



**Western Cape
Government**

Health

BETTER TOGETHER.

2020

The future of health care in
the Western Cape

**A draft framework for dialogue
November 2011**

2020 Strategic Framework

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Executive Summary

The Western Cape Department of Health is developing a strategic plan for execution by 2020. This builds on the foundation laid by the 1995 Health Plan and the 2010 Comprehensive Service Plan.

This discussion document is the start of a process to engage with our partners, clients and staff to develop the strategic framework for further reshaping of the service platform for 2020. This document will determine the framework within which the five-year strategic plan, annual and district health plans will be compiled. This document does not address the detail of the Provincial Strategic Objective of increasing wellness. An overview of the burden of disease and the steps to address the upstream factors that contribute to the burden is included in Annexures A and B; further information can be found at www.westerncape.gov.za.

The circulation of this document will be supported by facilitated conversations to better communicate and engage with all those involved. Questions are also raised in the document to stimulate thinking on certain specific areas.

It is important to reflect on the achievements to date, what worked (and what did not) and the lessons learned. While a formal external evaluation of the 2010 plan has not been undertaken, this document summarises the most important achievements and lessons learned. An important theme throughout the document is what should be done differently. (Section A).

What is the case for change? The compelling motivation for change includes changes in provincial demography, socio-economic determinants of health and the burden of disease; advances in technology; and the global, national and provincial policy environment. Sustaining the current good practices, and improving others, is key to becoming a world class organisation. We must focus on key priorities and the most cost-effective interventions within the limited resources available. (Section B)

The planning for 2020 takes cognisance of both national and provincial policy developments. Important policy frameworks include the “green paper” on the National Health Insurance, the national Human Resources for Health framework and the provincial strategic plan, with particular emphasis on Strategic Objective 4 (Improving Wellness). (Section B).

The main causes of the quadruple burden of disease in the Western Cape can be categorised as HIV/ AIDS and Tuberculosis; injuries, non-communicable diseases, such as cardiovascular disease, mental illness, etc. and women’s and childhood illness. Prevention of disease and the promotion of wellness is the basis of health service development. The upstream factors that contribute to the burden of disease will be addressed with the relevant stakeholders through a “whole of society” approach. This approach has been recently endorsed through the Cape Town Declaration on Wellness. The Department of Health will focus on prevention and downstream promotion within the health service delivery platform. (Annexures A and B).

The Department has drafted a broad strategic overview of a desired health care system in 2020. Seven guiding principles have been identified to guide the 2020 strategy (Section C):

- 1. Patient-centred quality of care**
- 2. A move towards an outcomes-based approach**
- 3. The retention of a Primary Health Care philosophy**
- 4. Strengthening the District Health Services model**
- 5. Equity**
- 6. Affordability**
- 7. Building Strategic Partnerships**

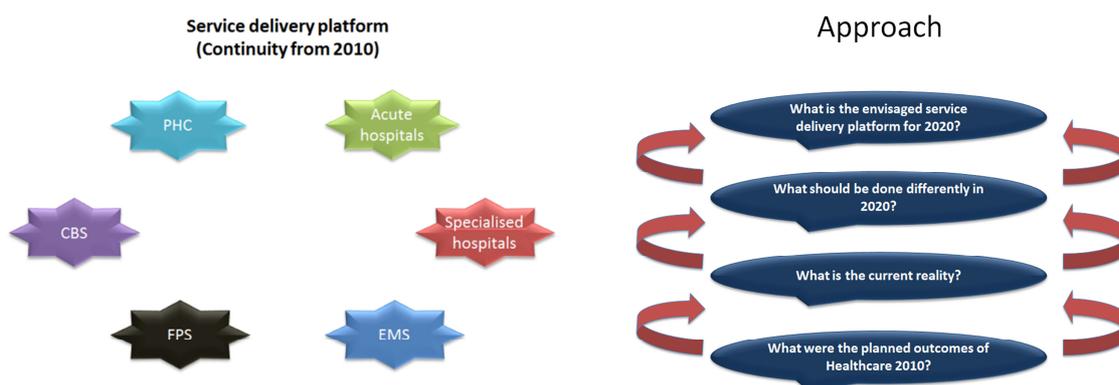
These principles are described in greater detail in the document to facilitate a shared understanding that will enrich the final 2020 document. (Section C: 6.1).

Addressing values is key to the building of a cohesive organisation as well as guiding how staff act and behave in the Department. The Provincial Government has adopted a values-driven approach. A Barrett's survey of the values of the provincial workforce - and within the Department - has identified the potentially limiting values as *bureaucracy, hierarchy, control, long hours* and *confusion*. There was a general consensus on the *desired* set of values across all categories of staff: *caring, competence, accountability, integrity* and *responsiveness*. The Department has added the value of *respect*. The challenge is how to translate the desired values into a daily reality in the department. (Section C: 6.2).

At the heart of the strategic planning process is the vision of achieving "Access to client-centred quality of care". A detailed "vision narrative" attempts to capture multiple perspectives from the viewpoint of a patient, a staff member, the community, the department, provincial government and strategic partners. The action steps in the narrative are highlighted to form the basis for annual performance plans that should contain incremental steps towards achieving the strategic vision for 2020. (Section C: 6.3).

The key outstanding question is how the service delivery platform should be structured by 2020? The Department has posed four strategic questions captured to each of the components of the platform as illustrated below. (Section D)

Figure 1



The approach promotes continuity from the Comprehensive Service Plan adopted in the 2010. While the document has expressed views on each of these questions it is hoped that the rich experience of many stakeholders in the health sector will assist in reshaping the future of public sector health care delivery in this province. The approach has been to strengthen the overall health service as a system. The framework therefore does not describe specific institutions, disciplines, health programmes or levels of service.

Improving the patient experience and the quality of care is at the heart of the vision for 2020. An audit of health facilities in the Western Cape is currently assessing compliance with the national core standards. The results of this audit will form an important baseline and identify the shortfalls within health facilities that need to be addressed. This will form the basis of a continuous quality improvement plan towards 2020. A coherent approach to improving quality will be developed over the next few months. (Section D).

Support Services, which include Human Resource Management, Financial Management, Strategy and Health Support; Infrastructure and Health Technology, will also be required to develop strategies to support the principles, values, vision, and reshaped health service delivery platform for 2020. The document outlines preliminary proposals in this regard for comment. These support services are a key enabler to the efficient and effective delivery of health services. (Section E)

This document envisages extensive participation from all stakeholders to partner with the Department to improve the health status of the population in the Western Cape Province. This participation ranges from an active role in the governance of health facilities to supporting community campaigns to promote healthy lifestyles. It also encourages people to take responsibility for their own health.

The Department will strengthen its capacity to assess the impact of the various initiatives on the health status of the population, including health programmes, the package of services being delivered and the upstream interventions being embarked upon through the Provincial Transversal Management System. This health impact and evaluation unit will play an important role in providing the necessary public health intelligence, including guidance based on local and international research, to demonstrate which interventions are most cost effective. This input will strongly influence the short, medium and long term planning and budgeting priorities. Quarterly monitoring of outputs against the annual performance plan will also be strengthened. This is important to monitor implementation and performance of public health services in the Western Cape. (Section F).

1. Introduction

The Department is developing a strategic planning framework for 2020. This is an exciting and important opportunity to shape the future of health services in the Western Cape. It is hoped that this process will generate a positive energy and momentum both within the Department as well as with our strategic partners.

This framework builds on the foundation laid by the 1995 Health Plan and the 2010 Comprehensive Service Plan. The health reform process should be seen as an on-going journey beyond 2020.

The final 2020 document will determine the shape and the functioning of the health service platform. It will provide the framework within which the five-year strategic plan, annual and district health plans will be compiled. This document does not address the detail of the Provincial Strategic Objective of increasing wellness. An overview of the burden of disease and the steps to address the upstream factors that contribute to the burden is included in Annexures A and B; further information can be found at www.westerncape.gov.za.

2. Comprehensive Service Plan 2010 – Lessons learnt and achievements.

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

The protracted 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, intensive 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.

2.1. Achievements:

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

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

2.1.1. District Health Services (DHS)

- Implementation of the district health system, including the unbundling of the Metro Primary Health Care service (PHC) into more manageable substructures,
- Strengthening the district health service by the appointment and training of family medicine specialists and expansion of the clinical nurse practitioner cadre,
- Improvement in access to health care by expansion of the community and home-based services,

2.1.2. Acute hospitals:

- Strengthening of general specialist services in rural regional and central hospitals,
- Re-classification of acute hospitals in line with the requirements of the comprehensive service plan,
- Improved co-ordination and rationalisation of tertiary services across certain areas of the central hospitals,
- Interim Khayelithsha and Mitchells Plain Hospitals have been established at alternate sites that will relocate to the new hospitals when they are commissioned.

2.1.3. Mental hospitals

- De-hospitalisation of chronic psychiatric and intellectually disabled patients,
- Several mental health care policies have been developed and a Mental Health Review Board that provides oversight has been well established.
- The Mental Health Care Act required the main streaming of the management of mentally ill patients. While there were formidable challenges in implementing the Act, significant progress has been made especially at district and regional hospitals.

2.1.4. Infrastructure

- Major progress in the revitalisation of the physical infrastructure of the rural regional hospitals, some district hospitals, several ambulance stations and forensic mortuaries.
- Upgrade and building of a number of PHC facilities.
- Constructed a state of the art Western Cape Rehabilitation Centre (WCRC) to replace an out-dated rehabilitation service facility at Conradie and Karl Bremer Hospitals.
- Construction of two new district hospitals in the Cape Town Metro in Khayelithsha and Mitchells Plain is at an advanced stage.

2.1.5. Emergency Medical Services (EMS):

- The communication centres in EMS have been modernised, a significant number of the ambulance fleet has been replaced, the staff complement was expanded and strengthened and "one man ambulances" was done away with.

2.1.6. Provincialisation:

- A range of services including those provided in 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, EMS provided by local government were transferred to the provincial Department of Health.

2.1.7. Human Resources:

- Revised organisational establishments have been developed for most institutions in line with the CSP.

2.1.8. Financial Management:

- Instruments to control expenditure and manage the filling of posts in line with the CSP have been developed and institutionalised.

2.1.9. Packages of care:

- A revised package of care for acute hospitals was finalised

2.1.10. Clinical governance:

- A clinical governance policy has been developed and will be revised in the light of 2020.
- Initially a system of co-coordinating clinicians and later general specialist heads, family physicians and provincial co-coordinating committees were appointed to provide leadership in this area.

2.1.11. Service Shifts:

- Rehabilitation services were relocated from Conradie and Karl Bremer Hospitals to the newly established Western Cape Rehabilitation Centre at Lenteguur. Level one obstetric services were moved out of Tygerberg Hospital (TBH) to Karl Bremer and level two services from Karl Bremer to TBH.

What are other major achievements that you would identify from the implementation of the CSP?

There are important policy and service developments not directly linked to the CSP that are not described here.

2.2. Lessons Learnt from the CSP 2010:

The above list does 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 complete separation of services in acute hospital by levels of care more especially in the central hospitals.
- Full access to specialist services at rural district hospitals by outreach and support from the regional hospitals in the designated catchment area.
- The relocation of specialist services from the larger designated district hospitals such as the GF Jooste District Hospital in the Cape Town Metro.
- The limitation of highly specialised Intensive Care Unit services only to the Central hospitals.

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.

From this 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 the planning and implementation toward 2020.

The above is not a comprehensive evaluation of the CSP or the health services.

The performance of the Department can be more accurately measured by the health outcomes and the many other service related achievements.

What other lessons can you identify that we should learn from implementing the CSP?

2.3. *What will be different from CSP 2010 as we plan for 2020?*

The Department believes that the CSP has laid a strong foundation and infrastructure for health services in the Western Cape. A major focus going toward 2020 will be to superimpose a new strategy on the existing base to:

- Improve the patient experience;
- Improve quality of care; and
- Strive for further operational efficiencies.

The provincial approach to health service development is directed by the principles, values and vision for 2020 outlined below. This involves a values-driven approach focusing on building the commitment of our staff to being client-centred, improving the patient experience of the service, and continuously improving the quality of care.

From a public health perspective, the focus will shift to the most cost-effective interventions required to address the upstream and downstream factors impacting on the burden of disease, and thus achieve the desired health outcomes. This implies an increased focus on prevention and promotion. The upstream interventions will require a “whole of society” approach as these factors fall outside the direct influence of the health sector.

The 2020 vision is based on improving health outcomes within demarcated geographic areas and defined populations. This is described in greater detail later in the document.

The Department will also increase the emphasis on improved information management and optimising the opportunities provided by advances in Information technology.

At the technical level there have been developments that were not factored into the planning of the 2010 CSP that must now be addressed. These include, for example, Extreme Drug-Resistant Tuberculosis (XDR-TB) and the increased service load on acute psychiatric services as a result of the TIK (crystal methamphetamine) epidemic.

The assumptions and technical aspects of shaping the 2020 health service platform are discussed in the service plan outlined below. The approach to 2020 focuses on a “care pathway” across the various levels of the health service and emphasises the strengthening of the general health service platform and system as opposed to individual health programmes or disciplines.

Suggest what you think should be different in the planning for 2020 and what should be done differently going toward 2020?

3. *What is the Compelling Case for Change?*

The Department is an organisation that is performing well in many respects and the province currently has amongst the best health outcomes in the country. Nevertheless, a compelling context for change remains:

Health outcomes: Despite the fact that the provincial health outcomes are good they are still significantly behind what is required by the MDG targets. Achieving these targets has now become one of the key drivers of the strategy for 2020.

Changing environment: Cognisance has to be taken of the on-going changes in the environment. These include demography, socio - economic determinants of health, politics, burden of disease and the associated risk factors, advances in technology, and finally the global, national and provincial policy environment.

Public expectations and accountability: There is a growing awareness and demand in the Western Cape for the right to adequate, good quality health care.

Sustaining and improving good practice: While the department currently performs well on many fronts and has consistently achieved an unqualified audit, there is a need to embed and institutionalise good practice to sustain and improve the performance. The culture of organisational learning needs to be improved to raise the performance bar even further.

Limited resources: There will always be a tension between limited resources and health needs with the latter being almost without limits. This requires that the department constantly stretch and optimise the value of the health rand. It is important to ensure that the priorities are identified and that scarce resources are allocated to the most cost-effective interventions. Productivity and operational efficiency must be addressed.

If the department aims to become a world-class regional Department of Health, then the above-mentioned contextual factors must be addressed.

What other contextual factors would you include other than those mentioned in this document?

4. **National context**

The National Government has finalised the national strategic priorities and it is encouraging that health has been identified as one of the top priorities.

The vision of the National Government for the health sector, "A long and healthy life for all South Africans", is reflected in the Negotiated Service Delivery Agreement (NDSA) between the President and the National Minister of Health. The ten point health plan is an additional important national framework.

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

- 1) Increase life expectancy
- 2) Decrease maternal and child mortality
- 3) Combat HIV and AIDS and decreasing the burden of disease from tuberculosis
- 4) Strengthen health system effectiveness.

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

The "green paper" setting out proposals for National Health Insurance has been released for public comment. Early indications are that there will be major implications for the public and private sector in terms of organisational arrangements as well as resourcing the provision of healthcare. The policy intent is to improve access to quality care and a more equitable resourcing of health service provision across the public and private sectors. The implementation of the NHI is seen as an incremental process over 14 years.

The National Health Act has been amended to provide for an Office of Standards Compliance. A baseline audit and related processes that has started in the Western Cape is an initial step in this regard. The PHC re-engineering strategy aims to strengthen the district health services with certain focus areas such as Mother and Child Health, Community-Based Services and School Health.

5. Provincial context

The Provincial Government of the Western Cape (PGWC) has released the Provincial Strategic Plan, which is available on the provincial website. This plan provides an important provincial context and the strategic direction for the provincial government for the next five years.

Strategic objective 4 (Improving Wellness), signals an important conceptual shift from focusing on management of disease to the promotion of wellness. This strategy has two major thrusts (i) a whole of society approach to wellness focused on primary prevention; i.e. preventing disease before it happens and (ii) improvement in the quality of care and the patient experience within the health service.

Understanding the nature and risk factors or drivers of the causes of mortality and morbidity, otherwise known as the “burden of disease” is the foundation of the provincial strategy. The burden of disease in the Western Cape is summarised in Annexure A.

The main causes of the quadruple burden of disease in the Western Cape are categorised as HIV/AIDS and Tuberculosis; injuries, non-communicable diseases, such as cardiovascular disease, mental illness, etc. and women’s and childhood illness.

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

The upstream factors contributing to the burden of disease are being addressed through the Provincial Transversal Management System (PTMS), which will address issues that are transversal across departments, spheres of government and civil society. The provincial initiative will be supported by a renewed focus on prevention and promotion within Department of Health. See Annexure B.

One of the key thrusts for improving health services is to address secondary and tertiary prevention meaning the early identification of disease and its effective management to reduce complications and undesirable sequelae that would result in high levels of morbidity and mortality.

The national and provincial health priority frameworks are both aligned with the Millennium Development Goals and targets.

The Provincial Strategic Plan of the Western Cape Government is available on the provincial website Cape Gateway: www.capegateway.gov.za/

Do you agree with the priorities and strategic direction in the plan?

6. Principles, Values and Vision for the Comprehensive Service Plan 2020

6.1. Principles that inform the vision for 2020

Each of the principles is described in detail to ensure that the meaning of each principle is fully understood and interpreted in the same way.

6.1.1. Client Centred Quality of Care

The quality of care, with a focus on patient experience, lies at the heart of Healthcare 2020. 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 drugs must be available at all times.

6.1.2. A move towards an outcomes based approach

The department will focus on improving the health outcomes, which will include improving life expectancy and reducing maternal and child mortality. Targets will be guided by the millennium development goals. 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.

6.1.3. The Primary Health Care (PHC) 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 or client. 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. As per the World Health Organization, health or wellness is not seen as the mere absence of disease but a holistic state of physical, mental and emotional well-being. This requires a strong inter-sectoral approach to improving health and wellness which is further elaborated below. A central tenet of the PHC philosophy is the community involvement in health. This implies not only taking ownership and responsibility for their own health care at a personal level, but as a community also being actively involved in the decision making and governance of health services.

6.1.4. Strengthening the District Health Services model

The DHS model gives a district manager and his or her team responsibility for achieving the health outcomes targeted for a specific geographical area that is a health district. All health services (public and private) provided within the area, are co-ordinated by the district health management team. The district manager is accountable and also plays a stewardship role in securing and accessing the support of other levels of the service. Health is delivered within well-defined sub-district and district boundaries in the province. All public sector health services should optimally be provided by a single authority. This is already the case for the rural districts. This consolidation will result in better co-ordination and improved efficiencies. The district model must be further strengthened to ensure the desired health outcomes in Healthcare 2020.

6.1.5. Equity

Serious inequity continues to exist after 17 years in post-apartheid South Africa. 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, important principle of social justice. While this is a broader issue for government, the Department will need to address equitable allocation of resources, provision of services and monitor health outcomes.

6.1.6. Affordable Health Service

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. 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.

6.1.7. 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.

There is a realisation that improving health status of the population requires a whole of society approach and that the capacity and resources within the private sector needs to be engaged given the disparity between what is spent versus the population coverage in the public and private sectors.

The provincial 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 which provides a structured opportunity for engagement with the private sector.

The document, Human Resources for Health Strategy for the Health Sector: 2012/13 – 2016/17, outlines the major challenges in the training of health professionals. The production of competent and caring health professionals is an essential requirement to enable the Department to deliver on its 2020 mandate. Research will play an important role in improving the performance of the Department. It is important that the partnerships between the department and the universities are strengthened.

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.

Primary Health Care services has been transferred to the provincial government - or provincialised - in all the rural districts. Provincialisation of health services in the City of Cape Town (COCT) will be addressed towards 2020. Good structural arrangements are in place to work with the COCT to co-ordinate and jointly manage the service in the Cape Town Metro.

The provision of environmental health is an important component of PHC and both spheres have to work together 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, non-profit and community-based organisations have become increasingly important as providers of community-based services. This will be a major area of further expansion and strengthening of the services towards 2020. Good structural and contractual arrangements, as well as strong collaborative management, are key to success in this area.

6.2. **A values-based approach**

The department renders a large and complex service every day of the year and the clinical environment is often stressful. Staff attitudes are the common source of complaints. A key issue is how greater commitment and engagement from our staff can be promoted on a daily basis, moving towards a more client-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. A Barrett's Survey was conducted to provide a baseline assessment amongst staff.

From this process the five core values of the provincial government were identified as *caring, competence, accountability, integrity* and *responsiveness*.

After an internal reflection the Department added *respect*.

The potentially limiting departmental values were identified as *bureaucracy, hierarchy, control, long hours* and *confusion*. There was a general consensus among all staff on the *desired* set of values for the department. These surveys will be done undertaken annually in the provincial government.

Department of Health: Core Values

Caring, Competence, Accountability, Integrity
Responsiveness, Respect

The challenge of the Department is how to make these values a living reality for each of the staff members across the Department as we move towards our vision for 2020.

How do these values align with your values?

What ideas do you have on how staff live out the values (actions and behaviours) in their daily work?

6.3. **The Visioning Process**

The strategic planning process provides an opportunity to redefine the departmental vision for 2020. 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, in partnership with the provincial government, to take responsibility for their health and for the Department to achieve amongst the best health outcomes in the world.

*At the heart of the vision for 2020 lies the concept of:
“Access to client-centred, quality care”.*

There are two other options for a clause that captures the vision for 2020 suggested in the box below. Your creative suggestions will be welcomed.

Access to client centred, quality of care

or

Improving health outcomes and patient experience

or

Making a difference to health outcomes and patient experience

What would you propose as the vision for 2020?

There was a debate regarding “patient centred” or “client centred”. Client centred was adopted as the term client is broader and includes people who are not ill but access health services for family planning, immunisation or screening programmes in schools. In addition there are both internal and external clients served by support services and other sections of the department.

The proposed vision statement for 2020 is:

Creating a superior patient experience by delivering the best possible health care for individuals and the community, through a well - managed, modernised and balanced health service. Competent, caring and committed staff work in partnership with communities, civil society and all spheres of government to help people achieve and maintain wellness.

To bring the vision for 2020 to life, we have described 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 actionable steps required to give effect to it are highlighted in the text. In this way, the vision can also be used to identify the incremental strategies and tasks for the next decade.

The expanded vision statement

Preamble:

Access to health care is a constitutional human right in South Africa. Achieving optimal health outcomes and health status 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 healthcare by 2020. This will be achieved in partnership with caring, competent and committed staff, aided by contemporary 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 2020 if the vision is achieved.

What does it mean for patients?

The client experience at a health facility:

A client 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 is equipped to respond to any queries of the patient or family member and to direct the patient to the necessary sections of the facility. The client will **not wait longer than is reasonably acceptable**; as their **file will be available, since the patient would have an appointment for a planned visit**.

The client will move smoothly through the well-sign posted facility without delays at any service point. The **relationship between the client or patient in this case, will be on a one-to-one basis, which will build trust and confidence in staff. Clients are respectful of health workers and the facility**. Further, the patient will be able to take responsibility for treatment compliance 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 **environmental friendly and efficient**.

The client 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 both clients and communities.

Staff is motivated and exercise initiative. The **attitude and actions of staff towards patients** is one of **caring and clinically competence**. Staff is empathetic, not only about the immediate illness that the patient faces but they also have an **understanding of the broader**

context and challenges faced by the patient, their family and community. Staff will feel a **part of the local community** and will be encouraged to participate in local activities.

Staff will be fully engaged, 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. Systems will be created to ensure that staff have access to knowledge networks and feel **supported by their peers, supervisors and management.** They will feel 'heard' **and their problems will be efficiently addressed. Staff will feel safe in their workplace.**

What does it mean for the community?

The health service operates such that the community **trusts and has confidence in the service and in 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.

There is a full team of community health workers (CHWs). 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 prevention and promotion. Patients are referred to the clinic when necessary or managed at home. They identify **social problems and liaise with local social services, when necessary. CHWs should, preferably, live in the same area in which they work and have a good working relationship with the staff of their local clinic.**

The community **takes responsibility for their health** by adopting healthy lifestyles. Patients will also feel supported because for example, community members will help people to ensure that they take their medication correctly and attend their health facility, when required.

The community is healthy and happy with low levels of unemployment. 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 opportunity. People feel it is safe to walk on the streets during the day or night because there is little or no crime. Good sporting facilities and libraries with internet connectivity raise the quality of life. Public transport is affordable and accessible.

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

The Department has achieved a reputation as the best Health Department on the continent, rendering a health service that is regarded as amongst the best public sector health service in the world. This reputation was 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 act on the determinant risks to the health of the people.

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 organisation operates **efficiently within its budget** and renders a service that is financially sustainable. It receives **unqualified audits** as a matter of course. The Department has clear **strategic and operational plans, with definitive targets and is publicly accountable for results, 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 with 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 goal** of providing better healthcare for the population. 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**, regards their interests as workers to be protected. There is a **good relationship** between organised labour and the Department resulting in **labour stability, which promotes good quality essential patient care.**

The relationship with universities is intrinsic to delivering an effective health service. Well-trained, competent and caring health professionals are essential to providing a quality, patient-centred experience. Research is necessary to better understand the complex health service and improve clinical care. Interventions need to be evaluated to learn lessons. Best practices will be shared and the relationship with universities used to improve the performance of the department on an on-going manner.

Information Technology is essential for the provision of the health services and progress in this field will enable the Department to make great strides in improving our service delivery and increase efficiency. The **availability of mobile technology amongst the general public provides great opportunity to interact with the community differently.** The Centre for e-Innovation (CEI) within provincial government will provide leadership and support to facilitate progress in this regard.

The Department of Transport and Public Works, as the implementing agent is a significant partner in enabling us to **build and maintain infrastructure cost-effectively** for health service delivery. The future vision is that the Department of Transport and Public Works is an effective implementing agent, which will consequently promote **modernised and adequately equipped facilities.**

There will be a strong contractual relationship with Non-Profit Organisations (NPOS) to improve access to basic health services, especially at a community level, based on an agreed funding formula.

The partnership with the private sector is essential in the interests of improving access to and the quality of patient care. Where there is capacity to provide specific services, the department will draw upon the private sector. Suppliers are paid on time and the mutually dependent relationship is strong.

What does it mean for the Western Cape Provincial 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 at all levels.

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

Institutions, support services and other components of the service are encouraged to develop their own 2020 vision narratives.

What would you wish to add to the Vision narrative for 2020?

7. Leadership and Governance

7.1 Leadership

The primary role of leadership in developing a shared vision of 2020 and effective strategies to implement the vision cannot be emphasised enough. Leadership is a collective responsibility between administrative and clinical management at all levels of the organisation. Strengthening this collective responsibility is an important enabler to 2020.

It is important that the leadership of the Department lead by example, live the espoused values of the organisation, are visible, accessible and show a willingness to listen to the staff, the public and stakeholders and provide the strategic direction and stewardship on an ongoing basis that amongst others includes advocacy for an inter - sectoral approach to improving wellness and fostering a culture of innovation and continuous improvement.

7.2 Governance

Governance is a complex area and described in various ways. In addition to models provided by the World Health Organisation, the King III Report on Governance Principles also applies to the public sector. In the context of 2020, it refers to the policy and institutional arrangements that refer to the power, authority, oversight and decision making arrangements in the provision of health services.

7.2.1 Legislation and 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.

Other policy and strategic planning frameworks have been referred to under the national and provincial context above. Operating within the rule of law is an important principle in good governance.

7.2.2 Public Participation

Broader public participation and local community involvement is an integral part of the 2020 principle of primary health care philosophy.

The provincial Facilities Boards Act makes statutory provision for community participation and this Act will be reviewed to provide more systematically for clinic committees and health forums. The provincial District Health Councils Act which provides a structured mechanism for local government representatives and community members and the Department of Health to engage has been proclaimed. The inaugural meetings of these councils are currently being convened. Greater efforts will be made to make the statutory structures more functionally effective as voices of the community.

2020 envisages participation from the public and local communities in partnerships 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 network of community based organisations and non-governmental organisations will be supported and engaged as part of this process.

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 sharing of information.

Patient satisfaction surveys and complaints and complements from patients will be important sources of feedback to the health service and used as a basis for continuous improvements.

7.2.3 Accountability

The Public Finance Management Act (PFMA) together with a range of treasury prescripts provides the legal framework for the efficient and effective 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). These processes are open to the public but generally poorly attended. Greater effort will be made to communicate these plans and reports to the public. Transparency and information sharing is an important prerequisite for accountability.

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.

7.2.4 Management

Management at all levels of the organisation have the responsibility of ensuring the efficient and effective use of resources in the provision of good quality health care.

Forging strong relationships with strategic partners and local communities are also an important responsibility of management. The strengthening of management cannot be emphasised enough.

8. A detailed review of the conceptual framework for the Service Delivery Platform for 2020

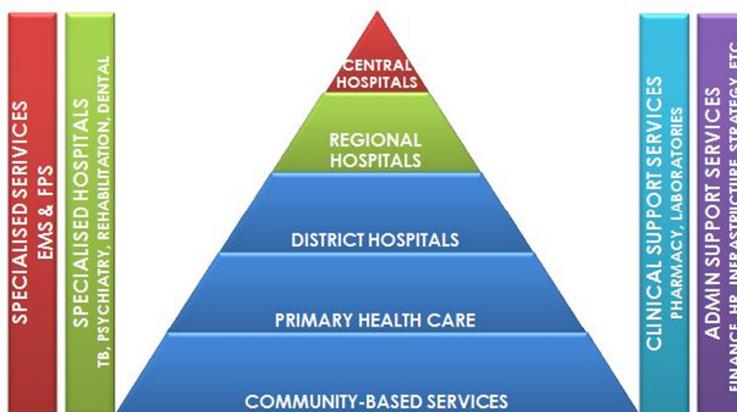
8.1 Preamble

The health service platform consists of various facilities and organisations through which the Department delivers a comprehensive health service to the people of the Western Cape and beyond. The service platform includes all types of service at all levels of care:

- District Health Services includes: community-based services, primary health care provided at clinics and community health centres and district hospitals or level 1 service.
- Regional hospitals provide general specialist care or level 2 services.
- Central hospitals provide general specialist services as well as highly specialised care or level 3 services.
- Specialised hospitals provide specific specialist services such as TB hospitals, psychiatric, rehabilitation and dental hospital services
- Emergency Medical Service provides emergency transport services and planned patient transport (HealthNET).
- Forensic Pathology Services whose responsibilities include death scene investigation and post mortems for unnatural deaths.

The service platform is captured in the conceptual diagram below.

Figure 2: Components of the Health Service Platform in the Western Cape



The broad conceptual design of the service that was developed for the Healthcare 2010 strategy and the Comprehensive Service Plan (CSP) will remain largely unchanged with more than 90% of patient contacts occurring at District Health Services. However, there are certain aspects of the CSP that require review and lessons from the process will influence future planning towards 2020.

Factors that need to be considered in the development of the 2020 service platform include the changes in the size of the population and other demographics, the health status and burden of disease of the population and socio-economic patterns.

The development of the service plan will provide guidelines for the quantum and type of service required per geographic area and the broad referral patterns or care pathways within the Province in order to provide equitable access to health care.

Based on the service requirements, the number and skills mix of staff can be determined as can the future infrastructure requirements. This information forms the basis for determining the financial cost of providing the service.

In planning future services it is important to forecast the impact of changes envisaged in one component of the service on other components. For example what will be the impact of strengthening community-based services on primary health care and acute hospitals?

This section analyses the approach to strengthening the health service platform as a whole. Superimposed on this will be the more focussed approach to addressing health outcomes and the quadruple burden of disease.

The following four questions have been used to examine each element of the “care pathway” within the Service Delivery Platform as a guideline for the approach in planning for 2020:

- 1) What were the planned outcomes of Healthcare 2010?
- 2) What is the current reality?
- 3) What should be done differently in 2020?
- 4) What is the envisaged service delivery platform for 2020?

In addition, we review technical progress, review a typical patient's journey on the “care pathway” and consider Geographic Service Areas.

The approach to 2020 has been to strengthen the mainstream health service in general. This focus does not address specific disciplines or types of services or institutions.

8.2 Overview

8.2.1 What were the planned outcomes of Healthcare 2010?

The driving force behind the development of Healthcare 2010 was the need to improve the quality of care and reshape the service delivery platform in a manner that would both address the health need and that would be financially sustainable. It was acknowledged that if nothing had been done to address these issues in 2010 there would have been a projected R1 billion shortfall (2001 Rand). An important factor contributing to the financial pressure was that patients were not managed at the most cost-effective level of care due to the lack of an effective district health system (DHS).

One of the underlying principles of Healthcare 2010 was the primary health care approach which led to the strengthening of district health services. This improved access to services without compromising the quality and access to care. An efficiently functioning district health system facilitates prompt diagnosis and treatment of patients and reduces the need for unnecessary and expensive hospital care. General specialists in regional hospitals have strengthened outreach and support to the DHS. Central hospitals primarily provide highly specialised tertiary health care within the allocated conditional grant as well as provide support to general specialists in regional hospitals.

An important component of an efficient district health service is a well organised community-based system which focuses on continuity of care and preventive and promotive health services.

8.2.2 What is the current reality?

In 2011, the Department achieved the target of providing approximately 90% of patient contacts in the district health system. In the 2010/11 Annual Report the primary health care headcount was 16.2 million, the community-based care headcount was 4.6 million and there were 1million patient “day equivalents” in district hospitals.

There are areas where the health outcomes remain a significant challenge as a result of various factors. Achieving the MDG targets remains a major challenge.

The Department has provincialised primary health care services in the rural areas but the provision of these services remains fragmented in the Cape Town Metro District where the services are provided by the City of Cape Town and the Provincial Government Department of Health.

The quality of care and patient experience are in many instances sub optimal.

8.2.3 What should be done differently in 2020?

The driving force behind 2020 is the need for a stronger patient-centred approach that focuses on improving the patient experience and the technical quality of care. There should also be a shift in focus from the management of disease to promoting wellness.

The primary health care approach adopted for Healthcare 2010 should be strengthened. A new focus is the provision of a comprehensive service within a particular geographic service area (GSA). The underlying principle is that the management of the GSA is the custodian of the health outcomes of the people in their area and responsible for ensuring that patients receive the continuity of care that they require at all stages of their illness. The district management will be responsible for ensuring access to services that fall outside of those provided by the district health system.

8.2.4 What is the envisaged service delivery platform for 2020?

The “care pathway” for patients in the health system that describes the patient’s journey through the health system will be dynamic and include:

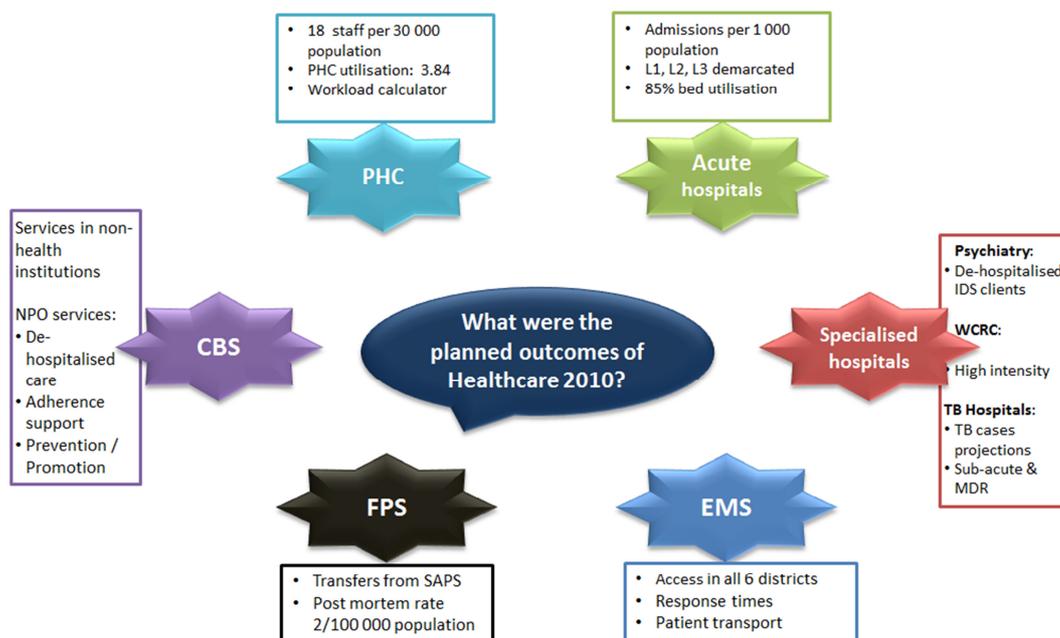
- A continuum of care that is planned to meet the needs of individual patients;
- A map of the patient’s journey through the system for the entire health care intervention;
- Consideration of the patient’s goals, needs and lifestyle.

The characteristics of the envisaged health service are described above in the 2020 vision statement. From a departmental perspective valid and reliable data will be available to monitor health outcomes against targets.

8.3 Application of the four questions to the respective components of the service delivery platform

8.3.1 What were the planned outcomes of Healthcare 2010?

Figure 3: Healthcare 2010 Plan



1) Community-based services (CBS):

The CBS platform consists of:

- De-hospitalised care which includes: chronic care, sub-acute care, palliative care, mental health care and home-based care;
- Adherence support; and
- Prevention of disease and promotion of health.

2) Primary health care (PHC):

The characteristics of the Healthcare 2010 model for PHC included:

- PHC utilisation for the total population of 3.84 visits, i.e. every member of the population will, on average, visit a public health facility 3.84 times per year.
- The basic staffing unit is 18 staff members per 30 000 population which provides the optimal number and skill mix of staff for a clinic.
- A workload calculator was developed to determine the number and skill mix of staff required at different types of facilities.
- A direct patient care factor of 75% was used in the workload calculator to determine the number of staff required.
- PHC facilities provide the packages of care as identified in the Comprehensive Primary Health Care Service Package for South Africa first published by the National Department of Health in 2001.

3) **Acute hospitals:**

- The number of beds required in Level 1 and 2 services was determined by the number of admissions per 1000 population.
- The number of Level 3 beds was initially planned as needed within a balanced health system but finally determined by the allocation of the National Tertiary Services Grant and other conditional grants.
- The average target bed utilisation rate was 85%.
- Staffing levels were determined by the level of care using workloads and time allocation per average patient and other responsibilities (admin, teaching and training etc.).
- Beds were clearly demarcated according to level.

4) **Specialised hospitals:**

- **Psychiatric hospitals:**

- The implementation of the Mental Health Care Act 17 of 2002 and the implementation of the Mental Health Review Board.
- The distinction between psychiatric patients and those with intellectual disability (IDS).
- Focussed on de-hospitalising long term psychiatry and IDS clients.
- Increasing capacity to manage acute patients both within the general mainline health service and the psychiatric hospitals.
- Developing models of care for managing stable patients within communities.

- **Western Cape Rehabilitation Centre (WCRC):**

- Patients requiring specialised rehabilitation were relocated from Conradie Hospital which was subsequently closed, and from Karl Bremer Hospital.
- The WCRC was developed as a brand and centre of excellence for rehabilitation.

- **Tuberculosis (TB) hospitals:**

- TB hospitals, previously managed by SANTA, were to be provincialised as per a national decision.
- Provided for the admission of all sub-acutely ill TB clients and all multi-drug resistant Tuberculosis (MDR TB) clients for four months.
- The number of TB hospital beds required was projected based on:
 - The number of TB cases projected in the ASSA model; and
 - The assumption that patients with certain levels of acuity required hospital admission.

5) **Emergency Medical Services (EMS):**

- In terms of the Constitution of South Africa, access to emergency medical services is a right.
- The aim of Healthcare 2010 for emergency medical services was to determine the requirements for emergency medical services which include the following components: ambulance services, rescue services, aero-medical services, planned patient transport and a specialised communication service.
- When a call for emergency medical services is registered with the communication centre the appropriate service must be dispatched.

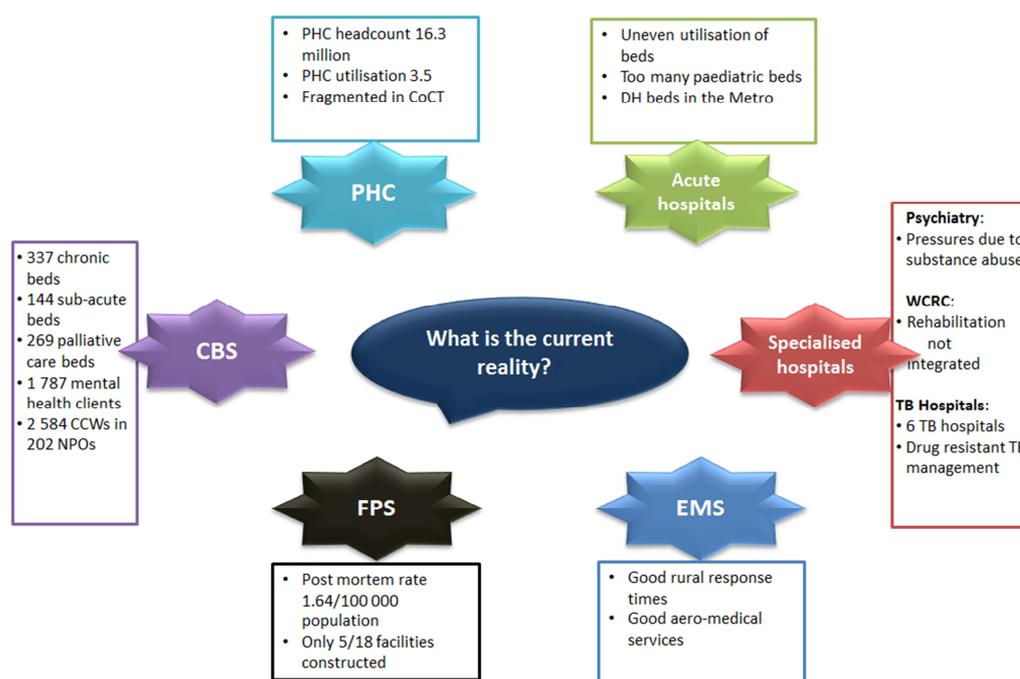
- The intention was that all communities must have access to emergency medical services within the response time targets which are:
 - Urban Priority 1 responses within 15 minutes;
 - Rural Priority 1 responses within 40 minutes; and
 - All calls with a response time within 60 minutes.
- Patients who need to be transported between health care facilities but who do not require emergency care should be transported by the non-emergency transport service (HealthNET) rather than using the resources required for emergency patients.

6) Forensic Pathology Services (FPS):

- Forensic services were transferred from the South African Police Services and a new Forensic Pathology Service was established within the Department of Health with effect from 1 April 2006.
- The service is provided via eighteen facilities which include two academic departments of forensic medicine and three referral laboratories. Physical infrastructure is a challenge and an infrastructure plan was developed for the construction of appropriate, fit for purpose facilities.

8.3.2 What is the current reality?

Figure 4: Current Reality of Health Services



1) Community-based services (CBS):

As reported in the Annual Report, during 2010/11 there were:

- 743 palliative, sub-acute and chronic beds;
- 1 787 mental health clients were accommodated in community facilities;
- 2 584 home-based carers were appointed via 145 non-profit organisations;
- The CBS headcount for 2010/11 was 4.65 million.
- The range and extent of community-care varies across the 32 sub-districts:
 - In the rural districts the community-care workers provide a comprehensive package of care;
 - Whereas in the Metro the service is fragmented and function specific.

2) Primary health care (PHC):

- A PHC utilisation rate of 3.5 visits per total population which resulted in a PHC headcount of 16.3 million during 2010/11.
- In the Metro District the PHC utilisation rate correlates with the daily migration of employed persons who seek some health services close to the places of employment, the unemployment rate, household income and modes of transport.
- The availability of the packages of care is not evenly distributed across the Metro where services are fragmented as a result of the dual authority provision of these services.
- In the rural districts there are pockets of high service coverage, others that are underserved due to rapid recent migration and medical officer coverage that is low in some areas.

3) Acute hospitals:

- It could be argued that there are a sufficient number of beds on the service platform but that they are neither all optimally utilised nor appropriately distributed.
- Patients are not cared for in distinct Level 1, 2 and 3 beds.
- There is under-utilisation of paediatric beds in some institutions on the service platform.
- The bed utilisation rate in some rural district hospitals is low.
- The Metro district hospitals do not provide the full package of care because of historical factors and the absence of hospitals in Khayelitsha and Mitchells Plain.
- High care and intensive care beds are not confined to specialist hospitals.
- The rate of increase in the annual service load especially in central and regional hospitals is slowing down.

4) Specialised hospitals:

• Psychiatric hospitals:

- There are four psychiatric hospitals, all of which are located in the Cape Town Metro District:
 - Alexandra Hospital
 - Lentegeur Hospital
 - Stikland Hospital
 - Valkenberg HospitalThere are two sub-acute facilities, i.e. William Slater and New Beginnings.
- Psychiatry:
 - Increased acute hospital capacity is required due to substance abuse co-morbidity and to support de-hospitalised care.
 - The removal of the chronic care safety net for treatment-resistant and difficult to place groups of people with mental illness has led to the development of innovative models of care in the community.
- Intellectual disability
 - Care has shifted from hospitals to alternative institutional care for several hundred clients.
 - The packages of care in the remaining facilities are not well defined.

- **Western Cape Rehabilitation Centre (WCRC):**

- There is still a 'silo' approach to rehabilitation services that are not integrated at all levels of care.
- The WCRC provides high intensity rehabilitation services. Much work needs to be done in developing rehabilitation services at other levels of care.

- **Tuberculosis (TB) hospitals:**

- There are six TB hospitals:
 - Brooklyn Chest Hospital: Cape Town Metro
 - DP Marais Hospital: Cape Town Metro
 - Sonstraal Hospital: Paarl
 - Infectious Diseases Hospital: Malmesbury
 - Harry Comay Hospital: George
 - Brewelskloof Hospital: Worcester
- Extreme Drug Resistant TB (XDR TB) has emerged since the development of Healthcare 2010.
- In terms of the policy for the decentralised management of drug-resistant TB patients not all patients with multi-drug resistant TB (MDR TB) are hospitalised.

- **Dental hospitals:**

- These hospitals provide the top end of specialised dental services for complicated patients.
- The bulk of dental services are provided within the District Health system.
- Training of dentists is one of the central functions of these hospitals. Dental students provide the workforce for the services they render.
- An oral health plan has been developed but not been systematically implemented owing to limited resources.

5) **Emergency Medical Services (EMS):**

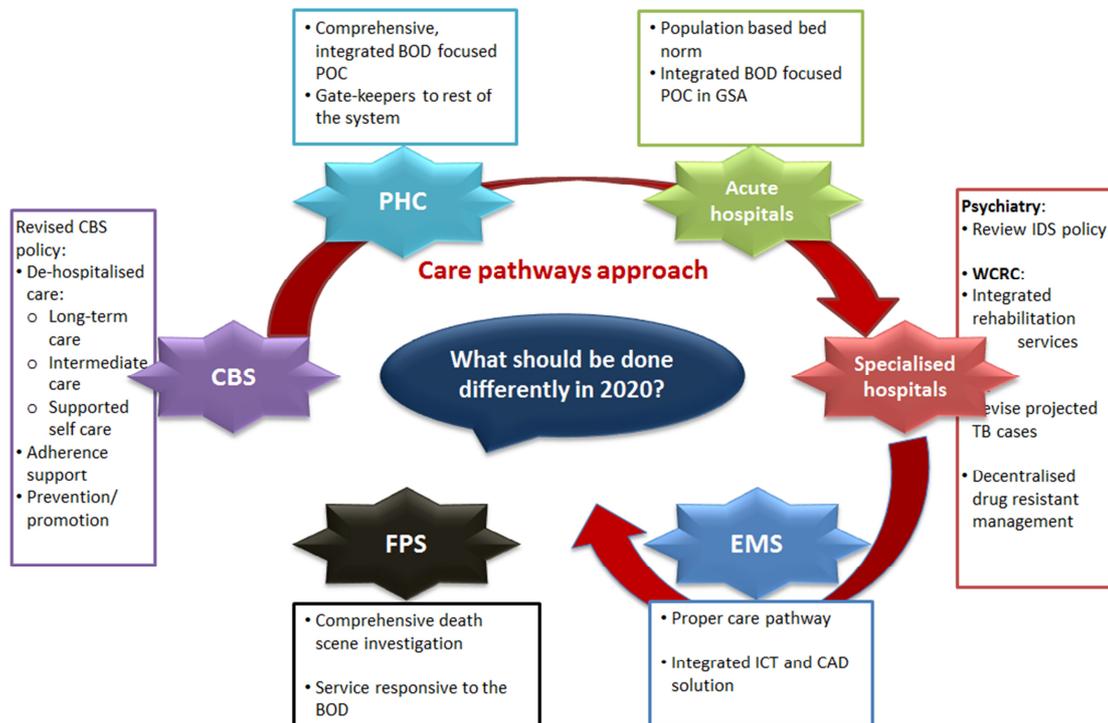
- The ambulance service is equitably distributed across the Province and although the response times in the rural districts are good, the service is under pressure to meet the demand in the Metro.
- An aero-medical service links rural hospitals to the central hospitals. This is not only beneficial to the patient who is transported by air but also means that the ambulances remain in their areas where they are available to other patients.
- Although there is equitable distribution of rescue equipment there are insufficient rescue personnel.
- There is a good Planned Patient Transport service in the rural districts but this service requires further development in the Metro.
- The evolving Communication service requires a new ICT solution to facilitate the optimal utilisation of resources.

6) **Forensic Pathology Services (FPS):**

- The post-mortem rate in the Western Cape is 1.64 per 100 000 in comparison to the national target of 2 per 100 000.
- The infrastructure plan is not fully implemented with only 5/18 facilities constructed.
- The inequity in the access to these services is reflected in the variances in the average turnaround time from admission to examination across the GSAs.
- The service is unable to fully deliver on its mandate of comprehensive death scene investigation due to limited capacity both in terms of personnel numbers and skills.

8.3.3 What should we do differently in 2020?

Figure 5: What should we do differently in 2020?



1) Community-based services (CBS):

- A revised CBS policy framework that describes the package of care, the HR strategy and the indicators and targets to monitor this service. Modelling will have to be done to determine the staff numbers required per geographic area.
- Community-based services include:
 - De-hospitalised care which includes intermediate institutional care (rehabilitation, palliative and convalescent care) and long-term institutional care (respite, custodial and social care).
 - Domiciliary care to deliver community delivered rehabilitation and psychiatric services. Supported self-care regardless of the type of disease offering assistive technology, respite care, day care, home adaptation and personal care assistance.
 - An integrated package of adherence support for all clients with long-term care needs.
 - Specific community-based prevention and promotion activities that focus on promoting wellness.
- Community care workers (CCWs) should function in PHC teams for a specific number of households in a designated geographic area.
- NPOs will be contracted to achieve specific outcomes as part of the 'care pathways approach'.
- The intermediate or long-term care services will potentially provide significant relief for acute and specialised hospitals by providing appropriate interventions to help patients improve their functional ability once their acute medical condition has been stabilised. The aim is to assist these patients to function independently or with

support in their home environments. It is anticipated that this will be of particular benefit in psychiatric and TB hospitals and the Western Cape Rehabilitation Centre.

- The supported self-care services will impact on PHC services and acute and specialised hospitals by providing a range of care interventions within the community.

2) **Primary health care (PHC):**

- Provision of client-centred quality care.
- Provision of comprehensive packages of care to improve health outcomes.
- An electronic population based PHC utilisation and workload calculator has been developed to assist in the estimation of number of staff required per facility and the most appropriate staff mix.
- Providers of PHC services are the facilitators responsible for co-ordinating the inputs of other services such as CBS, PHC, hospital and specialist teams, as required by their clients.
- If this facilitation of access to appropriate care functions effectively it will be of significant benefit to the client, ensuring seamless movement between the required services, and will also contribute to the effectiveness and efficiency of the service components.

3) **Acute hospitals:**

- A population-based bed norm is to be applied.
- The target bed utilisation rate is 85%. There will be optimal patient flow processes and bed management to get maximum utilisation of this resource.
- The acute hospitals will deliver packages of care that are appropriate to the burden of disease in the respective GSAs and which contribute towards the provision of an integrated service and the achievement of the health outcomes.
- Specialist led teams will ensure appropriate access to higher levels of care and strong outreach and support to DHS.
- Acute hospitals will have important links with:
 - Intermediate care, the PHC platform and CBS; and
 - Specialised hospitals and higher levels of care
- The home-based carers can be contacted to follow up patients after discharge, ensure compliance with treatment, reinforce patient education to prevent secondary complications, and arrange family support for the patient.

4) **Specialised hospitals:**

• **Psychiatric hospitals:**

- Psychiatry:
 - The model supported by the Mental Health Care Act and Healthcare 2010 is based on a PHC approach.
 - The focus is on the development of general mental health care service capacity at all levels of care.
 - Mental health care clients are to access chronic care in integrated services.
 - CBS for mental health will be provided in intermediate care/long-term care and supported self-care.
- Intellectual Disability Services:
 - Many of the long stay clients in these hospitals are not ill. This calls for a review of the model of services to be delivered in this context.

- Realistically evaluate whether the total de-institutionalisation of these clients is feasible within the context of the current socio-economic context.
 - The care pathway for these clients between home-based care, PHC services, intermediate care and the specialised psychiatric hospitals needs to be strengthened.
- **Western Cape Rehabilitation Centre (WCRC):**
 - The model of care is to be aligned with that of all other specialised services.
 - Rehabilitation services within the DHS needs to be strengthened.
- **Tuberculosis (TB) hospitals:**
 - Revise the number of projected TB cases and projected number of sub-acutely ill TB clients.
 - Fully implement a decentralised drug-resistant TB management service delivery model.
 - The patient flow between acute hospitals, TB hospitals, CBS and PHC needs to be more efficiently managed.
 - A strengthened CBS and PHC service will improve TB prevention, increase active case finding and starting patients earlier on treatment, improve compliance and reduce defaulter rates and therefore drug resistant TB. The cumulative effect of these interventions will reduce pressure on TB beds.

5) **Emergency Medical Services (EMS):**

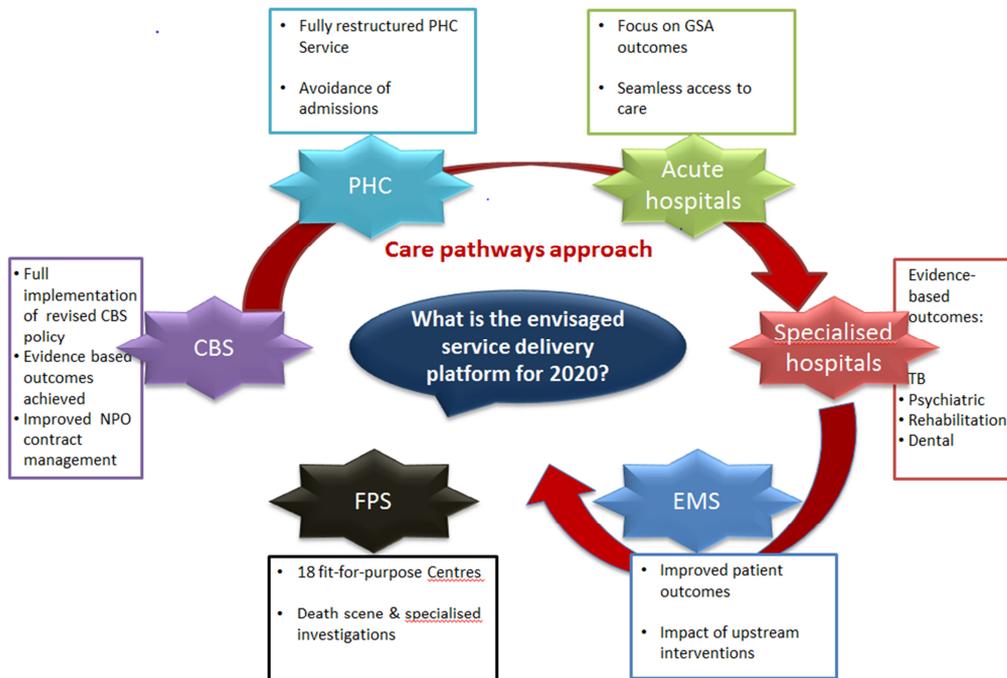
- Establish care pathways for people requiring emergency services.
- When a call is received in the Communications Centre an ambulance is dispatched to the scene of the incident for example, the client's home, the roadside or a health facility.
- In order to do this effectively and to reach the patients within the target response times, EMS needs the appropriate ICT and CAD solution.
- In addition a system that provides access to healthcare advice such as a helpline needs to be considered. This service could provide patients with information about the availability of health services in the area, first aid advice, help to access the ambulance service in the case of an emergency, help to decide whether treatment could wait for normal business hours or would require urgent intervention.
- Patient transport should be significantly expanded to facilitate access and manage appropriate access to facilities which will require close co-ordination with CBS and PHC services.

6) **Forensic Pathology Services (FPS):**

- There would be comprehensive death scene investigation, supported by specialised medico-legal investigation of death.
- There would be adequate laboratory support for qualitative analysis.
- Improve communication and relationship with partners:
 - South African Police Services;
 - Emergency Medical Services;
 - National Prosecuting Authority; (NPA)
 - Forensic Chemistry Laboratory (FCL)
 - Home Affairs (HA)
- Important service linkages for FPS are with EMS and acute hospital services.

8.3.4 What is the envisaged service delivery platform for 2020?

Figure 6: Service Platform in 2020



1) Community-based services (CBS):

- Full implementation of CBS across all 32 sub-districts resulting in achievement of health outcomes.

2) Primary health care (PHC):

- PHC service delivery platform fully restructured with an integrated CBS system.
- Avoidance of hospital admissions could be monitored as a marker of the good quality PHC and CBS services.

3) Acute hospitals:

- Delivery of focused packages of care and health outcomes within the GSA.
- Patients experience seamless access to comprehensive quality services where care is delivered by skilled and competent staff.

4) Specialised hospitals:

- Delivery of focused packages of care and health outcomes within the GSA.
- Only patients that are appropriate for these facilities will be admitted to them.
- The services at these specialised hospitals need to be seen in the context of strengthened health system, with optimal use of the mainstream service and care pathways.
- **Psychiatric hospitals:**
 - Intellectual disability: Residential care should be managed within a broader social network rather than by the health service.

- **Western Cape Rehabilitation Centre (WCRC):**
 - Appropriate service delivery models for orthotic and prosthetic services will be investigated to improve equitable access and provide these devices within acceptable waiting times for all districts.
 - Rehabilitation services will be integrated across the service platform and the WCRC will be at the apex of the service, providing the most advanced care.
- **Dental Training Hospitals:**
 - It is envisaged that Oral Health Services will have one central coordination structure with clinical governance provided by the Oral Health Centre Manager;
 - The Oral Health package of care will be aligned to the integrated care pathway.
 - All dental clinics in the Province will be strengthened to provide the basic package of primary oral health care which includes treatment of pain and sepsis, diagnostic radiography, scaling and polishing, oral health education, extractions and basic fillings as well as specialists care.
 - Prevention and promotion of oral health will be strengthened.

5) Emergency Medical Services (EMS):

- Improve access (response times) and outcomes (quality) for emergencies
- Implementation of upstream interventions will positively impact on reducing injuries and non-communicable diseases.
- Improve access to rescue services.
- Expand the staffed vehicle fleet within the Metro to improve access, distribution and therefore quality of contacts.

6) Forensic Pathology Services (FPS):

- Improved death scene investigations and specialised medico-legal investigation into causes of death by skilled and professional forensic pathology staff.
- There will be 18 facilities that are fit for purpose and meet the Occupational Health and Safety standards.

8.4 Progress with the technical planning processes:

A technical planning process is being conducted based on the principles of 2020 as outlined in this discussion document. This process will be modified if necessary depending on the inputs received during the consultation process. More specific details of this process will be contained in the next version of the document.

Models based on selected variables have been developed for both PHC and acute hospitals.

The technical approach to PHC services factors the deprivation index of local communities and the migration of the working population across sub - district boundaries. This is an advance on the 2010 approach that considered uninsured population only. The electronic workload and utilisation calculator based on variables such as population size and utilisation rate is used to calculate the number and skill mix of staff required to provide the service.

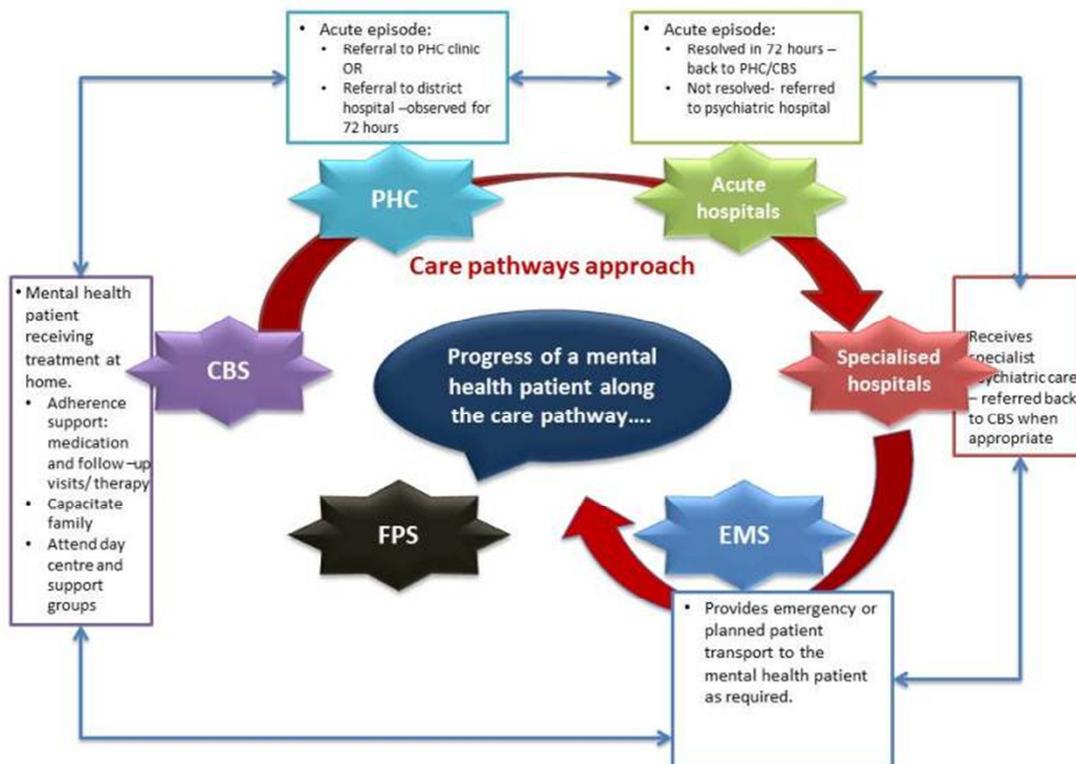
A model for hospitals considers variables such as bed norms, average length of stay and bed occupancy to calculate the number for beds required for the different types of

hospitals. The current utilisation patterns of hospital beds is also analysed and efficiencies proposed. The platform is seen as a continuum of care and the impact of one level on the other levels of the service is also considered.

8.5 Example of a patient's journey along a care pathway

The following provides an overview of a mental health care patient's journey along a care pathway.

Figure 7: Progress along a mental health care pathway



The envisaged pathway for a mentally ill patient is described as a case study to demonstrate the concept within the 2020 approach.

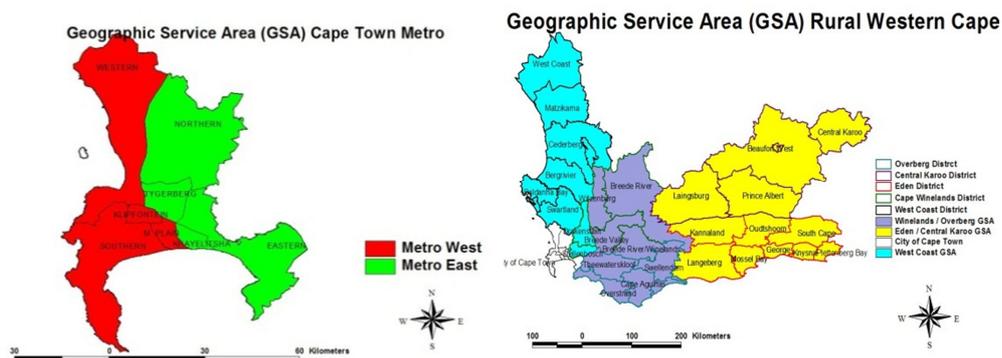
The mentally ill patient will be visited at home by home base carers that will check on the patient regularly, ensure that he/she is adherent with the prescribed treatment and attending the nearest facility as per appointments and that the family is capacitated to be supportive. When the patient has an acute psychotic episode, he will be transported to the nearest PHC clinic or Community Health centre or district hospital as deemed appropriate by the Ambulance personnel. At the facility, the patient will be clinically managed by a competent doctor/nurse. The patient will be observed for 72 hours. Should the patient be badly disturbed and not responding to sedation, he/she will be transferred to a specialist psychiatric hospital for further management without waiting for the completion of the 72 hour observation period. The appropriate referral forms will be completed. Once the patient has been effectively treated at the specialist psychiatric hospital, a decision will be made whether the patient is fit to be discharged home or to an intermediate care facility. When the patient is stable, he/she will be returned home and followed up by HBC worker within the Community based service platform. The patient will also be encouraged to join psycho-social group work and day care centres that will assist he/her on-going recovery.

8.5 Geographic Service Areas (GSA) :

The current departmental structure results in significantly fragmented services on the ground. Primary Health Care and district hospitals are within one division, while Emergency Medical Services, regional hospitals, central hospitals and forensic pathology services are in another division. The department has therefore created a functional arrangement to better co-ordinate services and respond to service needs in a more cohesive manner within defined geographic areas. The five GSAs: Metro West and Metro East and three rural GSAs: West Coast, Winelands/Overberg and Eden/Central Karoo are illustrated in the diagrams below.

The current functional arrangements remain suboptimal since these are mainly in line with the programmatic and divisional reporting arrangements, financial flows and managerial accountability. Furthermore without a single manager who is accountable for the total service delivered within a GSA there cannot be service integration. The Department has resolved that in future the GSA and district boundaries will be coterminous with the district municipal and metro sub-structure boundaries. The latter will divide the Cape Town Metro into Metro East and West.

Figure 8: Geographic Service Areas (GSAs)



9. Review of Support Services:

9.1 Strategy and Health Support

9.1.1 Current Reality

The Department made significant gains in the development and implementation of the CSP. However, the Department is a large organisation with about 28 000 staff and several hundred facilities located within different financial programmes, geographical areas and service divisions. Co-ordination, alignment and cohesion across the different sections within the Department have been a challenge.

The budgeting process within the Department has been largely historical. While progress has been made in bridging the gap between budgeting and planning, the need for rigorous priority setting and risk management calls for greater integration and alignment of these processes.

Processes to monitor progress against targets have been institutionalised in the Department at provincial and other levels. Greater robustness is required in target setting. Capacity within the Department to evaluate its performance and assess impact on health outcomes needs to be developed. The Department has created a structure to address this need.

The quality of data and information has been an on-going challenge that has been identified in the audit findings. Systematic processes and systems to improve this situation need to be institutionalised.

Clinical support services such as laboratories and pharmaceuticals that are crucial to the delivery of efficient and good quality health services need to be strengthened. The availability of medicines is a basic indicator of good quality service. The chronic dispensing unit has begun to operate within the Metro over the last few years. This service needs to be improved and expanded across the province. This will make a significant impact on reducing waiting times for patients to collect their medicines.

9.1.2 Towards 2020

Once the framework for 2020 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 as well as a monitoring and evaluation perspective. 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 provide this alignment, co-ordination and cohesion both at a provincial as well as district or geographic service area level.

Given the reality of limited resources compared to the health needs of the population, the setting of priorities and the targeted allocation of resources becomes increasingly important. 2020 calls for a focus, amongst others, on health outcomes. This requires a rigorous search for the most cost effective interventions based on sound evidence that should be targeted. The strong research capacity within the province will be accessed more effectively.

To address the principle of equity, measures need to be put in place to assess the current situation as well as develop mechanisms to address the inequity that exists. Important parameters to address equity would include access to services, resource allocation and health outcomes.

An important enabler to address the strategic direction of 2020 is the timely availability of good quality (accurate, reliable) 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 resource competency and capacity.

Good quality information is an important prerequisite for the planning, implementation and monitoring and evaluation of the 2020 plan. Annual institutional, district and provincial plans will be developed that will contain incremental steps and targets to give effect to 2020. A core set of indicators will be agreed upon that is used to measure and report progress. Building the capacity to regularly evaluate our health programmes and services will be important in improving our overall performance at various levels of the service.

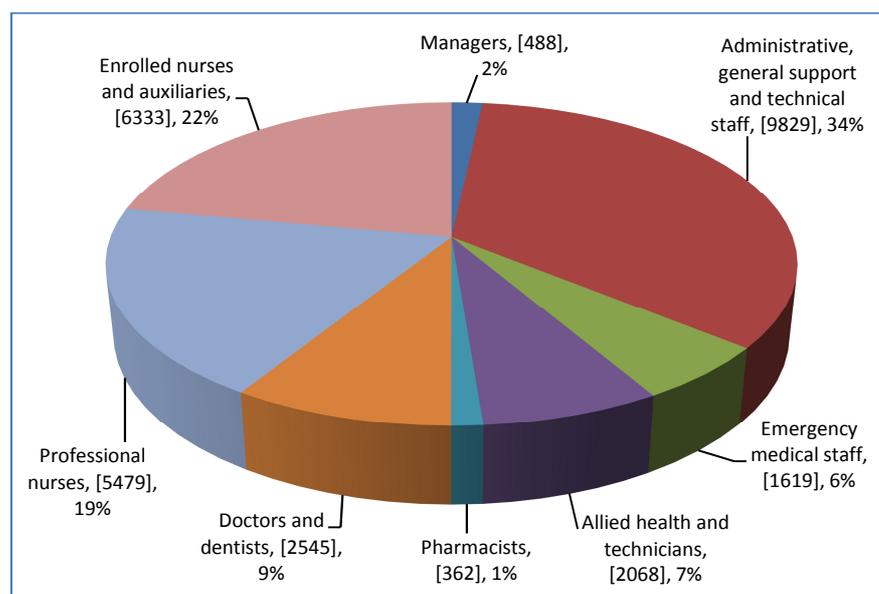
A clean audit on predetermined objectives (Information) will be an important objective. Institutionalising system improvements to address the audit findings will result in an overall improvement in the quality of data and information.

9.2 Human Resources

9.2.1 What is the current reality?

The Department currently has approximately 28 500 staff. The composition of which is shown by main categories in the pie graph below.

Figure 9: Department of Health: Health Personnel 2010/11



Notes:

- 1) Managers are 1.7% and administrative, general support and technical staff comprises 34.4% of the total number of employees.
- 2) 94 dentists are included in Doctors and dentists.
- 3) Doctors and dentists include medical and dental specialists.
- 4) Allied health professionals include physiotherapists, occupational therapists, clinical psychologists, radiographers, dieticians and other allied health professionals and technicians.

9.2.2 The main human resource challenges include:

- 1) The lack of appropriate competencies, both in the clinical and support functions, to deliver the package of care and a quality health service.
- 2) Recruitment and retention of certain categories of staff:
The implementation of the occupation specific dispensation for various categories of health professions has facilitated the recruitment and retention of medical and nursing staff. However, it has proved less successful in other categories such as emergency medical staff and pharmacists. There are also challenges in recruiting skilled staff in a range of non - clinical areas such as finance, Information management, HRM, artisans.
- 3) Staff attitudes which remain a common complaint from clients.
- 4) Achieving the correct balance between the need to comply with policies and prescripts and creating space for innovation and initiative.

9.2.3 *What should be done differently in 2020*

The Human Resources for Health Strategy for the Health Sector: 2012/13 – 2016/17, released by the Department of Health in October 2011, outlines the strategy for health services planning.

The National Minister of Health has identified the issue of management and leadership in the health sector as 'Priority Number 1' for the HRH. Similarly the Western Cape has identified the need for competent and committed leaders at all levels of the service as being a critical enabler in the 2020 strategy.

The national framework provides a useful structure within which the Western Cape Department of Health can plan the provincial human resource strategy for 2020.

The strategic areas identified in the framework are the following:

- 1) Leadership and governance
- 2) Intelligence and planning
- 3) Workforce for new service strategies – "Ensuring value for money"
- 4) Up-scale and revitalise Education, Training and Research
- 5) Academic training and service platform interfaces
- 6) Human resource management
- 7) Quality professional care
- 8) Access to health professionals in rural and remote areas

9.2.4 *Towards 2020:*

The availability of appropriate human resources is critical to the successful implementation of the 2020 strategy.

In addition to providing a technically correct service, the quality of the patient experience is dependent on their interaction with health workers. Therefore the staff plays a pivotal role in the vision of delivering a client-centred quality health service.

The human resource strategy will therefore focus on:

- Guidelines for the number and skill mix of staff will be formulated when the guidelines for the service platform have been determined.
- The significant focus will be on the development and nurturing of a competent and caring staff through a values-based approach and a change management strategy.
- The outcome and values-based approach will also be integrated into human resource functions. The optimal functioning of the human resource functions will enable line function staff to provide a better service to external clients. Some of these functions include:
 - **Recruitment and retention:**
 - Introducing innovative methods of internet advertising and web-enabled application processes to improve recruitment of skilled staff.
 - Shortening the turnaround time for the recruitment and selection of staff through flexible but focused interventions in human resource management processes.

- Specific strategies that will enhance retention of staff in all categories and make the Department an employer of choice will be investigated.
- Modern and well maintained infrastructure and medical equipment will create a working environment that will impact positively on morale and productivity.
- **Training**
 - Providing bursaries and training for staff, particularly in scarce skills will be a priority.
 - Engaging the universities to align the training curriculum of undergraduate and post graduate training of health professionals with the competencies required by the 2020 service plan.
 - On-going training and development of staff within their field of expertise is important to keep knowledge and skills current.
 - A training and orientation programme will be developed for staff to promote an information culture towards 2020.
 - In house training will be strengthened to improve compliance with policies and prescripts in a range of areas including supply chain, human resources, information management, and finances.
- **Employee wellness:**
 - Strengthening employee wellness to support staff, many of whom work under difficult and challenging circumstances.
 - Staff is encouraged to lead healthier lifestyles both in the workplace and at home.
 - Improving diversity management.
- **Performance Management :**
 - Ensuring that individual performance agreements are aligned with the overall strategic objectives of the Department.
 - Striving to become the employer of choice in both the public and private sector to attract caring and competent staff.

The Department will develop a provincial approach to human resources toward 2020 taking into account the national framework.

What do you propose that the Department should do to become the employer of choice in the public and private health sector?

9.3 Infrastructure and Health Technology

9.3.1 The Current Reality

Public sector 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 policy. Effective and efficient performance requires rigorous and well-institutionalised structures, systems and best practices, based upon a consistent, effective and agreed upon Service Delivery Model with clearly defined mandates, roles and responsibilities. All of this must be underpinned by appropriate and optimally placed personnel capacity, experience and skills. Currently, within the Health Department, such systems and capacity has not yet been achieved. Accordingly, the delivery of health facilities is generally slow, expensive, and inefficient.

Therefore, despite extensive infrastructure needs and backlogs, the Department along with its Implementing Agent (the Western Cape Department of Transport and Public Works), must each financial year engage in strenuous efforts to ensure expenditure of its allocated infrastructure budget.

9.3.2 Towards 2020

The modernisation, management and maintenance of health infrastructure will continue to remain a cornerstone to enable the delivery of the envisaged health service of 2020. The approach to infrastructure will be governed by the "4Ls" agenda¹ - Long Life (Sustainability), Loose Fit (Flexibility), Low Impact (Reduction of the Carbon Footprint), and Luminous Healing Space (Enlightened Healing Environment).

9.3.2.1 Principles for Infrastructure Delivery

A set of principles that will guide the approach to infrastructure delivery has also been developed based on improving service delivery and the 4Ls agenda. These are articulated below.

9.3.2.2 Infrastructure Sector

1) Western Cape Infrastructure Delivery Management System (WC IDMS)

The WC IDMS, approved by Cabinet during April 2011, was developed in order to provide an infrastructure delivery framework for the afore-mentioned "structures, systems and best practices, based upon a consistent, effective and agreed upon Service Delivery Model with clearly defined mandates, roles and responsibilities". It addresses the typical life-cycle of an immovable asset, such as a clinic, hospital etc. and illustrates some of the complexities involved.

The capacity necessary to underpin the systems and processes as outlined in the WC IDMS is currently being addressed through the implementation of the Human Resource Strategy in each of the Departments of Health, Education, Transport and Public Works, and Provincial Treasury. The purpose of this strategy is to define mandates, appropriate models for service delivery, functions, organisational structures and staffing requirements as a key step towards ensuring sustainable institutional capacity in each of the participating Departments. This will ultimately enable them to plan and deliver infrastructure in accordance with the WC IDMS and in compliance with relevant legislation.

1

Sir Alex Gordon RIBA President; <http://ckegroup.org/johnbaleblog/2011/04/long-life-and-loose-fit/>

The progressive institutionalisation of the WC IDMS has recently begun through the implementation of a work streaming process.

2) Life cycle Costing

Each new health facility will be planned for its entire life cycle and upon its successful commissioning, a building maintenance plan will be prepared which will apply for the entire life span of the facility.

Accordingly, an appropriate budget for maintenance of the facility will be ring fenced by the Department, and it is intended that in the future, the approval of new facilities will only be granted if an appropriate life-cycle budget had been allocated.

3) Prioritisation Model

A model will be developed which will ensure a more rigorous process for the prioritisation of capital projects in accordance with the needs and documented policies of the health service. As part of this process, a mechanism will be created which will enable a closer and more formalised collaboration between the Chief Directorate: Infrastructure Management and that of Strategy and Health Support.

4) Innovation in Delivery

In future, pilot projects will be undertaken that will test more innovative construction technologies and contracting arrangements – the aim will be endeavour both speed up the delivery of facilities on the ground as well as reduce costs.

9.3.2.3 Buildings

1) Affordability

The Department will ensure that there is a balance between the desire to build state-of-the-art, world class facilities and appropriateness in terms of the province's context and affordability.

2) Green Buildings

The Department will develop an environmental health friendly facility policy that guides the design and construction of facilities as well as the eco-friendly management of operations.

3) Flexibility

The layout and design of buildings will be flexible to facilitate alterations that occur as a result of changes in the service requirements over time. These include fluctuations in workload, gender-specific requirements, changing technology and policy changes.

4) Healing Environment

The building itself must be regarded as part of the healing environment. This requires consideration for, inter alia, noise levels, natural lighting and ventilation, safe and natural materials, ergonomics, and way-finding.

5) Building maintenance plan

The modernisation of many of the hospitals and clinics necessitates the provision of adequate maintenance. A preventative maintenance programme with a maintenance management system will be set up. A hub and spoke arrangement will be constituted in each of the GSAs.

6) Operational Efficiency

The design of facilities plays a major role in generating efficiencies such as improving patient flows and staffing movement. This can be significant in life saving emergencies and as well as normal routine duties.

7) Patient Needs

The design of facilities must provide for patient dignity, safety, respect for individuality and privacy.

8) Risk Reduction

Facilities will be designed and managed optimally to reduce risks such as nosocomial infections and to ensure improved security.

9.4 Financial Management

9.4.1 The current reality

There are on-going financial pressures in the light of limited resources and huge demands on the service. Choosing budget priorities within this context remains an annual challenge. This situation has been exacerbated by the recent economic recession, which will take us a few years to recover from. Thus getting better value from the existing health rand through more refined targeting of resources to the most cost effective interventions as well as improving efficiencies are the major thrusts of the forthcoming period.

In keeping with the direction of the CSP 2010, significant budget allocations were invested in the District Health services and Emergency Medical Services to strengthen the basic health services we provide to the population.

The Department has done well to contain its expenditure within the allocated budget over recent years. It has achieved this through focus, discipline and a range of instruments to tightly manage and monitor expenditure against budget. Personnel who accounts for about 55-60% of the total expenditure are managed through an approved post list (APL) system that ensures that every vacant post that gets filled has been budgeted for. The monitoring of expenditure against budget within financial programmes down to institutional level occurs through the Budget Management Instrument (BMI) on a monthly basis. The Head: Health convenes a Financial Monitoring Committee monthly to monitor the expenditure for the overall department.

Given the complexity and magnitude of financial administration within the Department where there are approximately 21 000 budget entities calculated per responsibility and

expense item, the traditional techniques that are currently available to manage the budget effectively are insufficient. The various systems are not integrated or adequately supported by the departmental, provincial and national structures. Yet it's important for the Department to be able to integrate data from Personnel, Goods and Services, and service outputs and outcomes to meaningfully assess value for money. Attempts to do this within the current systems is time consuming and prone to errors.

The annual reports of the Auditor-General have raised queries regarding procurement processes within the Department. While policies and prescripts have been significantly developed, implementation at institutional level remains a challenge.

9.4.2 Towards 2020

The planning and modelling tools make it possible to determine the number and skill mix of personnel required to render the required services on the comprehensive service platform. As staff costs constitute approximately 55% of total health expenditure the cost of goods and services can be estimated. Provision will also be made for capital expenditure, physical infrastructure and equipment maintenance.

9.4.3 Budgeting:

The Department will continue to improve its budgeting processes by:

- Ensuring that the most cost effective interventions that will impact on health outcomes will be adequately funded. This will require greater rigour in priority setting within the Department.
- Addressing inequities in resource allocation between districts.
- Considering improved measures to align patient workloads (both from the numbers of patients as well as their acuity) with the budget. The Diagnostic Related Groups (DRGs) or an equivalent methodology could be used to facilitate a better understanding of patient profiles at our hospitals.

9.4.4 Automation

The Department will progressively automate various financial administration functions such as:

- The complete budget administration process which will allow decentralised offices to control the budget database, administer budgets and capture projections.
- The Approved Post Lists that are used to manage staff numbers could also be automated.

9.4.5 Balance between decentralisation and centralisation

Further refinement of the delegations and decentralisation of functions to districts or geographic service areas or entities will be addressed.

The Functional Business Units (FBU) in regional and central hospitals allow a more refined approach to budgeting for specific disciplines and sections within institutions, as well as greater accountability by local FBU managers.

The aim of the FBUs is to delegate authority to manage the budget of a particular FBU, to the individuals who makes the clinical decisions that incur the expenditure.

9.4.6 Procurement and stock management

The entire supply chain management function will be reviewed as there is scope for significant improvement in this area. This will include assessing the feasibility of "just-in-time" procurement with direct deliveries from the supplier to the institution, the possibility of bulk ordering of certain items centrally to optimise discounts and better contract management of suppliers.

The principles of the Essential Drug List will be applied to the procurement of consumables and equipment to standardise the equipment used in the Department and to obtain cost-savings through volume discounts.

9.4.7 Improved financial co-operation

The communication and cooperation between the financial management staff at the decentralised offices and the centre situated at Head Office must be strengthened. This will improve compliance with financial prescripts as well as ensuring that the centre is better able to support staff at the various service points.

9.4.8 Assessment and improvement of cost-efficiency

The assessment of cost-efficiency in the Department, which is extremely complex due to the divergent nature of the departmental services, should be improved. The nature and acuity of patients differ, even at institutions that are intended to render the same service. A system such as that of Diagnostic Related Groups (DRG) will be investigated to address this challenge.

10. Towards patient-centred quality service

10.1 What is the current reality?

The Department has provided and increased access to the majority of health services since 1994 in this province. This is evidenced by the marked improvement in the levels of utilisation especially of PHC services since 2001. Challenges with long waiting times remain especially at many of the PHC clinics in the province. Specific specialised procedures such as hip replacements and even more routine surgical procedures such as hernias and tonsillectomies also have significant waiting lists.

In the past there was a structured routine approach captured in a departmental policy to quality based on three elements, which involved caring for the carer, patient satisfaction and technical quality. Regular annual surveys have been done to assess patient satisfaction at all hospitals and more recently staff satisfaction surveys have been undertaken. Other elements of a quality programme include mortality and morbidity meetings, patient complaints registers and clinical audits undertaken in clinical departments at selected institutions. Quality assurance managers have been appointed at most hospitals and districts but their responsibilities vary. Some quality assurance managers undertake infection control or health and safety and/or bed management. Other focused initiatives such as hand washing campaigns, adverse incident monitoring have not been uniformly implemented across the department.

From the monitoring and evaluation of our services as well as local site visits by senior management it is evident that the *quality of care significantly varies between facilities in our province.*

10.2 Towards 2020:

Client-centred quality of care is at the core of the vision for 2020. There is firm recognition that the *patient experience* in the services is as important, particularly in the eyes of the patient, as the *outcome of clinical treatment*. It is not enough for the patient to receive the correct clinical treatment but also very important to feel respected and cared for when receiving their treatment.

The approach to quality improvement is embedded within the vision, values and principles of 2020 on the one hand and in the national core standards on the other. The cornerstones to our approach to quality improvement are a concerted effort to address the patient experience, clinical outcomes and a focus on our staff.

Figure 10: Cornerstones of Quality Improvement in 2020



The Department aims to raise the profile of quality improvement in the Department. A systematic and systemic approach to quality needs to be developed.

The root causes for the significant variation in quality programmes across institutions is the lack of uniform standards and tools to measure their achievement. The National Department of Health in conjunction with provinces has developed a comprehensive set of core standards with criteria, measures and measurement tools. Baseline assessments for six priority areas (staff attitudes, waiting times, availability of medicines, infection control, and clean facilities) are being conducted at all facilities during 2012/13 undertaken in partnership with the Health Systems Trust.

The engagement with managers and staff at all levels around the baseline assessments is a step towards quality improvement. Training at local level will build capacity in institutions and districts to address quality improvement. The assessment provides an objective basis for each facility to identify its strengths and limitations around quality. The results will form a basis for a quality improvement dialogue at institutional level between management and staff providing a firm basis for developing local programs. The Department regards this as a developmental process that will engage the department over the coming years.

11. **Monitoring and Evaluation.**

The Department will develop a strong evaluation capacity to assess the impact of various health initiatives, the package of services delivered as well as the upstream interventions. The Directorate: Health Impact Assessment will play an important role in providing the public health intelligence and evidence for which interventions are most cost-effective and have the greatest impact based on local and international research. This will influence the short, medium and long term planning and budgeting priorities. Regular monitoring of outputs and outcomes on a quarterly basis against the targets of the annual performance plan will be strengthened.

12. **Conclusion**

This draft framework document captures our thinking for the strategic journey to 2020. At this stage we are seeking guidance on the principles and approach. Details of bed numbers and staff numbers will be included in a subsequent process after ensuring that the strategic approach is robust.

Participation and inputs into this process are essential so that we can harness the broadest wisdom available in what is a complex exercise. Each stakeholder input will be acknowledged and systematically considered.

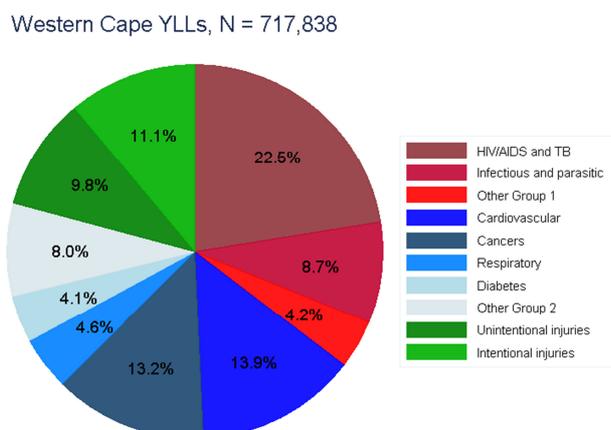
ANNEXURE A

The Burden of Disease Report

1. The nature of the burden of disease

The figure below reflects the main causes of disease that make up the burden of disease in the Western Cape.

Figure 11: Potential years of life lost (YLL): Western Cape



These can be broadly categorised into four groups, which make up a quadruple burden of disease:

- HIV/Aids and Tuberculosis

- Injuries (Violence and road traffic accidents)
- Non-communicable diseases (cardiovascular disease, high blood pressure, asthma, cancers and mental illness)
- Women's and Childhood illnesses
- Women's and childhood diseases are contained within the groups of infections, injuries and non-communicable disease. HIV is responsible for almost one third of the deaths in children while neonatal deaths comprise another third.

2. HIV/AIDS

According to the 2009 National HIV Survey the estimated HIV prevalence for the Western Cape was 16.9% (CI 95%: 13.8 -20.5%). The highest HIV prevalence estimates remain amongst the age groups of 25-29 and 30-34 years.

At the sub-district level, the 2009 survey estimated that nine of thirty-two sub-districts (32%) have an HIV prevalence that was greater than the provincial prevalence of 16.8%. These were the Klipfontein, Khayelitsha, Eastern, Western and Northern sub-districts within the Cape Town Metro district, Bitou, Knysna and Mossel Bay sub-districts (Eden district) and Overstrand sub-district (Overberg district). Since 2004, the Khayelitsha sub-district in the Cape Town Metro district has had a HIV prevalence estimate consistently higher than the national prevalence of 29.4%. The failure to observe a decline in prevalence in high HIV burden sub-districts may be partly due to the declining mortality as a result of access to antiretroviral therapy (ART).

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

The anti-retroviral treatment program continues to expand rapidly with approximately 2 400 to 2 500 persons began antiretroviral therapy per month during 2009. With this large burden of new ART clients accumulating annually, the ART program needs to expand its capacity to retain long-term ART patients in care.

3. Tuberculosis

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

The Western Cape incidence (new cases) of TB is 909 cases per 100 000. This gives the Western Cape the third highest incidence of TB in South Africa after Kwa-Zulu Natal and the Eastern Cape. However, the Department is making significant progress in addressing the epidemic through the implementation of the Enhanced TB Response Strategy. The programme achieved a new smear positive TB cure rate of 80.5% for the 2010/2011 financial year. This is the highest TB cure rate achieved in South Africa. The TB defaulter rate has decreased slowly over the past few years with the implementation of various interventions and now stands at 7%. More effort will be required to reach the national and global 2011 target of a defaulter rate of below 5% and various partners as well as the community-based services are working towards achieving that goal. Reducing the default rate not only decreases the size of the infectious pool in the community but prevents the generation of drug resistant TB, which requires a longer hospital stay, is much more costly to treat and has a very poor prognosis.

4. Injuries

The injury burden, which includes intentional injuries such as homicides, suicides, and unintentional injuries; such as road traffic injuries (RTI) and fire-related injury; accounts for 23.9% of the burden of disease in the Province. In comparison to the rest of the world violence is a particular problem in the Western Cape where the injury related mortality rate for men is ten times the global average, while for women it is seven times that average. Substance abuse, particularly alcohol abuse, is one of the most important drivers of the injury burden in the Western Cape as it fuels both violence and road traffic accidents.

5. Non Communicable Diseases

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

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

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

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

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

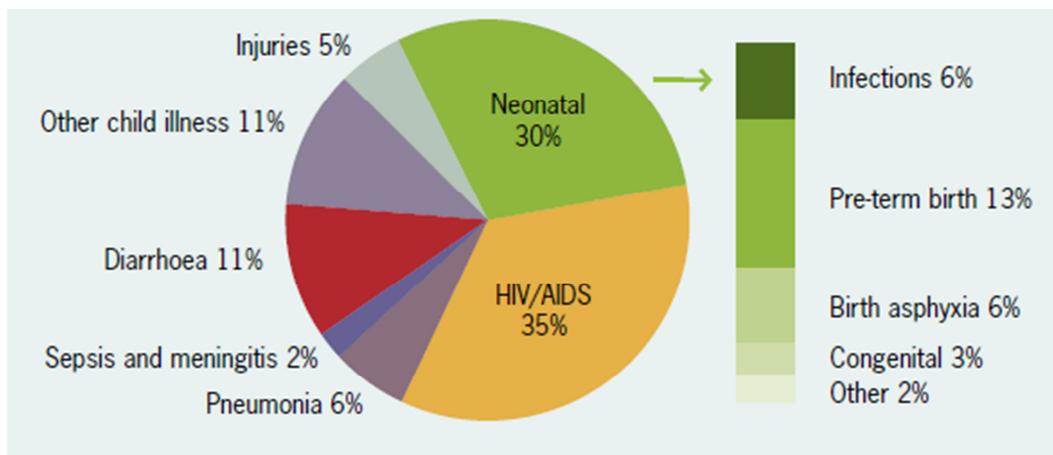
6. Childhood Illnesses

Childhood illnesses include malnutrition, diarrhoeal diseases and respiratory illnesses. Malnutrition is an underlying factor and not seen as a direct cause of death below. Acutely ill children often present with co-morbidity that involves multiple conditions. This raises the severity of their illness and they often have to be admitted to hospitals.

From the graph below, it is evident that for the period under review the majority of deaths of children under the age of five occurred in the first year of life and 30% of these deaths occurred in the first 28 days of life (neonatal). HIV and Aids accounted for 35% of childhood deaths. Thus neonatal services and HIV become the critical focus areas to impact on

childhood mortality. In the light of significant interventions in the area of HIV and AIDS and PMTC it is likely that this situation has changed significantly.

Figure 12: Causes of Death of Children under 5 years: 2000 – 2005.



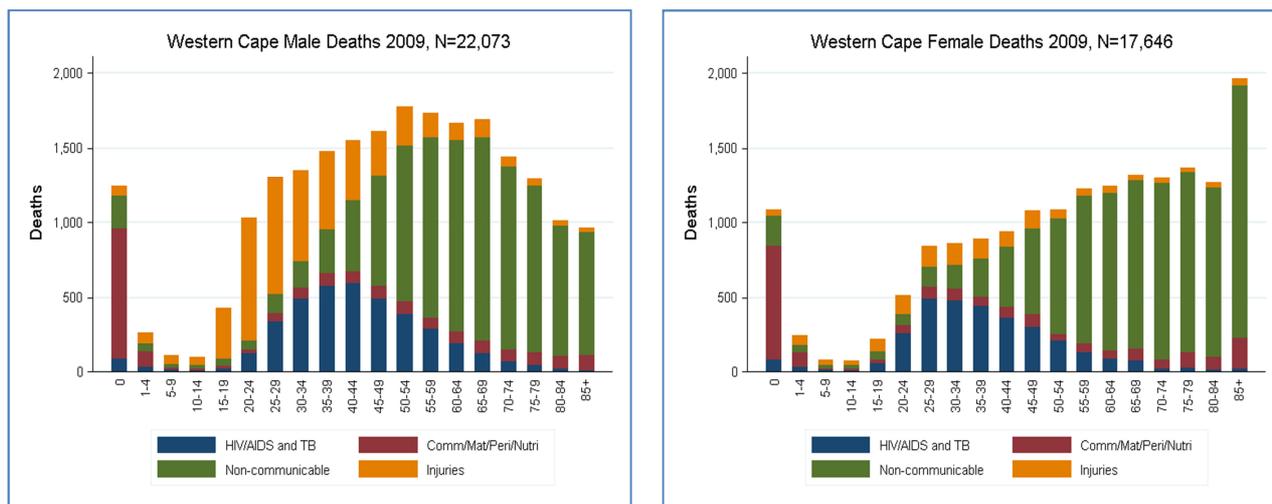
Diarrhoeal disease is a seasonal phenomenon, which peaks between the months of February and May each year and results in an enormous pressure on the health services. The critical causative factors are a lack of clean water, inadequate sanitation and feeding practices in informal settlements. Zinc therapy has been added to the management of diarrhoeal disease. Effective intervention at a community level with improvement of environmental factors, the introduction of the Rotarix vaccine from 1st November 2009 administered to children at six and fourteen months as well as effective oral rehydration therapy have resulted in a decrease in the prevalence of diarrheal disease and the associated mortality rate.

As part of the National Department of Health’s initiative, Prevenar, the vaccine to combat the spread of pneumococcal disease in infants, was provided in primary health care facilities in the Western Cape from July 2009. DTP-Hib was replaced with Pentaxim (DTaP-IPV/Hib). The province phased in Pentaxim from October 2009.

7. Women and Maternal Health

Women are a historically disadvantaged vulnerable group in our society who play a central role in giving birth to and nurturing children in society. Gender inequity is a well-recognised challenge in South Africa. Pregnancy is a particularly sensitive time when mother and foetus require protection. There is abundant evidence to show that harmful practices start to negatively impact on the baby during pregnancy. Women’s health is globally recognised as a priority as evidenced by the MDGs.

Figure 13: Mortality patterns in Western Cape: Male and Female 2009



From the mortality pattern above, it can be seen that while the age distribution of the disease in men and women differ and the impact of injuries on women mortality is much less, the quadruple burden of disease categories is the same. There is evidence that when one studies the morbidity patterns, mental ill health and injuries have a significant impact on women. Thus the comments in the HIV and TB, injuries and non-communicable diseases above sections equally apply to women and will not be repeated.

1.7.1. Maternal Mortality:

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

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

Table 1: Maternal Mortality Rates: Western Cape: 1999 - 2007

Triennial Period	MMR (W Cape)
(1999 – 2001)	56.4 per 100 000 live births
SM 2002 – 2004	86,2/100 000 live births
2005 – 2007	67.6/100 000 live births

The 2008-2010 triennial report is currently being completed. It is anticipated that there will be an increase in the MMR because of the impact of the H1N1 pandemic. This indicates that despite being the lowest in the country, the provincial MMR has fluctuated between respective triennia.

When calculating a district MMR, an annual and even triennial comparison could be misleading, as the numbers of maternal deaths in some districts are very small. Therefore in the Fourth Saving Mothers Report (2005-2007) it was decided to calculate the district MMR over a six-year period from 2002 -2007. The high rates in Eden of 92/100 000 live births and Central Karoo of 140/100 000 live births is of concern and requires a focused effort. This

indicates the importance of disaggregating the provincial data to understand the district differences in health outcomes.

Table 2: Institutional Maternal Mortality Ratio per district 2002 – 2007 in the Western Cape

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

Saving Mothers Fourth report on Confidential Enquiries into maternal deaths in South Africa 2005 – 2007: 312 (Table 12.1.3)

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

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

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

Strategies to address these causes are, implementation of the PMTCT programme, which has been very successful in the Western Cape, providing antiretroviral therapy to those in need thereof and improving clinical skills of staff in managing obstetric emergencies

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

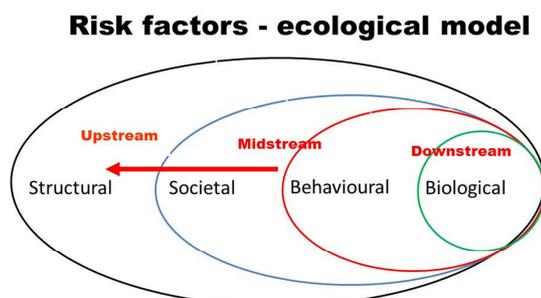
Other women’s health issues:

- Two of the commonest cancers in women are breast and cervical cancer. Cost-effective services to screen, diagnose and treat these cancers need to be strengthened.
- Access to reproductive health services requires strengthening, which forms part of the MDG targets.

Annexure B

Addressing upstream factors

Figure 14: Ecological Model of Risk factors



Source: TEACH VIP
www.who.int/violence_injury_prevention/publications/violence/en/index.html

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

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

Thus the health service usually focuses its work on midstream and downstream interventions while other provincial departments, spheres of government and civil society organisations need to work together to provide effective midstream and upstream interventions. All levels of intervention need to be rigorously pursued to decrease the burden of disease and enhance wellness.

The report identifies the main upstream factors that need to be addressed. The Provincial Transversal Management System (PTMS) initiated by the Provincial Government speaks directly to the need to address upstream factors in a collective, inter-sectoral manner. The provincial departments have been clustered into sectors that can address their strategic priorities collectively. The PTMS reports to the office of the Premier and the Cabinet.

After having considered the quadruple burden of disease and the MDGs, the Department has initiated four focus areas as summarised in the diagram below. Workgroups have been formed in each of these areas to identify the most cost-effective upstream interventions that should be pursued to impact on the desired health outcomes. This is currently exciting work in progress. Some of the early thoughts in each of the workgroups are summarised below.

Promotion of safety and reduction of injuries:

- Target certain communities with high burden of injuries.
- Focus on reduction of alcohol abuse as a key risk factor for injuries from inter-personal violence and road safety accidents.
- Social mobilisation and counter-messaging campaign around a documentary on risky drinking called Booza TV.
- Brief motivational interviewing of trauma patients at pilot sites.
- Improve trauma surveillance through collection of injury and risk factor data.
- Work with other departments and NGOs around a range of multi-agency interventions for community development – from ECD and schools to recreational facilities and safer interventions.
- Consider development of an over-arching violence prevention policy in provincial government.

Healthy lifestyles:

- The four main risk factors that cause non communicable diseases (NCDs) are: smoking, unhealthy eating habits, lack of exercise and alcohol abuse. The trend of risk factors is getting worse in the Western Cape.
- The burden of NCDs is as rampant in poor communities as it is in more affluent communities.
- The right choices are not the easiest choices – healthy foods are more expensive and less accessible especially in poor communities.
- Engage with the health promoting schools programme to address a range of interventions from availability of healthy foods in schools and non-availability of 'junk foods', physical exercise, recreational facilities, health promotion for teaching staff, etc.
-
- Provincial government politicians and employees to lead by example in terms of healthy eating, exercise and smoking.
- Engage with other departments in relation to development of sport and recreational facilities.
- Engage with retail business such as supermarket chains and gyms on partnering on certain strategies.
- Use the media to convey key healthy living messages.
- Health professionals to use the opportunity to counsel patients in their daily work.

HIV and Aids and TB:

- The Department, through SANAC and PIDAC, has developed a good network of partners to work in the areas of HIV and TB and will continue to use existing structures.
- There are five main areas on which to focus:
 - 1) Promote HIV Testing through the HIV counselling and testing campaign (HCT).
 - 2) Promote the use of condoms in males and females.
 - 3) Active TB case finding and promoting adherence to treatment until completion.
 - 4) Male medical circumcision.
 - 5) Behaviour change:

Sexual debut

Concurrency

Condom use

Multiple partners

Alcohol/drug abuse

- Social mobilisation to encourage:

Circumcision

HIV testing and counselling.

Women and child health:

Women's health:

- Many of the interventions described above under injuries, healthy lifestyles and HIV and TB apply significantly to women.
- Gender inequity is the fundamental upstream societal challenge that needs to be addressed.
- Intimate partner violence (IPV) impacts seriously on the well-being of women and needs to be addressed. Pilot projects in this regard are being considered.
- It is important to work with men in changing their behaviour towards women.
- Community-based workshops that address sexual health and equitable gender relationships will be piloted.
- There is global evidence that linking micro-financing initiatives with incentives has resulted in improved health seeking behaviour.
- There are downstream interventions such as improving access to antenatal care, reproductive health services and screening for cancers that will be addressed within the Department.

Children's health:

- Strengthening efforts to reduce mother-to-child HIV transmission rate from the current 3% to near zero.
- Pregnancy is a critical time for the health of the new-born. Improving antenatal attendance, reduction of risk factors such as smoking and drinking require renewed efforts.
- Within the service, strengthening the skills of doctors and nurses in neonatal resuscitation.
- The integrated management of childhood illness (IMCI) programme will be strengthened. It focuses on:
 - Improvements in the case management skills of health workers.
 - Improvements in the household and community practices for child survival, growth and development.
 - Improvements in the health systems required to deliver quality care.
- Engage with other departments such as Human Settlements and the City of Cape Town around the provision of clean water and sanitation.

ANNEXURE C

Overview of the Service Delivery Platform from 2010 to 2020

	What were the planned outcomes of Healthcare 2010?	What is the current reality?	What should be done differently in 2020?	What will be the envisaged service platform by 2020?
1. Community-based services	<ul style="list-style-type: none"> Services in non-health institutions: NPO services: <ul style="list-style-type: none"> De-hospitalised care Adherence support Prevention/promotion 	<ul style="list-style-type: none"> 337 chronic beds 144 sub-acute beds 269 palliative beds 1 787 mental health clients 2 584 community care workers in 202 NPOs Range and extent of services varies across the districts: <ul style="list-style-type: none"> Rural districts: comprehensive package of care; Metro: services are fragmented and function specific. 	<ul style="list-style-type: none"> Revised CBS policy being developed that describes the packages of care, HR strategy, indicators and targets. Includes: <ul style="list-style-type: none"> De-hospitalised care: including intermediate institutional care for rehabilitation, palliative care, convalescence; Institutional care offering respite care, custodial care and social care. Domiciliary care: community delivered rehabilitation and psychiatric care supported self-care, respite care, day care, home adaption and personal care assistance. Staff numbers per geographic area still to be modelled. Community care workers to function in PHC teams per number of households in a designated geographic area. NPOs to be contracted for specific outcomes along the care-pathways approach. Supported self-care will impact on PHC, acute and specialised services by providing a range of interventions within the community. 	<ul style="list-style-type: none"> Full implementation of the revised CBS policy across 32 sub-districts. Evidence based outcomes achieved. Improved NPO contract management.
2. Primary health care	<ul style="list-style-type: none"> 18 staff per 30 000 population PHC utilisation rate: 3.84 Workload calculator: <ul style="list-style-type: none"> Number and skill mix of staff Direct patient care factor of 75% to determine the number of staff required. Provide packages of care: NDOH, 2001. 	<ul style="list-style-type: none"> PHC headcount 16.3 million PHC utilisation 3.5 per total population. Fragmented in CoCT. Metro: Utilisation rate higher than anticipated in some areas but explained by the health seeking behaviour of 'dependent' population who seek certain services close to where they work. Packages of care not evenly distributed across the Metro due to fragmentation of service 	<ul style="list-style-type: none"> Comprehensive integrated BOD focused package of care. Population based PHC utilisation calculator using units of 30 000 population and an utilisation norm of 3.84 per dependant population to facilitate the estimation of the number of staff required per facility and the most appropriate staff mix. PHC service provision per sub district is weighted for the daily migration of workers between sub districts. This is necessary to ensure access to PHC services to people where they live but also where they work. Gate-keepers to rest of the system – co-ordinate the inputs of other services, such as CBS and acute hospital services. Objective is to minimise the number of hospital admissions by ensuring that clients are timeously and appropriately referred. Mutual benefit for client and 	<ul style="list-style-type: none"> Fully restructured PHC Service with an integrated CBS service. Avoidance of hospital admissions would be a marker of good quality PHC and CBS services. All PHC services including the City of Cape Town will be provincialised except Environmental Health

	What were the planned outcomes of Healthcare 2010?	What is the current reality?	What should be done differently in 2020?	What will be the envisaged service platform by 2020?
			contribute to an effective and efficient system.	
3. Acute hospitals	<ul style="list-style-type: none"> Beds in L1 and L2 determined by admissions per 1 000 population. Level 3 beds determined by NTSG. L1, L2, L3 clearly demarcated 85% bed utilisation rate. Staffing determined by level of care and time allocation per average patient and admin, teaching responsibilities. 	<ul style="list-style-type: none"> Patients are not cared for in clearly demarcated L1, L2, L3 beds Uneven utilisation of beds, beds neither optimally utilised nor distributed. Too many paediatric beds are underutilised in some institutions. Bed utilisation rate in some rural districts is low. District hospital beds in the Metro currently do not provide the full package of care. High care and intensive care beds – not confined to specialist hospitals. Rate of increase in service load especially in regional and central hospitals is slowing down. 	<ul style="list-style-type: none"> Population based bed norms per type of hospital will be determined in the on-going modelling process. Indications are that the current acute beds are underutilised and inappropriately utilised. At this stage it seems that the bed norm for 2020 will therefore not be increased but bed numbers will be adjusted to allow for population growth. The number of beds for central hospitals will be adjusted within the available conditional grant budget. Target bed utilisation: 85% facilitated by bed management and optimal patient flow. Hospitals function as a part of an integrated BOD focused package of care appropriate to the GSA to achieve health outcomes. Specialist led teams – strong outreach and support and access to higher levels of care in DHS. Acute hospitals will have improved links with: <ul style="list-style-type: none"> Intermediate care, PHC and CBS. Specialised hospitals and higher levels of care. 	<ul style="list-style-type: none"> Deliver focused packages of care to achieve the desired outcomes in the GSA. Seamless access to comprehensive quality services by skilled and competent staff. Khayelitsha and Mitchells Plain Hospitals will be fully functional. This will impact on current health seeking behaviour and referral patterns.
4. Specialised hospitals	<ul style="list-style-type: none"> Psychiatry: <ul style="list-style-type: none"> De-hospitalised IDS Distinction between psychiatric and intellectually disabled patients. De-hospitalise IDS and long-term psychiatric patients. Increase capacity to manage acute patients in general health service. 	<ul style="list-style-type: none"> Psychiatry: <ul style="list-style-type: none"> Pressure due to substance abuse. Innovative models of care in the community due to de-hospitalisation. Intellectual disability: <ul style="list-style-type: none"> Care has shifted from hospitals to alternative care. Packages of care are not well defined. 	<ul style="list-style-type: none"> Psychiatry: <ul style="list-style-type: none"> Develop general mental health care capacity at all levels of care. Access to chronic care in integrated services. CBS will be provided in intermediate care/ long-term and supported self-care. Intellectual disability: <ul style="list-style-type: none"> Review IDS policy Models of service delivery are envisaged to facilitate the de-institutionalisation of these clients. Care pathway is between home-based care, PHC services, intermediate care and specialised psychiatric care. 	<ul style="list-style-type: none"> Focused packages of care and outcomes for the specific GSA. Mainstream service strengthened with care pathways. Psychiatric hospitals: <ul style="list-style-type: none"> IDS residential care should be managed within the broader social network rather than by Health except for clients with dual diagnosis and complications that require specific health care
	<ul style="list-style-type: none"> Western Cape Rehabilitation Centre: (WCRC): <ul style="list-style-type: none"> High intensity rehabilitation 	<ul style="list-style-type: none"> Western Cape Rehabilitation Centre: (WCRC): <ul style="list-style-type: none"> Rehabilitation not integrated. Work needs to be done developing rehabilitation at other levels of care. 	<ul style="list-style-type: none"> Western Cape Rehabilitation Centre: (WCRC): <ul style="list-style-type: none"> Align model of care with other specialised services. Strengthen rehabilitation within DHS. 	<ul style="list-style-type: none"> Western Cape Rehabilitation Centre: (WCRC): <ul style="list-style-type: none"> Investigate alternate models for the provision of Orthotic and Prosthetic services, for improved waiting times.
	<ul style="list-style-type: none"> TB hospitals: <ul style="list-style-type: none"> National decision to provincialise TB 	<ul style="list-style-type: none"> TB hospitals: <ul style="list-style-type: none"> 6 TB hospitals Drug resistant TB 	<ul style="list-style-type: none"> TB hospitals: <ul style="list-style-type: none"> Revise number of projected TB cases 	<ul style="list-style-type: none"> Good quality TB Hospital care that works as part of an

	What were the planned outcomes of Healthcare 2010?	What is the current reality?	What should be done differently in 2020?	What will be the envisaged service platform by 2020?
	<ul style="list-style-type: none"> ○ hospitals ○ TB case load projections based on ASSA model and assumption that a certain level of acuity required hospitalisation. 	<p>management</p> <ul style="list-style-type: none"> • XDR-TB emerged since the development of Healthcare 2010. • Not all patients with MDR TB are hospitalised. 	<ul style="list-style-type: none"> ○ Implement decentralised drug resistant TB management. ○ Manage the patient flow between CBS, PHC and acute and TB hospitals more efficiently. ○ Strengthened CBS and PHC to increase active case-finding, improve compliance, reduce defaulter rates etc. 	<p>integrated platform with acute hospitals, PHC and CBS.</p>
5. Emergency medical services	<ul style="list-style-type: none"> • Access in all six districts • Response times • Patient transport: for patients requiring non-emergency transport between services. 	<ul style="list-style-type: none"> • Good rural response times • Good aero-medical services. • Rescue equipment equitably distributed but insufficient. • Planned patient transport requires further development in the Metro. 	<ul style="list-style-type: none"> • Establish care pathways for people requiring EMS. • Integrated ICT and CAD solution to facilitate dispatch. • Introduce a helpline. • Patient transport: expanded to facilitate access to facilities with close co-ordination with CBS and PHC services. 	<ul style="list-style-type: none"> • Improved access (response times) • Improved patient outcomes. • Improved access to rescue services. • Impact of upstream interventions.
6. Forensic pathology services	<ul style="list-style-type: none"> • Transfer from SAPS from 1 April 2006. • 18 facilities – physical infrastructure a challenge. • Post mortem rate 2/100 000 population 	<ul style="list-style-type: none"> • Post mortem rate 1.64 /100 000 population (national target 2 per 100 000) • Only 5/18 facilities constructed. • Limited capacity for death scene investigation. 	<ul style="list-style-type: none"> • Comprehensive death scene investigation, supported by medico-legal investigation of death. • Adequate laboratory support for qualitative analysis. • Service responsive to the BOD. 	<ul style="list-style-type: none"> • 18 fit for purpose centres. • Death scene specialised investigation.

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