kind of implementation support are usually identified through engagement with the district and other services. This includes amongst others, technical analysis to support decision making, development of planning and M&E frameworks, ensuring training priorities are addressed, development of communication tools and messages, development of standard operating procedures, guidelines and user manuals, support resource planning and management.
7. M&E : Health Programmes will provide the technical expertise to identify appropriate data and indicators to measure progress in the priority programmes. They will also help with the provincial collation of data, analysis and public health intelligence during the quarterly and annual M&E review sessions.

There are a number of health conditions that cause a significant burden of disease in the Western Cape Province and as such have been deemed priority conditions. Health Programmes will be structured accordingly and provide strategic and technical support to the health service delivery platform so as to optimise the health sector response to this burden. The priority programmes that have been identified in the short to medium term are HIV, TB, Child Health, Women and Maternal Health, Mental Health and Chronic Diseases. These priorities will be reviewed over time and revised in the light of any changes in the burden of disease patterns facing the population in the province.

The tension between a vertical programme structure and integrated service delivery must be managed on an ongoing basis. The needs of the service will primarily determine the support that is required. This will be tailored to meet the locally specific requirements of the service that may vary from district to district. Health programmes will also provide strategic direction and the national and provincial policy framework within which services should operate. The role of Health Programmes can be essentially categorised into policy development, Programme planning, implementation support including co-ordination, monitoring and evaluation. Health Programmes must work closely with other support services such as information management and strategic planning and health impact assessment, line function services and external partners to be able to effectively add value and carry out its mandate.

Health programmes are created around priority conditions within the burden of disease that impact on the health of the population

The National Department of Health is also be considered a 'client' of health programmes, given that health programmes has historically played a mediating role between national policy and national strategic directives and the implementation thereof via the operational arm in the province.

Policy development and translation

Policy development will focus on the priority areas identified above. Policies will developed *ab initio* within the province or translate national (or international) policies and adapting them to local circumstances, which might include differences in the burden of disease, resource constraints, conflicting local priorities, etc.

All relevant role players, especially the clinical staff and local management will be ultimately responsible for its implementation, are involved in the development of policies. The use of clinical and public health expertise and best available evidence are critical to good policy development.

Planning

Health Programme planning is the process of setting goals and objectives, developing strategies, and setting of specific measurable milestones and targets. The specific Health Programme Plans will have objectives and targets relevant to the defined programme priority. These plans are required to be able to focus on programmes priorities and often account for the spending of earmarked funds and the outputs achieved. Examples of such requirements are the HIV business plans for Global fund and the Division of Revenue Act (DORA).

The Departmental Plans such as the annual performance plan and district health plans are comprehensive service plans that are all encompassing and will include high level programme priorities and indicators. Thus there is an important need to achieve cohesive thinking and alignment through the various planning processes and to also keep it simple and less onerous as possible. The opportunity costs of duplicated efforts in planning (and reporting) is a reduced focus on implementation.

The planning within Health Programmes will be guided by a range of national and provincial policy and strategic frameworks. Examples include Healthcare 2030 in the province and the National 10 year Chronic Disease strategy and the National HIV/TB strategic plan.

The Department will also be developing annual operational plans that contain the micro detail at institutional or district level to give effect to broader plans and priorities of the Department.

The responsiveness of Health Programmes to the need for support by line function services will be re-examined in the light of the vision and priorities of Healthcare 2030.

Implementation support

Implementation support generally refers to support with policy implementation or statutory financial requirements or support with quality improvement cycles. The need for and kind of implementation support are usually identified through engagement with the district services or at M&E sessions when failure to achieve targets are identified.

The responsiveness of Health Programmes to the need for support by line function services will be re-examined in the light of the vision and priorities of Healthcare 2030. The review will include organisational culture, availability of technical capacity, clarification of roles and responsibilities, collaborative relationships and cross functionality with other sections within the Department and external strategic partners and most importantly the value add and modus of engagement with the line function services.

Some of the current areas of support provided, in close collaboration with the services, will include:

- Technical analysis and support informing decision making;
- Planning and Monitoring and Evaluation frameworks;
- Develop Standard Operating Procedures, Guidelines and User Manuals;
- Identify and ensure training priorities are addressed;
- Resource planning and management tools; and
- Communication tools and key messages (Health Promotion).

Monitoring and evaluation

The key function for programmes is evaluating the effectiveness of services, the outcomes and impact these have on the health and wellness of the population. Health Programmes will provide the technical expertise to identify appropriate data and indicators to measure progress in the priority programmes.

The quarterly and annual M&E sessions are important to assess the Department's performance against targets and identify the challenges that services face in this regard. This in turn informs the implementation support required as well as the planning priorities for the next cycle.

The Department will also increase its technical capacity and work in collaboration with HEIs and other research agencies, to undertake evaluations of key priority areas to assess the impact of its interventions on the envisaged health outcomes of Healthcare 2030. This is an important process to more robustly identify underlying structural and system challenges that need to be addressed.

COMMUNICATIONS

SUMMARY POINTS

1. Good communication is an essential ingredient to a vibrant, well-performing organisation that has a shared vision, focussed on its goals and committed to person-centred care. It's the basis of building strong and trusting relationships between all levels and categories of staff within the Department, between the health care providers and patients and between the Department and its strategic partners. The importance of good, two way communication cannot be emphasised enough.
2. The rapid advances in ICT have significantly impacted on communication. The speed with which we can communicate information, receive feedback and address issues has dramatically improved. Regretfully the trade off has often been the poor quality of communication, the perception of not feeling listened to and understood and failure to establish good, meaningful rapport.
3. Communication will receive constant and systematic attention for the Department to be able to achieve its intentions within Healthcare 2030. It should also be recognised as everyone's business and not the preserve of the Communication Officers in the Department.
4. Policy and Planning:
 - » Roles and responsibilities:
The primary responsibility for communication, especially its content, lies with management at all levels of the Department. The Communication Officers play a supportive role and assist with messaging, the choice of an appropriate medium, layout and design of written communication, compliance with branding

Good communication is the essential ingredient to a vibrant, well-performing organisation that has a shared vision, focussed on its goals and committed to person-centred care. It's the basis of building strong and trusting relationships between all levels and categories of staff within the department, between the health care providers and patients and between the department and its strategic partners. The importance of good, two way communication cannot be emphasised enough.

Good communication is everyone's business.

Communication happens in every transaction every day be it in the one-to-one interactions between staff or between staff and patients, in meetings, through our telephone conversations, documents, emails and more recently with the social media such as Twitter, Facebook and other messaging systems. While there is no shortage of opportunities to get it right, it's the one area that is constantly complained about as being inadequate.

The rapid advances in ICT have significantly impacted on communication. The speed with which we can communicate information, receive feedback and address issues has dramatically improved. Regretfully the trade-off has often been the poor quality of communication, the perception of not feeling listened to and understood and failure to establish good, meaningful rapport.

This is an area that will receive constant and systematic attention for the Department to be able to achieve its intentions within Healthcare 2030. It should also be recognised as everyone's business and not the preserve of the Communication Officers in the department.

The department will also explore the optimal mechanisms to communicate Healthcare 2030 to the broader community in the province, as its important for the user population to understand the strategic direction of the department.

Policy and Planning

i) Roles and responsibilities

The primary responsibility for communication, especially its content, lies with management at all levels of the Department. The Communication officers play a supportive role and assist with messaging, the choice of an appropriate medium, layout and design of written communication, compliance with branding requirements of the WCG and the logistics.

Communication for the Department is centralised through the Directorate Communications. However, the Communications Officers are actually based in the various districts and institutions. This hybrid model allows the Communication officers to be in

requirements of the WCG and the associated logistics.

- » Health promotion: Communication for Health promotion will be driven by Health Programmes in collaboration with Communication officers and line function managers.
- » ICT opportunities: Advances in this field have exploded and hold enormous potential for doing communication differently.

5. Implementation Support:

- Communication and listening to patients includes an SMS hotline for feedback in real time
- Interpretation service for foreign and local languages
- Communication and listening to staff

6. M&E: The Department will regularly dipstick the effectiveness and quality of communication both within the organisation as well as with external parties such as the media and strategic partners.

constant touch with the local service, understand the issues, develop strong relationships with the local staff and management and be more responsive to their needs. The Directorate works closely with the Office of the Premier to align with broader communication policies of the WCG.

ii) Health Communication/Promotion

Health communication, be it communicating medical information or health promotion refers to communication strategies, methods, programs, and interventions to inform, create awareness and influence individual and community decisions to improve wellness. It is important that the language is appropriate and free of medical jargon. The intended outcomes of health communication includes:

- » increasing knowledge and awareness of a health issue;
- » influencing behaviours and attitudes towards a health issue;
- » demonstrating healthy practices;
- » showing benefits of behaviour changes to public health outcomes;
- » advocating a position on a health issue or policy;
- » increasing demand or support of health services; and
- » arguing myths and misconceptions related to health.

This function will collaboratively be undertaken by Communication officers, Health Programmes and line function managers (See also section on Health programmes and HCBC)

iii) ICT Technology opportunities

The explosion of new Internet communication technologies, particularly through the development of various health websites, online support groups, web portals, TV programmes, electronic health records, social networking and mobile devices has created enormous opportunities to improve communication at all levels. The internet have resulted in fundamental changes in how the citizens approach their basic needs for information and communication. The rapid adoption of electronic communication is reflected by, amongst others, instant messaging, blogging, photo sharing, social networking, and video downloads. The Department together with its ICT partners in WCG will be exploring these opportunities to advance the objectives of Healthcare 2030 and will have dedicated Facebook, Youtube and Twitter sites as well as applications for smart phones.

The Department will set up an online health web-platform hosted on the current website where clients of all literacy and education levels can retrieve various health related information largely free of medical jargon. This platform will be managed by a content/web-developer who can instantly respond to citizens who submit queries for information on the website.

Implementation Support

i) Communication with and listening to Patients

Good communication and listening to patients is a core element of person-centred care and is a means to avoid errors, improve quality and achieve better health outcomes. The primary site for this to effectively happen is during the interaction between health providers and patients. This is discussed in greater detail under the section on quality improvement: voice of the patient.

Finding more meaningful ways to receive frequent feedback from patients is important. This will be done through the Health Hotline which is set-up as a quicker means of feedback and complaint resolution. Analysis of the aggregated results informs the Department of "what works" and "what does not work". Complaints should not be viewed negatively but rather as constructive feedback and opportunity to improve the service. The mindset shift should change from "what's the matter with our clients" to "what matters to our clients".

Other specific areas of communication with patients that will be addressed include the appointment of frontline marshals to be in constant communication with and help patients in waiting rooms at health facilities, installation of digital notice boards to communicate waiting times, entertainment through informative, educational and fun in-house radio or TV broadcasts.

The enormous potential of cellphone technology in improving services is discussed under the section on ICT. This includes informing patients of changes in appointments and health promotion messaging.

ii) Interpretation service

In recent years, the demographic composition of the population in the Western Cape has changed significantly. The migratory patterns are predicted to continue well into the future. A sizable population also only speak foreign languages.

To facilitate the communication between health worker and client, the Department will continue to expand its Telephonic Interpretation service. This service ensures clients can receive consultation and information from the health professional in their mother tongue through an interpreter, who is connected via telephone. This service currently caters for 30 languages and it is the Department's intension to have this service available at the majority of health facilities by 2030. Additionally, the Department will also move towards making documentation and material available in braille, audio format and "talking screen" software on computers to ensure the visually impaired have access to the relevant information they need. The availability of sign language services for the deaf will also be explored.

iii) Communication with and listening to Staff

Inadequate communication has been constantly raised by staff through the Barrets survey in recent years. Management at all levels need to find creative ways to regularly receive feedback, listen to the concerns and ideas of staff and generally improve communication at the local level.

Monitoring and Evaluation

It is important for the Department to be able to regularly dipstick the effectiveness and quality of communication both within the organisation as well as with external parties such as the media and strategic partners. The Department will tap into a range of sources including the Barrets and staff satisfaction surveys of staff, patient complaints and patient satisfaction surveys as well as more frequent, informal feedback. The findings should form the basis for continuous improvement.



SECTION I: **MONITORING AND EVALUATION**

SECTION I: MONITORING AND EVALUATION

SUMMARY POINTS

1. There is a need to strengthen support for M&E and to enhance the culture of continuous improvement for all levels and components of the organisation so that information is collected primarily to empower staff to continuously improve health outcomes, the patient experience and health-system efficiency.
2. The Triple AIM framework which identifies key dimensions for optimising health system performance will be used by the Department to monitor and evaluate the implementation of the 2030 strategy. These dimensions are:
 - » Population health outcomes;
 - » Health services taking into account acceptability, appropriateness, access, quality, equity, effectiveness, patient-centredness; and
 - » cost efficiency in service delivery;
3. The culture of M&E and continuous improvement is important for health system strengthening will be encouraged through:
 - i. Improving the quality of information collected;
 - ii. Deepening capacity to use and collect information;
 - iii. Ensuring leadership and accountability; and
 - iv. Widespread sharing of best practice.
4. Role of Research :
 - » Health research is critical to understanding the well-being of the population, the burden of disease, its associated risk factors and populations at highest risk as well as the performance of the health system with regards to access, quality, efficiency and impact.
 - » Key strategies to improve

Vision 2030 describes the health strategy for the province and emphasises the documented changes in health outcomes as the key indicator to monitor the impact of this strategy. The assessment of this impact requires the accurate and timeous measurement of changes in population health outcomes and the associated risk factors, including social determinants. Similarly the changes made in the health system in the areas on leadership and governance, human resources, finances, infrastructure, commodity (medicines, tests, supplies) management, information management also require accurate documentation in order for their effect to be assessed.

There is a need to deepen the importance of Monitoring and Evaluation (M&E) and enhance the culture of continuous improvement for all levels and components of the organisation such that information is collected primarily to empower staff to continuously improve health outcomes, the patient experience and health system efficiency and, secondarily, for reporting to the next level of authority.

The annual operational plan with specific targets for the incremental realisation of the 2030 objectives will also be monitored.

The Department will use the Triple AIM framework in its monitoring and evaluation processes related to their 2030 strategy. The Triple Aim framework was developed by the Institute for Healthcare Improvement (IHI) and identifies key dimensions for optimising health system performance as follows:

- » Population health outcomes;
- » Health services (acceptability, appropriateness, access, quality, equity, effectiveness, patient-centeredness); and
- » Cost efficiency in service delivery.

The Department will develop an integrated rich picture based on the dimensions described above and using data from within the health service as well as external sources and research. Noting the impact of social determinants on the health and wellness of the population, the need for information systems that triangulate with other departments and sectors is crucial.

Monitoring and Evaluation of Population Health Outcomes

The Department will be monitoring mortality, morbidity, quality of life and risk factor indicators, which include social determinants, to identify areas for intervention to prevent and address the disease burden and the consequences thereof.

A mortality surveillance system that links information from death notification and forensic pathology records has been developed and is being institutionalised. The use of relevant technology will be maximised to improve the quality and timeliness of information. The data from the mortality surveillance system will be used for the planning of interventions at local and provincial level for health sector and inter-sectoral action to improve health outcomes.

The vision for 2030 is to have a provincial web-based mortality surveillance system accessible to all health practitioners in the public and private sectors who notify deaths. This system will have multiple purposes that include statutory reporting requirements of deaths to the Department of Home Affairs, surveillance, monitoring and evaluation. Accessibility to this data will be protected by strict

research in the Department would include:

- Building a culture of using research to improve services;
- Development and dissemination of a research agenda;
- Capacity development to use and conduct research;
- Structured processes to collaborate with researchers; and
- Translation and dissemination of research findings into policy and practice.

5. Preliminary indicators to assess progress in implementing Healthcare 2030 and its impact on health outcomes are tabled. The indicators and targets of the National Development Plan will also be incorporated in the M&E framework.

6. The aim of the M&E approach is to improve decision making to improve services by using reliable information to measure the burden of disease, quality of life and the health system performance. The approach must also support the process of whole system change and allow for real time learning & feedback.

7. Strategic partnerships with academics would be essential to finalise process and outcome measures and methodologies that can prompt action, and document and track how Healthcare 2030 actually influences practice on the ground during implementation.

governance processes to ensure respect for patient confidentiality and will be governed by the principles of the Declaration of Helsinki developed by the World Medical Association.

Morbidity-, risk-factor and quality-of-life surveillance systems will be implemented at the following levels:

- » Community-based level through the periodic household profiling by the PHC outreach teams;
- » PHC level through the routine collection of national-and provincial indicator data sets;
- » Hospital level through the universal coverage of ICD-10 coding and monitoring, in particular the trends for avoidable hospitalisations that could have been prevented by improved health services at primary level or the prevention of risk factors (e.g. smoking); and
- » All levels: notifiable medical conditions.
- » The use of relevant technology that includes mobile devices will also be maximised.

The Department will enhance its public health intelligence by being constantly aware of the public health research and data put out by HEIs and allied organisations. This will help to build and monitor the rich picture of public health in the province that needs to be addressed.

Monitoring and Evaluation of Health Services

Healthcare 2030 is based on the principles of patient-centred quality of care, equity, outcomes, PHC principles, strong district health systems, affordability and cost efficiency. Patient-centred quality of care will be evaluated using the departmental framework as described in this document. The Department will explore a patient-centred quality of care index that can be developed, monitored and routinely published to be accessible to the public. Equitable access, health outcomes will be monitored for the population at large and, in particular, for vulnerable populations like children, the elderly, the disabled, and the poor based on the prevalent burden of disease profiles; the DHS and the PHC principles will be evaluated according

to the extent to which the set principles are met in line with the World Health Organisation definitions.

Integrated information that draws on data from, amongst others, HR, Finance, Health services (patient outputs and outcomes) will enable a more systematic and holistic assessment of the performance of the health system. Within the context of a growing burden of disease and diminishing resources, the health system analysis would ensure that resources are most efficiently and effectively used for the greatest impact on the burden of disease and the realisation of Healthcare 2030 principles of access and equity in particular.

Monitoring and Evaluation of Cost Efficiency

The growing burden of disease is not often aligned to the available financial resources. Thus, in as much as the 2030 strategy is to prevent disease and its consequence, it also aims to ensure that the scarce financial resources result in maximum benefit and the best value for money. The aim is to balance the inputs provided such as money, people, infrastructure or equipment against either intermediate outputs of headcounts, inpatient days, waiting time, etc. or final health outcomes such as reduction in premature mortality and improvements in the quality of life.

Three areas of efficiency will be measured in the province and these are technical, productive, and allocative

efficiency. Technical efficiency refers to the efficient use of particular inputs for a specific outcome – e.g. assessing the extent of rational prescribing of medicines to receive maximum benefit without prescribing unnecessary drugs or incorrect dosages for incorrect periods. Productive efficiency results from alternative interventions being compared that have different costs and produce the same or improved health outcome with less or more of a particular resource. Allocative efficiency refers to the equitable distribution of outcomes within the broader community. It aims to inform resource allocation decisions at a population level.

Health Economics capacity will be increased in the department to complement the financial management monitoring systems and deepen the analysis and understanding of the impact of the allocation of resources on Healthcare 2030 principles such as health outcomes, access and equity.

Information and Continuous Improvement

Improving Leadership and Accountability

In this area the Department will ensure the following:

- » Effective leadership at all levels to instil the culture of continuous improvement;
- » The inclusion of specific performance standards for all staff that are aligned with achieving the Triple Aims;
- » Continuing with departmental M&E meetings led by senior managers at all levels of the system to review achievement of results;
- » The dissemination of information using dashboards, league tables to staff, patients and communities;
- » The strengthening of community governance structures (health committees, hospital boards) to engage with M&E information and support the collaboration between the services and communities for continuous improvement;
- » Widespread communication and celebration of successes and innovations with staff and external stakeholders, with a reflection of challenges and plan of action to address these; and
- » The use of evaluation processes at three to five yearly intervals to evaluate outcomes and the impact of implementing 2030 that will contribute to the understanding why successes occurred when they did and why failures occurred, what lessons could be learnt and how these could be addressed.

Improving the Quality of Information

A key requirement in improving the culture of M&E and continuous improvement is the quality of information. This includes:

- » The identification of key indicators to assess the dimensions of the Triple Aim Framework that is relevant, actionable, valid, easy to collect and sensitive, so that changes in performance can easily be identified;
- » The development of data-collection- and data-management processes that make use of the relevant technology to minimise the transactional and opportunity costs that can adversely affect the patient experience and health outcomes; and
- » Robust interpretation and analysis of the information (from all data including research) to provide actionable recommendations for continuous improvement.

Improving Capacity

The following steps will be taken to improve capacity for M&E and continuous improvement in the system:

- » Ensuring an adequate number of people who are competent in M&E at all levels of the organisation;
- » Empowering staff to be part of the solution and to generate innovations for continuous improvement;
- » Incentivising continuous improvement and the development of innovations throughout the organisation; and

- » Partnering with academic institutions and non-governmental organisations to support M&E and research capacity in the Department, in particular to support process evaluations to understand how implementation could be improved.

The role of research

Health research is critical to understanding the well being of the population, the burden of disease, its associated risk factors and populations at highest risk. It also provides the evidence for the most cost effective interventions as well as the performance of the health system with regards to access, quality and impact. A robust and rounded understanding of the health system requires an inter-disciplinary approach that includes, amongst others, clinical disciplines, public health, health economics, management and social sciences to allow the evaluation of a wide range of interventions from clinical health services to organisational culture change, leadership development, collaboration with the private sector.

Health research is critical to understanding the well-being of the population, the burden of disease, its associated risk factors and populations at highest risk. It also provides the evidence for the most cost effective interventions as well as the performance of the health system with regards to access, quality and impact.

Similarly, the approach of Healthcare 2030 of increasing wellness necessitates an understanding of social determinants and with that also requires an inter disciplinary approach to research that includes social sciences as well participatory methodologies that include the communities which we serve.

The following would be key strategies to improve research in the department:

- » Building a culture of using research to improve services;
- » Development and dissemination of a research agenda;
- » Capacity development of staff on the utility of research and conducting research especially operational research;
- » Structured processes to collaborate with researchers (including researchers & specialists in training) on strategic research questions such as trials to evaluate the effectiveness of complex interventions aimed at behaviour change; and
- » Dissemination and translations of research findings into policy and practice to positively impact on service delivery and health outcomes.

The Department will engage and partner with the HEIs and other associated agencies to access their expertise to effectively undertake the above challenges.

Key Indicators of Success

In addition to detailed M&E processes that will be institutionalised in the Department, the preliminary set of indicators below will be explored as proxy indicators to determine the success of Healthcare 2030. These will be reviewed over time. The National Development Plan has also identified key indicators and targets that will be incorporated into the M&E framework of the Department.

Table 11: Key indicators of success

Population health outcomes	Increase life expectancy at birth
	Reduce infant mortality rate
	Reduce child mortality rate
	Reduce maternal mortality rate
	Reduce age-specific mortality rate
Health services outcomes	Increase patient-centred quality of care index
	Reduce waiting times
	Increase positive staff attitudes
	Increase level of staff engagement in the organisation
	Increase PHC utilisation rates
	Increase awareness rates of chronic disease status (HIV, TB, chronic diseases of lifestyle and mental health)
	Increase patient retention in care rates for (ART, TB, chronic diseases of lifestyle and mental health)
	Increase in rates of control/cure of chronic diseases (HIV, TB, chronic diseases of lifestyle and mental health)
Cost efficiency in service delivery	Cost per PHC headcount
	Cost per PDE
	Unit cost per diagnosis-related group

Real time learning and feedback

The aim of the M&E approach is to improve decision making to improve services by using reliable information to measure the burden of disease, quality of life and the health system performance. The approach must also support the process of whole system change and allow for real time learning and feedback. The process must not only monitor targets and explain variances but allow for meaningful dialogue to understand and address the underlying deeper issues of the system i.e. to move beyond compliance to performance and effectiveness.

The aim of the M&E approach is to improve decision making to improve services.

Strategic partnerships with academics would be essential to finalise process and outcome measures and methodologies that can prompt action, document and track how Healthcare 2030 actually influences practice on the ground during implementation. These partnerships could also support, evaluate and share processes and innovations taking place on the ground to give practical effect to the vision of 2030.





SECTION J: CONCLUSION

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Healthcare 2030 is a substantial piece of work built on the preliminary thinking, vision, principles and values circulated in earlier drafts, the extensive and valuable input received from staff and external stakeholders and the further evolution of conceptual thinking and technical work to date.

The 2030 process has started to energise, excite and engage the Department and its partners. The thinking and principles of 2030 have begun to infiltrate the daily language and conversations in the department. The journey to 2030 has begun in parallel to the process of finalising the 2030 framework.

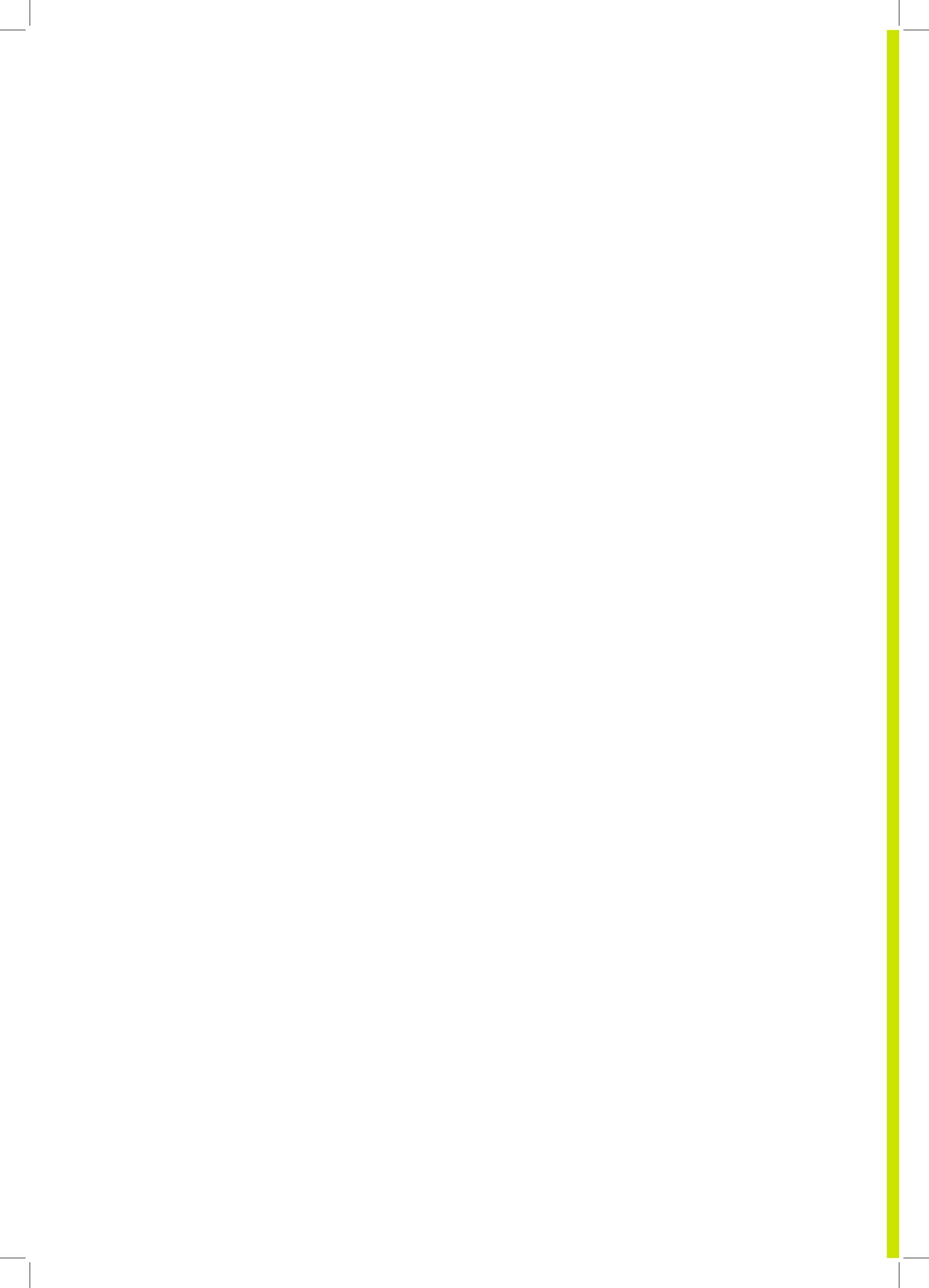
The process of consultation and engagement and coalescing of the multiple perspectives of people within and outside of the Department into a cohesive document is always a challenge. The Department believes that this final version is a fair reflection of the collective thinking to date. The Department will explore effective mechanisms to communicate Healthcare 2030 to the broader public in a user friendly manner.

The provincial cabinet has endorsed Healthcare 2030 in principle. The work will now shift to converting this broad strategic direction to more specific details by applying the models and approaches to specific services and geographic areas. This will include, amongst others, developing service plans for acute services (PHC and Hospitals), specialised services and identifying the priorities for incremental implementation through five year and annual plans within the affordability limits of allocated budgets.

The provincial cabinet has endorsed Healthcare 2030 in principle.

Healthcare 2030 as a strategic compass will have to be regularly revisited to be able to titrate its intention and assumptions with the changing realities of the next two decades.

History will judge us by the degree to which we have been able to put in place the various plans and processes we have outlined in this document and its actual implementation to improve the health status of our citizens.





ANNEXURES

ANNEXURE A: THE BURDEN OF DISEASE

The mortality profile

Figure A.1 below shows the quadruple burden of disease for all six districts that consists of HIV and TB, child and maternal health: other communicable diseases, maternal, perinatal, nutrition causes, non-communicable diseases and injuries from 2009 and 2010. It is significant that Overberg has the lowest mortality rates and that all districts except Overberg have had decreased mortality rates between 2009 and 2010.

Figure A.1: Age-specific deaths by broad cause and sex, Western Cape 2009 and 2010⁴

HIV and TB

The provincial antenatal survey results⁵ show the overall provincial HIV prevalence amongst pregnant women in 2012 to be 17.8% (95% CI: 16.7 – 18.3%) with HIV prevalence amongst the 15 – 24 year olds at 10.4%. This estimate has remained stable over the last few years implying that the HIV epidemic in the Western Cape has stabilised. The antenatal survey has, over the last few years, consistently showed that approximately 70 per cent of the burden of this epidemic is in the Metro District. A third of the sub-districts have an HIV prevalence that was greater than the provincial average. These are: Klipfontein, Khayelitsha, Eastern, Western and Northern sub-districts (metro district), Bitou, Knysna and Mossel Bay sub-districts (Eden district) and Overstrand sub-district (Overberg district). Since 2004, Khayelitsha sub-district in the Cape Town metro district has had an HIV prevalence estimate consistently higher than the national average.

Approximately half of the burden is in the age group 25-34 years. The failure to observe a decline in HIV prevalence in the province may be partly due to declining mortality as a result of access to antiretroviral therapy (ART) but unsafe sex is still an issue to be addressed.

Apart from mother-to-child transmission (MTCT), the risk of acquiring HIV primarily involves the practice of unsafe sex and is exacerbated by high partner turnover and partner concurrency. Other 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 overcrowding⁶.

The recently released evaluation of the prevention of mother-to-child-transmission (PMTCT) report⁷ shows that the Western Cape had the lowest MTCT rate of 1.98 percent compared to a national estimate of 2.67 percent. Even though this is good news, the risk factor for new infections is still prevalent. The Human Sciences Research Council (HSRC) household HIV study⁸ reports that in the province less than half of its adults used a condom at

⁴Groenewald P, Berteler M, Bradshaw D, Coetzee D, Cornelius K, Daniels J, Evans J, Jacobs C, Neethling I, Msemburi W, Matzopoulos R, Naledi T, Shand L, Thompson V, Visser M. Western Cape Mortality Profile 2010. Cape Town: South African Medical Research Council, 2013.

⁵Western Cape Government: Health. Antenatal Survey Report

⁶Western Cape Government: Health. Western Cape Burden of Disease Reduction Study, 2007

⁷Goga, AE, Dinh TH, Jackson DJ for SAPMTCT study group. 2012. Evaluation of the effectiveness of the National Prevention of Mother to Child

⁸Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V, Mbelle N, Van Zyl J, Parker W, Zungu NP, Pezi S & the SABSSM III Implementation Team (2009) South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers? Cape Town: HSRC Press

their last sexual encounter, only about a third of adults have the correct knowledge to prevent HIV and can reject major misconceptions, and less than a quarter had an HIV test in the previous 12 months. Much work is thus still required in the arena of behaviour change.

The ART programme continues to expand rapidly in the department, with approximately 134 212 people on ARVs 2012/13⁹. Death due to HIV is showing a decreasing trend as shown in figure A.1 above though the biggest risk factor for TB is concurrent HIV infection. TB has also been described as a social disease, as it is closely linked to the upstream issues of poverty, unemployment and overcrowding.

The Western Cape has the third highest number of new TB infections in South Africa (909 cases per 100 000) after KwaZulu-Natal and the Eastern Cape. Departmental records¹⁰ show that approximately 48 000 people were treated for TB in the Western Cape in 2012. Of these, approximately 41 500 were adults, of whom about forty-five percent were HIV infected. Of the approximately 6 500 children treated, about nine percent were known to be HIV infected, with a further twenty-three percent having no HIV status recorded. However, the Department is making significant progress in addressing the epidemic through the implementation of the Enhanced TB Response Strategy. The programme achieved a new smear-positive TB cure rate of 81.7 percent in 2012/13. Two districts (Overberg and Eden) achieved the World Health Organization (WHO) target of 85 percent. The provincial TB cure rate is the highest TB cure rate in South Africa¹¹.

The TB defaulter rate has decreased slowly over the past few years with the implementation of various interventions and stood at 7.0 percent in 2012/13 in comparison to the 9.4 percent recorded in 2008/09¹². Although this is a significant improvement, more effort will be required to reach the national and global 2011 target of a defaulter rate of below 5 percent. This is required to decrease the size of the infectious pool in the community and prevent the generation of drug-resistant TB, which requires longer stays in hospital, is much more expensive to treat, and has a very poor prognosis.

Between 2007 and 2012, the number of diagnosed multi-drug resistant TB (MDR TB) cases increased by sixty-eight percent, from 764 to 1 285. Over the same period diagnosed extensively drug-resistant (XDR TB) cases increased by sixty-one percent, from 72 to 189¹³. Drug-resistant TB has remained at one percent in new patients and four percent in retreatment patients. This data is in accordance to the 2001/2002 surveillance report. Eighty percent of MDR-TB is acquired through transmission from other infected patients.

Child and Maternal Health

Table A.1 shows Infant and child mortality rates in the Western Cape from 2007 – 2010. These show that infant mortality rate in particular has been decreasing in the province.

Table A.1: Infant and under-five mortality rate (per 1 000 live births)¹⁴

District	Infant mortality rate				Under-five mortality rate			
	IMR (< 1yr)				U5MR (< 5yr)			
	2007	2008	2009	2010	2007	2008	2009	2010
Cape Winelands	28,6	22,8	25,3	25,4	34	30,1	31,2	31,7
Central Karoo	45,2	44,2	40,7	33,8	60,3	58,6	51,7	44,1
Cape Town Metro	21,5	21,2	21,9	22,6	26,1	26,1	26,4	27,8
Eden	30,7	23,4	23,8	19,2	37,2	29,3	28,4	23,8
Overberg	36,8	28,1	28,8	33	45,6	35,2	33,9	46,3
West Coast	32,3	28,4	23,4	30,2	37,8	34,0	26,7	35,6
Western Cape	24,5	22,4	23	23,4	29,7	27,9	27,7	29,1

⁹Western Cape Government: Health. Annual report 2012/13

¹⁰Western Cape Government: Health. eTR.net report 2012

¹¹Western Cape Government: Health. Annual report 2012/13

¹²Western Cape Government: Health. Annual report 2012/13

¹³Western Cape Government: Health. eTR.net report 2012

The five significant causes of deaths in children under five years are neonatal conditions, diarrhoea, pneumonia, HIV and injuries as shown in Figure A.2 below.

Figure A.2: Causes of death in children under five years, Western Cape 2010¹⁵

Over the last few years deaths due to HIV and diarrhoea in particular have significantly decreased largely due to a very successful PMTCT programme; with little change in neonatal mortality rates. Whereas HIV was the number one cause of death, neonatal causes of death are now the most prevalent as shown in figure A.2 above. Figure A.3 below shows neonatal causes of death in 2009 and 2010. Causes due to prematurity and birth asphyxia have increased between 2009 and 2010 and the other causes have decreased.

Figure A.3: Causes of neonatal deaths, Western Cape 2010¹³

¹⁴Groenewald P, Berteler M, Bradshaw D, Coetzee D, Cornelius K, Daniels J, Evans J, Jacobs C, Neethling I, Msemburi W, Matzopoulos R, Naledi T, Shand L, Thompson V, Visser M. Western Cape Mortality Profile 2010. Cape Town: South African Medical Research Council, 2013.

¹⁵Groenewald P, Berteler M, Bradshaw D, Coetzee D, Cornelius K, Daniels J, Evans J, Jacobs C, Neethling I, Msemburi W, Matzopoulos R, Naledi T, Shand L, Thompson V, Visser M. Western Cape Mortality Profile 2010. Cape Town: South African Medical Research Council, 2013.

Social determinants of health (such as poverty, housing, inequity, unemployment, education levels) negatively influence child health outcomes, such as, infant mortality rates (IMR). It is recognised that breastfeeding rates in the Western Cape are low and that poor breastfeeding accounts for about 45 percent of the neonatal death burden, 30 percent of diarrhoea and 18 percent of pneumonia. On the basis of studies done between 1997 and 2009, nearly 9 percent of children were acutely malnourished and just 20 percent chronically malnourished, with about 20 percent of teens being overweight . Furthermore, the WHO reports that "adolescents and adults who were breastfed as babies are less likely to be overweight or obese. They are less likely to have type-2 diabetes and perform better in intelligence tests."¹⁶

Similarly, it is very well documented that downstream interventions, such as the provision of quality health services to increase coverage of immunisation, the early diagnosis and management of diarrhoea and pneumonia, have a profound impact in reducing both morbidity and mortality. Pneumococcal and rotavirus vaccines are good examples, as illustrated in Figures A.4 and A.5 below. The pneumococcal and rotavirus vaccines have had a significant impact on reducing the number of pneumonia cases and reducing the severity and mortality of diarrhoea.

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

Figure A.4: Pneumonia under five years: new cases in the Western Cape: 2008 to 2012¹⁷

¹⁶WHO. Ten facts on breastfeeding

¹⁷Western Cape Government: Health. Routinely collected health information. Sinjani, 2012

Figure A.5: Annual incidence of invasive Pneumococcal Disease¹⁸

In addition to the aforementioned issues largely showing up on the mortality estimates, other conditions largely related to morbidity such as Fetal Alcohol Syndrome (FAS) and oral health are also important. South Africa and the Western Cape in particular have the highest rates of FAS in the world. The prevalence is about 40.5 to 46.4 per 1000 children aged 5 to 9 years and age-specific community rates for ages 6-7 were 39.2 to 42.9. These rates are 18 to 141 times greater than in the United States¹⁹.

5 to 10% of children entering school have FAS or FASD in the province, and a more recent study in the West Coast highlighted a hotspot in the town of Aurora where the prevalence of FAS/FASD was estimated at 17%²⁰. These rates are about 20 to 100 times higher than 'high-risk' populations elsewhere in the world. It has been estimated that children with FAS/FASD have increased usage of health services by 3 to 4 times and many of them have learning difficulties and other developmental problems that impact on their ability to fulfil their full potential.

Most oral diseases are not life threatening but affect almost every individual during his or her lifetime. Aspects such as growth, cognitive development, general development, poor appetite, interference with sleep, poor school behaviour and negative self-esteem may be affected. Oral conditions are important public health concerns because of their high prevalence, their severity and public demand for services. A National survey conducted in 2003 showed that the dental caries rate for certain specific age groups in the Western Cape Province was double that found as a National mean.

Maternal and women's health

The Western Cape enjoys relatively high coverage of antenatal care, which is close to 90 percent, with most women visiting health facilities more than four times during their pregnancy. The key intervention to ensure women present before 20 weeks to health facilities has also been showing some successes. In 2008 just over 40 percent of women were presenting before 20 weeks for antenatal care and in 2012/13 this had increased to 58.1 percent. Maternal death trends have been erratic over the years but have been on the increase as shown in Figure A.6.

¹⁸von Gottberg A, Cohen C, de Gouveia L, Quan V, Meiring S, Madhi SA, Whitney C, Klugman KP. Group for Enteric, Respiratory and Meningeal Disease Surveillance in South Africa (GERMS-SA). Trends in invasive pneumococcal disease after 7-valent pneumococcal conjugate vaccine (PCV7) introduction in South Africa, 2005-2011. Poster presentation. Eighth international symposium on pneumococci and pneumococcal disease, Iguacu Falls, Brazil. 11 – 15 March 2012.

¹⁹May et al. (2000) Epidemiology of Fetal Alcohol Syndrome in a South African Community in the Western Cape Province AJPH 90: 1905-1912.

²⁰Olivier et al. Burden of fetal alcohol syndrome in a rural West Coast area of South Africa South African Medical Journal 2013;103(6):402-405. DOI:10.7196/samj.6249

Figure A.6: Maternal deaths in the Western Cape 2003 to 2010²¹

The Saving Mothers report, 2010 reports that the leading causes of maternal death in 2008 to 2010 were non-pregnancy-related infections, particularly those due to HIV and AIDS (36.1 percent), hypertensive disorders (16.3 percent), pre-existing medical disorders (11.9 percent), obstetric haemorrhage (8.3 percent). The peak in 2009 was due to the outbreak of H1N1 influenza.

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

The Couple year protection rate has been increasing steadily 40.3 percent in 2008/9 to 66.5 percent in 2012/13²⁰. The prevalence of family planning in sexually active women has, however, been decreasing since 1998, when it was estimated to be 73.7 percent²². Thus there is significant room for improvement in access and utilisation of family planning services. Cervical cancer screening has had particular success in the province, when it increased from 38.6 percent in 2007 to 60.2 percent in 2012/13²³.

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

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

²¹Saving Mothers: Report on Confidential Enquiries into Maternal Deaths in South Africa 1999-2010

²²Department of Health, Medical Research Council & Measure DHS+. South Africa Demographic and Health Survey 1998, Full Report. Pretoria: Department of Health; 2002.

²³Western Cape Government: Health. Annual report 2012/13

Community-based interventions for both adolescents and adult men and women aiming to improve sexual health and improve psychological well-being through building stronger equitable intimate partner relationships are therefore important.

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 those in developed countries.

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

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 percent) than nationally (38 percent)²⁴ and are the third leading cause of premature years of life lost in the province. According to the SANHANES report in 2013²⁵, the Western Cape has the highest prevalence of smoking of all provinces; i.e. 31.4 percent compared to 16.8 percent national average. This study also found both men and women in the Western Cape to be more unfit than the national counterparts and men in particular to be more obese than the national average.

The department has estimated from community surveys that there are about 950 000 people who have hypertension and 330 000 patients with diabetes. From departmental routine records and pharmacy data it is estimated that there are 450 000 people receiving care for hypertension, this indicates that 47 per cent of those who require treatment are on it. Similarly it is estimated that approximately 200 000 diabetics; about 61 per cent of those in need are on treatment.

It is also estimated that approximately 63 per cent of the pharmaceutical budget for district health services is spent on medicines used in the treatment of chronic illnesses. This excludes the budget at other levels of care, which tend to use even more complex and expensive treatment regimes as the patients are more complex.

With between 50-60 per cent of people requiring treatment receiving treatment and only half of those controlled²⁶, it is thus not surprising that non-communicable disease mortality rates are higher than any other broad cause as shown in Figure A.1.

Mental Health

Mental health is another key component of the burden of disease. Neuropsychiatric conditions such as depression and anxiety are the third highest contributor to the burden of disease in South Africa. The provincial lifetime prevalence for all mental disorders was 39.4%²⁷. The one-year prevalence of common mental disorders in South Africa is 16.5 percent and the lifetime prevalence is 30 percent²⁸. Furthermore, more than 80 percent of South Africans with mental health disorders do not receive the care they need²⁹.

In South Africa, some studies found that between 35 and 48 percent of women were diagnosed with postnatal depression, with as many as 12 percent in one study having moderate- to high risk of suicide³⁰. There is also high co-morbidity of mental illness with chronic diseases. About half of all hypertensive, diabetic and cardio-respiratory disease patients in the Eden pilot of PHC 101 had depression.

Mental illness is also prevalent in adolescents. About 41.4 percent of Grade 8 to 12 of Western Cape learners were classified as medium risk and 14.9 percent as high risk for mental health problems; this is so across all the districts. Research shows that the 12-month prevalence of child and adolescent mental disorders in the Western Cape was reported to be 17 percent. Most mental disorders have their origins in childhood and adolescence.

²⁴Bradshaw D, Groenewald P, Laubscher R, Nannan N, Nojilana B, Norman R, Pieterse D, Schneider M. Initial estimates from the South African National Burden of Disease Study, 2000 MRC Technical Report. March 2003. ISBN: 1-919809-64-3

²⁵Shisana O, Labadarios D, Rehle T, Simbayi L, Zuma K, Dhansay A, Reddy P, Parker W, Hoosain E, Naidoo P, Hongoro C, Mchiza Z, Steyn NP, Dwane N, Makoae M, Maluleke T, Ramlagan S, Zungu N, Evans MG, Jacobs L, Faber M, & SANHANES-1 Team (2013) South African National Health and Nutrition Examination Survey (SANHANES-1). Cape Town: HSRC Press

²⁶Western Cape Government Health, Integrated Chronic Disease Audit Report

²⁷Herman et al (2009) The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders S. Afr. med. j. vol.99 no.5

²⁸Williams et al (2007). Prevalence, Service Use and Demographic Correlates of 12-Month Psychiatric Disorders in South Africa: The South African Stress and Health Study. Psychological Medicine, 38(2), 211-220.

²⁹Seedat et al. (2009) Mental health service use among South Africans for mood, anxiety and substance use disorders. S Afr Med J. 2009 May; 99(5 Pt 2): 346 - 352

³⁰Cooper P.J, Tomlinson M, Swartz L, Landman M, Molteno C, Stein A, McPherson K, Murray L. Improving quality of mother-infant relationship and infant attachment in socio-economically deprived community in South Africa: randomised controlled trial. British Medical Journal. 2009;338:b974.

Approximately 50 percent of mental disorders begin before the age of 14 years. Mental illness remains highly stigmatised in society generally.

Injuries

Figure A.7 below shows the profile of injury-related mortality, interpersonal violence and transport related injuries are by far the most prominent causes of injury related deaths. Except for Central Karoo mortality rates due to interpersonal violence was fairly consistent at around 40 deaths per 100 000 across other districts. As shown in Figure A.6 above, with the exception of West Coast and Cape Winelands, these rates declined slightly in all districts between 2009 and 2010.

Transport injury mortality rates were highest in West Coast and lowest in Eden and Cape Metro. Marked declines were noted in the transport injury deaths rates between 2009 and 2010 in Cape Winelands (47 to 39 per 100 000) and Central Karoo (59 to 30 per 100 000).

Figure A.7: Injury mortality rates by district Western Cape, 2010³¹

In an analysis of mortuary data in the province, it was found that nearly 80 percent of injury related deaths were in men aged 20 to 34 years old.

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

³¹Groenewald P, Berteler M, Bradshaw D, Coetzee D, Cornelius K, Daniels J, Evans J, Jacobs C, Neethling I, Msemburi W, Matzopoulos R, Naledi T, Shand L, Thompson V, Visser M. Western Cape Mortality Profile 2010. Cape Town: South African Medical Research Council, 2013.

Social determinants

According to the South African Index of Multiple Deprivation, 72% (18/25) of the municipalities in the Western Cape are in the fifth quintile of multiple deprivation; thus they are the least deprived municipalities in South Africa. Prince Albert and Laingsberg municipalities are in third quintile and the most deprived of all municipalities in the Western Cape. Province-specific deprivation indices (StatsSA) show that the most deprived wards within the Western Cape are within the City of Cape Town municipality, particularly the townships on the Cape Flats alongside the N2, and in the Karoo. The Central Karoo comprises approximately one percent of the total population.

More detailed analysis also suggests that approximately half of the 50 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. As discussed above, social determinants play an important role in the distribution of disease and its consequences.

ANNEXURE B: MILLENNIUM DEVELOPMENT GOALS

Table B.1: Millennium Development Goals

Millennium Development Goal	Target	Indicators
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.
Achieve universal primary education.	Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.	Net enrolment ratio in primary education.
		Literacy rate of 15 – 24 year-olds.
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.
Reduce child mortality.	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.	Under-5 mortality rate (U5MR).
		Infant mortality rate.(IMR)
		Proportion of one-year old children immunised against measles.
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.
Combat HIV and AIDS, malaria and other diseases.	Have halted, by 2015, and begun to reverse the spread of HIV and AIDS, malaria and other diseases.	HIV prevalence among 15 – 24 year old pregnant women.
		Condom-use rate of the contraceptive prevalence rate.
		Number of children orphaned by HIV and AIDS.
		Proportion of the population in malaria risk areas using effective malaria prevention and treatment measures. (Prevention to be measured by the percentage of under 5 year olds sleeping under insecticide treated bed-nets and treatment to be measured by percentage of under 5 year olds who are appropriately treated.)
		Prevalence and death rates associated with Tuberculosis (TB).
		Proportion of TB cases detected and cured under the directly observed treatment short course (DOTS).
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 2030 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.
Develop a global partnership for development.	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.	Official development assistance.
	In co-operation with pharmaceutical companies, provide access to affordable, essential medicines in developing countries.	Proportion of exports admitted free of duties and quotas. Proportion of population with access to affordable essential drugs on an established basis.

ANNEXURE C: THE EKURHULENI DECLARATION ON MENTAL HEALTH

We, the participants in the National Mental Health Summit held on 12-13 April 2012, consisting of representatives of government departments, non-governmental organizations, the World Health Organisation, academic institutions, research organisations, professional bodies, traditional health practitioners, clinicians and advocacy and user organizations, gathered around the strategic theme 'Scaling up investment in mental health for a long and healthy life for all South Africans':-

Informed by the Constitution of the Republic of South Africa, 1996; the Mental Health Care Act 2002 (No. 17 of 2002); Resolution WHA55.10 of the World Health Assembly; United Nations General Assembly resolution 65/95; the United Nations Convention on the Rights of Persons with Disabilities; the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and the eThekweni Declaration of the 2nd Biennial Substance Abuse Summit.

Recognising that health is a state of mental, physical and social wellbeing and not just the absence of infirmity and that there can be no health without mental health; human rights of people with mental disabilities are entrenched in South African and International law; poor mental health and substance abuse is often associated with poverty, violence and other adversities and vulnerability while good mental health is an important contributor to social and economic development; attaining good mental health requires the commitment and practical involvement of a number of government and non-government sectors and partners; users of mental health services are integral to planning and delivery of mental health services; mental health service delivery must be accessible, affordable and acceptable; the right of all South Africans to the enjoyment of the highest attainable standards of physical and mental health must be achieved through increased services for mental health at all levels of the health care system, and that culture plays a key role in mental health.

Noting that mental and neurological disorders account for 13% of the global burden of disease and for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively; in South Africa neuropsychiatric disorders rank 3rd in their contribution to the overall burden of disease - after HIV and AIDS and other infectious diseases; over 16% of adults in South Africa have a 12 month prevalence of mental disorder; around three quarters of people in South Africa that suffer from a mental disorder do not currently receive any mental health intervention; mental and substance use disorders are closely correlated with physical diseases, including both communicable diseases such as HIV and AIDS and non-communicable diseases such as heart disease and cancer; mental and substance use disorders and intellectual disabilities impact on every strata of South African society, men and women, all races, economic groups, urban and rural populations and all age groups; there is considerable inequity in mental health service provision especially between the private and the public sectors and also between urban and rural areas; mental health services within general health care and community based mental health services are underdeveloped; people with mental disorders and disabilities continue to be stigmatised and discriminated against in most aspects of their lives; improved primary mental health care would reduce the number of mental health visits to secondary and tertiary health care facilities.

This national mental health summit was a culmination of an intensive process of consultation in provinces involving over 4000 people.

Realising that primary health care is the foundation of the health care system and that there is a need to fully integrate mental health care into primary health care in South Africa with the view to increasing prevention, screening, self-management, care, treatment and rehabilitation; in order to achieve equitable, efficient and quality health services, South Africa is in the process of implementing a National Health Insurance System and mental health must form an integral part of this system.

Hereby commit to:

1. Promoting mental health as an important development objective;
2. Eliminating stigma and discrimination based on mental disability and promoting the realisation of the United Nations Convention on the Rights of Persons with Disabilities (2006);
3. Full implementation of the Mental Health Care Act, 2002 (Act No. 17 of 2002) and changing the legislation where this is needed;
4. Ensure collaboration across sectors and between governmental and non-governmental organisations, academics and with other stakeholders to improve mental health services;
5. Providing equitable, cost-effective and evidence-based interventions and thereby ensure that mental health is available to all who need it, including people in rural areas and from disadvantaged communities;

6. Integrating mental health and substance abuse services into the general health service environment;
7. Providing mental health and substance abuse care to people within communities while referring to higher health care levels where clinically required;
8. Ensuring that all users of mental health services participate in the planning, implementation, monitoring and evaluation of mental health services and programmes;
9. Fostering person-centred recovery paradigm that respects the autonomy and dignity of all persons;
10. Increasing human resources to address mental health needs throughout the country through additional training across sectors, integration into general health care and through the National Health Insurance System;
11. Developing and strengthening human capacity for prevention, detection, care treatment and rehabilitation of mental and substance use disorders and build links with traditional and complementary health practitioners;
12. Providing physical infrastructure that is conducive to the needs and human rights of people with mental disorders and disabilities;
13. Reducing costs and increase the efficiency of mental health interventions, including making medicines more affordable, in order to provide essential health services;
14. Establishing comprehensive mental health surveillance mechanisms, health information systems and dissemination processes to assist policy and planning;
15. Developing and supporting research and innovation in mental health; and
16. Using the outputs from the summit to finalise the Mental Health Policy Framework 2012-2016 and to assist with its implementation and monitoring.

And consequently to:

1. Develop and implement a mental health service delivery platform based on community and district based models to ensure that prevention, promotion, treatment and rehabilitation services meet the needs of all;
2. Implement with vigour the Health Sector Mini Drug Master Plan;
3. Establish at least one specialist mental health team in each district;
4. Adequately fund mental health services as per WHO recommendations;
5. Embed and increase mental health human resources within the National Human Resource Plan;
6. Develop a fit for purpose plan for mental health infrastructure at all levels;
7. Revise norms and standards in line with the service delivery platform;
8. Strengthen Mental Health Review Boards;
9. Establish a national surveillance system and appropriate monitoring and evaluation systems for mental health care integrated into the National Health Information System;
10. Establish a national suicide prevention programme; and
11. Strengthen links with traditional, complementary and faith-based healers and non-governmental organisations

ANNEXURE D: PLANNING METHODOLOGY

Planning Methodology

The planning parameters and methodology for the health service used for 2030 are a major advance on those used for 2010 and are based on four major tenets:

- » Using a population base and the notion of dependent population.
- » Using the smallest geographic entity for which reliable health and socio-economic data is available.
- » Using an equity measure with household income as a proxy and where the distribution of health resources is weighted towards the poorest households.
- » Establishing norms and the creation of planning tools for different aspects of the health service that allows for its application to specific geographic areas. The tools used in one section of the health service takes into account the impact of developments in other sections of the service, thus looking at the health service as an integrated health system.

The general tenets are described below and the specific application to various aspects of the health service is described under the service components.

a) Population as a Planning base

i) Summary of key demographic trends – South Africa

The national demographic trends could be summarised as follows:

- » Continued population growth is projected until 2030 but will start to decline in absolute size thereafter.
- » Fertility rates are declining.
- » Life expectancy at birth is slowly increasing.
- » The population is ageing.
- » Age structures are changing.
- » Racial composition is changing.
- » The HIV and AIDS epidemic is projected to continue to have a significant impact on the demography of South Africa.

Although Johannesburg remains the city with the highest population, Cape Town's comparative growth rate was the highest in the country at 20.91% for the period 2001-2007. The State of Cities Report refers to the population growth rate for Cape Town as being consistently higher than the total population growth rate for the country.

ii) Key demographic trends – Cape Town 2030

The key demographic trends for Cape Town could be summarised as follows : (Source : "Demographics Scenario Discussion Paper", 2010, City of Cape Town.)

- » Cape Town's population will continue to grow significantly each year, due to natural births (although at a slower rate, with fertility levels declining) as well as migration.
- » Average household sizes have slowly decreased from 3.92 in 1996 to 3.72 in 2001, to 3.55 in 2008 (General Household Survey) and are likely to continue decreasing.
- » The nature and extent of migration, both internal and trans-national, are the most prominent unknown variables.
- » The number of refugees and displaced persons is likely to increase adding to Cape Town's population growth through migration.

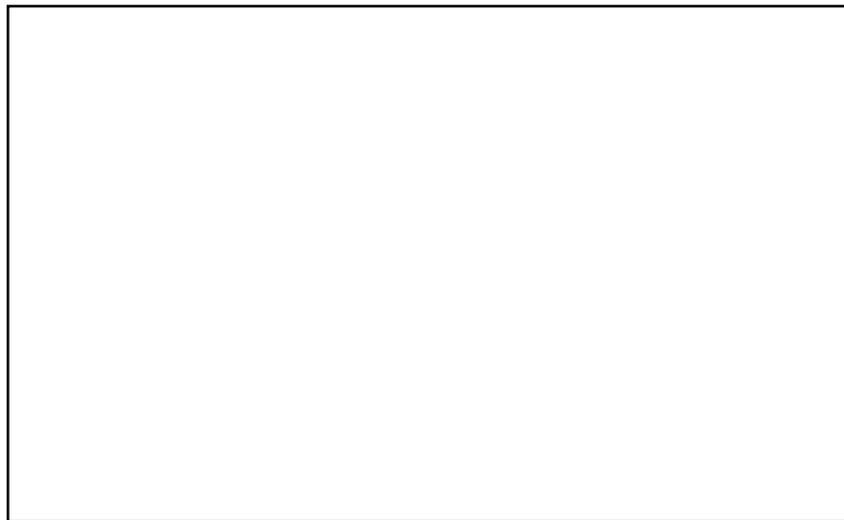
- » A lower mortality rate than originally predicted due to HIV and AIDS will also influence the population growth.
- » The population is ageing.

iii) Population projections up to 2030

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

The preliminary results of Census 2011 were announced in November 2012 and indicate that the total population of the Western Cape is 5 822 734. This is 1.0147 per cent higher than the Department's previously projected estimate of 5 763 653. The Technical team therefore decided to use the same linear regression approach to develop a high growth projection for 2030. Given the demographic trends discussed above, a low growth scenario was developed where the population growth would stabilise by 2030. The planning models used a midway approach referred to as the Spatial Development scenario.

City of Cape Town: population growth scenarios up to 2030



Population projection scenarios up to 2030:			
	Stabilise	Midway	High Growth
City of Cape Town	4 731 420	5 121 881	5 512 341
Western Cape	7 329 570	8 002 931	8 499 182

iv) Population in rural areas

A similar approach was followed in projecting the population of rural districts. However, given the population growth in rural areas differs significantly from area to area, the "Growth Potential of Towns" study (Department of Environmental Affairs and Planning, 2010) has been consulted to identify rural sub-districts where population growth can stabilise around 2031 as opposed to sub districts where continued relatively high growth can be expected. The low growth (Stabilise) projections were then applied to sub districts with potential low growth potential and the linear regression outcomes (high growth scenario) were applied to sub districts with a high growth potential.

Source: "Growth Potential of Towns", Department of Environmental Affairs and Planning, 2010

b) Geographic based approach

The 2030 philosophy is underpinned by a patient-centred, outcome-based approach where patient experience and health outcomes are the primary focus. A geographic based approach with clear insight into the prevalent burden of disease and understanding of the factors that determine the health-seeking behaviour of people in a specific area, is therefore advocated.

Electoral wards were used as building blocks to demarcate geographic drainage areas for the delivery of specific health services in the Cape Town metro. This enables PHC drainage areas to feed into district hospital drainage areas and district hospital drainage areas to ultimately feed into regional hospital drainage areas.

Socio-economic data, which is available at ward level, can be aggregated to higher levels (e.g. sub-district and district) and can then be integrated with health statistics to determine the burden of disease and population profile for specific areas.

Another advantage of using integrated data sets is that a population profile, based on ethnicity, age, gender, household income, etc., can be compiled for each ward or drainage area, which can then be used to estimate the PHC utilisation rate. This is done by allocating protocols as described in the package of PHC services to specific denominator groups. For example, children under one year of age are a denominator group and immunisation is an important protocol prescribed in the full package of care. Other defined denominator groups that can be associated with specific protocols are: children under five; women between 15 and 49; women 30 to 50; and people with TB, etc. The total PHC utilisation rate per catchment area can thus be estimated, as well as the skills mix of the staff required to manage the relevant burden of disease and workload.

However, a different planning approach is required for the rural and deep rural areas where 22.6 percent of the population reside. The smallest geographic planning unit used in these rural districts is a sub-district because many areas are so sparsely populated that it is neither practical nor meaningful to drill down to ward level. Similarly, the application of the income equity measure to relatively small settlements and towns would not yield meaningful results. The rural model is, therefore, based on estimated dependent population per sub-district. Allocation norms – for example, households per CHW – will be weighted, taking population density per catchment area and travel distances into account. The principle of critical mass must be applied in rural areas where the population numbers are too small to allow for the application of population- and workload-based norms.

Area	Census 2011	% of total population	Classification
Cape Winelands District Municipality	787 490	13.5%	
Witzenberg	115 946	2.0%	Rural
Drakenstein	251 262	4.3%	High density rural
Stellenbosch	155 733	2.7%	High density rural
Brede Valley	166 825	2.9%	High density rural
Brede River Winelands/Langeberg	97 724	1.7%	Rural
West Coast District Municipality	391 767	6.7%	
Matzikama	67 147	1.2%	Deep rural
Cederberg	49 768	0.9%	Rural
Bergrivier	61 897	1.1%	Rural
Saldanha Bay	99 193	1.7%	Rural
Swartland	113 762	2.0%	Rural
Overberg District Municipality	258 176	4.4%	
Theewaterskloof	108 790	1.9%	Rural
Overstrand	80 432	1.4%	Rural
Cape Agulhas	33 038	0.6%	Rural
Swellendam	35 916	0.6%	Rural
Eden District Municipality	574 265	9.9%	
Kannaland	24 767	0.4%	Rural
Langeberg/Hessqua	52 642	0.9%	Rural
Mosselbay	89 430	1.5%	Rural
George	193 672	3.3%	High density rural
Oudtshoorn	95 933	1.6%	Rural
Plettenberg Bay/Bitou	49 162	0.8%	Rural
Knysna	68 659	1.2%	Rural
Central Karoo District Municipality	71 011	1.2%	
Laingsburg	8 289	0.1%	Deep rural
Prince Albert	13 136	0.2%	Deep rural
Beaufort West	49 586	0.9%	Deep rural
City of Cape Town	3 740 025	64.2%	Urban
Western Cape	5 822 734	100.0%	
Summary: distribution			
Urban population	64.2%		
Population in high density rural areas	13.2%		
Population in rural areas	20.2%		
Population in deep rural areas	2.4%		
	100.0%		

c) Equity measure

The direct correlation between the burden of disease, poverty and associated deprivation is evidence-based and generally accepted. For this reason an equity measure, based on household income and that will ensure that resource allocation is sensitive to income deprivation, has been developed. This will ensure that poor settlements will receive proportionately more resources to address their relatively higher burden of disease. Instead of focusing on the insured versus the uninsured population, wards have been stratified into four income layers. An income analysis was then applied to estimate the percentage of households in each layer that were likely to be dependent on public health services. A dependency profile could then be determined for each ward in the metro and sub-district in the rural districts. For this reason, reference is made to "dependent" population rather than "uninsured" population. The equity measure comprises the income layers set below.

Table D.1: Equity measure income layers

Household income in 2013 Rands	
More than	R614 400
Between	R153 801 and R614 400
Between	R76 401 and R153 800
Less than	R76 400

It should be noted that the application of the equity measure not only results in a more equitable distribution of resources, but also enhances equitable access to health services.

In line with the broader 2030 philosophy the planning for hospitals is population based. An electoral ward is the smallest unit for which population and socio-economic data is available (Statistics SA). Pending the outcome of the 2011 Census and the availability of detailed census results, the data from the Dorrington scenarios is used to estimate population and a scenario midway between the medium- and high projections is used in order to accommodate migration.

Differentiated access to services is therefore provided using household income as a proxy to ensure that more services are provided in lower-income areas.

The household income bands used to determine the deprivation, is shown in Table D.1 above.

To ensure equitable access to district hospitals it is envisaged that there will be a district hospital for each catchment area. The spatial development boundaries demarcate more functional areas than the current sub-district boundaries across the province. These spatial development boundaries provide a framework for future development in terms of transport routes, human settlements and governance nodes. Sub-district boundaries remain for administrative and managerial purposes but are not optimally useful for technical planning.

The actual location of hospitals determines the catchment areas in terms of access to the hospitals.

d) Development of norms and flexible technical models

As the technical work progressed, the discussions centred on the required level of technical detail and the approach to target setting. In Healthcare 2010 and the Comprehensive Service Plan specific future targets were set that drilled down to institutional level and staff establishments. Achievement of these targets was dependent on the implementation of service shifts across the platform and institutions. Without intermediate targets and appropriate management tools these shifts proved to be complex and challenging.

Given the lessons learned from Healthcare 2010 and the CSP, it was agreed that norm-based- and flexible technical tools would be developed. These would facilitate the implementation of the 2030 philosophy and service delivery platform within the context of the seven 2030 guiding principles. The tools are focused on the use of appropriate key indicators for which current baselines can be determined and for which indicative interim targets can be set for specific points in time, e.g. 2015 and 2030. Details of the technical models and norms that have been applied are described in Section D: Service Platform.

The technical modelling was guided by the philosophy and principles of 2030. Embedded in the patient-centred care-pathways approach is the understanding that what happens in one sector of the service delivery platform directly impacts on other sectors. This was taken into consideration in the technical modelling. For example, if home-based care is effectively implemented it should enhance early detection and diagnosis of chronic disease. This would lead to the effective treatment and control of chronic diseases and result in fewer emergencies and admissions to hospitals.

The development of flexible technical models enables the Department to progressively move towards the service platform envisaged in 2030. Major service shifts can be achieved through smaller coordinated projects that are easier to manage. The Department would in this way be able to manage effectively the shift of funds within the baseline budget and to table well-motivated requests for additional funding where necessary.

ANNEXURE E: WORKLOAD CALCULATOR

1. Utilisation variables

"Utilisation rate" refers to the number of times the average person visits a PHC facility per year and is derived from the following formula:

$$\text{Utilisation per dependent person} = \frac{\text{Total head count (=number of patients)}}{\text{Total population}}$$

2. Workload variables

- » Direct patient care factor per category of staff; i.e. the percentage of time spent in direct contact with patients;
- » Minutes per consultation per category of staff; and
- » Number of contacts of a patient with health workers at different service points during one visit to a facility. A patient contact refers to a consultation or treatment event between the patient and a health care worker. During a visit to a health facility a patient may consult with or be treated by more than one health care worker and may therefore have more than one 'contact' per visit to the facility.

3. To calculate the utilisation rate it is necessary to estimate the average number of contacts that a patient has with health workers during one visit to a facility.

In terms of the second point under "Workload variables" above, "patient contact" refers to a consultation or treatment event between the patient and a health care worker. During a visit to a health facility a patient may consult with or be treated by more than one health care worker and may therefore have more than one 'contact' per visit to the facility.

4. Application of the workload and utilisation calculator

In the example in Table E.1 the calculator was applied to calculate the human resources required to render community-based- and clinical services to people in a ward.

Table E.1: Module 1 application of the workload calculator – a ward

Module 1 of Calculator: Workload and population variables									
Dependent Population 2030:							36 702		
Days open per annum:							250		
Post description	Working days per FTE per annum	Minutes /day	Direct patient care factor	Minutes / Patient Contact	Contacts per FTE/ day	FTEs (250 days)	Total Patient Contacts per annum (250 days) Clinical FTEs only	Contact Utilisation Rate per capita	
Health Counsellor (Mental Health)	221	450	0.80	20	18	2.94	11 692	0.32	
Clinical nurse practitioner	221	450	0.75	11.4	30	6.68	43 705	1.19	
Professional nurse consultations (Minor trauma, Supervise prep and dressing rooms)	221	450	0.33	6.6	23	1.34	6 643	0.18	
Enrolled Nurse / Nursing Assistant: prep, bandages and dressings rooms, etc.	221	450	0.80	4	90	4.58	91 107	2.48	
Medical Officer	221	450	0.70	10	32	1.34	9 300	0.25	
Pharmacist	221	450	0.75	3	113	1.47	36 538	1.00	
Pharmacy Assistant	221	450	0.90	4	101	2.2	49 326	1.34	
Admin Clerk: Admissions	221	450	1.00	5	90	4		-	
Chief Admin Clerk	221	450	-	30	-	1		-	
Community Care Worker	221	450	0.50	30	8	27.38	54 514	1.49	
Prof Nurse: Co-ordinate / Supervise / Training (CBS)	221	450	0.40	20	9	3.00	7 168	0.20	
Prof Nurse: Unit Manager	221	450				1.00			
Cleaner	221	450				3.00			
Admin Clerk: Information Management	221	450				1.00			
Prof Nurse Specialised: Mental Health	221	450	0.75	20	17	1.00	4 480	0.12	
Facility Manager	221	450	-	-	-	1.00	-	-	
Rehab Care Workers (RCWs)	221	450	0.50	45	5	3.42	4 543	0.12	
Rehab Care Therapists (OT & Physio)*	221	450	0.40	30	6	0.57	909	0.02	
Help desk (admin person)	221	450				1.00			
*Allocated to CHC					Total FTEs	65			
	FTEs required for Home and Community Based Care						34.37		
	FTEs required for Primary Care services						33.36		

Table E.2: Module 2 of workload calculator – estimation of “head count”

Module 2 of Calculator: Estimation of number of patients (headcount) that visit the facility based on the number of contacts calculated in module 1			
AVERAGE NUMBER OF CONTACTS WITH HEALTH WORKERS PER PERSON DURING ONE VISIT TO A CLINIC			
Assumption:			
Consults by clinical nurse practitioners and doctors will be supported by patient contact with clinical support staff such as professional nurses, staff nurses and pharmacists.			Contacts
Medical doctors (including dentists)			9 300
		Support factor*	
	Clinical support: prep room & dressing room: staff nurse & nursing assistant	100%	9 300
	Pharmacy	98%	9 114
Clinical nurse practitioner			43 705
		Support factor*	
	Clinical support: Prep room & dressing room: Staff nurse & nursing assistant	100%	43 705
	Pharmacy	90%	39 335
Professional nurse (33% consultation; 67% support)			6 643
		Support factor	
	Clinical support: Prep room & dressing room: Staff nurse & nursing assistant	75%	4 982
	Pharmacy	90%	5 979
Total number of contacts			172 065
Number of patients (=headcount) treated during the above contacts (Curative cases)			59 649
Total number of contacts per annum (calculated in module 1)			252 791
Number of patients with one contact per visit (including group sessions)			80 726
Average contacts per person during a visit to a clinic			1.8
Patients (head count) per annum			140 375
Dependent population utilisation rate			3.82
Home based Care			
Total visits per annum by CHWs			54 514
Total visits per annum by Prof Nurse			7 168
Grand total			61 682
Utilisation rate			1.7
RCWs: total home visits per annum			4 543
Rehabilitation care therapists: total home visits per annum			909
Total: rehabilitation home visits			5 451
Utilisation rate			0.15
Total utilisation rate			5.65

***Support factor: the support required by clinical workers can be adjusted in this column**

Note: Tables E.1 and E.2 are selected screen prints of the calculator and therefore do not display all the columns and functions.

Given the close relationship between the PHC service and HBC, the CCW and RCW from HBC and associated professional nurse, therapist and administrative support components based at the clinic are all included in the PHC staff allocation above. The calculator is also used in determining the utilisation and workload of community health centres and community day care services.

ANNEXURE F: DEFINITIONS

The definitions are drawn from national documents and amended and adapted in line with the service platform of Healthcare 2030.

These definitions apply to health services i.e. services that involve patient contact for diagnosis and treatment provided by health professionals. The definitions do not cover support services such as catering, laundry, estate management, power generation, logistics, information systems, security etc., which are not core business and can be and are routinely subcontracted out to external providers.

Range of services (general or specialised)

General

A unit delivering a range of services usually related to an expected package and within the scope of service of the health practitioners providing the services.

Specialised

A unit delivering a particular type of service relating to a particular patient group, disease or treatment.

Primary Health Care

Primary care

(Non-admitted care – consultations, interventions, tests)

Services, generally falling within the skill base of a professional nurse, technician, mid-level worker, counsellor, community health worker, midwife and emergency care technician. These services may be the first point of contact or for follow-up care. The service may be supported by a medical officer.

Health post

A health post is a room in a house or other structure in a community from which a range of elementary primary health care (PHC) services are provided.

Mobile

A mobile clinic is a temporary unit from which a range of PHC services are provided and where a mobile unit/bus/car provides the resources for the service. This service is provided on fixed routes and at a number of points, which are visited on a regular basis. Some visiting points may involve the use of a room in a building, but the resources (equipment, stocks) are provided from the mobile when the service is available and are not maintained at the visiting point.

Satellite clinic

A facility that is a fixed building where one or more rooms are permanently equipped and from which a range of PHC services are provided. It is open for up to eight hours per day and fewer than four days per week.

Clinic

An appropriately permanently equipped facility at which a range of PHC services are provided. It is open at least eight hours a day at least four days a week.

Community day centre

A facility that is open 8 hours a day from Monday to Friday, at which a broad range of PHC services is rendered and a Medical Officer is present.

Community health centre

A facility that is open 24 hours a day, seven days a week at which a broad range of PHC services is provided. It may offer 24 hour Emergency services and/or midwifery services.

Specialised health centre

A facility that provides specialised care to particular groups of patients, usually for fewer than 24 hours at a time. There are many possibilities for such units, but the most common are obstetric units (open 24 hours and providing midwifery services) and renal dialysis units.

Intermediate care

Transitional inpatient care that follows or forms the latter part of an acute episode in which the patient has been investigated and diagnosed. The patient is in a stable condition and has a treatment plan but requires on-going inpatient nursing or rehabilitation care for fewer than 90 days.

Hospice unit

These cater for terminally ill patients requiring palliative care or respite care. They will be staffed by allied professions and specialist nurses. These specialised units may be on or off hospital site. Patients may be discharged from hospital into off-site units.

Acute Hospital Care

Day care

Treatment, observation or assessment that requires an extended stay, usually beyond the treatment or consultation as an outpatient, but with a duration of less than one day. Day care patients do not get counted in the midnight bed count.

Outpatient care

Services provided by and requiring the skills of a general medical practitioner, a medical specialist or an allied health professional to which patients are referred, usually by appointment, for more specialised opinions or care.

In-patient care

Patients are admitted to hospital for at least one night for diagnosis, investigation or treatment.

Level 1 care

Services that are within the skills base of a general medical practitioner or family physician and do not require the intervention of other general specialists or sub-specialists. These include simple surgery requiring a general anaesthetic.

Level 2 care (secondary)

Services that at some point during the intervention are beyond the normal scope of a generalist and require the input of a registered general specialist.

Level 3 care (tertiary)

Services that at some time during the intervention are beyond the normal scope of a general specialist and require the input of a registered sub-specialist.

Regulations Relating to Categories of Public Hospitals

(IN TERMS OF THE NATIONAL HEALTH ACT, 2003)

The following are the categories of public hospitals used in the 2030 planning, as defined in the regulations relating to categories of public hospitals in terms of the National Health Act, 2003, published in Government Gazette No. 35101 on 2 March 2012.

Categories of public hospitals

The following are categories of public hospitals:

- a. District hospital
- b. Regional hospital
- c. Tertiary hospital
- d. Central hospital
- e. Specialised hospital

District hospitals

Categories

District hospitals are categorised into small, medium and large district hospitals, according to the number of beds:

- a. Small district hospitals with no fewer than 50 beds and no more than 150;
- b. Medium-size district hospitals with more than 150 beds and no more than 300; and
- c. Large district hospitals with no fewer than 300 beds and no more than 600.

Purpose

A district hospital must:

- a. Serve a defined population within a health district and support primary health care;
- b. Provide a district hospital package of care on a 24 hour basis;
- c. Have general practitioners and clinical nurse practitioners (CNPs) of PHC;
- d. Provide services that include in-patient, ambulatory health services as well as emergency health services; and
- e. Where practical, provide training for health care service providers.

Support

A district hospital receives outreach and support from general specialists based at regional hospitals.

Specialist services

A district hospital may provide only the following specialist services:

- a. Paediatric health services
- b. Obstetrics and gynaecology
- c. Internal medicine
- d. General surgery
- e. The WCG : Health includes Family Medicine in District Hospitals.

Regional hospitals

Purpose

A regional hospital must provide on a 24-hour basis:

- a. Health services in the fields of internal medicine, paediatrics, obstetrics and gynaecology, and general surgery;
- b. Health services in at least one of the following specialties:
 - » Orthopaedic surgery;
 - » Psychiatry
 - » Anaesthetics
 - » Diagnostic radiology
- c. Trauma and emergency services;
- d. Short-term ventilation in a critical care unit;
- e. Services to a defined regional drainage population, limited to provincial boundaries and receiving referrals from several district hospitals; and
- f. Where practical training for health care service providers

Support

A regional hospital receives outreach and support from tertiary hospitals.

Number of beds

A regional hospital has between 200 and 800 beds.

Tertiary hospitals

Purpose

A tertiary hospital:

- a. Provides specialist-level services provided by regional hospitals;
- b. Provides sub-speciality services;
- c. Provides intensive care services under the supervision of a specialist or specialist intensivist;
- d. May provide training for health care service providers;
- e. Receives referrals from regional hospitals not limited to provincial boundaries; and
- f. Has between 400 and 800 beds.

Central hospitals

Purpose

A central hospital:

- a. Must provide tertiary hospital services and central referral services and may provide national referral services;
- b. Must provide training of health care providers;
- c. Must conduct research;
- d. Receives patients referred to it from more than one province;
- e. Must be attached to a medical school as the main teaching platform; and
- f. Must have a maximum of 1 200 beds.

Central referral services

These are provided in highly specialised units; require unique, highly skilled and scarce personnel; and are located at a small number of sites nationwide.

National referral services

- a. Refer to super-specialised national referral units; and
- b. Represent extremely specialised and expensive services (e.g. heart and lung transplants, bone marrow transplants, liver transplants, and cochlear implants).

Specialised hospitals

Purpose

A specialised hospital:

- a. Provides specialised health services like psychiatric services, tuberculosis services, infectious diseases and rehabilitation services; and
- b. Has a maximum of 600 beds.

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